Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF
THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.divisionofpsychotherapy.org

BULLETIN

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2012 VOLUME 47 NO. 3

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PSYCHOTHERAPY BULLETIN

Published by the
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American Psychological Association

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PSYCHOTHERAPY BULLETIN

Official Publication of Division 29 of the American Psychological Association

2012 Volume 47, Number 3

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PRESIDENT'S COLUMN

Psychotherapy: The Treatment of Mental Disorders or Problems in Living?

Marvin R. Goldfried, Ph.D.
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Given the increasing pressures for empirical accountability by professional organizations, policymakers, and third party payers, it is important to examine the evolution of psychotherapy outcome research over the years. For the most part, outcome research began in the 1950s, and moved on to the second generation in the 1960s and 1970s. The current research paradigm—now called clinical trials—began three decades ago in the 1980s. These paradigm changes, especially the third, have very important implications, not only in how we carry out therapy research, but also how we conceptualize and conduct therapy.

A Brief Overview of Psychotherapy Outcome Research

In the 1950 A*nnual Review of Psychology*, Snyder provided a summary of the research that had been done on psychotherapy outcome to date; he was able to summarize it within the confines of a single chapter. At that time, as the field began to recognize the importance of obtaining evidence on whether therapy actually produced change, it did so by addressing the very general question: "Does psychotherapy work?" The therapy that was studied primarily consisted of psychodynamic treatment, the methodology lacked rigor and sophistication, and the specification of the therapy interventions and outcome was general and vague. Nonetheless as the first generation of therapy research, it set the stage for what was to come.

The second generation of outcome research took place during the 1960s and 1970s, and was directed toward addressing a more specific question, namely "Which specific interventions are more effective in dealing with which specific problems?" For the most part, the interventions consisted of different techniques associated with behavior therapy and cognitive-behavior therapy, and marked the beginnings of a greater methodological sophistication in outcome research. Behavior therapy had its roots in basic research, where it was assumed that the extrapolation of research findings from the laboratory could have important clinical implications for practice. As an additional benefit associated with this line of thinking, there came a methodological sophistication for conducting outcome research. With preliminary findings pointing to the promising impact of behavioral treatments, the NIMH began to provide funding for carrying out outcome research. In what eventually became an impressive array of different studies of behavior therapy, various clinical interventions, such as desensitization, relaxation, and role playing were applied to different target problems, such as phobias, anxiety and unassertiveness. This generation of research was also characterized by the use of therapy manuals, whereby behavior therapy techniques, which were clearly delineated, could be specified with clinical guidelines. Although there was an important methodological advance over the first generation, generation II of psy-

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chotherapy outcome research was limited by the fact that the participants in the studies consisted primarily of college students, with graduate students serving as therapists.

Psychotherapy outcome research moved into its third generation in the 1980s. Many of the methodological advances in the previous generation were retained and some improvements were made, such as the independent rating of whether therapists indeed followed the specific treatment manual. However, in line with the fact that the NIMH shifted its preferred research model to that used in the investigation of drugs, "target behaviors" became "DSM disorders" and "outcome research" became "randomized controlled trials" (RCTs). All of this was a portent of things to come, where biological psychiatry categorized what we had once thought of as "psychological problems" as now being "clinical disorders."

Has the Medical Model Highjacked Psychotherapy?

Change does not always equal progress. The shift to our third and current generation of psychotherapy outcome research—the RCT model that addresses DSM-diagnosed disorders—has raised concerns from practicing clinicians and therapy researchers alike. Some of these have been spelled out in detail elsewhere (e.g., Goldfried & Wolfe, 1996). And while we may have become accustomed to this being the way research should be done, it might not be in the best way to advance the field. Interesting enough, Allen Francis, chair of DSM-IV—and also a practicing therapist—highlighted the clinical limitations associated with RCTs that are directed toward treating DSM-disorders. In the introduction to the DSM manual (American Psychiatric Association, 1994), Francis was clearly aware of the gap between RCTs and the practice of therapy:

> Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable information about the person being evaluated beyond that required to make a DSM-IV diagnosis (p. xxv).

If he is correct in his observation—and most practicing therapists are likely to agree that he is—one need take great care in unquestioningly generalizing the results of RCTs to clinical practice.

At present, when we think about the evidence supporting the efficacy of therapy, we associate it with the findings of RCTs. With our current emphasis on the medical model that guides drug research, it not only changed how we conduct research on psychotherapy, but also how we think about clinical problems. As noted above, no longer do our patients have problems in living, but rather have "mental disorders." No longer are certain problematic issues in a person's life functionally related to other problematic difficulties, but rather there exists "comorbidity." As a therapist and researcher, I find it very difficult to bring myself to think this way. If a patient is both anxious and depressed, probably like most therapists, I look for the possible causal relationship between the two (e.g., anxiety may interfere with functioning, which then leads to anxiety).

The funding practices of the NIMH have very clearly shaped research on psychotherapy to follow the medical model, which is not always consistent with how one practices clinically. In more recent years, because of its shifting research priorities toward biological psychiatry, NIMH funding for psychotherapy re-

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search has become harder to come by. However, if they are supporting less of less of generation III therapy research because their priorities have been placed elsewhere, it may provide an opportunity to step away from the current research paradigm of investigating how to treat clinical disorders. Perhaps it provides us with the opportunity to return to an aspect of the earlier research model—generation II—where the research addressed such more focal and clinically relevant issues as perfectionism, passivity, reluctance to become involved in a close relationship, and the like. Perhaps we need a new paradigm, which includes some of the methodological advances of generation III, but with a focus on the more clinically meaningful issues of generation II. I would be interested in hearing your thoughts on this (marvin.goldfried@sunysb.edu).

The
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EDITORS' COLUMN

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This issue of the *Bulletin*, arriving on the heels of the APA Convention in Orlando, Florida, allows Division 29 members the opportunity to fondly recall colleagues seen and presentations heard, and consider avenues for greater involvement in the Division. It was a pleasure to meet current and future Division 29 members at the Convention booth, and thanks go to Annie Judge for organizing the booth and to the many Division 29 members for manning the booth during the Convention. Thanks also to Tracey Martin, who was also a regular fixture at the event!

We have an array of topics in this issue of the *Bulletin*, all of which we hope will be of interest. This issue includes a thought-provoking exploration of therapeutic presence as an essential factor for effective psychotherapy, an extremely useful piece on evidence based supervision, and two compelling articles from our award winners. We are proud to have three contributions from our students and interns, a collection that speaks to the broad scope of graduate training and interests: an article on brief interventions for corrections, a helpful look at the ethical importance of self-care for graduate students, and a discussion of pregnancy and psychotherapy. Finally, the Washington Scene contribution, as usual, includes up to date information related to psychology and politics.

We are absolutely thrilled that we continue to receive quality articles from students. This is a promising sign for our Division and our field. We encourage all readers to go green and please continue sending us your ideas, questions, comments, suggestions, and submissions to the email addresses provided below.

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Correction: In issue 47-1, the names of the authors of the article *Musings From the Psychotherapy Office: What We May Be* were inadvertently reversed. The correct order for that article is Barbara L. Vivino and Barbara J. Thompson. We regret the error and apologize for any inconvenience.

Therapeutic Presence: A Fundamental Common Factor in the Provision of Effective Psychotherapy

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In 1957, Rogers articulated the therapist offered conditions (TOC), which he believed were necessary for supporting clients' therapeutic change: empathy, unconditional positive regard and genuineness. Now, far beyond client centered therapy alone, these conditions are viewed as fundamental for the purposes of building a successful therapeutic alliance that can predict good client outcomes across many approaches to psychotherapy. As such, these conditions are now elevated to the status of effective elements of therapy relationships (Bohart & Watson 2011; Farber & Doolin, 2011; Kolden, Klein, Wang, & Austin, 2011; Norcross, 2011). At the end of his life, however, Rogers began to articulate an underlying quality that he felt was the deeper foundation of these therapist offered conditions. He noted:

> I am inclined to think that in my writing I have stressed too much the three basic conditions (congruence, unconditional positive regard, and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy—when myself is very clearly, obviously present (in Baldwin, 2000, p. 30).

Since Rogers' death, theorists have continued to explicate the nature of presence as an underlying condition to the relationship conditions (Bozarth, 2001; Bugental, 1983, 1986, 1987; Geller & Greenberg, 2002, 2012; Geller, Greenberg & Watson, 2010; Schmid, 1998; Thorne, 1992; Wyatt, 2000). We suggest here, as did Rogers, that presence is indeed the foundation upon which all therapist offered conditions stand, and that without this fundamental process 'effective elements' of relationship building in psychotherapy find themselves 'groundless.'

Presence is not a new concept. It has garnered attention in several academic communities—in the psychotherapy community as a fundamental quality of a facilitative psychotherapist and therapy relationship (Geller & Greenberg, 2012), in the nursing community as a therapeutic mode or 'gift of self ' offered to patients and the health care system (Bishop & Scudder, 1996; Gilje, 1993; McDonough-Means, Kreitzer, & Bell, 2004; McKivergin & Daubenmire, 1994; Osterman & Schwartz-Barcott, 1996; Paterson & Zderad, 1976), and as a vital component of teaching (Meijer, Korthagen, & Vasalos, 2009; Miller, 2005; Rodgers & Raider-Roth, 2006). Presence has also

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gathered attention in virtual reality and communication communities relating to 'as- if real' interaction with electronic interfaces and provision of virtual experiences (see Lee, 2004 for a review). This kind of virtual present experience is considered essential for clients undergoing virtual exposure therapy (Krijn, Emmelkamp, Olafsson, &Biemond, 2004). These literatures describe the experience of presence as being composed of a number of properties such as involvement, immersion, and the experience of being linked in embodied mutual ways with co-participants and place (Scheumie, van der Straaten, Krijn & van der Mast, 2001). One fundamental quality often described is an experience of being 'really all there,' having the experience of really being here in this place, being really together with this someone (Geller & Greenberg, 2012; Ijsselsteijn, Freeman, & de Ridder, 2001; Lee, 2004; Scheumie, et al., 2001).

Our assumption is that presence is an important common factor that necessarily underlies the provision of both effective therapy relationships and responsive psychotherapy intervention, and that it is time to turn more serious attention to this concept. In this spirit, we offer a way to define therapeutic presence, suggest elements of the experience of presence, including articulating fundamental features of therapeutic presence. We will then touch on an existing model of presence qualitatively derived from expert therapists. Following this, we will suggest how presence can be developed or undermined. Finally we briefly discuss measures of presence, and the nascent research on this concept. We end with a discussion on therapeutic presence as a transtheoretical and common factor in effective therapy.

What is therapeutic presence?

Therapeutic presence involves (a) being in contact with one's integrated, healthy self, while (b) being open to, receptive, and immersed in the here and now, and (c) having a sense of expanded or spacious awareness and perception. This grounded, immersed and expanded awareness must also co-occur with (d) an intention of being with, for, and in service of clients' healing process (Geller & Greenberg, 2012). Bringing one's whole self into the here and now encounter with the client requires a broadband awareness of multiple levels of functioning in both self and client physically, emotionally, cognitively, relationally, and spiritually (Geller, 2001; Geller et al., 2010; Geller & Greenberg, 2002, 2012).

Presence is often described as including sensory and perceptual experiences as well as focused attention. As such, presence is a core process of awareness standing somewhat related to both the gestalt idea of contact (Perls, Hefferline, & Goodman, 1951) and the dynamic idea of evenly suspended attention (Freud, 1912). However presence, we feel, is more than this. We believe the process of presence is more primary, more fundamental, by supporting good contact or readiness to be in receptive contact with one's self, others, and what is emerging in the between. This includes awareness of several sources of information, from the self and the other in the here and now—physical, emotional, cognitive, relational, and spiritual (Geller, 2001; Geller & Greenberg, 2002, 2012). To provide therapeutic presence therefore necessarily involves being grounded in one's embodied self in order to 'receive' the client's experience as it is occurring in real time, as well as concurrently being in contact with one's resonance to clients' experience and one's clinical wisdom.

Presence is, however, more than a capacity to access information. It is also a rela-

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tional attitude because it has as its intent being of service to the client's healing process (Geller & Greenberg, 2012). It is the 'gift of self' (Paterson & Zderand, 1976) a core readiness to be here with another, now. The present therapist brings 'being there,' but also the embodied willingness to facilitate their client's healing (Geller & Greenberg, 2012). This inner willingly receptive state of the therapist, fundamental to presence, supports therapists' understanding (being empathic) and sensitive use of this understanding in order to intervene responsively to the client's in-the-moment experience.

Fundamental features of therapeutic presence

A core element of presence often mentioned is that it is an embodied process. Your body is the interface for 'plugging into' and contacting your perceptions and awareness of any person, place or time. It is through your body by which all information comes to you (Geller & Greenberg, 2012). Only through full embodied contact in the here and now can you perceive- see, hear, intuit, and touch reality with both mind and heart. As such, quality of therapists' presence limits the completeness of information a therapist accesses.

Presence is also a process fundamental to other processes and scaffolds other therapeutic functions. The more one is present the more one can potentially perceive information (from situation, client and oneself). This then can allow for understanding, expressed empathy and compassion. Still, while fundamental to them, subsequent therapeutic functions can dynamically feedback into and intensify further the experience of presence in self and other. A present therapist 'receives' a client and communicates empathy. This often results in the client experiencing their own presence more vividly because being seen and heard can lead to experiencing increased existential certainty of both self and other (Buber, 1965) as well as can reduce anxiety so that a client feels safer and more willing to be present in the room with us.

We also hold a *therapeutic presence theory of relationship*. Presence is relational and communicative. Presence communicates ready willingness to be with and help the client, integrally contributes to deepening the therapeutic relationship, and is in its own right essential to effective therapy (Geller, 2009; in press; Geller & Greenberg, 2012). Also important is that as therapist and client become present with each other, *relational therapeutic presence* also can emerge. Client and therapist presence thereby also deepen as a function of relating fully with each other (Geller & Greenberg, 2012; Geller, in press). This experience of in the moment 'relationship between' creates a sense of spaciousness, access to wisdom, and flow between persons.

A final defining feature is that presence is dynamic and multi-modal. Deep presence provides access to many levels of simultaneous functioning, and facilitates capacities to simultaneously listen and hear, perceive implicit and explicit verbal and nonverbal reactions of self and other, and accurately track self and client in real time. However, let us note here that being present is not multi-tasking, but rather, is a process that gives one, instead, a sophisticated multi-dimensional expanded field of awareness. When deeply present we are not watching and switching across many screens, we are attending to and responding to a perceptual 'jumbo-tron' as it were, that provides us access to multiple dynamic occurring sources of information. A sophisticated, integrated, and holistic awareness of the client, ourselves, being in relation to the client, and 'the be-

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tween' thereby become simultaneously available.

Qualitative modeling therapeutic presence in expert therapists

The first author developed a model of therapeutic presence from a qualitative analysis of accounts from experienced therapists who intentionally practice presence (Geller, 2001; Geller & Greenberg, 2002). The emergent model of therapeutic presence consisted of three over arching categories, reflecting the *preparation, process*, and bodily *experience* involved in being fully in the moment with a client in a therapy session.

Therapeutic presence was reported to begin with **preparing** for presence, *prior to session*, by bringing one's whole being to the moment of meeting the client. This included intention and commitment to therapeutic presence, combined with an ability to bracket expectations, theories and preconceptions. This was also accompanied by approaching the session with an attitude of openness, acceptance, interest and non-judgment. One way therapists reported preparing for presence was by practicing it *in their daily lives* through meditation and attention to personal growth. Therapists also described the essential importance of on-going self-care of needs to creating their capacity for in-session presence with clients. These therapists knew that adequate self-care potentiated their capacity for presence.

Therapists' presence was also described as involving a moment to moment **process** where the therapist simultaneously experiences being *receptive* to the client's experience, *inwardly attending* to their own on-going flow of experience, and *extending towards* the client. Therapists expressed being ultimately guided by the immediacy of being 'now,' with and for the client. They also reported receiving client's experience in its totality, and using that experience to understand and respond, while maintaining ongoing contact with the client.

The actual in session **experience** of therapeutic presence was reported as involving experiential qualities of *grounding, immersion,* and *expansion*. Therapeutic presence was also experienced as healthy for the therapist, as they reported greater well-being, emotional regulation, decreased anxiety, reduced burn-out, enhanced internal and interpersonal connection, and heightened vitality when they were more present (Geller & Greenberg, 2002).

Facilitating and interfering with the provision of therapeutic presence

Many therapist dimensions can contribute to a capacity for presence. Work on attitude, emotional regulation and equanimity, the capacity to focus and expand attention, as well as developing the capacity to 'be' in a perceptual as opposed to cognitive modes can all help.

An attitude for presence means being willing and intent on approaching and connecting to the present moment and client, with open readiness to receive what is there without prejudice or expectation. Practicing silencing the mind and opening the heart so that one is ready to receive and perceive can be an important part of a preparatory regime for presence. Disciplined mindfulness practice of many types can help develop presence as it enhances attention and awareness of the present moment (Gehart & McCollum, 2008; Kabat-Zinn, 2005; McCollum & Gehart, 2010). Exercises for maintaining multi-track attention (such as feeling one's feet on the ground while being open and receptive) can impact capacities for presence as they strengthen the ability to hold concurrently-occurring bits of information simultaneously in awareness. Strength-

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ening perceptual tendencies, and learning to anchor oneself in embodied experiences of the here and now can also be practiced outside of therapy sessions. This can be as simple as 'staying consistently with,' noticing what is around you as you walk, such as image, colours or smells. It may also be simply pausing every now and then to be aware of what is present in that moment, be it a flower, person or sound.

In session, maintaining eye contact, not fidgeting and trying to assume a restful open and grounded posture support presence. Anchoring perception of both the room and one's body by feeling one's body in the chair, and feeling one's breathing pattern can all help. If strong emotional reactions to clients emerge during sessions, self-reflection outside of session or receiving supervision is essential to reduce emotional vulnerability that will interfere with presence in future sessions.

Presence of the client is facilitated by maintaining the client as 'figural' in your perceptions, welcoming eye contact as well as attuned responsiveness both communicate being with and hearing the client. In the virtual reality literature, the capacity to impact the environment is an essential component of the experience that that one is present in that environment (Scheumie et al., 2001). Fine responsive attunement to your client therefore likely gives the client the experience of both themselves and their therapist really being together. Provision of safety will also increase client presence as it reduces both client anxiety and the tendencies to avoid or escape the present that often accompanies anxiety.

Brain neuroplasticity, such as structural brain changes resulting from attending to the present moment with openness and acceptance, have been noted by functional MRi research (Cahn & Polich, 2006). Therefore consistently generating the experience of presence strengthens neural pathways by which presence can be again activated. Full presence has been shown to also result in a sense of calm alertness by activating fundamental, central circuits of the nervous system, and balancing the autonomic nervous system (Hanson, 2009). Therefore accessing and sustaining the capacity for presence with a client in part depends on developing this skill (Geller, in press). Inner training, ongoing practice and a commitment to continued growth and engaging in healthy relationships is required. For cultivating presence through practicing qualities of presence (i.e., through pausing, clearing a space, grounding, self-care) see Geller & Greenberg, 2012, Chapter 12.

Another way to understand presence is to consider 'anti-present' behavior, behaviors that communicate absence, leaving or the wish to leave, or distancing from the here and now, the client, or ourselves. Increasing vigilance for, working with, or removing the obstacles (i.e., busyness, technological demands, anxiety, unresolved issues, distractions) that can interfere with being present is therefore also important.

There are a myriad of ways that we as therapists 'leave' or 'break contact' with both our present sense of self, here and now, and the client. This can include behaviors occurring even before a session begins, such as being busy before a session (checking emails, texts, calls, pre-session anxiety, self-doubt) that interferes with being able to prepare for presence from even initiating.

Some indicators of non-presence from Geller (in press) prior to a session are: busyness, moving from one session right into the next without pause; not

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listening to bodily needs such as needs for a bathroom break, hunger, thirst; squeezing in email; and stressing about ongoing problems. In session markers may be continuously checking the time in session; constant breaking off eye contact; acting from predetermined ideas/theories of your client; holding a too objective distance from the client or conversely being too enmeshed; being self-judgmental; and feeling bored, fidgety or drowsy. Post-session markers may be lack of vitality, fatigue, and relief that the session is over. Being distracted or not present however is only a barrier if the therapist does not have self-awareness. If a therapist is distracted or distanced and recognizes this, he or she can use this awareness to invite attention back to the moment.

Developed measures of presence and nascent research

Research is beginning to contribute to a deeper understanding of therapeutic presence (Geller, 2001; Geller & Greenberg, 2002, Geller, Greenberg & Watson, 2010; Hayes & Vinca, 2011; Pos, Geller, & Oghene, 2011). For example, the model of therapeutic presence described above emerged from a qualitative study of experienced therapists who either wrote about or practiced presence in session (Geller & Greenberg, 2002). This subsequently resulted in the development of a measure of therapeutic presence, the therapeutic presence inventory (TPI), based on the model (Geller, 2001; Geller et al., 2010). Two versions of the TPI were created and studied: one from the therapist's perspective (TPI-T) and the second from clients' perception of their therapists' presence (TPI-C). Both versions of the TPI were found to be reliable and valid (Geller et al., 2010). Further, clients' perception of their therapists' presence (TPI-C) was found to predict a positive therapeutic alliance and session outcome across Person-Centered, Process-Experiential and Cognitive Behavioral Therapies (Geller et al., 2010). Therapists' self-ratings were *not* found to relate to the alliance or session outcome, suggesting clients' perceptions of therapists' presence is what is important.

Research also suggests that therapist rated therapeutic presence predicts clients' perception of their therapists' provision of empathy, congruence, and unconditional regard (Geller et al., 2010). With respect to presence and empathy in particular, findings suggests that they are related yet distinct variables; and that presence precedes empathy. For example, Hayes & Vinca (2011) found that therapists' presence (from both the therapist and the client's perception) was related to empathy; and suggest that presence is a prerequisite for empathy. A study by Pos, Geller, & Oghene (2011) also showed that in experiential therapy for depression clients' ratings of therapists' presence in the third session predicted client ratings of therapist empathy later in therapy as well as independently predicted the therapy alliance twelve sessions later, even after later clients' perceptions of therapist empathy were controlled for. Another interesting result found in this study was that clients' ratings of their therapists' presence were again better predictors of all other process variables than therapists' ratings of their own presence. Clients therefore do make distinctions between therapist communicated presence and empathy. In order for this to be possible clients must be referring to different therapist behaviors while making these distinctions. A question for future research is how do clients make this distinction between presence and empathy? Differentiating these therapist behaviors would permit a more refined examination of both therapist processes, help us differentiate presence from other therapist behaviors, as well as perhaps

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allow more refined training in skilful presence.

Presently, attempts are being made to address this issue using a task analytic methodology (Pascual-Leone & Greenberg, 2009). Using a rational model of presence developed from the literature, therapist behaviours within sessions of experiential therapies, previously rated by clients as high or low in therapist presence, are being observed for presence markers to inform an observational measure of presence that can be later validated in further process studies (Colosimo & Pos, 2012). Other directions for research on presence may fruitfully include functional MRi studies, or studies of other neural process such as ANS arousal or vagal tone (Porges, 1998). Relative activation of neural hemisphere paradigms might also be relevant as it may be that the integration of multiple areas of the brain occur in those therapists that achieve a present state consistently (Siegel, 2010).

Summary – Therapeutic presence as transtheoretical

The thesis we have presented here is that therapeutic presence is a foundational and transtheoretical therapist process. It underpins other therapy processes and is powerful in and of itself. Presence can promote a positive therapeutic alliance and allow for optimal efficacy when accompanied with modality specific techniques (Geller & Greenberg, 2012). Intervention delivered to clients without attuned contact to what is presently occurring in the dynamic field of client, self, and the relating between, 'hamstrings' the person-to-person encounter at the heart of all psychotherapy. It therefore also undermines the effectiveness of any intervention/techniques. Alternatively, intervention offered within therapeutic presence optimizes intervention of all modalities. This thesis is supported by presence psychotherapy research that indicates that therapeutic effectiveness is enhanced when techniques are delivered in the context of a positive relationship (Goldfried & Davison, 1976).

While the concept of presence 'naturally fits' humanistic principles, presence is not solely relevant to humanistic approaches. Rather, presence must be viewed as a common helpful stance across therapeutic approaches, whether psychodynamic, emotion-focused, gestalt, cognitive behavioral, and dialectical-behavioural. Presence is the first step to effective therapy. It is 'showing up' in the therapy hour to the client, to oneself as a clinician, and to the dynamic process that both therapist and client enter together in every moment of the therapy hour. Even if certain therapeutic approaches argue that their change processes are more technical than relational, such as cognitive and behavioural therapies may, these therapies increasingly identify therapeutic relationship or rapport as important, helpful, and facilitating for the use of such techniques (Goldfried & Davila, 2005; Holtforth & Castonguay, 2005; Kanter, Rusch, Landes, Holman, Whiteside, Sedivy, 2009; Lejuez, Hopko, Levine, Gholkar, & Collins, 2005; Linehan, 1993; Waddington, 2002). And while the primary focus in CBT is changing thoughts and behaviour in relation to the world "out there," current perspectives have begun to emphasize both the therapeutic relationship and the here and now of the therapeutic encounter as an important target of 'hot cognitive work' (i.e., Castonguay, Schut, Aikins, Constantino, Laurenceau, Bologh. et al., 2004; McCullough, 2000; Safran, 2002) .

We are not proposing that presence is a replacement for technique, rather therapeutic presence can validly be viewed as

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a foundation for all theoretical orientations and as an archetypal conduit for enhancing listening and attunement, accurate responding and optimal use of intervention (Geller & Greenberg, 2012). Hence, any psychotherapy training program will benefit treatment outcomes by cultivating therapists' capacity for therapeutic presence.

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

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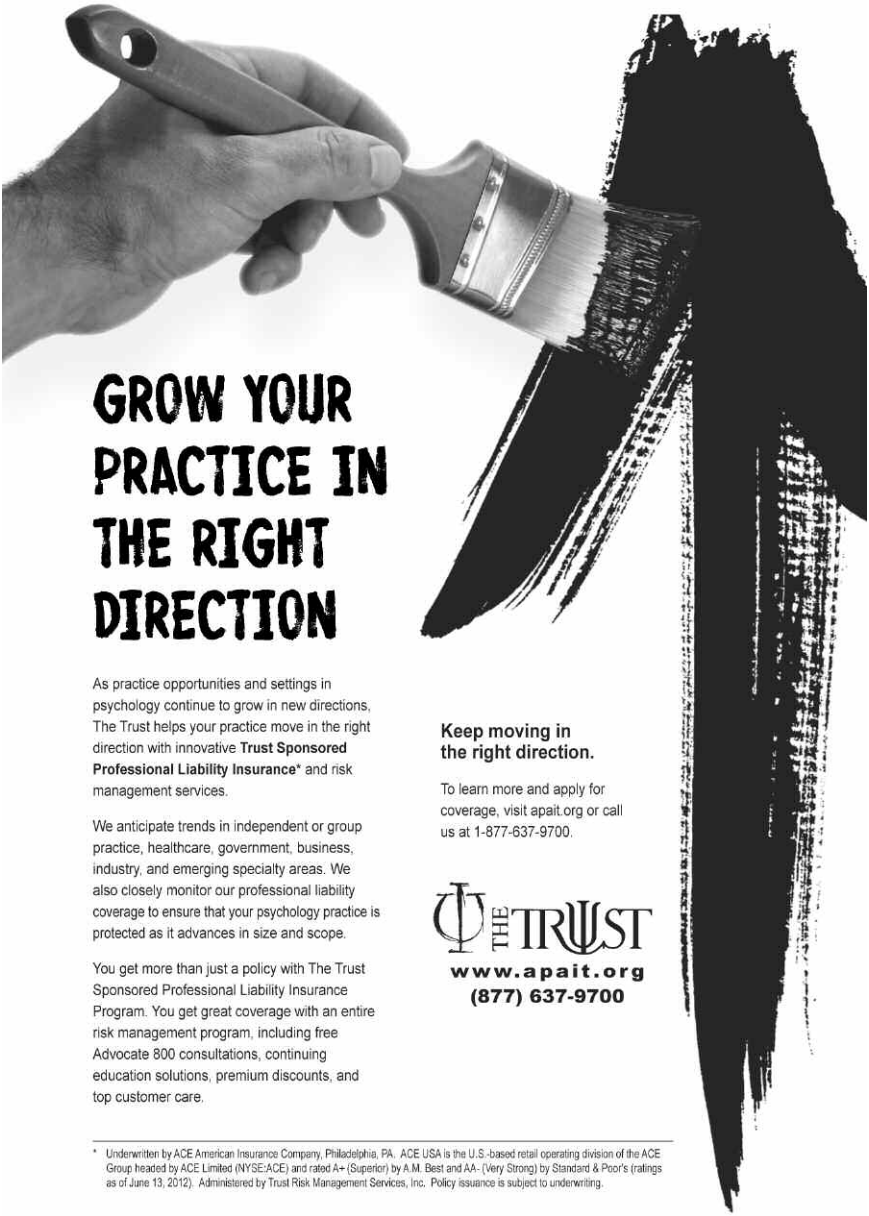

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Promoting Self-Forgiveness and Well-Being: Testing a Novel Therapy Intervention
Charles J. Gelso, PhD, Psychotherapy Research Grant Recipient

Marilyn A. Cornish, MS
Iowa State University

It was an honor to receive the 2012 Division 29 Charles J. Gelso, PhD, Psychotherapy Research Grant, which was established to advance research on psychotherapy process and/or outcome. This grant will cover a portion of the costs associated with my dissertation research, a study designed to examine the effectiveness of a new self-forgiveness counseling intervention. Below I present a summary of the research proposal for which I was awarded this grant. First, however, I would like to thank Division 29 for sponsoring this grant and especially for the explicit recognition of a graduate student in alternating years. In addition, I would like to thank my graduate advisor, Dr. Nathaniel Wade, for his support and mentorship. His dedication to graduate student mentorship has played a large role in my development of the skills necessary to complete this dissertation research.

Goals of the Study

The primary goal of the proposed research is to determine whether an individual counseling intervention can help people forgive themselves for past actions that have harmed others. Specifically, I am interested in whether a novel eight-week intervention helps people to increase self-forgiveness and decrease self-condemnation and psychological distress relative to a waitlist control. The intervention is designed to help people take appropriate responsibility for their actions, identify their own methods of making amends, develop greater self-compassion, and mitigate excessive self-criticism. The second goal of this research is to identify client variables that influence the rate of change in self-forgiveness over the course of the intervention.

Relevant Background

Offending or harming others is an inevitable part of life, ranging from comparatively minor offenses like speaking harshly to a loved one to much more severe acts of harm such as causing a car accident that seriously injures someone, being unfaithful to one's spouse, or verbally abusing one's children. Causing harm to another—whether intentional or unintentional at the time—can later cause deep remorse, self-blame, or shame. Although such responses can be appropriate following hurtful actions, the perpetuation of those feelings and the development of harsher, more critical feelings often create more problems than they solve. For example, research has demonstrated that holding on to shame and self-condemnation is related to negative psychological outcomes and a reduced capacity to effectively relate to others (Friedman et al., 2007; Ingersoll-Dayton & Krause, 2005).

Just as forgiveness of others has been found to be an effective means for victims to overcome past hurts (Baskin &

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Enright, 2004), it appears that self-forgiveness can lead to positive changes for the offender. Self-forgiveness has been defined as "a willingness to abandon self-resentment in the face of one's own acknowledged objective wrong, while fostering compassion, generosity, and love toward oneself" (Enright & the Human Development Study Group, 1996, p. 115). Those who are able to both accept responsibility for their offense and forgive themselves for it have lower levels of depression, anger, and anxiety; greater satisfaction with life (Thompson et al., 2005); and greater prosocial behaviors, such as repentance and humility (Fisher & Exline, 2006). Self-forgiveness has thus been linked to positive intrapersonal and interpersonal outcomes.

Counseling interventions that promote interpersonal forgiveness have been found to be effective (Baskin & Enright, 2004). However, no published empirical examinations of self-forgiveness counseling interventions were found in the literature. Therefore, the purpose of the current study is to develop and test the effectiveness of an individual counseling intervention for those struggling to forgive themselves for past interpersonal offenses. This is a manualized 8-session intervention I have developed in collaboration with my research advisor, Dr. Nathaniel Wade.

Due to the centrality of emotional awareness and expression in the self-forgiveness process, emotion-focused therapy (Greenberg, 2010) was used as the grounding theory for the intervention. The intervention is designed to help clients accept an appropriate level of responsibility for the offense, resolve the negative self-defeating feelings associated with the offense, determine appropriate ways of repairing the damage caused, and move forward with a renewed sense of self-acceptance and self-compassion. The intervention includes discussions, experiential exercises, and homework activities. Experiential activities include a two-chair exercise to reduce self-condemnation while accepting responsibility, an empty chair exercise in which participants express their remorse to the person harmed, and an imagery exercise that helps increase positive feelings of self-forgiveness. Sessions at the end of treatment focus on promoting personal growth to reduce the likelihood of future offenses, resolving lingering negative emotion, and increasing self-forgiveness.

The current study will test the effectiveness of this new intervention relative to a waitlist control. I hypothesize that the intervention will result in greater self-forgiveness and lower self-condemnation and psychological symptoms than what would naturally occur over time. Difficulty forgiving oneself has been linked to both self-condemnation (e.g., Fisher & Exline, 2006) and psychological distress (e.g., Thompson et al., 2005). Therefore, it is anticipated that the increases in self-forgiveness expected over the course of the intervention will also result in lower levels of these negative emotional states.

Secondarily, I will examine whether three client factors predict increases in self-forgiveness over the course of the intervention. First, I hypothesize that trait self-forgiveness (Thompson et al., 2005) will predict greater increases in state self-forgiveness over the course of the intervention because those who have a disposition to forgive themselves should find it easier to achieve self-forgiveness for the specific offense targeted in the intervention. Second, I predict that participants with higher levels of neuroticism will have more difficulty forgiving themselves over the course of the intervention, as neuroticism has been previously linked to such difficulty

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(Leach & Lark, 2004). Third, because of the role emotions play in self-forgiveness and the emotion-focused nature of the intervention, I predict that participants will benefit more from the intervention if they demonstrate greater clarity of feelings (i.e., ability to understand one's emotions). Indeed, clarity of emotions has been found to be a positive predictor of trait self-forgiveness (Hodgson & Wertheim, 2007) and has been associated with lower levels of depression and a greater ability to recover from ruminative thoughts after a negative event (Salovey, Mayer, Goldman, Turvey, & Palfai, 1995). Those who are better able to identify what they are feeling may be in a better position to work through their negative emotions surrounding the offense and then increase the positive, healthy feelings of self-forgiveness. An examination of these predictors will provide valuable information on client characteristics that may be associated with the treatment's effectiveness.

Target Population

Participants will be approximately 50 community-dwelling adults. Participants must be able to recall an offense they committed against another person that occurred at least three months prior to the start of treatment, and about which they have unresolved negative feelings. Participants will be excluded from the study if they (a) exhibit significant risk to themselves or others, (b) are currently diagnosable with a psychotic disorder, or (c) are receiving psychotherapy elsewhere.

Primary Measures

Established scales will be used to measure self-forgiveness for the offense (Wohl, DeShea, & Wahkinney, 2008), self-condemnation (Fisher & Exline, 2006), psychological distress (Evans et al., 2000), trait self-forgiveness (Thompson et al., 2005), neuroticism (Goldberg et al., 2006), and clarity of feelings (Salovey et al., 1995). Additional personality and offense-specific variables will be measured, as will participants' and therapists' evaluations of the counseling sessions, though these variables are not pertinent to the hypotheses described above. In addition, all counseling sessions will be recorded to allow for checks of treatment adherence.

Procedure

Participants will be recruited through flyers and brochures placed in public spaces, newspaper advertisements, and referrals by local professionals. Potential participants meeting the initial screening criteria will attend an in-person appointment. After providing informed consent for the study, participants will complete a questionnaire packet that asks for demographic information, a description of their offense, and the study measures. A structured clinical interview will then be conducted to assess harm to self and others and psychotic symptoms. Eligible participants will be randomly assigned to the intervention or waitlist condition.

Participants assigned to the treatment condition will start the intervention on the next available appointment that works with their schedule. The intervention will involve 8 weekly 50-minute individual counseling sessions with one of several therapists who hold at least a master's degree in counseling, are currently enrolled in a counseling psychology doctoral program, attended the 6-hour training workshop for the intervention, and receive weekly supervision from a licensed psychologist. During the treatment phase, participants will complete a questionnaire packet before the first session and after the fourth and eighth sessions to assess progress toward self-forgiveness and relief of psychological symptoms, as well as working al-

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liance with the counselor. Finally, participants will complete a 2-month follow-up questionnaire to assess the longer-term effects of the intervention.

Participants in the waitlist condition will wait 8 weeks before they start the intervention. Waitlist participants will complete questionnaires before the first session (their "post-waitlist" questionnaire) and after the fourth and eighth sessions of the treatment. They will also complete the follow-up questionnaire 2 months after treatment.

Data Analysis and Anticipated Outcomes

I will first examine differences in self-forgiveness between treated and waitlist participants by conducting an analysis of covariance (ANCOVA) with group membership (treatment vs. waitlist) as the independent variable, post-treatment/post-waitlist self-forgiveness as the dependent variable, and pre-treatment self-forgiveness as the covariate. Similar ANCOVAs will be conducted to examine the effect of the intervention on self-condemnation and psychological distress. It is hypothesized that treated participants will score significantly higher on self-forgiveness and significantly lower on self-condemnation and psychological distress compared to waitlist participants.

In addition, because waitlist participants will later receive the intervention and complete questionnaires during treatment, growth curve modeling can be used with the full sample to examine the hypothesized predictors of change over the course of the intervention. It is anticipated that trait self-forgiveness and clarity of feelings will positively predict the rate of change in self-forgiveness over the course of the intervention, whereas neuroticism will negatively predict changes in self-forgiveness.

Conclusion

If this new intervention is found to be effective, it can be utilized by therapists working on self-forgiveness with their clients, and it can be a target of additional research. Future research could examine which specific elements of the intervention are most helpful for clients, and the intervention can be tested against alternative treatments. Future research could also begin to tailor the intervention to people with specific concerns, including those with high neuroticism or those who have transgressed against themselves. Thus, this project will serve as an important starting place to spur more research on effective ways of intervening with those struggling to achieve self-forgiveness.

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

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

The Impact of Therapists' Attachment Styles on the Identification of Ruptures and Facilitation of Repairs in Psychotherapy

Norine Johnson, Ph.D., Psychotherapy Research Grant Recipient

Cheri L. Marmarosh, Ph.D.
The George Washington University

I am delighted that I was awarded the Norine Johnson, Ph.D., Psychotherapy Research Grant established by Division 29. Before receiving this award, I was not familiar with Norine Johnson and her work aside from being aware that she once served as the President of the American Psychological Association. After receiving this award, I familiarized myself with her contribution to the field and felt it was necessary to acknowledge the legacy she left behind, which has allowed my students and me to study therapist factors that influence treatment.

Norine was truly a pioneer, being the 9th woman to ever hold the title of APA President. She was also actively involved in state and national psychological associations and was passionate about psychotherapy and how it could be integrated into health care. One of her main priorities was graduate education and the training of future psychology students, and she was well aware of the dearth of research funds that negatively impact graduate training.

She once said, "In today's environment, students have enormous difficulties getting jobs that allow them to advance their careers in the ways that they want…It's not that they can't get jobs—they can get jobs—but frequently they have to take more than one job, and they're not getting the compensation they deserve or the supervision and mentoring that is most helpful" (Martin, 2000, p. 10). I could not agree more with Norine and her perception that we need to do better when we train psychologists. I hope that our research will be a step in that direction and continue the work that Norine pioneered.

This grant will greatly enable me to conduct research in our George Washington University Clinic, which trains approximately 35 new clinical psychology doctoral students every year. Our Clinic is unique because it allows clients to be seen for long-term and short-term psychodynamic psychotherapy, and students are able to work with underserved populations and clients from diverse backgrounds. Given our Clinic's limited resources, I am extremely grateful that this funding will allow us to both study and facilitate the understanding of how therapist factors influence psychotherapy practice. We will use a significant portion of the funding to purchase video equipment that will allow us to record sessions and explore what transpires between new therapists and their clients.

Relevant Background

We know that therapist personal attributes and the therapeutic techniques they employ significantly impact the thera-

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peutic alliance and treatment outcome (Ackerman & Hilsenroth, 2001; Baldwin, Wampold, & Imed, 2007). However, we know very little about what attributes are most helpful and how these attributes influence the specific interactions between therapist and client. Researchers have shown that three robust factors facilitate treatment—therapist empathy, genuineness and engagement (Beutler et al., 2004). In addition to these important attributes, therapists' ability to identify and repair ruptures in treatment has been shown to be important for successful psychotherapy (Safran, Muran, & Eubanks-Carter, 2011). Although we have some understanding of how therapists' skills and techniques influence treatment, we are just starting to understand what therapist personality factors underlie both their abilities to notice ruptures and to navigate repairs that requires empathy and attunement.

Attachment theorists argue that it is one's interpersonal history that underlies her ability to engage empathically, navigate relationship conflicts, take risks, and sustain intimacy in relationships (Bartholomew & Horowitz, 1991; Mikulincer & Shaver, 2005). Researchers have found empirical support for the influence of therapists' attachment styles on their abilities to develop and maintain positive therapeutic alliances (Black et al., 2005; Sauer, Lopez, & Gormley, 2003), engage empathically in response to ruptures (Rubino et al., 2000), cope with hostile countertransference (Mohr, Gelso, & Hill, 2005), and facilitate better outcomes with more severely ill clients (Schauenberg et al., 2010).

In addition to finding support for the influence of therapist attachment on the psychotherapy relationship, researchers have found that there are powerful interactions between therapist and client attachment styles. Romano, Fitzpatrick, and Janzen (2008) found that having a more avoidant therapist working with a more anxious volunteer client related to less session depth. Marmarosh et al. (2011), studying psychotherapy dyads, found similar results where avoidant therapist and anxious client dyads resulted in less client symptom improvement compared to other dyads. In essence, therapists' attachment styles interacted with the clients' attachment styles and influenced both the therapy relationship and outcome.

Although there have been several studies exploring the interaction between therapist and client attachment styles (Dozier, Cue, & Barnett, 1994; Romano et al., 2000; Tyrell et al., 1999), only one empirical study has explored how attachments influence therapist's awareness of ruptures. Rubino et al. (2000) explored the relationship between therapist attachment and empathic responses to ruptures in videotapes of actors portraying different attachment styles, and the results indicated that therapist anxiety negatively related to empathy. This study has never been replicated with actual therapy clients in treatment.

Studies are needed to explore exactly how therapists' attachment styles influence therapists' abilities to (1) identify ruptures with clients who have different attachment styles and (2) engage in the repair of ruptures once they are enacted. Studying clinicians in a training clinic, before they have engaged in years of clinical work, will facilitate an understanding of how therapists' innate interpersonal styles, before years of practice, influence various aspects of treatment, including rupture resolution, the quality of the therapeutic alliance, and treatment progress.

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Method

In order to study the impact of therapist attachment, all participating therapists will complete the self-report assessment of adult romantic attachment, the Experience in Close Relationships Scale (ECR-S; Bennan,Clark, & Shaver, 1998) at the beginning of their training. Participating clients will also complete the ECR-S, the Brief Symptom Inventory (BSI, Derogatis, 1993) and the Inventory of Interpersonal Problems-Short Circumplex Version (IIP-SC: Soldz, Budman, Demby, & Merry, 1995) immediately after the intake and before the first session of therapy.

After each of the first six treatment sessions, both therapists and clients will complete the Working Alliance Inventory—Short Form (WAI-S; Tracey & Kokotovic, 1989), the Session Evaluation Questionnaire (SEQ; Stiles, 1980), and a measure of perceived therapy ruptures (Muran, Safran, Samstag, & Winston, 2004). Clients will complete the Client Attachment to Therapist Scale (CATS: Mallinckrodt, Gantt, & Coble, 1995) following the first and third sessions. The first, third, and sixth sessions of the treatment will be videotaped, and the third session will be coded for ruptures and rupture resolutions by trained raters. At the conclusion of six sessions, participating clients will again complete the BSI and the IIP-SC.

Using two-level (client-level and therapist-level) hierarchical linear modeling (HLM), we will explore how the relationship between client attachment anxiety and avoidance and client-level therapy outcomes (e.g., client reported and observer rated *rupture presence, intensity, and repair*) varies across therapists with different levels of attachment anxiety and avoidance. Through these analyses, we will be able to estimate how much variation in ruptures and repairs could be explained by client rated attachment anxiety and avoidance while accounting for differences across therapists' attachment anxiety and avoidance. Interestingly, we will also be able to use video coded sessions to explore the differences between therapist self-reported ruptures and observer rated ruptures and how therapist attachment anxiety and avoidance influences accuracy of perceived ruptures.

Specific Research Questions

What are the effects of therapists' attachment anxiety and avoidance on client, therapist, and observer rated rupture presence, intensity, and repair while accounting for the effects of clients' pretreatment attachment anxiety and avoidance?

What are the effects of therapists' attachment anxiety and avoidance on alliance change while accounting for the effects of clients' pretreatment attachment anxiety and avoidance and clients'/observers' reported rupture and repair?

What are the effects of therapists' attachment anxiety and avoidance on client rated attachment to the therapist while accounting for the effects of clients' pretreatment attachment anxiety and avoidance and clients'/observers' reported rupture and repair?

What are the effects of therapists' attachment anxiety and avoidance on symptom reduction while accounting for the effects of clients' pretreatment attachment anxiety and avoidance and clients'/observer's reported rupture and repair?

When taking into account the therapists' attachment, we expect that clients' anxiety and avoidance will interact with therapist avoidance, replicating Romano et al.'s (2008) and Marmarosh et al.'s (2011) findings that counselor attach-

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ment will moderate the relationship between client attachment and session exploration, the working alliance, and early symptom reduction. Specifically, we expect that there will be more ruptures (client and observer rated), less repairs (client and observer rated), and less changes early in treatment (i.e., development of the alliance, attachment to the therapist, reduction of symptoms) when more anxious clients work with more avoidant therapists. We expect that less anxious and avoidant therapists will have the least ruptures, and that they will have more repairs when these ruptures do emerge.

My students and I are very excited about the opportunity to investigate these questions about therapist and client attachment interactions in our Clinic. We hope our findings will pave the way for future training interventions. We are also extremely grateful to have access to videotaping, as this will not only allow us to study the therapy process in more depth, but it will facilitate students' current supervision and training. We are eager to hear your thoughts about our research and welcome any feedback about things we might consider as we move forward with our study.

Conclusions

We want to thank the Division again for supporting and helping us move forward with this study.

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A Framework for the Provision of Evidence-Based Supervision

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Initially, much of what was believed about how to be an effective supervisor was derived from personal experience or evidence from other applied fields (e.g., Arredondo, Shealy, Neale, & Winfrey, 2004; Barnett, Cornish, Goodyear, & Lichtenberg, 2007; Bebeau, 1992; Chambers & Glassman, 1997; Epstein & Hundert, 2002; Goodyear & Guzzardo, 2000; Gray, Ladany, Walker & Ancis, 2001). Nevertheless, supervision has long been recognized as an essential aspect to graduate training in psychotherapy. Indeed, with emerging research and deepening of theoretical underpinnings, it has been suggested that supervision may be the most important training mechanism for developing clinician competencies (Stoltenberg, 2005). In an excellent paper underlining the importance of supervision, Falender and colleagues (2004) present a clear argument for training in supervision as a core competency of psychologists. Furthermore, it is necessary that training programs not only provide supervision, but also train students in supervision strategies as part of their development of core competencies (Falender et al., 2004; Rodolfa et al., 2005).

In addition to the rich theoretical literature that has amassed over time (see Watkins, 1997 or Falender & Shafranske, 2004 for excellent texts), the effect of supervision on trainee's in-session behavior has been well documented empirically, including: ability to display empathy, improved interpersonal skills, ability to implement specific treatments, and even trainee attitudes about their clients (Holloway & Neufeldt, 1995; Lambert & Arnold, 1987). In addition, supervisors impact client outcome (for a review of studies, see Freitas, 2002) generating a moderate effect size due, in part, to individual supervisor differences (Callahan, Almstrom, Swift, Borja, & Heath, 2009) or training clinic policies on supervision (Cukrowicz et al., 2005). One possible mechanism of action accounting for improvements in trainee therapy process and outcome may be enhanced confidence, which has been associated with greater motivation to continue learning about psychotherapy, greater participation in practicum training, greater self-efficacy, stronger therapeutic alliance, and better clinical outcomes (Garfield, 1995; Heinonen, Lindfors, Laaksonen, & Knekt, 2012; Martinez & Horne, 2007).

Recognizing the importance of supervision to the training process, and drawing

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from theory, research, and personal experience, Hatcher and Lassiter (2007) made several suggestions for improving supervision experiences in graduate training programs. These included (1) having licensed psychologists specifically trained in supervision, (2) having the necessary equipment for direct observation, (3) making supervision a value, (4) providing adequate feedback to students, (5) protecting the integrity of evaluation from multiple relationship issues, and (6) encouraging research validating assessments of competence. However, a remaining gap in the current literature is a feasible framework that can be used to evaluate supervision activities from an individual supervisor in their work with individual trainees. Perhaps it is not surprising that this gap remains. Training clinics inherently possess feasibility barriers to this kind of inquiry.

Specifically, within the naturalistic psychotherapy training setting, our observation is that assignment of trainees to supervisors may be made based on a variety of criteria other than individual training needs (e.g., equalizing the numbers of students across teams, distributing adjunctive supervisors evenly across trainees at different levels of training, consideration of which supervisors a trainee has already had, personality fit among trainees on a team, and continuity of client care for long-term cases, to name just a few examples). In addition, the small number of trainees on a supervisor's team at any given time is another significant barrier to empirical studies. Many programs admit only a small number of students on an annual basis (Council of University Directors of Clinical Psychology, 1998) and have just a few supervisors, who typically carry a small caseload of trainees (Heffer, Cellucci, Lassiter, Pantesco, & Vollmer, 2006). Thus, for most university-based training programs, it would be impossible to accumulate the necessary sample size to conduct inferential statistical analyses. Finally, the provision of psychotherapy supervision is often time intensive, for both supervisors and trainees, and is often associated with poor compensation for supervisors, in terms of salary/stipend, course credit, or both (Heffer et al., 2006). Any method that requires extensive time demands (e.g., those outlined by Keen & Freeston, 2008) is unlikely to be viewed as feasible by either the supervisor or their trainee clinicians. Thus, an additional consideration pertaining to implementation feasibility is that an evaluative framework must be efficient with respect to time and other resources demanded of supervisors and trainees.

While there are anecdotal accounts of factors that lead to greater supervision efficacy and student reports of methods they found useful for psychotherapy training (e.g., Allen, Szollos, & Williams, 1986; Carifio & Hess, 1987; Nelson, & Friedlander, 2001; Shanfield, Hetherly, & Matthews, 2001), it may be useful to individual supervisors to have a method for examining their own supervisory practices with their students. The current study therefore sought to address the need for a feasible framework to evaluate supervision activities in addition to considering the above-mentioned naturalistic barriers. In particular, the following study utilized a readily- available, succinct psychotherapy training guide, *Education and Training in Solution-Focused Brief Therapy* (SFBT; Nelson, 2005) to teach several basic psychotherapy components (i.e., addressing client complaints, perspective taking/empathy, effective use of questioning, and problem-focused talk about the future). Given associations among trainee confidence, participation in practicum, self-efficacy, and treatment outcome, trainee confidence in each of these skill sets was

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tracked during the course of this highly-feasible training method as an indicator of the effectiveness of supervision.

Method

Participants

Trainee clinicians (n = 6; 66% female, 50% minority; 33% post-masters degree) were pre-internship level students enrolled in a scientist-practitioner, accredited, doctoral program in Clinical Psychology. The standard procedure for this clinic was for the Clinic Director to make all assignments of both trainees and cases; supervisors did not select either students or cases for supervision. Each trainee clinician met with the same supervisor on a weekly basis across a 10-week summer term. In this clinic, supervisors routinely provide didactic instruction or experiential activities in addition to case-based supervision. The supervisor used in this study was previously empirically identified as a highly effective supervisor (Callahan et al., 2009). Although psychotherapy supervisors may serve as research mentors and/or advisors in this program, no such dual relationships occurred between the supervisor and the trainees in this study. Moreover, the supervisor had not previously supervised any of the trainees. Supervision and client services fell broadly within the cognitive-behavioral spectrum, though with case specific variability as needed.

Materials

Education and Training in SFBT (Nelson, 2005) was used as a guide for selecting the training activities used in this study. In addition to its availability (it was co-published simultaneously as *Journal of Family Psychotherapy,* Volume 16, Numbers 1/2, 2005) and concise psychotherapy training activities pertaining to common clinical skills needed for trainees of varying theoretical orientations, the text was chosen because of the set of studies supporting positive outcomes associated with its use (Ferraz & Wellman, 2009). Neither the supervisor nor the trainee clinicians had previously used this text. Although not prohibited, during the course of this study only the supervisor consulted the text for information on provision of the identified training activities. The following training activities were selected from Nelson (2005). However, it is important to note that similar activities delivered in a less structured format targeting non-specific psychotherapy training components may also be used. The activities are described in greater detail below only to aid in elucidating the components of the framework for assessing the effectiveness of supervision. The study is not meant to provide a manualized supervision procedure or support existing procedures.

Dealing with complaining. Trainee clinicians took turns taking on the role of "client" and spent 5 minutes complaining in detail about an issue of their choosing. After listening to the complaining, without interrupting, the trainee in the role of "therapist" generated compliments to the complaining trainee (e.g., complimenting the trainee on their resiliency during adversity). The purpose of the exercise was to switch the focus of the session from a negative perspective about the situation, to a positive attribute about the client given the client's situation (Nelson, 2005; pp. 63-65).

Perspective taking. Student psychotherapists were trained to ask specific questions to assist clients in creating a relational perspective for goal setting via role-play. The trainee "client" complained about another individual. Essentially, this took the form of the "client" agreeing that there is a problem in their relationship with the individual they are complaining about, but con-

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tending that it is the other individual that needs to change. The "therapist" was instructed to imagine the complained upon as if they were in the room and able to hear everything said. The "therapist" was charged with developing questions for the "client" that were fair to both the complainer and complained upon, with the goal of shifting the client's focus to one of joint relational goals (Nelson, 2005; pp. 45-47).

Curious questions. Via role-play, "therapists" were instructed to ask "clients" questions for 5 minutes. This exercise was repeated several times. The questioning began with a menial or boring topic from the "client's" daily life so the "therapist" could learn how to amplify a simple experience by eliciting additional details from the "client." Next, "therapists" were more selective about their curiosity and focused on a salient positive event or goal. In the final repetition, "therapists" focused on a more abstract theme, such as agency (Nelson, 2005; pp. 87).

Future. The purpose of this exercise was to practice helping clients shift from problem-focused talk to talk about the future. Trainees engaged in a conversation aimed at creating a picture of what it would look like when the problem for which the "client" had come in for therapy had been solved or was no longer a problem. The "therapist" was to continue to ask questions about this until (s)he had a clear picture in his/her mind (Nelson, 2005; pp. 119-121).

Confidence ratings. Previous research has suggested a relationship between supervision and self-report confidence levels of trainees (Fong, Borders, Ethington, & Pitts, 1997). Furthermore, trainee clinicians have reported that developing self-confidence in their ability to make appropriate treatment decisions independent of their supervisor was the most important supervision outcome to them (Rabinowitz, Heppner, & Roehlke, 1986; Strozier, Barnett-Queen, & Bennett, 2000). Thus, changes in confidence ratings were used as a measure of the effectiveness of supervision. Each week, psychotherapy trainees were asked to provide a confidence rating on the four skills targeted by the training activities. Ratings were on a scale of 1 to 10 with 1 being "I have no confidence" and 10 being "I feel very confident."

Procedure

Prior to the beginning of the summer practicum term, each week during the term, and following the conclusion of the summer term, trainee clinicians submitted confidence ratings with respect to the specific skills that were the focus on the psychotherapy training activities. The targeted training activities were conducted with trainees in dyads, using live supervision and immediate feedback. Other supervision experiences commenced as per usual, and included individual supervision, discussion of client progress, review of recordings and outcome measures, treatment planning, and review of weekly case notes. Trainees and data were treated in accordance with the American Psychological Association Ethical Code (APA, 2002) and with all Institutional Review Board policies and procedures.

Results

Data from the current study were analyzed using single case design methodology, due to its relative ease of implementation in clinical settings (Watson & Workman, 1981). Trainees' ratings were plotted on a graph across weeks for each of the training activities. Graphs are presented such that the X-axis is weeks of supervision, and the Y-axis presents the trainee's confidence ratings. An initial baseline was established with two weeks of ratings prior to any of the targeted psychotherapy train-

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ing activities being implemented. Only once did two dyads of trainees have the same lesson in one week.

The data were judged based on the four criteria outlined by Kazdin (2003), as he suggested specific aspects for visual inspection. These are mean (the average rating), level (the shift or discontinuity of ratings from the end of one phase to the beginning of the next), slope (the systematic increases or decreases in the variable measured), and latency (the period of time between the termination of the baseline condition and the change in the measured variable). Attached figures are not meant to be representative of the entire sample and were completed for individual trainees to illustrate assessment of the trajectory of changes in trainee confidence, which may be used to inform supervisor effectiveness.

Dealing with Complaining

Refer to Figure 1 for the plot of weekly ratings for two trainees with respect to their confidence in, "*delivering compliments to clients who are highly negative*." Trainee 5 did not participate in the psychotherapy training activity on dealing with complaints, due to illness (thus, the missing data point for this trainee as well as their yoked trainee on this training activity). In examining Trainee 5's ratings across the summer practicum term, it is clear that confidence in using the complimenting skill decreased across the term. In contrast, Trainee 2 participated in the training activity during the third week of the term (as indicated by the vertical dotted line) and demonstrates a clear shift, yielding a positive slope with minimal latency, and evidencing a change in mean following the training activity.

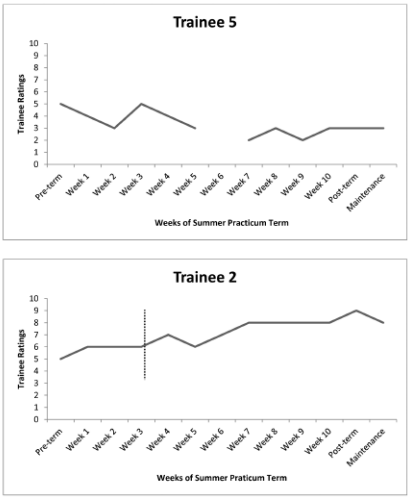

Figure 1. Values represent the confidence ratings provided on a weekly basis by trainees wi respect to the training activity on dealing with complaining clients. Trainee 5 serves as a cor having not participated in the training activity. The vertical dotted line for Trainee 2 indicate point of participation in the targeted training activity.

A paired samples *t*-test using the data available from all four trainees that completed this training activity was conducted to compare the mean rating score before and after the training activity. Results indicated that there was a significant difference in scores from pre-training ($M = 6.00$, $SD = 0.59$) to post-training [($M = 7.64$, $SD = 0.43$); t (3) = -14.21, p = .001]. Thus, both visual inspection and the results of testing indicate that this training activity was effective in promoting trainees' confidence in dealing with complaining clients by using the targeted skill.

Perspective Taking

Figure 2 plots weekly ratings for two trainees with respect to their confidence in "*assisting a client in engaging in understanding the point of view of another person (e.g., with an interpersonal problem)*." For both trainees, missing data is associated with week 6 of the summer practicum term, again due to illness. Despite the missing data point, visual inspection clearly indicates that Trainee 1 experienced a lowering in confidence following training (in week 9), with lower mean ratings and a visually apparent shift to lower confidence. The slope continues on a negative trajectory until a marked improvement during the main-

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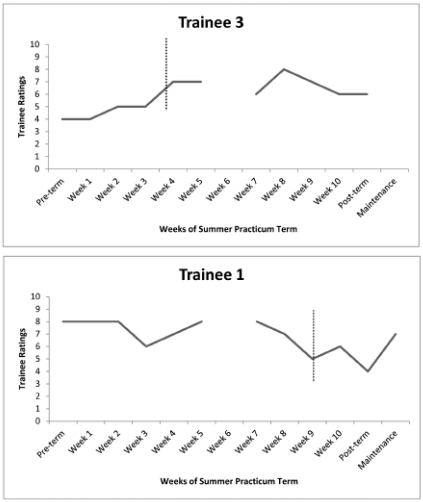

Figure 2. Values represent the confidence ratings provided on a weekly basis by trainees with respect to the training activity on helping clients to consider the perspectives of others. The vertical dotted line indicates the point of participation in the targeted training activity by each trainee.

tenance phase (measured at the start of the following semester). In contrast, Trainee 3 evidenced a clear shift with increased confidence following psychotherapy training (in week 4 of the term), yielding an increased mean rating following the training activity, a positive slope and minimal response latency.

A paired samples *t*-test was again conducted, using data from all of the trainees, to compare the mean rating score before and after the training activity of helping clients to consider the perspective of significant others when forming relational goals. Differences in scores from pre-training ($M = 5.28$, $SD = 1.39$) to post-training [($M = 6.17$, $SD = 1.76$); t (5) = -2.47, $p = .057$] trend towards statistical significance.

Closer inspection of the data indicates that a mean improvement following training occurred for 4 of the 6 trainees. However, the fairly large negative shift from pre-training ($M = 7.5$, $SD = 0.76$) to post-training ($M = 5.5$, $SD = 1.29$) for Trainee 1, coupled by a lack of reliable change by another trainee (pre-training $M = 2.88$, $SD = 0.83$; post-training $M = 3.0$, $SD = 1.41$), appears to have off-set the more modest mean gains post-training for the remaining 4 trainees (Range = 0.82 – 2.21). Thus, both visual inspection and the results of testing indicate that this psychotherapy training activity produced variable outcomes with respect to trainees' confidence in assisting clients in taking the perspective of significant others when forming relational goals.

Curious Questions

For the training activity centered on improving trainees' use of questions with clients, a paired samples *t*-test found that ratings from pre-training ($M = 5.98$, $SD = 1.52$) to post-training [($M = 7.01$, $SD = 1.66$); t (5) = -12.18, $p < .001$] were significantly different. In fact, every trainee exhibited a shift in mean rating from pre-training to post-training, with a mean shift of 1.03 ($SD = 0.21$; Range = 0.7 – 1.28), with respect to, "*using questions to foster interest in a client talking about something you would normally consider dull/boring*." See Figure 3 for illustration of this effect; Trainee 2 demonstrated minimal latency to shift to higher mean ratings, though the slope was modest.

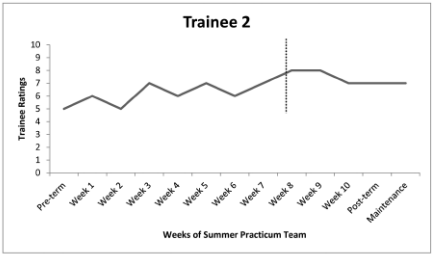

Figure 3. Values represent the confidence ratings provided on a weekly basis by trainees with fo the training activity focused on the effective use of questions during psychotherapy. The vertical dotted line indicates the point of participation in the targeted training activity by the trainee.

Future

Paired samples *t*-test found that ratings from pre-training ($M = 6.40$, $SD = 1.20$) to post-training [($M = 6.51$, $SD = 1.56$) were non-significantly different for the

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training activity on helping clients to talk more about a hopeful future. However, in examining the data more closely, four of the six trainees responded positively to this psychotherapy training activity with increased confidence in, "*being able to picture what the client's life will look like if the problem(s) were resolved*."

As is evident in Figure 4, Trainee 2's confidence shifted to a higher mean level with a positive slope, though there was some moderate latency for this effect to be visually apparent from the ratings. In contrast, Trainee 1, who was yoked with Trainee 2 for this training activity, evidenced a mild negative shift with lower mean confidence ratings (pre-training M = 8.20, SD = 0.84; post-training M = 6.86, SD = 0.69). The other trainee demonstrating a shift to a lower mean confidence rating was Trainee 5, but the slope and latency suggest that this might not have been linked specifically to the training activity since the decline began prior to the actual training activity.

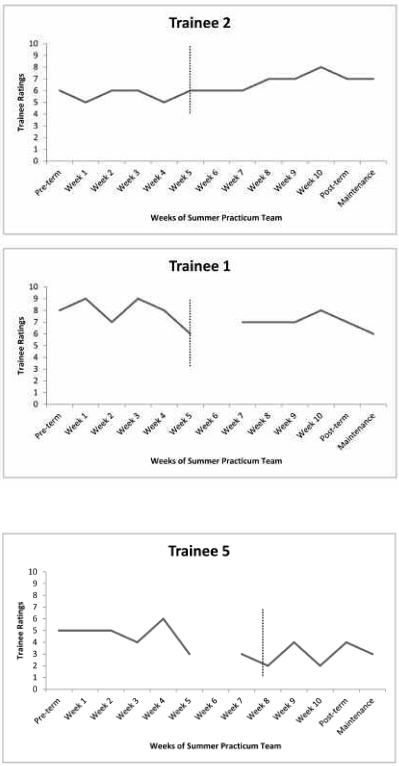

Figure 4. Values represent the confidence ratings provided on a weekly basis by trainees for the activity of helping clients to talk more about a hopeful future. The vertical dotted line indicates the point of participation in the targeted training activity by each trainee.

Discussion

Although numerous researchers and theorists have stressed the importance of being taught specific skills in supervision (e.g. Bernard & Goodyear, 1992; Kadushin, 1985; Munson, 1983; Shulman, 1993a; Shulman, 1993b), trainees have reported that self-confidence is the most important variable to them as they participate in supervision (Rabinowitz et al., 1986; Strozier, Barnett-Queen, & Bennett; 2000). The results of this study indicated that certain psychotherapy training activities were effective in increasing trainees' self-appraisals of confidence, including those related to using questions in session and in dealing with complaining clients. Confidence ratings related to other training activities during supervision were variable and did not seem to point consistently to positive outcomes. With respect to self-appraisals of confidence in the skill of perspective taking, the majority of trainees reported improvements in confidence, one trainee reported a fairly large decrease in confidence, and another showed no reliable change after supervision. Similarly, 2 of the 6 trainees evidenced a negative shift in their confidence ratings after training in talking to clients about a hopeful future.

The existing literature related to self-appraisals of confidence offers a possible explanation for the variability seen in confidence ratings across trainees in this study. Briggs and Miller (2005) noted that therapists, especially those with less

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experience, have a tendency to be self-deprecating and critical of their own performance. In addition, they suggested that psychotherapy supervision could result in a further lessening of confidence, undermining the development of necessary clinical competencies. Research suggests that such decreases in self-appraisals amplify baseline anxiety levels and are the result of fear of negative evaluation by one's supervisor during training (Hale & Stoltenberg, 1988). This increased anxiety has been referred to as objective self-awareness. In short, certain supervision techniques that involve being observed directly by a supervisor or being videotaped or audio-taped can increase self-awareness, heighten a trainee's degree of anxiety, and ultimately result in lower self-appraisals of confidence (Duval & Wicklund, 1972). The training activities in the current study were accomplished during live supervision, which may have contributed to objective self-awareness. However, interacting with supervisors in person cannot (and probably should not) be entirely avoided during training activities. In particular, trainees may learn essential interpersonal, collaborative, and coping (with assessment anxiety) skills for future professional pursuits and direct supervision may lead to a more accurate appraisal of the trainees' strengths, weaknesses, and needs to further enhance training.

Also worth noting is research demonstrating that development of self-confidence tends to occur further along in training (e.g., Marshack & Glassman, 1991; Shulman, 1993a). The poorer outcomes seen in this study were uniquely associated with trainees completing their 1st or 2nd year of graduate psychotherapy training and may lend further support to the observations of these previous researchers. Another possible interpretation is that the supervisor in this study may be more effective with relatively more advanced trainees. There is insufficient data in the current study to explore this possibility, but supervisors that adopt the framework presented in this study are encouraged to attend to possible trends that may emerge across terms.

When using students' self-confidence ratings as an indicator of the effectiveness of supervision techniques, it is important to take into consideration other related variables. Specifically, as Silverthorn et al. (2009) describe, there are many factors relevant in the confidence of the practicum student. Some factors that they described as most important to fostering confidence, such as live supervision, were not the focus of the current investigation; thus, it is unknown how they may have impacted the results. The presence of live supervision or tape review in which the supervisor pointed out positive use of the trained skill may have led to more positive outcomes than the role play exercise alone. The finding that adverse outcomes were associated with trainees early in training may indirectly lend support to this possibility. Students in their 1st or 2nd year of training in this practicum are focusing primarily on assessment referrals, with few (or no) therapy contact hours. Supervision of assessment cases may not have naturally involved much feedback salient to the training activities included in the current study. As noted previously, this was also the supervisor's first time using the above-mentioned training materials, which may have influenced the application of such principles to different types of clinical services.

Though the design of the study allowed for tight experimental control over many factors and variables, it does not necessarily allow for generalization of the findings about the training activities to other supervisors or other settings. Aside from the

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small sample size, the mixed and small effects appropriately limit conclusions about the effectiveness of the particular training activities presented, which may have occurred due to the limited amount of time that could be allocated to each activity. However, it is the methodological framework that this study is meant to highlight with the training activities serving primarily as illustrations.

As noted in the introduction, the established literature on supervision has not offered an economical, easily implemented framework that can be used to evaluate the immediate provision of supervision in the naturalistic conditions of a typical training clinic practicum team. The current study sought to address this gap in the literature, while being sensitive to real-world barriers facing practicum supervisors. This framework included the use of an easily accessible, brief training manual (*Education and Training in SFBT*) with several core modules related to addressing client complaints, empathy, effective questioning, and examination of future goals using problem-focused talk. This or similar training tools can be used with trainees of varying theoretical orientations on practicum teams of a few students with individual trajectories of training needs. Evaluation of the effectiveness of supervision for each of these core competencies can then be assessed by investigating individual trajectories of confidence in each of these domains. The results of the study suggest that the framework presented in this study is a useful and economical approach for evaluating training activities during supervision.

Future studies may want to adopt dismantling designs to assign outcomes with particular supervisory activities. Studies may also benefit from concurrently examining other indicators of successful supervision (i.e., trainee psychotherapy treatment process and outcome variables or supervisor ratings of skill-based competencies) and determining their relations with trainee confidence to explore underlying mechanisms that account for trainee development. Similarly, future studies may want to examine whether supervision modality (i.e., live versus other types of supervision), supervisor characteristics (when using several supervisors), training year, or other trainee characteristics moderate relations between supervision style/technique and training outcomes, while considering supervisee preferences. Researchers may also examine specific and overlapping components of supervision frameworks for clinical treatment versus assessment to facilitate evidence-based supervision practices. Additionally, tracking of particular skill acquisition or competencies over the course of training, across supervisors would aid in understanding the process of trainee development, which may be predicted by either early supervisor ratings or trainee self-assessment. Overall, more studies are needed to extend findings from this small sample, exploratory study and provide empirical evidence to build models of supervision.

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

Maximizing Therapeutic Impact: Brief Interventions in a Correctional Environment

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Working in a correctional environment presents many challenges for mental health clinicians. In most cases, therapeutic work done in this setting is unlike traditional therapy and involves a number of unique factors that influence the nature and effectiveness of treatment. According to the Bureau of Justice Statistics (2011), there were 7.1 million people under the supervision of adult correctional authorities by the end of 2010. Additionally, recent estimates of mental illness within this population report that between "6% and 20% for severe mental disorders… with even higher lifetime prevalence rates when all mental disorders are considered (Weinstein, H.C., Kim, D., Mack, A.H., Malavade, K.E., & Saraiya, A.U., 2005). In consideration of these statistics, it is clear that mental health care is both necessary and implicit for those who find themselves in the criminal justice system.

When considering ways to enhance the effectiveness of mental health treatment in correctional settings, additional factors to consider are the rates of undiagnosed mental illness and psychosocial factors that may influence both criminal behavior and mental illness. One such factor is a history of childhood trauma. Given what is now known about the prevalence of trauma in the general population, it can only be assumed that equivalent rates are present within the offender population. In fact, according to Renn (2002), research on young offenders showed a "history of maltreatment and loss" in almost 90% of those surveyed.

For many people, discussing traumatic experiences, or any experience of mental health symptoms, can be a difficult and painful experience. Additionally, the stigma that is generated about mental illness and treatment within correctional environments further perpetuates the propensity for offenders to deny mental illness or refrain from seeking out services. Furthermore, mental health services in jails and prisons often have limited resources, and thus can usually provide only basic services for offenders, which might include medication evaluations, brief interventions, and/or psychoedcuation. It is within these limited resources that mental health professionals must strive to make therapeutic interactions swift and effective.

While the nature and quality of mental health services may vary, depending on the institution (i.e., jail vs. prison, state vs. federal facility, etc.) intake and/or screening occurs in every correctional setting. According to the *Standards for Psychology Services in Jails, Prison, Correctional Facilities, and Agencies,* published by the International Association for Correctional and Forensic Psychology in 2010, the standard for intake is as follows:

> "All newly received inmates are briefly screened for mental illness and suicide risk as part of the admission to a jail or reception facil-

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ity *prior to* being placed in a general population room or cell. Inmates in need of a more comprehensive mental health evaluation are immediately referred to a qualified mental health services provider" (p. 784).

In a study by Diamond, P.M., Magaletta, P.R., Harzke, A.J., & Baxter, J. (2008), this type of mental health service was identified as the "centerpiece of correctional management and mental health care for offenders." Furthermore, their findings reinforce the idea that intake screening can be utilized as a valuable opportunity to both assess offenders for mental health symptoms and history and determine who may need or seek future services. Generally speaking, whether or not an offender chooses to utilize services, a correctional environment provides a unique opportunity to access an underserved and high-need population. Furthermore, according to Diamond et al. (2008), effective mental health treatment with this population can potentially lead to decreased rates of mental health symptoms, homelessness, substance abuse, suicidality, re-arrest, and re-incarceration.

There are a number of ways that therapeutic interventions can be effective for individuals in the criminal justice system. In particular, for the intake screening to be therapeutically effective, it is necessary for the clinician to focus on: (1) helping the offender to better understand his/her problem; and (2) identifying how they can seek help now or in the future. In a study that evaluated the barriers to treatment responsivity in correctional populations, Anstiss, B., Polaschek, D.L., & Wilson, M. (2009) posited that a lack of motivation to change behavior is often the largest obstacle to rehabilitation. These results suggest that, when possible, treatment interventions should help offenders to identify what their problems are and ways that they can go about addressing those problems. This kind of intervention might help increase self-efficacy, and give offenders a more concrete understanding of themselves and how they might go about initiating the change process.

Identifying the Problem

Helping offenders to identify their "problem" can often be a novel and, at times, impactful experience. Many individuals in the criminal justice system often have no prior treatment experiences, or they have been through a myriad of court-mandated treatment that often develops a treatment plan based solely on their criminal history. Consequently, it seems imperative that mental health clinicians make a focused and precise effort to help offenders generate hypotheses about why they have come to be in the system, and perhaps, how their mental health has influenced this process.

A starting point for this process may be simply obtaining a detailed mental health history. Utilizing a few detailed questions, this process only requires a few minutes. This includes asking the offender about the nature and duration of past treatment, and whether they can identify a history of mental health symptoms. In many cases, this might require psychoeducation regarding the nature and presentation of mental illness, and assisting the offender to provide an accurate history.

Once this process is complete, it is possible to have a discussion with the inmate about how his/her experience of mental health symptoms may have impacted their ability to make positive, prosocial choices in the past. Furthermore, it may be helpful to assist the offender in identifying other factors that may have influenced their criminal involvement. According to the *Risk-Need-Responsivity*

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Model for Offender Assessment and Rehabilitation, developed by Bonta, J. & Andrews, D.A. (2007), correctional treatment should focus on "criminogenic need" which are "dynamic risk factors" they posit to be directly linked to criminal behavior. These factors include: an antisocial personality pattern, pro-criminal attitudes, social supports for crime, substance abuse, poor family/marital relationships, poor performance/satisfaction in work or school, and lack of involvement in prosocial recreational or leisure activities. These concepts can be useful to mental health professionals working in correctional environments in quickly assessing an offender's primary issue(s), and helping them to gain insight into how they have influenced their behavior and thought processes.

How to Seek Help

This next stage of the intake screening process may vary, depending on the setting and availability of resources within a particular institution. For instance, the offender may need to be educated about the mental health treatment options available to them within the facility. On the other hand, they may only be incarcerated for a brief period of time, in which case, they would benefit from acquiring some resources for mental health treatment in their community. As cited in Diamond et al. (2008), the mental health treatment resources that are available within a correctional setting may far exceed what is available to offenders in their community. Consequently, taking advantage of the opportunity to provide treatment for this population and helping to steer offenders towards affordable and accessible services is valuable.

One important facet of this aspect of intervention is working to help increase the offender's motivation to change (and seek treatment). In the study by Diamond et al. (2008), where they evaluated offender characteristics associated with requests for mental health services, they found that only one-tenth of the offender sample had made a voluntary request for services. These findings serve to echo the well-known fact that all those who come into contact with mental health professionals in a correctional setting may not be interested and/or motivated to utilize or participate in services. Furthermore, these findings also have significant implications for the work that must be done by the mental health clinician to increase motivation and, in a sense, "sell" treatment to the offender.

One such approach may be through the use of Motivational Interviewing (MI) techniques. According to Anstiss et al. (2009), the use of a brief motivational interviewing intervention showed positive results in both reducing "criminal risk" and preparing offenders to make progress in future treatment. The primary principles of Motivational Interviewing, by Miller and Rollnick (2004), include developing discrepancy, avoiding arguments, rolling with resistance, expressing empathy, and supporting self-efficacy (as cited in Anstiss et al., 2009). According to Miller and Rollnick (2004), this treatment approach was initially developed to be utilized as a preparation for future treatment. They indicate that MI can be useful to increase client engagement, retention, and adherence to treatment, which suggests that it would be exceedingly useful during an initial treatment exposure or intake session. Through the utilization of these basic MI principles, a mental health clinician could not only offer an offender a sample experience of treatment, but also work towards increasing their intrinsic motivation to seek treatment and make some changes.

Conclusion

It is evident that the need for mental health services within correctional envi-

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ronments is invaluable and something that will continue to increase as we come to understand more about the origins and nature of criminal behavior and as the size of the incarcerated population continues to swell. In the year 2000, studies show that approximately 17,000 offenders received acute psychiatric care and another 122,000 received counseling or therapy within state facilities (as cited in Diamond et al., 2008). Given that these figures are likely an underestimate of the actual prevalence of mental illness or necessity for treatment, it can only be assumed that an increasing number of offenders will seek mental health services in the future while incarcerated.

Given the apparently high need for mental health services in correctional environments, it is increasingly necessary that clinicians make accurate and efficient assessments to best serve this population. Furthermore, maintaining a focus on delivering effective, brief interventions might increase the likelihood that offenders seek services, and thus, make progress toward rehabilitation and reintegration into the community. Mental health clinicians working in correctional settings are faced with a unique and important opportunity to both educate the offender population about mental illness, and to help identify those in need of services.

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Ethics and Self-Care: The Experiences of Two Doctoral Students

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As doctoral students, it is common to hear our peers describe high stress levels as they take challenging classes, complete time-consuming homework requirements, learn to treat clients for the first time, apply for competitive practicum sites, receive many hours of supervision, prepare for comps exams, and approach the daunting internship match, while trying simultaneously to have some sort of balanced personal life. According to Schure, Christopher & Christopher (2008), stress can lead to and worsen many mental disorders and physical illnesses, including anxiety, heart disease, depression, hypertension, substance abuse and gastrointestinal problems. Of course, mental health professionals are not immune from such problems (Schure et al., 2008). As psychologists in training, we have a duty to act in the best interests of our clients, and to ensure they are being treated with the best care possible, which means adhering to the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010), hereinafter referred to as the Code. Yet when we experience stress, it is more likely that we perform our duties subpar.

Barnett, Baker, Elman, & Schoener (2007) have argued that self-care is an ethical necessity to prevent impaired professional functioning. Clearly, clients benefit when student psychotherapists take proper care of themselves physically and mentally. Thus, we have written this paper to share our experiences on ensuring the enhancement of self-care as students, primarily through yoga and meditation.

Under Principal A: Beneficence and Nonmaleficence, of the Code, it is indicated that psychologists must endeavor to do good and do no harm. In particular, "psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (APA, 2002). Standard 2.06: Competence, of the Code further states, "when psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they should take appropriate measures…" (APA, 2002). Such appropriate measures include supervision, consultation, limiting, suspending, or terminating their duties as psychotherapists (APA, 2002). Thus, the Code indicates our obligation to take sufficient care of ourselves and requires that we take sufficient steps to do so. While many students can help clients manage stress, few actually follow through on their own advice (Myers et al., 2012). Yoga and meditation programs can be ways to help doctoral students practice better self-care.

Studies on yoga philosophy have indicated that our minds tend to fluctuate, gravitating towards our desires or away

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from what we find aversive, while running towards future worries or becoming overly concerned with past mistakes. However, when we are able to be fully present, our mind becomes focused on peace, calmness, and joy (Brown & Gerbarg, 2009). This state is desirable but difficult to acquire. In talking to our peers, handling high levels of stress by increased self-care and a peaceful mental state is obviously quite appealing. Nevertheless, many students feel unequipped to practice various kinds of mindfulness. Lack of time and other resources seem to present occasional obstacles for many graduate students, and it is likely that these barriers impede the ability to seek out healthy activities that increase self-care.

In order to improve our own self-care, we began to consider how to implement a yoga and meditation practice in our graduate program. Our journey began with requesting permission and space for a yoga or meditation class. We learned, however, that the university's risk management department prohibited this, so our next attempt focused on moving our meditations and yoga practices outdoors. Although many of our fellow students had verbalized an interest in yoga in the park, this winter was particularly frigid and it became clear that holding sessions outside was not an option. Thus, we offered our first yoga class off campus in one of our homes. Although this initial attempt was unsuccessful, we were hopeful that our continuing efforts would gain success.

The next venture was again held off campus, a chance to offer meditation 101 under the instruction of a mindfulness-based psychologist. While only three people attended, it was evident that our group was growing. We were encouraged by the fact that not only doctoral students participated, but people from masters programs as well. We remained optimistic after receiving positive feedback and support from two respected professors in our program. For the last event of the quarter, we introduced a mindfulness walk held in the park adjacent to the university, led by a professor who maintains her own dedicated meditation practice. Nearly a dozen students arrived to participate; our group had expanded again and excitement was building.

In continuing our quest for better self-care, we discovered that programs at other universities offer self-care and mindfulness techniques as elective classes. Students enrolled in such classes have reported positive physical, mental, emotional, spiritual, and interpersonal changes, with improved counseling skills and therapeutic relationships (Schure et al., 2008). Thus, in addition to continuing our current efforts, we are also we advocating for similar courses within our department.

Doctoral programs interested in helping students facilitate self-care might, therefore, consider the following:

- Work with other university members to negotiate the use of indoor space for yoga and meditation
- Consider approaching on-campus athletic centers to offer yoga or meditation classes specifically designated for psychology graduate students. Students may be more likely to utilize resources that are convenient to them (taking place at school) and easy on their budgets (part of an already-paid-for athletic center membership)
- Utilize the knowledge and skills of faculty who practice excellent self-care to serve as explicit role models
- Offer elective classes in self-care
- Approach interested students and support them in self-care efforts for groups of students, including walks, yoga, and meditation practices

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Despite some setbacks during our quest to establish a doctoral student mindfulness program, each of us has learned to practice yoga and meditation in ways that have benefitted us both professionally and personally. We have discovered that setting time aside for self-care helps us perform better academically and clinically. We will continue to work with our program to better infuse self-care into the curriculum, and encourage other doctoral programs to do the same. High stress levels may be an inevitable part of psychology graduate school; it is critical that students learn self-care techniques in order to offer ethical care to their clients, and to develop healthy patterns for successful long-term careers in psychology.

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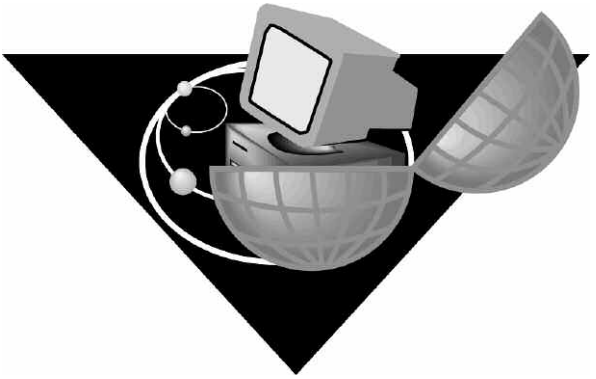

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FEATURE

Controversial 2008 Research Review Published in *Psychotherapy* Finds New Support

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Energy psychology—an umbrella term that encompasses a number of related unconventional treatments such as Thought Field Therapy (TFT) and Emotional Freedom Techniques (EFT)—has been vehemently criticized by portions of the professional community for more than a decade (e.g., Devilly, 2005; Herbert & Gaudiano, 2001; Lohr, 2001; McNally, 2001). A review of the preliminary evidence bearing upon the efficacy of the approach was published in a special theme issue on new treatments in Division 29's journal, *Psychotherapy* (Feinstein, 2008). The studies reviewed utilized the stimulation of acupuncture points (acupoints), usually by percussing on them, applied within protocols that also utilize imaginal exposure and verbal interventions. The paper concluded that "extensive clinical reports combined with the limited scientific evidence suggest that EP [energy psychology] holds promise as a rapid and potent treatment for a range of psychological conditions" (p. 212).

The paper drew scathing commentaries, published in the journal's June 2009 issue (McCaslin, 2009; Pignotti & Thyer, 2009), questioning the author's integrity, design, execution, premises, and conclusions. The author's rejoinder (Feinstein, 2009), published in the same issue, countered the commentaries point for point, while framing the long-standing controversy about energy psychology as reflecting a clash of paradigms, appropriately in my opinion.

Energy psychology adapts techniques from time-honored ancient healing and spiritual traditions as well as concepts—such as "subtle energies"—that are not yet widely accepted by Western science. The rejoinder also identified three other obstacles to energy psychology's wider acceptance: a) the procedures look patently strange (e.g., tapping on the body while repeating a specific phrase or humming a melody), b) its advocates had not provided sufficiently compelling explanatory models that made sense within conventional therapeutic frameworks, and c) its more enthusiastic proponents had made inappropriately dramatic public claims (e.g., "the five-minute phobia cure") with no peer-reviewed evidence to back them.

As is evident from psychotherapy's recent embrace of mindfulness meditation, psychotherapists do embrace unconventional procedures having roots in ancient traditions that do not yet have explanatory models within the prevailing psychological paradigm, as long as sufficient empirical evidence demonstrates the approach's effectiveness in treating psychological issues. To determine whether the most recent research findings pertaining to energy psychology continue to point in that direction, the author of the original article conducted a follow-up review that includes the studies published in the four years since his original report. It has just been published in *Review of General Psychology* (Feinstein, 2012).

A search using MEDLINE/PubMed, PsycINFO, and Google Scholar identi-

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fied 51 peer-reviewed clinical reports or outcome studies bearing upon the efficacy of acupoint tapping for addressing psychological issues. Thirty-nine of these 51 papers were published after the 2008 review article. Eighteen of those papers were randomized controlled trials (RCTs). The others included controlled trials without adequate randomization (4), outcome studies using standardized pre/post measures but no control group (14), systematic observations without standardized pre/post measures (8), and case studies (7).

Primary Findings

In the 36 outcome studies that utilized standardized pre/post-measures, nine conditions were each investigated in two or more of the studies. These included PTSD, phobias, specific anxieties, generalized anxiety, depression, weight control, physical pain, physical illness, and athletic performance. Positive outcomes were found in all 36 studies. In the 18 RCTs, at least one salient clinical measure improved at the .001 level of significance in 11 of the studies and at the .05 level in the other seven. Effect sizes were large in 15 of the 16 RCTs in which they were calculated and moderate in the remaining study. In the eight RCTs that were follow-up studies, each reported sustained improvement over time.

The 18 RCTs in the sample were critically evaluated for design quality along dimensions such as: a) use of objective measures, b) active-ingredient comparison groups, c) blinding, d) follow-up investigations, and e) effect sizes. The author concluded that "they consistently demonstrated strong effect sizes and other positive statistical results that far exceed chance after relatively few treatment sessions" (p. 14).

An Application of Acupoint Tapping with Longstanding PTSD

Four RCTs and five studies that compared pre- and post-treatment scores on standardized self-inventories, but did not use a control group, all showed strong clinical outcomes in the treatment of PTSD. Surprisingly, in three of these nine studies—two with genocide survivors and one with abused adolescent males—a majority of participants went from above to below PTSD thresholds after only one session.

By way of illustrating how a single acupoint tapping session appeared to be effective in treating chronically traumatized individuals, the paper relates the following account from Caroline Sakai, the principal investigator of a study conducted at a Rwanda orphanage, working with teens who had lost their parents during the 1994 genocide twelve years earlier (Sakai, Connelly, & Oas, 2011). Sakai describes the treatment of one of the 47 (of 50) participants whose scores went from above to below the PTSD cutoff after a single session, a 15-year-old girl who was three at the time of the genocide:

> She'd been hiding with her family and other villagers inside the local church. The church was stormed by men with machetes, who started a massacre. The girl's father told her and other children to run and to not look back for any reason. She obeyed and was running as fast as she could, but then she heard her father "screaming like a crazy man." She remembered what her father had said, but his screams were so compelling that she did turn back and, in horror, watched as a group of men with machetes murdered him.
>
> A day didn't pass in the ensuing 12 years without her experiencing flashbacks to that scene. Her sleep was plagued by nightmares tracing to the memory. In her treatment ses-

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sion, I asked her to bring the flashbacks to mind and to imitate me as I tapped on a selected set of acupuncture points while she told the story of the flashbacks. After a few minutes, her heart-wrenching sobbing and depressed affect suddenly transformed into smiles. When I asked her what happened, she reported having accessed fond memories. For the first time, she could remember her father and family playing together. She said that until then, she had no memories from before the genocide.

We might have stopped there, but I instead directed her back to what happened in the church. The interpreter shot me a look, as if to ask, "Why are you bringing it back up again when she was doing fine?" But I was going for a complete treatment. The girl started crying again. She told of seeing other people being killed. She reflected that she was alive because of her father's quick thinking, distracting the men's attention while telling the children to run.

The girl cried again when she re-experienced the horrors she witnessed while hiding outside with another young child—the two of them were to be the only survivors from their entire village. Again, the tapping allowed her to have the memory without having to relive the terror of the experience.

After about 15 or 20 minutes addressing one scene after another, the girl smiled and began to talk about her family. Her mother didn't allow the children to eat sweet fruits because they weren't good for their teeth. But her father would sneak them home in his pockets and, when her mother wasn't looking, he'd give them to the children. She was laughing wholeheartedly as she relayed this, and the translator and I were laughing with her.

We then went on to work through a number of additional scenes. Finally, when she was asked, 'What comes up now as you remember what happened at the church,' she reflected, without tears, that she could still remember what happened, but that it was no longer vivid like it was still happening. It had now faded into the distance, like something from long ago. Then she started to talk about other fond memories. Her depressed countenance and posture were no longer evident.

Over the following days, she described how, for the first time, she had no flashbacks or nightmares and was able to sleep well. She looked cheerful and told me how elated she was about having happy memories about her family. Her test scores had gone from well above the PTSD cutoff to well below it after this single treatment session and remained there on the follow-up assessment a year later. (Sakai, 2010, pp. 50 – 51, as quoted in Feinstein, 2012).

Implications

Feinstein's research review paper goes on to consider the psychophysical mechanisms that may be involved is such rapid amelioration of severe symptoms. It proposes inside-the-box explanatory frameworks that might explain how tapping on acupoints, while a presenting emotional problem is mentally activated, might efficiently produce desired neurochemical changes that could contribute to the amelioration of that problem. For instance, studies using fMRI

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imaging conducted at Harvard Medical School have demonstrated that stimulating certain acupuncture points sends signals that instantly reduce arousal in the limbic-paralimbic-neocortical network (Fang et al., 2009). Feinstein refers to this research in proposing that tapping on acupoints while mentally activating a stressful memory or trigger reduces its affective charge. Systematically applying this protocol to multiple aspects of the situation being addressed changes the neural landscape underlying the presenting problem. He concludes: "If favorable outcome research on energy psychology continues to accumulate—as recent developments would predict—and explanatory models for the observed effects continue to evolve, acupoint stimulation will offer clinicians a technique that can be used with confidence for quickly altering the neural pathways that underlie psychological problems" (p. 14).

In publishing the 2008 review article and the subsequent critical commentaries and rejoinder, *Psychotherapy* brought attention to the earliest studies lending efficacy support to energy psychology protocols. The new paper suggests that *Psychotherapy's* editor made a professionally responsible decision to bring the journal's prestige to the fledgling body of energy psychology research that was available at that time. The 39 peer-reviewed reports and studies that have been published since then all continue to support the efficacy of this method. Not one disconfirming study was found in the most recent literature search.

Despite this, the renewed attention on the apparent efficacy of energy psychology might well intensify the controversies surrounding the acceptance of these methods. In 1999, the APA took the unprecedented step of censuring the approach, instructing its CE sponsors in a memo that was also reported in the *APA Monitor* (Murray, 1999) that they could no longer offer APA CE credit for courses in Thought Field Therapy, the earliest established form of energy psychology. This restriction is still in place, has been generalized to all energy psychology protocols, and has been upheld in proceedings with organizations applying to be APA CE sponsors providing training in the method. Meanwhile, research findings coming from independent investigators in more than a dozen countries all point to similar conclusions, suggesting that, controversy notwithstanding, this approach is not only durably effective, but unusually rapid. The ensuing dialogue may in fact, as was previously predicted (Feinstein, 2009), lead to an expansion of conventional clinical frameworks.

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STUDENT FEATURE

Pregnancy and Psychotherapy

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Considerable literature exists regarding pregnancy and psychotherapy; however, it is somewhat dated, narrow in scope and limited in focus. Many articles are comprised solely of subjective reports of therapists' personal experiences, mostly written from a psychodynamic perspective (e.g., Dyson, & King, 2008, Stuart, 1997, Waldman, 2003). While the emotional implications of therapist pregnancy have been widely discussed, pragmatic suggestions for maintaining best practices are few and far between. Further, pregnancy can serve as a microcosm for the therapist's challenge in balancing personal and professional demands. Traditionally, pregnancy has been conceptualized as detrimental to the therapy process (Chandler, 2008). Yet, more recent literature highlights positive aspects including that parenthood may increase a therapist's empathy, judgment, and skill. Four general themes regarding issues of therapist pregnancy are identified in the literature: clinical, cultural, ethical, and practical. The purpose of this paper is to synthesize existing literature, to discuss the general themes, to offer practical suggestions for therapists, and to recommend broader directions for future research. Consistent with the literature, the focus here is on the female psychotherapist; obviously the issues are somewhat different for males.

Literature Review

Clinical Issues

Pregnancy raises several different clinical issues for psychotherapists. The theoretical orientation from which a therapist conceptualizes and practices may determine how much and in what way the pregnancy is addressed and discussed within the therapy (Chandler, 2008). Regardless of what theoretical approach is used, the therapeutic relationship is impacted by pregnancy in a number of ways. Pregnancy can create emotional distance between psychotherapist and client, both before the baby is born and after the therapist returns to work. During a pregnancy, the client may have negative feelings toward the therapist for becoming pregnant, or the client may feel as though the therapist is not capable of caring both for the client and an unborn baby (Bienen, 1990). On the other hand, Chandler (2008) stated that the experience of pregnancy and parenthood can lead "to a deeper richness and sense of connection with my clients."

When the therapist returns to work post-partum, the pregnancy and new baby will continue to impact the therapeutic relationship (Waldman, 2003). Fenster, Phillip, and Rapoport (1986) conceptualize two stages in the return to

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work for previously pregnant therapists: Anticipated Loss, where the therapist experiences feelings of loss of connectedness to her baby; and Dual-Role Integration, where the therapist must learn to separate from her baby while simultaneously reconnecting with her clients. Again, this conceptualization addresses the inevitable stress that comes with such a major life change. Alternatively, Waldman (2003) emphasizes that caring for a new baby can increase the psychotherapist's empathy, compassion, and humility.

Cultural Issues

Pregnancy is not only a biological and psychological process, it is also a socially and culturally defined process (Chandler, 2008). Even talking about, or not talking about pregnancy can raise cultural issues. Cultural factors in pregnancy and subsequent parenting include consideration of the therapist's culture (including age, race, ethnicity, gender, sexual orientation, disability issues, socioeconomic status, religion, family of origin, and trauma history), as well as the client's culture (Chandler, 2008). It is essential to consider the immediate relationship in determining when and how to discuss pregnancy. Disclosure and impact of pregnancy on the therapeutic relationship will differ if the client is, for example, a 5-year-old child in foster care, a 35-year-old conservative Muslim woman who is struggling with infertility, or a 65-year-old man with paranoid schizophrenia. Depending on their cultural background, clients may be more likely to want to give advice or even baby gifts. Other clients may not want to discuss the pregnancy because it is culturally inappropriate for them to do so, and respecting this cultural belief is important in informing the decision about how to proceed in therapy. Further, the therapist's own culture will guide the experience of pregnancy in the psychotherapeutic frame: for example, whether the therapist is pregnant herself, a man whose partner is pregnant, or a lesbian woman for whom disclosing pregnancy or a partner's pregnancy would also signify a disclosure of sexual orientation and a potential host of negative consequences.

It is also important to consider the cultural context of the therapeutic relationship. In one study by Katzman (1994, as cited in Saltzberg & Bryan, 1998), upon revealing pregnancy in a hospital setting, women were then identified with the maternal role rather than the professional role. The culture of other treatment settings may also impact the relationship (e.g., military bases, correctional institutions, infertility treatment centers, eating disorder clinics, child protection agencies). Cultural factors, then, that have largely been ignored in the general literature on self-disclosure (Constantine & Kwan, 2003), are extremely important to consider in thinking about pregnancy and parenting in the psychotherapy relationship.

Ethical Issues

Pregnancy may raise ethical issues that can have significant implications for both psychotherapist and clients, including issues such as self-disclosure and self-care. According to Chandler (2008), traditional theories of psychotherapy encouraged therapists to disclose only minimal information about themselves and revealing a pregnancy was viewed as a potential violation of therapeutic boundaries. However, the therapist has little control as her pregnancy becomes more visible and inevitably she must self-disclose in order to discuss future plans and create opportunities to process the client's response to the pregnancy. The level of self-disclosure varies across the stages of pregnancy and can elicit a range of emotions within the therapist and the client. Saltzberg & Bryan (2008) highlight the prospect to use

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self-disclosure in a way that is beneficial to clients. Consequently, the therapist must balance exposing her personal life with important clinical issues. This includes plans for taking maternity leave, maternity policies and procedures if the therapist is working within an organization, continuity of care considerations, and how this impacts the therapeutic relationship (Chandler, 2008).

In addition to self-disclosure, self-care is a crucial ethical issue during and after pregnancy. Balsam and Balsam (1974) state that "The pregnant therapist may find that her inner life varies more intensely than before. At times her inner life may be so full and active that it is hard for her to attend to the patient. At other times it will be a rich background against which to react to a patient while monitoring her own associations and careful responses. It is a question of balancing one's own needs and feelings vis-à-vis the patient" (as cited in Chandler, 2008, pg. 3). As such, self-care is a critical component for the therapist personally, especially as it can impact the therapeutic alliance. Chandler (2008) notes the importance of seeking support from colleagues and spending time in healthy relationships with friends and family. In addition, she describes the importance of maintaining boundaries, including ending on time, taking periodic breaks in the day, and not accepting new clients. Pregnancy is a transitional time for the therapist and there are personal and professional issues involved in beginning or expanding a family. Careful planning is recommended in order to prepare clients for the effect that visible pregnancy might have on the therapeutic alliance. Taking appropriate steps for emotional self-care can help the therapist to maintain balance and enjoy the pregnancy while simultaneously attending to the client's needs.

Practical/Financial Issues

Beyond examining the various ways in which both the therapist and client's emotional experiences must be taken into account when planning for a therapist's pregnancy, recent literature highlights a number of practical considerations which the therapist must also address (Gerber, 2005). These include the timing of the pregnancy in relation to the therapist's practice, accommodations for the pregnancy and related care, contingency plans for potential complications, the timeline for informing clients, length of maternity leave, client coverage during leave, and the transition back to work. While any working parent must develop plans that take these, or similar, issues into account, the personal nature of psychotherapy makes this situation unique.

While the timing of a pregnancy may not be as relevant for psychotherapists working in hospitals or other large agencies, it can be significant in settings that have a seasonal ebb and flow of work, such as university counseling centers or schools. This issue is also highly relevant for therapists in private practice who may consider the risks and benefits of getting pregnant early on in practice, before having many clients who are dependent on them, or whose practices already have an established client base. This issue may be especially significant for early career professionals who must balance their desire to shift their focus from their profession to their personal life with their need to begin developing their career, establishing a livelihood and paying back student loans.

In addition to the ethical issues of balancing the self-care needs of the psychotherapist and the client, there is a wealth of practical issues that need to be addressed during pregnancy (Gerber,

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2005). Every pregnancy is different but factors may include: how to manage morning sickness or increased fatigue during sessions, the discomfort of sitting for long periods of time later in the pregnancy, accommodating increasing numbers of doctor's appointments, finding time for the necessary number of meals and snacks. A therapist could be impacted by none of these issues, but it is better to be aware of them and anticipate how they will be managed than taken by surprise.

No pregnant woman wants to think about complications, but psychotherapists in particular must consider how they will practice self-care in the event of a miscarriage, serious health issues, or loss of the baby (Cullington-Roberts, 2008). This may raise concerns about if or how they will maintain their work with clients if they are placed on bed rest, how clients will be informed if the therapist delivers significantly earlier than her anticipated due date and how her maternity leave will be adjusted or extended should her baby spend time in a Neonatal Intensive Care Unit.

The length of maternity leave is another decision that the pregnant therapist must make. While therapists working in larger agencies may have a set amount of time to which they are entitled, and may have client coverage provided, therapists in private practice have, for better or for worse, more freedom to make these decisions. Anecdotally, therapists are said to take maternity leaves that are significantly shorter than the standard three month leave; six to eight weeks is said to be common (Cullington-Roberts, 2004). However, many wish that they were able to take longer time away from work, but feel pressured to return, either by their agencies or by their need to maintain their client base and the source of their income. While clients may accept a leave of two months or so, an absence of longer than this may, understandably, lead a client to seek services elsewhere. Related to the issue of maternity leave is the question of whether a therapist will arrange for a colleague to see her clients in her absence or to be available for emergency coverage or whether she will trust that her clients will be able to manage their own needs during her time away from their work together (Saltzberg & Bryan, 2008). If a therapist is paying a colleague to provide coverage, this may be another motivating factor for taking a shorter leave. Working up until the due date or birth provides the benefit of maximizing the work that the client and psychotherapist can do before the break, and enables the therapist to maximize her income. However, it can also lead to a situation in which the therapist goes into labor before completing termination or transition plans.

Finally, little has been written on the transition back to work for the psychotherapist who has had a child. There are a number of issues that a therapist may need to consider and plan for, including the possibility of post-partum depression, how to maintain high quality services while sleep-deprived, arranging child-care and back-up plans for disruptions in child care, how to accommodate nursing and pumping for breast-feeding mothers, and creating a physically comfortable work environment for mothers who may be physically healing after birth.

Summary

Aspects of pregnancy and psychotherapy have been previously described in the literature; this paper attempts to summarize that literature around four general themes, and to offer general suggestions for psychotherapists, balancing

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cited concerns with more positive implications of pregnancy related to psychotherapy. Although pregnancy has surely impacted countless psychotherapists and clients, it may gain in future importance as a consideration for both clinicians and researchers due to the "feminization of psychology" (e.g., Ostertag & McNamara, 2006). Because much of the existing literature is personal or anecdotal, research is sorely needed with regard to the clinical, cultural, ethical, and practical/financial implications of pregnancy and psychotherapy.

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Technological Imperative

Patrick Deleon, Ph.D.
Former APA President

One direct consequence of the advent and steadily increasing presence of technology within the health care arena will be the need for psychology to finally seriously address the issue of licensure mobility. The Department of Veterans Affairs (VA) recently announced its plan to increase veterans' access to mental health care by conducting more than 200,000 clinic-based, telemental health consultations by mental health specialties this fiscal year. Earlier the VA indicated that it would no longer charge a copayment when veterans receive care in their homes from VA health professionals using video conferencing. The Secretary: "Telemental health provides Veterans quicker and more efficient access to the types of care they seek. We are leveraging technology to reduce the distance they have to travel, increase the flexibility of the system they use, and improve their overall quality of life. We are expanding the reach of our mental health services beyond our major medical centers and treating Veterans closer to their homes." Since the start of the VA Telemental Health Program, VA has conducted over 550,000 patient encounters.

The Fiscal Year 2013 budget request for the Office of Rural Health Policy, which is located within the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services, notes that there has been a significant Departmental focus on rural activities for over two decades. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers, and maintaining the economic viability of hospitals and other health care providers in isolated rural communities. There are nearly 50 million people living in rural America who face ongoing challenges in accessing rural health care. Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts. Rural areas also continue to suffer from a shortage of diverse providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts. Of the 2,052 rural counties in the nation, 77 percent are primary care health professional shortage areas (HPSAs), where APA's Nina Levitt reports that psychologists are eligible for the National Health Service Corps Loan Repayment Program which places health professionals in underserved rural communities.

HRSA's Telehealth Grants initiative is designed to expand the use of telecommunications technologies within rural areas, seeking to link rural health practitioners with specialists in urban areas, thereby increasing access and the quality of healthcare provided. Telehealth offers important opportunities to improve the coordination of care in rural communities by linking its providers with specialists and other experts not available locally. The strengthening of a viable rural health infrastructure is viewed as critical for long-term success, including

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facilitating distance education experiences. The budget request for the office of rural health office once again proposed $11.5 million, which has subsequently been approved by the Senate Appropriation Committee, and thus allows the continuation of the Licensure Portability Grant initiative, in order to assist states in improving clinical licensure coordination across state lines. This particular initiative builds on HRSA's 2011 Report to Congress indicating: "Licensure portability is seen as one element in the panoply of strategies needed to improve access to quality health care services through the deployment of telehealth and other electronic practice services (e-care or e-health services) in this country…. Overcoming unnecessary licensure barriers to cross-state practice is seen as part of a general strategy to expedite the mobility of health professionals in order to address workforce needs and improve access to health care services, particularly in light of increasing shortages of health professionals. "

For some colleagues, and particularly for those who are not comfortable with fundamental change, the relationship between telemental health and licensure mobility might seem to be a tenuous one. And yet, we would suggest that they are intimately linked. The public policy rationale for professional licensure is to protect the public from untrained and/or unethical practitioners, not to enhance the status or economic well-being of the profession. Historically, and we would expect for the foreseeable future, licensure decisions and qualification criteria have been made at the individual state level, where each of the professions plays a major role in determining its requirements for membership and its scope of practice, albeit through the political process. Within the federal system the governing statutes and implementing regulations generally require licensure in at least one state (regardless of practitioner geographical location) and facility approval (i.e., being credentialed). As improvements in technology allow for increasingly higher quality utilization, the congressional committees with jurisdiction have been systematically "cleaning up" potential lingering statutory restrictions. And, at both the state and federal level, expanding reimbursement paradigms are evolving. APA estimates that 13 states now require private sector insurance companies to pay for telehealth services. Over the years, we have not been aware of any objective evidence which suggests that the quality of care being provided via telehealth is in any way compromised. To the contrary, as the VA, the Department of Defense (DoD), and the federal criminal justice system are demonstrating, access has been significantly enhanced and new state-of-the-art clinical protocols have been developed and implemented.

A First Hand View—From Tripler Army Medical Center: "I joined the Telebehavioral and Surge Support (TBHSS) Clinic in February 2011, during its infancy. At that time, the program was fully staffed with providers and support staff, making us 24 strong. TBHSS provides healthcare access by connecting eligible beneficiaries to providers who are able to identify and treat their clinical needs. These services are provided through secured video technology which allows accessibility from remote locations worldwide. I was very excited to have the opportunity to work in a clinic that has the ability to reach out to those off island, typically in areas where the demand for services is far greater than that of the availability. To date, the clinic has been able to support Alaska, Texas, Korea, Japan, Okinawa, and American Samoa, as well as various sites on the island of Oahu and

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in the Continental United States. As a provider, it was refreshing to be able to provide multiple services such as therapy, consultation, administrative evaluations, and both neuropsychological and psychological assessments. In addition, we provided surge support during different points within the ARFORGEN cycle whenever there was a need for augmented behavioral health resources. In February 2012, I was fortunate to be commissioned in the USPHS as a Lieutenant (0-3) and detailed to Tripler. As a clinical psychologist, I was able to utilize all the skills within the Department of Psychology that I acquired from my time at TBHSS. Recently, I had the honor to be promoted to the position of Clinical Director of TBHSS. Returning back to my roots has been exciting as I get to work with individuals who have a passion and commitment to serve service members and their families. My journey as a clinical psychologist civilian contractor to active duty clinical director has just begun and I am looking forward to the ongoing relationships that the TBHSS team forges with the different regions" [Sherry Gracey, Lt. USPHS].

ASPPB: We were very pleased to learn from Steve DeMers that the Association of State and Provincial Psychology Boards (ASPPB) was successful in its application this year for one of the licensure portability grants issued by HRSA. ASPPB will receive approximately $1 million over the next three years to provide support for state psychology licensing boards addressing statutory and regulatory barriers to telehealth, focusing upon continuing the development and implementation of its Psychology Licensure Universal System (PLUS) initiative. As an integral means of addressing the present barriers associated with telepsychology, ASPPB has developed an on-line application system, the PLUS, that can be used by any applicant who is seeking licensure, certification, or registration in any state, province, or territory in the United States or Canada that participates in the PLUS program. This also enables concurrent application for the ASPPB Certificate of Professional Qualification in Psychology (CPQ) which is currently accepted by 44 jurisdictions and the ASPPB Interjurisdictional Practice Certificate (IPC). All information collected by the PLUS is deposited and saved in the ASPPB Credentials Bank, a Credentials Verification & Storage Program (The Bank). This information can then be subsequently shared with various licensure boards and other relevant organizations. Therefore, streamlining future licensing processes.

ASPPB is an active participant in the APA/ASPPB/APAIT Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, established by former APA President Melba Vasquez and co-chaired by Linda Campbell (APA) and Fred Millan (ASPPB). The members have backgrounds, knowledge, and experience reflecting expertise in the broad issues that practitioners must address each day in the use of technology—ethical considerations, mobility, and scope of practice. Several of the meta-issues discussed to date center on the need to reflect broadness of concepts when incorporating telecommunications technologies and to provide guidance on confidentiality and maintaining security of data and information. In addition, a number of meta-issues focus on the critical issue of interjurisdictional practice. The underlying intent behind the proposed guidelines is to offer the best guidance to psychologists <u>when</u> they incorporate telecommunication technologies in the provision of psychological services, rather than be prescriptive. The Task Force met twice in 2011, June of 2012, and plans to meet once more this Fall. Feedback on their recommendations

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were sought at the Orlando APA convention, throughout the APA governance, and continuously from the membership at large. Their goal is to have the guidelines adopted by APA as policy and approved by ASPPB and APAIT sometime in 2013.

The U.S. Supreme Court: As we all must be aware, this summer the U.S. Supreme Court upheld the underlying constitutionality of the President's landmark Patient Protection and Affordable Care Act of 2010 (ACA), including it's far reaching individual mandate provision, by a 5-4 vote. For legal scholars, the most critical issue was probably the Court's deliberations regarding the federal government's power to regulate Commerce vs. its power to raise Taxes, as a government of limited and enumerated powers. "We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation's elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions."

For health policy experts and practitioners, the Court's musings on our nation's health care system makes for particularly intriguing reading. * "Everyone will eventually need health care at a time and to an extent they cannot predict, but if they do not have insurance, they often will not be able to pay for it. Because state and federal laws nonetheless require hospitals to provide a certain degree of care to individuals without regard to their ability to pay, hospitals end up receiving compensation for only a portion of the services they provide. To recoup the losses, hospitals pass on the cost to insurers through higher rates, and insurers, in turn, pass on the cost to policy holders in the form of higher premiums. Congress estimated that the cost of uncompensated care raises family health insurance premiums, on average, by over $1,000 per year." * "Indeed, the Government's logic would justify a mandatory purchase to solve almost any problem…. (M)any Americans do not eat a balanced diet. That group makes up a larger percentage of the total population than those without health insurance. The failure of that group to have a healthy diet increases health care costs, to a greater extent than the failure of the uninsured to purchase insurance…. (T)he annual medical burden of obesity has risen to almost 10 percent of all medical spending and could amount to $147 billion per year in 2008. Those increased costs are born in part by other Americans who must pay more, just as the uninsured shift costs to the insured." * "In enacting [ACA], Congress comprehensively reformed the national market for health-care products and services. By any measure, that market is immense. Collectively, Americans spent $2.5 trillion on health care in 2009, accounting for 17.6% of our Nation's economy. Within the next decade, it is anticipated, spending on health care will nearly double. The health-care market's size is not its only distinctive feature. Unlike the market for almost any other product or services, the market for medical care is one in which all individuals inevitably participate." * "Not all U.S. residents, however, have health insurance. In 2009, approximately 50 million people were uninsured, either by choice or, more likely, because they could not afford private insurance and did not qualify for government aid."

Bringing Psychology To The Table – State Leadership In Health Care Reform: At this year's impressive State Leadership conference, Katherine Nordal exhorted our state association leaders to appreciate that: "We're facing uncharted territory with proposed new models of care delivery. New financing mechanisms that we're going to have to

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understand and appreciate, and the ways that they are going to impact practice, whether it's private practice or institutional practice. We know that the states are in the drivers' seat, and most of what happens about health care reform is going to happen back home. We know that we can't do it alone. Our advocacy depends on effective collaborations and effective partnerships. We have to be ready to claim our place at the table. We need to be involved at the ground level. You've got to get involved in coalitions. If we don't participate, then we abdicate our responsibility there and we let other people—physicians, nurses, social workers, MFTs, whoever—define what our future is going to be as a profession. And that's just not an option for us. If we're not at the table, it's because we're on the menu…. When you get home and you turn your focus to health care reform, I want you to remember that other groups don't automatically think about psychology and invite us to the table when they're having these discussions. We have to identify health care reform initiatives that impact psychological practice and our patients and get involved in those in a proactive way. If you wait…." Aloha.

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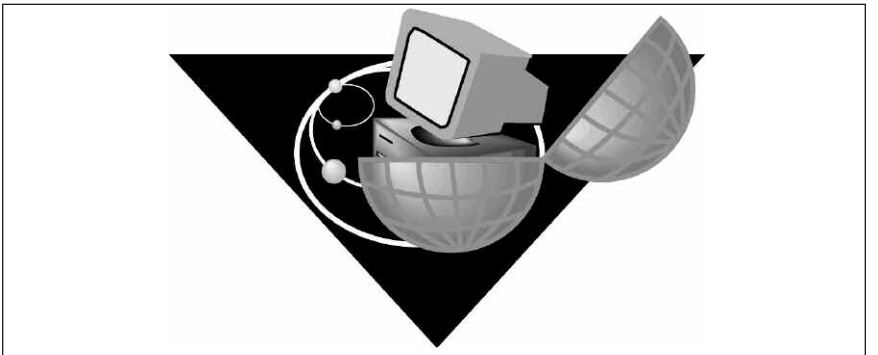

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DIVISION 29 PSYCHOTHERAPY OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)

Call for Nominations

Distinguished Psychologist Award

The APA Division of Psychotherapy invites nominations for its 2013 *Distinguished Psychologist Award,* which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

Deadline is January 1, 2013. 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. Marvin Goldfried, at mgoldfried@NOTES.CC.SUNYSB.EDU

Call for Nominations

Division 29 Award for Distinguished Contributions to Teaching and Mentoring

The APA Division of Psychotherapy invites nominations for its 2013 *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 1, 2013. All items must be sent electronically. The letter of nomination must be emailed to the Chair of the Professional Awards Committee, Dr. Marvin Goldfried, at mgoldfried@NOTES.CC.SUNYSB.EDU

CALL FOR NOMINATIONS
DIVISION 29 EARLY CAREER AWARD

About the American Psychological Foundation (APF)

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

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

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

About the Division 29 Early Career Award
This program supports the mission of APA's Division of Psychotherapy (Division 29) by recognizing Division members who have demonstrated outstanding promise in the field of psychotherapy early in their career.

Amount
One $2,500 award

Eligibility Requirements & Evaluation Criteria

Nominees should demonstrate and will be rated on the following dimensions:

- Division 29 membership
- Within 7 years post-doctorate
- Demonstrated accomplishment and achievement related to psychotherapy theory, practice, research or training
- Conformance with stated program goals and qualifications

Nomination Requirements

- Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable)
- Current CV

Submission Process and Deadline
Submit a completed application online at **http://forms.apa.org/apf/grants/** by **January 1, 2013**.

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

Questions about this program should be directed to:
Parie Kadir
Program Officer
at **pkadir@apa.org**.

CALL FOR FELLOWSHIP APPLICATIONS DIVISION 29—PSYCHOTHERAPY

Tammi Vacha-Haase
Chair, Fellows Committee

The Division of Psychotherapy is now accepting applications from individuals who would like to nominate themselves or recommend a deserving colleague for Fellow status with the Division of Psychotherapy. Fellow status in APA is awarded to psychologists in recognition of outstanding contributions to psychology. Division 29 is eager to honor those members of our division who have distinguished themselves by exceptional contributions to psychotherapy in a variety of ways such as through research, practice, and teaching.

The minimum standards for Fellowship under APA Bylaws are:

- The receipt of a doctoral degree based in part upon a psychological dissertation, or from a program primarily psychological in nature;
- Prior membership as an APA Member for at least one year and a Member of the division through which the nomination is made;
- Active engagement at the time of nomination in the advancement of psychology in any of its aspects;
- Five years of acceptable professional experience subsequent to the granting of the doctoral degree;
- Evidence of unusual and outstanding contribution or performance in the field of psychology; and
- Nomination by one of the divisions which member status is held.

There are two paths to fellowship. For those who are not currently Fellows of APA, you must apply for Initial Fellowship through the Division, which then sends applications for approval to the APA Membership Committee and to the APA Council of Representatives. The following are the requirements for initial Fellow applicants:

Completion of the Uniform Fellow Blank;
- A detailed curriculum vitae;
- A self-nominating letter (which should also be sent to your endorsers);
- Three (or more) letters of endorsement of your work by APA Fellows (at least two must be Division 29 Fellows) who can attest to the fact that your "recognition" has been beyond the local level of psychology; and
- A cover letter, together with your CV and self-nominating letter, to each endorser.

Division 29 members who have already attained Fellow status through another division may pursue a direct application for Division 29 Fellow by sending a curriculum vitae and a letter to the Division 29 Fellows Committee, indicating specifically how you meet the Division 29 criteria for Fellowship.

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Call for Fellowship Applications, *continued from page 55*

APA is instituting an on-line, all electronic Fellows Nomination and Submission process this year. The new system will allow the applicant, the endorsers and the Fellow Chairs to submit all of their materials online.

Please visit APA's website for more information:
http://apa.org/membership/fellows/

DEADLINE FOR SUBMISSION:
The deadline for submission to be considered for 2013 is **December 15, 2012**.

Initial nominees (those who are not yet Fellows of APA in any Division) must submit the following electronically using APA's on-line system:
(a) a cover letter,
(b) the *Uniform Fellow Application,*
(c) a self-nominating letter,
(d) three (or more) letters of endorsement from current APA Fellows (at least two Division 29 Fellows), and
(e) an updated CV.

Current Fellows of APA who want to become a Fellow of Division 29 need only send a letter attesting to their qualifications with a current CV.

For questions about the submission process, or for guidance and advice about the application and forms, please contact:

Tammi Vacha-Haase, Ph.D.
Chair, Division 29 Fellows Committee
Tammi.Vacha-Haase@colostate.edu
Phone: 970.491.5729

Incomplete submission packets after the deadline cannot be considered for this year.

Please feel free to contact Tammi Vacha-Haase or other Fellows of Division 29 if you think you might qualify and you are interested in discussing your qualifications or the Fellow process. Also, Fellows of our Division who want to recommend deserving colleagues should contact Tammi with their names.

NOTICE TO READERS

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

CALL FOR NOMINATIONS

APF Rosalee G. Weiss Lecture for Outstanding Leaders

The American Psychological Foundation's Rosalee G. Weiss Lecture honors an outstanding leader in psychology or a leader in the arts or sciences whose work and activities has had an effect on psychology. The lecture is delivered at the annual APA convention; the 2011 Convention will be held in Washington, DC. The APA Divisions of Psychotherapy (29) and Independent Practice (42), administer the lectureship in alternate years. The lecture was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee G. Weiss, Ph.D. The lecturer receives a $1,000 honorarium.

Eligibility Criteria
The nominee must be an:
- Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology; or,
- Outstanding leader in any of the special areas within the sphere of psychology.

Nomination Materials
Self-nominations are welcomed. Letters of nomination should outline the nominee's credentials and contribution. Nomination letters and a brief CV ***should be submitted electronically*** to the Division 29 2013 Awards Chair, Dr. Marvin Goldfried, at mgoldfried@NOTES.CC.SUNYSB.EDU

Deadline: January 1, 2013

DIVISION OF PSYCHOTHERAPY 29 · AMERICAN PSYCHOLOGICAL ASSN.

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REQUEST FOR NOMINATIONS
APF DIVISION 37
DIANE J. WILLIS EARLY CAREER AWARD

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

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

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

About the APF Division 37 Diane J. Willis Early Career Award
The APF Division 37 Diane J. Willis Early Career Award is named after Dr. Willis, to honor her life-long advocacy on behalf of children and families. Dr. Willis's work cuts across many areas including clinical child, pediatric, developmental and family psychology. Through her publications, clinical work, and mentoring/teaching she has changed policy at the local, national and international level. She has advocated for children's rights at the United Nations, developed programs on prevention and early intervention for Native American children living on reservations, and established services promoting the wellbeing of children with developmental disabilities, chronic illness, and those who have suffered from maltreatment.

The APF Division 37 Diane J. Willis Early Career Award supports talented young psychologists making contributions towards informing, advocating for, and improving the mental health and well-being of children and families particularly through policy.

Program Goals
- The APF Division 37 Diane J. Willis Early Career Award
- Advances public understanding of mental health and improve the well-being of children and families through policy and service.
- Encourages promising early career psychologists to continue work in this area.

Funding Specifics
One $2,000 award

Eligibility Requirements
Applicants must be:
- psychologists with an Ed.D., Psy.D., or Ph.D. from an accredited university
- no more than 7 years postdoctoral

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Request For Nominations, *continued from page 58*

Evaluation Criteria
Nominations will be evaluated on:
- Conformance with stated program goals and qualifications stated above
- Magnitude of professional accomplishment in advancing public understanding of mental health and improves the well-being of children and families through policy and service.

Nomination Requirements
- Nomination letter outlining the nominee's career contributions
- Current CV
- Two letters of support

Submission Process and Deadline
Submit a completed application online at
http://forms.apa.org/apf/grants/ January 31, 2013.

Please be advised that APF does not provide feedback to grant applicants or award nominees on their proposals or nominations.

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

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The Impact of Therapists' Attachment Styles on the Identification of Ruptures and Facilitation of Repairs in Psychotherapy
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PSYCHOTHERAPY BULLETIN

Psychotherapy Bulletin is the official newsletter of Division 29 (Psychotherapy) of the American Psychological Association. Published four times each year (spring, summer, fall, winter), *Psychotherapy Bulletin* is designed to: 1) inform the membership of Division 29 about relevant events, awards, and professional opportunities; 2) provide articles and commentary regarding the range of issues that are of interest to psychotherapy theorists, researchers, practitioners, and trainers; 3) establish a forum for students and new members to offer their contributions; and, 4) facilitate opportunities for dialogue and collaboration among the diverse members of our association.

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

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