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BULLETIN

In This Issue

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PRESIDENT'S COLUMN

Keeping Diversity at the Forefront of the Society's Work

Rod Goodyear, PhD
University of Redlands

The Society for the Advancement of Psychotherapy is committed to increasing both its relevance to and membership of psychotherapists who are members of traditionally underrepresented and marginalized groups in the United States. It has a corresponding commitment to providing its members with resources (convention programming, publications, and web content) that will help in their continuing development of multicultural competence. As part of its continuing effort to better address these commitments, our Board of Directors set aside a day at its February 2015 meeting to engage in diversity-related strategic planning. The board voted a few years ago to set aside one day every three years to discuss progress and needs for the society with respect to diversity and this strategic planning meeting.

This planning meeting, of course, included an assessment of where we are especially strong as well as where we should be strengthening our resources and efforts. One particular and quite significant strength of the Society has been in the leadership our members have exercised with respect to diversity-related policy, scholarship, and practice. There are a number of indicators of this, but one that deserves specific notice is our Society's representation among the select group who have been named Distinguished Elders at the National Multicultural Summit (NMCS). These have included, for example, Beverly Greene, Lillian Comas-Diaz, and Guillermo Bernal at the 2013 NMCS and Melba Vasquez, Roberta Nutt, and Armand Cerbone at the 2015 NMCS. Beverly and Armand—Diversity Domain representative on the Board and President-Elect, respectively—are featured elsewhere in this issue of the *Bulletin*.

Of course there also are a number of diversity-related areas in which the Society needs to be focusing on continuing improvement. The strategic planning document that is a follow-up to our February meeting will finalize a plan that will identify specific goals and timelines. Under consideration, for example, are: developing a more effective pipeline to bring psychotherapists from diverse groups into leadership positions in the Society; establishing a stronger collaborative role with respect to the National Multicultural Summit; partnering with other divisions with respect to diversity initiatives; and funding projects that have social justice purposes.

But the Board continues to welcome ideas that will help us address that priority. Suggestions can be sent to any member of the Board, but especially our Diversity Domain Representatives, Jairo Fuertes and Beverly Greene, or our Diversity Committee Chair, Astrea Greig (contact information for all Board members can be found on the Society's webpage: http://societyforpsychotherapy.org/). In the meantime, our Diversity domain will continue to advance issues related to practice, research, and training through the work of its committee, including highlighting timely issues in our *Bulletin*, website, awards, and other business of the Society.

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Finally, I want to provide the following affirmation of the Society's values that the Board developed and approved by unanimous vote during its February meeting:

> The Society for the Advancement of Psychotherapy values and honors diversity (as defined in the APA ethics code) in its Board of Directors, Committee Chairs, committees, as well as in its membership. We work to create and maintain an inclusive environment that welcomes the perspectives and voices of all participants. We recognize the contributions of all and that diversity strengthens the work we do. Our honoring of diversity extends to the products, projects, publications, convention programming, awards, and grant programs generated by the Society.

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

NOTICE TO READERS

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

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Welcome to our first issue for 2015, with a special welcome for our incoming officers, Publications Board, and everyone new to the Society for the Advancement of Psychotherapy!

This year marks the 50th anniversary of the *Psychotherapy Bulletin*, and we would like to recognize and extend our warmest gratitude to all of the contributors, editors, domain representatives, officers, and members who have done their parts to support the practice of psychotherapy and this publication for the past five decades—and to those who continue to support our mission and vision, and who serve in so many ways.

In honor of this milestone, we asked two former editors, Drs. Jennifer Cornish and Lavita Nadkarni, to share their thoughts about their time with the *Bulletin*.

Jenny Cornish, PhD, was *Psychotherapy Bulletin* editor from 2008 to 2011. Her goal was to uphold the excellent reputation of the *Bulletin*, continuing in the tradition of previous editors by giving voice to not only famous psychotherapy researchers, educators, and practitioners but also to students and early career professionals, many publishing for the first time. She was fortunate to work with outstanding contributing editors, including several excellent student editorial assistants. She also started the practice of mentoring an associate editor into editor, working with the fantastic Lavita Nadkarni (who in turn mentored the current editor). Overall, she remembers her time as editor as rewarding, fulfilling, and a great way to connect with so many wonderful Division 29 members.

Lavita Nadkarni, PhD, was editor of the *Psychotherapy Bulletin* from 2011-2014. Her goal was to continue the vision of previous editors, who fostered a sense of community for those who practice and promote psychotherapy and give voice to a stimulating dialogue among its members. One of the hallmarks of her editorship was the quality and quantity of student submissions, speaking to the issues directly impacting their professional and personal growth as psychologists. In Lavita's words, "Working with passionate Presidents, talented contributing editors and domain reps, and amazing mentors, co-editors, and editorial assistants was truly one of the highlights of my professional career. The *Bulletin* would not have been as timely or as much fun without Tracey Martin and Jeff Barnett! We have an amazing opportunity to be as ground breaking and forward thinking as we have been in years past to advance psychotherapy to meet the needs of our changing technological and global communities."

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In this issue, we are once again fortunate to be able to present a variety of perspectives from students, clinicians, and scholars on practice-related topics, as well as Society-specific information for our membership (including greetings from our new President, Dr. Rod Goodyear, and Candidate Statements). Please also explore content from this and other issues of the *Bulletin*, as well as a wealth of additional information and resources, on the Society website (http://societyforpsychotherapy.org/).

We hope to build on the work of our predecessors in the year to come, and we invite you to join the conversation by contributing an article, providing feedback through the contact information provided below, becoming more active or taking on a leadership role in the Society, or simply becoming a member if you are not already (you can find more information and an application in the back of every issue of the *Bulletin*, or on the website).

Together, let's make 2015 the start of another great 50 years.

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SPECIAL FEATURE

Improving Expertise in Psychotherapy

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We wrote an article entitled "Expertise in psychotherapy: An elusive goal" (Tracey, Wampold, Lichtenberg & Goodyear, 2014), which has garnered several written (Hendlin, 2014; McMahan, 2014; Oddli, Halvorsen, & Rønnestad, 2014; Shanteau & Weiss, 2014) and oral reactions. We take this opportunity to clarify and expand our view. In our article, we argued that there is no evidence of expertise within the professional practice of psychotherapy. We focused our discussion on the profession itself, arguing that there was no relation between time spent in professional practice and improved practice. Among professional therapists, there is common lore that experience results in greater clinical "wisdom" and better skill. We found no support for this view with respect to clinical decision-making or clinical outcomes. While this is a regrettable state of affairs, we do not see it as inherent to the profession. We then proposed that expertise can be developed with explicit feedback of clinical outcome in several ways: within clients over time ("Is this client improving relative to last session?"), across clients ("Is this client doing better than my other clients?"), and across therapists ("How do the outcomes that I obtain compare to those of other therapists?"). While we view this feedback as necessary, we do not view it as sufficient. There needs to be a reflective practice that accompanies clinical work and that such practice should manifest explicit hypothesis testing in a disconfirmatory manner, whereby common heuristics are minimized.

Thus our arguments focused on the profession rather than on the identification of expertise in individuals. Hendlin (2014) includes both definitions (profession and individual) when he takes umbrage at the implication that there are no therapists with expertise. There may indeed be individuals who have expertise but such a determination is different from our focus in the article. The issue of the determination of individual expertise is an interesting one, though, and

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merits review to clarify where it differs from and overlaps with the issue of the expertise of the profession.

Defining Individual Expertise in Psychotherapy

A therapist's expertise has been variously defined or understood in terms of (a) reputation, degree attainment, professional distinction, and experience, (b) skill, competence, or adherence to a prescribed standard of performance, (d) clinical accuracy, or (d) outcomes—that is, success with clients. We will review each in turn.

Reputation, Degree, Professional Distinction, or Experience as Expertise Criterion

Reputation as an expert often is employed as a criterion for expertise. In studies of expert performance in psychotherapy, researchers often use nominations of peers (see, e.g., Burlingame & Barlow, 1996; Linehan et al., 2006; Jennings & Skovholt, 1999; Skovolt & Jennings, 2004, as reputation is presumably derived from both skills and outcomes. Overholser (2010), in his attempt to identify the core elements of clinical expertise in psychotherapy, indicated that for a professional to be an expert "the professional must possess a terminal degree in the field… [and] the professional is visible in the professional community at a national level" (p. 131). Unfortunately, reputation, degrees, and professional recognition may not relate to performance. For example, therapists others view as experts have been found to fare no better than non-experts in the accuracy of their decisions (Faust, 1991; Faust & Ziskin, 1988; Garb, 1998, 2005; Witteman, Weiss, & Metzmacher, 2013).

Professional experience also has been used in definitions of expertise. Overholser (2010) defines the expert, in part, as a "professional [who] has accumulated multiple years of clinical experience in the direct provision of clinical assessment, psychological testing, or psychological treatment" (p. 131). We noted that there is little evidence of the superiority of more experienced therapists (e.g., Berman & Norton, 1985; Beutler, 1997; Beutler et al., 2004; Budge et al., 2013; Hattie, Sharpley, & Rogers, 1984; Laska, Smith, Wisclocki, & Wampold, 2013; Minami et al., 2008; Okiishi et al., 2003; Stein & Lambert, 1984, 1995; Strupp & Hadley, 1979; Wampold & Brown, 2005). So expertise definitions that include reputation, degree attainment, and experience are insufficient.

Task Performance as Expertise Criterion

Many definitions of expertise stipulate that experts are those who perform various tasks with a high level of skill. Overholser (2010) made such a stipulation: "The [expert] professional has demonstrated evidence of superior clinical skills in a specific application of psychology" (p. 131). Research on aspects of psychotherapy often identifies experts according to these criteria, such as using psychologists who have been awarded diplomate status by the American Board of Professional Psychology (e.g., Eugster & Wampold, 1996; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003). Of course, this is general and others have been more specific, usually referring to the core skills as competencies or the psychotherapist who has the skills as being competent. This definition of expertise, that of matching standards of practice, is also advocated by Shanteau and Weiss (2014) in their comment on our article.

Another example would be those who advocate specific treatments and emphasize that expertise depends selecting and administering the optimal evidence-based treatment protocol (Waltz, Addis, Koerner, & Jacobson, 1993). Most evi-

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dence-based treatments define what constitutes competence within such treatments. For example, Rector and Cassin (2010) have recently outlined the competencies necessary for expertise in delivering cognitive-behavioral treatments.

The identification of core competencies of professional practice (e.g., Kaslow, 2004) provides criteria against which to assess therapist behavior. But these competencies are important for understanding expertise only if those who have these competencies demonstrate levels of performance greater than those with only basic levels of competence. That is, are therapists who possess the core competencies, or have higher levels of such competencies, more effective than others? Shanteau and Weiss (2014) note the inherent problem with defining expertise as adherence to established standards of practice using the example of expertise in astrology. While one may indeed be an expert with respect to adhering to astrology standards, one is no more accurate. When discussing the competencies, Kaslow (2004) noted,

> Competencies are composed of knowledge, skills, and attitudes, which, as a coherent group, are necessary for professional practice. They *correlate* with performance, can be evaluated against well accepted standards, and can be enhanced through training and development. (p. 775, emphasis added)

However, the literature that attempts to identify core competencies rarely, if ever, relies on evidence that the competencies are causally, or even correlationally, related to outcomes. It appears that (a) experts' ratings of competence after observing therapists' performance with clients do not predict outcome in general (Webb, DeRubeis, & Barber, 2010), although they did find some support for the treatment of depression (Wampold & Imel, 2015); (b) adherence to clinical protocols (i.e., degree to which the therapist follows the treatment manual) appears to be unrelated to outcome (Webb et al., 2010; Wampold & Imel, 2015); and (c) strict adherence to those protocols might even attenuate therapeutic outcomes (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Henry, Strupp, Butler, Schacht, & Binder, 1993). So there is little basis for the validity of using task performance as a criterion of expertise.

Clinical Accuracy as Expertise Criterion

Much of the research on expertise in psychotherapy has concerned therapists' cognitive accuracy in certain clinical task domains—specifically, their clinical judgment, clinical decision making, and case formulations (Betan & Binder, 2010; Eells et al., 2005; Faust, 2007; Garb, 1989; Spengler et al., 2009; Wierzbicki, 1993)—and there is little support that skill increases with greater experience. For example, Witteman et al. (2012) found that master's level students were better at diagnosing depression than experienced therapists. In fact, Shanteau's (1992) determination that clinical psychologists do not demonstrate expertise was made in part on the basis of the accuracy of their clinical judgment. Perhaps it is relevant as well that mechanical, actuarial approaches to prediction consistently outperform psychologists' clinical judgments (Meehl, 1954; 1986), though the extent to which this is true depends on the type of data being employed in prediction (Grove, Zald, Lebow, Snitz & Nelson, 2000). Despite the lack of evidence regarding the relation of experience and clinical decision making, there has never been a demonstration that more accurate clinical judgments are related to better outcomes in psychotherapy. While this connection appears logical and necessary, it still remains to be empirically evaluated.

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Clinical judgment and decision making also has been discussed with respect to experts' thinking processes. That is, experts should perform cognitive tasks *differently* than novices (Bereiter & Scardamalia, 1986), at least with respect to reasoning about and solving domain-relevant problems. Oddli et al. (2014), in their comment on our article, focus on this by noting that there is a body of literature that demonstrates that more experienced clinicians think differently from less experienced clinicians (e.g., Huppert et al., 2001; Kivlighan & Quigley, 1991; Martin et al, 1989; Miller, Hubble & Duncan, 2008; Ronnestad & Skovholt, 2013). While this may be true, there is no direct connection between the different processes used and better outcome. Indeed, with respect to expertise in general, these cognitive differences can cause non-experts to match or out-perform experts (e.g., Ericsson & Lehmann, 1996). Given this, any definition of individual expertise needs to incorporate information on actual performance as indicated in outcomes.

Outcome as Expertise Criterion

Client outcome might seem the ultimate definition of expertise. Indeed, it would seem curious to claim expertise for any therapist who did not reliably produce exemplary client outcomes. The classic expertise research on chess masters (Chi, 2006) identified those individuals who were extremely skilled in the domain (i.e., those who had long histories of winning) and then examined how these winning individuals approached the game and thought about it differently from those who were not as skilled. Hence strong outcomes are essential in any definition of expertise as it is a means of identifying those who are skilled.

Achieving consistently better outcomes across a range of clients is one means of defining expert therapists (Baldwin, Wampold & Brown, 2005). Baldwin, Wampold and Imel (2007) found that therapists who generally have better outcomes also are better able to form alliances with their clients. However, recent research (Budge et al., 2013) has found that, even using client outcomes, experienced psychologists actually perform worse than intern/postdocs. Based on a longitudinal study of 173 therapists treating over 6000 clients over a period of an average of 5 years, it appears that over time therapists gradually achieve *poorer* outcomes (Goldberg et al., submitted). Thus there appears to be little relation between professional experience and increased skill when client outcome is used as the basis of skill definition.

But there are difficult definitional issues even with outcome as the expertise criterion. It is recognized, for example, that outcomes of psychotherapy are due in large part to client variables, including severity of dysfunction, diagnosis, motivation (e.g., stage of change), social support, and resources (e.g., Bohart & Tallman, 2010; Groth-Marnat, Roberts, & Beutler, 2001). So the issue of how to use outcome information is important. Caseloads vary in client difficulty (e.g., more experienced clinicians often carry more difficult clients), so any mean outcome may not take this into account. Caseloads will also vary by predominant diagnoses. Can outcome scores be compared across clients with depression, personality disorders, and substance abuse? The possibility of needing separate outcome cutoffs for each diagnostic grouping may seem warranted but this also makes it difficult to make determinations of who is an expert. The metric of outcome varies. This could be taken to imply that expertise should only be determined within diagnostic grouping such that one would get a mean outcome score for work with clients with a diagnosis of depression (e.g., the work

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Minami et al., 2008, who focused on benchmarks for depression outcomes) and perhaps another one with clients with a diagnosis of borderline personality disorder. Of course, the metric could be standardized such that comparisons can be made (or aggregated) across different diagnostic groups, although such a procedure would obviously require an adequate set of base rates against which to compare the outcome of any individual's caseload. Unfortunately, there are no such norms of group outcome readily available to clinicians, much less quality information on the outcomes of individual clinicians themselves.

In conclusion, there are issues with any definition of individual expertise in psychotherapy. These are emblematic of the difficulties of the development of expertise: If it can't be defined, then it is difficult to say when it has been attained. But with respect to any definition of expertise, we see actual outcomes as a necessary ingredient and more work is needed to specifically examine expertise at both the individual and profession level.

Expertise of the Profession of Psychotherapy

We are concerned about the lack of empirical demonstration of expertise in the profession as a whole. Hendlin (2014) expressed outrage that we argued that there is no empirical support for expertise. He felt that our comments were insulting and erroneous and that better research is needed to demonstrate that experience leads to expertise. We agree that more research is needed but differ in that we do not dismiss the research that exists. Shanteau and Weiss (2014) offered two criteria for establishing expertise: *coherence* and *correspondence*. Coherence is the agreement with theory/common practice; correspondence is the agreement with an external reality. Psychotherapy would demonstrate expertise if the coherence criterion was adopted, according to Shanteau and Weiss. It is probable that over time clinicians become more aligned with prevailing practice norms or theories. The field fails, however, with the lack of demonstration of correspondence: We have not demonstrated the relation of professional experience with increases in outcomes (the external reality). While agreeing that psychotherapy does not demonstrate expertise using the correspondence definition, Shanteau and Weiss believe that the adoption of the coherence criterion may be appropriate for our profession.

On this we disagree strongly. In our opinion, the correspondence criterion is the only appropriate one and we should use clinical outcomes as the external reality/standard against which to evaluate expertness. At the same time we do not think that the failure to demonstrate this correspondence relation to date must be accepted as an established fact. In this regard, we made explicit arguments for feedback elements that could (and should) be incorporated into practice to enhance the development of expertise of the profession as defined by correspondence with outcome. And we argued further that a lack of quality feedback about what is done in therapy and its clinical outcomes and how such feedback information is used are the sources of limits to establishing expertise in psychotherapy.

Improving Expertise

We posited that for the attainment of expertise in psychotherapy it is necessary for therapists to obtain quality information about outcomes. It is still relatively atypical for therapists to obtain quality psychometrically supported information regarding their work with clients. With respect to distal outcomes, such as assessments at termination and 6 months

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to one year later, assessments are quite rare. As a result, therapists have little knowledge (other than perhaps if the client returns in the future) of eventual outcomes and thus there is no corrective information on impressions gleaned at termination. More information on distal outcomes is essential both with respect to within-therapist comparisons (which are one's best and worst cases) but also with respect to normative comparisons (how are one's outcomes relative to those of others?). Such information is rarely provided but is crucial if there is to be any learning from experience.

Furthermore, proximate, session by session information is also important (e.g., symptomology prior to each session and alliance assessments after each session). While there are some good programmatic efforts to study the provision of outcome feedback (both proximate and distal) to the therapist (Duncan, Miller, Wampold, & Hubble, 2010; Lambert et al., 2005; Lambert & Shimokawa, 2011; Miller, Duncan, & Hubble, 2005; Reese, Norsworthy, & Rowlands, 2009), this is just beginning and not yet widely adopted. And while the provision of such feedback is related to better outcomes, it has not been shown to lead to better outcomes over time for a given therapist. As a consequence, although quality outcome feedback (both proximal and distal) is necessary for the development of expertise, we do not see it as sufficient.

One of the findings from the expertise literature is that expertise develops with deliberate practice (Ellis, Carette, Anseel & Lievens, 2014; Ericsson, 2006, 2009). It has been argued (e.g., Miller, Duncan, Sorrell, & Brown, 2005; Miller, Hubble, Chow, & Seidel, 2013) that dedicated time should be set aside for the examination of practice. In this regard, Chow et al. (in press) have found that whereas experience itself did not predict outcomes, the amount of time spent targeted at improving therapeutic skills did. However, the specifics of what should be incorporated into this deliberate practice aimed at improving skills are vague. We specified several aspects that should characterize this deliberate practice (i.e., adopting a disconfirmatory approach, explicitly testing hypotheses, and avoiding heuristics).

Incorporation of these strategies into deliberate practice should increase the chances of learning from the feedback embedded in outcome information. Our article focused on the lack of relation of experience and expertise and possible mechanisms to ameliorate this. Specifically, we called for much more quality outcome information (proximal and distal) and suggested that conscious attempts to use this information in deliberate ways (e.g., minimizing heuristics) would increase the relation of expertise and experience.

Some reactions to our article focused on practices that might lead to skill acquisition that in turn would lead to expertise. McMahan (2014) noted that in our paper we ignored supervision, which is the most widely used mode of improving practice. We see supervision as an important vehicle for obtaining and processing feedback (a key issue). But most supervision is performed while in training and our comments focused on development after training where there is much less supervision provided. In addition, whereas there is some evidence that supervision positively affects client outcome (Bambling, King, Raue, Schweitzer & Lambert, 2006) there also is recent research showing that there are no differences in client outcome across supervisor (Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2014). Perhaps the issue should not be one of

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increasing supervision post degree but rather of examining the key elements within supervision that lead to better outcomes. It is our assumption that these too will be similar to our components of deliberate practice.

Oddli et al. (2014) viewed our recommendations for deliberate practice as a bit too narrow in that they would exclude implicit reasoning and intuitive practice decisions. We agree that these are subtle and potentially important aspects of cognitive development; but, without specifying new ways that these can be increased or honed, it is an example of proposing exactly what we already have. How specifically can these context-dependent decisions be enhanced and increased, and would this lead to better outcomes? Further, it is crucial that these intuitive decisions be separated from the common heuristics associated with such processing, because the errors of such processes have been well demonstrated (e.g., Dawes, 1994; Garb, 1997, 1998, 2005). There is some emerging research in this area of logical intuition (e.g., De Neys, 2012) but its application to psychotherapy awaits.

Admittedly psychotherapy is a difficult profession in which there are no clear answers and for which the definition and identification of expertise may be contentious. But we see our practices as open to improvement with careful attention and empirical evaluation. Stronger research-based attempts to help ensure that experience is used appropriately and results in increased skill and improved outcomes are needed. Our recommendations are in line with this view. That said, we do not think that ours are the only potential solutions to gaining expertise as a therapist, but believe that they are promising given the empirical base garnered from other areas.

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

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COMMENTARY

The Role of Vulnerability and Peer-Supervision in Establishing Clinical Competency

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With the growing emphasis on Evidence-Based Psychotherapies (EBPs) it is important to take notice that in the community there are generally no assurances of fidelity to a treatment methodology. Consider the following scenario: A young man experiencing symptoms of Panic Disorder is advised by a savvy primary care physician to seek psychotherapy. This gentleman does some research online and finds that Cognitive Behavioral Therapy (CBT) with Interoceptive Exposure is generally accepted to have the most empirical support for treating Panic Disorder. He calls a local psychotherapist, whose website describes the clinician's orientation as "CBT." If that young man obtains psychotherapeutic services from that therapist, would he actually receive CBT similar to that described in the research that he read about online? According to a recent study by the Aaron T. Beck Psychopathology Research Center published in *Administration and Policy in Mental Health and Mental Health Services Research*, we do not actually know what type of services might be provided (see Creed, Wolk, Feinberg, Evans, & Beck, 2014), as a therapist's self-identified theoretical orientation might not be a valid predictor of what is actually done in session (see McKay, 2014).

In the referenced article, Creed et al. (2014) state that their purpose was to look at the relationship between clinician self-report of theoretical orientation and competency in that method as measured by ratings of audio recordings of work samples. The researchers were focused on competency in CBT, but the implications of this research will be discussed broadly. With a sample of 321 community clinicians, they found that the ratings of fidelity to the CBT model for the audiotapes of the therapists who identified as CBT-therapists were scored as roughly equivalent to those of their non-CBT counterparts. In other words, clinicians who reported using CBT in session would not be considered to be doing so when adhering to objective standards of competence and fidelity. In fact, the average CBT competency ratings were indistinguishable between CBT and non-CBT self-identified community clinicians. Upon closer examination, both groups were in the "good" range for items relating to empathy, warmth, and collaboration; however, both groups were in the less than "satisfactory" range for the CBT-specific items. Notably, the majority of these clinicians were later trained to competency in CBT per the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980). Creed and colleagues recognized that people seeking psychotherapeutic services may be in a precarious situation, as their findings indicated that how psychotherapists represent themselves may

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not reflect the quality or content of what they actually do in session. They state that the public may need to rely on specialty certifications such as those available through the Academy of Cognitive Therapy and the American Board of Professional Psychology.

Implications for Psychotherapists

While Creed and her colleagues looked at CBT specifically, these findings are relevant to the field of psychotherapy in general. The potential negative outcomes for clients—who may not be receiving the services they seek—are clear and should be cause for concern. The results of the study should provide clinicians with an opportunity for reflection as well. We assume that the therapists in the study were not being deliberately deceitful, but the findings do raise questions about professional self-awareness and perhaps therapist training. An important concept to review is the *better-than-average effect* (Hilbert, 2012; Hoorens, 1993)—a finding that most people deem themselves better than average. This natural overconfidence is dangerous to our clinical work, and a way to address this cognitive bias is through *practicing vulnerability* (Brown, 2012).

Audio-Recording Therapy Sessions

The topic of audio-recording psychotherapy sessions has been a hot-button topic in the literature (Aveline, 1992). A regularly reported concern is a fear that audio recordings will inhibit client self-disclosure (Gelso, 1973); however, it has been found that as the session progresses both the client and the therapist often forget about the recording device, and clients do not report feeling inhibited by the recording process (Brown, Moller, & Ramsey-Wade, 2013). Shepherd, Salkovskis, and Morris (2009) explored the utility of audio-recording sessions and found that the majority of clients are open to having sessions audio recorded for the purposes of therapist peer-supervision. Further, it was found that clients liked having copies of these recordings to review the session content in between sessions. Thus, not only are clients open to therapists recording sessions for the purposes of peer supervision, but allowing the client to have a copy of these recordings may accrue additive benefits to the services being provided. Shepherd and her colleagues found that clients rated this practice as being both highly acceptable and highly useful. This is certainly consistent with our anecdotal experience.

The review of audio-recordings of sessions has long been suggested as a core component of both CBT and psychodynamic supervision (Aveline, 1992; Pretorius, 2006). Interestingly, Shepherd and her colleagues (2009) found that psychotherapists were more likely than their clients to express concern about recording sessions. A possible reason for this hesitancy might be that professional psychotherapists might associate audio-recording their sessions with being in the trainee role and this may invoke feelings of unease, anger, or shame. There is a wealth of literature showing that a common reaction to all of these feelings is avoidance (see Brown, 2012; Linehan, 1993), and, as the adage goes, the only way out is through.

Revisiting the Concept of Peer-Supervision

Peer-supervision is ideally a practice in vulnerability, where therapists choose to tolerate feelings of unease in order to refine their skills and deliver better client care. A core-component of peer-supervision should be work-sample review. The literature on the use of audio recordings in traditional supervision has demonstrated that clinician memory may not be completely reliable and that the nuances of a case are more easily under-

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stood when listened to than explained (see Aveline, 1992; Brown et al., 2013; Shepherd et al., 2009). In our experience, having a flexible schedule of who will be presenting works well. It allows for clinicians to come prepared to share and for the addressing of any pressing needs that develop in between peer-supervision sessions.

One could think of peer-supervision as having three goals: (1) Providing emotional and practical support for the therapist, (2) Refining the therapist's clinical skills/acumen, and (3) Ensuring better client care. To facilitate these goals a peer-supervision group would need to establish an emotionally-safe environment and have competent clinicians within the group. We'll first discuss establishing a safe space and then measuring clinician competency.

A useful model to consider is that presented by Linehan (1993), in which clinicians come to peer-supervision with specific consultation questions, are reminded to practice a nonjudgmental stance, receive validation and support from the team, and have a *fallibility clause* stating that clinicians are fallible and that's okay. Typically, we find that practicing vulnerability through embracing our imperfect human nature and owning up to mistakes needs to be modeled by more senior clinicians to reassure newer clinicians that peer-supervision is a safe space. The words of John Steinbeck from *East of Eden* (1952) illustrate the usefulness of the fallibility agreement: "And now that you don't have to be perfect, you can be good."

To aid in the assessment of clinician competence we recommend the use of competency rating scales. In order to receive a valid score on these measures you often need to be calibrated to the measures; nevertheless, the content of these freely available tools can be useful when reviewing your own or a peer's session audio. The most widely used measure of CBT competencies is the CTRS (Young & Beck, 1980). For clinicians who do not identify as CBT practitioners, a number of useful non-CBT competency measures have been developed. For example, the Yale Adherence and Competence Scale (YACS; Carroll et al., 2000) measures competency of addiction counselors and the Common Factor Therapist Competence Scale for Youth Psychotherapy (Brown, 2011) was recently developed for therapists who espouse an eclectic orientation.

Specialty Competency-Based Certifications

The following question has been raised: How do we protect the public from those who unknowingly or inadvertently misrepresent their services? Returning to the gentleman we previously discussed, how do we ensure that he actually receives the services he researched? Currently, the best bet is through specialty competency-based certifications such as those available through the Academy of Cognitive Therapy and the American Board of Professional Psychology (McKay, 2014). What distinguishes competency-based certifications from other existing options is the use of practice sample review and objective standards of competency. For example, when a clinician applies for certification through the Academy of Cognitive Therapy the review process involves verifying training and licensure, having supervised experience in CBT, having been practicing CBT for a number of years with a number of clients, having read the essential treatment manuals and textbooks, letters of recommendation, and a work sample review consisting of submitting a thorough treatment summary and audio sample which is rated on the CTRS.

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Thus, it is clear that when we say that these specialty certifications protect the public it is because they thoroughly assess the competency and qualifications of a psychotherapist. If we were to refer the gentleman we previously discussed for therapy and we wanted to ensure he received high-quality CBT, we would first look for a therapist who was certified by a body such as the Academy of Cognitive Therapy. For those of you reading this article who do not practice CBT, we'd encourage you to seek high-quality training, supervision, consultation, and certification in the therapeutic orientation in which you provide services. For example, the American Board of Professional Psychology also provides certification in psychoanalysis. Additionally, many other specialty certifications exist; interested parties should be wary of vanity certifications and should seek consultation with reputable professional bodies regarding the merit of these credentials.

Summary and Conclusions

In summary, we reviewed a recent troubling finding that a discrepancy exists between how therapists describe their theoretical orientations and their competence in those orientations. We highlighted barriers such as the better-than-average bias and avoidance that may prevent professional clinicians from seeking peer supervision. We reviewed the utility of peer supervision, audio recording sessions, competency measures, and specialty certifications. Overall, the goal is to do whatever you do really well, and to recognize that in order to grow as a clinician you may need to practice some vulnerability.

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

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PSYCHOTHERAPY RESEARCH[1]

A Multi-site Study of Mindfulness Training for Therapists

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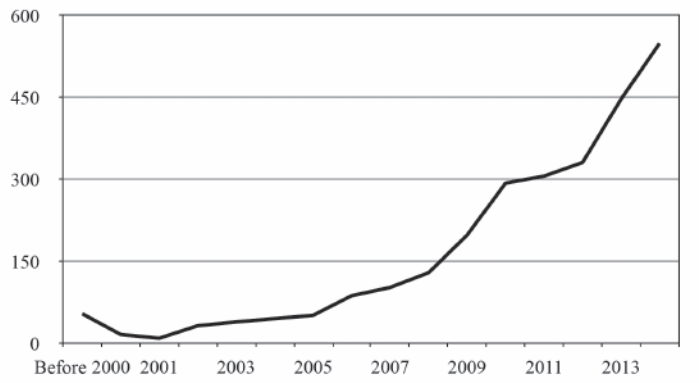
The past decade has seen a spike in research testing the use of mindfulness in the treatment of many physical and mental health problems. As one example of the increasing popularity, a PsycInfo search using the keyword "mindfulness" identified 2,672 peer-reviewed articles published through 2014. When citations are separated by year, the recent popularity is clearly evident (see Figure 1)! This body of research has found evidence supporting the efficacy of mindfulness as a treatment or adjunct treatment for anxiety, cancer, chronic pain, depression, diabetes, eating disorders, PTSD, and substance use disorders, to name a few.

Figure 1. Number of Citations per Year for a PsycInfo Search Using the Keyword "Mindfulness"



In addition to the research demonstrating the efficacy of mindfulness for clients, a smaller, but also growing, body of research has tested the utility of mindfulness for psychotherapists. The existing research examining the benefits of mindfulness for psychotherapists has demonstrated that it can lead to personal benefits such as reduced stress and greater self-compassion (Aggs & Bambling, 2010; Cohen & Miller, 2009; Schure, Christopher, & Christopher, 2008; Shapiro, Brown, & Biegel, 2007), as well as the development of psychotherapy skills such as increased comfort with silence and the ability to show empathy (Aggs & Bambling, 2010; Greason & Cashwell, 2009; McCollum & Gehart, 2010; Moore, 2008; Schure et al., 2008). Less research has examined whether the therapists' use of mindfulness is associ-

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ated with client and session outcomes.

Studies examining the relationship between psychotherapist mindfulness and treatment outcomes have produced mixed results. In one study, Stanley, Reitzel, Wingate, Cukrowicz, Lima, and Joiner (2006) tested the correlation between self-reported mindfulness and client outcomes for 23 therapists from a psychology department training clinic. While therapist mindfulness was not related to clients' ratings of their own improvement, it was actually negatively correlated with termination GAF scores and therapists' ratings of their clients' improvement. Although informative, this study was limited given its correlational nature and the fact that outcome ratings were based on therapist judgment, which does not always match client-reported treatment outcomes. In contrast to the findings from Stanley et al. (2006), two studies conducted by Grepmair and colleagues have found more favorable results for therapist mindfulness. In the first, Grepmair, Mitterlehner, Loew, and Nickel (2007) compared inpatient treatment outcomes for psychiatry residents who engaged in daily Zen meditation for nine weeks to treatment outcomes that had been observed during the nine weeks prior to beginning the daily meditation. Compared to clients seen during the first nine weeks, clients who were seen during the Zen meditation period showed a greater reduction in symptoms by the end of their inpatient stay. In the second, Grepmair, Mitterlehner, Loew, Bachler, Rother, and Nickel (2007) randomly assigned a group of psychiatry residents to either a nine-week daily Zen meditation group or a control group (no meditation). Similar to their first study, compared to clients seen by the control group of therapists, clients who were seen by the therapists who practiced daily Zen mediation showed a greater reduction of symptoms by the end of their treatment. Although promising, the results of these two studies conducted by Grepmair and colleagues are limited in generalizability because they were conducted in the same German inpatient hospital; they only tested one method for promoting mindfulness (Zen meditation); that method was relatively intense for the study period (1 hour of meditation per day); and the trainees were comprised exclusively of psychiatry residents.

Given the inconsistent findings and the limitations of the existing studies, we recently conducted a pilot study examining the impacts of a five-week mindfulness training for beginning psychotherapists (Ivanovic, Swift, Callahan, & Dunn, Under Review). Participants were 31 trainees who were completing their in-house practicum at one of two psychology department training clinics. Client ratings of session effectiveness were recorded for two weeks before and after the mindfulness training program. Those sessions that were conducted after the mindfulness training were rated by clients as being more effective (d = .30). Although the results of our pre-post pilot study were promising, the study did not include a control condition. Thus, it is difficult to conclude that the improved ratings were actually due to the mindfulness training. The purpose of the current study was to further examine the effectiveness of a brief 5-week mindfulness training against a control condition using a cross-over design. In this study we have collected data on therapists' ratings of their state and trait mindfulness, therapists' ratings of their in-session presence, clients' ratings of their therapists' in session presence, and clients' ratings of the effectiveness of the psychotherapy sessions.

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Participants
Graduate students from two psychology department training clinics (20 at each university) in separate regions of the U.S. were recruited to participate in this study. These two clinics are the in-house practicum training sites for five graduate programs, including an M.S. in clinical psychology (n = 10), a Ph.D. in clinical-community psychology (n = 10), a Ph.D. in clinical psychology (n = 6), a Ph.D. in counseling psychology (n = 8), and a Ph.D. in clinical health psychology (n = 6). The average age of the trainees was 27.2, and the majority of them identified as female (70%) and Caucasian (75%). Seven of the trainees were in their first year of training, 12 in their second, 19 in their third, one in fourth, and one in fifth year.

Procedures
In this study we used a crossover design which allowed us to compare the mindfulness training to a control condition, but still allowed all participants to receive the mindfulness training during the course of a semester. During the baseline period all of the therapist participants completed a demographic form and a baseline assessment of state (Toronto Mindfulness Scale) and trait (Five Facet Mindfulness Questionnaire) mindfulness. Additionally, for one week all adult sessions conducted by the participating therapists were evaluated by their clients using the Session Rating Scale and Therapist Presence Inventory-Client. Therapists also rated their level of presence in these sessions using the Therapist Presence Inventory-Therapist. Therapists were then randomized into either the mindfulness training (MT) or the control group (wait). After five weeks of MT or wait, the therapists' again completed measures of trait and state mindfulness and for one week the session measures were administered at the end of all sessions that were conducted. Then, therapists who were originally assigned to the control group received the MT and those who originally received the MT waited for five weeks for a follow-up assessment. Last, after this second set of trainings, the same assessment procedures for therapist state and trait mindfulness and session effectiveness and presence occurred.

Measures
Five Facet Mindfulness Questionnaire (Administered at each of the three assessments)—The FFMQ (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) is a commonly used measure of trait mindfulness that includes 39 self-report items. Adequate internal consistency and predictive validity have been reported (Baer et al., 2008).

Session Rating Scale (Administered at the end of all therapy sessions during the three week-long assessment periods)—The SRS (Johnson, Miller, & Duncan, 2000) is a 4-item measure of session effectiveness completed by clients at the end of their therapy sessions. Adequate internal consistency, test-retest reliability, and sensitivity to change have been reported (Duncan et al., 2003).

Toronto Mindfulness Scale (Administered at each of the three assessments after a brief mindfulness exercise)—The TMS (Davis, Lau, & Cairns, 2009) is a commonly used measure of trait mindfulness that includes 13 self-report items. Adequate internal consistency has been reported (Lau et al., 2006).

Therapist Presence Inventory-Client (Administered at the end of all therapy sessions during the three week long assessment periods)—The TPI-C (Geller et al., 2010) is a 3-item measure asking clients to rate their therapists' level of presence in the preceding session. Adequate internal consistency and predictive validity have been reported (Geller et al., 2010).

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Therapist Presence Inventory-Therapist (Administered at the end of all therapy sessions during the three week-long assessment periods)—The TPI-T (Geller et al., 2010) is a 21-item measure asking therapists to rate their level of presence in the preceding session. Adequate internal consistency and predictive validity have been reported (Geller et al., 2010).

Mindfulness Training—A manualized, five-week mindfulness training program that we developed and tested in our pilot study (Ivanovic et al., Under Review) was used in this study. Broadly speaking, the training program was developed based on the principles from Jon Kabat-Zinn's MBSR program, except it was abbreviated to a five-week program and additional applications for the therapists' use of mindfulness were discussed. Each weekly session was offered in a group format and was 30 minutes long. Each session began with some general information/discussion about some of the core principles of mindfulness (Week 1: introduction to mindfulness; Week 2: acceptance and non-judging; Week 3: letting go and patience; Week 4: trust, beginner's mind, and non-striving; Week 5: applications to therapy and therapeutic presence). Following the general information/discussion, group participants were led in a formal mindfulness exercise (Week 1: a mindful breathing exercise; Weeks 2 & 3: a mindful thought exercise; Weeks 4 & 5: a mindful centering exercise). Homework was then assigned, including daily formal (practice of the exercise that was used in the training program during the week) and informal (e.g., mindful eating, mindful teeth brushing) practices and brief readings from Jon Kabat-Zinn's (2012) book *Mindfulness for Beginners*. During the five training weeks, participants were also asked to record their engagement in the mindfulness exercises that were assigned as daily homework. A copy of this manual may be obtained through either of the Principal Investigators.

Preliminary Findings

In conducting this project we had hypothesized that, compared to the control group, those who received the mindfulness training first would show greater improvements in therapist self-reported state and trait mindfulness and presence during session and client-reported therapist presence and session effectiveness. Here we present preliminary findings for the therapist self-reported state and trait mindfulness. The more detailed findings of ratings of therapist presence and session effectiveness will be reported in a later peer-reviewed manuscript.

Similar trait mindfulness (FFMQ) scores were observed at baseline for the mindfulness-first, $M = 135.38$, $SD = 16.91$, and the wait-first group, $M = 131.33$, $SD = 13.03$. After the first five weeks of training, the mindfulness training group reported higher levels of trait mindfulness, $M = 144.08$, $SD = 10.57$; while the wait-first group showed no change in reported levels of trait mindfulness, $M = 132.58$, $SD = 13.79$ – $d = 0.94$ for the between groups comparison at this time point. Over the course of the second five weeks during which the wait-first group also received the mindfulness training, the wait-first group reported similar increases in trait mindfulness, $M = 142.43$, $SD = 12.47$ – $d = 0.79$ for the improvement seen pre/post training. Even though the mindfulness-first group did not receive additional training during the second five weeks, at follow-up they reported even higher levels of trait mindfulness, $M = 153.50$, $SD = 9.09$ – $d = 1.33$ for the overall baseline to follow-up improvement seen in this group. Figure 2 displays these results.

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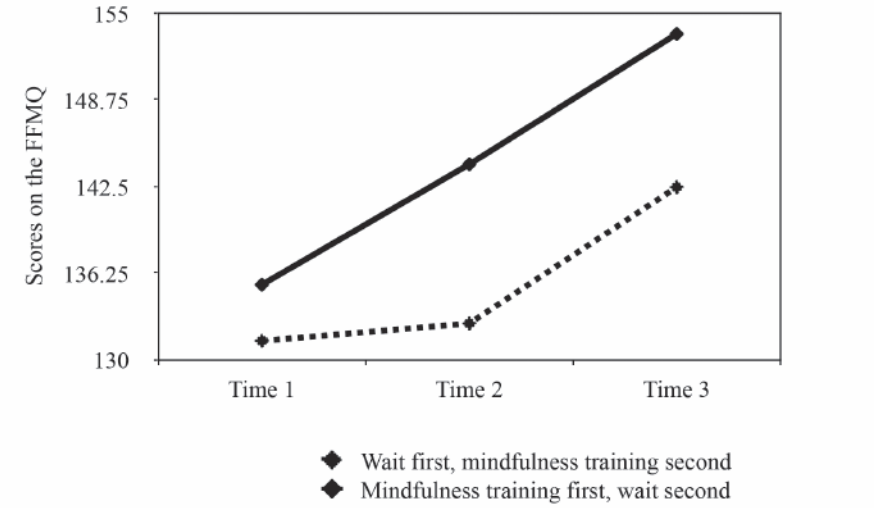
Figure 2. Changes in Trait Mindfulness for Mindfulness-First and Wait-First Groups Over the Course of the Study.



Prior to the mindfulness training the mindfulness-first group's average self-reported state mindfulness score (TMS) during a formal mindfulness exercise was $M = 31.18$, $SD = 6.64$. At the end of the five weeks of training, this group's average state mindfulness score was $M = 32.29$, $SD = 8.27$, showing a small, but non-significant improvement, $d = 0.15$. Prior to the mindfulness training, the mindfulness second group's average state mindfulness was $M = 31.07$, $SD = 8.54$. At the end of their five weeks of training, this group's average state mindfulness score was $M = 33.00$, $SD = 9.57$, similarly showing a small, but non-significant improvement, $d = 0.21$.

Discussion

These preliminary results suggest that the five-weeks of mindfulness training did improve therapists' perceptions of their level of overall mindfulness in their lives. However, they did not see an increased ability to invoke a mindful state during a formal guided mindfulness exercise. It is possible that our particular training focused more on helping beginning clinicians develop a global ability to be mindful in their lives rather than just during a guided exercise. It may also be that participants completed their state mindfulness ratings relative to their trait mindfulness ratings. At lower levels of trait mindfulness prior to the training, participants may have more easily noticed their ability to be present during the formal exercise. Even if their ability to invoke a mindful state had improved, it may not have been as noticeable after their training due to the higher level of mindfulness that they were noticing throughout their day-to-day lives.

Although improvements were only seen for trait mindfulness in these preliminary results, these findings are promising and have implications for training. Compared to the training that has been used in previous studies, the mindfulness training that was used in this study was brief (5 weeks, 30 minutes per week with brief daily practices), and so it

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could easily be integrated into a training setting. This type of training could also be added to a beginning therapy skills course or in a practicum/supervision setting. However, lengthier or more in depth training and practice may be needed to improve student's ability to invoke a mindful state. In further analyzing the results, it will be interesting to see if therapist presence and session effectiveness will be rated higher after the mindfulness training. In addition, in further analyses we will examine therapists' prior experience and knowledge of mindfulness as well as adherence to daily practices as covariates to the changes in state and trait mindfulness over the course of the training.

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

[1] In addition to several student and career awards, The Society for the Advancement of Psychotherapy regularly provides funding for research through two competitive grants—the Norine Johnson, Ph.D., Psychotherapy Research Grant and the Charles J. Gelso, Ph.D., Psychotherapy Research Grant. One Norine Johnson, Ph.D., Psychotherapy Research Grant of up to $10,000 is awarded each year for a project designed to study psychotherapist factors that may impact treatment effectiveness and outcomes. As many as three Charles J. Gelso, Ph.D., Research Grants of up to $5,000 are awarded each year for projects designed to study psychotherapy process and/or psychotherapy outcome. This year, the Psychotherapy Research feature articles will present brief reviews of some of the studies that have recently been funded through these grants.

An Important Aspect of Educational Orientation in Psychotherapy Supervision: Providing Supervisees with a Conceptual Framework for Understanding Their Own Therapist Development

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In my supervision practice, I work with doctoral students at the beginning of their work as therapists. These students have either had no therapeutic experience or limited experience. As Chessick (1971) indicated, three critical issues often confront therapists in their shift from classroom to clinic: (a) learning to manage anxiety early on during the treatment process; (b) developing a sense of therapist identity; and (c) developing conviction in the power and possibility of psychotherapy as treatment. Because this beginning training period can be particularly trying, with student vulnerability being most pronounced and awareness of practice deficits being most acute, I believe it is crucial that I create a *safe learning container* within which beginning therapists can freely grapple with those issues with impunity. In creating such a container, the foundation for my thinking is richly informed by both therapist development theory and research *and* adult learning theory and its application (e.g., Knowles, Swanson, & Holton, 2011; Ronnestad & Skovholt, 2013). Building on that developmentally anchored body of work, the question uppermost in my mind in starting any new supervision experience is: How can I create a safe learning container that best meets the specific learning needs of this particular supervisee now?

In creating that learning container, I believe strongly that educationally orienting supervisees about all aspects of supervision (e.g., purposes of supervision, roles of supervisor and supervisee) is always the best place to start. Educationally orienting supervisees, recognized transnationally as an important supervision competency (e.g., Pilling & Roth, 2014), (a) provides clarity and enhances conceptual understanding about the supervision process and (b) enhances supervisor-supervisee collaboration. Supervisees are at their best when fully informed, and I want my supervisees to be as fully informed as possible from the outset (e.g., through use of supervision agreements, discussions, role induction)—the hope being that they will then be better able to effectively use supervision and take a more active role in its unfolding process.

In what follows, I would like to accentuate one aspect of educational orientation that I regard as particularly crucial for any supervision: *Conceptualization*. As defined here, conceptualization refers to supervisees having a framework for understanding their own therapist development experience. As a supervisor, I foremost want to *provide supervisees with such a developmental, conceptually anchoring framework.* I believe that this aspect of educational orientation can be all too easily overlooked and shortchanged in importance. It is a developmentally-in-

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formed first step that can get supervision started off most favorably and contribute to supervisees' learning enhancement—the hope being that supervisees will be better able to understand and effectively respond to the vagaries and vicissitudes of their own developmental process in the moment.

Orlinsky and Ronnestad (2005), Ronnestad and Skovholt (2013), Skovholt (2012), and Stoltenberg and McNeill (2010), in my opinion, are the best sources for gaining understanding about the importance of (a) thinking developmentally, (b) incorporating a developmentally-informed perspective into supervision, and (c) providing a developmental rationale and framework within which to locate the therapist/supervisee growth process. Their work (a) captures nicely the unfolding trajectory through which therapists pass on their way to developing a *practice self* or therapist identity and (b) identifies or suggests supervisory actions that stimulate therapist growth along the developmental continuum. As Hess, Hess, and Hess (2008) stated, "If supervision is educative, then it makes sense to feature an educational process model" (p. 165). A crucial part of any such model would involve educating the participants about the very educational process in which they will be participating; a critical component of that participant education would be helping supervisees better understand their own therapist growth process that is now in motion.

From the perspective of adult learning theory (Knowles et al., 2011), educating for process preparedness provides answer to the "why" of the learning experience for supervisees and can contribute to their feeling more sense of process ownership. From the perspective of therapist development theory, educating for process preparedness can allay anxiety and equip supervisees for what lies ahead. The forewarned supervisee is a forearmed supervisee (Skovholt & Ronnestad, 2003). We educate to elucidate. We educate to collaborate.

Frank and Frank's (1991) conceptual framework about helping and healing relationships can also be used by extrapolation to inform supervisory thinking. In their model, those individuals seeking therapeutic assistance—typically in a demoralized, confused state of struggle—benefit from: (a) entering into a confiding relationship with a sanctioned helper in a designated helping setting; (b) being provided with a conceptual scheme or *adaptive explanation* by which they can understand their struggle and see remedy; and (c) actively and collaboratively working with the helper to implement a program of action that is based on that conceptual scheme. Where those elements are in place, the patient's embrace of meaningful help and the instigation of desired patient change become increasingly likely (Budge & Wampold, 2015; Wampold & Budge, 2012; Wampold & Imel, 2015). From the helpee's vantage point, positive expectations and hope of favorable outcome emerge.

Becoming a therapist is a developmental journey that also involves professional struggle and identity formation (Ronnestad & Skovholt, 2013; Stoltenberg, Bailey, Cruzan, Hart, & Ukuku, 2014). It is a unique learning experience for which there is no preexisting personal blueprint; that blueprint actually develops as beginning therapists immerse themselves in therapeutic practice and the process of therapist becoming. The blueprint for a therapist self develops "in the process of the process." Further compounding the problem, learning/personality characteristics (e.g., being highly organized and planful, being adaptively obsessive) that have been quite helpful before may not be

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helpful now. Developing a therapist identity is a different sort of learning problem that requires a different sort of learning resolution. Supervisees understandably experience varying degrees of confusion, anxiety, doubt, and demoralization as they struggle to develop a practice self. As new therapists begin their practice of therapy and begin receiving supervision, their own self-scrutiny and the scrutiny that they receive from others (supervisor and practicum team members) ratchet up as never before and make for a time of heightened vulnerability, exposure, and shame.

In parallel with Frank and Frank's (1991) model, beginning supervisees seeking educational assistance can similarly benefit from: (a) entering into a confiding relationship with a sanctioned supervisor in a designated educational setting; (b) being provided with a conceptual scheme or *adaptive explanation* by which they can understand the therapist development process, the struggles involved, and educational measures of remedy; and (c) actively and collaboratively working with the supervisor to implement a program of action that is based on that conceptual scheme (Watkins, 2012). Where those elements are in place, the supervisee's embrace of meaningful supervision help and the instigation of desired supervisee change become increasingly likely (Watkins, Wampold, & Budge, 2015). Supervisee positive expectations and hope of favorable outcome emerge.

Adaptive explanation ideally is provided in which: (a) the therapist growth process is developmentally framed and its typical trajectory mentioned; (b) unpleasant yet necessary aspects of that growth process are normalized and validated (i.e., "strength is in the struggle"); and (c) supervision is identified as the educational catalyst that most contributes to therapist development. Providing new supervisees with such a developmental rationale and framework gives accessible, understandable context to their learning experience, *reframes their evolving process as a vital necessity for advancement*, and fosters positive supervision expectancies. An adaptive explanation example follows:

> "Becoming a psychotherapist is a process that occurs through such repeated experiences as seeing clients, being supervised, and ongoing self-reflection. Being a developmental process, what you're experiencing occurs in stages; you're at the beginning stage in that growth process—where confusion, anxiety, and doubt and wondering 'Can I really do this?' can be quite common. Though it has been a long time since I sat where you are sitting, I definitely remember having felt what you are feeling, too. I assure you that you are not alone in what you are feeling now. All you are doing now is what you need to be doing to establish a sense of therapist identity. Supervision is the crucial catalyst in making that happen. I will do all that I can to help you on your way to becoming a psychotherapist. I have worked with many supervisees who have had questions and doubts identical to yours, and I have seen the supervision process enormously benefit them in proceeding developmentally and putting in place a more solid sense of who they are as a therapist." (Watkins, 2012, p. 200)

Far more detailed examples can be found in Watkins (2015).

Consideration of developmental rationale and framework, best when accompanied by supporting reading materials (e.g., Pica, 1998) and practicum team

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discussions, is in my view ongoing. This intervention provides an orienting reference point that is revisited as supervisees' needs require. For instance, should supervisee discouragement be triggered by work with a particularly challenging client, supervisees can be reminded about the developmental framework and its continuing relevance for them. Where supervisees become impatient with the slowly unfolding therapist development process, an explanation that emphasizes that slow-build aspect can help. Supervisees need hope, too, and providing them with a conceptual framework for understanding their own therapist development process can build hope into the supervision experience from the outset.

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

NOTICE TO READERS

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

Understanding Two Basic Person-Centered Principles and Their Relevance for Psychotherapy Practice

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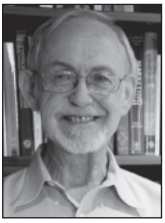

Two basic postulates of the person-centered therapy approach of Carl Rogers (1986) are of use to therapists of all persuasions. The first postulate, which most therapists already ascribe to, has to do with the importance of the relationship in psychotherapy. The second is that the client is not only an active contributor to, but a generator of, the change process. Everyone thinks they know about this, too. However, I believe that the full implications of this are not fully appreciated.

For Rogerians the term "person-centered" refers to the second postulate. Carl Rogers believed that persons were capable of generating their own positive growthful directions both in psychotherapy and life. Evidence on human resilience and self-generated change in everyday life supports this (see summary in Bohart & Tallman, 2010). As discussed below, research on psychotherapy supports the importance of clients being active participants in therapy. However, this has typically been interpreted to mean that clients must be engaged in and open to the process. For example, clients must be at the appropriate stage of change, be motivated, and must comply with the therapist's interventions (Bohart & Wade, 2013).

While this is true, there is more to the person-centered view of the client as an agent than this. In medicine, even though the physician wants to involve patients in their own treatment and needs to gain their cooperation, it is ultimately the physician who knows best. By contrast, Rogers believed that clients were fundamentally generative. It was they who ultimately knew what was wrong (intuitively, not necessarily consciously), and ultimately what would help them fix things in terms of their personal psychological ecology (again, intuitively). Put another way, it is clients who are the ultimate transformative agents in therapy.

Therefore, the therapeutic relationship is of a fundamentally different order than that of physician-patient. Clients' participation in therapy as intelligent agents is also of a fundamentally different order. If therapists choose to use techniques and interventions, these must interface with the client in a different way than do interventions in medicine. Techniques and interventions must "meet" the client in terms of where the client is at—what the client believes and feels and knows. Interventions will work best to the extent that the client is willing and able to creatively and intelligently interact with them, operate on them, and transform them into something useful—rather than merely "absorbing" interventions as if they were medications.

There is evidence (reviewed in Bohart & Tallman, 2010; Bohart & Wade, 2013) that clients are indeed generative. Evidence, in varying degrees, supports the following:

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- Clients focus on aspects of the therapy environment that are useful to them. These are often not the things therapists think are important.
- Clients actively work to maintain the therapy relationship and work to repair ruptures.
- They do private work in therapy sessions that they do not share with therapists.
- They generate insights that they often keep to themselves.
- They creatively operate on therapy to interpret what is going on in ways that they find most useful. They may creatively and usefully misunderstand and misinterpret therapists' communications and interventions. They may interpret the same intervention in different ways depending on what they need in the moment.
- They map what they are learning into their own schemas for dealing with problems, which again may have little to do with how therapists are seeing the interventions.
- They generate their own interventions outside of therapy.
- They creatively map what they are learning into their lived-in environments.
- They creatively merge what they are learning with what they are hearing from friends, talk shows, television therapists, and everyone else.
- They creatively "internalize" the therapist's voice to help them deal with problems in everyday life.

This implies that the language we use to describe what therapists do is misguided. We do not intervene to make things happen in clients. We do not literally "restructure their cognitions," for instance, as I have heard cognitive therapists say. We do not "operate on them." Rather we provide "aliment"—interactive experiences and tools—which clients utilize to extract useful experiential information and refashion their lives in ways that fit within the parameters of their self-organizing systems.

I particularly want to emphasize the generativity aspect. According to person-centered theory clients have a capacity for self-organizing wisdom (Bohart, 2013). That means they have a capacity to grow, change, and organize and reorganize themselves over time in more and more wise ways. My graduate students and I have done a small bit of research and have found some support for this.

This is one thing I believe the field does not get about person-centered therapy: Its focus not only on the client as collaborator, but as generator of change. Gendlin (1990) pointed out that most theories do not deal with clients as creative change agents. Despite the emphasis on collaboration in both modern psychodynamic therapy and cognitive-behavior therapy, neither theory has a role for client generativity as a major component in their theories of change. Rather, the focus is on therapists' modification of clients' ways of being through the provision of corrective experiences, insight-providing interpretations, cognitive restructuring, skills training, or exposure procedures. Change comes from outside, at least theoretically speaking. This is also true of positive psychology, with its emphasis on things like gratitude exercises.

All these interventions are useful. However, without the client's active, creative, and intelligent contribution, therapy would not work. There is no therapy that does not depend on that. Psychoanalysis, going back to Freud, can be seen as helping people become less defensive so they can think objectively and intelligently. Cognitive-

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behavior therapy only works because of its ability to rely on people's potential to think intelligently. And strategic and solution-focused therapies depend on clients' unconscious wisdom. We are working with intelligent agents, and ultimately it is clients' creative intelligence that makes therapy work by mapping what they get into their lives. Clients are co-therapists, if you will.

So how does the client as active generator of change contribute to your practice? First, be aware that clients are often creatively operating on the material you are providing. They are not merely "absorbing" it. Second, be on the alert for their ideas, including their creative misinterpretations of what is going on. Third, understand that your clients are going to make (perceived) lemons into lemonade. Fourth, be aware of how much effort clients are putting in to blending what you are offering with their ideas. Do not merely assume that your homework assignments or your interventions are just the right things for them or that what clients learn from them will be what you think they will learn. Fifth, listen to their objections, not just as signs of resistance, but as signs of their creative problem solving ability. Perhaps what seems like resistance may be because your ideas do not fit with their ideas.

This does not preclude using interventions from your own theory, although it might preclude using a cookbook approach. Indeed, Westra et al. (2010) found that cognitive-behavior therapists who practiced in person-centered ways, that is, creatively listened to and adjusted to their clients, had better outcomes than those who followed the manual in a cookbook fashion.

Now to the relationship. One of Rogers' main contributions was that the relationship is important in therapy. It is the relationship that frees up a client's ability to be generative. I suggest that it does this in part by reducing clients' feelings of defensiveness. That opens them up to the kind of receptive mind state that provides the basis for creativity. I would go further and make the suggestion that, at core, all therapies work by most fundamentally doing two things in addition to whatever else they do: a) reduce defensiveness so that b) clients' natural fluid intelligence can operate more effectively. For Rogers, that was sufficient. Beyond that, other therapists work in various ways to actively support this achievement, such as through training skills, providing insightful comments, helping clients think through dysfunctional thoughts, and so on.

Reducing defensiveness can occur from fostering clients having any or all of the following experiences:

1) feeling validated
2) being understood and understandable
3) being liked and prized and related to as a person
4) being treated genuinely as a person (this refers to the therapist's willingness to be genuine)
5) experiencing an increased sense of hope
6) feeling a reduced sense of threat
7) feeling more powerful and efficacious
8) feeling an increased sense of meaningfulness and purpose

Reducing defensiveness opens up attentional space. This has the effect of naturally making information available. Reducing threat increases the probability that the person can scan experience better. This can spontaneously lead to reductions in repetitive and ritualistic or

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ruminative over-focusing on negative experience. Second, experiences more naturally fall into a balanced relationship with one another—a trauma or a slight may shrink in comparison to the emergence of and attention to positive goals and experiences more important in one's life. Third, attentional shifts can spontaneously lead to seeing new opportunities, including what narrative therapists call breaks in the dominant dysfunctional narrative. Fourth, the opening up of attention can lead to creative ideas bubbling up.

As typically understood, Rogers' (1986) view of the relationship focused on the facilitative conditions of positive regard, empathic understanding, and congruence. I want to mention a different way Rogers had of talking about the relationship. At almost the same time he postulated the importance of the facilitative conditions, he said, in a dialogue with Martin Buber, that the important thing in therapy was that it be a "meeting of persons" (Cissna & Anderson, 1994). In fact, he said that therapy was a byproduct of a meeting of persons. Empathy, for instance, is not merely a technological way of responding, but is the essence of a deep grasping and sharing between two persons. It is at heart recognizing the personhood of the other. And this comes first. According to Rogers, this, by itself, is therapeutic. Everything else comes second. This is different than medicine, where doctors also want to meet the person—not as a fundamental component of healing, but as a kind of support base for what they are going to do. What Rogers was saying is that meeting the other person as a person is not just a nice way of treating the client so that you can do what you do, it is the essence of therapy. It does not preclude using other things, but they are built upon this core meeting, this responding to, and this recognizing of the other person as person, which is itself intrinsically therapeutic, particularly for people who feel lost, worthless, self-critical, shamed, out of control, or who have been in traumatic and dehumanizing situations.

Empathy in this context is not empathy as it is commonly understood. For Carl Rogers, empathy was not empathic responding. Empathic responses were not interventions. Rogers rejected the term reflection of feeling late in his life. He said he was not trying to reflect feelings (a technological approach), but rather trying to test his understanding of the other (Rogers, 1986). His focus was on hearing, on his receiving, not on doing something to the client. The direction of therapy was not "I-thou," but, as Peter Schmid (2004) has said, "thou-I." The therapeutic element was in the therapist's ability to listen, hear, and recognize the personhood of the other. Similarly, empathy was not "having compassion for," or "feeling the same feeling as," or "understanding the client's pain." It was receiving them as a sentient other trying to convey their struggle to find a meaningful way of being on the planet as they understand and grasp their situation, no matter how disturbed or even psychotic they are. It requires the utmost dignity in listening, and that is why person-centered therapy is first and foremost an ethical stance. The therapist's goal is not to show empathy to or for clients, although it is important that that also happens, but rather to open up and empathically receive them as persons in their own right.

This sounds deceptively simple. However, it does not always happen, even with well-meaning professionals. Consider the following story from Larry

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Leitner's time as a psychological intern:

> I first saw Tom on intake at a Veteran's Hospital. He was clearly agitated and confused and was, at times, incoherent. His family filled us in on his increasingly bizarre behavior… (including hiding in his closet petrified about what hallucinatory voices said). When the admitting physicians excused themselves to make arrangements for his hospitalization, I said to him, "You seem really confused about things." Tom's eyes welled with tears and he said, "I am so confused I cannot even think."…I told him that it broke my heart to see him in such pain. He looked at me and replied, "As long as I don't think about Vietnam, I don't get confused." I then suggested that, perhaps while he was in the hospital, we could talk about …Vietnam.
>
> I was met with incredulity when I argued that perhaps clients like Tom were saying things that were personally meaningful and important. For example, when I suggested that Tom's confusion and erratic behavior might be related to something that happened…in Vietnam, I received a lecture on the nature of schizophrenic thought disorganization. Tom was attributing his confusion to Vietnam due to a desperate search for a cause when the reality was that a schizophrenic process was the cause....Sadly, I saw Tom again a few days later on the inpatient unit. He was on heavy doses of neuroleptics and speaking even a few words required great effort. To this day, I still wonder what might have happened in Vietnam. (Leitner, 2009, pp. 364-365)

I'm sure the psychiatrists in this hospital would view themselves as having both empathy and compassion for Tom. They might have even considered themselves "person-centered" in their concern for their clients. However, they didn't listen and they didn't receive Tom as a person. In a similar manner Sabat (2001) has described how Alzheimer's patients are often not listened to by doctors or other staff because it is assumed that what they are saying comes from their illness. Yet when Sabat listened he found sensible persons inside.

In conclusion, providing a good relationship does not merely mean being warm, caring, and empathic. It means really recognizing the person as a person, as a sense-making other, and listening to and responding to them as such. This does not contradict the use of techniques. Rather, I am talking about the manner and attitude with which the therapist approaches clients. I suspect good therapists of every stripe respond to their clients in this respectful, collaborative, dialogical person-to-person way. It is the honoring the personhood of the person that ultimately underlies the effectiveness of therapy.

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

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Ethical Considerations When a Client Crosses Sexual Boundaries: My Experience as a Student Therapist

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I'll never forget the day that a friend of mine quoted a professor from my university: "The only way you can screw up as a psychologist is by having sex with your clients. As long as you don't do that, you're set!" Forgive the crass language, but the words and tone used at the time definitely put my nerves at ease. I was a second-year master's student in a clinical psychology program and it was one of the first days that I was working at my first-ever clinical externship—a residential treatment facility for adolescent males who had sexual behavior problems. Participating in multiple relationships with a client never crossed my mind. I was well trained by the Chair of the APA Ethics Committee, and more importantly, I wanted a future in the profession. It didn't hurt that I was currently providing psychotherapy to individuals who had committed sexual offenses. Yes, I recognized that working as a female with adolescent males with boundary issues put me in a position to potentially experience encounters and attempts of an inappropriate nature. However, the reciprocation of their feelings toward me was never in the cards. Although I was well educated on the theories, reasons, and understanding of the ethical considerations regarding intimate relationships with clients, I was unprepared to face the ethical decisions I was going to have to make when a client of mine sexually assaulted me.

Sexual intimacies between mental health professionals and their clients are considered one of the most immoral acts within the profession. They not only violate the law, but also the principles of beneficence, nonmaleficence, and autonomy in the American Psychological Association Ethical Principles and Code of Conduct [Ethics Code] (APA, 2010), as well as multiple ethical standards within the Code. More importantly, such acts can cause significant damage to the client's mental health, emotional health, and general well-being.

Sexual intimacies are defined by the Maryland Psychology Board Laws and Regulations Chapter 5 Article, §1-212, 18-311, and 18-313(7) as

> acts engaged in with or without clothing involving: (a) Genital contact; (b) Nongenital contact with the hips, loin, thigh, buttocks, or breasts; (c) Exposure or observation of genitals or nude portions of a body involving breasts, buttocks, or genitals; or (d) Other behaviors engaged in for the purpose of sexual arousal or sexual gratification.

When discussing the topic of multiple relationships in terms of sexual intimacies, one should also take into account the terms boundary crossing, boundary violation, and sexual intimacy itself. According to Knapp and VandeCreek (2012), boundary violations accounted for almost half of the 2004 American

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Psychological Association's (APA) Ethics Committee disciplinary actions, with most such violations regarding sexual intimacies involving a client and his or her therapist. More recently, of the nine cases that were opened regarding boundary violations in 2011 by the APA Ethics Committee, 56% percent of them were considered cases of sexual misconduct (APA, 2012). Barnett, Lazarus, Vasquez, Moorehead-Slaughter, and Johnson (2007) add that a boundary violation may also be viewed by the client as unwelcome or unwanted, and may be considered contradictory to the therapist's obligations to the client.

That being said, I had been trained well to monitor my own behavior. Ways to appropriately, respectfully, and empathetically express one's position of power, the importance of the therapeutic and professional relationship, and the absence of shared feelings were all discussed at length in my ethics class. Yet I was still unprepared for what happened next.

I had been seeing my client for a few months at this point. He was an adolescent male with an apparent and yet undiagnosed developmental disorder, and was participating in sex offense treatment. We were finishing up our therapy session, and, as I stood to open the door for us, he grabbed my breast. I immediately exclaimed, "No! What do you think you are doing?" and backed away from him. I told him to stand up and follow me to get another staff member, which we did; and then I had my client take accountability for his actions by sharing his previous behaviors to the staff member.

Despite having conversations with, and learning from, professionals in the field, I was neither prepared for the event, nor the decisions I would have to make afterward. I struggled to make sense of what had happened and how to understand its meaning for both my client and for me personally. Some said that I should have physically defended myself, others commended me on the way I handled it. According to Maryland law, my client had engaged in an unlawful sexual act—but what implications did that have? At first I downplayed the significance of the event. Perhaps I had been desensitized from working in sexual-offense specific therapy settings. Or perhaps I was determined to demonstrate empathy for my client's history and cognitive abilities. I struggled in taking on the role of a "victim" over maintaining my role as his therapist. I wanted to be ethical and professional, but I didn't know what that meant in this context.

In exploring the decisions that I was faced with, I was very fortunate. The team with which I was working was extremely supportive, and my supervisor was nothing less than extraordinary. They began by focusing on me and my experience; encouraging me to see myself as an individual, and not as a therapist. Despite my determination, I could no longer be neutral or objective. After facilitating and encouraging me to process through the events, they asked me if I wanted to press charges. There was the question of the year … did I want to press charges?

Standard 3.04 of the Ethics code encourages psychologists to take appropriate and reasonable steps to avoid causing harm to anyone that they have a working relationship with (APA, 2010). Wouldn't pressing charges cause harm to my client? What would happen to him? Would he learn anything as a result of the new charges and/or the subsequent consequences? Would he shut down and be defensive to future treat-

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ment? These were the only questions I was asking at that point. However, my supervisor sat me down and pointed out that in this situation, I was not just a therapist, but a woman who had just been violated. She forced me to take a real look at the situation, and put myself first, pointing out that if I didn't deal with my own feelings, I could not be effective as a psychotherapist. After long deliberation, many hours of supervision, consultation, and extreme ambivalence, I chose to press charges against my client. This choice was considered in the long term interests of the client as well as my own self-care obligations. Yet the obstacles were not over.

"Choices about whether to cross a boundary confront us daily, are often subtle and complex, and can sometimes influence whether therapy progresses, stalls, or ends" (Pope & Keith-Spiegel, 2008). After pressing charges, the next step I faced was deciding whether or not to continue working with my client as his therapist. Standard 3.05 part (a) of the Ethics Code cautions psychologists to refrain from entering into a multiple relationship if the relationship could hinder the objectivity, obligations, competence, or effectiveness of the psychologist's role (APA, 2010). It also warns psychologists against entering into a multiple relationship that could cause risk of exploitation or harm to the client. Part (b) of Standard 3.05 states that psychologists finding themselves in a multiple relationship that could be considered risky should take the necessary steps to resolve the situation to fit the client's best interest, and in adherence to the Code (APA, 2010).

As a novice psychologist in training, I felt that I had a lot to prove. I wanted to continue working with my client and also felt the need to demonstrate that I was capable of leaving my personal issues at the door. I wanted to be the best therapist that I could have been. Yet continuing therapy with my client would have been entering into a multiple relationship, one in which not only was I the therapist, but also his victim. My objectivity would have been compromised, even though I tried to argue that it wouldn't have been. In addition, by pressing charges I had added a level of power over my client that could have negatively affected his ability to truly and successfully gain something from treatment. Swallowing my pride, I terminated treatment with my client. This was done through a monitored session by my supervisor where my (former) client was given the opportunity to verbally and personally take accountability for his actions, express his feelings toward the termination of our professional relationship, and for me to express my own feelings about his actions and the subsequent consequences. Due to my client's existing residence at a facility focused on providing treatment for similar behaviors, he continued to participate in treatment at the same facility with a different therapist.

Although I was well educated on the theories, reasons, and understanding of the Ethics Code, I was unprepared for the ethical decisions I faced when a client of mine sexually assaulted me. I was forced to take myself out of the role of the therapist, to temporarily make myself and my needs a priority over the client's, to determine whether or not to press charges, and then to decide whether or not to terminate the therapeutic relationship. I was challenged when to focus on my client's needs and when to focus on my own. There is no formal code of ethics for clients, only for professionals, and even those don't cover every situation.

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Despite being the most difficult situation both personally and professionally in my career as a psychologist-in-training to date, it did present me (and the client) with great opportunities for growth.

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

The Diversity of Perfectionism and the Early Career Psychologist

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We used to think things would only get easier after graduate school. To even be considered for doctoral study required perfection: astronomical GRE scores, great field experiences, and evidence of research potential. The pace only picked up during graduate training. We now needed to earn top grades in each and every domain of psychology, become self-aware of our blindspots and insecurities, secure great externships and practica with sufficient client contact hours, slog through the dissertation process, and still be pleasant and brilliant and memorable enough to impress our professors and supervisors to write great references for us. All this was for the opportunity to maybe, possibly, *please* match for predoctoral internship! The demands of perfectionism were not shed with those heavy velvet robes at graduation. Our doctoral degree entitled us to the responsibilities of finding a postdoc, sitting for the EPPP, and obtaining a license. Then we needed to maybe, possibly, *please* land a job or open a practice. As early career psychologists, working with clients and students brings new anxieties: Are we competent and expert enough to be helpful, are we following our training closely enough, and are they going to come back? We look enviously at our mid and later career psychology colleagues and imagine that once we reach their stage in the profession the need for perfection will cease.

However, as psychologists, early career or not, we have learned several things that help us understand the process of becoming a psychologist. First, past behavior is the best predictor of future behavior. Because we showed an earlier disposition toward perfectionism, it is most likely that our mid and later career will be tinged with this same perfectionistic style (and our relaxed-looking colleagues probably are still swimming upstream just like us). From our observation, psychology as a field seems to be populated with perfectionists. The profession of psychology, in its training and its practice, has the tendency to select for perfectionists, to amplify existing perfectionist traits among its members, or to exert a chronic level of stress that exhorts its members toward perfectionism. One of us (KSM) teases our doctoral students when learning about personality disorders that most *good* psych graduate students will have Obsessive-Compulsive Personality Disorder. Perhaps we should be careful about reinforcing this pressure toward perfection, but regardless, perfection seems to be part of the profession.

Second, we know more about the trait and experience of perfectionism, not just from personal anecdote, but from the psychology literature. Perfectionism is not a unidimensional construct distin-

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guishing psychologists from non-psychologists. Instead, the conceptualization of perfectionism has changed from being unidimensional to multidimensional (Burns, 1980; Hewitt & Flett, 1991), encompassing factors like the high standards we internalize for ourselves and others and the degree of functionality found in how we relate to those standards. One way of measuring the facets of perfectionism, including both its positive and negative attributes, is the Almost Perfect Scale-Revised (APS-R; Slaney et al., 1996). In the APS-R, the Discrepancy subscale measures the perceived difference between the standards one has set for one's own behavior and actual performance (Slaney & Ashby, 1996). The other two subscales are High Standards, which measures the standards one sets for performance, and Order, which measures the tendency to value a sense of order and organization. Based on the three subscales of the APS-R, three types of perfectionists have been classified: maladaptive perfectionists (high Discrepancy, Standards, and Order scores), adaptive perfectionists (high Standards and Order scores, but low Discrepancy scores), non-perfectionists (lower Standards and Order scores and moderate Discrepancy scores). Research consistently indicates that maladaptive perfectionists have lower self-esteem, more depressive symptoms, and more anxiety (Rice, Ashby, & Slaney, 1998; Suddarth & Slaney, 2001; Rice & Slaney, 2002) because these individuals do not feel as though they can meet their personal standards, which then become debilitating. In contrast, adaptive perfectionists also espouse high standards, however, they are not self-defeated by their expectations. Instead their high standards are used as a motivational tool. A fourth type of other-oriented perfectionist has been documented, involving lower Standards but higher Discrepancy scores (Nakano, 2009; Wang, Slaney, & Rice, 2007; Wang, 2012), and research on the possible existence of this group is beginning. Other-oriented perfectionists may take on the expectations of their family and important social institutions (as opposed to generating their own high standards). These individuals, as with non-perfectionists, tend to exhibit more average levels of self-esteem and depressive symptoms. Clearly there are variations in the types of perfectionism experienced by psychologists.

Finally, how our perfectionism plays out within our identity as psychologists is perhaps moderated by our other multicultural identifications. Overall, Asian Americans tend to report higher scores on several negative dimensions of perfectionism when compared to Caucasian Americans and African Americans (Castro & Rice, 2003; Chang, 1998). African Americans might experience more types of certain perfectionism (e.g., expectations from family) than might Caucasian individuals, but not for all types of perfectionism (e.g., criticism from family; Castro & Rice, 2003). Maladaptive perfectionism in minority individuals may be related to earlier development on scales of racial identity (Elion et al., 2012). Other-oriented perfectionism (high Discrepancy but lower Standards) is not often found among Caucasian or African American samples (e.g., Elion et al., 2012; Grzegorek, Slaney, Franze, & Rice, 2004; Rice & Richardson, 2014; Wang, 2012) and may be exclusive to Asian individuals (for a discussion, see Wang, 2012; for an exception, see Wang, Puri, Slaney, Methikalam, & Chadha, 2012). As an example, in Asian Indian culture an individual has an obligation to excel and live up to the standards of the family/community. Asian Indians are expected to bring honor and esteem to the family, through achievements at

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the cost of their own personal sacrifices and freedom (Durvasula & Mylvaganam, 1994; Sandhu, 1997). Thus, Asian Indians might feel more pressure to excel and strive for perfectionism because it is expected from the family. Interestingly, however, few gender differences have been observed in the experience and expression of perfectionism (e.g., Grzegorek et al., 2004). This may be due to a true similarity between men and women or that our instruments and methods are not well equipped to detect the standards on which men and women might differ. For instance, items are often describing high standards generically, but it may be that men hold more perfectionistic beliefs about agentic concerns (work, aging, competency) and women more about interpersonal concerns (relationship quality, appearance).

How might these cultural identities and values intersect with our career as psychologists and the demands of our field, especially at our emergence into our profession? We provide some vignettes here of times we have caught ourselves being perfectionistic with ourselves, our clients, and our students, and offer some comparisons of our experiences.

BM: As an early career professor I have high expectations for myself and my students' experiences in the classrooms. I can spend days or sometimes more prepping for a lecture. For example, it takes a while thinking of interactive exercises, thought-provoking films, and discussion questions. Ultimately, as a new faculty member I want my students to leave my courses feeling energized and well-trained in the course material. If students don't understand material, as evidenced by exams or papers, I wonder how I might have been unsuccessful as a professor. On the contrary, if students do grasp material I don't delight in it and actually don't think too much about it. Instead, I am always thinking about how I can better my teaching skills, and think of new and innovative ways to present the material.

KSM: One of my clients is a delightful middle-aged man with mild Intellectual Disability, and most of the work we do together is supportive therapy (learning affect management skills and relaxation techniques, testing the reality of certain thoughts, encouraging relationships, and planning enriching activities). Recently, he reported being distressed by panic attacks and anticipatory anxiety. Having some expertise in evidence-based treatments for panic, I quickly attempted to initiate one of the structured protocols I was familiar with. However, *my* progress in the treatment was stymied by his unique evaluation of the techniques we were using: The ones I thought most helpful he either did not wish to do or did not practice outside the session. I felt incredibly guilty for not being able to coax him into doing what I thought my training told me was best. However, he gained most out of asking me to write down statements that reassured him (something that I was reluctant to do because I assumed it promoted dependence and avoidance of panic feelings). Indeed, he asked me to photocopy one of the papers I had written for him because it had become tattered and faded from use.

BM: For the past several years, I have been serving as a dissertation chair for a student who has been a pleasure to work with mostly be-

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cause she is self-motivated and has a strong work ethic. She has accomplished tasks with ease and has been successfully collecting data while applying for internship. Recently, she emailed to inform me that she received interviews from nearly all of the internship sites to which she had applied. Of course, I congratulated her and then immediately asked her about the dissertation! I reminded her that while obtaining these interviews is excellent news, she also needs to move along in the dissertation process. After I sent my response I wondered what was wrong with me, and why I could not relish in this exciting news with her? Instead, I had to remind her that there was more that was expected of her. In my mind I felt that there was still more for her to do.

In each of these examples, we see the high standards being unnecessarily applied to ourselves and others toward a frustrating effect. Clearly they are examples of the various ways maladaptive perfectionism can present itself. Interestingly, the context of with whom we were interacting did not matter—we both could easily come up with numerous examples in our emerging professional life. We chose these three to be brief and illustrative, however, there were no shortages between the two of us, suggesting perfectionism affected us equally regardless of gender. The quality of the episodes were slightly different: BM, identifying as a Indian American female, reported more shame and self-recrimination and a lack of the experience of individual pride, whereas KSM, identifying as a European American, reported more failed initiative and guilt.

What then might we do about this perfectionism that pervades our profession? First is self-awareness. Noticing that some of the stress in our professional (and personal!) lives is due to the standards we set for ourselves is important, especially given our personal experiences and cultural backgrounds. Even then, it is easy to get carried away with judging ourselves as the examples of perfectionism mount up, as a perfectionist is likely to do. We might display signs of maladaptive perfectionism in one area, but be more adaptive in other areas. Being mindful of these incidents, as well as the positive effect high standards might have for a person (some of us *are* adaptive perfectionists, after all), might give us compassion and psychological distance from these events. BM did this in her example of working with a student and was able to correct herself and choose a new way of relating to her mentee. Finally, working with what works, that is, our own perfectionism, might be helpful. For instance, in selecting the *perfect* reading for a class, KSM will say that he will read only five articles and will select from those five. None of the articles will be perfect, in fact, their limitations are good for discussion and learning in class. Replacing rules with better rules might be a congruent method to help perfectionists. Our profession may in part shape us into perfectionists, but thankfully it also gives us the psychological knowledge and tools to be better and better perfectionists!

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

The Therapy Relationship in Multicultural Psychotherapy

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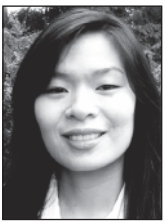

The most consistent and robust predictor of outcome in psychotherapy is the quality of the client-therapist relationship (Lambert, 2013). While we know that therapists' overall competence and client factors, such as motivation, are relevant and important to treatment, the client-therapist relationship is considered essential to effective treatment, at least in most therapies (Norcross & Lambert, 2011). This may be particularly true for those of who work with diverse clients, defined here as persons who identify or are identified by others as different from the prevailing dominant culture on the basis of race, ethnicity, culture, and/or other human diversity characteristics.

One prominent way of conceptualizing the therapy relationship is in terms of a working alliance (i.e., agreement on goals and tasks, and an emotional bond), a real relationship (i.e., perceptions that befit the other as a person and an ability to be genuine), and the configuration of transference/countertransference (i.e., distortions, displacements from the past brought into the relationship; Gelso & Hayes, 1998). In this brief paper we intend to highlight how the client-therapist relationship is particularly important in multicultural therapy and how each of these three dimensions of the relationship is relevant to it. We also discuss important therapist factors, such as knowledge, attitudes, and skills that foster the development and strengthening of the relationship. This paper is a continuation of a fruitful round-table discussion that the authors held at a recent APA conference. We have organized the content below in terms of the questions that were raised and discussed with the participants.

A few caveats. First we use the terms multicultural, diverse, and minority inclusively as described above. Second, we recognize that all people are socialized, cultural beings, so therapeutic interactions are inherently multicultural. We also recognize that for some dyads in therapy, race, ethnicity, culture, and

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other human diversity characteristics and experiences will be more relevant and more likely to impact the therapeutic relationship and, thus, the core of the work (e.g., a dyad in which the therapist is Euro-American and the client is African-American or dyads in which race relations and racism are central topics of discussion). Third, we acknowledge the critical importance of therapists' ongoing commitment to developing knowledge and awareness of their identities and how they might be perceived by clients who are from various cultural backgrounds. Finally, although the relationship in multicultural therapy could be conceived of and defined from other theoretical perspectives, our focus in the current paper is to make connections with what we considered to be the traditional perspectives of the relationship.

The first question raised at the roundtable discussion was how one establishes therapeutic trust and rapport with an individual who is culturally different. In the discussion, it was noted that it is important to treat each client as an individual; thus, the therapist's competence in assessment and intervention and ability to approach and engage clients will be key in establishing a relationship. For competent therapists, establishing an effective relationship in multicultural psychotherapy may not require significant changes from what they normally do successfully with other clients. However, at times, modifications in approach and timing may be necessary in order for the relationship to develop. In the working alliance, there is an emphasis on building trust, and, to an extent, on the importance of there being some level of a bond between the client and therapist. This is crucial to the relationship in multicultural therapy, and it may take a special sensitivity and patience on the part of the therapist for trust and mutual respect to develop with some clients. We believe that it is also important to explore the client's perspective on the nature of therapy and the therapeutic relationship (through immediacy, for example) and to use this understanding to assess and meet the needs and expectations that the client brings to therapy. The emphasis in the working alliance on agreement is also crucial here, so that the client feels understood. While establishing the therapeutic relationship, it may be particularly important for the therapist to express openness to discussing the client's experiences, including those that may be difficult or different for the therapist to hear, such as those involving bias, oppression, and racism. Validation of the client's experience is critical at this stage. While therapist openness and validation is important throughout treatment, it seems essential early on, to help the client begin to explore and process painful and difficult experiences of a racial, cultural, or social nature. In the process of maintaining and strengthening relationships, therapists may need to regularly check in with clients to confirm their understanding of these experiences, with empathy and with respect for the cultural beliefs and perspectives, strengths, and resources that might be available or of value to their clients (i.e., family, religion, and community).

The second question was: What is the role of the therapist's own identity and worldview in multicultural therapy? As mentioned above, therapists' professional awareness of and competence surrounding issues of race and ethnicity, as well as power and privilege, seem fundamental to building therapy relationships (Helms & Cook, 1999). This is relevant for all therapists, since we are all socialized beings whose values, beliefs, worldviews, and expectations influence the formation and development of therapeutic relationships. Beyond

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self-awareness, therapists can remain cognizant that the interpersonal process during the therapy hour reflects a social microcosm, where social and economic tensions, inequities, injustices, and misunderstandings might be brought into the relationship and inform the process and outcome of treatment. Good therapists will empathize with their clients, continually check the accuracy of their understandings of clients' circumstances and experiences, and work with patience and respect to forge relationships with clients in a way that reflects what Egan (2009) calls a "just society." The therapist will need to multi-task: on the one hand, engaging in the traditional forms of assessment and relationship building inherent in all psychotherapy treatment; and, on the other hand, modeling openness about racial, cultural, and other differences, and sometimes probing clients about racial and cultural differences and the extent to which race and culture-based experiences are relevant to work in treatment.

Our collective experience tells us that for some clients racial, cultural, and other diversity factors may be central to the work, but for others these experiences may be peripheral or less relevant or central to the work in therapy. While knowledge about the plight and history of various racial and cultural groups in the U.S. is valuable, the therapist must be cautious not to generalize or stereotype the client as fitting a profile; the therapist can approach the minority client as an individual who may have internalized a set of values and beliefs that stem from various environmental sources including race, ethnicity, culture, and more. A focus on the client as an individual personality, developed psychologically, socially, and culturally through human relationships and experiences, might help the therapist better establish a genuine and affirming therapeutic relationship. The concept of the real relationship (Gelso, 2011) emphasizes the importance of each participant, client and therapist, to be "who I am" in therapy, with the other; the real relationship highlights the importance for both client and therapist in being able to be "who he/she is" in therapy, and for the two to be able to perceive each other in realistically ways that befit them. The real relationship thus emphasizes the value in treatment for participants to see each other authentically in a person-to-person "I/Thou" frame, without the distortions that come from stereotypes and biases. It also emphasizes the ability for each participant to be genuine with each other, with the therapist being genuine in a way that is clinically oriented and in the service of the client.

In most therapies, there are moments when tensions and feelings, at times very strong feelings, arise in the relationship between therapist and client. These feelings may include anger, frustration, and disappointment, and may not be exclusively experienced by the client, but by the therapist as well. A question raised at our roundtable discussion was what to do when difficulties arise in the relationship in multicultural therapy. From our relationship-based perspective, it becomes a matter of whether the difficulties can be approached from a working alliance, real relationship, or transference/countertransference perspective, or perhaps a combination of these perspectives. The alliance could explain the difficulties (e.g., feelings of boredom, frustration, or sense of being stuck) if the client or therapist or both have experienced difficulty in establishing trust with one another, or if one of them perceives them as not being "on the same page" and working on mutually agreed upon goals. Difficulties in the alliance may indicate that the tasks associated with meeting the goals of treatment need to be revised, or

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that the client has not received the proper level of support from the therapist in engaging in the tasks of therapy. Difficulties may also arise from the client experiencing a lack of sensitivity, including what have been termed "microaggressions," from the therapist, which are subtle, perhaps unintended slights or failures to respond or validate meaningful experiences for the client (Sue, D. W. & Sue, D., 2013). Clients' reactions would necessitate a therapist response that is affirming, responsive, and open to the client's experience. Therefore it is important that therapists initially create a strong therapeutic alliance and safe environment for clients to feel comfortable enough to voice their feelings about the relationship with the therapist.

From a perspective of the real relationship, where genuineness and realistic perceptions are key to process and outcome, the participants may be experiencing difficulties being "who they are" with each other—thus the relationship lacks authenticity, the client may not feel safe, and the client or therapist may no longer be properly invested in the work. Gelso (2011) contrasts genuineness with being phony, which could happen when either the therapist or the client feels the need to put up appearances, for example out of fear of being judged or humiliated. When examined from a transference or countertransference lens, the difficulties in the relationship or the impediments in the therapeutic work may come from past experiences, feelings, or relationships that are unconsciously being reenacted in the hour. An example of transference in multicultural therapy may be a situation where the therapist is perceived or unconsciously experienced as an oppressor or as a hurtful person from the past; another example may be if the therapist is seen in the midst of a transference reaction as a representative of an unjust system or oppressive group. In these types of client reactions, possibly stemming from valid, reality-based past experiences, feelings such as anger, hurt, or fear may be seeking expression in the hour and will need to be empathically identified, examined, or worked through. An example of therapist countertransference in multicultural therapy may be when the therapist retreats or withdraws psychologically, even temporarily, out of discomfort or anxiety when the client brings up thoughts, feeling, or experiences with racism, bias, and/or oppression.

Participants at the roundtable also asked whether there is a "best" theoretical or technical approach to establishing a solid working relationship in multicultural therapy. For us, multiculturalism stimulates an appreciation for the individual in context and as formed and sustained through group memberships, beyond the individual and universal dimensions of being human (Leong, 1996). At the round table we noted that current research indicates that no one theoretical approach is superior or more effective to helping clients across a variety of settings and treatment issues. Outcome research has yielded similar therapeutic effects for a wide range of therapies when they are practiced competently by the therapist. In the context of multicultural therapy, our clinical experience tells us that the quality of the relationship remains the key component to process and outcome. Moreover, for some clients, an authentic, trusting, and therapeutic relationship may represent by itself the most important therapeutic process and outcome to be achieved from treatment. Therefore, at this point, there does not seem to be one best theoretical or technical approach to establishing a relationship in multicultural therapy. There are possibly many good approaches; however, therapists' sensitivity to racism and oppression, aware-

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ness of the socialization process for all human beings, ability to maintain an accepting, respectful, and collaborative therapeutic stance, and empathy informed by racial identity and historical and social-political realities can supplement an otherwise competent approach to treatment in a way that promotes effective therapy with an array of minority clients (Smith, Rodriguez, & Bernal, 2011). Also of great importance is multicultural training, which consists of educational training experiences that focus on working with diverse client populations, developing self-awareness and overcoming personal biases, and receiving quality supervision from experienced and culturally-sensitive professionals (Fuertes, Spokane, & Holloway, 2013).

Finally, during our roundtable, we discussed the differences between treating clients who come from more collectivist cultures, as opposed to more individualistic cultures. From an applied clinical perspective, this issue presents a possible challenge to therapists, as many minority clients, particularly refugees and recent immigrants, have a deep commitment and sense of obligation to their families and communities. At the same time, these same clients may simultaneously present in therapy with concerns about personal growth, personal achievement, personal freedom, and self-efficacy. In some cases they may have needs in therapy to question, criticize, and work through familial or cultural beliefs and expectations that are being experienced as burdensome or that create some conflict. As an example, consider a first-generation Pakistani female college student who is nearing her graduation from college and has an outstanding job offer that would require her to move to another city. She expects her parents would reject this option, and this causes her great anxiety and stress. Therapeutic work in this type of scenario would include helping the client achieve a balance between her personal goals and her obligations to family—and research suggests that this work would be facilitated, in most therapies, by a solid therapy relationship.

We end by noting that much more theoretical and empirical work in needed in the areas of the therapy relationship and multicultural psychotherapy, and that this work is crucial given the demographic and cultural changes taking place in the U.S., changes that are inevitably reflected in psychotherapy practice.

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

NOTICE TO READERS

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

STUDENT FEATURE

Ten Ways to Feel Connected on Your Doctoral Internship

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Spalding University

Has reality set in? You are preparing to start your internship. A lot of changes will occur when students leave for internship. It is an exciting time, but also a time of great transition. This transition impacts students who are moving across the country and students staying put. Routines to which students were once accustomed are now in the past. Your identity changes and so does your caseload. With all that occurs, most importantly, internship allows interns to learn greatly about themselves and prepares them to enter into the field as psychologists. Therefore, this list was created as a way to help ease the transitions that come with adjusting to new changes in your environment. The list is set up in no particular order, but utilizing one or all may help address any changes, challenges, and uncertainties interns have during their internship year.

Stay in Contact With Peers
As you adjust, it is helpful to have connections to supports. In today's social media landscape, there are now multiple ways to engage with and stay connected with friends. You can use Facebook, Skype, Facetime, Twitter, Vine, or Instagram. You can also connect through classic venues such as text messages, emails, phone calls, and holiday cards. Peers can set times to connect online and engage in activities in which they would have done when together. This can include, but not be limited to, watching TV shows and sports events. Peers can also send each other care packages with local finds from their new community.

Build Relationships Within Your Community
A great way to establish yourself in a new environment is learning about organizations, groups, and events you can join and be a part of the community. Joining local organizations, a spiritual organization, a club, or volunteering can create opportunities to build relationships that last longer than internship year. These relationships and connections to the community can create networking opportunities for interns. This also adds to the support system of an intern, and an intern can have greater information about the area from locals who know the ins and outs of the intern's new home.

Connect With the Other Intern(s)
Going on internship, interns leave their familiar cohorts. The internship year is a time you are likely able to connect with a peer who is experiencing the same challenges as you. This person can be someone with whom you interact at work as well as after work for support. As interns, you can plan events, dinners, or trips together to relax and learn more about your new community, but also about each other. You can be partners in self-care and balance. The interns can celebrate achievements and milestones together. Relationships with your fellow interns can last beyond internship year and can build into long-lasting professional and personal support.

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Bring/Engage in Things That Remind You of Home

Pictures, mementos from home, and cooking your favorite meal will help the transition, but also try to continue to stay engaged in activities you were involved in before starting your internship. For example, interns who may have been involved in a yoga class or active in a bike club should try to find those opportunities in the new community. However, do not let the things that remind you of home keep you from exploring the new things. You do not want to be focusing on the past to a point where new opportunities are missed.

Engage in Self-care

This is a message that graduate students always tell their clients, but it is vital for a successful internship year. The workload changes and internships sites vary in terms of work demands. At some sites, interns will be done at five at night; other interns will come home to work on reports. Some interns will have their dissertations complete, while others will spend the year working on theirs. Interns must find a way to strike a balance in their lives during a stressful internship year. Potential self-care activities include golfing, biking, running, hiking, exercising, participating in yoga, sleeping well, eating healthy, and making time for yourself. You can set times to disconnect from technology, get outside, get a pet, eat new or favorite foods, read a book, or connect with family and friends. Maybe try to check something off your bucket list.

Find Cultural Points of Interest

Going online or talking with colleagues at the internship site can help interns learn about exciting places in their new community. You could also get out and explore and learn what locals like to do. Interns can find unique places that might not be advertised. If you did not move far, go to the places you have always wanted to see, but could not because of school. Creating weekly-to-monthly outings to the cultural points of interest are great ways to learn about the area, learn something new, and create memories from the internship year.

Plan for the Future

It never hurts to start planning for a postdoc or a future job in academia. Having goals in mind for the internship year will make the transition into internship easier and help interns to see the value in this change. You can make this the year you pass the EPPP or submit an article for publication. Future plans give purpose to your current actions during internship.

Plan Mini Trips Outside of the City

For those moving halfway around North America or for interns staying close, trips outside of your city are an excellent way to reenergize. Internship year may also allow interns to be closer to multiple regional attractions, national parks and monuments, as well as thriving metropolitan areas and charming rural communities. Opportunities to see these sights may be limited in certain interns' futures and this may be the right time to enjoy these experiences. It will give a lifetime of memories and insight into areas you may want to live in the future. The mini trips may also be chances to meet up with and connect with friends, graduate peers, and family.

Realize Being on Internship May Only Last a Year, But Expanding Your Professional Network Lasts Longer

It is important to take advantage of networking opportunities within the community, but do not neglect chances to network with the clinical staff at your internship site. Making connections through the relationships made with staff may be as important as the rela-

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tionships made with professionals within the community. The clinical staff have established relationships within the intern's new community, and they also may have networks created outside, where interns may have opportunities to teach, continue research, develop a postdoc, or get a job. Staff connections are an excellent resource for interns starting out after graduate school.

Again, Realize Internship Will Only Be One Year

Breathe in and breathe out…repeat. You might be away from family, friends, and loved ones, but remind yourself this is a transitional point in your life. When you realize you or others from your cohort are moving across the country, when reality sets in, or when you "hit the wall" during internship year, try to remember this is not permanent. Still, make an effort to utilize the opportunities that present themselves, because this internship is a one-time experience and a capstone for many. Do not miss out on the chances to grow as a clinician and person.

Overall, interns must utilize what will work for them. These options provided are intended to be helpful ideas to create a smooth transition into and during internship year. As an intern who is wrapping up a wonderful internship year, I know firsthand how the changes and challenges expand you as a clinician and a person. Furthermore, relationships built, fostered, and continued during this year create feelings of connectedness and help you have a rewarding experience on internship. So remember, internship may only last a year, but the opportunities created and friendships continued can last a lifetime.

Society for the Advancement of Psychotherapy (29)
American Psychological Association

Enter the Annual Society for the Advancement of Psychotherapy Student Competitions

The APA Society for the Advancement of Psychotherapy offers four student paper competitions:

- The Donald K. Freedheim Student Development Award for the best paper on psychotherapy theory, practice, or research.
- The Diversity Award for the best paper on issues of diversity in psychotherapy. The APA defines diversity as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.
- The Mathilda B. Canter Education and Training Award for the best paper on education, supervision, or training of psychotherapists.
- The Jeffrey E. Barnett Psychotherapy Research Paper Award for the best paper that addresses psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role of psychotherapists' personal characteristics.

What are the benefits to you?

- Cash prize of $500 for the winner of each contest.
- Enhance your curriculum vitae and gain national recognition.
- Plaque and check presented at the Society's Awards Ceremony at the annual meeting of the American Psychological Association.
- Abstract will be published in the *Psychotherapy Bulletin,* the official publication of the Society for the Advancement of Psychotherapy.

What are the requirements?

- Papers must be based on work conducted by the first author during his/her graduate studies. Papers can be based on (but are not restricted to) a masters thesis or a doctoral dissertation.
- Papers should be in APA style, not to exceed 25 pages in length (including tables, figures, and references) and should not list the authors' names or academic affiliations.
- Please include a title page as part of a separate attached MS-Word or PDF document so that the papers can be judged "blind." This page can include authors' names and academic affiliations.
- Also include a cover letter as part of a separate attached MS-Word or PDF document. The cover letter should attest that the paper is based on work that the first author conducted while in graduate school. It should also include the first author's mailing address, telephone number, and e-mail address.
- All applicants must be members of the Society for the Advancement of Psychotherapy. Join the Society at www.societyforpsychotherapy.org
- Applicant must specify for which award he/she is applying. Applicants can submit multiple papers for awards, but an individual paper may only be submitted for a single award.

Submissions should be emailed to:

Maria Lauer
Chair, Student Development Committee, Division of Psychotherapy
marialauer2@gmail.com

Deadline is April 1, 2015

WASHINGTON SCENE

As We Live a Life of Ease

Pat DeLeon, PhD
Former APA President

The *Accountable* Care Act

With the implementation of President Obama's Patient Protection and Affordable Care Act (ACA), our nation's health care environment is gradually undergoing fundamental change. Change of such magnitude that we would suspect the majority of practitioners do not yet fully comprehend how it will eventually impact upon their daily professional lives. In December, 2014 the Commonwealth Fund (CF) reported that for the first time in modern U.S. history, the uninsured rate fell precipitously—from 20% to 15%—among adults ages 19 to 64 by the end of the first open enrollment period for the ACA health insurance marketplace. An estimated 10 million fewer Americans were uninsured. And, based upon preliminary figures for the still-open second enrollment period, the uninsured rate seems likely to plunge even further. In 2014, health expenditures grew more slowly than at any time since Medicare was enacted 50 years ago. Medicare spending alone is $1,200 less per beneficiary per year than predicted just four years ago.

The CF report further noted that the Republican Party will begin 2015 with firm control over both Houses of Congress (for the first time since 2006), 31 governorships, and an advantage of more than 800 members in state legislatures around the country. Whether divided government at the federal level will lead to an armistice over health reform, or intensified trench warfare, is anyone's guess. Full repeal of the ACA is unlikely as long as President Obama remains in the White House. However, more targeted attacks—perhaps through the budget reconciliation process—should be expected. At the state level, Republican control will likely mean slower-than-expected expansion of Medicaid eligibility. As an aside, we would note that this is in spite of the fact that during the initial U.S. Senate committee deliberations, a concerted effort was made to include Republican recommendations in order to develop bipartisan consensus—for example, carefully looking at the specifics of Governor Romney's Massachusetts Health Care Reform legislation.

More than 600 public and private accountable care organizations (ACOs) already exist, covering an estimated 20 million Americans. The percentage of private health insurance payments that are "value-based" jumped from 11% to 40% in the past year. ACOs and value-based payments are central components of the ACA and reflect efforts to encourage higher-quality care and lower costs through increased provider accountability for cost and quality. Systematic efforts to reduce hospital-acquired conditions were estimated to save 50,000 lives and $12 billion since 2010. And, not to underestimate the practice implications, five years after the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act, there were $25.4 billion in incentive payments resulting in 80% of eligible professionals and 98% of eligible hospitals having qualified for these payments by adopting electronic health records

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(EHRs), potentially resulting in a transformative digital revolution within the health care system. This technological evolution alone will significantly increase the likelihood of systematically developing across-provider and across-clinical population and diagnostic comparisons (i.e., clinical effectiveness research) with its accompanying public health orientation. One must expect the utilization of data-based, gold standard protocols to increasingly impact clinical decision making and eventually include the all-important psychosocial-economic-cultural gradient of care.

Interprofessional Care

Under the visionary leadership of APA President Nadine Kaslow, the Council of Representatives endorsed moving towards Competency-Based Education and Training. Espousing a similar training philosophy, in 2009 the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools and Programs of Public Health formed the Interprofessional Education Collaborative (IPEC) in order to promote and encourage efforts to advance substantive interprofessional learning experiences with the goal of preparing future clinicians for the team-based care of patients. Fundamental to the ACA is the development of integrated *systems* of holistic patient-centered primary care, provided by integrated interprofessional teams of providers. Although psychology's training institutions are just beginning to appreciate the magnitude of this paradigm shift in orientation, studying health policy and developing skills to practice collegially with colleagues from other disciplines is one of the required competencies for the Doctor of Nursing Practice degree.

The Doctor of Nursing Practice—Growing Acceptance

The Alliance for Health Reform, which in our judgment is one of the most objective sources of non-partisan policy information for congressional staff, recently held a briefing entitled "Preparing the Nursing Workforce for a Changing Health System: The Role of Graduate Nursing Education." The key messages were: *Nurse practitioners can help alleviate the growing demand for primary care. Using nurse practitioners and physician assistants as part of a team can reduce the primary care shortage, improve access, and deliver more cost effective services. *Graduate nursing education demonstrations are showing early positive results. Cost estimates of advanced practice nursing (APN) clinical education derived from the Center for Medicare and Medicaid Services (CMS) graduate nursing education demonstration (GNE) show a favorable return on investment. Enrollments and graduations doubled during the first two years of the demonstration. *New models of care integrate nurses into the community. The CMS demonstration benefits the community by integrating more nurse practitioners into community clinics. And, *Advance practice nurses must receive post-baccalaureate training. APNs (nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse midwives) must complete baccalaureate plus master's or doctorate-level training. The American Association of Nurse Practitioners estimates that today there are 205,000 NPs, double the 2004 number.

A recent editorial in *The New York Times* rhetorically asked: "Are Midwives Safer Than Doctors?" Citing the findings of Britain's National Institute for Health Care Excellence that it is safer for

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healthy women with uncomplicated pregnancies to give birth under the supervision of midwives than in a hospital maternity ward run by doctors, the *Times* concluded that there is "no good reason that midwives should not play a more important role in childbirth here, despite a longstanding turf war between obstetricians and midwives that has tended to keep midwives under the thumb of doctors." Last year there were more than 3.9 million births in the U.S., only 9% of which were attended by nurse midwives. The professional society for obstetricians consistently raises the traditional "public health hazard" argument. Notwithstanding, the *Times* concluded: "In a time of spiraling medical costs and increasing demand for health care, midwives can offer a cost-effective way of providing good maternity care. They could also provide greater geographical reach: Nearly half the counties in the United States have no maternity care professional, either midwife or obstetrician." [This, of course, has historically been the essence of psychology's public policy argument for expanding its coverage.]

Serving at the Department of Defense (DoD) Uniformed Services University of the Health Sciences (USUHS), I have become particularly interested in programs targeting military personnel, their families, and veterans. Last fall, the Jonas Center for Nursing and Veterans Healthcare announced its Policy Scholars Program, which, in conjunction with the American Academy of Nursing, will recruit 12 doctoral and post-doctoral nursing students for a two-year experience whereby they will be matched with an expert panel to learn from leading nursing experts about major health policy issues. The underlying strategic objective is to develop leadership in the policy work that is needed to create healthy communities and to transform the nation's health care system. "The Jonas Policy Scholars will create a pipeline of early-career nursing scholars who will contribute to shaping practice, education, and research policy relevant to nursing and the work of the Academy of Nursing; provide a mechanism for Academy expert panel leaders to mentor early-career Jonas Policy Scholars on key issues relevant to the panel's area of focus and strategies for shaping those policies; and support expert panel chairs in advancing work to inform and shape policy and improve the health of the public."

The Jonas Center for Nursing and Veterans Healthcare was established in 2006 by Barbara and Donald Jonas and is dedicated to improving healthcare by advancing nursing scholarship, leadership, and innovation. Its two main programs are the Jonas Nurse Leaders Scholar Program, which aims to address the dire shortage of nursing faculty by preparing nurses with doctoral degrees to step into this critical role, and the Jonas Veterans Healthcare Program, which seeks to improve the health of veterans by supporting doctoral-level nursing candidates committed to advancing veterans' healthcare. These programs currently support more than 600 doctoral scholars nationwide, with the goal of supporting 1,000 Scholars by 2016.

A Personal View

"As a Psychiatric Mental Health Nurse Practitioner who is not only educated to provide psychotherapy and pharmacotherapy but also trained to embrace a holistic model of care, I am especially grateful to have the training and skills to provide acupuncture therapy to psychiatric patients. In my practice, acupuncture has been an effective adjunct treatment of complex psychological and physical trauma acquired from combat. I

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found that my patients benefited from the unique practitioner-patient interaction that happens during acupuncture treatment. Patients verbalized satisfaction as they report relief from debilitating symptoms such as insomnia, pain, and anxiety. They appreciate the relaxation component that happens outside psychotherapy when they receive acupuncture. They become proactive in their care by requesting and calling for more acupuncture time. Albeit some of the effects of acupuncture are short term for those who have severe psychiatric symptoms, the momentary relief they gain could be revitalizing and result in increased function even for a few days. After an acupuncture therapy, some of my patients report: 'I haven't slept that well in a long time since deployment'; 'I was able to spend time with my child without feeling tired and fatigued'; 'I did not have an anxiety attack this week.' These momentary gains in quality of life are significant as we care for those who have experienced trauma in combat settings [LCDR Jane Abanes]."

Prior to enrolling in the USUHS Daniel K. Inouye Graduate School of Nursing Ph.D. program, Jane was Head, Mental Health Department & Substance Abuse Rehabilitation Program, Naval Health Clinic Hawaii.

Unmet Needs; Uncharted Waters; Unprecedented Opportunities?

I recently participated in a conference call for a HRSA national advisory committee during which it was noted: "Mental health disorders rank in the top five chronic illnesses in the U.S. An estimated 25 percent of U.S. adults currently suffer from mental illness and nearly half of all U.S. adults will develop at least one mental illness in their lifetime. In 2007, over 80 percent of individuals seen in the emergency room (ER) had mental disorders diagnosed as mood, anxiety and alcohol related disorders." And the band begins to play. We all live in a yellow submarine.

Aloha.

BOOK REVIEW

Book Review of *The One and the Many: Relational Approaches to Group Psychotherapy.*

Edited by Robert Grossmark and Fred Wright. New York: Routledge, 2015, 270 pp. ISBN: 9780415621809.

Mary Dluhy, MSW, LICSW, BCD, FAGPA
Georgetown University

The One and the Many, edited by Robert Grossmark and Fred Wright, lays before us a varied and rich plate to metabolize and digest on the more recent thinking in relational approaches to group psychotherapy. It is indeed an advance on building the theoretical space for all of us who are interested in the theory and practice of group psychotherapy.

This book demonstrates that a clear shift has taken place in the theoretical underpinnings of what constitutes the work and practice of group psychotherapy. We have moved from the classical conception of the neutral therapist, as one who is outside of the process, to the engaged therapist who is inextricably located within the matrix of the group. The book, particularly through Grossmark's chapters of captivating, detailed work, demonstrates how we now can understand groups and group process from mutual enactments that involve all of the group participants—including the therapist.

The title itself, *The One and the Many*, stands out for its relational quality. As the introduction clarifies, the phrase comes from philosophical origins, Aristotle's *Metaphysics*, and it captures the essence of group life: "We are both individual and intrinsically part of something greater—society, community" (p. 3). This resonates with Pines' (1998) elaboration on Bakhtin's concept of alterity, or the idea that in the group we gain ourselves through our dialectical relationship to the other, and that we need others for help in the creation and in the completion of ourselves.

In *The One and the Many*, chapter authors develop their perspectives, each from a particular relational approach. Through thought-provoking vignettes that explicate how this approach works in practice, we are exposed to the self of each of the therapists. As if in a parallel process to what the authors are exploring, we as readers can track the various lenses from an experience-near perspective and have the opportunity to explore our own reactions to some of the challenging material presented in the vignettes.

In his chapter on the work of Hugh Mullen, Fred Wright provides clinical grounding for the use of self disclosure on the part of the group therapist. In the 1960s, Fred Wright was in a psychotherapy group of Hugh Mullen, an existential analyst, who argued for and demonstrated mutuality and non-rational thinking on the part of the therapist as offering the most promise for facilitating change and growth in group treatment. Mullen's approach, far ahead of its time, truly resembled current relational writers and contributors such as Aron, Benjamin, and Bromberg, to name a few, as they each make explicit the therapist's use of self-revelation and mutuality in their work.

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Grossmark makes it clear early on that heightened awareness of internal process is key to resolving enactments; in Chapter 2, "Being Seen, Moved, Disrupted and Reconfigured: Group Leadership from a Relational Perspective," Wright explores what a challenge it can be for therapists to use themselves as modeled. Grossmark advances our understanding and appreciation of enactments in both of his chapters in this book. As working partners and editors of this volume, Grossmark and Wright, through their own vignettes, have created a field where we can understand dissociation as adaptive, resistance as what story is being told rather than what is being resisted, and healing as truly involving the creation of "moments of meaning" in our work (p. 83).

This book is filled with helpful, descriptive language around material that is difficult to explain in practice. We are able to be inside intimate processes. It is an attunement to the reader to have vignettes describing the interior of the way the therapist works. It is a theoretical advance, as well, to elaborate and acknowledge the therapist's role and participation in the resolution of the inevitable conflicts that arise in group therapy. Haim Weinberg in his chapter, "The Group as an Inevitable Relational Field, Especially in Times of Conflict," does a nice job attesting to the group serving as a supervisor in unlocking relational tensions between himself and a member. When the therapist can appeal to the group for what is going on in what is otherwise perceived by the therapist as either a "stuck place" or unresolvable conflict in the group, it gives the group the chance to move on in the work. Weinberg helpfully points out in the example given in the vignette that, viewed from an object relations' perspective, the patient involved would have been viewed as a "difficult patient" (p. 53), as opposed to the one who contained a difficult position in the midst of the intersubjective field that Weinberg illuminated.

In her excellent chapter on systems theory, Barbara Cohn gives voice to the difficult patient or the scapegoat as holding complex affect for the group. She posits that system theory is a tool to extricate ourselves as therapists from enactments; further, a systems focus can provide self experience that is more enduring in an ever-changing relational field. Cohn also heightens our awareness and reminds us of context (i.e., what is in the world outside, that is being imported into the group matrix, as a factor not to be ignored in the system and that might be at play when we are trying to clarify complex dilemmas).

Clinical vignettes illuminate and fill in the narrative envelope in many of these chapters. Ronnie Levine's chapter on regression explores the use of the therapeutic relationship as the most important tool in working on regressive relationships in a group. A student of Ormont's, who was a pioneer in an interactional approach to resolving transferential issues, Levine highlights the use of herself in a regressive pull, as she works in a group enactment. In one example, she courageously acknowledges that she relied on the group for what she could not give. This key relational modeling allows the group members to work closer to their own truths.

Billow's conception of the development of a nuclear idea within the group is an advance in relational theory building. As clinicians we maintain that group is a container and a holding environment that builds historical tissue over time. According to Billow, as ideas flow in and out of the container or consciousness, some ideas linger or may impinge, as in a perturbation within the system.

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A nuclear idea may emerge or develop from interchanges, enactments, or the therapist's own reverie that can become clarified in language, making it truly relational or an intersubjective experience. Reading Billow's vignettes helps to build on and clarify his thinking on nuclear ideas. It is reminiscent of Jacques Lacan's conception that the work of psychotherapy is in determining the "real" and then to signify it (Leupin, 2004). In this same vein, it seems that the nuclear idea expands what is thinkable. It can serve as a place for new meanings and/or what is "unthought known" (Bollas, 1987).

In chapters 8 and 9, we have the opportunity to reflect on self psychology's integration into relational theory. The language of empathy and vicarious introspection, explored by Fosshage as central constructions and contributions of Heinz Kohut, expands the paradigm shift that has taken place, from objectivism to constructivism, and from intrapsychic to relational. Further, Kohut recognized that in the therapeutic endeavor, as in scientific theory, the field observed includes the observer (Kohut, 1984). Fosshage posits that these shifts have affected our listening/experience perspectives.

Fosshage goes on to delineate his own conceptualizations of two additional listening/experiential perspectives as "other centered listening" and the "analyst self perspective" (p. 130). Additionally, he opines this thinking includes explicit and implicit non-verbal and verbal communication (Stern, 1997) that can deepen the work and broaden it to explore who is contributing what through observation and listening.

Livingston continues the integration of self psychology and intersubjectivity into the work of group psychotherapy in his chapter on impasses. He postulates that "sustained empathetic focus" by the therapist (p. 146) on the patient's emotional vulnerabilities is key to developing "moments of meaning" within the group. In my view, it is similar to Wright's description of the therapist being moved and disrupted by the work of the group, as an experience-near approach to promoting change.

The bridge from self psychology and intersubjectivity is continued by Flores in the chapter, "Group Psychotherapy and Neuro-Plasticity: An Attachment Theory Perspective," as he makes substantial links into building the conception of deficit thinking into expanding the horizon of relational theory. Flores brings biology into the mix by offering the reader a clear and concise understanding of attachment theory as providing a new framework to understand clinical and developmental phenomena. Flores highlights Bowlby 's work on attachment as being a motivational force with its own dynamic, not only psychological, but biological as well. Flores continues with Schore who, through his important work, confirmed that attachment cannot be reduced to a secondary drive; we are biologically determined to form close emotional attachments. Now through brain mapping studies, we have neuroimaging techniques to record and visualize brain functions.

Flores considers what all of this means to the study of group psychotherapy. It is revolutionary to consider how the brain can be intentionally altered, not only in how the brain operates in its neuro-plasticity, but in how it can respond to psychological interventions. Strong attachment bonds prime the brain to change. Group offers more possibilities to see attachment theory at work. As Flores says there are few things as stressful as isolation and it follows that we feel better in groups.

The culmination of *The One and the Many*

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takes us to the Large Group. We can begin to see the influence of relational theory on the larger system. We are presented with two groundbreaking chapters, one by Rizzolo on rethinking Tavistock in relational terms, and another by Segalla as she details an actual description of Large Group work being done in a more relational way. For those of us interested in the practice and work of Large Group, as a contrast from the reified thinking and process embedded in the Tavistock model, these chapters help to illustrate a profound shift. There is an emphasis on engagement with the other in true dialogue, as a more dynamic, versatile way to proceed in our theoretical thinking—a newer way, and, in my view, a more hopeful way of working in the Large Group.

One thought I had as I read this fine book was it might have been improved by organizing the chapters in groups by headings such as theory, technique, and application that might have added historical context to the development of relational theory; maybe this is a later evolution. More importantly, however, we in the field of group psychotherapy owe Grossmark and Wright a debt of gratitude for advancing and helping to clarify key concepts and ideas in the development of relational approaches to group psychotherapy. *The One and the Many* is truly an impactful and relational approach to the reader and any student of group therapy.

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

Jeff Zimmerman, Ph.D.

Having served as Finance Committee Chair, a mentor of our early career psychologists, Treasurer and a member of the Society's Executive Committee, I am deeply honored to be nominated to run for the President of the Society.

I am devoted to continuing to build a sense of breadth and inclusiveness throughout the Society from our core membership to our Board of Directors. We recently expanded our scope from that of research and practicing American and Canadian psychologists to that of a truly international association of interdisciplinary professionals interested in the study and practice of psychotherapy. We now need to implement many steps to position the Society, the field, and the communities we serve to actually benefit from all we have to learn from and share with one another. This means bringing diversity into our organization across many different dimensions and from a position of respect and value as we hear each other's perspectives that are different from those we ourselves hold as "truth."

I envision the Society holding an international meeting where researchers and clinicians meet with colleagues from around the world to share information, inform each other of our unique needs and plan future agendas. We need to use our research and clinical skills to help communities and systems in need, from the individual to the family, village, city and even regionally and beyond. Collectively, we have a tremendous amount to offer. With the synergy developed out of mutual respect and healthy communication and understanding we can make a difference.

To share some of my experience, I am a practicing psychologist in Connecticut and New York, USA. I have been in practice since 1981. In the 1990s I served as President of the Connecticut Psychological Association and also began developing ways to use my skill set to help children in high-conflict families of divorce beyond the role of psychotherapist. I am also a trained mediator and have worked in small and mid-sized businesses and consulted with other boards and not-for-profit organizations to help them resolve conflict and plan strategically to address the needs of the organization and stakeholders they serve. I have served on an APA Presidential Task Force and on the Board of APA Division 42 (Independent Practice). I also have co-authored three books (two on divorce and one on ethics and practice) and presently serve as adjunct faculty at a PsyD program and also at an APA-approved internship.

I believe our Society needs to continue to build superb alliances among our colleagues who are specialists in research, education, training and practice. We also must address the needs of our students and early career members. We need to work together to help them play an active role in the Society and work together to shape its future.

I encourage you to vote in the election and would very much appreciate your vote. Please let me know if you want to help with all we have to do. I'd love to hear from you. ■

Jesse Owen, Ph.D.

I am humbled and honored to be in consideration for the treasurer position of Division 29. I have been the Division 29 Education and Training (E&T) Domain Representative for the past three years, and prior to this role I was on the E&T committee. I also serve as an Associate Editor for our flagship journal, Psychotherapy. Through these positions, I have learned a great deal about the operations of the Division, budget considerations, and how the board manages the multiple needs of our membership. In addition, I have previous experience working with budgets via grants, which has enhanced my understanding of efficient budgetary processes. Beyond my experience within the Society for the Advancement of Psychotherapy, I am an Associate Professor and Training Director in the Counseling Psychology program at the University of Denver. I stay current in both research and practice, as I conduct couple and individual therapy studies, and I have had a small private practice over the years. Ultimately, I believe that my drive, passion, and commitment for the promotion of psychotherapy will be an asset in this position. Thank you for voting and contributing to our Society. ■

Jeff Reese, Ph.D.

I am humbled by the opportunity to be considered for Treasurer of Division 29. We are, indeed, part of an excellent Division that has had excellent leadership and continues to make an impact on the theory, science, training, and practice of psychotherapy. My priority as Treasurer would be to work with the Board to ensure that the Division's financial assets would be used to promote and continue to fulfill the mission of Division 29. The Division is doing many wonderful things!

Currently, I am an Associate Professor of Counseling Psychology and serve as the Chair for the Department of Educational, Counseling, and School Psychology at University of Kentucky. I teach within our APA-approved Counseling Psychology program. Within APA, I have served as the Secretary and the Chair for the Promotion of Psychotherapy Science Section within Division 17. I serve on the editorial boards of *Psychotherapy* and *The Counseling Psychologist*, and previously served on the *Journal of Counseling Psychology* editorial board. My research is focused on psychotherapy process and outcome and the use of technology to deliver psychotherapy (telepsychology) to underserved populations.

Previously, I have served in multiple administrative roles including Director of Graduate Studies and as an Executive Director of an office that provided a variety of university-based services, including career development, student retention, and testing and assessment. I believe my previous and current administrative experiences would serve me well in taking on such an important role within Division 29. Thank you for your consideration. ■

CANDIDATE STATEMENTS
Diversity Domain Representatives

Beverly Greene, Ph.D., ABPP

I am a candidate for a second term as a Member at Large, Diversity Domain Rep, on the Divisions' Executive Committee. It has been a pleasure to serve in this capacity and I would be honored to continue to do so. I have a record of extensive participation in APA governance at both national and divisional levels as well as on many working groups and task forces addressing issues deemed important to the association directly relevant to research, professional training and practicing psychotherapy. As an educator, scholar and practitioner both my professional work and personal identities are representative of a wide range of diverse settings, constituencies and interests in the context of psychotherapy research and practice. I bring those interests and the breadth of my experience to this position. Delivering competent services to all clients but particularly marginalized and vulnerable populations is challenged by a continued struggle for resources for mental health services. Maintaining funding to support the rigorous training of future psychologists is also challenging. Our division has a distinct position of leadership in the dissemination of cutting edge research relevant to psychotherapy and its importance in the overall scheme of interventions that contribute to better health outcomes. I would like to continue to serve the division by contributing to our efforts to seek solutions to those problems and view psychotherapy as an important tool in the pursuit of optimal mental health outcomes and social justice. ■

Gary Howell, Ph.D.

Dr. Gary Howell is an Associate Professor Candidate and the Director of Practicum Training at FSPP. He earned his PsyD from the Adler School of Professional Psychology in Chicago in 2008 and received his MA in Counseling Psychology along the way in 2004. He also completed the Clinical Hypnosis Certificate program while attending Adler and is a full member of the American Society of Clinical Hypnosis (ASCH). Prior to FSPP, he taught undergraduate psychology courses for over six years and taught graduate courses at the Adler school for over three years. Dr. Howell is the 2014 inaugural recipient of the APAGS ACT "Guardian of Psychology Award." He is the former chair of the Illinois Psychological Association's Sexual Orientation and Gender Identity section and is actively involved with APA. He is a licensed clinical psychologist in Illinois and Florida and took over as President for the Bay Chapter of the Florida Psychological Association in December 2013. He is the Diversity Committee Chair for FPA and will attend as the FPA Diversity Delegate for the 2015 State Leadership Conference in DC. He served as the programming chair for the Division 44 APA 2013 Convention and was the suite programming coordinator for Division 44 at the 2012 convention. Dr. Howell currently serves as the Division 44 Mentoring Committee Chair and

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Fundraising Dinner Coordinator. He was appointed by the Hillsborough Board of County Commissioners to serve as 1 of 2 representatives for the LGBT population on the newly formed Hillsborough County Diversity Advisory Council. He serves as an LGBT Advisor to United Nations Association of Tampa Bay. He specializes in working with LGBTQ clients in his private practice and has a diverse clinical background. Some of his current research is centered around clinical implications and issues related to the transgender community, and he provides consultation to physicians providing hormone therapy and gender affirming surgery for trans clients. In addition to teaching the LGBT-related courses, diversity, community psychology, therapy practicum seminar, professionalization group, and supervision and consultation, Dr. Howell frequently presents at conferences in the area of LGBTQ issues and anti-bullying initiatives. ■

CANDIDATE STATEMENTS
Education and Training Domain Representatives

Jennifer Callahan, Ph.D.

Before completing my doctoral work, I served as the training coordinator for a large non-profit residential treatment center. I subsequently graduated from the University of Wisconsin-Milwaukee where my dissertation sought to test the applicability of psychotherapy models to a training clinic setting. My internship and postdoctoral training was accomplished at Yale School of Medicine. Following licensure, I attained ABPP certification in Clinical Psychology. My first faculty appointment was as a tenure-track Assistant Professor at Oklahoma State University (OSU). While at OSU, I also completed a 3-year term as the Clinic Director. I subsequently became an Associate Professor at the University of North Texas where I am currently in my 5th year as a Director of Clinical Training.

I am proud to be a 6-year recipient of the National Institutes of Health Loan Repayment Program (NIH LRP) for Individuals from Disadvantaged Backgrounds. To date, I have more than 70 peer-reviewed publications and am the most frequent first author of published articles in the APA journal *Training and Education in Professional Psychology* (*TEPP*). Articles written with my current or past students won the Society's (Division 29) 2012 Distinguished Publication award and the APPIC 2013 Outstanding Contribution Award in *TEPP*. Further, I am a co-recipient of the 2013 Norine Johnson Ph.D. Psychotherapy Research Grant. Currently, I serve as a consulting editor for the journals *Psychotherapy* and *TEPP*. I also serve on the board for the Council of University Directors of Clinical Psychology (CUDCP) and Chair the Division 29 Education and Training Committee. If selected, it would be an honor to serve as the Society's Education and Training Domain Representative. ■

Stewart Cooper, Ph.D.

I am honored to be on the *Education and Training Domain Representative* Slate and would be delighted to serve if elected.

My passion to serve as the *E&T Domain Representative* is based on my desire to contribute to the advancement of psychotherapy for psychology and the public. My background in both counseling and consulting psychology education and training, my clinical work in both institutional and private practice, my research on psychotherapy topics, and the knowledge and skills I have garnished from my experiences in APA governance should be assets to the Division and its members in this important role.

My primary professional work is as Director of Counseling Services and Professor of Psychology at Valparaiso University. In addition, I have a solo private clinical and consultation practice. I have written/edited four books on college mental health including one on psychotropics; four journal special issues, including one on multiculturalism and another on international consultation; and numerous article publications in refereed journals. I have presented on psychotherapy related topics at numerous conferences.

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My various positions on the Executive Boards of Counseling Psychology and Consulting Psychology included being Past-President and current Council Representative for the latter. I was Chair of the APA Membership Board in 2010 and Chair of the APA Board of Professional Affairs in 2014. I am a Fellow in the Divisions of Psychotherapy, Counseling Psychology, and Consulting Psychology. I also hold ABPP Board Certification in Counseling Psychology and in Organizational and Business Psychology. I had the privilege of being a liaison from consulting psychology to the 2002 Ethics Revision Task Force.

I believe that the above background, in combination with my style of collaborative and cooperative co-leadership in governance roles, can further advance the education and training agenda of the Society for the Advancement of Psychotherapy. ■

NOTICE TO READERS

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

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

CANDIDATE STATEMENTS
Membership Domain Representatives

Jean Birbilis, Ph.D.

Division 29 is beginning a new chapter of its growth and development as the Society for the Advancement of Psychotherapy. I would be honored to have the opportunity to serve as the Membership Domain Representative and continue contributing to the Division's growth. As the Chair of the Membership Committee, I have assisted the current Membership Domain Representative, Dr. Annie Judge, in implementing innovative strategies for recruiting members, such as replacing the APA Convention Suite with a booth in the Exhibit Hall the past three years in order to be more visible and accessible to potential members. I am delighted that during this time, the Division has been making a concerted effort to increase the diversity of its membership in many aspects of identity, particularly from members of marginalized groups. We have farther to go in this respect, but it has been a good start. I'm also pleased that the past couple of years have seen the number of Division 29 members with Psy.D.s increase; given that the majority of new psychologists are graduating with Psy. D.s and that most Psy.D.s identify as practitioner scholars, Division 29 is a natural professional home for psychologists with Psy.D.'s. Furthermore, now that we are a society, we can also draw membership from other mental health professions. In sum, I would appreciate your support of me for Membership Domain Representative so that I can continue the work that Annie and I began. ■

CANDIDATE STATEMENTS
Practice Domain Representatives

Jennifer Gafford, Ph.D.

I am honored to be considered for the position of Psychotherapy Practice Domain Representative for Division 29. I am a staunch believer in the effectiveness of psychotherapy and have been practicing in the field for over 15 years, the last seven of which as a licensed psychologist in the state of Colorado.

As the Chief Psychologist for the Denver Sheriff Department, I have the unique opportunity to both provide and oversee the provision of psychotherapy services to incarcerated men and women. As such, my interests lie in the universal mechanisms of change that are evident in my work with our diverse population. I am consistently amazed by the power of the therapeutic relationship and impact of the therapist upon therapy outcomes.

Our robust training program supervises 12 Master's and Doctoral level students who practice individual and group psychotherapy. My secondary interest in the area of psychotherapy lies in supervision and training. I have certainly witnessed the effects of poor as well as excellent training and supervision and recognize the difficulty of shaping clinicians into highly effective practitioners. I view psychotherapy as an intersection of art and science. I am committed to nourishing that intersection by helping clinicians increase self awareness to develop their own "art" or style as well as integrate "science," both theory and effective intervention, into practice.

As a representative for Division 29, I will advocate for the advancement of psychotherapy as a critical method for change for people in all situations. In addition, I will advocate for the development of superior methods to help both educators and supervisors in their shaping of new professionals. As a member of the psychology community, I have both a passion and a responsibility to enhance the profession in the development of emerging clinicians. ■

Barbara J. Thompson, Ph.D.

It is an honor to be nominated to continue to serve as the Practice Domain Representative. In the 20 years that I have been in practice, the landscape of our profession has shifted dramatically, with the advent of HIPPA, evidenced-based treatments, electronic medical records, Obama-care, and ICD-10. Technology has created new vistas and challenging ethical considerations. In addition, therapists are in the forefront in dealing with issues related to trauma and oppression, and there are growing opportunities to embrace and foster diversity. It is rewarding to have a voice in an organization of leaders and advocates for psychotherapists amidst all of these changes.

The Society is facing challenging issues. Our membership is aging, and younger psychotherapists have many options and demands on their resources, which

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affect membership maintenance and recruiting. Among the tools we have to meet this challenge is maximizing the potential of our newly revised website, which provides a vehicle for sharing resources and connecting therapists in ways we are just beginning to realize. In addition, the Society has opened membership to a broader professional and geographic range of practitioners, providing an opportunity to expand our reach and to be relevant to a larger community of psychotherapists.

As Practice Domain Representative, I will continue to address these concerns. I will promote the Society to non-member therapists nationally and internationally. Working with the Practice Committee, I will reach out to Society members about ways the Practice Domain can better serve their interests and needs, for example, by advocating for increased CE opportunities especially related to skill building and diversity issues.

My commitment to improving the practice of psychotherapy through informed practice, research, teaching and supervision creates a solid foundation from which to serve as the Representative for the Practice Domain. ■

CHARLES J. GELSO, PH.D., PSYCHOTHERAPY RESEARCH GRANTS

Brief Statement about the Grant:

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

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

Submission Deadline: April 1, 2015

REQUEST FOR PROPOSALS
Charles J. Gelso, Ph.D. Grant

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

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

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

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

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Evaluation Criteria

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

Proposal Requirements for All Proposals

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

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

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

Additional Information

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

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

Submission Process and Deadline

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

DEADLINE: APRIL 1, 2015

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

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT for Early Career Psychologists

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

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

Submission Deadline: April 1, 2015

REQUEST FOR PROPOSALS
NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

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

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

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

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

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

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

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

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

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Submission Process and Deadline

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

DEADLINE: APRIL 1, 2015

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

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

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