Psychotherapy

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

www.societyforpsychotherapy.org

BULLETIN

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2015 VOLUME 50, NUMBER 2

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PSYCHOTHERAPY BULLETIN
Published by the
SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
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PSYCHOTHERAPY BULLETIN

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

2015 Volume 50, Number 2

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PRESIDENT'S COLUMN

Next Stop: The World
Opportunities for Members Abound as SAP Goes Global

Rod Goodyear, PhD
University of Redlands

The Society has taken important steps to position us for a significantly broadened global membership and the enriched understandings of psychotherapy that this will afford. In particular:

- I hope all of you have noticed that our webpage has been completely redesigned, with content that is constantly fresh, interesting, and relevant to psychotherapy researchers and practitioners. Beyond that, webmaster Brad Brenner, PhD, has arranged that our webpages can be translated into most of the world's major languages with a click of a button (see bottom right corner of the website). This is very exciting!

- In adopting the name, Society for the Advancement of Psychotherapy (SAP) we have signaled a wider focus than was the case with our previous identification as APA's Division of Psychotherapy.

- To support that wider focus, SAP has developed a new affiliate member category that requires neither APA membership nor even a psychology doctorate. This acknowledges, first, that most countries do not require psychologists to have a doctoral degree to practice, and, second, that psychology is only one of the professions that delivers psychotherapy services. Opening our membership in this way has the potential to enrich scholarly and professional conversations through the new cultural and cross-disciplinary perspectives.

Our journal, *Psychotherapy,* is a member benefit that is important in our efforts to become an international organization. Its continually increasing quality is evident both in its impact factor scores and in the steadily growing number of article downloads. That more than a third of those downloads occur outside the U.S. speaks to its perceived value to psychotherapists globally.

Our Board of Directors took an important additional step toward globalization in February when it created a new International Affairs Task Group, which Fred Leong, PhD, and Patrick Leung, PhD, are co-chairing. They discuss the Task Group and its purposes, as well as some other international possibilities, elsewhere in this issue of the *Bulletin*.

Growth of SAP internationally will be helped by our having a presence at key international conferences. To that end, I had the pleasure of representing both APA and SAP at the IX International Congress of Mental Health at the University of Guadalajara in March and will "fly the SAP flag" at the InterAmerican Congress of Psychology in Lima, Peru, in July. But many other SAP members also present at conferences outside the U.S. If you will be one of those, please do let Drs. Leong and Leung know so that we can consider ways you might represent or otherwise help SAP. I would add that if you are an SAP member who lives outside the U.S., we could use your help in various ways (e.g.,

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through representing us in one way or another there, "on the ground" in your country; through providing an occasional contribution to the *Bulletin*; etc.), and I would encourage you also to contact Drs. Leong and Leung.

As an additional way of establishing its international presence, SAP is capitalizing on Dr. Changming Duan's connections with the Chinese Clinical and Counseling Psychologists Registration System (CCCPRS) of the Chinese Psychological Society to cosponsor a supervision training program with them. Carol Falender, PhD, and I are delighted at the opportunity to provide that training. The CCCPRS is the only national professional organization that provides quality assurance for psychotherapy service in China, setting standards for training programs and certifying psychotherapists/counselors and supervisors. CCCPRS presently certifies about 660 therapists/counselors and 120 supervisors in the entire country (from among close to 400,000 individuals who have governmental permission to practice as therapists/counselors). We hope this pilot venture will lead to other training cosponsorships, in China and elsewhere.

The SAP leadership also has begun some early discussions of how we might be more involved in global policy matters. As an initial step, Jeff Zimmerman, PhD, and Lauren Behrman, PhD, served as unofficial SAP representatives at the United Nations' Psychology Day in April. Whether this is a direction SAP wants to take and how we might do that will be important future discussions among members of our leadership.

The Promise of Enriched Dialogue and Perspectives

SAP's internationalization efforts will succeed only to the extent that all members, regardless of country of residence, are open to the influence of new ideas and perspectives. In recognition of this, SAP took the lead in developing the following two symposia for the upcoming APA convention. I should note that the second is in lieu of my offering a Presidential address: It is, I believe, that important. Please do put both on your convention calendar:

> *Clinical Supervision Around the Globe—Small World Isn't It?* (Thu 8/6/2015, 08:00 AM - 09:50 AM; Location: Convention Centre Room 716A).
>
> *Ecologically and Culturally Appropriate Treatment—The Present and Future of Indigenous Psychotherapies* (Fri 8/7/2015, 09:00 AM - 10:50 AM; Location: Convention Centre Room 104B).

Ways You Can Help Advance Our International Agenda

So far I have described steps the Society's leadership has taken or supported to make SAP more of a global organization. But I hope that all SAP members will join in this initiative as well.

Here are some possible ways:

> If you have friends or colleagues who are psychotherapists in countries other than the U.S., please let them know of these important developments in the Society, and encourage them to join!
>
> If you are an SAP member who lives outside the U.S. and will attend the APA convention in August, I hope you will join us in conversation during the SAP Social Hour on Friday August 7 from 5 to 6 pm at the Fairmont Royal York Hotel Library (this is not limited, of course, to international members; I invite all of you to attend!).
>
> Please feel free to let any of us in the SAP leadership know as you have ideas about strengthening our internationalization efforts.

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Finally, I would encourage you to consider getting international announcements on a biweekly basis from the APA Office of International Affairs via its announcement only listserv—*International News Bulletin*. This concerns news, resources, and international opportunities on Conferences/Meetings; grants for travel and international work; publication information; international opportunities; and training opportunities on international topics. To sign up, send an email to listserv@lists.apa.org with the subject line blank and the following in the body of the message: subscribe INTLANNOUNCE Your first name, Your last name -[hyphen] country of affiliation (e.g., subscribe INTLANNOUNCE John Doe-Panama).

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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We are delighted to welcome you to the second issue of *Psychotherapy Bulletin*'s 50th anniversary year, and we hope you will enjoy perusing these pages as much as we have enjoyed working with your colleagues in putting them together. We have several timely and thought-provoking practice-centered pieces, student contributions, and informative updates from our Domain Representatives and governance. We are especially excited to introduce you to a new contributor to the *Bulletin*, Dr. Jonathan Jenkins, author of *Wednesday Afternoons with Dr. J* (2014). Dr. Jenkins will be pairing print and online content on various topics related to child clinical practice and the unique experiences of the diverse clinicians in the field of psychology through a recurring feature, Clinical Notes with Dr. J; you can find the first installment in this issue (and stay tuned for more). Don't miss the Student Awards and APA Convention Programming Guide—and, as always, look for additional content and special features on the Society's website (http://societyforpsychotherapy.org/).

On a much more somber note, we mark with sadness the passing of Dr. Mathilda Canter, who died on January 30, 2015, at the age of 90. The space here is inadequate to do justice to her numerous accomplishments, contributions, and positions of leadership and service, but many readers will remember Matty as the first woman President of the Division of Psychotherapy, a staunch advocate for professionalism and ethical practice, and a tour-de-force in the field. In the "Concluding Remarks" to her *A History of the Division of Psychotherapy* (Canter, 1992), Matty observed:

> We do not wish this history to be a finalized version of our first twenty five years. We really want it to be a living document, open to additions and your enrichment. So if, on reading this, you find that it has stimulated some memories, comments, or additions, please communicate them so that we can add to what we hope will be an ongoing, living document, as the Division itself is a growing, developing organization! (p. 69)

As we continue to reflect on the first five decades of *Psychotherapy Bulletin* and look forward to the future of both this publication and the Society, we could ask for no more.

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CLINICAL NOTES WITH DR. J[1]

That Day in the Empty Play Therapy Room

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As the family play therapy session drew to a close, my young patient, Madison[2], began to begrudgingly return the dollhouse to its usual orderly state and place the simplistic wooden figures back into their bedrooms with care. I remember smiling and playfully nudging Madison to action while patiently listening to a brief, but passionate, protest to the end of the session. My focus then turned to the patient's parents as we began the mundane task of discussing the logistics of the next session, including the introduction of my patient's sibling, Morgan, into the therapeutic dyad. At the time of this appointment, we had worked together for several weeks on the goal of improving the family's communication and conflict resolution strategies in the midst of raising a child with cognitive and developmental concerns. As a unit, we had experienced much together in our brief therapeutic relationship; we had laughed together when the patient told us jokes and we cried together when the patient's parents painfully reflected about how no classmates had accepted their child's birthday party invitation. In the midst of my brain attempting to juggle retaining the recently completed therapeutic work, planning ahead for the next session, and trying to negotiate my upcoming commitments for the following week in order to schedule our next appointment, it happened.

"…And don't worry, I warned Morgan that you were Black."

The words rolled out of my patient's parent's mouth with such ease, but pierced my ears with such unavoidable force as she left the office with a loving wave and smile. And there I was, left with those words in my head and a stunned look on my face as the door slowly closed and I was left in the empty play therapy room with only my thoughts and my fears. Upon reflection on that moment, I always wished that I had some witty retort to give, something like that of a sitcom where my comeback would have been followed by audience applause and hollering of solidarity. But no witty retort was uttered from my mouth and instead I was left in stunned silence while coming to terms with the deafening truth: Becoming a psychologist would not guard against or camouflage me from the stereotypes associated with my Blackness and, as soon as therapy ended, I would be, to some, just another potentially "dangerous" Black male.

As in many therapeutic interactions, both similarities and differences in culture can cause themes of power and privilege to surface within the therapeutic space. For Black clinicians specifically, maintaining authenticity and staving off assimilation are main concerns for therapists given the psychological community's often-homogenized demographics (Minsky et al., 2006). When I look back upon the moment retold above, the strongest feeling I felt was a feeling of banishment from the therapeutic space. With her comment, I felt

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violently thrown into a position where I had gone from being so closely knit with this family to occupying the role of the "other" in the room. Whereas before it was "us against the world," I now felt like my every move was being analyzed to either support or disprove stereotypes of people I have never met, but who look like me. This would inevitably hamper the therapeutic work if it were not addressed in an appropriate and swift manner. Thankfully, via the support of both my school and my individual supervisor, I was able to process this incident in a space where I felt supported and heard. A key aspect of this particular clinical situation was how to address this comment with the family given the way in which it elicited such a visceral reaction in the moment. The goal of this eventual conversation with the family would be to acknowledge the comment, but do so in a way to promote further discussion, not limit it. Although race, ethnicity, and culture may not be spoken about in therapy, these constructs are always present in therapy given the seen and unseen cultural affiliations and biases of both the clinician and the patient. In situations involving a cross-cultural therapeutic relationship, there exists a conscious and subconscious expectation regarding the course of therapy for both the patient and the clinician (Minsky et al., 2006) and this reality cannot be ignored. My supervisor did an amazing job of both recognizing and validating my initial anger, but encouraging me to look deeper into the context of the comment to better understand the motives and meaning behind the statement. Through deeper analysis of the context of the situation and through the eventual conversation with the parent, I was able to honor my humanity by recounting my initial shock and also honestly listen to her reasons for making the comment. Although the work eventually continued and the patient and his family were able to make great progress in treatment, I never truly could cast aside her words and the feeling of forever being an outsider to this well-functioning unit I had helped create.

I felt especially concerned about what this particular family thought of me due to the realization that, in the world of clinical psychology, my presence and the presence of men who look like me is unexpected and uncommon. Although it is commonly understood and appreciated that African American and Caucasian clinicians have similar training and capabilities as therapeutic supports for children (Abrams et al., 2006), there are an underwhelming number of African Americans in the field of psychology and psychiatry. This demographic imbalance can be related to several key factors, including psychology's regrettable history of mistreating minorities, especially African Americans (Richards, 2012), as well as other factors that many draw African American candidates towards fields other than psychology. Based upon the 2011 article of Michalski and Kohout, it was estimated that only 2.7% of American psychologists are African American, compared to Caucasian psychologists occupying 87.5% of the workforce. When these numbers are examined further, the number of African American male psychologists is even lower, reflecting the historic discrepancy between Black male and female academic achievement and the general low number of males in the field of psychology (Willyard, 2011). This not only impacts the field as a whole but it also impacts the general expectations of patients when they enter the office to meet with "Dr. Jonathan Jenkins," a name that gives no hint of culture, racial affiliation, or skin tone hue.

This harsh reality was one of the driving forces behind me writing an illustrated children's book called *Wednesday After-*

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noons with Dr. J (Jenkins, 2014). This book was created as my Doctoral Project at the University of Denver Graduate School of Professional Psychology. In doing so, I sought to provide children with a fictional narrative in which the main character, Ari, engaged in psychotherapy with a safe, successful, warm, and engaging professional Black male psychologist named Dr. J. The main reason for the creation of the book was to have the narrative address several misconceptions that youth frequently have about psychology, including confusing the roles of psychiatrists and psychologists, whether they will "get in trouble" for talking about certain emotions, what confidentiality means in psychotherapy, and what a clinician may due to keep a child safe. Due to the amount of evidence to support the importance of parental psychoeducation in child psychotherapy outcomes (Mendenhall, Fristad, and Early, 2009), the psychological community has produced numerous resources explaining child psychotherapy to adults. Although this is a helpful addition to the literature, the main target audience of the child patient is lacking in resources and acknowledgement. For me, it was important to explain key aspects of therapy directly to children in order to empower them to be more engaged in psychotherapy and to help them advocate for their mental healthcare needs when necessary. Given how children are often strongly encouraged or "forced" to attend therapy by the adult caregivers in their lives, it is important to provide them with appropriate acknowledgement of their unique perspective as the patient who is without total control over the course of treatment, or even confidentiality. Additionally, children are just as capable as adults of harboring misconceptions about therapy or prejudices regarding emotions, and their concerns need to be addressed with the same attention and nuance as adult patients.

Another goal of the book was to utilize it as an arena to foster dialogue about topics such as race. By having two characters of different ethnic and racial backgrounds interact in the narrative, the audience has the opportunity to discuss this dynamic and the various ways in which culture or identity might influence the relationship between the patient, the family, and the clinician. As a child, I grew up devoid of many examples of people who looked like me in children's books, cartoons (Klein & Shiffman, 2009), and television. In addition to the lack of viable role models, the expectations for people with brown skin were, and continue to be, somewhat limited, given how many in our community view people with darker skin tones as either primarily athletes or prone to criminal behavior (Eberhardt, Goff, Purdie, and Davies, 2004). This lack of fictional and actual role models who occupied professions that I was interested in as a child had a tremendous impact on me and made me feel like there were several professions unavailable and unobtainable with Black skin, with the most salient childhood example being President of the United States.

The power of narratives with main characters of various skin tones was first highlighted in Ezra Jack Keats' 1962 beloved and award-winning story *The Snowy Day*, which was the first story to chronicle an African American child in a normal and undistorted narrative where the child was effortlessly integrated into the story instead of unduly highlighted for her or his race. During the 50th anniversary of the story, an NPR segment highlighted how Keats purposefully wanted to craft a holistic narrative with a minority child, which he saw as an especially important endeavor during the 1960s with the Civil Rights Movement and segregation at the forefront of the nation's collective consciousness. The

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success with which Keats was able to accomplish this task is best observed in the remarks from a teacher who wrote to the author after using his book in her classroom with her young students: "The kids in my class, for the first time, are using brown crayons to draw themselves. These are African American children. Before this, they drew themselves with pink crayons. But now, they can see themselves" (NPR, 2012). For me, the creation of *Wednesday Afternoons with Dr. J* (Jenkins, 2014) was so that both Black children AND Black male psychologists could *see themselves*. As much as I wish that my book provides motivation for young minority children to explore a career in psychology, I am also conscious of how the book can provide solace and support to those already in the profession as they look down at the cover and *see themselves* looking back at them.

Upon reflection, that moment in the empty play therapy space, born from such a confusing and painful moment in my life, birthed a meaningful and beautiful retort: a book that will advocate for the mental healthcare needs of ALL children, while also speaking to the talents of ALL psychologists in the community. In the end, the book is a love letter from me to both my brown skin and my profession, both of which I have learned to love more dearly since that day in the empty play therapy room. Cue the studio audience applause and hollering of solidarity.

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]See more from Dr. Jenkins on the Society website (http://societyforpsychotherapy.org/).

[2]All identifying information has been disguised to protect client confidentiality.

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Humility: The Paradoxical Foundation for Psychotherapy Expertise

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"The humble man makes room for progress; the proud man believes he is already there."

Ed Parker (1983)

In their series of articles, Tracey and colleagues (Tracey, Wampold, Goodyear, & Lichtenberg, 2015; Tracey, Wampold, Lichtenberg, & Goodyear, 2014) explore barriers psychotherapists face in developing expertise. Specifically, Tracey et al. (2014, 2015) noted that psychotherapists often (a) struggle to obtain meaningful feedback on their work with clients and (b) fail to engage in deliberate practice. Because clients can withhold or not be asked to provide critical feedback during the treatment process, psychotherapists may develop an overly positive view of their work and misunderstand their limitations. Thus, it is unsurprising that research has not demonstrated a strong link between psychotherapist experience and psychotherapist expertise (Beutler et al., 2004; Hill & Knox, 2013).

Tracey et al. (2014, 2015) give several helpful recommendations for developing psychotherapist expertise. These recommendations focus on obtaining accurate feedback from clients about how the psychotherapist is doing and then implementing planful action based on the feedback received. Although these suggestions are helpful, we believe they are likely to fail if not accompanied by a paradoxical set of psychotherapy skills that is grounded in humility (Hook, Davis, Owen, Worthington, & Utsey, 2013; Paine, Sandage, Rupert, Devor, & Bronstein, 2015). Humility involves both intrapersonal and interpersonal characteristics (Davis et al., 2011). On the intrapersonal dimension, humility involves an accurate view of self, including an awareness of and ability to acknowledge personal mistakes and limitations; on the interpersonal dimension, humility involves a relational stance that is other-oriented, rather than self-focused. Openness, perhaps humility's most critical defining feature, infuses both intrap-

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ersonal and interpersonal dimensions and underlies all its components (Davis et al., 2011; Davis, Worthington, & Hook, 2010; Hook et al., 2013; Paine et al., 2015). At face value, humility may appear to be the opposite of expertise, but we argue that humility is foundational to implementing the suggestions put forth in the Tracey et al. (2014, 2015) articles.

First, a psychotherapist must be humble to seek out and incorporate feedback. Openness, valuing input from the other (or client), ability to acknowledge possible need for skill improvement, and willingness to engage in self-scrutiny would all be therapist prerequisites of any such feedback incorporation efforts. Some reasons for, and roadblocks to, successful incorporation of client feedback are: (a) because of its potentially threatening nature, psychotherapists can shy away from requesting client feedback and instead prioritize their own subjective sense of how clients are doing (Lambert, 2010; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005); and (b) because low humility is associated with compromised openness (Davis et al., 2011), psychotherapists with low humility can interpret client feedback as being a product of "client issues" (e.g., labeling the client "resistant" or "difficult") and fail to accept their own need for behavioral change. We believe that humility is a crucial and necessary antidote to the removal of both roadblocks.

Second, a psychotherapist must also be humble to engage in deliberate practice. Deliberate practice is difficult and strikingly different from the type of practice most of us do in our everyday work lives: It is *designed* specifically to improve performance (Colvin, 2008). Often a teacher or supervisor is an important component to deliberate practice because of the depth of knowledge needed for delivering critical performance feedback and stimulating continued improvement (e.g., McMahan, 2014; Paine et al., 2015). Again, openness, valuing input from the other (teacher or supervisor), ability to acknowledge possible need for skill improvement, and willingness to engage in self-scrutiny would all be therapist prerequisites of any such feedback incorporation efforts. For many psychotherapists, this kind of designed practice is unfortunately rare once graduate school has been completed and one's license obtained.

Deliberate practice also occurs at the *edges of one's abilities and performance* (Coyle, 2009). For example, in one research study comparing elite and sub-elite figure skaters, the elite figure skaters spent more time practicing difficult skills, such as jumps, than did the sub-elite figure skaters, and it was suggested that very elite figure skaters spend a larger amount of time working on skills that are at the edges of their abilities (Deakin & Cobley, 2003). Over time, psychotherapists can come to most resemble sub-elite figure skaters, in that they may find a type of work or population with which they feel comfortable and stay in their comfort zone. Humility is necessary for challenging any such comfort and working to master the more difficult "jumps" of therapeutic expertise; it requires a relentless willingness to wrestle with the learning struggles, demands, and failures of change, and to constantly work at the edges of ability *and* performance.

Expertise is a preeminent goal of psychotherapy education and a preeminently desired practitioner objective. But what prerequisite variable or set of variables makes the process of acquiring therapeutic expertise possible? If psychotherapists are to meaningfully incorporate the suggestions proposed by

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Tracey et al. (2014, 2015), we contend that humility is that very foundational characteristic—the *sine qua non*—for actualizing expertise. When operating from a place of humility, psychotherapists are increasingly freed to incorporate client (and supervisor) feedback, further fortified in maximizing deliberate practice efforts, and better positioned to make treatment expertise a psychotherapeutic reality: The expert psychotherapist is foremost a humble psychotherapist.

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NOTICE TO READERS

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

Trainee Therapist Characteristics Related to Therapeutic Alliance and Technique: Project Summary

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Ample research suggests that therapists differ in their level of effectiveness (Baldwin & Imel, 2013; Blow, Sprenkle, & Davis, 2007; Wampold, 2001). Even more striking is that therapist effects appear to be larger than treatment effects (Kim, Wampold, & Bolt, 2006; Lindgren, Folkesson, & Almiqvist, 2010). Moreover, therapist training, experience, and theoretical orientation do *not* appear to explain the majority of therapist effects (Beutler et al., 2013; Okiishi, Lambert, Nielsen, & Ogles, 2003; Stirman & Crits-Cristoph, 2011). Therefore, it has been hypothesized that therapists' personal characteristics may impact treatment (Heinonen, Linfdors, Laaksonen, & Knekt, 2012; Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009).

Hypotheses regarding what makes a good therapist often center on constructs such as intelligence (Shedler, 2006), empathic ability (Hill et al., 2008), interpersonal and attachment styles (Marmarosh et al., 2013), and history of personal therapy (Gold & Hilsenroth, 2009). Unfortunately, the empirical literature has largely ignored some of these factors and produced inconclusive or limited results for others. For example, a therapist's empathic ability is theorized to be critically important (Rogers, 1957). Nonetheless, research on the degree that pre-screening measures of empathy can predict later therapeutic effectiveness is mixed (Hill et al., 2008; Moyers & Miller, 2013).

Thus, while there is considerable evidence that therapist characteristics influence the process and outcome of therapy, much more work is needed (Blatt, Sanislow III, Zuroff, & Pilkonis, 1996; Blow et

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al., 2007; Lebow, 2006). Greater understanding of which therapist factors are most important and the degree to which these factors are innate versus developed through training will have important implications for graduate school admissions criteria as well as types and methods of training. This study aims to contribute to this need by using a multimethod evaluation to assess students at the beginning of graduate school to determine which trainee characteristics predict later success in forming an alliance and implementing therapeutic techniques.

Method

Participants. Participants in the current study are graduate students enrolled in a Masters in clinical psychology program at a southeastern university. Presently, data have been collected from two cohorts of graduate trainees (N = 19). The participant group is currently 74% female (n = 14) with a mean age of 24 years (SD = 6.74). The racial composition of the sample was reported as 68% European American, 21% African American, 5% Asian American, and 5% biracial. Thirty-seven percent (n = 7) of the present sample endorsed having received therapy, with a mean time spent in therapy of 26 months (SD = 34.66). In addition, participants' academic records indicated an overall mean undergraduate grade point average (GPA) of 3.57 (SD = 0.23), a mean quantitative Graduate Record Examination (GRE) score of 147.72 (SD = 7.63), mean verbal GRE score of 152.22 (SD = 5.85), and a mean analytic GRE score of 3.81 (SD = 0.57). Finally, at the time of this report, 16% (n = 3) of the sample had either withdrawn from, or been asked to leave, the program. For those participants failing to complete the program, three months was the average amount of time completed (SD = 1.73).

The undergraduate students serving as practice therapy clients are also recruited from the same university. The students who consent to participate in the sessions do so as one of the class project options in a course focused on personal growth and exploration. These students receive course credit for participating in the sessions and writing a reflection essay about their experience. Importantly, none of these practice clients know the researchers in this project and their professor is not provided any information about the therapy sessions other than that the students participated. Presently, the practice client group (N = 16) is 50% female, 50% European American, 25% African American, 12.5% Asian American, and 12.5% Hispanic. The mean age of the group is 20 years, (SD = 2.13). Moreover, 31% (n = 5) reported previous therapy experience, with the mean time spent in therapy of 15 months (SD = 58.38).

Multi-Method Assessment

At the beginning of their graduate training (2nd day of class of the 1st semester), all students enrolled in the Masters of Clinical Psychology program complete a multi-method personality assessment as part of the course work for their Personality Assessment class. The assessment battery is designed to assess the following individual characteristics: personal therapy experience, attachment and interpersonal style, empathy, and implicit dynamics related to self and others. A research assistant (RA) unaffiliated with the program administers, deidentifies, and scores the assessments. Importantly, all student responses are kept confidential and are not shared with anyone in the program (including the professor of the course). The following is a list of the measures used in this assessment:

Academic achievement. The participants' college GPA and GRE data are acquired

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from the students' applications to the program.

Personal therapy experience. Trainees complete a demographic questionnaire that also includes one yes/no question regarding whether they have been in personal therapy and, if so, for approximately how many months.

Experience in Close Relationships-Revised (ECR-R). The ECR-R (Fraley, Waller, & Brennan, 2000) is a five-point Likert-type self-report scale. It consists of 36 statements assessing attachment-related anxiety and avoidance in different types of relationships. The scale includes two subscales: Avoidance and Anxiety (Fraley et. al., 2000). The statements utilized in the questionnaire reflect worries about attachment-related concerns, as well as discomfort with intimacy. Research has confirmed the two factor structure of the measure as well as its temporal stability, with 86% of the variance shared between two administrations of the scale over a six week period (Sibley & Liu, 2004).

The Inventory of Interpersonal Problems-Short Circumplex (IIP-SC). The IIP-SC (Soldz, Budman, Demby, & Merry, 1995) is a 32-item four-point Likert-type self-report scale which assesses eight separate domains of interpersonal problems. The measured domains consist of four items each and yield eight scale scores: Domineering/Controlling, Vindictive/Self-Centered, Cold/Distant, Socially Inhibited, Nonassertive, Overly Accommodating, Self-Sacrificing, and Intrusive/Needy (Horowitz, Alden, Wiggins, & Pincus, 2003). The measure has been reported as having excellent overall reliability (r = .93) and moderate scale reliability, with Cronbach alpha coefficients for the eight scales ranging from .68 for Intrusive/Needy to .87 for Cold/Distant (Horowitz et al., 2003).

Interpersonal Reactivity Index (IRI). The IRI (Davis, 1980, 1983) is a 28–item, five-point Likert-type self-report scale. The measure evaluates four separate aspects of the global construct of empathy with items divided into the following four subscales: Perspective Taking; Fantasy; Empathic Concern; and Personal Distress (Davis, 1983). Research has provided evidence of convergent and discriminant validity of the IRI (Davis, 1983), as well as its four-factor structure (Pulos, Elison, & Lennon, 2004).

Thematic Apperception Test (TAT). The TAT (Murray, 1973) is a set of 32 black-and-white stimulus cards with stylized images depicting specific life scenes. Individuals are shown TAT cards and asked to make up a story in response to each respective card. These stories are then examined in an effort to draw conclusions regarding the respondent's internal world. For this study, the following seven cards: 1, 2, 3BM, 4, 13MF, 12M, and 14, were administered in a group format in which the cards were projected on a screen and participants were asked to write their responses in a notebook. After the TAT was administrated, responses were transcribed, deidentified, and independently scored by two trained raters using the *Social Cognition and Object Relations Scale-Global Rating Method* (SCORS-G; Stein, Hilsenroth, Slavin-Mulford, & Pinsker, 2011; Westen, 1995). The SCORS-G is comprised of eight constructs which are rated using a seven-point Likert-type scale, where lower scores are indicative of more pathological aspects of object representations and higher scores are suggestive of more mature and adaptive functioning. The two expert raters used for this project had previously completed manualized training on the SCORS-G (Stein et al., 2011; Westen, 1995) and achieved "good" to "excel-

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lent" reliability on the SCORS-G in previous research (Stein et al., 2014).

Therapy Sessions

In the students' second semester, all graduate trainees take an introductory therapy course. This four-credit course focuses on therapeutic technique with curriculum based on Hill's three-stage model of helping as presented in *Helping Skills: Facilitating Exploration, Insight, and Action, Third Edition* (2009). As part of the requirements of the course, all students participate in a series of four practice therapy sessions with undergraduate student volunteers. The first session is a 1.5 hour intake and the remaining three sessions are 45 minutes and focus on whatever issues the client presents.

The practice therapy clients are told that they can use the sessions to work on whatever feels most important to them at the time. However, they are instructed not to share concerns which would necessitate an intervention by a licensed professional, such as suicidal or homicidal ideation, or child or elder abuse. Any clients presenting with these issues are directed to the campus counseling center. Common presenting problems have included difficulties in interpersonal relationships, anxiety related to school performance, and concern regarding choosing a career path.

All sessions are videotaped and the trainees receive supervision from the instructor who is a licensed psychologist. Following sessions one, two, and four, trainees receive 1.5 hours of group supervision (2-3 trainees per group). In addition, students receive 1.5 hours of individual supervision following session three. Supervision focuses heavily on the review of video-recorded case material with emphasis on conceptualization, process, interpretation, and clinical interventions.

Post Session Evaluation

At the end of the third session, clients fill out a measure to assess therapeutic alliance. In addition, the third session videotapes are rated for technique use by two trained raters. The following is a list of the measures used in this assessment:

Working Alliance Inventory, Client Form (WAI-C). The WAI-C (Horvath & Greenberg, 1989) is a 36-item seven-point Likert-type self-report scale designed to assess three facets of the therapeutic relationship: Task, Bond, and Goal (Horvath & Greenberg, 1989). Good reliability (Hanson, Curry, & Bandalos, 2002; Horvath & Greenberg, 1989) and construct validity of the WAI-C (Tichnor & Hill, 1989) have both been reported.

Helping Skill Measure (HSM). The first 13 items of the HSM (Hill & Kellems, 2002) capture basic exploration, insight, and action therapy skills using a five-point Likert format ranging from "strongly disagree" to "strongly agree." For the purpose of this study, three additional items were added to assess the use of interventions intended to support the client, to employ immediacy in the session, and to utilize personal disclosure. In addition, all negative items (e.g., "In this session, the helper did *not* encourage the client to express what he/she was thinking or feeling") were reworded to have positive content (e.g., "In this session the helper encouraged the client to express what he/she was thinking or feeling"). Hill and Kellems (2002) found estimates of internal consistency to be adequate for the Exploration and Action scales, but less so for the Insight scale. The study also reported low to moderate intercorrelation among the scales, suggesting that the three scales were related, yet distinct.

The instructor and a master's level research assistant underwent training on the HSM. The training consisted of read-

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ing Hill (2009) and Hill and Kellems (2002), practicing coding on 17 videotaped sessions, and discussing the rating categories as a team. After completing the training, the two raters will watch each trainee's third session videotape in its entirety and then immediately rate the session independently using the HSM. Regular reliability meetings have been held during the coding process to prevent rater drift. The raters have demonstrated inter-rater reliability in the average (*ICC*(2,2) = .60 - .74; Shrout & Fleiss, 1979) to excellent range (³ .75) for each of the items. In addition, their intraclass reliability coefficients, *ICC*(2,2), for the three scale scores Explore, Insight, and Action are in the good to excellent range (.87, .74, and .78).

Planned Statistical Analyses

Two multiple regression analyses will be conducted. The first regression will be used to predict client rated alliance as measured by the total score on the WAI-C. The second regression will be used to predict therapist technique as measured by the average external rater score on the HSM. For both analyses, the independent variables will be the following therapist characteristics: (a) College GPA; (b) Verbal GRE; (c) Performance GRE; (d) Avoidant Attachment scores on the ECR-R; (e) Anxious Attachment scores on the ECR-R; (f) IIP-SC total Interpersonal Problems score; (g) Empathic Concern subscale scores on the IRI; (h) Perspective Taking subscale scores on the IRI; (i) Number of months of personal therapy (none/0 – X); and (j) Average score on the SCORS-G. Additionally, we will examine incremental validity of the above listed variables using hierarchical, alternating, and block regression.

Anticipated Outcomes

Given that past research has shown therapists' empathic ability, attachment, and interpersonal styles to be related to alliance (Ackerman & Hilsenroth, 2003; Diener & Monroe, 2011), we expect the ECR-R, IIP-SC, and IRI subscales to predict client-rated alliance. Relatedly, we may also expect the SCORS-G to be positively associated with alliance. However, given the lack of previous research on implicit measures of object relations as they relate to the process of therapy, the hypothesis about the SCORS-G is more tentative.

Finally, given that undergraduate GPA and GRE scores have been shown to predict graduate school performance such as graduate GPA, comprehensive exam scores, and faculty ratings (Kuncel, Hezlett, & Ones, 2001), we may expect that higher scores on these two domains will relate to the ability to learn and implement therapeutic techniques (i.e., higher scores on the HSM). However, similarly to the previous hypothesis, due to the paucity of existing research, this prediction is also tentative.

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.

Parallel Process in Multicultural Supervision[1]

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One of my best friends is a skilled storyteller. During our internship year, she would regale the staff of the counseling center with tales of suspicious occurrences surrounding Area 51, the "secret" government location where UFOs are purportedly stored and studied. She would wax on about mysterious sightings and disappearances with oratory inflections akin to a female Rod Serling. She always ended her yarn with the animated phrase, "Coincidence? I think not!"

How is this relevant to parallel process and multicultural supervision? I invite you to consider the back-to-back articles published in *Psychotherapy* Volume 49(3), in which Tracey, Bludworth, and Glidden-Tracey (2012a) provide evidence for parallel process in supervision and Watkins (2012) questions the veracity of the claim by saying, "What might be construed as parallel process, might be real process that parallels" (p. 345). Is what "has become the best-known phenomenon in supervision: perhaps even the signature phenomenon," (Bernard & Goodyear, 2014, p. 65) simply a coincidence?

Tracey et al. (2012a) analyzed patterns of dominance and affiliation between pairs of clients and trainees and trainees and supervisors, finding that "[supervisors and trainees] altered their behavior from their own general patterns in line with what would be predicted by the theory of parallel process" (p. 339). Client and trainee dyads were more similar on dominance and affiliation in the beginning of therapy than trainee and supervisor dyads, then became increasingly dissimilar mid-treatment, during which time the most successful trainee-supervisor dyads became more similar. Toward the end of therapy, client-trainee similarity ratings increased again. The results supported the contention that "The trainee brings the 'less adaptive' behavior of the client into supervision, and the supervisor and the trainee enact a minor version of the same interaction…then the supervisor alters her/his behavior away from these client-defined patterns, theoretically with the intention to promote alternatives for the therapist to employ in the session" (p. 340). Positive client outcome was associated with a pattern in which the trainee's behavior resembled the supervisor's mid-treatment.

For Watkins, the crux of the issue centers on whether *unconscious processes* are at play. Is the supervisee *unconsciously* enacting the client's process in supervision? Was there sufficient evidence to claim that client-therapist dynamics get played out in supervision and vice versa? In their response, Tracey, Bludworth, and Glidden-Tracey (2012b) asserted that they "found strong support for the presence and value of an interpersonal conception of parallel process in supervision" (p. 348) that might reflect but not preclude an unconscious element.

The purpose of this article is twofold: a) to step outside of an either/or mentality about parallel process and adopt a stance of both/and (Hardy, 1995), given that parallel process may be *both* an unconscious replication of intrapsychic dynamics *and* an interpersonal one; and

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b) to examine how parallel process in multicultural supervision may be *both* a resource *and* a liability. Unnoticed and unexamined unconscious processes and interpersonal behaviors may be transmitted in either direction across the therapeutic triad (Doehrman, 1976) and may have positive or negative effects. It is the trainee who is operating in the middle of these dynamics (Frølund & Nielsen, 2009) and is *both* reflecting *and* mirroring the inter- and intra- personal dynamics of the client and supervisor. By taking a both/and stance, parallel process may be recognized as *both* a vehicle for the transmission of bias *and* a conduit for identifying and reducing biased practices and promoting or enhancing culturally responsive psychotherapy (Inman & DeBoer Kreider, 2013; Ladany, Inman, Constantine, & Hofheinz, 1997).

One way bias is communicated is through *microaggressions* (Sue et al., 2007). "Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (Sue, 2010, p. 3), and are associated with a range of negative attitudes towards singular (Sue, 2010) and intersecting cultural identities (Lewis & Neville, 2015). Microaggressions are often delivered by well-meaning individuals who are oblivious to the impact of their behavior. According to Sue (2010), *microinsults* (rude, demeaning insensitive comments or actions) and *microinvalidations* (diminishing behaviors or statements that nullify or redefine the target person's own phenomenology) are often unconscious (p. 8), whereas *microassaults* (explicit words or actions that denigrate and intend harm) are often conscious and intentional.

Microaggressions create "psychological dilemmas" (Sue, 2010, p. 11) among and between people (Sue et al., 2007; Zetzer, 2015), including clients and trainees and trainees and supervisors (Bartoli & Pyati, 2009; Constantine & Sue, 2007; Hernández, Carranza, & Almeida, 2010; Murphy-Shigematsu, 2010). Microaggressions are unavoidable. Even the most committed psychologists and trainees are going to bumble into them. Each of us holds *both* the propensity to emit *and* the potential to reduce the likelihood of enacting microaggressions.

Microaggressions and parallel process are complementary constructs, and supervisor self-knowledge is the bridge between them. Self-knowledge includes awareness of the historical and cultural context for the expression of intersecting identities and "awareness of the effects of one's behavior on others, and changing behaviors that no longer serve healthy growth or relationships" (Butler-Byrd, 2010, p. 12). For example,[2] I identify as a White, 50-something, LGBT ally, who is committed to social justice and a feminist multicultural approach to psychotherapy and supervision. While supervising a case transfer between trainees, I intentionally paired a sexual minority client with a sexual minority trainee because I thought that the client would benefit from working with a positively identified sexual minority therapist. Without thinking twice, I encouraged the transferring therapist to describe the benefits of the arrangement with the client. Shortly thereafter, the client left therapy.

What happened? I trust that you can generate many hypotheses, but it may be helpful to look at this from the standpoint of microaggressions and parallel process gone awry. The transferring trainee brought the client's internalized oppression related to their[3] sexual

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orientation identity (Worthington, Savoy, Dillon, & Vernaglia, 2002) into supervision and expressed the hope that the client would become more self-affirming. The client was a sweetheart and the first trainee and I liked the client tremendously. Here was someone who deserved the kind of love and care that flows to people who feel worthy. The trainee and I felt a "pull" (Hill, 2014) to make life better. Now, here is the key: Our response was a "microinvalidation," a set of actions that denied the reality of the client's experience as a sexual minority who was raised in *both* a loving *and* homonegative family and is living in a heterosexist culture. The incoming clinician saw this instantly and confronted me about process and the outcome. The new trainee's experience mirrored that of the client. That experience said, "We know what you need," and "Here's what you should do."

Defining someone else's contribution is a hallmark of privilege (Zetzer, 2011), and it is connected to structural/institutional forms of oppression (Reynolds, 1997). Outing the new clinician and prescribing a certain type of relationship was a significant error with a real consequence. Uncontaminated attunement to parallel process and vigilance regarding microaggressions might have led to a more positive outcome. I feel fortunate that I was able to repair the relationships with the trainees. I am especially indebted to the incoming trainee who spoke candidly to me. We have worked closely together since then and while this represents a "tear and repair" (Beutler & Harwood, 2000) of the supervisory relationship, there was no repair in the relationship with the client. They left.

This is an example of parallel process as a *liability*. One way to guard against repeating this mistake and to move toward making parallel process an *asset* is to apply a model of multicultural supervision that relies on *both* self-knowledge *and* an external framework. Inman and DeBoer Kreider (2013) defined multicultural supervision and counseling competence as "the development of an understanding of the contextual and systemic issues on each member of the client-counselor-supervisor triad, as well as the process and outcome of counseling and supervision" (p. 346). They offered two approaches to supervision that would have been useful in my first case example.

The Critical Events Model (CEM; Ladany, Friedlander, & Nelson, 2005) is a systematic approach to multicultural supervision that can be used to map out complex intra- and inter- personal interactions into events that have a beginning, middle, and end. The event begins with a "marker" that is observed by the supervisor or trainee. Markers are discontinuities in the therapeutic or supervisory process. According to Ladany et al. (2005), once a marker is identified the supervisor moves into the "task environment" and applies interventions to supervision with the intention of cultivating culturally competent responses on the part of the trainee. If successful, the task environment leads to the resolution of the critical event. In this case example, noticing critical markers would have resulted in greater attunement with the client's experience of internalized oppression or greater awareness of my unabashed hopes for client change. Such awareness would have led me to offer a different task environment.

As a supervisor, I would also have benefited from using Ancis and Ladany's Heuristic Model of Nonoppressive Interpersonal Development (HMNID; 2010) to draw attention to how a trainee's and supervisor's membership in a "socially privileged group" (SPG) and/or "socially oppressed group"

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(SOG) may influence psychotherapy and supervision. The first trainee and I were responding from our sociopolitical locations (Watts-Jones, 2010) as members of an SPG. The client and second trainee viewed the case transfer process as members of an SOG. All four of us have multiple memberships in SOGs and SPGs. However, the locations related to sexual minority/majority status are the most salient for understanding the outcome of this case.

Sociopolitical locations related to race/ethnicity, gender, and class were the most salient features of a second case example, in which parallel process was used to foster a more positive outcome (Zetzer & Reese, 2014). I supervised an Asian American male trainee working with a 30-something Asian American female client who sought therapy for depression caused by the sudden termination of an engagement with a European American man who was ten years older. He borrowed a large amount of money from her, cheated on her, and then ended the relationship. He was exploitive, coercive, and violent while they were together. However, she missed him terribly and wanted him back.

The trainee administered weekly measures of outcome and the therapeutic alliance using the Partners for Change Outcome Management System (PCOMS; Duncan, 2012). At session three, the client's sense of wellbeing, as measured by the Outcome Rating Scale (ORS) indicated reliable deterioration. She told the trainee that she was looking for ways to reunite with her ex- to get her money back. At session four, the total ORS score continued to decline and the quality of the therapeutic alliance, as measured by the Session Rating Scale (SRS), showed deterioration. The client wanted direction. The therapist asked me for direction. I focused my concern on the client's safety and directed the trainee to work with her to form a plan in case she met with her ex-partner and he became abusive. I insisted that they work together to build the plan even after he said, "She won't like it."

Session five went poorly and the Total SRS score did not change. The client said she was confused. The trainee came into supervision feeling confused. Then, I felt confused. How could a call for a safety plan, clearly a demonstration of caring, elicit so much confusion? Though this trainee was highly skilled at cultivating therapeutic relationships, the low SRS score (31 out of 40) suggested that the alliance was weak (36 and below is cause for concern; Miller & Duncan, 2004; see Figure 1.) Hence, there were two markers: a) the confusion and b) the low SRS scores.What is a feminist multicultural supervisor to do? Look for the intra- and inter- personal dynamics of power and privilege in the triadic relationship (Enns, 1997). I hypothesized that neither the client nor the therapist felt safe enough to challenge authority. I wondered how race, gender, and class differences were contributing to the interpersonal dynamics. Perhaps the client's assertions of autonomy and capability were being expressed in a culturally consonant manner as "confusion" and carried by the therapist into supervision. After recognizing the parallel process, I immediately moved to a one-down position with the trainee and said, "Oh my! I have asked you to take a position of authority with a client who has been disempowered in relationships all her life. I am sorry. What do you think should happen next?" The trainee suggested that he ask the client the same question, and voilà! The next session the total SRS score increased. Despite continued fluctuations, by session 10 the ORS revealed reliable, but not clinically significant, change (from a low of 11.8 to a high of 21.8) and the SRS score was 35.9.

It is my interpretation that the trainee

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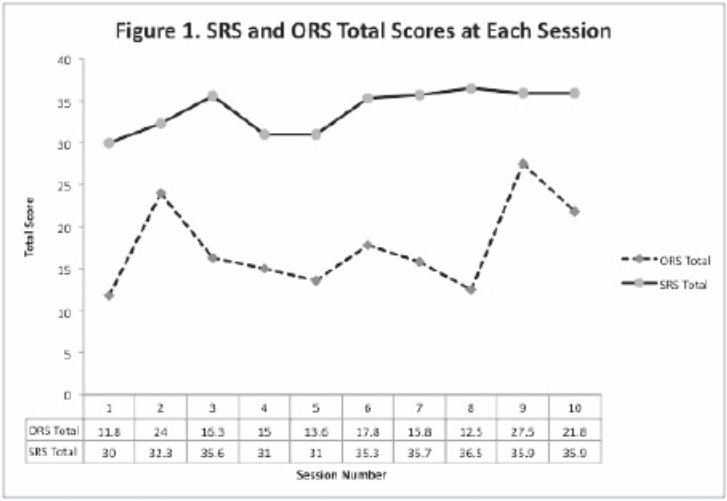

Figure 1. Total Outcome Rating Scale Score (ORS) and Total Session Rating Scale Score (SRS) Per Session. Range is 0-40. Higher scores are better. Reliable change index for ORS is 6. Total ORS scores below 25 suggest client's sense of "how well" they are doing is similar to an outpatient population. SRS scores above 36 are desired.

brought the "less adaptive" behavior of the client into supervision by reporting confusion (Tracey et al., 2012a, p. 340). Fortunately, after much feminist soul-searching and some obvious empiricism, I was able to step back and take a more reflective, collaborative, honoring, and empowering stance with the trainee, who offered that same shift to the client, who in turn showed improved sense of well-being and greater satisfaction with therapy.

Adopting a *both/and* stance towards parallel process allowed me to use critical event markers to reflect on practice (Schön, 1983) and then hypothesize about invisible internal states (e.g., internalized oppression, unconscious privilege) as they were elicited and expressed in the visible interpersonal interactions across the therapeutic triad. By witnessing the ways in which trainee behavior paralleled that of the client, I was able to observe and then select interventions in the "task environment" that supported culturally responsive interventions on the part of the therapist—and that led to improvement.

Coincidence? I think not!

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] Author's Note: Portions of this article were presented at the Society for Counseling Psychology Conference, Atlanta, Georgia, March, 2014.

[2] Identities of trainees and clients have been de-identified and disguised throughout this article.

[3] I am using the plural pronoun to *both* mask the gender of the client *and* to remind the reader of the fluidity of gender identity and the binary hegemony that we see in the English language.

Discrepancies Between Beginning Psychotherapists' Clinical Self-Perceptions and Their Presentation to Supervisors and Teachers

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A dilemma commonly experienced by therapists in training: How to negotiate the conflicting needs between being as honest as possible with supervisors (including acknowledging clinical mistakes and/or deviations from prescribed models and protocol) and presenting oneself, perhaps somewhat less than honestly, in ways assumed to evoke positive regard and excellent evaluations. While the first position reflects the mandates of personal integrity and professional ethics, and also increases one's opportunities for being helped as much as possible, the second position is certainly not without its real-life advantages, including the avoidance of potential criticism and shame. To what extent, then, do beginning therapists allow their supervisors to know how anxious, confused, or overwhelmed they have felt, or how warm, self-disclosing, or boundary-extending they have been in sessions with their clients?

There are several sources of this conflict or dilemma. As they learn to do the work of what Freud (1937) termed an "impossible profession" (p. 401), beginning therapists are typically beset with multiple stressors, including a greater awareness of their own personal issues; the myriad of difficulties and frustrations inherent to treatment per se; the confusion that may be attendant to learning diverse treatment options and forming a professional identity; the scrutiny and evaluation of multiple teachers and supervisors; and the awareness of disjunctions between their preferred personal style (e.g., informality; friendliness) and the assumptions of a more professional demeanor (Eckler-Hart, 1987; Farber, 1983, 2006; Gold, 2005; Hill, Sullivan, Knox, & Schlosser, 2007; Skovholt & Rønnestad, 2003). Their responsibilities and expectations—both internally and externally imposed—are considerable, and despite their typically outstanding scholarly achievements, many trainees feel distressed by the demands and challenges of clinical and supervisory work. While such experiences are normative, disclosure of these feelings, or of seemingly non-prescribed clinical interventions, may nevertheless be problematic given trainees' understandable wish for approval from supervisors, complementary fears of being judged as "less than" or wanting in some respect, and eventual need for highly complimentary letters of recommendation for externships, internships, and/or jobs (Bernard & Goodyear, 2014; Hahn, 2001; Skovholt & Rønnestad, 2003; Wallace & Alonso, 1994). Moreover, as Farber (2006) has

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noted, fears of failing oneself and/or one's supervisor may be particularly acute because clinical work is so inextricably tied to the therapist's sense of self: "The work of the psychotherapist... draws so palpably upon an individual's skills as a caring, well-related human being. Thus, acknowledgement that one is struggling with the work all too often feels tantamount to admitting that one is struggling to be the human being one wants to be and should be" (p. 182).

In fact, studies have shown that trainee anxiety and fear of unfavorable supervisor evaluations are significantly related to greater nondisclosure and more frequent manipulation of presented clinical material during supervision (e.g., Mehr, Ladany, & Caskie, 2010). Studies have also shown that supervisee nondisclosure may be nearly universal. In one study (Ladany, Hill, Corbett, & Nutt, 1996), over 97% of a sample consisting primarily of doctoral students in counseling and clinical psychology reported withholding at least some information from their supervisors. In another study (Yourman & Farber, 1996), 47% of clinical supervisees acknowledged telling their supervisor—at moderate to high levels of frequency—"what he or she wanted to hear" (p. 571).

Research has determined that trainees are most likely to conceal negative reactions to their supervisors and clinical mistakes (Ladany et al., 1996; Mehr et al., 2010; Yourman & Farber, 1996). Although valuable in its own right, this line of research has neither examined the specific types of emotions or behaviors that trainees find difficult to acknowledge nor the extent of the discrepancies between what trainees experience while doing clinical work (e.g., feelings of anxiety or sexual attraction) and their reports of these experiences to supervisors—the dual focal points of the current study.

Method

Participants.The sample consisted of 133 students in psychotherapy training programs. Most were female (84.2%), Caucasian (74%), and between the ages of 25-34 (70.5%). These students were divided among PhD (39.7%), PsyD (30.8%), and license-eligible MA programs (28.8%). They were well distributed regarding the theoretical orientation that "informs their work" on a 7–point scale (1 = not at all; 4 = somewhat; 7 = to a great extent); their responses indicated that their work is at least moderately informed by psychodynamic (M = 5.02; SD = 1.65), humanistic/existential (M = 4.52; SD = 1.78), and cognitive-behavioral therapy (CBT) (M = 4.29; SD = 2.42) perspectives. On average, these beginning therapists were currently seeing 5.4 clients, and to date had seen 12 clients (M = 12.18). Among this sample, 96 (72.2%) had at some point been in their own psychotherapy. There were no significant differences between men and women in terms of perceived adherence to each of the three theoretical orientations assessed in this study, nor in regard to age or ethnicity.

Instrument and procedure. The "Experiences of Beginning Therapists Survey" (BTRS; Farber, Geller, Coren, Hazanov, & Lyman, 2013) consists of several sections; for the purposes of this report, the relevant section requested participants to compare, on a 1-7 Likert-type scale, the extent to which they believe they are less, about the same, or more (1 = far less; 4 = about the same; 7 = far more) "compassionate, "disclosing," "warm," etc. (over a total of 32 items) in their actual clinical work than they disclose to their supervisors.

Participants were recruited through networking, primarily by sending announcements to Directors of Clinical Training throughout the country. Partic-

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ipants completed the survey online (via Survey Monkey).

Results

Descriptive data. The basic research question posed was, "Which emotions and behaviors common to beginning therapists are most likely to be over- or under-reported to supervisors?" To answer this question, we looked at participants' self-reports (i.e., mean scores) on 32 distinct therapy-related feelings and behaviors. As Table 1 indicates, the most discrepant items were "anxious," "uncertain," "overwhelmed," "humorous," "protective," "compassionate," "advice-giving," "confused," "encouraging," "self-assured," "friendly," and "chatty"; in each case (except "self-assured"), trainees' experiences of these feelings or behaviors were greater than they reported to their supervisors. Notably, though, none of these scores exceeded 5.0 on a 7.0 scale (where 4 = about the same, and 7 = far more). Several items had mean scores at or around 4.0 — including, for example, awareness of one's own and the client's erotic feelings, and one's availability outside of sessions—suggesting a near exact correspondence between trainees' reported felt experiences and their reports to supervisors. While a Principal Components Analysis of the survey items (followed by regressions of these factors on selected demographic variables) would have been instructive, the small sample size precluded this.

Hierarchical regression analyses: Effects of demographics on factor scores. Five hierarchical regressions were computed to determine which demographic variables, including age, gender, ethnicity, current year in psychology program, type of graduate program, and current status of personal therapy, predicted scores on each of the five "most discrepant" items. Only the top two most discrepant items, anxious and uncertain, yielded significant overall R-squared values (.15 and .16, respectively). Two variables—gender and ethnicity—were significant predictors of the anxious item; three variables—age, ethnicity, and current status of personal therapy—significantly predicted the uncertain item. Younger age, male gender, non-minority status, and being in therapy were predictive of higher scores (i.e., greater discrepancies) on these items.

Discussion

Although this sample of beginning therapists did indicate discrepancies on several items between their self-experiences of clinical work and their reports of these experiences to supervisors, these discrepancies tended to be minimal to moderate. Thus, despite decades of research suggesting that psychotherapy trainees inevitably experience a great deal of stress and anxiety, and that nondisclosure to supervisors is normative, the results of this study indicate, somewhat surprisingly, that beginning therapists are generally honest in their reporting of their clinical experiences. This may be due, in large part, to supervisors' ability to provide a sufficient "holding environment" (Winnicott, 1960) for trainees' distress.

We also believe that training programs, increasingly aware of and attentive to the results of psychotherapy research, have increased their attention to relational factors and the critical importance of developing a strong therapeutic relationship across multiple theoretical perspectives. The current zeitgeist—one that typically encourages therapists to be genuine, empathic, and open—has likely created an atmosphere in which clinical trainees feel more authorized than trainees of previous generations to disclose their in-session relational experiences with supervisors—and that supervisors, compared to previous gen-

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erations, are more receptive to hearing and processing such experiences. To explicitly acknowledge that one is self-disclosing or spiritual—self-attributions which would almost certainly have led to significant under-reporting to supervisors a generation ago—is now seen as acceptable, representing a significant shift in the therapeutic and supervisory landscape.

Nevertheless, this sample of beginning therapists did, to a certain extent, mask some of their distressed feelings. The three most under-reported items—experiences of anxiety, uncertainty, and feeling overwhelmed—reflect a complex tension inherent to beginning therapists' development. Even as trainees feel mostly unconstrained to disclose many of their relationally-oriented clinical experiences with their supervisors, they still struggle somewhat to report doubts about their ability to do the work well. Despite trainees' awareness that clinical work is inevitably difficult, and despite their (presumed) awareness that supervisors recognize this fact, it may still feel shameful to fully acknowledge these difficulties. Clearly, though, while it may be adaptive for supervisees to conceal distress at times (e.g., defending against supervisor criticism protects supervisee self-esteem), "half truths" in the context of supervision may ultimately hinder beginning therapists' professional development by limiting opportunities to process and understand how their in-session experiences affect their therapeutic work and professional sense of self.

It is notable, too, that beginning therapists were hesitant to fully acknowledge the degree to which their sense of humor is part of their work. We speculate that this reflects trainees' fears that their supervisors and teachers might judge this aspect of their clinical work as unprofessional. Thus, while some aspects of relationality are deemed eminently disclosable, humor, and to a somewhat lesser extent compassion, advice-giving, encouragement, friendliness, and chattiness, are apparently viewed more cautiously in terms of their clinical appropriateness. These qualities, we imagine, feel a bit too close to the margins of "soft," and somewhat too far from whatever stance or technical interventions (e.g., interpretations; refutations of self-deprecating patient self-statements) trainees have been taught. Our sense is that most beginning therapists feel authorized to act relationally with their clients and report doing so to their supervisors, but also that most trainees want to feel more technically competent, not just reliant upon their usually well-honed and considerable interpersonal skills. Thus, they may somewhat downplay those aspects of themselves that are self-judged as too far in the realm of friendship or informality.

Surprisingly few predictor variables significantly affected scores on those items with highest discrepancies. That younger trainees hide feelings of uncertainty from supervisors more than their older counterparts is easily understood and perhaps even expectable; we imagine their need to appear certain of themselves would be especially pronounced if they are part of a cohort that is significantly older. Notably, ethnicity was the only demographic factor to significantly predict the top two most discrepant items. That Caucasian beginning therapists report concealing more anxiety and uncertainty than non-Caucasian trainees is a somewhat puzzling finding about which we can only speculate. Perhaps as programs become more diverse, Caucasian students experience an unarticulated, mostly out-of-awareness pressure to look relatively unshakeable; perhaps minority trainees are simply more comfortable expressing their self-experi-

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ences; perhaps these differences are due to the demographics at clinics located in urban communities wherein Caucasian students working with minority clients struggle to acknowledge their difficulties in working with people whose backgrounds are different from their own.

The sole use of self-report measurement has inherent limitations. Some beginning therapists are likely to be reluctant to acknowledge, even on an anonymous survey, the extent to which they have concealed some of their experiences to supervisors. In addition, since participants in this study were asked to report on how they represent their experiences of self in therapy to supervisors "in general," it is possible that some responses were influenced by a single, salient supervisory experience or by a recent and/or specific supervisory exchange. Furthermore, this study did not investigate the extent to which supervisor factors—for example, the quality of the supervisory alliance or supervisors' willingness to disclose personal information—affect beginning therapists' willingness to accurately disclose their self-experiences. Follow-up research, either involving a larger sample or employing qualitative analyses, would likely provide more detailed information on the processes involved in trainees' decisions to withhold, distort, or accurately disclose their clinical experiences.

The results of this study suggest that in training settings, particularly in clinical supervision, supervisors and teachers should normalize and validate the distress that beginning therapists inevitably experience. If supervisors and teachers invite beginning therapists to acknowledge and express the full extent to which they feel anxious or uncertain or overwhelmed in session, and if they (individuals in charge of training) facilitate such discussions by sharing anecdotes from their own training and practice, trainees are likely to feel more comfortable disclosing the true nature of their own experiences. Such authentic exchanges are likely to facilitate a particularly trusting supervisory space, one in which it becomes more fully possible to discuss emotionally charged interactions between patient and therapist (and supervisor and supervisee). In turn, this safer and more mutually disclosing space may provide trainees with greater opportunities to develop therapeutic interventions and skills that help them feel more competent and confident (e.g., less distressed) during clinical sessions and supervision.

We would suggest, too, that participants in supervisor-trainee dyads sensing tension surrounding the disclosure of trainee feelings would benefit from finding the courage to address it. A trainee would likely feel proud, if somewhat apprehensive, of being able to say to a supervisor: "I'd like to talk about how overwhelming this work is for me, but I'm also a bit fearful of how you will see me if I do." A supervisor would do well to say, "It strikes me that you disclose a great deal to me about some of your feelings and behaviors—and I appreciate your honesty in doing so—but I also have a sense that you may be leaving some of the really hard pieces out of our work together, pieces that we all experience."

Since shame and anxiety are inevitable aspects of clinical training, the finding that beginning therapists hide some of their clinical behaviors and emotions when reporting to supervisors is not surprising. What is greatly encouraging, though, is the extent to which this tends to occur minimally, a testament apparently to the honesty of beginning clinicians and the safety and trust provided by clinical supervisors.

References for this article can be found in the online version of the *Bulletin*

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published on the Society for the Advancement of Psychotherapy website.

Table 1. *Psychotherapy Trainees' Self-Experiences Compared to their Reports to Supervisors: Means and Standard Deviations (N = 133)*

	Mean	SD	Min.	Max.
Anxious	4.68	.95	2	7
Uncertain	4.53	.87	3	7
Overwhelmed	4.50	.91	2	7
Humorous	4.47	.73	2	6
Protective	4.46	.80	3	7
Compassionate	4.36	.70	3	7
Advice-giving	4.33	.81	1	7
Confused	4.33	.96	1	7
Encouraging	4.32	.70	3	7
Self-assured	3.68	.85	2	7
Friendly	4.31	.53	4	6
Chatty	4.31	.77	2	6
Empathic	4.30	.74	3	7
Warm	4.29	.63	3	7
Frightened	4.29	.79	1	7
Confrontational	3.73	.78	1	7
Stuck	4.27	.85	0	7
Self-disclosing	4.26	.82	1	6
Boundary-extending	4.25	.74	1	7
Bored	4.22	.70	2	6
Interpretive	4.21	.70	1	6
Praising	4.21	.65	2	6
Impatient	4.20	.72	2	7
Irritated	4.19	.73	2	7
Frustrated	4.18	.77	2	7
Talkative	4.18	.63	2	6
Defensive	4.12	.58	2	6
Aware of my own erotic feelings	4.10	.71	2	6
Spiritual	3.95	.55	1	6
Aware of my client's erotic feelings	3.98	.70	1	6
Available outside sessions	4.01	.60	2	6
Quiet	4.00	.50	2	6

Note. Scores based on a scale where respondents indicate the extent to which they believe they experience less, about the same, or more (1 = far less; 4 = about the same; 7 = far more) of this feeling or behavior in their clinical work than they disclose to their supervisors. Thus, scores higher than "4" indicate that the respondent typically feels more of this experience than reported.

Reflections on Authenticity in Psychotherapy

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Lately I've been thinking about therapist authenticity.Since moving to private practice three years ago I have worked primarily with adult survivors of childhood sexual, physical, and emotional abuse. Due to years of chronic violence during developmentally important periods, clients' life experiences are typically characterized by an insecure (often disorganized) attachment style, a chronically activated nervous system, and difficulty with emotion regulation. These complex trauma dynamics adversely affect clients' ability to form and sustain relationships. The vulnerability required for any form of intimacy is intolerable and, as one of my clients put it plainly, "obviously a really bad idea."

Not surprisingly—and as most of you know—developing rapport with clients who fear connection is quite challenging. Building relationship with any client requires patience, respect, and consistency. And yet, with a few select clients my typical approach to forming rapport is sorely insufficient. There are simply some important relationship competencies they do not have. It feels more accurate and empathic to conceptualize these clients as having an underdeveloped skill set rather than to consider them resistant. Because I, as the therapist, *do* have these skills, I see part of my task as being to work in creative ways to help them engage in the task of co-creating our relationship.

What can I do in these circumstances to facilitate a real bond?Might these cases be what Greenson (1967) terms the "special considerations" (p. 223) in which the real relationship between a client and myself is permitted more leeway?What constitutes a "real" relationship, and how do I present aspects of my authentic self in a way that serves the client and not myself? Two clients[1] come to mind as I think through these questions.

Annie is an articulate young woman from rural Maryland. She is bright and funny. Her parents worked long hours and Annie was responsible for the care of her younger siblings. When home, her mother was often drunk, unpredictable, depressed, or sleeping. Several times Annie's mother "went missing" at night, and Annie recalls searching for her in the middle of the night while Annie was still in grade school. Annie's depression went unnoticed and her pleas for help unheeded. Her mother's feelings took precedence at home. Annie was bullied in school, experienced the death of several friends during her adolescence, struggled with an eating disorder and alcohol addiction, and has attempted suicide multiple times. Her parents continue to deny her struggles. Her most important attachment figures have not been attuned to her needs, so much so that she claims that needs are "irrelevant if they are not going to be met."

Annie has done a lot of work. She has been sober for years, attends AA regularly, and has been successful in both inpatient and outpatient treatment programs. Now Annie requires that people in her life be real. In fact, she demands it. She resents the typical gentle thera-

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pist voice and approach because it is patronizing. She wants to know what I think. Unless I am real, she does not participate in therapy. I am challenged to navigate her genuine need for an authentic encounter because when Annie is engaged with me the work she does in therapy is admirable.

William, on the other hand, is more guarded than any other client with whom I've worked. He presents as cordial and polite, a highly intelligent man with an impressive vocabulary, a sharp wit, and a high status career. He is a survivor of severe physical and emotional abuse at the hands of a wildly unpredictable mother. His stories of beatings, neglect, and abandonment threats are brutal. He was a victim, but also served as his mother's emotional partner, mediator to his parents' fights, and parent and protector of his younger siblings. Nor was school a safe haven; William was severely bullied and placed in remedial classes due to an undiagnosed learning disability.

During the first six months of our work together, William demonstrated little self-understanding. His responses to my probes were nebulous. Often I had little idea what William said or meant. Just when I thought we were forming a connection, he would become formal and distant; from my perspective, it felt as if we had never met. I truly had no idea why he kept his appointments. At one point I wondered if he were, in fact, affectively limited—if perhaps his emotional reservoir is simply shallow. Quite the contrary: It turns out that he possesses an exceptionally deep emotional well, but shields it in a cloak of intellectualized reserve. Connecting with clients fairly quickly is one of my strengths. However, my typical approach did not work with him at all, not because he is resistant but because he is that wounded.

Keeping It "Real": Building Connection Through Authenticity

I am tasked in different ways to reach these two clients. How do I shift in order to develop the solid therapeutic relationship that I feel is necessary to do the work?I begin by thinking through some questions.

What is the impact on development of early childhood abuse?

I find it helpful to use a framework of a resource loss model to understand the impact of early childhood trauma (Cloitre, Cohen, & Koenen, 2006). Although Annie and William experienced different forms of abuse, for both the abuse happened repeatedly during critical developmental periods. Each lost important resources, including a sense of security and personal safety, the development of self-knowledge, trust in self and others, and an ability to identify and regulate strong affect. Experiences at home affected their attention and concentration at school, both in the classroom and on the playground, and contributed to diminished social development and negative social experiences.

Due to these losses, neither Annie nor William developed the requisite psychological and social resources needed for recovery from abuse. They both continue to struggle to forge relationships characterized by trust and appropriate levels of intimacy (Cloitre, et al., 2006). Despite their different presentations, both Annie and William report feeling damaged and unworthy, alienated from others, and pessimistic about relationship success.

What is the contribution of attachment experience?

We learn to care for ourselves from the way we are cared for (van der Kolk, 2014). An infant naturally seeks the parent when alarmed, but if the parent be-

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havior itself is alarming, the child is placed in the frightening position of wanting to approach and flee simultaneously (Main, 1996). Herein lies the paradox for clients like Annie and William. Both individuals looked to their primary parent to assess safety and/or threat level, and found her to be unpredictable and untrustworthy.

Neither protected nor soothed, Annie and William bring their internal working model of others into childhood, adolescence, and adulthood, and use these templates to guide their relationship expectations. William would like me "take charge" in our work because he does not understand interpersonal objectives. When I process relationship dynamics he seems disoriented and confused by what is happening. His current important relationships follow a similar path; when his partner wants to discuss emotion or conflict in their relationship, he feels numb and unable to think clearly. Annie expresses sadness because her parents are not attuned to her, but becomes angry with me when I ask about her needs and wishes. Similarly, she experiences challenges in her friendships and romantic relationship because she resents when others do not consider her needs, even while she denies the importance of those needs.

My job as a secure base is to be a different sort of anchor than these clients have had before. Annie and William have learned that relationships hurt, that no one will step in to help them because they are not worth saving, and that to be connected means they will be abused. To be a responsive caregiver with clients like Annie and William means I need to be attuned to their needs and adjust my approach if indicated. I hoped that offering these two clients aspects of my authentic self might break the impasse to the development of a trusting therapeutic relationship.

What aspects of the therapy relationship become more salient for clients with attachment trauma?

Most of us agree that the connection between client and therapist is of vital importance to overall therapy process and outcome, though the emphasis each of us places on the therapeutic relationship will vary. It is the real relationship that feels most salient when thinking about authenticity, but defining the real relationship has been challenging (Gelso, 2011). Greenson (1967) proposes that the real relationship consists of genuineness and realistic perceptions; Gestalt therapists emphasize the I-thou relationship; and Rogers (1957) emphasizes congruence, or genuineness, as one therapist-offered condition necessary and sufficient for change. What these general descriptions have in common is a certain willingness in the clinician to be herself.

Rogers' (1965) concept of transparency particularly resonates with me. While I do not want all of my clients to "see all the way though me" (Rogers, 1965, p. 2), I do want clients to know when they have had an impact on me, particularly when they have learned otherwise in their most significant relationships.

So what about Annie and William, and what does any of this have to do with authenticity?

After nearly a year of working too hard with William, I thought:*I just need to have a relationship with this guy*. It turns out that reaching William involves simple interpersonal exchanges where we share interests and I demonstrate some vulnerability. He is amused by my fascination with Stonehenge, and he shares the aspects of coin collecting that intrigue him. We exchange and discuss books, although he does not enjoy fiction and reading his nonfiction recommendations feels like homework to me. When he observes a sale tag on the bottom of my

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new boots his eyes soften, I am slightly embarrassed, and we both laugh.

My willingness to relax boundaries in these ways has helped him to trust me. He begins to take more ownership of the session and spontaneously begins to share his story with me. The nature of our interaction shifted rather dramatically when I decided to be different. He now explores in some depth how certain skills which saved him in childhood are no longer adaptive. For instance, as a child William became skilled at "listening for" openings to de-escalate violence and chaos, but in his current relationships struggles to "listen to" others. His ability to observe and make process interventions helps him in his work, but confirms the childhood message that he is a manipulative liar. When I ask about ways in which he might manipulate me, he became upset and worried about my reaction between sessions. The following week, however, he shared his concerns with me and we processed his feelings and sustained our bond.

Annie is interested in my values. She wants to know my position on gay marriage. What do I think about what is happening in Baltimore?What was my reaction to the Bruce Jenner interview?Do I understand the implications of the wage gap? She wants me to communicate my understanding of the impact that power and privilege have on her daily life. She wants to bring her dog to our sessions.

To be authentic with Annie does not mean that I will answer or gratify all of her questions and demands. However, I will be clear and direct with her. Her need to feel that her therapist is authentic and true is grounded in her real experience that important figures were not attuned to her and that she does not matter. We explore how needs can be affirmed but not always met. She may not bring her dog to my office, although he is awfully cute. We can discuss our similar stance on social issues. I empathized with Annie's hurt feelings when, at a family gatherings, her girlfriend introduced Annie as simply a good friend. However, when I would not say her girlfriend was "absolutely wrong," Annie became angry because she felt I was unsupportive. I reminded her that our relationship is grounded in an authentic exchange of thoughts and feelings, and she smiled. She expressed sadness because her mother cannot engage with her in this way, and I expressed my true feeling that I would be proud to have a daughter like her.

As I was gathering my thoughts for this piece I wondered about the necessity of clarifying my relationship approach to clients?As it happened, I was asked to articulate my position the very next day during a consultation with a prospective client. The person stated that he was looking for a therapist like Dr. Malfi from The Sopranos. *Dr. Malfi?*I was intrigued and, quite honestly, a bit uneasy. He remarked that I was a little too friendly, and that, yes, he would like me to send him some referrals. I considered whether I might be less transparent, but decide that going against my basic nature is inauthentic because I become stiff and unnatural. Instead, I seek to create a connection in which both participants can be real with one another. I strive to be myself in the therapy room to assess what is needed of me so that a productive working relationship can emerge.

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] All identifying information has been disguised to protect client confidentiality.

Personality Disorder Treatment in Private Practice: A Specialty That Is in Demand

Jeffrey Magnavita, PhD, ABPP
Past President of the Division of Psychotherapy (2010)

Personality disorders are a common phenomenon encountered by psychologists in private practice as well as other health care settings. The prevalence of personality disorders in the general population is estimated to be about 9%, according the results from a National Institutes of Health funded national comorbidity study (Lenzenweger, Lane, Loranger, & Kessler, 2007). Having the knowledge, tools, and skills to address the unique issues of patients who present with a personality disorder is not only a highly desirable specialty, but will enhance treatment of the common co-morbid clinical syndromes (anxiety, depression, substance abuse, etc.) and relational disorders (marital/couples, parent/child issues) that are often the result of a "dysfunctioning personality system." In this article, I present some of the critical concepts and issues that enhance our understanding of how to identity and more effectively manage and treat these ubiquitous and heterogeneous clinical conditions (Magnavita, 2004). I will also discuss the issue of clinical decision-making, a central aspect of working with personality dysfunction, which is necessarily complex, and often without the advantage of a robust evidence-base to guide these critical decisions (Magnavita, in press). Over the course of three decades, I have had the opportunity in my independent practice to work extensively with patients, many of whom manifest what I prefer to view as personality dysfunction. Psychologists, as mental and behavioral health specialists with solid training in personality theory, psychopathology, and psychotherapeutics, are well situated to treat personality dysfunction. Some additional study, training, and supervision can enhance the ability and increase the comfort of working with these challenging conditions. Effectively assisting an individual, couple, or family in changing long-standing and maladaptive personality patterns has been one of the most rewarding aspects of my professional career. The gratitude that comes when patients are successful in altering these patterns is deeply satisfying. Once an independent practitioner becomes more comfortable with identifying and effectively treating personality dysfunction, referrals are likely to follow.

Personality Dysfunction in a Nutshell

Personality dysfunction may be reflected in our semantics. We hear other professionals describe "difficult people," "treatment refractory cases," "challenging clients," "complex cases," and so forth. These terms often reflect the presence of personality dysfunction—things in life are not going well, and often the individual's personality is implicated. There is an abundant and immensely informative literature on characterological disturbances going back to Freud. The study of personality disorders became more formal after they were given a prominent position on "Axis II" in the nomenclature of the third edition of the *Diagnostic and Statis-*

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tical Manual of Mental Disorders (*DSM*) (American Psychiatric Association, APA, 1980). Although the multiaxial system was eliminated with the release of *DSM-5* (APA, 2013), the criteria-based classification structure remains. An ongoing controversy exists regarding whether personality is best viewed as categorical (a list of criteria to be met), dimensional (existing on a continuum), or relational (expressed in our dyadic and triadic relationships). Although these issues are important for diagnostic and research purposes, probably the central issue for the practitioner is having a basic understanding that personality is our adaptive system for dealing with our world; when the strategies are not maximizing adaptive responsiveness, we can say that the personality, which is best characterized as a system, becomes dysfunctional.

A chronic state of dysfunction initiated by early trauma and developmental insults can create a chronic state of dysfunction or personality disorder. Anyone under severe stress will likely experience a dysfunction of their personality system, but generally will return to premorbid level of adaptation after the stressor is reduced or time has passed. We all have an inherent resilience and capacity to process information related to traumatic experiences that allows us to overcome adversity, and yet we are not all equally resilient. Some of us will get stuck in maladaptive personality patterns that cannot be easily dislodged and restructured. Personality disorders can be identified when the clinician distills information from history, interview, and patient presentation of repetitive maladaptive behaviors, disturbances in interpersonal relationships, problems with perceptual processes, and affective and cognitive dysregulation. Other clinical syndromes generally do not cause these issues, although they may exacerbate the personality dysfunction or mimic some of the disturbance; effective management of the symptoms of depression or substance-related issues, for example, may allow the underlying personality to reconfigure and operate more effectively.

There are various styles of personality disorders with which most psychologists are familiar, especially when presented in their textbook forms. However, these "textbook cases" are generally not the case in actual practice, and most patients diagnosed with a personality disorder will qualify for a diagnosis of at least one other. This represents the overlap and conceptual fuzziness with nosology, likely because of common underlying issues with regulatory, perceptual, and relational processes common to most types of personality dysfunction.

There are certain heuristics that are helpful when considering the presence of a personality dysfunction. The first is, if a patient who enters treatment with a clinical syndrome or relational disturbance does not respond to first-line, evidence-based treatment after an expected period of time, then a personality dysfunction should be ruled out and the psychologist should consider shifting the focus to the personality system. Another indicator of personality dysfunction is when a patient reports numerous previous courses of treatment but has not derived much benefit or has worsened over time. The third indicator is when a patient has a profound and intense transference response to the clinician (often in the first meeting).

A Unifying Framework

After an extensive review of the literature and analysis of hundreds of patient videotapes, it seems apparent that adopting a unified framework is optimal when working with complex conditions such as personality dysfunction, with their attendant comorbid clinical

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syndromes and relational disturbances (Magnavita, 2005). A unified framework essentially is comprised of a *biopsychosocial system model*—the emphasis being on the interrelationships among the various levels of the system, from the micro- to the macro-system. A unified framework is based solidly in the relational matrix—humans are born, shaped, and operate in relational systems. A unified framework allows us to flexibly navigate the human ecological system and cautions us about becoming fixated at anyone explanatory level such as neurobiological, intrapsychic, interpersonal, familial, or societal. All levels of the system should be considered for comprehensive treatment planning. These include the intrapsychic (mind/brain, or what happens in our heads); dyadic (what occurs between two people), triadic (what occurs in threesomes), and sociocultural-familial (the interrelationships of the individual, family, and sociocultural system). For the most part, psychologists focus on what goes in in the mind-body. We are interested in cognition, affective-emotional experience, and internalized relational schema, as well as what occurs interpersonally or in dyads, such as defenses and interpersonal schema and processes. Family psychologists also honor the triadic and work with triangulated relationships common in families where there is a low level of differentiation in the members (another sign of a personality dysfunction), and the dysfunctional families that often engender personality dysfunction in their members. Ecologically-oriented psychologists focus on the community and social system. A unified framework utilizes all of these perspectives, as in a hologram, and encourages flexibility and utilization of multiple treatment modalities and approaches.

Contemporary Psychotherapeutics

There are a number of evidence-based approaches to treating personality disorders that are worth learning about and provide basic treatment approaches. It is beyond the scope of this article to review these, but generally they represent combinations of cognitive, cognitive-behavioral, psychodynamic, and interpersonal approaches. Any approach should be solidly based in evidence-based principles such as the importance of monitoring and maintaining the therapeutic alliance, which can be challenging; maintaining a high level of engagement; keeping the focus on the central or core issues or themes; and dealing with the reactions engendered in the therapist during the process. The clinician should never lose sight of strengthening and maintaining a collaborative relationship. Without collaboration, treatment will falter and the patient will terminate. It is good to elicit ongoing feedback from the patient or patient system (couple, family, group, community) to adjust the treatment and address any smoldering therapeutic misalliances, which are common in the treatment of personality dysfunction.

Pattern Recognition Tools

All clinical practice is rooted in an extensive knowledge base, experience, supervised practice, and the ability to recognize patterns in complex situations. The complexity and clinical experience/judgment required in managing personality dysregulation make it unlikely that less trained psycho-technicians can apply manualized treatment approaches with positive outcomes. Effective clinicians are able to recognize the patterns that are the hallmarks of dysfunctioning systems, and with this knowledge craft interventions that successfully alter the way these systems operate. Our clinical constructs are in a sense pattern recognition tools (Magnavita & Anchin, 2014). These include cognitive and relational schema, which are tools we use to or-

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ganize our experience and guide our interventions. These schemata are networks of encoded beliefs about others and ourselves, and we use them as guides to navigate our relational world. Other useful pattern recognition tools come from a variety of theoretical systems. Viewing clinical process through a lens of transference and countertransference events is another way clinicians map past attachment configurations which, if unresolved, remain problematic. For example, a patient who is immediately demonstrating issues with authority manifested by defiance and sarcasm provides a portal with which to consider early relationship encoding from experiences with significant figures. The clinician's own feeling of annoyance when a patient communicates that they deserve special treatment because of entitlement might suggest a possible narcissistic injury in the patient's past experience.

Essential Concepts and Domains Necessary to Enhance Treatment

A unifying framework for treating personality dysfunction rests on the foundation of the holistic interrelated levels of human functioning, from micro-processes (cells, neurotransmitters, neural networks) to larger levels, each becoming increasingly macro—encompassing the interacting levels of the total ecological system (TES). As noted previously, most contemporary approaches, in contrast, operate at a specific level such as intrapsychic-biological (what occurs in the brain-mind), interpersonal-dyadic (what occurs between two people), relational-triadic (what occurs in three-person configurations), and sociocultural-familial (what occurs in the interaction between the individual, family, and social systems). To effectively address the complexities of personality dysfunction, practitioners should include each of the following in their understanding of and work with their patients.

Ten Important Domain and Skill Areas

There are important domain areas and skill sets to develop for specializing in personality dysfunction. The following ten have been distilled for psychologists who want to enhance how they treat or want to begin treating personality dysfunction: (1) recognizing pathways of anxiety (somatic, cognitive, character), (2) identifying and cataloguing defenses, (3) assessing the structural integrity of the intrapsychic system (psychotic-borderline-neurotic), (4) identifying and restructuring cognitive schema, (5) enhancing emotional differentiation, (6) mapping and modifying interpersonal patterns, (7) improving coping strategies, (8) enhancing psychological mindedness and self-awareness, (9) improving communication skills, (10) assessing and restructuring family systems, and (11) and maximizing social and family support.

Key Interventions and Strategies

Once a familiarity with the basic domain levels has been achieved, there are a number of key intervention strategies that emerge from an examination of the various schools of psychotherapy. These include:

Boundary maintenance. Managing the boundaries between the patient system and clinician effectively, and especially avoiding boundary violations.

Self-differentiation. Enhancing the patient's ability to relate to others as separate from self or being able to hold an "I-thou" perspective; having a theory of mind concerning self and others.

Trauma Resolution. Identifying and resolving various types of physical, sexual, emotional, and developmental trauma using an evidence-based approach.

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Affective differentiation and recognition. Enhancing ability to experience, recognize, label, and communicate feelings. Developing an increased capacity for emotional regulation—neither overly restricted nor poorly regulated emotional responding.

Restructuring faulty schemata. Identifying and restructuring dysfunctional or maladaptive cognitive beliefs and encoding more adaptive self-other and relational schema.

Attachment system remediation. Elucidating the patient's attachment style and targeting these for modification to enhance more mature relationships and improved capacity for intimacy and closeness.

Disruption of self-defeating patterns and learning new, more adaptive ones. Utilizing a key set of interventions revolving around disrupting habitual, often nonconscious ways of behaving and interacting.

De-stabilization of chronically dysfunctioning systems. Disrupting chronically "stuck" couples, families, or larger systems so that they can be re-organized at a higher level of adaptation, as when a partner is encouraged to move out of the house in a case of chronic substance abuse.

Use of Multiple and Concurrent Modalities of Treatment

It is optimal to be trained in multiple treatment modalities, so that the most effective treatment package can be developed and offered. There is a lack of empirical literature on what treatment modalities are best. Some evidence suggests that a number of individual (Magnavita, 2004) and group therapies administered in day treatment are effective (Ogrodniczuk & Piper, 2001). Less has been determined about couples and family therapy; from anecdotal evidence, these modalities, especially couples therapy, are probably essential. It is imperative that clinicians who are not trained in multiple modalities be part of a team of other professionals who can deliver high quality treatment using different modalities. Continually assessing the effectiveness of any treatment intervention and modifying the treatment plan by changing approaches or adding another modality (such as individual, couples, group, or family) to augment treatment is important. Using concurrent modalities can also enhance treatment potency. For example, a phase of individual treatment for both members of a couple while they are also engaged in couples work can be more powerful than either alone. The important consideration when developing or modifying a treatment package is to do a cost-benefit analysis by weighing all the potential benefits and adverse reactions that might occur, as well as cost and resource considerations. More modalities or treatment may not be better; the optimal plan is balances the competing forces to enhance growth, development, and acquisition of new adaptive patterns.

The Utility and Necessity of a Team Approach

One cannot regularly treat patients with personality dysfunction, especially in its more severe forms, without adequate support from and use of a multidisciplinary team. Clinicians must practice within their respective areas of expertise and competency. There are important ethical considerations, such as the benefit versus potential harm of diagnostic labels and the danger of failing to recognize the impact of comorbid personality dysfunction on patient response to a variety of treatments (Magnavita, Levy, Critchfield, & Lebow, 2010). Many patients require regular physical monitoring, expert psychopharmacotherapy,

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and access to community resources. Collaboration with capable medical professionals is required in cases involving physical comorbidities, eating disorders, and so forth. Treating personality dysfunction is truly at its best a team approach. Independent practitioners may find it necessary to develop collaborative relationships with others, including hospital and community-based practitioners, who offer services they are not trained to deliver. This collaboration and communication among providers represents true integrated health care delivery. Support from a team can benefit practitioners who treat any form of severe or physical disorder. Vicarious traumatization of the clinician is common and should be anticipated, so that one has a way of metabolizing the stress and strain inherent in dealing with a population that has a substantial trauma history. Self-care is an important component, as working with this population as a solo practitioner often necessitates being on call 24/7, with relief from a colleague when time off is needed.

Final Thoughts

Psychologists who enjoy collaboration and conducting intensive forms of psychotherapy can expand their practices by developing or enhancing their skills working with those who suffer from personality disorders. This is not a specialty area to be entered into lightly, however: One should consider the ethical issues and reflect carefully on one's skills, competencies, and limitations, seeking out needed education, training and supervision where necessary. Treating personality dysfunction is an area in which there is a strong need for practitioners, but should not be undertaken without having a devotion to the art and science of clinical 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.

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

CREATION OF AN INTERNATIONAL AFFAIRS TASK FORCE

As part of his presidential initiative on internationalization, Rod Goodyear has established the International Affairs Task Force co-chaired by Patrick Leung (Chinese University of Hong Kong) and I (Frederick Leong, Michigan State University). Members of the earlier international task group will continue as members of the Task Force. These include Changming Duan, Jeff Barnett, Mark Hilsenroth, and Jeff Zimmerman.

During the Division's mid-winter meeting in Washington, D.C., I presented my initial ideas for activities to be undertaken by the Task Force. Given the importance of globalization, the board also discussed and approved moving forward with a by-laws change proposal to the membership to ask for the establishment of an international affairs domain. If approved, the new Domain representative would be elected in 2016, to begin office in 2017. In the meantime, the International Affairs Task Force will continue working as the interim group until the establishment of the domain.

Some of the possible activities recommended by me to be undertaken by the International Affairs Task Force included: (a) establishing international liaisons from different countries (e.g. these liaisons could be invited to submit reports regarding the status and development of psychotherapy in their respective countries for Psychotherapy Bulletin), (b) partnership with Psychotherapy societies in other countries and/or the World Council for Psychotherapy (which organizes the World Congress of Psychotherapy) for exchange of information and resources, (c) Given the unique position of the division journal, develop a special issue of *Psychotherapy* on International Perspectives on Psychotherapy.

Another idea discussed at the mid-winter meeting which came from the earlier task group was the possibility of organizing an international conference. Some members of the board expressed concern regarding international conferences since these events tend to run at a loss. One alternative to a fully independent conference (which would be costly) would be a satellite meeting for one day before the World Congress of Psychotherapy. This allows participants to the satellite meeting to attend the World Congress after the one-day meeting and may be draw a larger group than an independent meeting abroad. The Task Force is currently reviewing this option.

In a related matter, the Board approved the Society's co-sponsorship of training in China that Carol Falender and Rod Goodyear are going to offer this year under the auspices of their national psychological association's registration system. That approval for similar training going forward will be on a program-by-program basis.

Finally, several members of the Task Force will be participating in the Presidential Symposium at the 2015 APA convention in Toronto which will focus on **Ecologically and Culturally Appropriate Treatment—The Present and Future of Indigenous Psychotherapies.**

Submitted by Frederick Leong
Co-Chair, International Affairs Task Force

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
APA 2015 Convention Program

THURSDAY, AUGUST 6, 2015

SAP sponsored collaborative program:
Clinical supervision around the globe—small world isn't it?
8:00 – 9:50 • Convention Centre, Room 716A
Chair: Carol Falender, PhD
Discussant: Rodney Goodyear, PhD

Symposium: *Anti-Oppression Psychotherapy™—The Diverse Client*
8:00 AM - 8:50 AM • Convention Centre, Room 206B
Cochairs: Roberta K. Timothy, PhD, MEd & Mercedes D.C. Umana, MEd

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Symposium: *Supervision—Master Supervisors of Various Orientations Show and Discuss Their Supervision Session Videos*
8:00 AM - 9:50 AM • Convention Centre, Room 104C
Cochairs: Hanna Levenson, PhD & Arpana G. Inman, PhD
Participant/1stAuthor:
Joan E. Sarnat, PhD | Brian McNeill, PhD | Elizabeth Holloway, PhD
Discussants: Hanna Levenson, PhD | Arpana G. Inman, PhD

Skill-Building Session: *Enhancing Client Motivation by Accessing Positive Emotions Through Positive Psychology*
11:00 AM - 12:50 PM • Convention Centre Room 204
Cochairs: Michael J. Scheel, PhD & Collie W. Conoley, PhD

Skill-Building Session: *Applications of Positive Psychology in Counseling and Psychotherapy*
1:00 PM - 1:50 PM • Convention Centre Room 203D
Chair: Jeana L. Magyar-Moe, PhD

Symposium: *Developing Cultural Competence in Supervision—A Multicultural Framework*
2:00 PM - 2:50 PM • Convention Centre Room 104B
Chair: Jorge Wong, PhD
Participant/1stAuthor: Richard H. Enriquez, BA | Melinda M. Joseph, BA
Kammy K. Kwok, MA | Lynn Y. Hsu, MA
Discussant: Jorge Wong, PhD

Symposium: *Stalking the Best Response—Gifts, Money, and Client Curiosity about the Therapist*
3:00 PM - 3:50 PM • Convention Centre Room 103A
Chair: Randolph B. Pipes, PhD
Participant/1stAuthor
Caroline Burke, PhD | Charles Waehler, PhD | Randolph B. Pipes, PhD

Thursday, August 6, continued on page 42

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Reception with Masters
5:00 PM – 6:50 PM • Intercontinental Toronto Centre Hotel, Grenadier Room

FRIDAY, AUGUST 7, 2015

Committee Meeting: *Psychotherapy Journal Editorial Board ~ invitation only*
8:00 AM - 8:50 AM • Intercontinental Toronto Centre Hotel, Humber Room

SAP Presidential Symposium: *Ecologically and culturally appropriate treatment – The present and future of indigenous psychotherapy*
9:00 AM – 10:50 AM • Convention Centre Room 104B
Chair: Rodney Goodyear, PhD
Participant/1stAuthor:
Frederick T.L. Leong, PhD | Patrick Leung, PhD
Louise K.W. Sundararajan, PhD, EdD

Poster Session
11:00 AM – 11:50 AM • Convention Centre, Exhibit Halls D and E

Amrita Pain, MA
Krista D. Socholotiuk, MA
Lisa Do Couto, MA
Lisa Do Couto, MA
Hui Xu, MA
Satoko Kimpara, PhD
Kayla R. Nalan-Sheffield, MA
Claudia V. Crawford, MEd
Michael D. Saleeby, MA
Evan J. Lima, MA
Sneh Kapoor, PhD, MA
Andrew Pomerville, BA
Clifton E. Watkins, Jr., PhD
Dennis M. Kivlighan III, BA
Kristina Fredericksen, BS
Sara Miller, MA
Geoffrey C. Tan, PhD, MD
Dakota J. Kaiser, MS
Alex Lengerich, MS
Shannon O'Neill, MA

Business Meeting and Award Ceremony
4:00 PM – 4:50 PM • Fairmont Royal York Hotel, Confederation Room 3

Social Hour
5:00 PM– 5:50 PM • Fairmont Royal York Hotel, Library

SATURDAY, AUGUST 8, 2015

Symposium: *Client Feedback in Psychotherapy — Where We Are and Where We Are Going*
8:00 AM – 8:50 AM • Convention Centre, Room 204
Chair: Robert J. Reese, PhD
Participant/1stAuthor:
Robert J. Reese, PhD | Michael J. Lambert, PhD | Barry L. Duncan, PsyD

Symposium: *A Contextual Approach to Treating Dissociation*
9:00 AM – 9:50 AM • Convention Centre, Room 205B
Chair: Steven N. Gold, PhD
Participant/1stAuthor:
Steven N. Gold, PhD | Amy E. Ellis, PhD | Bryan T. Reuther, PsyD
Discussant: Laura S. Brown, PhD

Saturday, August 8, continued on page 43

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Poster Session II
11:00 AM – 11:50 AM • Convention Centre, Exhibit Halls D and E

Sang-Hee Hong, MA
Gargi Roysircar Sodowsky, EdD
Changming Duan, PhD
Cheri L. Marmarosh, PhD
Jonathan Kodet, EdS
Elizabeth A. Harwood, PhD
Marty Amerikaner, PhD
Maria Lauer, MEd
Leora Trub, PhD
Amy M. Mitchell, MA
Xu Li, MEd
Igor Vasilj, MS
Jessie Wall, MA
Rachel Nicholson, BS
Courtney L. Henry, PhD
Lori F. Merling, MS
Amber J. Gorzynski, BS
Norah C. Slone, PhD
Hannah M. Kersting, BA
Joanna M. Drinane, Med

Symposium: *Psychotherapy Revealed—A Glimpse of Eminent Psychotherapists in Session*
11:00 AM – 12:50 PM • Convention, Centre, Room 707
Chair: Jeffrey J. Magnavita, PhD
Participant/1stAuthor:
Jeffrey J. Magnavita, PhD | Sue Johnson, EdD
Peter C. Costello, PhD | Howard Liddle, EdD
Discussant: Nadine J. Kaslow, PhD

Symposium: *Straddling Allegiances—A Client-Centered Therapist Does REBT on a Dare and for Science*
12:00 PM – 1:50 PM • Convention Centre, Room 205C
Chair: Stevan Lars Nielsen, PhD
Participant/1stAuthor:
David M. Erekson, PhD | Raymond A. DiGiuseppe, PhD
Arthur Freeman, EdD | Charles J. Gelso, PhD | Abraham M. Wolf, PhD

SAP sponsored collaborative program: *Ethical practice in multicultural contexts*
12:00 PM – 1:50 PM • Convention Centre, Room 714B
Chair: Jean Carter, Ph.D.
Presenters:
Andrea Barnes, JD, PhD | Mihaela Robila, PhD | Armand Cerbone, PhD
Maria Riva, PhD | Lisa Suzuki, PhD

SUNDAY, AUGUST 9, 2015

Skill-Building Session: *Understanding Cognitive-Behavioral Conjoint Therapy for PTSD and Body-Oriented Techniques*
8:00 AM • 8:50 AM • Convention Centre, Room 709
Chair: Hsin-Tine Tina Liu-Tom, PhD
Participant/1stAuthor:
Hsin-Tine Tina Liu-Tom, PhD | Mimi M. Andjelic, PsyD

Sunday, August 9, continued on page 44

Sunday, August 9, continued from page 43

Symposium: *Determining Standards of Care for Clients With Access to Lethal Means*
9:00 AM – 9:50 AM • Convention Centre, Room 206C
Cochairs: Bruce Bongar, PhD & Joyce Chu, PhD
Participant/1stAuthor:
Lori J. Holleran, MA | Megan McCarthy, PhD | Larry E. Beutler, PhD
Discussant: Gerald P. Koocher, PhD | Larry E. Beutler, PhD

Symposium: *REBT in the 21st Century—Theoretical, Training, and Empirical Advances*
10:00 AM – 10:50 AM • Convention Centre, Room 205B
Chair: Michael Hickey, PhD
Participant/1stAuthor:
Kristene A. Doyle, PhD | Mark D. Terjesen, PhD
Elena Moioli, PhD | Lindsay Nicolai, PsyD
Discussant: Raymond A. DiGiuseppe, PhD

Symposium: *Applying Reflective Practices in Clinical Supervision to Promote Evidence-Based Psychotherapy*
10:00 AM – 11:50 AM • Convention Centre, Room 103A
Chair: David F. Curtis, PhD
Participant/1stAuthor:
Patty Duran, PhD | Kat T. Green, PhD | Stephanie G. Chapman, PhD
Discussant: Caroline L. Watts, EdD

Symposium: *Emotion-Focused Therapy for Generalized Anxiety Disorder*
11:00 AM – 11:50 AM • Convention Centre, Room 206D
Chair: Jeanne Watson, PhD
Participant/1stAuthor:
Leslie Greenberg, PhD | Robert Elliott, PhD | Jeanne Watson, PhD

Symposium: *Ego Development in Survivors of Childhood Sexual Abuse—Clinical Implications*
12:00 PM – 12:50 PM • Convention Centre, Room 202A
Chair: Steven N. Gold, PhD
Participant/1stAuthor:
Nicole Sciarrino, MA | Amy E. Ellis, PhD | Steven N. Gold, PhD
Discussant: Bryan T. Reuther, PsyD

Skill-Building Session: *When the Heart Runs Away With the Mind Even Smart People Do Crazy Things*
1:00 PM – 1:50 PM • Convention Centre, Room 203D
Chair: Lorna Smith Benjamin, PhD

CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY AWARD WINNERS!

Please join us as we honor our award winners at the Society Awards Ceremony, Friday Business meeting and Award Ceremony, Friday, August 7th, 4:00–4:50 at the Fairmont Royal York Hotel Confederation Room 3. The awards ceremony will be followed by the Social Hour, in the Library Room, where you are cordially invited to join us for refreshments and fellowship.

Distinguished Psychologist of the Year – Douglas Snyder, PhD

Dr. Douglas Snyder is Professor and previous Director of Clinical Psychology Training at Texas A&M University. He earned his doctoral degree from the University of North Carolina at Chapel Hill in 1978, and interned at Duke University Medical Center. Prior to his appointment at Texas A&M, he served on the faculty at Wayne State University in Detroit and at the University of Kentucky, where he also served as Director of Clinical Training and Associate Dean. Dr. Snyder has been recognized nationally for his research on couple assessment and therapy. He has two books with Guilford Press that address working with couples recovering from an affair, including Getting Past the Affair: A Program to Help You Cope, Heal, and Move On and Helping Couples Get Past the Affair: A Clinician's Guide. He is also coeditor of two books on Treating Difficult Couples and Couple-Based Interventions with Military and Veteran Families published by Guilford Press, and is coeditor of a text on Emotion Regulation in Couples and Families published by the American Psychological Association. He has recently co-edited the 5th edition of the Clinical Handbook of Couple Therapy released this Summer by Guilford Press.

Dr. Snyder's couple therapy research has been funded by the National Institute of Mental Health. He received the 1992 Outstanding Research Award from the American Association for Marriage and Family Therapy, and the 2005 Award from the American Psychological Association for Distinguished Contributions to Family Psychology. He is a Fellow of the American Psychological Association and served as Editor of the Clinician's Research Digest, as Associate Editor for the Journal of Consulting and Clinical Psychology, and as Associate Editor for the Journal of Family Psychology. He chaired Division 29's Fellows Committee from 2000-2002. He also maintains a clinical practice specializing in couple therapy.

APF /Division 29 Early Career Award – Stephanie Budge, PhD

Stephanie L. Budge, PhD is a visiting assistant professor in the Department of Counseling Psychology at the University of Wisconsin-Madison. She received her PhD in 2011 from the University of Wisconsin-Madison. She is currently an Associate Editor of *Psychotherapy*. Her research interests focus on therapist cultural competence and clients' experiences of identity within psychotherapy. Specifically, her research focuses on improving psychotherapy for lesbian, gay, bisexual, transgender, and queer (LGBTQ) clients. She also focuses on psychotherapy outcomes—including changing the ways in which outcomes are theorized and collected, as well as how efficacy and effectiveness are conceptualized. She is also a licensed psychologist and supervises trainees at the Counseling Psychology Training Clinic (CPTC) at the University of Wisconsin-Madison.

APF Rosalee G. Weiss Lecture for Outstanding Leaders in Psychology– Beverly Greene, PhD

Dr. Greene was awarded a Ph.D. in Clinical Psychology from the Derner Institute of Adelphi University, and was a Doctoral Fellow in Mental Retardation at the Mental Retardation Institute of New York Medical College in Valhalla, New York. She has served on the editorial boards of numerous scholarly journals and is the author of nearly 100 publications in the psychological literature. Nine of those publications have received national awards as significant contributions to the psychological literature on women, women of color, sexual minorities, African American women and families. She is the founding co-editor of the APA Div. 44 book series Psychological Perspectives on Lesbian, Gay & Bisexual Issues. She is also the recipient of numerous national awards that include the 1996 Outstanding Leadership Award from the APA Committee on Lesbian, Gay and Bisexual Concerns; 2000 APA Society for the Psychology of Women Heritage Award; 2003 APA Committee on Women in Psychology Distinguished Leadership Award;2004 Award for Distinguished Senior Career Contributions to Ethnic Minority Research(APA Division 45); 2005 Stanley Sue Award for Distinguished Professional Contributions to Diversity in Clinical Psychology (APA Division 12); 2006 Helms Award for Scholarship and Mentoring (TC, Columbia Univ Cross Cultural Roundtable); 2006 Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology(APA Division 12); 2007 Distinguished Scientific Contributions to LGB Psychology Award (APA Division 44); 2007 Distinguished Career Award (Assn for Women in Psych); 2008 Carolyn Wood Sherif Award(APA Division 35); 2009 Distinguished Contributions to Psychology in the Public Interest Senior Career Award(APA).

A Fellow of 7 divisions of APA (9,12,29,35 42,44,45), she has served in many leadership positions in the association and currently serves on the Division 29 Board of Directors, the Division 35 Executive Board, the Association's Policy and Planning Board and a representative of Division 44 to the APA Council of Representatives.

GRANT WINNERS

The Society for the Advancement offers five research grants annually: the Norine Johnson Psychotherapy Research Grant for $10,000; up to three Charles Gelso Psychotherapy Research Grants for $5,000 each; and, the Diversity Research Grant for Pre-Doctoral Candidates for $2,000. This year's recipients are to be congratulated!

Charles Gelso Psychotherapy Research Grant

This year, there were three recipients of the Gelso Grants, each awarded $5000

Stephanie Hoover, PhD, for her research "In-Session Process of Culturally-accommodated and Standard Therapy for Latino Adolescents"

Stephanie Hoover is an Assistant Professor of Psychological Sciences at Western Oregon University. She received her Ph.D. in Counseling Psychology from the University of Utah. Dr. Hoover aims to promote the well-being of marginalized groups by improving mental health services and training. Her social justice training research is in press with the *Journal of Counseling & Development* and *Ecopsychology*. Her dissertation received the graduate research award from the American Psychological Association Counseling Psychology Division's Section for the Advancement of Women. Currently, she leads consensual qualitative research on culturally adapted group therapy with Latino adolescents.

Samantha Bernecker, for her research, "Can lay–people learn to be their own therapists? 'Crowd-sourcing' Mental Health"

Samantha Bernecker is beginning her fifth year in the University of Massachusetts' Clinical Psychology Ph.D. program and is advised by Dr. Michael Constantino. Her research is focused on understanding how psychotherapy and other interpersonal interactions promote mental health, and she is particularly interested in investigating how interactions facilitate emotion regulation and coping. Her goal is to use this research to inform the design of innovative interventions that enhance public psychological well-being."

Joel M. Town, DClinPsy, for his research, "Halifax somatic symptom pilot project: Characterizing therapist technique and exploring associations to post-session ratings of process and symptom change"

Joel M. Town is an Assistant Professor with the Department of Psychiatry and Department of Psychology and Neurosciences at Dalhousie University, Canada. He received is DClinPsy in 2008 from the University of Sheffield, England. Since 2011, he has held a faculty position at Dalhousie where he is currently the primary investigator on two clinical trials exploring process and outcome in intensive short-term dynamic psychotherapy for somatic symptom disorders and treatment refractory depression. He currently serves as a Consulting Editor of the American Psychological Association Division 29 Journal, *Psychotherapy*. His interests include psychotherapy process, health services research and their integration towards advancing psychotherapy training and practice.

Norine Johnson Psychotherapy Research Grant for Early Career Psychologists

Jesse Owen, PhD, is the incoming Chair and Associate Professor in the Counseling Psychology Department at the University of Denver. He is an Associate Editor for three top-tier journals (Psychotherapy; Journal of Counseling Psychology; Archives of Sexual Behavior). His research interests focus on psychotherapy process and outcomes as well as romantic relationships. Recently, he has been investigating mental health disparities in psychotherapy outcomes as well as therapists' multicultural orientation. He is also the Training and Education Domain Rep for Division 29.

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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Personal Reflection on Suicidal Ideation Within Psychotherapy

Chantal Bushelle
University of Denver
Graduate School of Professional Psychology

Most states in the U.S. require a psychotherapist to break confidentiality when a client verbalizes suicidal intent (National Conference of State Legislatures, 2013). The purpose of this paper is to share a personal reflection on suicidal ideation within the therapeutic relationship, and to question whether a psychotherapist's ethical responsibility and personal morality are consistently clear-cut.

Imagine you, as a psychotherapist, have a client who is terminally ill. She has come to you for help navigating the complex emotions and logistics around knowing she has limited time to live. During the course of therapy your client tells you that she does not want to suffer the burden of the imminent and inevitable physical and mental degeneration that results from having a terminal illness; because of this, she has been formulating a plan to commit suicide. In addition to her desire to avoid painful mental and physical suffering, her rationale for taking her life includes that she does not want her family, especially her children, to see her suffering; she has made peace with herself and her family; her family is emotionally secure with her decision, and she feels successfully accomplished through her work. This scenario is not about a person who is expressing suicidal ideation as a cry for help. Rather, this hypothetical woman is contemplating suicide before becoming so ill that she would be forced to seek an assisted suicide, if such an option would even be possible. Would this example influence your feelings around this issue? If so, why would it take an extreme situation, such as terminal illness, to consider someone else's personal choice? Perhaps the client's spiritual values are such that she believes in an afterlife or reincarnation. Why should the law govern an ethical issue by essentially placing judgment on what this client believes is right for her? Furthermore, why does the double standard exist where one can sacrifice one's life in an act of heroism (i.e., to save someone else's life; in war; in political protest, etc.), however, one cannot do so for one's self?

I find myself reacting personally to this dilemma. It cuts at the heart of my belief system regarding the control of an individual's own body, mind, and soul. It stirs up emotions around the violation of human rights, and I tend to feel stifled by the prohibitive nature of this hypothetical case example. I also notice feeling guilty for my thinking on the subject. The guilt comes from my proclivity to be a helper, a caretaker, and a believer in persevering through life. I intuitively and instinctively know I would not break the law, but nevertheless this topic provides an ethical predicament for me. I believe in "do no harm," but my moral conflict arises with the supposition that harm means

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different things to different people in different contexts. It is without question that I know I would do my best to assist my client. I do not take lightly the concept of ending one's life, and my first instinct would be to protect my client from hurting herself in any way. In general, I would work to create a safe space within therapy where my clients can come to terms with their past experiences, as well as uncover and modify stale patterns of thoughts and maladaptive behaviors to live healthful, successful, and purposeful lives. But my client in this example is different. My client's well-being would be of the utmost priority. I would ensure my client felt heard, validated, and understood, especially with regard to her suicidal deliberation. Gaining her trust would be imperative. Would she be less likely to confide in me if she risked being intruded upon by my reporting her and breaking our therapeutic alliance?

Philosophy, Religion, and the "Right to Die"

My values center on a conviction in the power of individuals to guide their own lives by the choices they make. While there is no law against the act of committing suicide in the United States, attempting or aiding in attempted suicide may be, and psychotherapists whose clients express an intent to end their lives may face sanctions if they do not act in accordance with their legal and ethical mandates (Mental Health Daily, 2014, p. 1). What role does an individual's religion play in the public discussion surrounding suicide? What are the potential institutionalized religious undertones and subtexts regarding the ethics of suicide? "Christianity's respect for life mirrored that of the Hippocratic physicians—each human life was in the image and likeness of God. Christian physicians were Hippocratic both by profession and by doctrine" (Holt, 2013, p. 1). Is it possible that, within the Christian religious context (and, by extension, codified into law in the U.S.), suicide is thus never acceptable? From a career standpoint, in addition to legal liability, I risk potential loss of respect, support, and acceptance from my colleagues as well as censure by or removal from professional organizations, if, in my hypothetical client's case, I fail to follow these principles.

In his article, *The Interpersonal-Psychological Theory of Suicidal Behavior: Current Empirical Status* (2009), Dr. Thomas Joiner discusses his opinion on the two psychological states that most often lead to suicide. One is perceived burdensomeness to significant others, and the second is a sense of low belongingness or social alienation, in which one does not feel adequately involved with one's own life. Where does my hypothetical client fit into this model? An interesting, factual case that does not fit into this model is that of Brittany Maynard. Brittany, whose story was in the center of a recent controversial right-to-die movement (Egan, 2014), ended her own life on Saturday, November 1, 2014, at 29 years old:

> Goodbye to all my dear friends and family that I love. Today is the day I have chosen to pass away with dignity in the face of my terminal illness, this terrible brain cancer that has taken so much from me… but would have taken so much more. My glioblastoma is going to kill me and that's out of my control. I've discussed with many experts how I would die from it and it's a terrible, terrible way to die. So being able to choose to go with dignity is less terrifying. For people to argue against this choice for sick people really seems evil to me. For me what matters most is the way I'm

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> remembered by my family and my husband as a good woman who did my best to be a good wife and a good daughter. Beyond that, getting involved with this campaign, I hope to be making a difference here. If I'm leaving a legacy, it's to change this health-care policy or be a part of this change of this health-care policy so it becomes available to all Americans. That would be an enormous contribution to make, even if I'm just a piece of it.

The philosopher Friedrich Nietzsche said, "When one has one's *wherefore* of life, one gets along with almost every *how*" (2004, p. 4). I propose the reverse is also true with regard to having a wherefore for which to die. Existential therapy suggests that "we are not victims of circumstance, because to a large extent we are what we choose to be. A major aim of therapy is to encourage clients to reflect on life, to recognize their range of alternatives, and to decide among them" (Corey, 2013, p. 131). The decision to end one's life can be examined within this framework. "A characteristic existential theme is that people are free to choose among alternatives and therefore have a large role in shaping their destinies" (Corey, 2013, p. 138). An existential idea is that death kills us *but without it we would not know we are alive*. Every individual is unique and all meaning matters. With respect for the concept of free will in existential theory, if a wish can be summarized by the desire to be in touch with what we want, then a will is how we organize ourselves and our lives in order to achieve that wish or goal. My experiences travelling through Southeast Asia, before beginning my master's program in International Disaster Psychology at the University of Denver, led me to believe that some cultures and societies view life and death in an infinite balanced continuum, where beginning and end are indistinguishable.

Relevant Ethical and Legal Standards

There is a provision of the American Counseling Association (ACA) ethical code that lends itself to respecting an individual's right to self-determination or the right-to-die. B.2.b. Confidentiality Regarding End-of-Life Decisions states that "[c]ounselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws" (ACA Code of Ethics, 2014, p. 7).

Some states, including Colorado, have a Mandatory Duty to Protect/Warn law whereas other states, such as Texas, have a Permissive Duty to Protect/Warn law, which may provide some legal and ethical flexibility. Maine, Nevada, North Carolina, and North Dakota all have No Duty to Protect/Warn, which translates to a client's confidentiality being enforced in every instance (National Conference of State Legislatures, 2013). Perhaps No Duty states and some of the Permissive Duty states would be more apt in applying ACA code B.2.b.

Other ACA codes (ACA Code of Ethics, 2014) that support the opinion of allowing freedom of choice to clients are:

> A.4 Avoiding Harm and Imposing Values, especially A.4.b. Personal Values: "Counselors respect the diversity of clients... and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature" (pp. 4-5).
>
> B.1. Respecting Client Rights, especially B.1.a. Multicultural/Diversity Considerations: "Counselors

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respect differing views toward disclosure of information" (p. 6).

B.1.d. Explanation of Limitations provides some non-judgment and flexibility: By initiating discussion from the beginning of therapy regarding situations in which confidentiality must be breached, and then maintaining ongoing discussions on this topic with the client throughout therapy, it would appear that this framework could provide the safety and trust required for the client to work through the steps of any dilemma around suicide (p. 7).

These American Psychological Association (APA) codes (2010) could also be used to support and argue for client autonomy in deciding what is right for their bodies (Pope & Vasquez, 2011):

Principle D: Justice: "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices" (p. 333).

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority: "Under no circumstances may this standard be used to justify or defend violating human rights." (p. 334).

In theory, clients should also be protected from intrusion into their lives in all three of the following (Pope & Vasquez, 2011): 3.04 Avoiding Harm (p. 337); 4.01 Maintaining Confidentiality (p. 340); 4.05 Disclosures [Duty to Protect] (pp. 341-342).

Best Practices and Ongoing Dilemmas

In considering possible and probable courses of action for my hypothetical case example, I would be forced to remind my client of the disclosure law that we would have discussed before we began therapy. In addition, I would want to discuss all of the angles of the issue from her perspective, and I would assess her state of mind and reasoning throughout our sessions. Bearing in mind our therapeutic relationship, facts and truths about her terminal illness would have been discussed on an ongoing basis over the course of our therapy sessions. In the context of my ultimate duty and my disclosure to her of this legal obligation, I would also want to explore with my client the idea of putting certain parameters and a time frame around our discussions concerning her suicide plan. I would trust that we could both come to an understanding of her decision as well as what the consequences of my reporting would be in the event that she was steadfast in her desire to commit suicide. The unfortunate reality is we cannot offer a client one of the most valuable aspects of therapy if we must disclose regardless of the client's deeply-held convictions, or our own.

One lingering aspect of the issue that I would find difficult to negotiate ethically is: What if I follow my state's statutory disclosure guidelines, leading to my client's involuntary hospitalization; she feels betrayed and abandoned by me, but remains committed to her decision to end her life, and ultimately does so? I would have fulfilled my legal duty but failed my client. Dr. Atul Gawande, discusses how medical and psychological professionals can be a destructive force in their patient's life by practicing heroic medicine (Bethune, 2014):

There are lots of humiliating, grim, bodily-fluidic aspects to living all the way to the end, and a beautiful

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> death with dignity may not happen. When I was putting this together, I was a surgeon who took on problems I could not always fix... band a writer coming to realize I'm not the only one who seems to be struggling with these situations. But, yes, an ending always comes, and we need to honour people's wishes during it as much as we can (p. 1).

I believe perhaps if I were to go through a real-life scenario with a client such as this one, I might work to amend legislation to honor the human rights of a client, but, equally as important, to honor those of the psychotherapist. It takes just one exception, in this case terminal illness, to call into question and taint a rule as a whole. Legislation could be proposed that would allow therapists some discretion in working with clients and their medical teams around death with dignity issues, with the goal of supporting clients' mental health needs at the end of life. At some point down the line, this debate could lead to a dialog regarding the even more taboo subject of non-terminal illness right-to-die.

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

Congratulations to two board members for recent awards in the realm of diversity

Two board members of the Society for the Advancement of Psychotherapy have recently won awards at the National Multicultural Conference and Summit [NMCS] in Atlanta earlier this year. Dr. Armand Cerbone, who is also President-Elect, won a Distinguished Elder award. The NMSC Distinguished Elder award is given to honor those for their pioneering work and years of distinguished service, which helps to lay the path for others.

Dr. Beverly Greene, a Diversity Domain Representative, won the Henry Tomes 2015 Award for Distinguished Lifetime Contributions to the Advancement of Ethnic Minority Psychology. This award is given biennially to one senior and one early career psychologist in honor of the work of Dr. Henry Tomes and his advocacy for the psychological well-being of underrepresented communities throughout the U.S. Congratulations to both Armand Cerbone and Beverly Greene!

New Mentoring Hour Program for Early Career Psychologists: Getting Mentorship One Hour at a Time

Rayna D. Markin, PhD
Villanova University

When Early Career Psychologists (ECPs) are asked what they want from the professional organizations to which they belong, the answer almost always includes "*mentorship*." Yet, mentoring programs can be difficult to get moving off the ground. Perhaps one reason for this is that while it sounds simple in theory, mentorship is actually a complicated endeavor that is inherently interpersonal. Mentorship involves a relationship between at least two people (the mentor and mentee). Arguably, like psychotherapy, for the mentee to learn something of value from the mentor, there must be an underlying relationship that is in least "good enough" to facilitate learning. Mentoring programs that pair mentees and mentors may be throwing the "relationship dice," betting the success of the program on whether the mentor and mentee paired together happen to be a good interpersonal match. A separate potential problem with common mentoring programs has to do with content. The needs of ECPS are varied and diverse. ECPs want mentorship and guidance on a variety of topics from professional practice to teaching and research. The mentor and the mentee may not agree on the topics that should be covered or addressed within their mentoring relationship, or the same mentor may not be able to meet all the diverse needs of the mentee. Lastly, ECPs are busy. We are establishing private practices, working toward tenure, planning new classes, balancing family and work life, and juggling a number of other balls in the air.

All of these potential problems with common mentoring programs led me to establish a new mentoring program for Division 29 called the "mentoring hour series." This new mentoring program is designed to connect ECPs to several mentors, as well as to other ECPs, around a number of different topics, in a relatively short time frame. In this new program, several mentees meet with an expert in our field (the mentor) over cyberspace for a one-hour mentoring event. Each of these one-hour events are topic specific and present a range of issues that are relevant to ECPS in the areas of psychotherapy research, practice, and teaching. This is a quick but meaningful way to obtain mentorship from an expert in psychotherapy while also meeting other ECPs. And, it is completely FREE. Dr. John Norcross recently led the first mentoring hour on the therapeutic relationship in teaching, research, and practice. Please see our web site (http://societyforpsychotherapy.org) for upcoming mentoring hours, and don't forget to preregister! If you are an ECP with an idea for a mentoring hour topic, or would like to volunteer to serve as a mentor, please do not hesitate to contact me at Rayna.Markin@Villanova.edu. This is one of several mentoring opportunities that our Division offers ECP members; others include our 1-year ECP mentoring program and our annual Reception with the Masters event at the APA annual convention.

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Many ECPs want mentorship but for a variety of reasons are often left frustrated when their specific needs for mentorship are unmet. Division 29 offers a variety of mentoring programs for ECPs in varying formats so that the individual mentee can choose the format that feels like the best fit. Mentoring relationships can be difficult to navigate, and looking toward one mentor to meet all the diverse needs of a mentee may be a tall order. The hope of the mentoring hour program is to meet in least some of the mentoring needs of our ECP members one hour at a time.

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

Donald K. Freedheim Student Development Award
Marilyn A. Cornish, PhD (paper completed during doctoral studies at Iowa State University)
"Working Through Past Wrongdoing:
Examination of a Self-Forgiveness Counseling Intervention"

Mathilda B. Canter Education and Training Award
Xu Li, Doctoral Student in Counseling Psychology,
University of Maryland, College Park
"Does Helping Skills Training Make a Difference? A Longitudinal Multilevel Analysis of the Effects of Helping Skill Use on Working Alliance and Session Outcome With Chinese Trainees"

Diversity Award
Marilyn A. Cornish, PhD (paper completed during doctoral studies at Iowa State University)
"When Religion Enters the Counseling Group:
Multiculturalism, Group Processes, and Social Justice"

Jeffrey E. Barnett Psychotherapy Research
Simon B. Goldberg, University of Wisconsin
"Do Psychotherapists Improve With Time and Experience?
A Longitudinal Analysis of Real World Outcome Data"

Please join us as we honor our award winners at the Society Awards Ceremony, Friday Business meeting and Award Ceremony, Friday, August 7th, 4:00–4:50 at the Fairmont Royal York Hotel Confederation Room 3. The awards ceremony will be followed by the Social Hour, where you are cordially invited to join us for refreshments and fellowship.

Understanding the Stressors and Types of Discrimination That Can Affect Multiracial Individuals: Things to Address and Avoid in Psychotherapy Practice

Astrea Greig, PsyD
Boston Health Care for the Homeless Program

As the multiracial population is vastly growing in the United States (Humes, Jones, & Ramirez, 2011), it is important to know about the unique experiences that affect multiracial people, as these can arise in psychotherapy or during casual interactions in the clinic or office. Multiracial people are racially and culturally diverse and identify with two or more races. Multiracial clients are often young, and multiracial children are the fastest growing demographic group in the U.S. (Saulny, 2011). Moreover, interracial marriages have been at an all-time high recently (Chen, 2010). This increase is likely related to the historic racist laws in the U.S. that made interracial marriage illegal in many states, until federally overruled in 1967 with the *Loving v. Virginia* case. Yet, despite the fact that multiracial people are now one of the fastest growing populations in the United States, it is still one of the smallest demographic groups, comprising only 2.3% of the American population (Humes, Jones, & Ramirez, 2011). Additionally, though mental health professionals should have adequate multicultural or diversity training, the multiracial population is often not studied as extensively as other racial and ethnic groups.

Multiracial people can experience discrimination and/or microaggressions that are tied to being racially and ethnically mixed (Johnston & Nadal, 2010; Salahuddin & O'Brien, 2011). *Microaggressions* often are unconscious implicit social acts or statements that insult and discriminate against others. They are less explicit than straightforward verbal discrimination. Often, it is difficult to identify microaggressions and, when microaggressions occur, the receiver may be met with disbelief and is often told to stop being overly touchy or sensitive (Johnston & Nadal, 2010; Sue et al., 2007). Examples of multiracial microaggressions are explained further in this article and can include invalidation of one's racial identity, exclusion and isolation, objectification, assumption that multiracial people are monoracial, denial of multiracial reality, and pathologizing of multiracial identity (Johnston & Nadal, 2010). Multiracial people can even receive discrimination from their own family members. Additionally, these microaggressions can occur in the clinical setting during psychotherapy. By understanding these microaggressions as they happen in society, psychotherapists can be better equipped to avoid them in clinical practice. Moreover, understanding these stressors can help psychotherapists to knowledgably address them when they are part of a multiracial client's presenting problem. This is important, as these stressful situations can definitely affect the emotional well-being of a multiracial person (Root, 1992; Salahuddin & O'Brien, 2011; Sanchez, 2010; Shih & Sanchez, 2005).

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A common stressor is when multiracial people are not allowed to self-identify as multiracial. Denying multiracial people the right to identify themselves as multiracial can be detrimental. It can cause negative moods and negative self-views amongst multiracial people (Sanchez, 2010). In a study where multiracial people were forced to choose one race only on a questionnaire, the multiracial participants felt they had less power over their social environment (Townsend, Markus, & Bergsieker, 2009). This situation unfortunately happens often on demographic forms in multiple situations, from applying for a job or providing information at a new dentist's office to signing up for a mailing list. In social interactions this stressor often pops up with use of the question "what are you?" by both innocent persons and people with negative biases. During such conversations, a multiracial person may disclose multiracial identity only to have the other person deny it, saying something like, "That's not possible, you don't look Black," as if the other person is an expert on the way mixed race persons are "supposed" to look. A multiracial person may experience this invalidation of one's racial identity over and over again by many people and/or organizations many times throughout a day. Johnston and Nadal (2010) call this microaggression *exclusion and isolation*. For example, a multiracial client with an American Indian and White background talks about wanting to attend an American Indian community event during psychotherapy. Then the psychotherapist says, "But you're not Native American, you're so pale." This leaves clients feeling as if they do not belong in the racial groups with which they identify, or that they are not allowed to identify with their racial and cultural groups.

Another common microaggression includes objectifying multiracial people or labeling multiracial people as exotic. These types of comments can make multiracial people feel as if they are not "the norm," or are different, simply because the person making the comment may not often see or know of many mixed race people. In addition, such comments may make the person feel like an object, which can be dehumanizing (Johnston and Nadal, 2010). An example of this during psychotherapy would be if a mulitiracial client with low self-esteem is complaining of perceived faults or negative traits, and the psychotherapist says, "But you are so exotic looking!" as an attempt to point out something positive.

Another stressful situation can arise when multiracial people are assumed to be monoracial, or when people mistake the identity of a multiracial person (Johnston and Nadal, 2010). An example of this would be a psychotherapist who feels "safe" to speak negatively about Asian culture in front of a client who identifies as Asian and White, because the psychotherapist is assuming the client is not of Asian background. Events such as these leave multiracial clients exposed to comments that are "not meant for their ears," yet are still hurtful and insulting. It can also leave a multiracial person feeling as if their physical appearance does not match what it "should." Again, this "should" is being arbitrarily determined by others.

Denial of multiracial people's reality is another microaggression (Johnston and Nadal, 2012). Psychotherapists may accidentally do this when multiracial clients bring up issues that have to do with their multiracial background in psychotherapy, such as racially-related discrimination from others. For example, a psychotherapist may say in disbelief that racism does not exist or, as the client is racially mixed, that they are exempt from racial issues and do not ex-

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perience racism. A psychotherapist may tell a part-White, part-Black client they should not be offended by discrimination directed at Whites because they are "not really White." These comments are invalidating, and racial discrimination that is perceived by multiracial individuals is an issue that should not be overlooked.

Lastly, an important microaggression to avoid is pathologizing multiracial people's identities and experiences. This occurs when others view the multiracial identity itself, or multiracial person's experiences, as abnormal (Johnston and Nadal, 2010). An example of this is when people believe mixed-race couples should not exist, as they would make biracial children unfit for society. This view was a common reason why interracial marriage was illegal decades ago (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2009). Similarly, this microaggression happens when people assume biracial or multiracial people have psychological or identity "issues," simply due to having a mixed racial background. These stereotypes imply multiracial people are abnormal, wrong, or that having multiracial offspring is deviant.

Generally, having a community or network of social support in which one can confide helps racial and ethnic minority populations deal with discrimination and the resultant stress that is associated with it. Having such a community is particularly important for multiracial people, as multiracial people can have difficulty finding a multicultural or multiracial community with which to identify (Phillips, 2004; Wehrly, Kenney, & Kenney, 1999). If unable to find role models with similar mixed racial backgrounds, multiracial youth may find it difficult to navigate periods of racial identity development (Shih & Sanchez, 2005). Moreover, qualitative research with multiracial children, adolescents, and young adults by Nakazawa (2003) has shown that, even if biracial children's families openly discuss multiracial issues, the children may feel their parents are still not be able to completely grasp what it is like to be multiracial, and thus the issues that can stem from it. Additionally, a multiracial person by definition has family members of different races, meaning racism and/or lack of acceptance of multiracial people by family members is also very possible. Such discrimination is, of course, confusing and frustrating, and has been linked to depression, low self-esteem, and lack of social connectedness (Salahuddin & O'Brien, 2011). Given these realities, it may be important, especially with younger clients, to address their levels of social support and whether they have social networks in which they feel accepted. This community does not necessarily need to consist of others who are multiracial. Helping clients find social support where their multiracial identities are supported can help them with healthy multiracial identity development, and provide a space to be able to frankly discuss their experiences with discrimination or microaggressions.

Some studies have shown that multiracial people experience lower self-esteem than Whites. For example, in a study involving negative feedback after completing a task, multiracial participants were significantly more likely to show lower self-esteem when they were asked to disclose their multiracial identity. This result was not found for White participants in the study. Additionally, the multiracial participants were significantly more likely than the White participants to experience anxiety in response to negative feedback (Sanchez & Bonam, 2009).

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Research has found multiracial adolescents use more drugs and alcohol than all, or some, adolescent groups of one race, or who are monoracial (Chavez & Sanchez, 2010; Choi, Harachi, Gillmore, & Catalano, 2006). Racial discrimination in their neighborhoods and at school was significantly correlated with more substance abuse and violent behavior, underscoring the importance of inquiring about substance use and abuse, and what role substances play in multiracial clients' lives. However, caution must be taken not to assume a multiracial client uses or abuses substances simply due to their multiracial background, as no causal relationship has ever been found between substance abuse and being multiracial.

Multiracial clients benefit from developing positive views of their multiracial identity, as an integrated multiracial identity is a protective factor promoting psychological well-being in adults (Jackson, Yoo, Guevarra, & Harrington, 2012). Adolescents who do not have a stable racial identity have shown lower self-esteem (Sanchez, Shih, & Garcia, 2009). For example, researchers have found that biracial people who identified as being biracial had significantly higher levels of self-esteem and significantly lower levels of depression than their biracial peers who did not identify as being biracial (Lusk, Taylor, Nanney, & Austin, 2010). If a multiracial client's family or social environment invalidates, or does not support, the client's mixed race identity, psychotherapists can be of great service by helping the client foster pride in that identity. Additionally, it would be helpful to provide multiracial people, especially children and adolescents, education on different identity stages and/or stressors they may face, and how to cope with difficult situations.

Despite the existence of many possible social stressors, multiracial people are resilient. A study revealed multiracial identity increases both an appreciation and empathy for cultural diversity among others. This shows that multiracial people may be more open to forming friendships with people from different racial groups than others (Shih & Sanchez, 2005). Moreover, multiracial adolescents and young adults are less likely to be subject to stereotype threat that causes poor performance on tasks. This may be because the multiracial participants are more likely to understand that race is not biological, but rather a social construct (Shih, Bonam, Sanchez, & Peck, 2007). These areas of resilience, and others, can be used as an aid in helping to strengthen the self-esteem of multiracial people and can help to counteract the effects of discrimination and microaggressions.

The development of the Multiracial Challenges and Resilience Scale (MCRS), a scale that measures multiracial discrimination and resultant stress, can be a useful tool when working with multiracial clients. The development of this measure also reflects the increasing need for clinicians to be able to determine if a multiracial person has experienced discrimination and how much stress they experience from it (Salahuddin & O'Brien, 2011). When using measures with the multiracial population, it is important to use the MCRS or similar scales as discrimination measures, as other tools are often normed with monoracial populations and do not have items that capture the stressors and discrimination multiracial people experience.

In conclusion, if a biracial or multiracial client describes experiences with racism as a presenting problem, it is of upmost importance for the clinician to understand that multiracial discrimination exists. Depending on the type of discrimination, it can leave the multiracial person feeling socially ostracized; not accepted by family, loved ones, or soci-

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ety; confused; and forced to choose one of racial background, and therefore family, over another (Root, 1992; Salahuddin & O'Brien, 2011; Sanchez, 2010; Shih & Sanchez, 2005). Such feelings of discrimination can be stress inducing (Salahuddin & O'Brien 2011), yet it is vital not to assume that simply because someone has a multiracial background that person must have psychological instability. By being aware of these unique types of multiracial discrimination, a clinician could more competently discuss the topic of discrimination with a multiracial client. The clinician could then begin to normalize the client's feelings and experiences and provide psychoeducation on how and why discrimination occurs. Validating multiracial clients' experiences with discrimination will help clients feel supported in therapy, allowing them to develop increased coping skills and resiliency in the face of these unique challenges.

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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The Misuse of Psychology

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Public Interest and Social Justice

The American Psychological Association (APA) has been in the press again, and once again it is bad press. The old specter of collusion between psychologists and CIA interrogators and torturers was raised in an article in *The New York Times* (Risen, April 30, 2015). There really should not be anything controversial about this issue. It is clear from our Code of Ethics that psychologists are prohibited from engaging in inhumane practices, yet it took a Task Force (APA, 2005) to reiterate that psychologists are always bound by their ethical responsibilities, regardless of work setting. There are no exceptions. The "Nuremburg defense" does not hold. In 2013, APA adopted the Policy Related to Psychologists' Work in National Security Settings and Reaffirmation of the APA Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (APA, 2013). Last year, after continued dismay that several license boards had failed to hold psychologists responsible for their involvement in dubious interrogation practices, APA elected to conduct an independent review. The report from Mr. David Hoffman, attorney with the law firm of Sidney Austin, is pending.

The reports in the press have been confusing for the public and for psychologists alike. The question may come up in psychotherapy, so psychotherapists may wish to consider how they might deal with this with clients. The torture methods used in detention centers post-9/11 are a prime example of the misuse of psychology, but by no means the only case. Also much in the news recently is the issue of police brutality and the use of lethal force, particularly against African American men. The riots and indictment of six police officers in Baltimore this week must be seen in the context of persistent, daily injustices and microaggressions affecting the lives of many in poor minority neighborhoods. The question has been posed: Why do police officers act and react this way? One suggestion from Dr. Seth Stoughton of the University of South Carolina School of Law (Cornish, 2015) lies in the type of training they receive. A paranoid, hypervigilant stance is fostered by training videos in which members of the public are depicted as armed and dangerous, and hesitancy or complacency can be fatal. Officers face real challenges and risks, but may be trained to see themselves as soldiers among enemies, resulting in an exaggeration of the actual danger in a given situation. Stoughton calls for a paradigm shift starting in the Academy, from the "warrior mindset" to a "guardian" role (Cornish, 2015). Profiling, a psychological skill, is often misused. Instead bias and stereotypes prevail. FBI Director James Comey recently pointed out the danger of "mental shortcuts" that lead to biased policing, and Dr. Joshua Correll's research into racial bias and threat perception at the University of

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Colorado has demonstrated that participants in a video game test situation are more likely to shoot a Black person than a White person, and shoot more quickly when the simulated target is a Black person rather than a White person (Correll, Park, Judd, & Wittenbrink, 2002). There is now a move to train police officers in "Fair and Impartial Policing," attempting to neutralize bias. Psychologists who work with police officers or departments are well situated to assist in education and fostering a new mindset (Kaste, 2015).

These examples are from settings outside traditional therapeutic contexts. Even within the clinical domains of diagnosis and therapy, however, there are cases of misuse of psychology, some egregious. Whole groups of people have been pathologized in various iterations of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Only in *DSM*-5 (APA, 2013) has Gender Identity Disorder been changed to reflect the fact that not all who question their assigned gender have a "disorder." In therapy, ineffective and often harmful techniques have been used to "convert" nonheterosexual patients to heterosexuality (APA, 2009). In 2010, President Obama appointed Amanda Simpson to the Commerce Department. She is the first openly transgender woman to be a presidential appointee. She recently made a strong stand urging that conversion therapy be banned, pointing to its long correlation with misery and suicide (Hudson, 2015). Despite APA's longstanding opposition, conversion therapy is still offered by some mental health providers and may be sought out by members of the public (Grisham, 2015), often parents who want to "make" their teenaged children "straight." Psychologists and psychotherapists have a responsibility not to provide such damaging therapy, and need to take part in educative, as well as therapeutic, activities to help their colleagues and clients better understand the issues.

These are all matters of public interest, social justice, and professional ethics. In and out of the psychotherapy room, psychologists and their clients are affected by these issues. Pursuant to the Code of Ethics (APA, 2010), psychologists have an obligation do to good and not harm (Principle A, Standard 3.04), to prevent misuse of psychologists' work (Standard 1.01), to promote and protect civil and human rights and dignity, and to be aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making (Preamble, Principle E).

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STUDENT FEATURE

Digital Weight Management: Behavior and Technology

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Obesity is a nationwide epidemic that is measured by a person's body mass index (BMI), or weight in kilograms divided by height in meters squared (Devlin, Yanovski, & Wilson, 2000; Shugart, 2013). In 2012, two-thirds of American adults were considered to be overweight or obese (Mitchell, Garcia, de Zwaan, & Horbach, 2012), and it is expected that obesity will account for 16% of U.S. healthcare expenditures by 2030 (Marcus & Wildes, 2012). According to the World Health Organization (WHO, 2000), those with a BMI of over 40 kg/m^2 are declared morbidly obese, those with a BMI of 30-39 kg/m^2 are declared obese, and those with a BMI of 25 kg/m^2 are declared overweight.

The first known weight loss diet in America was established in the mid-nineteenth century, with dieting becoming the norm by the 1920s (Wolchover, 2012). The diet industry, a $70 billion-per-year business, is continuously growing, as successful weight-loss methods are in demand (Wolchover, 2012). Medical professionals consider a 5-15% loss of initial weight successful, as this could help decrease the risks and/or symptoms of common co-morbid disorders (e.g., hypertension, type-2 diabetes; Wadden, Brownell, & Foster, 2002). However, for someone who is looking to lose more of their initial weight, these figures may be disappointing (Wadden et al., 2002). Thus, this discrepancy between desired weight loss and the practical amount that can be lost—usually about 10%—could lead to feelings of defeat and hopelessness, ultimately resulting in abandoning the weight loss regimen (Wadden et al., 2002).

With the exception of surgical procedures for weight loss, low calorie diets, group behavior therapy, and pharmacology have been shown to be the most effective methods for weight management among overweight individuals (Herpertz, Kielmann, Wolf, Hebebrand, & Senf, 2004). However, with the recent emergence of telehealth in psychotherapy, there has been an increased utilization of technology for weight management (Shigaki, Koopman, Kabel, & Canfield, 2014). Increases in access to the Internet have made it a real and popular medium for public health intervention, including weight management (Tate, Wing, & Winnet, 2001). Technology-based behavioral health interventions reduce barriers to treatment, as they increase engagement in self-monitoring (Shigaki et al., 2014). Currently, the development and practice of weight management applications are in their in-

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fancy, and specific intervention content has not been extensively examined (Tang, Abraham, Stamp, & Greaves, 2015). This review is intended to familiarize readers with the (admittedly scarce) literature regarding these new weight management technologies, and to increase awareness of the possibilities for utilization of such methods within psychotherapy sessions.

Technology in Weight Management

In a qualitative meta-analysis, Khaylis, Yiaslas, Bergstrom, and Gore-Felton (2010) looked at 21 peer-reviewed articles that used an experimental or pre/posttest design to evaluate the efficacy of a technology-based intervention for weight loss. They found five common factors across these studies to be crucial for successful technology-based weight management interventions. These include self-monitoring, counselor feedback and communication, social support, use of a structured program, and use of an individually tailored program.

Self-monitoring, often characterized as tracking diet, exercise, and self-weighing (Burke, Wang, & Sevick, 2011), seemed to be the most predictive factor of successful weight loss. Before the availability of technological applications, these factors were traditionally tracked with paper diaries (Burke et al., 2012). This often led to poor adherence, as it was not always possible to record all necessary information for the diaries quickly and efficiently (Burke et al., 2012). In a two-year study by Burke et al. (2012), 210 overweight adults received group behavioral treatment for weight loss which included dietary and physical activity goals. Researchers found that a daily feedback message delivered to participants' smartphones enhanced adherence and improved weight loss, suggesting that technology can play a role in improving weight-related outcomes.

mHealth Technology

Mobile Health (mHealth) utilizes mobile communication devices to help facilitate primary care and chronic care management in order to capture, store, and communicate health information (Malvey & Slovensky, 2014). mHealth is a feasible, low-cost platform that provides easy engagement and communication between healthcare providers and patients, allowing them to exchange information and feedback for managed health care and wellness (Runkle, 2013). The most popular types of health applications are used to monitor exercise, diet, and weight (Malvey & Slovensky, 2014). The Pew Internet Health Survey (Fox & Duggan, 2012) found that 38% of mHealth users utilize applications for exercise, fitness, pedometer, and heart rate monitoring; 31% of users use mHealth applications for diet, food, calorie counting; and 12% of users use mHealth for weight monitoring (Malvey & Slovensky, 2014).

About 85% of Americans already utilize smartphones and information technology for time and cost efficiency, as well as global connectivity (Krukowski et al., 2013; Shigaki et al., 2014). It is estimated that by 2017 half of the 3.4 billion smartphone and tablet users worldwide will be using mobile health applications, and at least 30% of Americans will regularly wear a device to passively track sleep, food, exercise, heart rate, blood pressure and bio-readings (Malvey & Slovensky, 2014). In addition, an estimated 170 million devices may be produced to monitor health status by the means of bio-sensing devices incorporated into clothing and accessories (Malvey & Slovensky, 2014). Currently, health and wellness applications have been identified as the largest consumer market for application development. The focus of many of these applications is on consumer empowerment, allowing the user

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to take an active role in the management of their personal health.

Clinical Applications

In a review of the literature on the status of mHealth-related applications and trends, it was concluded that these applications have and will continue to have an active role in healthcare; that mobile technologies benefit users because applications allow for immediate support, convenience, low cost and efficiency, and portability; and that mHealth applications facilitate more communication between patients and therapists (Liu, Zhu, Holroyd, & Seng, 2011).

Mental health clinicians could play a unique role in weight management, as research suggests that counseling and support comprise one of the five essential components necessary for successful weight management using technology (Khaylis et al., 2010). Short-term results of technologically-driven weight-loss interventions using these components have been promising, but long-term results have been mixed. This could possibly be due to the lack of continuous psychosocial support while self-monitoring. Thus, we postulate that a mental health clinician could utilize the applications with the client in sessions, processing through any moments in the week that were hard for the individual. For example, a client who logs having eaten something outside of the parameters of the diet plan, or who reports having skipped exercising for a few days, may feel emotions of hopelessness, guilt, and despair. Thus, a professional could process through such feelings in order to encourage the continuation of weight management.

Despite the benefits that mHealth interventions can provide, limitations are present in the literature, including potential communication problems, breach of confidentiality, and lack of evidence-based interventions. Furthermore, many practitioners are not familiar with mHealth applications and would need to gain adequate training in them (Okorodudu, Bosworth & Corsino, 2014). The technology has been labeled as a "disruptive innovation," with its prime intention being to facilitate accomplishing health goals with greater efficiency and lowered costs (Malvey & Solvensky, 2014, p. 187). Eric Dishman, MD, founder of Digital Health group, stated that there must be a "culture of innovation" that includes customizable care, networking, and change, and that measures scalability and assurance of mainstreaming (Malvey & Slovensky, 2014, p. 187). The question, therefore, remains: Will mHealth be a fundamental changer in reforming the healthcare system or a supplemental supportive tool? The future of mHealth remains open, and this question has yet to be explored in depth.

Conclusions

Current use patterns and projections suggest that technological interventions for weight management could potentially bring great change to the diet industry and behavioral health therapies; however, a lack of empirical data illustrating efficacy may have resulted in underutilization of these treatment methods to date (Maclean et al., 2015). Given the context of how individuals operate within the frame of technology, it would be helpful to integrate the practice of behavioral health within the construct of technology, and psychotherapists may be uniquely positioned to provide their clients with counseling services grounded in technological best practices. As technology advances, there will be a need for greater innovation, interaction, accessibility, and decreased costs for weight management interventions (Okorodudu et al., 2014). Short-term results of technologically-driven

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weight-loss interventions using these components have been promising, but long-term results have been mixed. Although more longitudinal studies are needed, the interface of technology and behavior change is an effective foundation of a successful, short-term weight-loss program, and may be the foundation for long-term weight loss.

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

NOTICE TO READERS

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STUDENT FEATURE

Manifestations and Outcomes of Pediatric mTBI

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Each year in the U.S., nearly 500,000 children between the ages of zero and fourteen report to the Emergency Room related to head trauma (Langolis, Rutland-Brown, & Thomas, 2005). Current estimates show that 180 of every 100,000 children under the age of fifteen are diagnosed with traumatic brain injury (TBI) each year (Kraus, 1995). The majority of these are clinically diagnosed as having "mild" traumatic brain injuries (mTBI; Aitken et al., 1998; Langolis, Rutland-Brown, & Thomas, 2005; Lee, 2007). The highest occurrence of pediatric mTBIs is among children under the age of five and teenagers (Bazarian et al., 2005; Hooper & Baglio, 2001). It is difficult to know if these figures are complete, as it is believed that many mTBIs go unreported or undetected (Buck, 2011). The occurrence of mTBI is likely underestimated historically because a past unavailability of accurate diagnostic criteria made it challenging for clinicians and others to consistently identify and account for mTBI, which lead to misdiagnosis or underreporting (Aitken et al., 1998; Lee, 2007). Despite this problem, research tells us that pediatric mTBI is often caused by falls, car accidents, bicycle accidents, and sporting accidents (Bazarian et al., 2005; Pondsford et al., 2001; Thiessen & Woolridge, 2006). It is thought that 40-50% of children hospitalized as a result of any TBI may have long-term cognitive, behavioral, or functional deficits (Hawley, Ward, Magnay, & Long, 2004). It is for this reason that evaluation, treatment, and monitoring of mTBI is essential focus of continued study.

Description

Because symptoms and outcomes vary depending on TBI severity, particularly in children, it is important to clarify which injuries are considered here. As a result of diagnostic challenges in the field, in 1993, the American Congress of Rehabilitation Medicine (ACRM) formed The Mild Traumatic Brain Injury Committee in order to establish formal uniform criteria for the diagnosis of mTBI. This was one of the first available clearly-defined standards for mTBI, and is still referenced today. The standard promulgated by the ACRM to define mTBI is as follows:

> A person suffers a traumatically-induced physiological disruption of brain function manifested by at least one of the following: (a) any period of loss of consciousness (LOC), (b) any loss of memory for events immediately before or after the accident (posttraumatic amnesia; PTA), (c) any alteration in mental state at the time of the accident, and (d) focal neurological deficit(s) that may or may not be transient but where severity does not exceed the following: (1) loss of consciousness of greater than 30 minutes; (2) after 30 minutes post-injury, an initial Glasgow Coma Scale of 13-15; and (3) posttraumatic amnesia is not greater than 24 hours. (Mild

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Traumatic Brain Injury Committee, 1993, pp. 86-87)

Diagnosis of mTBI is often a challenge, despite promulgation of standards, as the term mTBI is often used interchangeably with terms such as concussion and minor closed head injury (Kirkwood et al., 2008). It is important to bear in mind that pediatric mTBI is particularly difficult to evaluate, not only because of lack of report, but because brains of pediatric patients are not fully developed and continue to mature post-injury through adulthood. This makes evaluation, monitoring, and treatment challenging, as functional progress may result from improvement of mTBI symptomology or may result from the patient's natural brain maturation.

Evaluation

The existence and extent of TBI is diagnosed at the time of injury and classified as mild, moderate, or severe based on a number of relevant factors. These factors have historically included the duration of unconsciousness, the length of the patient's posttraumatic amnesia, and the outcomes of physical and neurological examinations (which may or may not include neurological imaging; Borg et al., 2004). The most common and widely used test or scale for clinician evaluation of TBI is the Glasgow Coma Scale (GCS). This scale was originally developed by Teasdale and Jennett (1974) to uniformly and reliably assess patients' TBI severity. Scores on the GCS range from 3-15, resulting from aggregation of individual scores on three subscales that assess verbal responses, motor responses, and eye opening. Injury severity is classified as: mild (score of 13-15 with no skull fracture), moderate (score of 9-12 or a score of 13-15 with a skull fracture), or severe (score of 8 or less; Wassenberg, Max, Lindgren, & Schatz, 2004). Thus, discussion of pediatric mTBI by definition focuses on youth who are diagnosed with a TBI scored between 13 and 15 on the GCS with no associated skull fracture.

Symptoms

Acute signs of pediatric mTBI may include physical, cognitive, and/or behavioral repercussions. Physical symptoms are common and often consist of loss of consciousness, headaches, dizziness, fatigue, nausea, vomiting, sensitivity to noise or light, blurred vision, diplopia, and sleep disturbance (Roberson, 2004). The cognitive impairments involved may include reduced attention, impaired concentration, short-term memory dysfunction, word-finding difficulty, or delayed complex processing. Many patients also experience behavioral changes such as increased aggressiveness, irritability, emotional ability, depression, or anxiety (Blinman, Houseknecht, Synder, Wiebe, & Nance, 2009; Cook, Schweer, Shebesta, Hartjes, & Falcone, 2006; Guerrero, Thurman, & Sniezek, 2000; Taylor et al., 2010). Research has shown that there is a cluster of symptoms which is most common immediately after injury. Yeates and Taylor (2005) found that 40% of patients presented with a loss of consciousness, 76% with headache, 44% with vomiting, 41% with nausea, 32% with posttraumatic amnesia, 26% with dizziness, 12% with double or blurred vision, 10% with disorientation, and 2% with transient neurological deficits. While this appears to be the most common cluster of acute symptoms, patients may experience some or none of these.

Within the first month after the injury a number of differences become apparent between children who have experienced mTBI and those who have not. For example, mTBI group members in one study produced significantly lower scores on response speed tests one week post-injury than did members of the control group (Gagnon, Swaine, Friedman,

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& Forget, 2004). Children with mTBI also appear to suffer from significantly more memory problems than their uninjured counterparts and performed more poorly on test of concentration (Krivitzky, 2011). Surprisingly, the mTBI groups did not show measurable immediate (or long term) differences in academic performance or cognitive evaluations (McKinlay, Dalrymple-Alford, Norwood, & Fergusson, 2002).

At six and twelve months post-injury, additional differences emerge between groups. The mTBI group had worse performance on a limited time test, *visual closure scores*, in which children were asked to locate hidden objects within a picture. The mTBI group children were significantly more likely to have sustained another mTBI within the first six months after their initial injury (Wrightson, McGinn, & Gronwall, 1995). The same study showed that mTBI children also demonstrated lower reading comprehension scores. Dennis and Barnes (2001) conducted a study suggesting that children with a history of mTBI demonstrated poorer language comprehension than their non-injured peers, specifically on tasks of ironic criticism, deceptive praise, and speech acts.

Immediate Recovery

Research shows that children who sustain mTBI often recover naturally, with the majority of their symptoms normally resolving two to three months post-injury (Carroll et al., 2004; Kirkwood et al., 2008). Some of these children, however, still experience ongoing physical, cognitive, or behavioral problems after the first three-month period following injury (Cook et al., 2006; Ponsford et al., 2001). These symptoms include, but are not limited to, headaches, fatigue, memory impairments, attention difficulties, anxiety, hyperactivity, and conduct disorder (McKinlay et al., 2002; Ponsford et al., 2001). Overall, a child who experiences mTBI has a positive prognosis for complete recovery, notwithstanding the immediate presenting challenges (Carroll et al., 2004).

Despite research demonstrating the resilience of children diagnosed with mTBI, there is evidence that points to significant difficulties in psychosocial and cognitive functioning. These studies tend to show that children experience physical challenges, cognitive deficits, or ongoing emotional and behavioral problem after sustaining mTBI, although the sample size of some of the studies is limited (Cook et al., 2006; Ponsford et al., 2001). One study found that children who sustain mTBI under the age of five were particularly likely to show signs of hyperactivity/inattention and conduct disorder post-injury in their early teens (McKinlay et al., 2002). Luis and Mittenberg (2002) determined that children who sustained mTBI showed new mood disorders, and are at an increased risk for psychiatric disturbance.

Thus, while the immediate and longer-lasting effects of mTBI can be severe and debilitating, research indicates that many children who suffer mTBI recover naturally, and many others can eventually regain abilities, with little or no long-term loss of functionality. In addition, as discussed below, the affected areas can be targeted with a variety of treatments to reduce the overall residual impact of mTBI.

Treatment

It is important to remember that, particularly with young patients, all clinical care must be individualized. This includes taking into account each child's past and current developmental level and unique circumstances, which include family and community support (Kirkwood et al., 2008). The treatment of mTBI in children cuts across multiple

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environments of functioning, such as the individual, family, school, and athletics. Because of the scope of the life domains potentially impacted by mTBI, children who require rehabilitation typically work with treatment teams composed of numerous professionals (Hawley et al., 2004). The initial management of a pediatric patient with a diagnosis of mTBI requires complete physical and cognitive rest, to allow recovery (Kirkwood et al., 2008). This often requires that the child remain in bed and refrain from engaging in activities such as school or intensive family obligations. A child should not return to strenuous activity, such as athletics, until all symptoms have resolved (Carroll et al., 2004).

When rehabilitation is needed, it is important for the child's caregiver to be involved in the rehabilitation processes, because the child patient is often not able to provide all the necessary information about pre-injury state. Caregivers are able to make observations and reports that the child would not be able to otherwise handle, such as behavior or symptom monitoring (Kirkwood et al., 2008). Collateral information can come not only from caregivers, but from schools or other social outlets and groups. It is also important that the caregiver be present in the event that an emergency or unusual symptom emerged after the child returns home. For this reason, psychoeducation of child patients and their caregivers is highly important in the treatment and rehabilitation of mTBI (Hawley et al., 2004).

Patients and caregivers of younger children need encouragement that the symptoms are likely temporary, as the developing brain will accommodate damage through the wonder of brain plasticity (Anderson, Catroppa, Morse, Haritou, & Rosenfeld, 2005). This ability is particularly true in cases of mTBI, where the cognitive load taken on by healthy brain tissue is much less than that required with a severe injury. This means there is a higher likelihood that another region of the brain will participate in the process impacted by the injury, which will in turn increase functionality and reduce the patient's symptoms (Anderson et al., 2005; Kirkwood et al., 2008). Because of this natural recovery, it is important to assess the cause of persistent symptoms. If a child is still experiencing mTBI symptoms after one to two weeks, an evaluation is likely in order to identify reasons for the continued problems and aid in the formation of an adjusted clinical plan (Kirkwood et al., 2008). Any evaluation done in this regard must carefully and precisely define the extent of the continuing injury and rule out more significant neurological injury or medical concern, such as an undiagnosed subdural hematoma (Yue et al., 2013). If there is no underlying medical condition, psychoeducation should be employed to be sure that the patient's expectations for recovery are realistic (Hawley et al., 2004). It is also imperative to assess the patient's activity level and restrict such activity if the level is too high for the patient's condition (Kirkwood et al., 2008). It is necessary that patients and caregivers know that, even when initial recovery is accomplished more slowly, there is still a high chance of full recovery (McKinlay et al., 2002). In such cases, a primary concern is reducing the occurrence of a second injury, particularly prior to full recovery (Bazarian et al., 2005).

Future Research

As additional research is done in this area, it would be beneficial to focus on the subjective experience of mTBI in children and their caregivers. It would be interesting to know if children who experience mTBI and their families agree with the research suggesting few

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long-term consequence of mTBI for many child patients. There has been limited focus on the reported quality of life of clients who have sustained TBI, although much of this research involves moderate to severe TBI (Emanualson, Andersson Holmkvist, Bjorklund, & Ståringlhammar, 2003). Meta-analysis on the limited work done demonstrates mixed results, and is itself limited by the lack of tight controls and small samples sizes in the studies included in the analysis (Petchprapai, & Winkelman, 2007).

Recent research has also identified the potential for olfactory dysfunction in pediatric clients with these types of injuries. While the primary focus of such studies has been on TBI in general, some evidence suggests that a subset of mTBI patients may experience this symptom, as well (Bakker, Catroppa, & Anderson, 2014). Additional work should be done on the extent and frequency of limited or persistent olfactory dysfunction in pediatric mTBI patients in order to determine the impact of this issue on the population.

Work is also being done on potential risk factors associated with poor long-term functioning after pediatric mTBI (Zonfrillo et al., 2014). External factors that appear to impact posttrauma functioning include less parental education, low household income, and Medicaid insurance. Other factors likely will be identified through future work. It will be important to determine the extent of the influence of these factors, as the findings so far seem to indicate that youth who are socioeconomically disadvantaged should receive additional intervention to mitigate the effects of mTBI.

One of the potential intervention methods requiring more study is the use of telehealth interventions. These interventions can be cost-effective ways for children's caregivers to gain access to needed medical or therapeutic support when financial or time constraints limit a family's access to care (Woods et al., 2014). This method includes a manualized treatment program for caregivers and others involved in the child's recovery, along with available telephonic support from professionals. Pilot research has shown this program to be helpful in the management of mTBI care, although additional work must be done to confirm these findings (Woods et al., 2014).

Conclusion

The sheer number of children each year who experience mTBI is cause enough to examine the repercussions of these types of injuries in this population. Increased diagnostic accuracy and more standardized definitions make this increasingly realistic. While many injuries remaining undiagnosed, those that are reported have given a broad picture of what is involved in common pediatric mTBI. When evaluation shows that the injury sustained is mTBI, service providers and families can draw on a readily-available body of research, treatment options, and resources. While work is still being done to expand the information available and control for some of the limitations of mTBI studies, the physical, cognitive and behavioral consequences of such an injury are well documented. It is also well documented that most occurrences of mTBI resolve naturally, although there is a subset of the injured who do require additional support. When managed with appropriate supervision and education, even more complex forms of these injuries may resolve in time. Future research in this area will add to the body of knowledge available to aid in the treatment and recovery of all types of TBI.

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

WASHINGTON SCENE

I Saw Her Again Last Night …

Pat DeLeon, PhD
Former APA President

The Best of APA

The annual APA Practice Directorate State Leadership Conference (SLC) continues to be the highlight of my APA year. This Spring, 530 colleagues, including an impressive number of early career psychologists and first time attendees, were treated to another spectacular event. Highlights included new models of service delivery, the importance of integrated and patient-centered care, and a focus on developing effective business plans while simultaneously providing "value-add." The Illinois Psychological Association's recent prescriptive authority success, thanks in large part to the dedication and persistence of Beth Rom-Rymer, brought new life to the RxP movement, with a number of states reporting their membership being re-energized. Ann Compton, former White House correspondent for ABC News, presented a fascinating look at the inner workings of the Oval Office, when Hillary would finally announce, and the unique perspectives of the First Ladies. This was also the 10th anniversary of David Ballard's visionary Psychologically Healthy Workplace and Organizational Excellence Awards ceremony, which actively engages psychology with the best of the business community at both the local and national level. Under Norman Anderson's leadership, APA itself was recently designated as one of the "Best Places to Work" by the *Washington Post*. As always, the enthusiasm and excitement of the audience was palpable.

The theme for this year's conference was *Practice Innovation*, and Practice Directorate Executive Director Katherine Nordal challenged those present to step up and become visionary leaders. "Innovation involves new ideas and processes, change, upheaval, and transformation. To be innovators we need to **shake off** some old ways of thinking about traditional practice models. We also need to **shake off** the negative attitudes some of our colleagues have about what's happening in health care. The world is changing and health care is moving ahead—with or without psychology. Whether we move forward will be up to us! We need to think differently about our professional roles and the way we provide services. Too many psychologists are stuck in the traditional 50-minute therapy box. And that box is way too confining. We need to think creatively . . . how we practice . . . where we practice . . . and what we practice.

"How can psychologists participate in the evolving system in ways that are good for us, our profession, and our patients? What effects will reforms in health care systems, financing, and technology have on us? And, how do we, as leaders in our profession, support our members as these changes unfold? We need to see and understand the bigger picture—the health care environment in which psychology lives. Psychology should be the discipline that defines and expands the mental health quality measures available for Medicare and other public and private payers as these measures become more widely required.

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"Clinical practice guidelines provide an example of our asserting a leadership role. Historically, psychology has not been at the table. That has enabled others to control the process, and payers have used *their* guidelines to determine what they will and will not pay for. That will change as APA finalizes three initial guidelines—for PTSD, depression, and obesity. Guidelines developed by other disciplines often ignore the rich psychological science that informs good practice. APA guidelines will identify the most effective psychological treatments for these disorders, regardless of the discipline providing the care. Our guidelines development process is innovative. APA's panels are multidisciplinary. One of our cutting-edge, best practices is including community members on each panel to represent the patient perspective.

"You'll need a dose of courage to face the resistance you're going to encounter back home. There will be times when your colleagues push back at your efforts at innovation. Sometimes you'll hear your colleagues complain, 'We shouldn't change the way we've always done it.' Or, 'That's not how I was trained.' When you get that push back, what 3-word message are you going to give back to them? '**Shake it off**.' You are the leaders with the focused vision and vigilance needed to influence a challenging, changing health care system. You are the leaders who will shape a vibrant future for professional psychology."

The Administration's Vision

At a recent HRSA national Advisory meeting, the acting administrator discussed the Accountable Care Act's vision for improving access to quality care; fostering a more diverse workforce emphasizing team-based, interdisciplinary care; developing healthy communities (i.e., a population-based focus); and giving priority to prevention ,while addressing historical health disparities. This *is* Katherine's charge.

A Special Personal Journey

"The APA Congressional Science Fellowship program had a *profound* impact on my life and my career, and I am profoundly grateful for the experience. At the most recent APA Council of Representatives meeting, former Congressman Brian Baird gave a talk at the plenary session and commented on the importance of the Fellowship for both the profession of psychology and for Congress itself. You might recall that I was the first psychologist to be a Robert Wood Johnson (RWJ) Health Policy Fellow, and this predictably led to 'Potomac Fever.' I loved working on the personal staff of Senator Tom Daschle, and cherish the time I spent with Tom (in both South Dakota and DC) and being mentored by Rima Cohen, his health policy legislative assistant. Of course, the two-month Institute of Medicine (IOM) orientation helped too (e.g., our half-day lecture about and tour of HHS was given by then Secretary Lou Sullivan). I wrote lots of speeches, drafted legislation, met with constituents, attended committee hearings, and was intimately involved with the reauthorization of funding for the National Health Service Corps. Bob Frank was the second psychologist picked as an RWJ Fellow; I'm sure his time working for Senator Jeff Bingaman (D-NM) at least partially was responsible for his current position as President of the University of New Mexico.

"Realizing that I could never go back to running a neuropsychology lab, I resigned a tenured full professorship at the Marshall University School of Medicine, determined to reshape my life as a health policy maven. I applied for both the APA Congressional Science Fellowship and the MPH program at Harvard. I was accepted for both, but opted to

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stay in DC and continue to learn about the fascinating world of health policy. Ted Kennedy, Jay Rockefeller, and Pete Stark all offered me jobs on their personal staff, but Congressman John Conyers then chaired the House Government Operations Committee, and I accepted a position on his committee staff, in part because of my interest in promoting a Canadian-style single payer health care system for the United States, something Congressman Conyers passionately supported. In addition, after a year working in the Senate, I wanted to learn more about the House of Representatives.

"While spending two years on the Hill, I had an opportunity to get actively involved with APA activities and operations (Fellows are invited to participate in almost all relevant APA conferences, meetings, events, and summits). This eventually led to my active participation in APA governance and presidency of three divisions (12, 46, and 52) as well as participation for several terms on the Council of Representatives. During this second year working for the Congress, my former Dean at Marshall became the Dean of the School of Medicine at the University of Missouri. Although a thoracic surgeon, this Dean was very psychologically minded, and he was determined to bring me back to the Academy. He offered me an opportunity to direct the Missouri Institute of Mental Health (MIMH), a policy, research, and training 'think tank' with over 100 employees and a budget of about $6 million. MIMH operated at the interface of the University of Missouri and the Missouri Department of Mental Health, and our mission was to serve anyone in Missouri with a mental illness, addiction, or developmental disability. The job required lots of time in Jefferson City (the state capital) as well as tracking state legislative policy. It was a job that wouldn't come around again, so I accepted the Dean's offer and happily spent the next 20 years running the Institute. I never went back to being a neuropsychologist . . . but I never regretted making the shift from direct patient care to being a 'policy wonk.'

"I simply couldn't have done the job at MIMH—and it would never have been offered—had I not spent time on the Hill as a congressional science and health policy fellow. I like to think I made a real difference during the two decades I spent in Missouri, and I've had opportunities to introduce literally thousands of students to health policy issues, both in Missouri and while serving as an Associate Dean at the California School of Professional Psychology (CSPP). I also make sure the medical students I'm now teaching at the American University of Antigua know something about how health policy is shaped and how profoundly their professional lives will be affected by what happens in the halls of Congress and in state legislatures. (A fortuitous and entirely unexpected benefit of being a former APA/AAAS Fellow was being invited to Canberra to testify before a subcommittee of the Australian Parliament about my experiences working on the Hill.) Our 40th Congressional Science Fellowship anniversary celebration at our last convention was truly memorable" [Danny Wedding].

Change Is Inescapable, Although It Does Take Time

As Katherine so aptly notes, a number of our colleagues appear to be intractably resistant to change. Apparently, however, this fundamental orientation is not limited to the discipline of psychology. In reading about Rear Admiral Grace Hopper, who was a pioneering computer specialist, and who retired in 1986 as the Navy's oldest serving officer (having served for 42

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years), I smiled learning: "In general, applied mathematicians were looked down on by their colleagues in pure mathematics. There was a widespread belief that 'you turned to applied mathematics if you found the going too hard in pure mathematics.'" Thank goodness for colleagues like former Division and APA President Ron Fox, who continues to press for change, now meeting almost monthly with APA's Heather Kelly strategizing about how to get psychologists—who are themselves veterans—to insist that they should continue to have access to the services of prescribing psychologists within the VA, as they did while on active duty.

Former USAF Prescribing Psychologist Elaine Foster recently wrote her own elected official: "After graduating from the DoD Psychopharmacology Demonstration Project (PDP) I served as a prescribing psychologist in the Air Force for over 20 years. I continued to serve our active duty military after retiring, again as a prescribing psychologist under contract with the Air Force. During that time, I prescribed for our veterans when we had space available at our military clinic . . . If I walked across the hospital parking lot to our annexed VA clinic, I could no longer prescribe to that same patient I'd been prescribing to while he or she was active duty. The current VA restrictions are illogical . . . Because New Mexico recognizes prescribing psychologists, I can now prescribe to our veterans, but only in New Mexico, and only through a third party contractor . . . This just does not make sense and is a clear waste of federal funds." It makes me feel so good to know . . . "It always seems impossible until it's done."

Aloha.

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BOOK REVIEW

Book Review of *The Therapeutic Imagination: Using Literature to Deepen Psychodynamic Understanding and Enhance Empathy* by Jeremy Holmes. New York: Routledge, 2014, 200 pp. ISBN: 978-0-415-81957-2.

David H. Thurn, PhD, LCSW-R
William Alanson White Institute,
New York, NY

Jeremy Holmes (2014) offers here a book, rich with the wisdom of an experienced clinician, that celebrates the imagination as an essential component of the psychotherapeutic process, using examples from literature to provide insight into important aspects of clinical work. He argues that literature and psychodynamic therapy share an "aesthetics" based upon a "paradoxical combination of security of form with creative uncertainty and exploration" (p. x), and says his goal is not so much to use psychoanalytic concepts to explain literature, but rather the reverse—to bring "artistic insights to bear on clinical work" (p. xii).

Literature is useful to clinicians, according to Holmes, for, like the psychoanalytic frame, it marks off a privileged space for a complex play of interactions that can, if things go well, lead to a greater capacity to understand the mind (both one's own and that of another). Like therapy, in other words, literature, in staging encounters with otherness, promotes the ability to "mentalize," to think about the other thinking, to become "mind-minded." The links Holmes posits here between the literary and the psychotherapeutic imagination allow him to claim, in an undeclared nod to Freud, that "literate therapists . . . make better therapists" (p. ix).

Holmes asserts that his book has a practical orientation and structure, each chapter addressing a specific clinical problem, "using literature to extend its range of reference and reverberation" (p. x), in order to help therapists enhance their therapeutic empathy, understanding, and skill. But Holmes also acknowledges important theoretical, literary, and philosophical commitments—principally to attachment theory (he has written several earlier books on the subject), which, I will suggest, despite occasional gestures toward the very different theoretical models of Freud, Klein, and Lacan, informs his use of literature throughout.

Holmes also acknowledges a significant debt to English Romantic writers and to the tradition of German philosophical idealism that informs some of their work. Coleridge, in particular, is an important touchstone for Holmes, the central figure in a lineage he traces back to the philosophy of Kant and Schelling, and forward to a tradition of psychoanalytic thinking that includes Sharpe, Bion, Winnicott, Rycroft, Britton, Ogden, and Ferro. While he provides little detail on the complex vicissitudes of thought within this lineage, Holmes associates it with a Romantic idealist philosophy that "celebrated mind as an autonomous sphere in which, in the imagination, all things are possible" (p. 162). The imagination becomes here a supreme creative

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power which rivals that of nature, and even of divinity.

The imagination is thus the mental faculty that makes possible the creative or therapeutic event. It disposes the mind to attend to what has not yet come into presence, and allows the poet or analyst to re-present the raw materials of experience in ways that break free of old constraints and open onto new possibility. The clinical encounter is here conceived as an opportunity for spontaneous reciprocal exchange within the safe structure of the analytic frame, an exchange which, however asymmetrical, serves as the basis for the possibility of mutual understanding and the creative transformation of negative relational patterns. In its emphasis on playful reciprocity as the vehicle for the emergence of new relational harmonies, the clinical situation is for Holmes not unlike the Romantic poet's encounter with nature as represented by the metaphor of the aeolian harp in Coleridge's famous poem, according to which the harp, producing music in response to an inspiring breeze, is like the poet's receptive mind, which, stirred into action by changing perceptions of the natural landscape, engages in a process of thought, reflection, and creative expression (p. 7).

It is not difficult to see how this model of poetic creativity, based as it is upon principles of reciprocity, affective resonance, and communicable meaning, offers an attractive basis for understanding the therapeutic process according to a particular strand of the psychoanalytic tradition that culminates in attachment theory. Like the reading and writing of literature, the practice of psychotherapy is understood to be a dialectical process that leads, by way of mutual recognition and understanding, to new synthesis or resolution. For Holmes, however much this process may be complicated by obscurity, disruption, or failures of meaning, the therapist can go forward "secure in the knowledge that a resolution will emerge, given time and attentiveness and faith" (p. 173; see also p. 59). Few clinicians would deny the usefulness of this model for understanding a significant dimension of the therapeutic experience, and it captures an important aspect of the phenomenology of literature as well. But it also has limitations. I will come back to this.

The book has four parts. Part I, "The Poetics of Psychotherapy" begins with a chapter—Holmes calls it "a manifesto" for the whole book— that lays out a "model of 'the therapeutic imagination' underpinning clinical encounters" (p. xiii). According to Holmes, the clinical encounter involves a therapeutic sequence in five stages: "primary attachment," "reverie," "logos," "action," and "reflection" (p. xiii; pp. 7-8). Holmes illustrates this sequence with a moving scene from George Eliot's novel *Daniel Deronda*, in which the title character rescues a young Jewish woman from suicide. The second chapter, also central to the overall argument, places "the process of discovery" (p. 16) at the heart of therapeutic work.

The remaining chapters of Part I offer readings of several poems, each tracing a movement toward some kind of resolution. A poem by Robert Lowell, for instance, demonstrates how, like the analytic transference, the figure of metaphor, by establishing a link between disparate realms of experience, facilitates "pattern-recognition" and a movement toward "coherence" and "integration" (pp. 32-41). And Wordsworth's "Ode on Intimations of Immortality" is used to illustrate a movement from grief to consolation, as an experience of loss gives way to a re-

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deeming sense of an underlying continuity. For Holmes, literary language carries an implicit promise of "wholeness": although fraught by ambiguity, disruption, and obscurity, the literary and clinical experience of language is underwritten by a faith in the possibility of reconciliation, resolution, and unity.

In Part II, "Psychotherapy and Narrative," Holmes shifts away from poetry to consider the relationship between forms of prose narrative and the therapeutic process. The basic argument is that psychological health depends on an ability to dismantle constricting stories in response to new experience, to allow the narrative of self-understanding to develop within a dialectical movement between "fluidity and form" (p. 78). This dialectic of "story-making and story-breaking" (p. 78) is what allows the patient to revise the rigid narratives by which she has tried to account for herself, and to find more accommodating stories that can express new or unformulated experience, or give containing narrative form to unruly experiences of trauma.

In the following chapter, Holmes makes the broad claim that all novels have an "underlying emotional structure" (p. 86) and movement—from the presentation of a problem, to explication and modification, and finally to resolution or accommodation—and argues that it resembles the general sequence of the therapeutic process. The final chapter in this section offers an oedipal reading of the central character in Jane Austen's *Emma*. But Holmes also expands the scope of his argument here, moving beyond the psychological analysis of character to present a political critique of the insulated worlds of Austen's fictional Hartfield and of psychoanalysis itself, which he says must look outside the "park walls" (p. 99) to respond to the ethical demands presented by social inequality and injustice.

Part III, "Psychotherapeutic Approaches to Psychiatric Diagnoses," deploys selected works of literature as illustrations of specific diagnostic conditions: anxiety (Wagner's *Siegfried*), dissociative splitting (Stevenson's *Dr. Jekyll and Mr. Hyde*), grief (Milton's "Lycidas," Tennyson's *In Memoriam*, and Donne's "A Valediction: Forbidding Mourning"), and narcissism (Ovid's rendering of the Narcissus myth and Wilde's *The Picture of Dorian Gray*). Finally, Part IV, "'Only Connect': Psychotherapy and Psychiatry," argues for an integration of art and science, and for a psychodynamic therapy with roots in Freud and in literary culture that will serve to mitigate the limitations of what he calls a "diagnostically-oriented managerial psychiatry" (p. 161).

No one could fairly claim that Holmes lacks ambition. His book is copious, far-ranging, richly suggestive, and generically various. Holmes makes a passionate argument for the central role of the imagination in clinical practice, and the personal, political, and professional values that inform his work deserve our respect.

The book also has some limitations. For one thing, while he briefly acknowledges that his project has precursors, Holmes neglects to place his work clearly in the context of the long tradition of psychoanalytic criticism beginning with the classical readings of literature by Freud (1900), Jones (1976), Maria Bonaparte (1949), and others, continuing with ego psychological efforts to develop a theory of art (Kris, 1952), archetypal interpretations of literature and myth (Frye, 1957; Jung, 1976), object relational aesthetics (Klein, 1975; Winnicott, 1989), through to structural and post-structural criticism, which includes marvelous readings, for instance, of

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complex transferential phenomena set in motion by Poe's "The Purloined Letter" (Derrida, 1975; Johnson, 1977; Lacan, 1972), and by Henry James' "The Turn of the Screw" (Felman, 1977). While Winnicott and Klein figure prominently in Holmes' argument, it would be helpful to delineate their theoretical positions on psychoanalytic aesthetics in relation to other figures in this tradition, whose assumptions, methods, and goals are widely various, and often starkly opposed.

In a gesture of winsome humility, Holmes states early on that he claims "no literary sophistication or expertise," and admits that his selections, which come mostly from the "mainstream English literary canon," reveal the limitations of his "class, generation, and ethnicity" (p. xii). Indeed, with the exception of three women and one Peruvian, all of the literary texts cited by Holmes are by white men. To be fair, however, Holmes compensates for the rather restricted cultural range of his selections with a nice sensitivity to matters of class, race, and gender as they arise in several of the works he discusses, as well as with his urgent plea for psychoanalysis to open itself more fully to the harsh realities of social inequality.

But Holmes' relative innocence in literary matters also leads him to make some questionable general claims, as when, for instance, he declares that "the business of poetry is to generate truthful and beautiful images" by which—and here he cites Hannah Segal—lost objects may be "reinstated" in the mind (p. 51) While literature may indeed perform this consoling function, one could equally argue that literature is a verbal practice of singularities that works to suspend and resist the comforting resolution suggested by such substitutions—or, to put it another way, that whatever else it may be, the work of literature, bearing within itself irreducible traces of absence, is always also an act of mourning without end.

Elsewhere, Holmes makes an untenable distinction between poetry and prose, aligning poetry with what he sees as the liberating power of raw sensory experience, and prose narrative with an organizing function that "contains, reassures, [and] soothes" (p. 80). But the powerful effects of sensory immediacy in, say, Woolf's *Mrs. Dalloway* (1925), the uncanny effects of Hoffmann's "The Sandman" (1982), or the confounding effects of Beckett's prose works (1955), which put the very categories of "character" and "plot" in radical question, are sufficient to disable this distinction. Holmes also associates poetry with the "primal" experience of self and other in the pre-Oedipal dyad, and prose with the triangular dynamics of the Oedipal phase. In this pairing, poetry is concerned with "primal contact and communication with the object," while prose addresses experiences of rivalry, loss, power, and time (p. 65). But we need not look to prose for literary explorations of these issues, as Shakespeare's sonnets (Booth, 1977), or Milton's portrait of Satan in Book 4 of *Paradise Lost* (Elledge, 1993), well attest.

Holmes states at the outset, we recall, that "rather than using psychoanalytic ideas to illuminate the arts," his project "aims in the opposite direction, bringing artistic insights to bear on clinical work" (p. xii). It is true that Holmes marshals the imaginative resources of literature to challenge certain reductively "scientific" approaches to clinical work. But apart from its uses in this general polemic, Holmes draws on literature not to put pressure on the concepts of psychoanalysis, but rather to provide allegorical confirmation of these concepts. Psychoanalysis, that is, remains the dominant discourse, while literature

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serves for the most part only to illustrate its insights. This is most evident when the critical readings tip into rather heavy-handed translation of a literary passage into the jargon of clinical psychology, as happens, for instance, in his discussion of the scene from *Daniel Deronda*: "At the end of his 'assessment interview,' we see Deronda align his imaginative identification with the girl, and his formulation ('suicidal, alone, in need of Maenad-like feminine succor'), with the referral possibilities" (Holmes, 2014, p. 11); or when Ovid's mythic characters are used to exemplify psychological types, and treated as patients with psychological histories: "Narcissus and Echo could be seen as typifying the avoidant and ambivalent strategies. As her son was the product of a rape, Liriope may have had difficult feelings about Narcissus from the start" (p. 150).

One could turn the axis of this critical strategy to show how Holmes' literary examples may be deployed to disturb the very psychological formulas used to interpret them. Deronda's rescue of the Jewish Mirah, for instance, stands in the plot as an allegory of Deronda's later discovery of his own identity as a Jew, and of his destiny as a savior of the Jews. In this sense, the sequence of the novel's plot may be understood to lie implicit in the "imaginative identification" that Deronda establishes with Mirah in this scene—the kind of identification that for Holmes serves as the basis for the therapeutic sequence. But the complex narrative strategy that leads to the revelation of Deronda's identity in the novel works to undermine the very concept of identification that allows the plot to move towards its "resolution." A consideration of identification as the positing of an illusory equivalence could usefully complicate our understanding of the straightforward roles played by Deronda and Mirah in Holmes' account of their "therapeutic" encounter.

Or again, Conrad's *Heart of Darkness*, which gets only a brief paragraph in the longest chapter of the book (on attachment), is used by Holmes to illustrate the dialectic of "form" and "fluidity" in the making and re-making of stories. This way of framing the relevance of the novel to Holmes' argument suggests a rather benign understanding of its narrative as a progressive formal accommodation of the unruly flux of Marlow's experience on his journey upriver. But this overlooks the role of Kurtz, who functions in the novel as a figure for the tragic kernel at the heart of human experience, an unrepresentable horror that refuses accommodation in narrative form, and that resists and annuls any movement toward dialectical resolution.

Holmes' model of the literary and therapeutic imagination depends upon a Romantic philosophical idealism and a theory of attachment that defines the clinical encounter according to a measure of resonant reciprocity and a faith in the possibility of relational harmony. The series comprised by the terms "unity," "wholeness," "coherence," "interconnectedness," "resolution," "synthesis," "reciprocity," "consolation," "reparation," and "understanding" sounds the keynote of the book. It is a series defined by a principle of (imaginary) equivalence. What this approach obscures, in my view, is the radical alterity at the heart of human subjectivity, a discordant otherness that refuses to be harmonized by the logics of reciprocity, of correspondence, or of opposition resolved in a dialectic leading to new synthesis. It is a vision of human subjectivity suggested by the Freudian unconscious, the Lacanian Real, or the enigmatic signifier of Laplanche . This notion of an irreducible otherness or untranslatable re-

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mainder as constitutive of the human subject is, I think, what leads Laplanche to make the provocative charge that attachment theory is "a war machine against psychoanalysis" (Laplanche, 2011, p. 16).

Literature is itself testimony to this dimension of human subjectivity. While literature does indeed invite us to establish symbolic equivalences and make imaginative identifications, it also troubles these hermeneutic actions—each text in its singular way—by putting a resistance in play, by suspending the movement toward meaning and reference. We could point, for instance, to the way Mallarmé (Caws, 1982), in calling attention to the linguistic signifier, disturbs the interpretive movement from rhetoric to cognition; to the way in which Célan's poetry (2001) generates a force of destruction against the German language which is its vehicle; or to the fictions of Kafka (Glatzer, 1971), which repeatedly stage the failure of readings that strive for symbolic equivalences.

But these are merely more dramatic examples of an aspect of literary writing that appears, I would argue, in all works of literature, including those of Coleridge, Wordsworth, and Keats. It is that aspect of literature, we could say, that disturbs all "reference and reverberation." Kafka (1977) captures one sense of what this may mean in a letter to Oskar Pollak dated January 27, 1904: "I think we ought to read the kind of books that wound and stab us. If the book we are reading doesn't wake us up with a blow to the head, what are we reading it for? . . . we need the books that affect us like a disaster, that grieve us deeply, like the death of someone we loved more than ourselves, like being banished into forests far from everyone . . . A book must be the axe for the frozen sea inside us" (p. 16).

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

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

REPORT OF APA COUNCIL

The first APA *Council of Representative* (COR) meeting of 2015 was held in Washington, DC from February 20-22, 2015.

Division 29/Society for the Advancement of Psychotherapy is fortunate to have three COR's in 2015. The Society is represented by Jean Carter, John Norcross, and Jeffrey Magnavita, who is the "new kid on the block" and beginning his three-year term. Remember that every year when it comes to allocating your votes, the more you give to our Division the better chance of having greater APA representation on issues that matter. Unfortunately, based on the 2014 allocation results , we will return to two Council representatives next year.

This year we experienced the excitement of being in DC when a record for the coldest day since the 19th century was broken. We can attest that as with much of the country and especially the Northeast we were in the deep freeze. That being said, the COR is a robust group of dedicated psychologists who commited to improving APA and did not let the weather hold us back. Our first 2015 meeting was led by our new President Barry Anton, who has served in a number of leadership positions prior to his election.

Public Policy
The meeting started with a state of the union report. One notable achievement is the impact Psychology has on Pubic Policy. APA is influential in shaping public policy. Under the leadership of APA General Council Nathalie Gilfoyle, JD, a number of amicus briefs have been written and are often referenced in Supreme Court decisions. In fact, the Supreme Court cited APA amicus briefs in 26 decisions. When thanked for her work on marriage equality by one grateful council member, Attorney Guilfoyle was visibly touched. Some influential Amicus Briefs include:

- False confessions
- Eyewitness misidentification
- The death penalty
- Supporting same sex marriages

It is clear that judges and politicians need psychological science to inform decision-making and policy. There are so many issues facing this country that can benefit from psychological research. It is rewarding to know that APA is at the forefront in influencing many aspects of our society.

Financial Condition
On another front, we are happy to report that our CFO Archie Turner reported: "Our balance sheet remains healthy." A financial report presented by APA's Treasurer Bonnie Markham showed that we have recovered from a deficit in our budget three years ago; for the last two years there has been large positive operating margins. APA continues to do well in its investments in real estate holdings, as well as in its investment portfolio. Our healthy financial status allows APA to fund a number of worthy initiatives.

Graduate Psychology Education
APA has achieved increased funding for the federal Graduate Psychology Education (GPE) program from $2.7 million to $7.9 since 2013

Advocacy and Influence
Association Trends magazine ranked APA 12th "most savvy" among national nonprofits for its use of social media. In order to remain at the forefront of science, practice, education and policy, advocacy is a critical mission. Here are a few highlights:

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- APA has provided advocacy training to over 200 psychologists
- Numerous APA members present congressional testimony each year
- APA's *Stress in America Report* is frequently cited by the media and reached 1.6 Twitter users
- Five video profiles have been featured on Public Television stations and two more will be added this year

APA Good Governance Project
APA has been going through a process of restructuring called the *Good Governance Project* (GGP), which grew out of APA's strategic plan adopted by Council in 2009. The GGP team began its work in 2011 and was charged with seeking to maximize organizational effectiveness by assuring that APA's governance processes and structures are aligned with what is needed to thrive in a rapidly changing and increasingly complex environment. The GGP Implementation Work Group (IWG) was established in 2013 and charged with developing an implementation plan for each of the GGP motions approved by Council at its July 2013 meeting.

Visit the following site to learn about the history of the Good Governance Project (GGP) www.apa.org/about/governance/good-governance/index.aspx. A video of President Kaslow can be found on the site along with links to the GGP reports. Here's a direct link to the Final GGP Report released in June 2013: www.apa.org/about/governance/good-governance/final-report.pdf

You are encouraged to view the following video from December 2013 which provides a quick overview of the Good Governance Project: www.youtube.com/watch?v=iiVRBhunavg

Part of the recommendations of the Good Governance Group was the institution of a new role for council and establishment of Clinical Leadership Team (CLT). This was the most hotly debated issue of the COR meeting.

Practice Assessment
As many of you are aware, a settlement has been reached between APA and a group of psychologists who filed suit alleging that the practice assessment fee was inaccurately presented as mandatory for APA membership. The $9.02 million settlement will be paid by the insurance carrier and will reimburse members who have paid their assessment fee since 2001

COR Actions
Council members voted on several matters important to our members and for the way APA functions. Some noteworthy items include overwhelming support for:

- *Competencies for Practicing in Primary Care*, which provides the basic requirements for psychologist who are interested in practicing within primary care settings
- APA will be a data driven organization, meaning that as far as possible decisions will based on relevant empirical data

Strategic Plan
The strategic initiatives plan sets aside $2.1 million for 2012 to fund seven initiatives designed to support and advance APA's three strategic goals: maximizing organizational effectiveness, expanding psychology's role in advancing health, and increasing the recognition of psychology as a science. The seven projects are:

- Improve APA business models, member communications, and the convention to increase member engagement.
- Analyze the psychology work force to meet national needs.
- Continue to develop and promulgate treatment guidelines to promote

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the translation of psychological science into health interventions.

- Continue to expand the APA public education campaign to include the entire discipline of psychology.
- Expand opportunities for graduate education and continued professional development for psychologists and psychology students in order to advance the discipline's participation in interdisciplinary health delivery and interdisciplinary science.
- Increase support for research, training, public education, and interventions that address and reduce health disparities among underserved populations.
- Forge alliances with health-care organizations to increase the number of psychologists working in integrated health-care settings.

Each of the strategic plan initiatives is designed to be a multiyear project. Their progress will be evaluated and further funding provided on a year-by-year basis.

The next Council meeting will be held during the APA Convention in Toronto. As always, we appreciate your feedback and support as the represrentatives of Division 29/SAP.

Cordially yours,

Jean Carter
Jeffrey J. Magnavita
John C. Norcross

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PSYCHOTHERAPY BULLETIN

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

Contributors are invited to send articles (up to 2,250 words), interviews, commentaries, letters to the editor, book reviews, and announcements to Lynett Henderson Metzger, JD, PsyD, Editor, *Psychotherapy Bulletin*. All submissions for *Psychotherapy Bulletin* should be sent electronically to Lynett.HendersonMetzger@du.edu with the subject header line *Psychotherapy Bulletin*; please ensure that articles conform to APA style. If graphics, tables or photos are submitted with articles, they must be of print quality and in high resolution. Deadlines for submission are as follows: February 1 (#1); May 1 (#2); August 1 (#3); November 1 (#4). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.societyforpsychotherapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or the Society should be directed to Tracey Martin at the the Society's Central Office (assnmgmt1@cox.net or 602-363-9211).

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