Psychotherapy

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

www.societyforpsychotherapy.org

BULLETIN

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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

2016 Volume 51, Number 1

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PRESIDENT'S COLUMN

A New Year for Enhancing Old Commitments

Armand R. Cerbone, PhD, ABPP
Chicago, IL

By the time you read this, the New Year will be three months old and we will have met for our first semi-annual business meeting.

I want to wish you health and wealth, however you define them. As your President, I want to make this year one in which you feel more personally and professionally at home in our Division. I know that our Board is committed to enriching the experience for all of us while we go about the business of promoting the advancement of psychotherapy as a profession and discipline.

In this quarter's column I want to mention several new initiatives the Board is undertaking and to provide with the rationale and history behind them.

Expanding International Affairs: A New Domain and a New Bylaw

This past year, under the leadership of then-President Rod Goodyear, the Board has been developing and expanding our international initiatives. Rod Goodyear and Changming Duan's visit to China last year has resulted in ongoing collaboration with Chinese psychologists on education and training. They are working with the APA's Office on International Affairs to develop a memorandum of understanding between our Society and psychologists in China. With the wise guidance and support of Fred Leong, who chairs the International Committee, growth has been such that the Board has agreed it is time to elevate the committee to the status of a Domain. As a Domain, International Affairs can inform our agenda more effectively. In addition, we hope this will encourage the participation of our international members and increase their number and voice in the Division.

Under the leadership of Drs. Fred Leong, Changming Duan, and President-elect Jeff Zimmerman, and Past-president Rod Goodyear, the Society is developing a new and promising collaborative relationship with the World Council on Psychotherapy with our Board's endorsement. The Society is preparing programs for the WCP's meetings in April in Paris, some of which will be related to bringing psychotherapy to underserved populations.

Please note that establishing a new domain requires a change to the bylaws. There is information in this issue of the Bulletin asking, among other things, for you to consider and approve the establishment of an International Domain. Please vote!

There will be several other proposed amendments to the bylaws on the ballot. We encourage you to read them and vote. You may vote using the paper ballot in this issue of the Bulletin, or you may vote immediately on-line at our website: www.societyforpsychotherapy.org

Domain Day: A New Initiative

Prior to the annual midwinter meeting of the Board of Directors and Committee Chairs, the Society held its first Domain Day. All the Domain Representatives participated in a one-day workshop before the full Board convened. The intent was to build a stronger Board that is better able to attend to the needs of our members through the expertise of each elected Representative. In the process the workshop promoted collaborations among Domains to generate creative programs and initiatives that engage

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members and move our mission forward.

A bit of history will help to understand the rationale and purpose of the Domain Day.

Several years ago Jean Carter as President moved to change the structure of the Board. I was Secretary at the time. Then, our Board was organized as many other division boards were, with an executive committee, members-at-large, committee chairs and members. Her suggestion invited us to think outside the box. How could we be more effective? In the course of many discussions and debates, sometimes heated but always frank, respectful, and supportive, we determined that we wanted to increase the number of seats at the table to create more room for new voices and energies.

We also recognized that it would be smart to replace member-at-large seats with Domains. Domains would be specific seats that would represent the Division's several and perennial undertakings. Thus, we created Domains for psychotherapy, scholarship and research, membership, early career psychologists, students, education and training, public policy and social justice, and diversity. Representatives elected to a Domain would be responsible for creating relevant initiatives and recruiting committee members to support those initiatives.

The Domains have been effective in facilitating concentrated work in multiple areas. The Domain Day was planned to take us a step further. We encouraged cross-domain collaborations in such ways that initiatives from one Domain would be informed and supported by the perspectives and resources of one or more others. The expectation is that this will generate more far-reaching and ambitious enterprises.

The Domain Day was staged as a pilot program at the end of which we assessed its success to determine its value before institutionalizing it as an annual event. While the day did not produce the collaborative initiatives we hoped for, all Reps reported that the day built cross-domain relationships that they saw as fundamental to creating shared ventures. When the full Board met the next day, the Board considered the reported experiences and recommendations of the Domain Reps. After thoughtful discussions the Board voted to continue the Domain Day for a three-year trial period. As President, I agreed to encourage further collaborations during the months before our fall meeting in September.

Core Values: Front and Center

The change to Domains made were not conceived as improving Board functioning and inclusiveness only. In a bold stroke, the Board created two Domains for diversity and a Domain for public policy and social justice. During this reconceptualization, the importance of human rights as a core value in psychotherapy emerged as a foundation to our work. Issues like access to appropriate treatment, socioeconomic factors, cultural differences, and competency came into prominent focus as an imperative. To express this in our new structure, we created Domains for diversity, public policy, and social justice. We combined social justice and public policy into one Domain seat but added *two* Domain seats for diversity.

This was important. Diversity as we understand it is itself diverse. People are denied access to psychological services, for instance, for many reasons. The result is always marginalization for one or many personal attributes such as those just mentioned. Having two Diversity Domains communicates not only our *collective* responsibility to uphold human rights but also avoids burdening one Domain Representative from having to represent *all* diversities.

Establishing Domains for diversity and social justice that carry votes rather than committees without votes evidenced to

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all our intent to empower rather than to marginalize as well as our fidelity to our core values.

To that end, the Board has committed to conducting tri-annual diversity trainings. These are day-long workshops led by trained diversity experts. They are educative as well as personally engaging. Staging them once every three years, consistent with our election cycle, guarantees that every Board Member and Committee Chair will participate in a training. Having them once every three years uses our financial resources judiciously. The most recent training was led by Roger Worthington in February 2015. The next will be at the mid-winter meeting in 2018. The assessments following each training have been positive. And each training has been as or more successful than its predecessor.

Last year the training workshop developed a strategic plan for diversity that is meant to dovetail with and inform our research, training, and practice agenda. A significant benefit arising from such workshops are stronger personal ties based on mutual respect and trust. These, in turn, are translating into greater effectiveness and efficiency as a working team.

Membership: A New Investment

Our Society is one of the largest divisions of APA. It remains such because of the continuing commitment of you, our members. That loyalty is much appreciated. This year I hope we can convey our appreciation of your trust and investment in improved member experience. This was a primary objective informing our first Domain Day and is my major presidential initiative.

The winds of change are strong in APA these days. Improving the membership experience is key among the changes needed. To that end, in 2015 APA created a Membership Office with a new staff under a new Director with expertise in professional membership organizations, Ian King. Ian's office is charged with developing visionary programs to enhance membership. Ian is not a psychologist but a membership expert who comes to us with considerable experience with not-for-profit professional organizations like ours. A piece of his vision sees divisions as specialty boutiques offering the rewards and benefits of smaller professional societies. Our Society plans to be part of this vision. We invited Ian to participate in our Domain Day to stimulate the interest and energies of our Board Members in enriching your experience, justifying your loyalty, and boosting our collective commitment for psychotherapy.

As the year progresses, I will keep you informed of our work.

Convention 2016: Science, Sexuality, and Psychotherapy

A brief alert about the APA annual convention in August.

As President, I have the privilege of determining the theme for the Society's call for programs for this year. I chose the intersections of science, sexuality, and psychotherapy. The intent is to encourage an exploration of human sexuality in psychotherapy that is based on evidence from research and practice. Programs have been selected that highlight sexuality in psychotherapy with underserved and under-recognized groups, such as differently-abled persons, and examine human sexuality from different perspectives, e.g., feminism and race. The hope is that the programs will build practice skills as well as generate thoughtful, stimulating discussions. We are seeking Continuing Education credits for many of the programs.

I will provide more details in the next issue of the Bulletin.

A Closing Word

I want you to know I am thankful for the trust you invested in me with your votes two years ago when I ran for office as President-elect. I will do everything I can to keep your trust and hope at the end of my term you will feel that trust justified.

EDITORS' COLUMN

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The Editors of *Psychotherapy Bulletin* would like to wish all of our readers a happy New Year. We know you join us in bidding a fond farewell to those leaving the ranks of governance, and in warmly welcoming those who have taken on new roles. Our deepest thanks to outgoing President Rod Goodyear, the Board members, Domain Representatives, Contributing Editors, and everyone else who worked so hard to make 2015 such a successful year for the Bulletin. We are delighted to welcome Dr. Armand Cerbone as our incoming President, along with a wonderful group of new Society leaders and Bulletin contributors (including our new Editorial Assistant, Elizabeth Coyle, MA, LPC). In this month's President's Column, Dr. Cerbone has outlined a number of exciting new plans and initiatives for the Society in the coming year—we cannot wait to see the great things in store for 2016!

Please read through this issue of the Bulletin for interesting and timely articles, commentary, and student pieces on topics ranging from ethical considerations in Animal Assisted Therapy to cross-cultural competency and best practices in the mental health treatment of Brazilian immigrants. Make sure to check out Dr. Jesse Owen's Education and Training piece on the role of psychotherapists in the training of master's level counselors, including the accompanying Resolution, and do not forget to review the Candidate Statements found in the back of this issue.

As always, check out the Society's website (http://societyforpsychotherapy.org/) for additional content and resources. The next Bulletin deadline is May 1, 2016, and we would love to hear from you! Complete guidelines can be found in the back of this volume or online, and we accept submissions on a rolling basis.

It looks to be a year of possibility, growth, and opportunity for the Society and the Bulletin—we are glad you are a part of it.

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SPECIAL FEATURE

Beyond Acceptance: Promoting Second-Order Change in Families With Lesbian, Gay, and Bisexual Adolescents[1]

Joseph A. Micucci, PhD, ABPP
Chestnut Hill College

While lesbian, gay, and bisexual (LGB) youth are at high risk for emotional and behavioral problems, research has documented that family rejection increases these risks and family acceptance decreases them (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In this article, I will apply concepts from family systems theory to work with families who are struggling with issues related to an adolescent child's sexual minority status. Systems theory considers the ways in which multiple influences on a problem interact with and mediate one another (Guttman, 1991). Problems and symptoms are not considered properties or characteristics of individuals, but rather are embedded in a social network wherein particular modes of interaction become habitual and contribute to instigating problems, exacerbating them, or sustaining them. The emergence of symptoms in a family member points to the presence of flaws in a family's structural organization, or dysfunctional transactional patterns that exist within the family and/or between family members and representatives of larger systems, such as social service agencies.

Although I will focus on LGB youth in this article, many of my remarks will apply to transgender youth as well. However, transgender youth pose specific challenges that require more extensive treatment than space permits. I also recognize some youth refuse to adopt traditional labels, and instead prefer non-traditional labels (e.g., queer). Here I focus on those young people who acknowledge an attraction or sexual desire for members of their own sex. Some of these youths might use traditional labels, and others might not. As in all cases, cultural factors are also important to consider, but space does not permit a thorough examination of these issues in this article.

When an adolescent "comes out" as LGB to a family—whether the disclosure is deliberate and planned, or the family learns indirectly, such as by discovering sexually-oriented material or LGB literature in the child's possession—a crisis may be precipitated, in that the family faces an irrevocable turning point. Some families become preoccupied with the disclosure, while other families attempt to cope by ignoring it. In either case, the relationships between the sexual minority adolescent and the family members become organized around the disclosure, and other aspects of their relationship are neglected; this, in turn, reinforces or intensifies the distance or conflict among them (Micucci, 2009; 2015). All family members, including the LGB adolescent, are actively contributing to this cycle. Moreover, what appears to be a crisis that has been precipitated by the disclosure might not be related solely to the issue of sexual orientation. Weaknesses in family relationships or conflicts in the family that pre-dated the disclosure might inhibit the family from resolving concerns related to the child's sexual minority status. Working to promote second-order change (Hoffman, 1981)—that is, work-

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ing to restructure the family and the processes underlying their interactional patterns—not only can help the family address the immediate crisis of the disclosure, but also could help build greater resilience to crises in the future. While facilitating acceptance is an important goal, a broader focus on the family system can have long-term beneficial effects for all members of the family, including the LGB adolescent.

These ideas are illustrated in the following case. Maureen called to request a joint session with her son, Adam, age 16, who had recently told her he was gay. Although she admitted she initially had difficulty accepting this news, she believed she had come to terms with it. However, she was worried about the reaction of her husband and Adam's father, George, who had vocally expressed anti-gay attitudes in the past. Adam reported a close relationship with his older sister, Erin, a freshman at college four hours away, but had not disclosed his sexual orientation to her. Maureen's extended family also held unaccepting attitudes toward nonheterosexual individuals. Maureen's younger brother came out to the family 15 years ago, whereupon her parents and two older brothers terminated contact with him. Maureen stayed in touch with her brother, but tried to keep this a secret from her family and her husband. In the initial phone call, Maureen reported that Adam asked her not to tell George, as he wanted to tell his father himself and intended to do so within the next few days. Fearing George's reaction, Maureen encouraged Adam to wait before telling his father, and instead come to therapy first.

While Adam's announcement to his mother precipitated a crisis, the effect on the family must be seen in the context of the family's pre-existing structure and dynamics. Adam's disclosure uncovered weaknesses in the family structure (Minuchin, 1974), weaknesses impeding the family's ability to handle crises, such as Adam's coming out. Rather than focusing exclusively on family acceptance of Adam's sexual orientation as the primary goal, the crisis apparently precipitated by Adam's coming out can be an opportunity to help the family make a second-order change by reorganizing into a more functional and resilient structure.

Of course, potential safety issues should be assessed, including any risk Adam may have for depression, suicide, substance use, unsafe sexual behavior, or other concerns. But more can, and should, be done. In terms of family structure, George and Adam have a distant relationship, which is complementary to the close, perhaps enmeshed, relationship between Adam and Maureen. George and Maureen do not appear to have a strong parental alliance, in that Maureen appears to accommodate to George and fears his reaction, should he disagree with her decisions. She rebels stealthily—both against George, by showing support for her son, and against her family of origin, by maintaining contact with her brother.

These structural weaknesses remained unchallenged until exposed by the crisis of Adam's coming out. So, in addition to providing support to Adam and monitoring his risk, interventions to foster second-order change in this family would be beneficial (Minuchin, 1974). Assuming it is physically safe to do so, Maureen must be empowered to address her concerns directly with George; Adam and George need to draw closer, and, in turn, there needs to be more distance in the relationship between Maureen and Adam. Erin's departure from the family has also created a challenge for the family system. Whatever needs

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Erin was meeting for the family members will have to be addressed in other ways. Adam has lost a source of support, and Maureen has lost an ally. Strengthening extra-familial connections can help to provide some compensation for these losses (Minuchin, 1974). While, for Adam's safety, agreeing to keep his sexuality a secret for a short time might be a reasonable compromise, maintaining this secret over the long-term would not be beneficial to the family system. The question is not *whether* to tell George, but *how*. It is important to support Adam's preference to tell his father himself, rather than have Maureen act as his go-between.

In some cases, the family appears to be providing support and acceptance for the child while covertly communicating a prohibition against expressing upsetting feelings. When 17-year-old Toni came out to her parents, they reassured her they still loved her. However, in the weeks following her disclosure, Toni had withdrawn from the family and her parents had grown increasingly concerned. In a family session, Toni tearfully talked about ruining her family's plans for her and "upsetting a happy family life." Her parents were visibly disturbed by her distress, and frantically offered reassurance. But, by working so hard to reassure Toni and not allowing her space to express her feelings, they communicated the message that her discomfort made them uncomfortable. Toni, overly sensitive to parental distress, hid her own discomfort to spare her parents from discomfort. The more her parents anxiously tried to reassure her, the more Toni distanced from them in order to protect them from feeling upset. They were more than willing to accept Toni, but what they could not accept was her own, and their own, ambivalence about her sexuality. In addition to adjusting to Toni's disclosure, this family also needed to increase its tolerance for distress and conflict.

A child's disclosure of an LGB identity might threaten precarious boundaries, alignments, or hierarchy that, until then, had remained untested and unchallenged. In these cases, rather than creating a crisis, the disclosure might uncover one. Families that maintain a strict boundary about talking about sexual topics might find this boundary threatened by the child's disclosure. A tenuous parental hierarchy might be stretched to the breaking point if parents disagree on their reaction to the child's disclosure. A close alignment between a child and a parent might be threatened if the parent is disturbed by the child's disclosure. Sometimes the turmoil surrounding the child's disclosure can provide the family with a distraction from dealing with another stressful issue. For example, a family dealing with the terminal illness of a grandparent might experience temporary reprieve from this potentially devastating loss by focusing on the recent disclosure by a daughter that she is a lesbian. Similarly, a child's coming out that coincides with escalating marital conflict around a father's protracted unemployment can help to deflect attention from other concerns that are more threatening for the family to address directly.

In addition to standard interventions, such as mobilizing support for, and ensuring the safety of, the adolescent, providing educational resources as appropriate, and reminding the family that acceptance can be a gradual process, I advocate the therapist use the crisis apparently precipitated by the child's coming out to help the family make a second-order change, one that will benefit them all because it will make them more resilient to crises in the future. Doing so requires fostering an alliance

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with all family members and avoiding induction into a coalition with the adolescent against the other family members. Sometimes this goal is best accomplished by meeting with individuals or subsystems; at other times, whole family meetings are appropriate. In any case, the goal is the same: helping the family members not only to move beyond the current crisis, but also to improve their capacity to handle future crises.

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] This article was adapted from Micucci, J. (2015, August). Division 43 (Division for Family Psychology), New Fellows Symposium, American Psychological Association Annual Convention, Toronto, Ontario, Canada. All identifying information has been changed to protect client confidentiality.

NOTICE TO READERS

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

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

COMMENTARY

Is Expertise in Psychotherapy a Useful Construct?

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This question was asked by Clara Hill as a moderator for a structured discussion section on expertise in psychotherapy in the last international meeting of the Society for Psychotherapy Research in Philadelphia in June 2015. The background for the discussion was an article by Tracey, Wampold, Lichtenberg, and Goodyear (2014) in which the authors argued that psychotherapy is not a field with any expertise. The article has been followed up by Tracey, Wampold, Goodyear and Lichtenberg (2015). Echoing and extending the critique proposed by Robyn Dawes (1996) in the book *The House of Cards*, the authors argued that there was no relationship between psychotherapists' experience level (defined as number of years in practice) and client outcome. In other words, psychotherapists did not become more effective over time. As a participant in the discussion, I would like to share some perspectives on the issue.

Tracey and collaborators have raised an important issue that deserves the serious attention of everybody involved in the training and provision of mental health services. Not to be misunderstood, they emphasized that their focus was on [characteristics of] the profession, rather than on the identification of expertise in individuals. They suggested the lack of expertise development within the field of psychotherapy could be attributed to the lack of information available to therapists regarding the outcomes of their interventions, to the difficulty in using the information that does exist, and also to the lack of adequate models about how psychotherapy produces client change.

In their discussion of the concept of expertise, Tracey et al. (2014) suggested three ways to define or understand expertise—by *reputation*, by *performance*, and by *client outcome*—and discussed the limitations of each. The authors discarded the first two as relevant definitions, and stated that, in spite of limitations, client outcome is the preferred criterion in their view.

To answer the question of whether expertise is a useful construct for psychotherapy, it is necessary to define both expertise and psychotherapy. Conceptually, to define expertise only by reputation confuses *where to look* to locate expertise with *outcome* and the *performance* associated with expert behavior. So, although expertise should not be defined by reputation, it can be considered a *search tool*, albeit an imperfect one, for expertise. This approach has been successfully applied to the study of master therapists (e.g., Jennings & Skovholt, 1999; Jennings, Skovholt, Goh, & Lian, 2013). Defining expertise solely by outcome has limitations similar to those found in the early phase of psychotherapy research, when only input and output data were analyzed in pre-post research designs, thus providing limited or no knowledge of what takes place during psychotherapy.

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I share the view suggested by Tracey and his collaborators that client outcome, in spite of its limitations, is probably the best criterion for expertise. However, contrary to what they suggest, I believe the construct of expertise needs to be supplemented with what therapists do (i.e., performance) to give it substance. As they also recognized, performance criteria are complex, difficult to define and assess, and hard to aggregate into an indicator of expertise. Nevertheless, we need to take on the task of overcoming these challenges in order to arrive at a comprehensive and in-depth understanding of expertise.

To do so, we also need to keep in mind that the arguments proposed in the debates on expertise are embedded not only within theoretical frameworks (i.e., theories of psychotherapy), but also within explicitly or implicitly articulated epistemological frameworks. This becomes evident in the authors' extensive reference to an earlier published critique of psychotherapy launched by James Shanteau (1992) and followed up by Shanteau and Weiss (2014). I will argue that Shanteau's conception of expertise cannot be applied to psychotherapy. It is epistemologically inconsistent to do so. Also, to limit the discussion of expertise to Shanteau's (1992) conception of expertise is to restrict what can be discussed and observed, thereby limiting the lenses through which the phenomenon of expertise can be studied.

Two of the task characteristics Shanteau found to be associated with good performance (e.g., represented by astronomers, chess masters, physicists, and grain inspectors) were: 1) *that stimuli are relatively constant,* and 2) that *repetitive or similar conditions arise over time.* Neither of these are relevant descriptions of psychotherapy unless you see psychotherapy within a traditional medical model conception (i.e., where you as a therapist, a subject, provides or administers a treatment to a client, as an object). However, if you view psychotherapy as a continually changing interpersonal enterprise where meaning making subjects (not subjects/objects) interact and where processes and directions continually vary, these task characteristics can never apply. They belong to an epistemological universe that implies an objectivation of the client and suggests clients with similar diagnoses are equivalent on all parameters that may impact outcome. Therefore, to my understanding, Shanteau's conception of task characteristics associated with expertise is mostly (or possibly only) relevant for understanding how people relate to inanimate objects, and not relevant to understanding how people (i.e., therapists) relate to other people (i.e., clients) as subjects.

Back to the question of whether expertise is a useful construct in psychotherapy: The answer is yes and no. As suggested above, it depends on how we define expertise, and also how we define psychotherapy. If we define expertise the way Shanteau does, and only in terms of client outcome, it is not a useful construct, as it provides no information that can be applied in the understanding of what contributes to good outcome; neither can it be applied to draw implications for training or practice.

However, expertise is a useful construct if we define it in terms of nuanced and rich descriptions of performances of those psychotherapists who are more likely than others to obtain good results (particularly lasting good results) with their clients across a variety of client problems. That was the aim in a study of highly reputable and experienced psychotherapists (the criterion of reputation), who were also psychotherapy teachers (Rønnestad et al., 2014). In this

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"treatment as usual" study of private practitioners, client dropout rate was low and preliminary results suggest that good client outcome was maintained and continued to improve three to four years post-therapy. The significant effect size (Cohen´s *d)* of change on OQ-45 from initial assessment to assessment three to four years post-therapy was 1.45. Low drop-out rate and extending client outcome to include enduring client outcome (i.e., outcomes that are maintained for some defined follow-up period) could be considered as additional criteria for expertise.

Given the good client-outcome of the above study, the results suggest the following task characteristics as empirically-supported candidates for a concept of expertise in psychotherapy: (1) the ability to engage clients in a collaborative relationship, which finds its expression in a high client-rated working alliance (Oddli & Rønnestad, 2002; Rønnestad et al., 2014)**;** (2) a high degree of variability in client-assessed changes and change processes (Ekroll & Rønnestad, 2016), which suggests that expert therapists have available to them and use a broad range of strategies to assist their clients; (3) psychotherapists' use of forward-driven strategies, context-sensitive decisions, implicit and intuitive processes, and engagement in therapist/client interactions characterized by flexibility and moment-to-moment adjustments to the non-linearity of psychotherapy processes (Oddli & Halvorsen, 2014; Oddli, Halvorsen, & Rønnestad, 2014; Oddli, McLeod, Reichelt, & Rønnestad, 2014); (4) the ability to work efficiently with "difficult to treat clients," which requires psychotherapists to maintain a therapeutic attitude and not be drawn into dysfunctional patterns of interaction, but rather invite clients into a reciprocal, resource-focused change project, while consistently expressing sensitivity to the client's agenda (von der Lippe, Oddli, & Halvorsen, 2014); (5) psychotherapists' deep engagement in the client's welfare, willingness and capacity to confront the client's dysfunctional behavior, maintenance of optimism and a resource-focus while also being playful (Råbu, Halvorsen, & Haavind, 2011); and (6) psychotherapists' careful attention to, and skillful handling of, the termination process (Råbu, Binder, & Haavind, 2013; Råbu, Haavind, & Bindner, 2013).

As a conclusion, and with reference to the perspectives and results presented above, the following recommendations are made to advance the knowledge of expertise in psychotherapy: 1) Studies should be designed to enable careful and in-depth quantitative and qualitative analyses of *performances* of therapists' who obtain exceptionally *good client outcomes*; 2) *Reputation* of psychotherapists is one option to locate these psychotherapists; 3) Designs should include frequent measurements of processes and outcomes (including micro-outcomes), enabling assessments from different observational perspectives (i.e., from clients, psychotherapists, and external observers) and analyses from different theoretical perspectives, as well as frequent registration of life events, both during therapy and in the follow-up period; and 4) The timeframe of studies should be sufficient to enable assessment of long-term outcome. By doing so, we may reach a conception of expertise that is rich, complex, and nuanced, and from which we can draw implications for training and 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.

PSYCHOTHERAPY RESEARCH[1]

What About the Words? Natural Language Processing in Psychotherapy

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> By 'augmenting human intellect' we mean increasing the capability…to approach a complex problem situation…a way of life in an integrated domain where hunches, cut-and-dry, intangibles, and the human 'feel for a situation' usefully co-exist with powerful concepts, streamlined terminology and notation, sophisticated methods, and high-powered electronic aids. (Engelbart, 1962/2001, p.1)

Psychotherapy is certainly a complex situation, represented by the manifold of words, sounds, facial expressions, and body movements a therapist and client may present during a session. To help clients, therapists rely on their own skill and training to manage a series of psychological processes that occur during a session—often isolated in their counsel-

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ing rooms with little external support (Miller, Sorensen, Selzer, & Brigham, 2006). Psychotherapists find themselves confronting concerns about variability in quality of care (Institute of Medicine, 2015), whether therapists improve with experience (Goldberg et al., 2016; Tracey, Wampold, Lichtenberg, & Goodyear, 2014), and the decline of psychotherapy as a percentage of mental health care (Olfson et al., 2002). Indeed, a recent article in Science Magazine questioned whether humans make good therapists at all, raising the specter that emerging natural language processing (NLP) technologies may one day improve upon and replace human therapists with computers (Bohannon, 2015)—a worrisome thought, but unlikely to occur anytime soon (Barrett & Gershkovich, 2014).

The most successful technological innovations in computer science are not those in which humans are replaced entirely, but instead involve the augmentation of human ability (Isaacson, 2014; Narayanan & Georgiou, 2013). However, since the 1940s and Carl Rogers' first recording of a psychotherapy session, little has changed in the evaluation of psychotherapy. Patients fill out self-report surveys and, at times, human coders are trained to rate therapy sessions, assessing adherence or competence in the use of a particular treatment (Imel, Steyvers, & Atkins, 2014). The practice of coding a psychotherapy session involves significant resources, including the cost of training and maintaining reliability amongst a team of coders assessing for theoretically driven criteria. Thus, outside of well-funded research settings, direct observation of psychotherapy is rare and often unfeasible.

But 70 years after Rogers' first recordings, and 50 years since Engelbart's seminal paper quoted above, we are on the cusp of major advances in psychotherapy research and delivery. New methods are being developed that allow researchers to model the linguistic and semantic raw data of psychotherapy, which may improve both the specificity and scale of research on how treatments work. This work may generate new approaches to providing process feedback to therapists. Indeed, rather than replace humans, technology may soon make it possible to provide therapists and patients rapid, objective feedback on treatment, and conduct large-scale mechanism analyses of data from thousands—and eventually millions—of therapy sessions.

What Is Natural Language Processing?

NLP is a subfield of computer science and machine learning where the goal is to "learn, understand, and produce human language content" (Hirschberg & Manning, 2015, p. 261). In essence, NLP methods take large collections of unstructured text as inputs and generate more useful information. For example, NLP might use transcripts from psychotherapy sessions to help answer questions like: "What were they talking about?," "Is this person depressed?," or "Is this therapist empathic?" With NLP, large text corpora, that were previously unusable without human interpretation and judgment, become accessible rich data sources. Some of the recent successes of NLP include sentiment analysis: NLP models can now identify whether complicated statements are positive or negative, almost as well as humans (Socher et al., 2013). These models can detect whether sentences are paraphrases of each other, and can translate between different languages (Socher, Huang, Pennington, Ng, & Manning, 2011; Bahdanau, Cho, & Bengio, 2015). NLP models can summarize large documents and classify the topic of an article (Stevyers & Griffiths, 2007), or identify

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authorship (Pearl & Steyvers, 2012; Zhao & Zobel, 2005). More recent NLP models attempt to produce language and dialogue (Vinyals & Le, 2015). In mental health, researchers have made progress toward using individuals' Twitter feeds to identify those who are depressed or later go on to be diagnosed with schizophrenia (Mitchell, Hollingshead & Coppersmith, 2015; Mowery, Way, Bryan & Conway, 2015).

Psychotherapy and NLP

Psychotherapy typically involves a conversation, and conversations contain an abundance of words. A typical 50-minute session may include about 12,000 to 15,000 words (Lord et al., 2015). In a small clinical trial (say 10 sessions x 20 patients) there could be 2.7 million spoken words. Thus, similar to other large text corpora, NLP provides a platform to analyze this text, using methods that do not rely solely on labor intensive human coding. Below, we describe several examples from our own work, and several from others, in which NLP methods are utilized to evaluate psychotherapy, including: a) testing theoretical models of emotional/relational processes; b) exploring content and symptoms discussed; c) categorizing treatment and utterance level coding of provider fidelity to treatments; and d) fully automatic rating and feedback to providers directly from session audio.

Relational/emotional processes. A primary focus of the early use of NLP methods in psychotherapy has been to evaluate complex relational/emotional processes (e.g., empathy) using the words from treatment sessions. Much of this work has involved the use of computerized dictionaries that place specific words in psychologically meaningful categories (e.g., emotion words, reflecting or experiencing; e.g., Mergenthaler, 2008). For example, Anderson and colleagues (1999) found that when the patient used more emotion words, therapists obtained better outcomes when minimizing responses with cognitively geared verbs (e.g., think, believe, know). Using a similar technology, Mergenthaler and colleagues have assessed temporal trends in emotional tone (i.e., words that indicate emotional relevant language) and abstraction (i.e., "conceptual language") across the course of a therapy session (Buchheim & Mergenthaler, 2000; Mergenthaler, 2008, p. 113; Mergenthaler, 1996).

More recently, we tested a hypothesis about the development of empathic synchrony (Preston & de Waal, 2002), using therapist and client linguistic style synchrony (LSS) in neighboring talk turns (here LSS implies a matching of specific word tokens in therapist-client phrases). LSS was significantly higher in sessions rated by humans as high versus low empathy (Lord, Sheng, Imel, Baer, & Atkins, 2015). However, as the categories in these NLP programs are defined by humans, a primary limitation is that the computer cannot "learn" underlying structure from the data. For example, these models can struggle with polysemy (i.e., words can have multiple meanings depending on context), and thus the word "like" may erroneously fall into a positive emotion category, when it is being used as filler in the sentence (e.g., "Like, how are you doing?").

Exploring content and classifying interventions. As human methods for examining the content of psychotherapy are so labor intensive, it is relatively rare to conduct large scale explorations of what therapists and clients talk about. In a more recent study, we used an NLP method called a topic model (Steyvers & Griffiths, 2007) to classify the content of 1,533 psychotherapy or pharmacotherapy session transcripts—1.2 million

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words and 223,000 patient-therapist talk turns (Imel, Steyvers, & Atkins, 2014; see Atkins et al., 2012 for a tutorial on topic models and a similar example in couples therapy). The model identified specific semantically relevant topics (e.g., the topic "depression" included word tokens, such as self, fine, sad, hopeless, appetite, helpless, and esteem). We were able to use these session level topic labels to identify specific talk turns where that topic occurred (Gaut, Steyvers, Imel, Atkins, & Smyth, 2015). In addition, we used a "labeled" topic model (i.e., a semi-supervised topic model; Rubin, Chambers, Smyth, & Steyvers, 2012) to learn the language associated with a particular therapeutic label. For example, the following was predicted to be an utterance related to Cognitive Behavioral Therapy (CBT): "To succeed. That is kind of your main or irrational belief. 'I should not have to work as hard as other people to succeed.'" The model also automatically assigned sessions to one of four types of treatment (i.e., CBT, Humanistic/Experiential, Psychodynamic, and Medication Management) with high accuracy (Imel et al., 2014).

Utterance Level Coding of Transcripts

Perhaps the most time demanding task in coding psychotherapy sessions is the painstaking process of assigning unique labels to each and every utterance that occurs in a session—essentially reducing the mass of words in a transcript to a reduced set of psychologically meaningful labels. For example, a recent meta-analysis (Magill et al., 2014) of the literature focusing on treatment mechanisms in Motivational Interviewing (MI;) included 0.3% of MI sessions included in clinical trials (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). A major focus of our team's work has been to train various NLP models to annotate transcripts based on the words in a therapist or client utterance. In an initial paper, we used a version of the topic model noted above to predict utterance level Motivational Interviewing Skills Codes (MISC; Miller, Moyers, Ernst, & Amrhein, 2008; e.g., reflections, questions, etc.) in 155 MI sessions (Atkins, Steyvers, Imel, & Smyth, 2014). In a larger follow-up study ($n = 341$ sessions; 78,977 patient-provider talk turns), we used other text-based models that considered the syntax and semantics of a statement [i.e., (a) discrete sentence features and (b) recursive neural networks; Tanana, Hallgren, Imel, Atkins & Srikumar, in press]. We identified closed and open questions, simple and complex reflections, affirmations, and giving information behavioral codes as well or better than human coders (see http://sri.utah.edu/psychtest/ for testing the models on your own text and correct errors; Tanana et al., in press).

From sound to codes. A limitation of the above NLP work is that the models require transcripts, limiting the potential of NLP models to scale up to larger tasks. Automatic speech recognition (ASR; the technology used in applications like Siri or Cortana) is a method where a speech recognition system transcribes spoken content (see Hinton et al., 2012, for a recent implementation). In a fully automated system that combined ASR with an NLP prediction model for therapist empathy, we found computer based empathy ratings starting from audio recordings were strongly correlated ($r = 0.62$) with observed, human-rated sessions (Xiao, Imel, Georgiou, Atkins & Narayanan, 2015). In a follow-up using the same algorithm, we role-played 20 MI sessions in the lab. These sessions were split between "good" and "bad" MI therapy conditions, where the counselors in the former condition intentionally emphasized MI adherent counseling skills and the latter emphasized MI non-adherent skills (see Figure

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1). Even in this new data, human and machine scores were strongly correlated ($r = 0.61$), and machine-generated scores were clearly differentiated across the two therapy role play conditions, $t(18) = 6.2$, $p < .001$, $d = 2.9$ (see Xiao, Huang, Imel, Atkins, Georgiou, & Narayanan, under review, for a more detailed technical description of the system).

Figure 1: Human Versus Machine Empathy Ratings

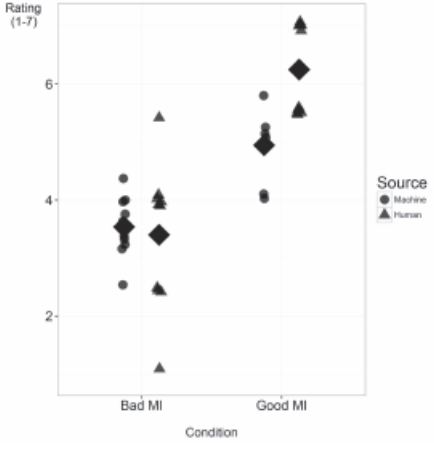

Figure 1. A comparison of human versus machine empathy ratings of 20 role-played "good" and "bad" MI therapy sessions. The machine ratings are represented by circles and the human ratings by triangles. Each circle or triangle is a single session rating. The diamonds represent the mean rating for each category.

The Future

In this brief review, we have focused on one technical solution to a problem that limits progress in psychotherapy science and practice—namely a need for scalable tools that can evaluate what occurs during the treatment hour. At present we are beginning a National Institute of Health (NIH) funded usability study that uses the "sound to codes" infrastructure highlighted above, to provide rapid feedback to counselors on their use of MI. The provider feedback is a web-based tool with ratings on standard MI fidelity measures (e.g., empathy and reflections), but will also include a detailed session view in which the counselor can examine ASR-generated text from the entire session and associated behavioral codes, changes in emotional arousal, and talk time. Of course, this work need not be focused on MI, and we hope it will soon be adapted to a variety of interventions and contexts.

In the last decade, we have seen a revolution in the use of practice-based evidence in psychotherapy. As soon as it became possible to measure client outcomes in large-scale databases, it also became possible to study variability in dosage, response, and therapist-to-therapist variability (e.g., Stiles, Barkham, Wheeler, 2015; Wampold & Brown, 2005). However, that data leaves us wondering why some therapists are "good" and why others are "bad." ASR and NLP tools provide the framework to understand critically important psychotherapy processes on a previously impossible scale. A future possibility is that NLP modeling could focus on outcomes (rather than treatments), and attempt to identify the linguistic features of treatments characterized by "good" and "bad" treatment outcomes. These results could inform practice and generate feedback to therapists. As such, this technology may open the door to explore the use of highly detailed, practice-based evidence to inform evidence-based practice. It is our hope that this sort of detailed feedback could one day be available to individual therapists to promote reflective practice and facilitate ongoing development of expertise, ultimately reducing the suffering of the patients we aim to help.

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

EDUCATION AND TRAINING

The Role of Psychotherapists in the Training of Master's Level Counselors

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The landscape of higher education is definitely shifting (e.g., higher tuition costs, increase reliance on adjuncts for teaching). Along with these shifts, we have seen the rise and influence of accrediting bodies in the execution of mental health graduate programs. Indeed, there are a number of professions training graduate students to conduct psychotherapy, such as psychologists, professional counselors, social workers, marriage and family therapists, addiction counselors, school counselors, and psychiatry, to name a few. Accompanying these professions are their accreditation boards/commissions overseeing the standards of each profession. Additionally, there are licensing boards ensuring professionals have met the necessary and sufficient requirements to obtain a license to practice. I believe accreditation can be a positive force in the training of mental health providers. However, there is also a shadow to this process, which, if not attended to and challenged, can create undo divisiveness among professionals who, on many levels, have a common goal.

Regarding the Society for the Advancement of Psychotherapy (SAP), I believe we would be wise to open our hearts and minds to possibly building bridges, forging new initiatives, and honoring the unique perspectives among professions training students in psychotherapy. For those who engage in psychotherapy, conduct research on psychotherapy, and train/supervise those who are providing psychotherapy, we have a common mission—regardless of professional identity (e.g., professional counselor, psychologist, social worker). For instance, there are no clear and consistent findings demonstrating one profession has better psychotherapy outcomes, compared to others (e.g., Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2015; Okiishi et al., 2006). This is not to say there are not differences among the professions; there can be both within- and between-group differences. However, there have not been clear and consistent differences in psychotherapy outcomes, and there are slim differences in the core definitions between professionals. For example, the definitional foundations of what constitutes a professional counselor from a counseling psychologist are notably similar. They both share a focus on vocational work, multiculturalism, social justice, counseling, supervision, and development. I would argue that other professions also share in these identities. Clearly, there are similarities and differences within and between our professions. Yet, if those similarities and differences *are honored and respected,* that process can be a source of richness, growth, and development.

Why a Training Resolution?

Before describing the training resolution, it would be useful to provide some background for why I decided to get involved in this endeavor. First, I believe

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professionals should be judged according to their professional acumen, not a degree. For instance, Dr. A. T. Beck was trained as a psychiatrist. It would be hard to imagine that any training program would not hire him to train the next generation of mental health professionals. However, due to the mandates in some accreditation rules/policies, this could not happen. Some of the most foremost scholars and theorists in *all* of our fields would not be considered for core faculty positions in some programs due to their terminal degree—regardless of what they have accomplished, or whether the programs themselves utilize information from those theorists to train their students.

Second, my hope is to bring down the walls between the professions. If we do not unify among those who provide psychotherapy, then there will be further fractioning, which will leave each profession advocating for its own special interests. Many fields are moving toward a competency-based approach for training (Falender et al., 2004). Yet, competence is not a static state. As psychotherapists, we need to continue demonstrating effectiveness, and failure to do so for any professional should be addressed. Let us stop conflating education level, experience, competence, and effectiveness. If research findings have not provided a clear and consistent relationship between these factors, we need to take a step back to consider what truly constitutes expertise in psychotherapy (Anderson et al., 2015; Goldberg et al., 2016). Consider the following example to illustrate the difficulty in answering this question: Do Socratic questions have a differential impact when delivered by a psychologist versus a social worker? This seems a fool's errand, but could be a logical examination of psychotherapy, if we wanted to demonstrate differences among our professions. What would we gain by this approach? Simply, when it comes to doing the same task (e.g., psychotherapy), why should different professions be privileged or disadvantaged based on the degree conferred? Especially, when there is no consistent or meaningful evidence demonstrating an advantage of one profession over another in this domain. Are we not supposed to use empirical evidence to guide our decisions? Or is that only when the evidence fits our ideological pursuits? There needs to be a new way to understand therapist expertise, especially across disciplines.

Overlap

There has been a growing division between American Psychological Association (APA) and American Counseling Association (ACA). To overly simplify matters (due to space), over the decades, APA commonly has asserted the profession of psychology is within the domain of psychologists (assuming doctoral level professionals in psychology; APA, 2016). ACA declared the profession of counseling is within the domain of professional counselors (assuming master's level professional counselors and doctoral level professional counselors; see CACREP, 2015). Note the difference in the terms of psychology and counseling. I am not sure we will ever fully disentangle these concepts. However, if we try to do so, it will likely draw bigger lines between colleagues and professions in ways that are both unnecessary and divisive.

I have taught in both psychology and counseling programs and there is much overlap. For instance, the foundational theories for the practice of psychotherapy are consistent between programs and the empirical studies supporting practice are from the same literature pool. In my opinion, APA (as an organization) has never truly embraced our master's level colleagues, even though

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many of its members spend countless hours training master's level professional counselors and other master's level mental health practitioners. In many ways, APA may have cast the first (of many) stones in this situation. At the same time, ACA is not innocent in this regard either. For instance, ACA as an organization supports CACREP (Council for Accreditation of Counseling and Related Educational Programs) accreditation as the only accreditation body to train professional counselors (even though there is another viable accreditation body for professional counselors). To this day, the Society for the Advancement of Psychotherapy (SAP) does not have a specific domain for professional counselors, or any other master's level practitioner conducting psychotherapy. We, too, have room to grow.

Main Issues

To provide a brief background on the main issues behind this resolution, let me start with the CACREP accreditation policies. CACREP is a driving force in the accreditation of master's level programs training professional counselors. In ACA's latest accreditation policies, there is strict language declaring core faculty must have a doctoral degree in Counselor Education and Supervision (CACREP, 2015). Accordingly, this policy would exclude counseling psychologists, clinical psychologists, social workers, psychiatrists, etc., from being hired as a core faculty in a CACREP accredited program. There is also a grandperson clause exempting core faculty who taught in counseling programs prior to 2013 (CACREP, 2015).

The faculty qualifications for core faculty are even more problematic for our international colleagues, who may not have the degree of Counselor Education and Supervision in their respective countries. They, too, would be ineligible for hire into a CACREP accredited program as a core faculty member, sending a clear message to the international community regarding its status in ACA and CACREP. Consistent with my position above regarding my psychiatrist colleague, CACREP policies do not seem to have much empirical backing or flexibility for exceptions. For instance, there are some master's programs in clinical mental health preparing students to be licensed professional counselors, and those students consistently score above the national average and above the average for CACREP programs on the National Counselor Exam (NCE), which is utilized for licensure (similar to the EPPP for psychologists). For some of these programs, none of the core faculty graduated from a Counselor Education and Supervision program. However, they are obviously providing quality preparation for their students' professional futures on this metric (as well as many other program outcome metrics).

The situation gets more complex. CACREP members have been supporting efforts to change licensure laws to have only those individuals who graduate from a CACREP program be eligible for licensure as a professional counselor. These efforts have been successful in some states (e.g., Ohio, Kentucky). Accordingly, in combination, if CACREP-only licensure laws for professional counselors are enacted, then colleges and universities will need to have CACREP master's level programs—and core faculty positions in those academic programs are restricted to only those who graduate with a doctoral degree in Counselor Education and Supervision (with the exception of the grand-person clause).

The Training Resolution Initiative

Given my comments above about how I believe we have moved away from a more evidence-based and personalized view of expertise, I decided to act upon

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SAP members, as their Training and Education representative (2012-2015). Consequently, I authored a resolution so we, SAP (Division 29), can clarify our beliefs about training master's level professionals (see below).

The SAP Board voted to approve this resolution (see below). Additionally, the Boards of Divisions/Societies 17, 22, 35, 43, and 49 have also endorsed this resolution. There are other divisions/societies currently reviewing this initiative.

This is a first step in the conversation. Training future psychotherapists is an important topic. At the same time, I believe we also need to support our colleagues in their independent practices. In regard to professional counselors, we

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

Resolution: *#2917*
Subject: *Inclusive Training of Master's Level Counselors and Related Licensed Professionals by Trained Psychologists and Other Mental Health Professionals (e.g., Social Workers, Counselors, Psychiatrists, Marriage and Family Therapists)*

WHEREAS, *Trained Psychologists and Other Mental Health Professionals (e.g., Social Workers, Counselors, Psychiatrists, Marriage and Family Therapists) have an important and vital role in training Master's level counselors and related licensed professionals,*

WHEREAS, *Trained Psychologists and Other Mental Health Professionals (e.g., Social Workers, Counselors, Psychiatrists, Marriage and Family Therapists) have shaped the nature of training of Master's level counselors and related licensed professionals,*

WHEREAS, *Trained Psychologists and Other Mental Health Professionals (e.g., Social Workers, Counselors, Psychiatrists, Marriage and Family Therapists) affirm inclusivity in training to those from a variety of professional backgrounds and nationalities,*

RESOLVED, *That the Society for the Advancement of Psychotherapy (Division 29, APA), fully support the role of Trained Psychologists and Other Licensed Mental Health Professionals (e.g., Social Workers, Counselors, Psychiatrists, Marriage and Family Therapists) in the training and education of Master's level counselors and related licensed professionals,*

RESOLVED, *That the Society for the Advancement of Psychotherapy (Division 29, APA), cannot support any efforts or programs that limit core faculty or supervisors to only those from one designated training/professional background (e.g., Counselor Educators, Counseling Psychologists, Psychiatrists, Clinical Psychologists, Social Workers).*

Submitted by: *Jesse Owen, PhD, Training & Education Domain Representative*

Supported by: APA Divisions: 17, 22, 29, 35, 43, 49

train them to be licensed professional counselors who can practice independently. We should support those efforts in a more active and supportive manner.

Here is an initial list of efforts I believe APA and its divisions/societies should embrace:

- Develop relationships with master's level professionals from other disciplines (e.g., professional counselors, social workers, marriage and family therapists).
- Develop strategies for recruitment of master's level professionals (i.e., outreach for identifying individuals who would like to join APA and/or its divisions/societies), based on their needs and alignment with the division/society's mission. (Note, some colleagues may not want anything to do with APA or its divisions/societies, which is completely understandable). If we are to welcome new colleagues to the table, it may be useful to have a specific domain within divisions/societies to have a true home for our colleagues. For instance, SAP does allow master's level professionals to join our division.
- APA and its divisions/societies need to publically endorse psychotherapy practice at the master's level. We train master's level practitioners to provide services independently, and this resolution supports our efforts to this end. However, it is hypocritical to support efforts to train master's level professionals to practice independently, and then not support their independent practice of psychotherapy. This must change, providing an opportunity to build bridges.

Conclusion

In closing, I hope my efforts are not misconstrued. Do I like what CACREP is trying to do with CACREP-only language for licensure laws, and the support they received from ACA? Absolutely not. At the same time, I am not a member of those communities. If CACREP and ACA governance want to continue down this current path, with member support, that is their right. At the same time, we (especially SAP) can be an alternative, as we share in a common mission—psychotherapy. I am not trying to change ACA or CACREP. I am trying to encourage APA and its divisions/societies to be inclusive of our master's level colleagues. We have an opportunity to be a home for many professional counselors and master's level practitioners who do psychotherapy. Many of these individuals do not stand united with those who preach divisiveness. We have our own work to do at APA. We can do better, and we need to do better.

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

NOTICE TO READERS

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

PSYCHOTHERAPY PRACTICE

Practice Oriented Research: Clinical Implications and Benefits

Soo Jeong Youn, MS
Henry Xiao, MS
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The practice of psychotherapy is not an easy task. Many psychotherapists are balancing multiple responsibilities and roles at any given moment. As clinicians, they have to conduct assessments, develop case conceptualizations and treatment plans, relate to their patients therapeutically, and deliver interventions effectively. As mental health providers, they have to find time to manage responsibilities such as paperwork and documentation, communication and coordination of care, and insurance issues. When dealing with these competing demands, therapists generally resort to knowledge and expertise derived from their own training, clinical experience, colleagues, and supervisors—and, much less so, to research. There is a well-recognized divide between research and clinical practice, and many psychotherapists do not rely substantially on empirical results in their clinical practice (Castonguay, Youn, Xiao, Muran, & Barber, 2015). For many clinicians, these findings are viewed as not applicable to the everyday clinical reality (Castonguay, Locke, & Hayes, 2011).

One way to address the gap between science and practice is through practice-oriented research (POR), a bottom-up approach that encourages a sense of joint ownership, mutual collaboration, and respect between researchers and clinicians when conducting psychotherapy research, so that it is clinically informative and scientifically rigorous (Castonguay, Barkham, Lutz, & McAleavey, 2013). In POR, practitioners, in collaboration with researchers, can be actively involved in all aspects of research, including the design and implementation of research protocols, collection of data, analysis, and dissemination of results. By emerging from, and taking place in, the setting in which therapists practice their clinical work, POR is a way to "confound" research and practice (Castonguay, 2011) by involving specific tasks that simultaneously meet both research and clinical purposes. At a broader level, because it is based on complementary expertise, POR allows for innovative methods of conducting psychotherapy research that embed and enhance the vision of both researchers and clinicians.

A variety of POR studies have already been conducted in different naturalistic settings across the world and have addressed several topics, such as the effectiveness of psychotherapy, client and therapist characteristics, utilization of services, process studies, including the therapeutic alliance and principles of

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change, as well as supervision and training initiatives (Castonguay et al., 2015). The patient-focused approach has been a particular focus of naturalistic research. It involves the careful assessment and tracking of patients' progress over the course of treatment, using standardized outcome measures, and providing clinically relevant feedback to therapists that can be useful to their practice (Boswell, Kraus, Miller, & Lambert, 2015). This type of research aims to provide clinicians with tools that can be used to augment clinical decision making with results that are directly applicable to day-to-day practice.

How Can Outcome Monitoring Inform Clinical Practice?

Drapeau (2012) has identified 10 different measures/systems developed to track mental health change in routine care, each with its own strengths and limitations. Regardless of the system used, the most common use of outcome monitoring has been to track symptomatology change. By administering an outcome measure pre- and post-treatment, clinicians can have access to data from the client to supplement their clinical judgment as to when to conclude treatment. Outcome monitoring can also provide more frequent information regarding the patient's progress when administered at shorter intervals, such as after each session. Not only can this information be helpful for therapists in terms of treatment planning and implementation, it can also serve as a powerful tool for patients to have information regarding their own improvement—which can further improve the therapeutic alliance, as well as their adherence to and belief in treatment (Youn, Kraus, & Castonguay, 2012).

Regularly monitoring outcomes can also aid therapists in detecting when patients are "off-track" in their treatment. For example, if clinicians are alerted to the fact that a patient's progress is slower than expected when compared to other patients who shared similar demographics and initial severity status, they can use this information to inform treatment, discuss it with the patient, and/or seek supervision. Additionally, some feedback systems have also shown to accurately predict potential treatment failure, risk of hospitalization, or other negative outcomes, such as drop-out (Boswell, et al., 2015; Xiao et al., 2013). It is difficult for psychotherapists to predict who will deteriorate or be at risk for experiencing negative outcomes during treatment (Lambert, 2010). Therefore, clinical tools that can aid judgment and decision making surrounding this type of care for patients can help to intervene effectively, while reducing the probability of premature termination or harm during treatment.

In addition to tracking symptomatology change, the inclusion of standardized outcome measures in routine care can serve a diverse range of clinical functions. For example, for various reasons, such as embarrassment, ambivalence about areas of distress, or unawareness, patients may be reluctant to verbally discuss or bring up difficulties with psychotherapists during session. In these situations, outcome measures can provide alternative communication outlets through which patients express distress to their providers (Youn, Kraus, & Castonguay, 2012; Youn et al., 2015). Additionally, ongoing assessments can provide clients feedback about their progress, which can also be discussed with providers in relation to treatment goals and various clinical interventions, such as development of new perspective of self. For example, seeing improvements in outcome scores, or areas of strength if using a multidimensional outcome measure, can help clients increase their sense of agency in their de-

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velopment, as well as highlight positive attributes (Youn et al., 2015).

Challenges Conducting Practice Oriented Research

As is the case with the implementation of any kind of research, a number of obstacles and challenges have been identified when trying to build clinician-researcher partnerships, as well as conducting POR (Castonguay et al., 2013). One of the biggest challenges is encountered when POR is perceived as irrelevant, or even hindering the clinical work. For example, from the practitioners' perspective, if outcome monitoring is viewed as impeding the therapeutic relationship, increasing client resistance, or resulting in negative evaluation of services (and potentially decreasing referrals or income), then the likelihood that the research is actually conducted in clinical practice decreases substantially (Boswell et al., 2015; Fernández-Álvarez, Gómez, & García, 2015; Holmqvist, Philips, & Barkham, 2015; Strauss et al., 2015). Additionally, as is the case with any partnership, problems of collaboration and communication can impact the sense of shared ownership that is the backbone of all POR (Castonguay et al., 2015). Last but not least, there are pragmatic obstacles, such as availability of time, staff, and resources to implement the research procedures, especially if there are incompatibilities between research and clinical tasks.

Benefits of Conducting POR

Despite some of the challenges in conducting research in private practice, clinicians have reported benefits in conducting POR. For example, some therapists have found it professionally validating to investigate phenomena that occur in their day-to-day routine (Koerner & Castonguay, 2015). Clients have reported experiencing a feeling of pride in their contribution to projects that increase our understanding of psychotherapy (Castonguay, Nelson et al., 2010). The implementation of different research protocols can also lead to immediately useful clinical information. For example, clients' feedback about helpful and hindering events in session has allowed clinicians to be more attuned to their clinical needs while also collecting research data (Castonguay, Boswell et al., 2010). Training studies provide therapists with tools to implement evidence based treatment procedures (Koerner & Castonguay, 2015). Additionally, if desired, clinicians can use their own outcome data for quality control, as well as for making referral decisions, and even to advocate for increased reimbursement for their services (Adelman, Castonguay, Kraus, & Zack, 2015). Across varied naturalistic settings, POR can not only be clinically informative, but can also seamlessly integrate and potentially bridge the gap between research and 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.

The Impact of a Mindfulness Intervention on Burnout Levels in Direct Care Staff

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Studies have found burnout is prevalent among mental health workers (Paris & Hoge, 2010), with 21% to 67% endorsing "high" levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Burnout occurs when individuals are unable to effectively cope with high levels of prolonged occupational stress. Burnout can be characterized by three distinct dimensions: emotional exhaustion, depersonalization or cynicism, and reduced personal accomplishment (Maslach, Schaufeli, & Leiter, 2001). Recently, there has been a growing interest in the impact of burnout on direct care staff (e.g., Gray-Stanley & Muramatsu, 2011), who assist in activities of daily living and recreational activities, and provide supervision and crisis counseling to patients in treatment facilities. Due to the emotional and physical demands of direct care work, these employees are considered to be particularly susceptible to burnout, although the prevalence rate of burnout in this population is not known (Ito, Kurita, & Shiiya, 1999).

Burnout negatively impacts both individual employees and the organizations for which they work. Burnout has been associated with poor physical and mental health in employees (Ahola et al., 2005; Peterson et al., 2008; Saleh & Shapiro, 2008; Toppinen-Tanner, Ojajarvi, Vaananen, Kalimo & Jappinen, 2005). It is correlated with high levels of staff absenteeism and turnover, which negatively impact the effectiveness of mental health organizations and potentially impair client care (Martin & Schinke, 1998; Parker & Kulik, 1995; Toppinen-Tanner et al., 2005). Patients report lower levels of satisfaction when they are cared for by staff members who endorse high levels of burnout (Garman, Corrigan, & Morris, 2002; Leiter & Harvie, 1998). In addition, staff members who endorse symptoms of burnout are more likely to perceive their clients in a negative fashion (Holmqvist & Jeanneau, 2006).

Researchers have begun to explore the impact of mindfulness on burnout among health care professionals. For example, Goodman and Schorling (2012) found health professionals who participated in an eight-week Mindfulness Based Stress Reduction course and a seven-hour retreat showed a significant decrease in burnout level. This research suggested mindfulness interventions may be effective in targeting burnout, but researchers have not used mindfulness techniques with direct care staff specifically (Bernier, 1998; Innstrand, Espnes, & Mykletun 2004; Scarnera, Bosco, Soleti, & Lancioni, 2009).

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This mixed method study intended to address this gap in the literature by conducting a pilot study on mindfulness intervention with direct care staff. We predicted direct care staff would report high levels of burnout at baseline. There is overlap between the construct of burnout and symptoms of depression; however, research also suggests they are separate constructs (e.g., Ahola et al., 2005). Hence, we predicted there would be an inverse relationship between burnout and mindfulness, even when controlling for depressive symptoms. We predicted individuals who participated in a mindfulness intervention would endorse decreased levels of burnout and increased mindfulness. Finally, this study looked at the subjective experience of direct care staff to better understand their experience of burnout, and the role of mindfulness.

Methods

Participants. Participants were recruited from a residential treatment facility providing psychiatric care to young adults. Recruitment involved informational flyers and presentations at staff meetings. A total of 22 direct care staff members (9 males and 13 females) completed the baseline questionnaires (seeTable 1). The average length of tenure for direct care staff at this facility was 7.41 years (SD = 7.66 years).

Measures. Burnout was measured with the Maslach Burnout Inventory - General Survey (MBI- GS; Maslach & Jackson, 1986), a 22-item scale assessing for burnout across three dimensions: emotional exhaustion, cynicism, and personal achievement. The authors of the scale provided cutoffs for low, moderate, and high levels of burnout. Meta-analyses indicated reliabilities of 0.88, 0.71 and 0.78 for the three dimensions (Aguayo, Vargas, de la Fuente, Lozano, 2011; Shapiro, Astin, Bishop, & Cordova, 2005). Cronbach's alpha for this study was 0.79.

Staff members also completed the Center of Epidemiological Studies Depression Scale (CES-D; Klinedinst, Dunbar, & Clark, 2013), a 20-item scale assessing depressive symptoms. Reliability for this measure produced an alpha coefficient of 0.76 to 0.91. Cronbach's alpha for this study was 0.85.

Participant mindfulness was measured with the Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith & Allen, 2004), a 39-item scale measuring mindfulness across four subscales to assess observation, describing observed phenomena acting with awareness, and accepting without judgment. The KIMS has demonstrated high test-retest reliability and internal consistency (Baer et al., 2004). Cronbach's alpha for this study was 0.76.

Semi-structured interviews with participants who completed the mindfulness training intervention were conducted via telephone and recorded by the first author. Interviews were later transcribed and de-identified. The interviews were coded and analyzed by the first author using grounded theory methodology (Auerbach & Silverstein, 2003).

Procedures. Direct care staff were invited to complete the questionnaires and to participate in a mindfulness group. Direct care staff who agreed to complete only the questionnaires formed the control group, and were entered into a lottery to win a $15 gift card. Staff who agreed to complete both the questionnaires and the mindfulness group made up the experimental group, and were entered into a lottery to win a $75 gift card.

Staff members who agreed to participate in mindfulness training were asked to attend an initial session introducing the fundamental principles of mindfulness and burnout. Participants were provided with psychoeducation about the

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role of physical sensations, thoughts, and emotions in the experience of stress, and also about mindfulness. Participants were introduced to informal mindfulness practices such as the Raisin Exercise (Williams, Teasdale, Segal, & Kabat-Zinn, 2007), and formal mindfulness practice, such as a guided body scan. Participants were provided with materials to encourage them to develop their own practices. They were then invited to attend follow-up group sessions. After a month of offered follow-up sessions, the experimental group completed the questionnaires again and were invited to participate in a semi-structured interview conducted via telephone.

Results

Levels of burnout among direct care staff at baseline. The average level of emotional exhaustion among direct care staff was 15.86 (SD 8.31), the mean for cynicism was 12.23 (SD = 10.54), and the average score of personal achievement was 26.5 (SD = 6.38), which all fell in the moderate range (Maslach & Jackson, 1986). In addition, 45.5% of participants scored in the high range of emotional exhaustion, cynicism, and personal achievement (see Table 2).

Relationship between burnout and mindfulness. A partial correlation was used to explore the relationship between burnout and mindfulness, while controlling for depression (see Table 3). Contrary to our hypothesis, the relationships between the components of burnout and mindfulness were non-significant and most were small in size. The largest correlation was between emotional exhaustion and acting with awareness (r = -.289, n = 17, p = .230).

Impact of mindfulness invention. Seven staff members expressed interest in participating in the mindfulness group, but only three, two men and a woman, were able to commit to the time requirements. An independent t-test was used to compare the experimental and control groups at baseline. For the cynicism subscale, the Levene test indicated a violation of the assumption of homogeneity, so the separate variance version of the t-test was used to analyze this subscale. There was a significant difference in cynicism scores between the control group (M = 12.61, SD = 10.94) and the experimental group [M =5.67, SD = 1.53; t(19) 2.55, p = .02]. There were no significant between-group differences in mindfulness (see Table 4).

The three staff members who agreed to participate in mindfulness training were asked to attend an initial group session introducing the fundamental principles of mindfulness and burnout, and were then offered additional scheduled trainings. Participants expressed a desire to attend the additional trainings but had to cancel several times due to extenuating circumstances (e.g., being called in to work another shift). Two staff members attended one training session while the third staff member attended a total of two sessions. The participants were unable to attend the trainings at the same time, so the training sessions were conducted individually.

Staff members completed the questionnaires for a second time after the mindfulness intervention. A paired t-test was used to compare participants' baseline scores to their scores after the mindfulness intervention (see Table 5). There were no significant changes in overall levels of mindfulness, as measured by the KIMS (Baer, Smith & Allen, 2004). Additionally, there were no significant differences in the levels of cynicism and personal achievement. Participants' levels of emotional exhaustion were reduced (pre-test M = 12.33, SD = 5.50; post- test M = 4.33, SD = 4.50) and this

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approached significance [$t(2) = 4.00$, $p = .057$].

Qualitative Results

The results of the qualitative analysis of the interviews are summarized below. Repeating ideas were identified when all three participants endorsed the idea or when two out of three participants endorsed the idea with at least one of those individuals endorsing it more than once. The repeating ideas were grouped into themes. The themes were then grouped into two overarching constructs of Burnout and Mindfulness.

Burnout. The participants noted burnout negatively impacted their work environment, and led some of their colleagues to use ineffective coping skills, while others struggled to maintain an empathetic stance toward clients and co-workers (theme of Prevalence and Negative Impact of Burnout). They attributed the development of burnout to the overwhelming demands, which they felt often superseded their own needs, and they reported these sacrifices were generally unappreciated (theme of Feeling Unsupported; repeating ideas of feeling under-appreciated and suppressing own needs to meet job demands). They reported that burnout was associated with a sense of enormous demand, resulting in difficulty focusing and the development of ineffective habits (theme of Burnout as the Antithesis of Mindfulness; repeating ideas of difficulty focusing on the present moment and formation of ineffective habits).

Mindfulness. The participants observed their experience of mindfulness practice to be in stark contrast with their subjective experience of burnout (theme of Mindfulness as a Form of Coping). They explained that mindfulness practice was rejuvenating and soothing (repeating idea of mindfulness as a "break"). They reported mindfulness practice allowed them greater insight into internal processes, such as the sensation of stress in their bodies and their thought processes (repeating idea of increasing awareness of the internal process), and noted a desire to share their feelings with an impartial person (repeating idea of making the internal external through sharing). The participants thought mindfulness would be beneficial for all staff members, but expressed concerns about significant barriers to implementing this strategy (theme of barriers to effective coping). Some concerns were concrete in nature, such as juggling busy schedules, while other concerns related to a sense of distrust among staff members about new interventions. Staff also identified a stigma against feeling stress at work, which might reduce willingness to openly discuss stress or burnout and participate in interventions to reduce it.

Discussion

Burnout in direct care staff. In this sample of direct care staff (n=22), almost half the participants scored in the high range of emotional exhaustion and cynicism, but the average level across the three domains of the burnout inventory fell in the moderate range. Interestingly, only 22.7% of staff reported a low level of personal efficacy, while 45.5% of workers reported high levels, suggesting that staff received a sense of identity, purpose, and pleasure from their work. In fact, only three participants out of 22 (14 %) displayed a profile of high levels of emotional exhaustion and cynicism paired with a low sense of personal achievement. The sense of personal accomplishment among the direct care staff in this sample may help to explain the relatively long tenure at this facility (average of 7.41 years). Contrary to our predictions, we did not find a significant inverse relationship between burnout and mindfulness levels.

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We were only able to recruit three staff members to participate in a mindfulness group. The qualitative analysis of the three staff members' interviews identified themes of burnout being prevalent and having a negative impact on the work environment, staff members feeling unsupported, and burnout as the antithesis of mindfulness. The participants endorsed less burnout after the mindfulness intervention, but only the difference in emotional exhaustion approached statistical significance. These results must be interpreted with caution due to the very small sample size, but these findings suggest the mindfulness intervention shows promise in helping staff reduce their sense of feeling emotionally overwhelmed at work. These findings are consistent with the theme that emerged from the qualitative analysis of mindfulness as a helpful way to cope with burnout. The participants in the mindfulness group did not display a significant increase in mindfulness levels following the intervention. This suggests mindfulness practice may have an immediate positive impact on emotional exhaustion, while the acquisition of mindfulness skills in a meaningful and long-lasting way may require more sustained practice.

Limitations

This study relies on a small sample, so the results may not accurately represent the relationship between burnout and mindfulness. Staff members who were willing to participate may not have been representative of direct care staff at this site. Participants were not randomly assigned to the control group and the intervention group, and the intervention group showed lower levels of cynicism at baseline. Additionally, the participants were recruited from a single mental health agency, and thus the results from this study may not generalize to direct care staff at other facilities. Finally, results of this study may be limited by some staff members' desire to respond in a socially acceptable manner. To this point, during the initial phase of this study, staff members expressed reluctance to complete surveys because they were worried their results could potentially be traced back and result in negative repercussions from administration. Initially, we had planned to assess all participants' levels of burnout and mindfulness at two time points. However, participants' concern about the administration gaining access to their data was so great that we modified our protocol to assess the control group at only one time point, in order to allow for completely anonymous responses.

Clinical Implications and Future Directions

While only a few participants in this study fit the high emotional exhaustion and cynicism and low personal achievement profile, many endorsed moderate to high levels of burnout on at least one of the categories. Furthermore, during interviews, staff members noted burnout negatively impacted staff members. This suggests the need for effective interventions to combat burnout. The pilot mindfulness intervention showed promise for reducing emotional exhaustion. The high levels of personal efficacy reported by many participants point to a potential protective factor that is worthy of additional research: in spite the challenges of direct care work, many direct care staff derive a high degree of personal achievement from their jobs.

The difficulties we encountered in conducting this study were themselves important findings. Our struggles with recruitment highlight barriers to reducing burnout levels: (a) the stigma against admitting stress, which was evident from staff members' concerns that ac-

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knowledging burnout would be perceived negatively by the administration; and (b) the difficulty of scheduling mindfulness interventions with participants who often work more than one job and are caregivers outside of work as well. These concrete issues may need to be addressed at an institutional level. Interventions, such as including mindfulness in trainings during the work day, could provide staff with tools for coping, as well as help to change the culture of the institution by creating a safe space for staff to acknowledge job stress and receive support and appreciation for their contributions to patient care. Finally, while mindfulness interventions with direct care staff may help them cope with stress, we were also impressed by the need for systemic change to reduce their stress, by decreasing the demands of a difficult job.

Authors' Note: This article is based on a doctoral research project by Francesca Lewis-Hatheway.

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

Table 1
Demographic Information

Demographic	Number of Staff	Percentage
Age		
20-29	5	22.7%
30-39	7	31.8%
40-49	6	27.3%
50-59	3	13.6%
60+	1	4.5%
Education Level		
High School only	1	4.5%
Some college	10	45.5%
Graduated college	8	36.4%
Advanced degree	2	9.1%

Table 2
Levels of burnout among staff members at baseline measurement

Burnout Category	Level of Burnout	Percentage of Staff
Emotional Exhaustion	Low	22.7% (5 out of 22)
	Moderate	31.8% (7 out of 22)
	High	45.5% (10 out of 22)
Cynicism	Low	40.9% (9 out of 10)
	Moderate	13.6% (3 out of 22)
	High	45.5% (10 out of 22)
Personal Achievement	Low	22.7% (5 out of 22)
	Moderate	31.8% (7 out of 22)
	High	45.5% (10 out of 22)

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Table 3

Correlation between Emotional Exhaustion and mindfulness while controlling for depression

Measures	1	2	3	4	5
Emotional Exhaustion	-	-0.222	-0.134	-0.289	0.022
KIMS Observing	-	-	0.248	-0.162	-0.666
KIMS Describing	-	-	-	0.669	0.154
KIMS Acting w/Awareness	-	-	-	-	0.294
KIMS Acceptance w/o Judgement	-	-	-	-	-

Correlation between Cynicism and mindfulness while controlling for depression

Measures	1	2	3	4	5
Cynicism	-	-0.085	0.053	-0.146	-0.36
KIMS Observing	-	-	0.248	-0.162	-0.666
KIMS Describing	-	-	-	0.669	0.154
KIMS Acting w/Awareness	-	-	-	-	0.294
KIMS Acceptance w/o Judgement	-	-	-	-	-

Correlation between Personal Achievement and mindfulness while controlling for depression

Measures	1	2	3	4	5
Personal Achievement	-	0.037	-0.151	-0.145	0.009
KIMS Observing	-	-	0.248	-0.162	-0.666
KIMS Describing	-	-	-	0.669	0.154
KIMS Acting w/Awareness	-	-	-	-	0.294
KIMS Acceptance w/o Judgement	-	-	-	-	-

Note. MBI=Maslach Burnout Inventory. KIMS=Kentucky Inventory of Mindfulness Skills.

Table 4

Comparison of Burnout and Mindfulness at Baseline Measurement

	Control Group	Experimental Group	*t*-value	df	*p* (2-tail)
MBI Emotional Exhaustion	15.94	12.33	0.69	19	0.497
MBI Cynicism	12.61	5.67	2.54	19	0.020*
MBI Personal Achievement	25.78	29.67	-0.95	19	0.350
KIMS Observe	40.63	43.67	-0.48	17	0.637
KIMS Describe	29.94	35.33	-1.51	17	0.148
KIMS Acting w/ Awareness	32.31	33.33	-0.24	17	0.811
KIMS Accepting w/o Judgement	29.31	31.00	-0.35	17	0.728

Note. MBI=Maslach Burnout Inventory. KIMS=Kentucky Inventory of Mindfulness Skills.
* $p < .05$

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Table 5

Changes in burnout and mindfulness levels among experimental group

Subscale	Pre-test *M* (SD)	Post-test *M* (SD)	*t* (2)	*p*
MBI Emotional Exhaustion	12.33 (5.50)	4.33 (4.50)	4.00	0.057
MBI Cynicism	5.67 (1.52)	4.67 (1.15)	0.65	0.580
MBI Personal Achievement	29.67 (1.52)	29.0 (7.55)	0.17	0.875
KIMS Observe	43.67 (6.42)	47.67 (0.57)	-0.99	0.427
KIMS Describe	35.55 (3.51)	35.67 (5.85)	-0.13	0.902
KIMS Acting with Awareness	33.33 (11.67)	32.67 (10.01)	0.55	0.635
KIMS Accepting without Judgment	31.00 (2.64)	35.67 (3.05)	-1.71	0.229

Note. MBI=Maslach Burnout Inventory. KIMS=Kentucky Inventory of Mindfulness Skills.

NOTICE TO READERS

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

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

ETHICS

Ethical and Safety Considerations for Use of Animals in a Therapeutic Setting

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Graduate School of Professional Psychology

Studies have demonstrated notable benefits of the use of Animal Assisted Therapy (AAT) with clients (Hart & Yamamoto, 2015; Nimer & Lundahl, 2007). As AAT gains in popularity and becomes more prominently used by psychologists and psychology trainees in mental health settings (Fine, Tedeschi, & Elvove, 2015), it is crucial that the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 2010), particularly Standard 2: Competence and Standard 3: Human Relations, be addressed and applied to this clinical practice. This article will summarize the paramount ethical and safety considerations unique to the field of AAT, including therapist training, animal training and welfare maintenance, and client well-being and safety. To educate practicing psychotherapists or therapists in training, a brief explanation of the current terminology will also be provided along with the documented benefits of AAT in healthcare and mental health settings. This article may serve as a preliminary guideline if you are considering incorporating AAT into your therapeutic work.

Current Terminology

Throughout the literature, many terms are used to describe interventions in which animals are incorporated to promote mental and physical health in humans. For the purposes of this paper, Animal Assisted Therapy (AAT) will be the term used; however, it is important to differentiate between the following terms. Animal Assisted Interventions (AAI) is an overarching term used to describe interventions involving animals, and encompasses Animal Assisted Activities (AAA) and Animal Assisted Therapy (AAT). AAA are generally informal, recreational or educational activities utilized to improve an individual's quality of life. AAA occur in many settings and are provided by a "trained professional, paraprofessional, and/or volunteer" (Kruger & Serpell, 2010, p. 34). In contrast, AAT is a goal-directed intervention implemented by a mental health professional, such as a licensed professional counselor, social worker, and/or clinical psychologist. These psychotherapists specifically integrate AAT into their work to facilitate client treatment objectives and goals while monitoring client progress as they (i.e., therapist, client, and animal) work together (Kruger & Serpell, 2010).

Benefits of AAT

The benefits of AAT are documented across a variety of settings, including schools, hospitals, hospice centers, rehabilitation clinics, and residential facilities (Gee, Fine, Schuck, 2015; Martin & Farnum, 2002). AAT can be applied across the lifespan (i.e., from pediatric to geriatric patients), and is most often used in conjunction with other therapeutic interventions to reach client treatment goals and address many medical, mental, and physical concerns. Incorporating

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an animal into psychotherapy can have numerous positive effects, and has specifically been shown to reduce symptoms of depression and promote emotional well-being (Nimer & Lundahl, 2007). Research has shown AAT is especially useful in treatment for those with "autism-spectrum symptoms, medical difficulties, behavioral problems," as the presence of an animal can promote safety and allow clients to feel more comfortable sharing their experiences with professionals (Hart & Yamamoto, 2015, p. 59; Nimer & Lundahl, 2007).

As an example of the ways animals may be helpful to humans' mental health, Tedeschi, Sisa, Olmert, Parish-Plass, and Yount (2015) noted that talking to and petting a dog can reduce stress, in part by releasing oxytocin, which promotes overall well-being. Interestingly, the oxytocin receptor gene helps "fine-tune" an individual's ability to respond to social stressors, as well as empathize and trust others, which are important aspects of psychotherapy (Tedeschi, Sisa et al., 2015, p. 314). In addition, it is "therapeutically significant that a high degree of similarity has been found between the human and the dog oxytocin system, and that friendly contact between humans and dogs increases oxytocin levels in both species" (Tedeschi, Sisa et al., 2015, p. 314). Given these notable benefits, it is important therapists are adequately trained and provided with the necessary education to properly incorporate AAT into their work.

AAT Training and Integration for Psychotherapists

Formal AAT education can aid in developing a unique specialty area to strengthen a psychotherapist's primary training focus in a mental health profession (i.e., psychology, counseling, psychiatry). There are many educational programs individuals can attend to acquire the competence needed to ethically incorporate animals into their work. For example, the Pet Partners Program in Denver, Colorado (developed by the Delta Society; http://www.denverpetpartners.org) offers a valuable introductory course, including in-service trainings that provide appropriate guidelines for quality practice (Tedeschi, Pearson, Bayly, & Fine, 2015). However, it is up to the individual to embrace and properly apply this acquired knowledge, as the field of AAT evolves and the necessary guidelines are developed (Fine, Tedeschi, & Elvove, 2015). Receiving adequate training minimizes risks and maximizes benefits of the human-animal interaction, to both human and animal participants. Additionally, client well-being and safety is a core focus in the field of psychology. Therefore, it is essential that safety measures are in place when utilizing AAT. Therapists interested in incorporating animals into their clinical practice must seriously consider many factors, including: 1) the safety and welfare of the animal and client; 2) the APA Ethics Code (2010), including Standards of Competence and Human Relations, and the five Ethical Principles (Beneficence and Nonmaleficence; Fidelity and Responsibility; Integrity; Justice; and Respect for People's Rights and Dignity); 3) the most applicable AAT delivery model; and 4) educating members of the therapeutic environment.

The introduction of the animal to the therapy sessions must be a gradual transition, in which boundaries are established and limits set for both the client and the animal. Prior to introducing an animal to the client, therapists must provide informed consent, verify the absence of any breed-specific allergies, and determine whether the client has fears or phobias about animals or prior traumatic experiences, such as being bitten by a dog. Although research has shown the risk of transmission of zoonotic dis-

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eases is minimal, simple precautions (e.g., rigorous health care monitoring for the animal) must be taken to ensure the safety of both the animal and the client, especially for high-risk clients, such as immune-suppressed patients and hospitalized patients (Fine, 2015). Furthermore, some clients' beliefs (e.g., religious, cultural, ethical) may not align with the principles of AAT, which may make the integration of AAT into psychotherapy challenging or impossible (Jegatheesan, 2015; Standard 3.01: Unfair Discrimination; APA, 2010). In such circumstances, therapists must have alternative treatment options. Such safety measures help ensure that the addition of the animal will enhance, and not complicate, psychotherapy, as well as ensure compliance with the five Ethical Principles of the APA Ethics Code (2010).

Given the unique client-therapist-animal relationship, the therapist must be aware of and consider the potential impact of Multiple Relationships (Standard 3.05: Multiple Relationships), and/or impaired objectivity (Standard 3.06: Conflict of Interest) on the client's treatment (APA, 2010). Psychotherapists must develop the skill to split their attention equally between the client and animal "without compromising the quality of service being offered" (Fine, 2015, p. 163). Therefore, the therapist's role becomes to both protect the animal's safety and well-being and to stay attuned to and be protective of the client's experience (MacNamara, Moga, & Pachel, 2015). Regular check-ins with the client regarding relationship status and comfort level with the therapy animal, as well as check-ins on the impact of the therapist's own relationship with the therapy animal, are imperative. As animals, like humans, are susceptible to injury, illness, disease, and death, clients (and co-workers) must be appropriately educated, prepared, and allowed time to process the temporary or permanent, absence of the therapy animal.

Therapists can serve multiple roles in AAT and training can provide education about the delivery approaches most suitable to unique client needs. Two common delivery approaches fit the needs of most client, therapist, animal, and overall environment combinations (MacNamara et al., 2015). First, the Diamond Model consists of four individuals: the animal, the trainer, the therapist, and the client. The role of trainer is typically fulfilled by an individual with ample training (which could include an appropriately-trained therapist), and the trainer is the person primarily responsible for the animal's safety and well-being (Standard 2.05: Delegation of Work to Others; APA, 2010). This approach is most often used with large therapy animals, such as horses, or when psychotherapy is offered in a group setting. Second, the Triangle Model consists of three individuals—the animal, the therapist, and the client—and the therapist, therefore, serves dual roles, as both therapist and animal handler (see Standard 3.05: Multiple Relationships and 3.06: Conflict of Interest; APA, 2010). This model is frequently used in the therapist's professional environment (e.g., private practice, hospital, school, or community mental health facility) and with the therapist's own animal that has been trained to serve as a therapy animal.

Educating facility personnel, co-workers, and staff (essentially everyone) within the facility in which animals are integrated is essential for environmental safety and for adherence to ethical standards (Standard 3.09: Cooperation with Other Professionals; APA, 2010). The therapist must ensure fellow co-workers feel comfortable and safe around the animals. Obviously, in environments inte-

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grating many types of animals (e.g., farms), employees are typically comfortable and motivated to work with a wide variety of animals. However, in more traditional psychotherapeutic environments (e.g., clinics, hospitals, community mental health centers, and educational facilities), there is likely to be greater variability in receptivity to the presence of animals. Some individuals may have grown up with animals; others may be allergic, fearful of the animal's presence, and/or concerned about the potential for various health or liability issues. Therefore, it is essential therapists communicate with the facility personnel, co-workers, and staff prior to introducing the animal to the clinical setting, and then, upon approval of the animal, educate them on how appropriate care of the animal will be maintained. This education should include details regarding animal grooming, the animal's health care routine, safety precautions, and assurance of procedures in place to protect any individuals who are uncomfortable with the animal's presence. The therapist must model healthy and respectful behavior toward the animal for the benefit of the animal, coworkers, and clients (VanFleet, Fine, O'Callaghan, MacKintosh, & Gimeno, 2015). As Tedeschi, Sisa et al. (2015) noted, "It is highly significant that the behaviors and stimuli that work best in the creation of these wonderful service dogs are the same positive, nurturing behaviors on which all human friendship and families thrive" (p. 316).

Animal Training and Welfare Maintenance

Functional knowledge of not only the principles of AAT, but also animal behavior and animal welfare, is essential to competently and safely integrate AAT. General knowledge of animal behavior and appropriate human-animal interaction facilitates the therapist's ability to detect the animal's signs of discomfort and stress, as well as to distinguish appropriate from inappropriate human behavior towards animals (e.g., children jumping and bending over animals, pulling tails/ears, and/or sitting on the animal), as such knowledge minimizes risks for both the animal and the client (Jegatheesan et al., 2014).

By those insufficiently trained in AAT, animals may be viewed as tools, rather than co-workers in the therapeutic process (Fine, 2015). Distinguishing this role as a co-worker emphasizes that animals have needs that deserve to be attuned to as well, as they are susceptible to the same harm, overwork, stress, and long-term health problems within the rigorous therapeutic environment that affect human therapists (Evans & Gray, 2012). It is important also to recognize that "not all pets make good adjunct therapists" (Fine, 2015, p. 152). In other words, acknowledgment of the animal's temperament and skills facilitates the determination of whether an animal is suited for AAT, and, if so, for which specific type of work. Given the plethora of canine training organizations within the U.S. (see, e.g., Warrior Canine Connection, 2016), we will be using this specific animal as an example for how a therapist might incorporate a dog into the clinical setting.

Fine's (2015) "Guidelines for Incorporating Animals in AAT" outlines how dogs are judged by trained professionals in well-qualified organizations (e.g., Canine Companions, 2016) and, thereafter, selected as a co-worker in AAT (p. 151). These guidelines include animal selection requirements, preparatory training requirements, and safety and comfort guidelines. Dogs with excellent temperament, calm and gentle natures, who enjoy being around people, are able to sit quietly for extended periods of

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PROPOSED CHANGES TO SAP BY-LAWS

All members of the Society for the Advancement Psychotherapy are encouraged to participate in voting on revisions to the division's bylaws. West's Encyclopedia of American Law (2008) describes bylaws as the "The rules and regulations enacted by an association or a corporation to provide a framework for its operation and management. Bylaws may specify the qualifications, rights, and liabilities of membership, and the powers, duties, and grounds for the dissolution of an organization." Thus, bylaws are important for the effective functioning of any organization. Periodically, they are updated and revised as the mission and functioning of an organization change to better meet its members' needs.

If you are a voting member of the Society (regular and associate members and fellows), you are asked to participate in the current updating of the Society's bylaws. Student and non-APA Psychologist Affiliate members are not eligible to vote. Please visit http://societyforpsychotherapy.org/ to see the division's current bylaws, the proposed changes, and pro and con statements (as required by the current bylaws) that explain the rationale for and against these proposed changes. The changes proposed to the bylaws have been approved by the Board of Directors and are now presented to you for your vote on them.

Thank you in advance for participating in this important process by visiting http://societyforpsychotherapy.org/ and voting on the proposed Society for the Advancement of Psychotherapy bylaws revisions.

If you prefer to vote via mail, you may use the mail in ballot provided in this issue of the Psychotherapy Bulletin.

Proposed Changes to SAP By-Laws
January 2016

Election to Fellow, Article II, Section H

ARTICLE II, Section H (concerning criteria and processes for election to Fellow; it concerns the insertion of the two words: "or advancement;" bold font)

> "Documentation of the ways in which the Member's activities, contributions, and/or performance have had a discernable and salutary effect on the development **or advancement** of the discipline of psychotherapy. "

Pro and Con Statements for change to ARTICLE II, Section H

> PRO: Including this additional criterion (i.e., "advancement" of the field) acknowledges more clearly the work of members whose work may not necessarily have contributed to the development of the field of psychotherapy (e.g., through scholarship), but who have been instrumental in the important work of promoting it through for example, their organizational leadership (note that the Merriam Webster definition of advancement includes "promotion or elevation to a higher rank or position"). The inclusion of this criterion brings our stated policy more directly in line with what has been the Society's practice, as is reflected in the guidelines that the Society's Fellows Committee has been using to evaluate candidates for Fellowship (http://www.apa.org/membership/fellows/division-29.pdf).
>
> CON: It is sufficient to state that candidates for Fellow must demonstrate having had positive effects on the development of the discipline. Advancement can be considered implied in the term "development."

Role of the Secretary, Article V, Section E; Article IX, Section C; Article XV, Section D

ARTICLE V, Section E (defining the role of the Society's secretary; added wording is in bold font)

> "The Secretary shall be a Member or Fellow of The Society, elected for a term of three (3) years. During that term, the Secretary shall be a member and the secretary of the Board of Directors, with the right to vote; shall safeguard all records of The Society; shall keep the minutes of the meetings of The Society, of the Board of Directors, and of the Executive Committee; shall maintain coordination with the Central Office of the American Psychological Association; shall issue calls and notices of meetings; shall issue an annual report; shall keep and maintain a book of the extant policies of The Society based upon actions of the Board of Directors; **shall record all votes of the Society Board of Directors taken at in-person meetings and via other methods; shall send all bylaws amendments to the membership as required and record those votes**; and shall perform all other usual and customary duties of a secretary."

ARTICLE IX Section C (Clarification of the role of Secretary with respect to counting and reporting votes; added text in bold font)

> "Upon certification by the Secretary, the Board of Directors shall direct the holding of a vote on the matter via a ballot format to be determined by the Board. The Secretary shall be responsible for distributing the ballot and voting instructions to each voting member within ninety (90) days of the certification that the referendum is in order, **and shall be responsible for counting the votes, and reporting the outcome to the Board of Directors and the membership**. Said ballot shall be accompanied by arguments for and against the proposed referendum. Ballots must be returned by a deadline established by the Board but no later than 30 days from the date of distribution. An affirmative vote by a majority of members voting shall be required to sustain the matter contained in the referendum."

ARTICLE XV Section D.

> **The Secretary shall be responsible for counting votes, and reporting the outcome to the Board of Directors and to the membership**.

Pro and Con Statements for changes affecting the role of the Secretary:

> PRO: These amendments clarify the role of the secretary in direct responsibility for the legal functioning of the organization. The responsibility for these activities has not been previously specified.
>
> CON: The Society has not experienced problems with the responsibility remaining ambiguous.

3. Expand the name and activities of the Publications Board, Article VI, Section A 3; Article VI, Section G; Article XIV, Sections A-F

Add the words "and Communications" to the title of what now is the Publications Board, to reflect the actual scope of the Board's work, in all cases in which the title is noted. (Article VI A 3; VI G; XIV B, E, F)

Add the words "and other media" in all cases in which publications are noted. (Article XIV A, B5, E and F)

Pro and Con Statements for changes affecting the Publications Board:

PRO: For many years the Publications Board oversaw the Society's (then Division's) journal and bulletin. The organization then developed a rudimentary website that functioned as an online bulletin board for the Division. However, in recent years the Society has overhauled and expanded its website to be an online publication and has added the use of social media, e-mail communications, and other electronic communications with our members and the public at large. Thus, in addition to publications, the Society now engages a range of communication activities beyond its print publications. Accordingly, the Publications Board is now overseeing both the Society's publications and a range of other communications. Thus, the appropriate name of this oversight and planning board is The Publications and Communications Board and the bylaws should reflect this change.

CON: Maintaining the title keeps a sense of continuity with the Society's history

4. Clarify Role of Committee Chairs following their term as chair, Article XI, Section D

ARTICLE XI, section D (text to be deleted indicated in bold and strikethrough)

"The President-elect shall appoint, with the approval of the Board of Directors and in consultation with the current chair, a chair designate who shall serve as a member of the appropriate committee during the year preceding the one in which he or she shall serve as chair and shall assume the duties of the chair in the year in which the President-elect becomes President. **~~The immediate Past Chair shall remain as a member of the committee during the year following his/her service as Chair, if possible.~~** Except as otherwise specified in these Bylaws, committee membership shall include a chair, and other members who may be appointed by the chair with the approval of the president and corresponding Domain Representative. Chairs may be reappointed for a subsequent term as chair."

Pro and Con Statements for changes to ARTICLE XI Section D:

PRO: The deletion of this sentence is intended to reflect what is current practice on the Committees: Past Chairs have not routinely stayed on the Society's committees. Removing this statement does not, though, preclude the immediate past Chair from remaining on the particular committee if that were to be his or her choice. The organizational structure of elected Domain representatives and corresponding committee chairs and members helps to ensure continuity of agenda and perspective across years.

CON: To require the past Chair to remain on the committee provides important insurance that continuity will occur as well as the signal that this continuity is valued

5. Add International Domain, Article VI, Section A; Article XI, Section G

ARTICLE VI, Section A (adds an International Affairs Domain; added text in bold font)

"**Nine** ~~**Eight**~~ (~~**8**~~ **9**) Domain Representatives, to be elected for staggered three (3) year terms. The Domains represented by these positions shall be: a) Science and Scholarship; b) Education and Training; c) Psychotherapy Practice; d) Public Interest and Social Justice; e) Membership; f) Early Career Psychologists; and g) **International Affairs; and h)** two (2) Diversity. Annually, the Nominations and Elections Committee shall recommend to the Executive Committee a composition of slates intended to ensure breadth of representation on the Board by individuals representing diverse backgrounds, interests, identities, cultures and nationalities. Domain Representatives will coordinate with appropriate committees of the Society."

ARTICLE XI, Section G (Adds an International Affairs Committee that complements the proposed new International Domain; mirroring the committee-Domain relationship for the Society's other domains and committees. Added text in bold font)

> **"The International Affairs Committee, which shall consist of a chair, and additional mebers of the Society in good standing as appointed by the committee chair. The committee shall be responsible for ensuring that international perspectives are represented in the Society's activities and initiatives including in its web and print media and for providing consultation to the Membership Domain Representative in efforts to recruit and retain members from other countries. The Committee Chair will coordinate with the International Domain Representative on the Board."**

Pro and Con Statements for change to ARTICLE VI, Section A and ARTICLE XI, Section G:

> PRO: To pass the suggested by-law additions of an International Affairs Domain and Committee will enable the Society to become more fully global. These changes are consistent with APA's priorities (e.g., the 2009 Vision Statement spoke to becoming "a "principal leader and global partner promoting psychological knowledge and methods to facilitate the resolution of personal, societal and global challenges in diverse, multicultural and international contexts"). Other APA divisions are increasing their own commitments to international efforts (e.g., the Society for Counseling Psychology has in the past several months added its first Vice President for International Affairs).
>
> Importantly, these by-law changes should be seen as simply one additional step to those that the Society already has taken to express its commitment to a broader and more inclusive mission.
>
> The recent adoption of "Society for the Advancement of Psychotherapy" as its name has signaled an organizational identity that is broader than simply that of an APA division. The Society's new Affiliate Member category permits psychotherapists who are appropriately credentialed in their home country to join, regardless of their profession. Finally, our recently revamped webpage is engaging, easy to navigate, and rich with continually refreshed content and a button at the bottom of the page to translate content into many different languages.
>
> As well, our very strong journal (*Psychotherapy*) already has a global influence. For example, a third of the downloads of its articles are from countries other than the U.S.
>
> This year an International Affairs Task Group has helped the Society develop an infrastructure to better support internationalization as a two way enterprise: that SAP not only increase international membership but also be enriched by the perspectives on psychotherapy that an increasingly global membership brings. As a first step in that latter purpose, the Task Group has begun this year to ensure that in each issue of the *Bulletin* there will be at least one article addressing psychotherapy-related issues in countries outside the U.S.
>
> One result of all of these efforts had been a sharp rise this year in the number of affiliate memberships by psychotherapists in countries other than the U.S. The creation of the Domain and its associated Committee will be a necessary next-step that builds on these efforts to make the Society truly global.
>
> CON: To add a Domain and Committee would increase the costs of Governance Board meetings as it would require the Domain representative to attend two and the Chair to attend one per year. Even though the upturn in international memberships this year are promising and having Domain and Committee structure is intended to accelerate this trend, nothing is assured.

6. Change information provided to members regarding bylaws amendments to an explanation, Article XV, Section C

> "The ballot to vote on the proposed bylaws amendment(s) shall include ~~statements that specify the arguments for and against the proposed amendment~~ **statements that provide an explanation of the proposed amendments, including the rationale and any benefits and drawbacks.**

Pro and Con Statements for changes affecting the need for pro and con statements:

> Pro: Proposed bylaws amendments are carefully vetted by the Society's Board of Directors; only those that the majority of the Board of Directors believe are in the best interests of the Society and its members are forwarded to the membership for a vote. The pro statement is therefore necessarily a stronger statement than a con statement. However, unless the vote by the Board of Directors is unanimous, there are valid reasons to retain the bylaws as they have been, and the members should have the benefit of understanding the Board's thinking. An explanation, rather than pro-con statements, can better capture the spirit of the Board's thinking and provide better guidance to members.
>
> Con: Pro-con statements may more easily capture sharp distinctions between alternatives, when they exist.

VOTING BALLOT

ARTICLE II, SECTION H	❍ Approve	❍ Reject
Changes related to the Secretary's duties in ARTICLE V, SECTION E; ARTICLE IX, SECTION C; ARTICLE XV, SECTION D	❍ Approve	❍ Reject
Changes related to the name, function, and responsibilities of the Publications Board in ARTICLE VI, SECTION A 3; ARTICLE VI, SECTION G; Article XIV, SECTIONS A-F; Article VI A 3; VI G; XIV B, E, F. Article XIV A, B5, E and F	❍ Approve	❍ Reject
Article XI, Section D	❍ Approve	❍ Reject
Article VI, Section A	❍ Approve	❍ Reject
Article XI, Section G	❍ Approve	❍ Reject
Article XV, Section C	❍ Approve	❍ Reject

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Signature _____

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_____

Division29
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time, are able to handle unusual circumstances, and have adequate obedience and training are judged to be well-suited for therapy animal work (Fine, 2015). These animals must then earn an obedience training certificate by demonstrating mastery of several skills (e.g., comfort around strangers, the ability to walk in the heel position on a leash and ignore a neutral dog, and the ability to obey commands). If animals meet all these requirements, they are then matched with a trained AAT specialist (e.g., a therapist).

It becomes the responsibility of the therapist to adhere to the following animal safety and comfort guidelines: a) always protect your therapy animal; b) remove your animal from all stressful situations until they become more comfortable with the situation via time and training; c) give your animal consistent breaks; d) provide walks and play breaks to reduce the animal's stress; e) always have fresh water available and present favorite toys during breaks; and d) have a safe, low stimulus resting spot available in the therapy environment (Fine, 2015). With specialized training, therapists can learn how to properly incorporate AAT, and thereby create and maintain a healthy therapeutic environment for both the animal and the client.

Conclusion

As animals continue to be incorporated into the therapeutic work of mental health therapists, it becomes crucial that ethical and safety best practices, as well as adequate training for both the therapist and the animal, be implemented and maintained (Tedeschi, Pearson et al., 2015). As AAT evolves, the development of formal training guidelines and practices are needed to ensure therapists are indeed trained in a manner ensuring the safety and well-being of not only clients, but animals as well. Additionally, it is imperative therapists continue to explore the human-animal bond and conduct rigorous empirical studies examining the therapeutic benefits of AAT across different populations and settings. As Tedeschi, Sisa et al. (2015, p. 316) note,

> Our increasing awareness of the similarities between the neural, neurohormonal, and genetic mechanisms that regulate stress and social behaviors in an all mammals, specifically the oxytocin system, supports the hypothesis . . . that oxytocin's 'calm-connect' effects underlie the evolution of the human-animal bond . . . [and] illuminates how and why the human-canine bond can be so emotionally and therapeutically powerful . . .

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

CLINICAL NOTES WITH DR. J

Cross-Training Your Therapeutic Ear Through Hip Hop

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Harvard Medical School Instructor in Psychology (Psychiatry)

> …Initially rap was America's informal CNN because when Rap records came out somebody from far away could listen to a Rap record because it uses so many descriptive words and get a visual picture from what was being said…Rap is now a worldwide phenomenon. Rap is the CNN for young people all over the world because now you can hear from rappers in Croatia and find out what they talk about and how they're feeling. Rappers from Italy, rappers from Africa. Rap has become an unofficial network of the young mentality. (Ridenhour & Jah, 1997, p. 256)

Chuck D's (i.e., stage name for Carlton Douglas Ridenhour) famous words still ring true today as they did almost 20 years ago. Rap has grown tremendously from its origins and other cultures have adopted rap as a supplemental form of communication. In Asia, Southern-style rap music has recently gained significant popularity amongst the youth of Korea (Townes, 2015), and the aboriginal people of Canada (i.e., the members of the First Nations) have utilized rap music to provide a powerful voice for their often-targeted and underserved community (Pastuck, 2016). Whereas other forms of music were created primarily for entertainment and merriment, hip hop in general can be seen as an art form created out of necessity, given its roots in Negro Spirituals dating back to slavery. During slavery, in addition to songs being utilized as educational resources to provide general instruction and hints regarding escape, these beautiful and beloved ballads were also seen as vivid auditory portraits broadcasting the shared triumphs and tribulations of people of color during their internment (Kentucky Education Television, 2016). In the United States specifically, African American music has been a consistent conduit through which Black America has been able to speak to White America about the Black experience. The more recent incarnation of hip hop was begot for similar reasons as the general American culture lacked representation of the Black experience in the various communities around the country, especially those in urban areas where poverty, crime, trauma, and racism were prevalent. Without hearing their experiences reflected on the radio, many early hip hop artists took it upon themselves to utilize rap music to begin to engage in a dialogue about their lives, communities, relationships, and emotions. Although the early image of hip hop is a group of individuals enjoying the flow of a local rapper in their neighborhood, hip hop has grown into a tremendous multibillion dollar industry in which songs travel with lightening quick speed across the entire globe, especially given the rise of the internet as a new mode of transportation for both media and art.

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Music, and hip hop in particular, are powerful forms of communication providing access into the minds and experiences of others. Through rap music, an individual has the potential to gain greater understanding of the collective stressors, loves, triumphs, and trials of a specific person whose voice might not have reached our ears without such a powerful medium and a melodic beat. The power behind a microphone is significant, as the lyrics from these songs slowly seep into the consciousness of the listener and help foster a connection based on the sharing of experiences and the commonality of human emotions. This is why I believe rap music can help us all become better therapists.

I know many of you may think of me as an unabashed hip hop supporter, but hear me out. When we think of hip hop, we often think of the gratuitous nature of the songs and the bravado of some of hip hop's most prominent kings and queens (e.g., Kanye West). Although this is a reasonable connection to make, doing so neglects the vast sea of artists and visionaries in hip hop who expand the art form and provide a truly unique listening experience. Additionally, hip hop is deeper; hip hop is itself an eclectic art form that tackles a vast range of themes and topics in its verses and "bars." From songs that deal with growing up in a fatherless home (e.g., "This Can't be Life" by Jay Z [i.e., stage name for Sean Carter] featuring Beanie Siegel and Scarface [i.e., stage name for Brad Jordan], 2000); domestic violence (e.g., "Love is Blind" by Eve [i.e., stage name for Eve Jeffers], 1996); trauma (e.g., "Traumatized" by Meek Mill [i.e., stage name for Robert Williams], 2012); suicidal ideation (e.g., "Suicidal Thoughts" by the Notorious B.I.G. [i.e., stage name for Christopher Wallace], 1994); teen pregnancy (e.g., "Brenda's Got a Baby" by Tupac Shakur, 1991); Black pride (e.g., "Alright" by Kendrick Lamar, 2015); and feminism (e.g., "U.N.I.T.Y." by Queen Latifah [i.e., stage name for Dana Owens], 1993), hip hop has not shied away from difficult topics in an effort to educate and inform its listeners.

By having these often private topics discussed in a public space, hip hop can reduce some of the stigma and shame associated with particular events and life experiences that often carry significant emotional currency. The listener, who may have experienced a similar experience as the one captured in a song, might now not feel so alone. Additionally, the listener may be able to find some type of significant or slight support, understanding, or acknowledgement from the words of the artist.

Hip hop and rap music is all about a shared language and communication. When one follows an artist, one begins a journey of acculturation in which the listener develops a shared understanding of the performer's experiences and vernacular. Through this experience, the words of the artist take on increased meaning and the listener's experience of "being with" the artist is enhanced and is forever evolving and changing.

A similar process occurs in psychotherapy. When a clinician starts a new therapeutic relationship with a client, the clinician is beginning that relationship from a position of vulnerability, where there is no shared language or vocabulary for the client's thoughts, feelings, behaviors, or experience. But this "newness" slowly fades and is gradually replaced with familiarity. As the client and clinician meet, the clinician listens intently to the words said, and those not said, to begin to catalog and define words, phrases, mannerisms, and colloquialisms in order to piece together the world and dogma of the client. As this world begins to come together and take

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shape, the clinician can then more accurately anticipate opportunities to intervene with the client and also find more nuanced methods to effectively communicate in a unique and efficient manner.

Given how psychotherapy is heavily language-based, I encourage therapists in training to utilize hip hop or other forms of lyrical music or poetry as methods to hone their therapeutic ears. For the artists, these songs are not only entertainment, but cathartic pieces of art—dispelling painful emotions, entertaining wild thoughts, and sharing intimate portraits of otherwise private lives and experiences. Through listening to a style of music relying so heavily on word-play and literary gymnastics, the therapist can practice deconstructing the experiences of artists in an effort to better understand not only the messages behind the songs, but also the psychology and overarching themes artists are attempting to transmit through their records. In the same ways in which an individual can dissect a new song to uncover the verbal repartee (i.e., wordplay) of the artists and the hidden meanings of double entendres, the well-trained therapist can search deeper to uncover the themes and meaning behind the client's presentation and the auditory portrait painted in the therapeutic space.

Conversely, the therapist can also craft a personal auditory language that is a mixture of therapeutic personality, clinical skills, and specific therapeutic relationship with a client. Like a good rapper, the therapist needs to engage in subtle or significant word play in order to entice, motivate, support, and redirect the client. That does not mean therapists should now make sure all of their sessions rhyme or are accompanied by instrumental tracks in the background, but it does highlight the importance of thoughtful communication during a time when verbal communication is so essential to the effectiveness of the treatment. Listening to hip hop songs is a convenient method of practicing active listening skills, as these songs are abundant and can be enjoyed and "studied" anywhere and at any time.

Instead of attempting to schedule actual or mock therapy sessions, clinicians in training can sit in the comfort of their own homes or offices and listen to music while exercising many of the same "listening muscles" required in psychotherapy. Through this method of learning, the therapist is able to get more "reps" and be able to develop this skill in a less stressful and more forgiving environment. In addition to the ease of this type of clinical training, this method presents zero risk for the therapist besides discovering new artists to love and enjoy, or listening to a horrible song. For example, for early therapists there might be significant hesitation in sessions, due to safety concerns with clients, fears of themselves being triggered by powerful affective content, a lack of developed confidence, or fears of "saying the wrong thing." This training eliminates these challenges and allows the therapist to focus solely upon the development of a single important skill. This type of skill building might be useful as an initial introduction to active listening in both graduate and undergraduate psychology courses, and could provide students with the opportunity to begin to transition from strict journalistic listening to more active and flexible listening.

In order to better understand the method behind my suggestion, let us briefly explore some of the ways in which a therapist might listen to and experience Beyoncé's new song "Formation," which was released right before this year's Super Bowl (if I am going to write an article about Jay Z, then I obvi-

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ously am going to write an article about Beyoncé—duh.). Besides having a tremendous beat, the keen listener would note how Beyoncé uses the vehicle of this song to tackle aspects of her life and identity, including gender, race, sexuality, and socioeconomic status. When addressing the portions of the song that speak to her racial identity, it is noteworthy how Beyoncé reclaims aspects of her Black physical appearance and displays a sense of both pride and acceptance of her aesthetic, which is often marginalized and neglected by the mainstream culture [e.g., "I like my Negro nose with my Jackson Five nostrils" (Knowles & Lee, 2016)]. In addition to reclaiming her looks, Beyoncé also speaks proudly of her family heritage and her family's ability to strive through prejudice and discrimination in order to provide her with the opportunity to be successful and live freely [e.g., "My daddy Alabama, Momma Louisiana/You mix that Negro with that Creole make a Texas 'Bama" (Knowles & Lee, 2016)].

As a therapist well-versed in racial identity development and multicultural psychology, hearing these words could provide you with insight into Beyoncé's racial identity development and how she conceptualizes her experiences as not only a person of color, but also as a wealthy woman of color. The song also provides insight into Beyoncé's overall identity formation, as she appears to define herself, or at least highlight herself, by a combination of her gender, race, economic status, status as a mother, and her overall artistic talents. And this is just one song. Imagine the data we could gather about Beyoncé via analyzing this whole album or her entire discography!

Beyoncé's one song is similar to a client's first visit; just as our curiosity is piqued by listening to Beyoncé's first track, our ears and interest also need to be piqued on the heels of our first session with a client, as we begin the initial deconstruction and preliminary analysis of potential themes, strengths, and challenges for this individual. By approaching therapy like one approaches a new song from a favorite artist, a therapist is able to turn on active listening skills and better anticipate new and novel information, while also listening for recurrent language to reflect back to the client to help further build the therapeutic alliance.

So, listen to your rap music, or the music of your choice, with pride—and make sure to bob your head. And if anyone tells you to "turn down that loud music," tell them you are studying!

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EARLY CAREER

Lessons From the ECP Playbook: What? There is no Playbook?!!

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I have always appreciated having a plan. Much to the chagrin of my partner, I am known to wake up in the morning and immediately start talking about what the plans are for the day ahead or what we would like to make for dinner that night. In my defense, I come from a long line of planners. For example, I recall the daily morning ritual of my mother writing out her to-do lists. It was common for her to start prepping our Halloween costumes in August, and begin her Christmas shopping and baking in September. As a child, I experienced this as always having something to look forward to, always knowing what was coming next, and always having something new to work toward.

As one can imagine, this appreciation for planning and predictability suited me well throughout my educational career. As a student, there was always the next exam, the next grade level, and the next degree to work toward as I navigated the various challenges of my education; the path was clear. This was especially true in graduate school. From obtaining practicum placements and hours, to preparing for comprehensive exams, negotiating the steps of the dissertation process, and applying for doctoral internships, it was clear what the next step was, even if it felt daunting at times. The evaluative nature of being a graduate student also provided me with ongoing updates about my progress; I regularly received feedback about whether I was on the right track and if I needed to make any midcourse adjustments. In my role as a student, there was familiarity and comfort in knowing where I was going and how I was doing, by having the path ahead of me clearly outlined by the expectations and obligations of my graduate program and professional field, and from the regular input received at each step along the way.

Like many graduate students, however, I began noticing that over time the seemingly never-ending task of working toward becoming a psychologist started to take its toll. At times it was hard to even imagine ever being anything but a graduate student. I was often asked by family members and friends, particularly after milestones such as passing my comprehensive exams or defending my dissertation, "So, does this mean you are done yet?" Even after obtaining my degree, there was still a post-doctoral fellowship, preparing for the EPPP, completing the state jurisprudence exam, and, oh yes, finding a job. As I neared the end of my graduate school career, I became excited for what I naively imagined to be extra time and freedom to pursue professional goals on my own terms. Like the big fish in the little pond, I felt ready to go off on my own and begin the next stage of my life.

Almost instantly upon becoming an early career psychologist (ECP), like the good student I had been all of those years, I hit the ground running. I had envisioned my ECP identity as one in

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which I could have, and do, it all in both my professional and personal life—a real-life Superwoman, PsyD! In addition to obtaining a full-time job with a two-hour daily commute, I started to make plans for how I would build a part-time private practice on the side, further develop my professional niche, look for teaching opportunities, and find a way to pay off my student loans. I was also excited to have more time and attention to devote to my personal life, no longer having graduate school work or licensure preparation taking up my weekends and evening time. Did I mention that all this was less than six months after becoming licensed? Suddenly, I found myself voraciously saying "yes" to most commitments and professional opportunities that came my way. While I had prided myself on my ability to balance and maintain decent self-care in graduate school, self-care was quickly tossed aside and I struggled with saying "no" now as an ECP.

In graduate school, we spend our time working toward the finish line of becoming a psychologist, a feat that occasionally seems impossible. And when the finish line is finally crossed, it seems understandable that some ECPs, including myself, are left wondering, "So… now what?" Like a two-act play, I had broken down my life into two parts: Act One—the graduate school phase, and Act Two—everything else that would come after. My post-graduate school professional identity became filled with all of the goals and dreams I created and held on to while I pushed through the countless obstacles and challenges. Navigating one's professional and personal identity as an ECP is a common challenge (Green & Hawley, 2009). Left to my own devices, without the structure and direction of graduate school, I had created an ECP identity for myself in which I envisioned accomplishing all of my professional plans at the very start of my career. Needless to say, I quickly realized I had not only taken on more than I could reasonably handle, but I was rapidly on my way to developing some serious professional burnout.

In my work with college students, I often find myself encouraging them, particularly incoming freshman, to practice patience and self-compassion towards the challenge of adjusting to a new environment and phase of life. I now see how I neglected to consider that for myself, as I transitioned from graduate student to ECP. One of the many benefits of our field is the opportunity to take on a variety of different roles and positions. What I have come to learn, however, is that I do not need to try out or pursue all of these roles and positions right now—and some of these may never be a good fit for me. My professional career is a lifelong journey that requires, *in addition to planning*, patience, flexibility, and openness to embracing that which is unexpected and unplanned. This was a hard lesson for someone like me who, thus far, had thrived on being a planner. What has allowed me to let go of the strict plans I set for myself, at this stage of my career, was rewriting my definition of my ECP identity to better reflect my values, self-care, and the reality of the graduate-student-to-ECP transition.

As we leave behind our graduate school identities and enter into the next (but not final!) Act as ECPs, we are left to our own devices to write our own scripts, define our own standards of success, and review our own progress. It is up to us to decide what our next steps are, and we will hopefully free ourselves of the pressure to do it all or accomplish everything within a certain period of time. As I begin to loosen the reigns and allow this journey to unfold ahead of me, I have also come to see how openness to

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new and unexpected possibilities can allow for other opportunities to present themselves that I may never have considered before. Embracing the unpredictable parts of this journey can help to better prepare us for the ever-evolving nature of our field, and allow us to make the most of what this great career path has to offer. This can be liberating or overwhelming—or, for some (like me, for example), perhaps a little of both. Regardless of how each of us entering this new phase of our professional lives envisions our ECP identity, it is important to recognize this as one of many Acts of a career-long story. At this point, I may not know the exact plan for how my story will unfold, and this is something I am beginning to embrace.

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Humility and Care in the Mental Health Treatment of Brazilian Immigrant Clients: A Reflection on Cross-Cultural Competency and Best Practices

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"It took me months to find you," said Luciana, during her intake session, discussing the difficulty of finding a clinician with whom she could converse in her native Portuguese language. While there are mental health settings in the Boston area that serve Portuguese speaking individuals and families, these resources pale in contrast to the significant Brazilian population in the area. In addition, individuals are often not aware of the resources available to them. For the purposes of this paper, "Luciana" represents a composite case study. I am utilizing a pseudonym for this symbolic client, as well as disguising features of her presentation by merging details from multiple individuals I have encountered in my clinical work and my phenomenological research with Brazilian immigrant women (Bessa, 2013). Luciana's story is not presented as a story representative of all Brazilian immigrants—indeed, there is no such prototypical story (Martes, 2011). However, the details I have chosen to include are present for many individuals migrating from their home country, including difficulties with identity negotiation, stress related to documentation status and acculturation, and alienation from family and larger society. Luciana's case is comprised of non-fictitious details drawn from the lives of multiple Brazilian immigrants I have encountered in my work to elucidate key clinical considerations when working with this population, and to suggest that many of these considerations may be relevant for working with underrepresented groups, particularly immigrant populations.

Luciana sought treatment in order to address depressive symptoms related to her immigration experience. She had migrated to the United States several years ago from Brazil, during which time she felt she "had not accomplished anything" in her life. She felt a lack of purpose, as well as significant disappointment in herself for her difficulty with motivation. She felt ashamed for not having mastered the English language yet, stating, "I feel stupid." She had attempted several times to engage in English classes, only to drop out in frustration. She had left most of her family behind in Brazil and planned, one day, to return home, but found her timeline extending steadily with every year she remained in the U.S. She lived with her husband and daughter, who learned English in school, and who spoke more English than Portuguese, even at home. She had migrated to the U.S. two years after her husband, and her daughter had been born in the U.S. "It is difficult for me to have a serious conversation with her," Luciana stated, "since I stutter my way through the conversation, as I struggle

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to communicate with her in English." She had worked cleaning houses, sometimes three or four in one day, but had been unemployed over the past couple of years. She described feeling somewhat connected to a church community, but experiencing feelings of alienation, superficiality in her social connections, and intensely missing her family in Brazil. She also described living in consistent anxiety due to her undocumented status.

The Brazilian immigrant population in the United States has been referred to as an "invisible minority" (Margolis, 1994). Although Brazilians and Brazilian Americans are a fast-growing group in the U.S., there is a dearth of psychological literature on this population. Brazilian migration to the U.S. began in earnest in the 1980s, a period of economic instability for many Latin American countries. In 2007, the Brazilian government estimated the Brazilian population in the U.S. to be 1.1 million, which was four times higher than the official census figures at the time (Bernstein & Dwoskin, 2007). This discrepancy may be due, in part, to underestimation of immigrant populations with a large number of undocumented individuals, in addition to Brazilian respondents not being substantially accounted for by the Census (Margolis, 2003; Siqueira & Jansen, 2008). Margolis (1994), an anthropologist who conducted an ethnography of Brazilians in New York City, estimates the undercount of the Brazilian population to have been 80% or higher in 1990. The possibility that official demographic data can be so discrepant with the reality of population numbers has significant implications for effective needs assessments and distribution of services to underrepresented groups. At the same time, as mental health practitioners, it is critical for us to recognize cultural competence as an essential aspect of clinical competence (Sue & Sue, 2012).

The immigration experience is a significant life transition necessitating a re-negotiation of the self. This often means a re-negotiation of one's role in the home, one's role in society, and even one's racial/ethnic identity. Immigration experiences can also lead to significant shifts within family systems, sometimes leading to more egalitarian financial arrangements, occasionally leading to increased relational strain as partners, parents, and children acculturate at different rates and in different ways (DeBiaggi, 2002; Hervis, Shea, & Kaminsky, 2009; Hondagneu-Sotelo, 1994; Min, 2001; Smart & Smart, 1995). Research on acculturation and acculturative stress is an important and growing body of work that increasingly suggests a process marked by complexity, individual differences, and nuanced blending of native and host cultures (Nguyen & Benet-Martinez, 2007). The Brazilian immigrant population is only one example of many immigrant populations that are currently underrepresented, understudied, and underserved.

A word of caution is in order, however: Clinicians should not assume that a client's immigrant status is the primary presenting concern—or, indeed, a treatment concern at all. Interventions should be tailored to the ideographic needs of the individual client in the room. While we should remain open to the possibility of exploring themes such as those described above, we should avoid attempting to apply a rigid nomothetic framework based on our own assumptions or preconceived notions. As mental health professionals working with clients from a variety of cultural and ethnic backgrounds, we must be aware of the complexity of the acculturation

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ative process, as well as cognizant of our role in establishing safety, rapport, and trust within the therapeutic relationship. We must also be willing to be lifelong learners, aware that cultural competence is never achieved, but is marked by curiosity and open engagement, rather than rigid generalizations about groups (Sue & Sue, 2012). Rogers-Sirin, Melendez, Refano, and Zegarra (2015) conducted a qualitative study of immigrant perceptions of the cultural competence of therapists, with several categories emerging: openness on the therapist's part to learn about the client's culture, addressing cultural differences appropriately, separating cultural issues from treatment concerns when appropriate, responding to client with patience and support, and exhibiting empathy. This study represents an important, but nascent, body of research.

Clinical Recommendations

As mental health professionals, it is essential we strive to serve the needs of our clients in the most effective and ethical manner, adhering to standards of best practices. To that end, the following list of clinical recommendations is provided as a non-exhaustive list of points to keep in mind when working with immigrant clients, based upon my clinical and research experiences with Brazilian immigrant women, as well as research on cultural competence, the relationship between immigration experience and mental health, and the particular experiences of Brazilian immigrants.

Be aware of your positionality. For Luciana, it was important to meet with a clinician who spoke her native language. While this was, in part, due to concern about her limited English fluency, it was also, in large part, due to a concern about the potential for relating to, and being understood by, her provider. As clinicians, it is essential to be aware of our own multiple identities (e.g., race, nationality, gender, sexual orientation, SES), our relationship to each of those identities, our own areas of privilege and marginalization, and ways in which our multiple identities interact with those of our clients. It is also essential to be aware of how we set and adjust our clinical boundaries, such as choices about self-disclosure, choices about whether or not to engage in physical touch (e.g., hand shaking; allowing for a hug hello or goodbye) at the client's initiative, and choices about therapeutic techniques (e.g., being more or less directive). Are our boundaries rigid in ways that might damage therapeutic alliance building, or that is more related to our habits and own cultural lens than about what is therapeutically appropriate? What may be perceived as professional by one client may be perceived as cold or impersonal by another.

Awareness of our positionality in relation to our clients is not something we do alone, but rather in clinical consultation as necessary, as well as in dialogue with the client. While we can consult resources about cultural norm differences, or potential areas to consider when working with certain cultural groups, there is no substitute for assessing those factors for the individual sitting in the room with us. Research shows that the acculturation process is far from standard, and that different individuals have vastly different approaches to relating to their host and native cultures (Berry, 1997; Berry, Phinney, Sam, & Vedder, 2006; Nguyen & Benet-Martinez, 2007). Understanding how the clients sitting in front of us make sense of their experiences, and relate to us, is of utmost importance, rather than assuming knowledge or basing our case conceptualization on group generalizations, or even our own experience. Assumptions

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can include beliefs about a client's experiences, a client's preferred language for self-identification, and expectations about what language a client may wish to receive treatment in, to name a few.

Inquire (gently) as to client's immigration experience and documentation status. Luciana described to me the terror she felt, upon beginning her life in the United States, every time a plane flew overhead. She had made her way to the U.S. illegally by utilizing a "*coyote*" (a travel broker), traveling with a group of other immigrants. In addition to facing the risk of being detained or returned to her home country at any moment, she also faced the risk of losing thousands of dollars (that she did not have)—the fee charged to utilize a *coyote's* services, which is often paid in part up front, the rest to be paid off upon arrival to the destination country, but which individuals are responsible for, regardless of whether or not they are deported at some point. Luciana also described the fear of sexual assault that haunted her throughout her migration journey, indicating a stranger posed as her husband for protection. For the first several months of her stay in the U.S., every time a plane flew overhead, she was afraid she would be identified as an illegal immigrant and deported. She reported avoiding leaving the house due to this fear, as well.

Experiences of fear, abuse, and other traumas in transit, or before migration, have significant implications for mental health, and for areas to be explored and addressed in mental health treatment (Foster, 2001). To that end, it is important to assess for immigration trauma in addition to other mental health factors at intake, as well as throughout treatment. These experiences may be related to traumatic stress reactions (e.g., feelings of fear, discomfort, and alienation) and may potentially serve as barriers to treatment. When meeting with a client of undocumented status, it may beparticularly important to delineate client rights to confidentiality and focus immediately on psychotherapy as a safe space.

Employ a systems- and family-informed lens to treatment. Luciana had originally come to the United States to work for a "couple of years" with her husband and return to Brazil more financially stable, but instead they remained in the country for 10 years. In the meantime, she and her husband had exhibited different styles of acculturation. While he practiced English at his restaurant job and was able to respond to their American-born daughter in English, he nevertheless struggled with Luciana's newfound financial freedom. While Luciana appreciated the chance to contribute financially to the home, and in some ways felt increased agency, she rejected many aspects of American culture and clung to the idea of returning "home." She struggled with feelings of alienation, not only from the broader culture, but also from her own immediate family.

In our clinical work, it is important to ask: Where does this client fit into the culture of origin, family, and broader society? How does the client identify ethnically/racially/culturally? Be aware of potential aspects of identity negotiation to be addressed in treatment, including gender role renegotiation and conflict, potential difficulties in relating to family members in the U.S. and in the native country, and potential feelings of alienation from family members, cultural group, and greater society. For example, clients may have a strong support network with other people in their cultural communities, but may feel alienated and lack confidence when visiting their children's schools and interacting with

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other parents or teachers. It is crucial to recognize the social context in which the client is embedded, and help the client navigate potential struggles in renegotiating a sense of self.

Foster (2001), in her review of the literature on immigration and mental health and discussion of related treatment guidelines, discusses the importance of approaching the assessment process with sensitivity, urging clinicians to be attentive to cultural and relational factors and to avoid over-pathologizing of clients. A client speaking in a non-native language may exhibit detached affect while struggling to communicate effectively, which may be related to language difficulties, as well as relational factors; clinicians should avoid simply assuming "affective blunting" related to "more severe psychological states" (p.165). Foster (2001) states, "The fear and frustration of not being understood—particularly when such high stakes as psychiatric hospitalization are involved—can be paralyzing for some" (p.166).

Provide treatment through a lens informed by particular barriers faced by client. After several sessions, Luciana obtained employment at a fast-food restaurant and informed me she would be starting the following week. Given the fact that her lack of employment over the past couple of years had been a significant contributor to her depressive symptoms, both she and I agreed taking the job would be helpful in fostering her sense of purpose and boosting sense of self. However, this was also a job where shifts were assigned on a week-to-week basis, and she felt the pressure to be available during large chunks of time, which meant she was quite reluctant to continue having a standing appointment time with me. As much as Luciana discussed her appreciation for our sessions, and indicated improvement in her mood in the time we had met, she felt the need to prioritize her job and expressed anxiety about informing her employer she was unavailable at a given time on a regular basis. Although I discussed her right to mental health treatment, and her legal right to prioritize her physical and mental health, including offering to write a letter confirming her attendance in treatment, Luciana chose to terminate treatment at that time in service of prioritizing availability to her employer, with the understanding that she could re-engage in treatment at any time.

Conclusions

In working with immigrant clients, it may be necessary to adjust treatment goals based on internal and external barriers to treatment. Effective clinical intervention requires informing clients of their legal rights, emphasizing confidentiality in session and utilizing an approach that is collaborative, curious, and flexible to the client's needs. Ethical treatment may include being less rigid with treatment structure and being aware of our own biases and assumptions for what treatment 'should' look like. For example, it may be necessary to adjust treatment frequency when clients experience difficulty in obtaining child care. We may need to re-examine our assumptions around physical touch: while one client may identify with a religion that bars physical contact with non-family members, another client may wish to extend a hand or hug a therapist, seeing complete lack of physical contact as a barrier to the therapeutic alliance. Ethical treatment may also include addressing anxieties clients face about the therapeutic process, such as concerns about the therapeutic alliance, worries about being misunderstood, and concerns about the stigma of therapy. Al-

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though we as clinicians may value cultural competence, we do not always have a clear understanding of the ways in which individual clients negotiate aspects of their identity, the immigration experience, or the presenting concerns that bring them to treatment. We should strive to continually expand our cultural competence generally, as well as engage in an ongoing conversation with our clients about their needs, experiences, and goals for treatment. Both in research and clinical work, it is also critical to be aware of our positionality given our own multiple identities, and our own experiences of privilege and marginalization.

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STUDENT FEATURE

From Airman to Student

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2,969 days…just shy of eight years. This is how long I spent as an active duty Airman, or more specifically, as an officer in the United States Air Force. If you count the four years in the Reserve Officer Training Corps (ROTC) throughout college, it totals almost 12 years responding to the call of duty. Considering the fact that I am now 31 years old, it is safe to say my entire adult life has been spent serving in the military ranks. I knew I wanted to join the military since I was 12 years old, after reading Rick Atkinson's *The Long Gray Line: An American Journey of West Point's Class of 1966* (1989) the summer before eighth grade. I knew I wanted to be part of something "bigger than myself." Next, came commissioning into the officer ranks, two deployments, four relocations, and hundreds of soldiers, sailors, airmen, and marines who humbly served alongside me. I loved every second of my time in the service because it taught me teamwork, leadership, integrity, service before self, and discipline.

Six months ago, I decided it was time to leave the service I loved and pursue my next dream of becoming a clinical psychologist. Growing up with my father working in this field, I was always interested in psychology. However, it was my time in the service that solidified my desire to be involved in clinical psychology as my next career. As an officer in the military, your people are (in many ways) more important than your mission, and it was the experience of helping my subordinates through difficult times that made me realize I wanted to practice psychotherapy full time. As I am sure most of you know, it is quite a lengthy process, and committing to half a decade of school at age 31 is a bit daunting. This past December, I finished my first semester of the PsyD program in Clinical Psychology at Loyola University Maryland. I spent a majority of the semester adjusting to civilian life, learning how to be a student again, and coming to the realization that service to the country comes in many forms.

I met my 12 classmates at fall orientation, and we will all attest that we coalesced quickly from the first day. After four months together, I can say they are the most supportive and nurturing group of individuals I have had the honor of knowing. As a former military service member, I do not make that statement lightly. Military members quickly bond together as we constantly move around, spend holidays away from family and friends, and serve together in support of a shared mission. So, when I say my cohort is like a family, I speak as someone who has a great deal of experience making family out of those with whom I work.

I noticed early on that my cohort varied greatly in age and experience. The youngest woman in my class is 21 years old, fresh out of college (and out early, I might add). Wow, do I admire her! It took me eight years post-undergrad to gather the courage to apply to a doctoral program. This young woman knew

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what she wanted before she had graduated with her undergraduate degree. Out of my classmates, there are 11 others like her: driven, ambitious, and extremely intelligent young professionals. I admire them all, as I admire the young men and women who graduate high school and enlist into the service. They all are on a mission to better themselves, a quality that cannot really be learned, but is innate within you. Whether such betterment comes through military training or education, it makes no difference to me. Yes, there is an age difference between myself and my classmates, but ambition is admirable no matter the age.

Another difference in my cohort I quickly noticed was the variance in experience. Impressive is not the right word for what my classmates brought to the program: several master's degrees, externships at VA medical centers, experience working with children whose diagnoses fall on the autism spectrum, participation in research, skills working in inpatient centers, and jobs in psychometric assessments, to name a few (my classmates also no doubt brought in high GPAs and GRE scores, but I have nothing to confirm this but the knowledge that they are all extremely bright) —and all before the age of 30! In no way does this diminish the importance of my own experiences; however, while I have led and trained military members, spent time in the "sandbox" (in my case, Iraq), and had involvement in national military events, these individuals are going to help me learn about my new passion by sharing their experience in the field. In return, I hope to lead by example to show them how teamwork, discipline, leadership, and a commitment to service will help them as they continue through graduate school and transition into roles as clinical psychologists.

I previously mentioned the transition out of military life and into life as a graduate student was difficult. The structure I was used to living in was no longer present; instead, I faced a more fluid path that I would determine. For the first time in my adult life, I decided what interested me, what I wanted to do with my career, where I wanted to live, and how I wanted to affect change in the world. This was a novel experience for me. Since my freshman year in college, I was told "you'll have a chance to voice your desires on job and location, but it all comes down to what the Air Force needs." This newfound freedom was a bit intimidating! I immediately sought out mentors and, with their support, have since found myself creating my own structure, using my ability to plan to help me sort out an often hazy outlook regarding which electives to take, which externships to apply to, and anticipating the daunting APPIC process.

Another now-absent aspect of life in the service is the heavily-structured hierarchy I became accustomed to functioning in every day. In the military, you wear your hierarchical-mark on your sleeve or collar in the form of rank. It, along with badges and ribbons, displays your experience—anything from which wars of which you have been a part to specific training you have received to your level of expertise in any number of tasks. These things do not exist in academia (or anywhere outside the military in all honesty). To those who have never lived in this kind of culture, the lack of such apparent structure may not seem to be something to which one need adjust. So, there is not much of a hierarchy—who cares? It makes everyone relative equals and promotes collaboration. As far as learning about peoples' experiences and training, just ask them! Or, if necessary, read about them on their websites. Who

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needs to wear this stuff on their clothing…to work…every day? To this I say: Imagine walking into a grocery store with no labels on the packaged food. You do not know which brand is which, what a product is made with, or even how much it costs. It would be disorienting, at least at first, until you figured out how to manage your way through purchasing what you need. Well, that is what the first semester of graduate school felt like for me. In this professional setting, which seemed to be missing something I relied upon heavily, I needed to come up with another way to manage my surroundings and navigate towards those who could help me mold a path for myself as a clinical psychologist.

Throughout my first semester, many asked if I thought I made the right decision by leaving a military career I truly loved to go back to school as a civilian and eventually start an entirely new career in my mid-30s. Throughout the semester, I was challenged by the transition into civilian culture, being a student again, and living without a paycheck for the first time in my adult life. However, I have no doubt that I made the right decision to return to school for my doctoral degree in clinical psychology. I also have no doubt that Loyola University Maryland is the right place for me to do this, because of the support I have received—not just from my classmates, but also from the faculty and senior students as well. I also believe, beyond the shadow of a doubt, I will be able to take the lessons of integrity, service, teamwork, discipline and leadership the military taught me, and influence the field of clinical psychology in a positive way.

Author's Note: I would like to extend a personal thank you to Dr. Jeffrey Barnett, whose suggestion to write out my thoughts on my transition from the military to civilian life as a graduate student allowed me to focus my energy and feelings on this major change in my life.

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

CALL FOR NOMINATIONS

Student Member of the Society for the Advancement of Psychotherapy's Publications Board

The Society for the Advancement of Psychotherapy (APA Division 29) seeks nominations and self-nominations of student members of the Division of Psychotherapy to be considered for a two (2) year renewable appointment on the Society for the Advancement of Psychotherapy's Publications Board. The Publications Board provides oversight and recommends publication policy for the division's journal, *Psychotherapy,* its bulletin, *Psychotherapy Bulletin*, its e-mail lists, its website (www.divisionofpsychotherapy.org), social media, and any other publications or means of communication with the division's members that are developed or used. Service on the Division 29 Publications Board provides an excellent opportunity to gain experience in processes involved in ensuring high quality publications, becoming more involved in Division 29, and expanding one's professional network by working collaboratively with published psychotherapy scholars.

The selected student member will be a full-voting member of the Division 29 Publications Board. The student member will attend one meeting each year in Washington, D.C., typically in January or February for one day. Additionally, the student member will participate in up to three conference calls and periodic e-mail communication throughout the year. All reasonable expenses incurred for attending the meeting in Washington, D.C. are reimbursed by the Society for the Advancement of Psychotherapy in keeping with its governance reimbursement policies.

To be considered for this appointment, interested individuals should forward the following materials to the Chair of the Publications Board, Dr. Jeffrey Barnett, at jbarnett@loyola.edu:

1) The nominee's identifying information to include name, degree, contact information to include e-mail address and telephone number, school and program, year in school,
2) The nominee's c.v.,
3) A brief statement of interest in service on the Pub Board, and a brief description of the nominee's experience relevant to service on the Pub Board, and
4) A letter of recommendation from a faculty member that addresses the student's abilities, strengths, and any other attributes or issues relevant to service on the Publications Board.
5) Additionally, the nominee must include a statement of willingness to serve for the two-year term and to attend all meetings and participate actively on the Pub Board if appointed to this position as well as a statement that verifies that the nominee will not graduate prior to the end of the two-year term.

To be considered for this position, submit all materials to Dr. Barnett by midnight on October 15, 2016.

WASHINGTON SCENE

"These Boots Are Made for Walkin'"

Pat DeLeon, PhD
Former APA President

For the past several conventions, I have had the exciting opportunity to join with visionary colleagues (from a broad range of professional backgrounds) hosting symposia addressing the wide range of issues surrounding "meaningful retirement." All of us have noticed that a number of our well-known senior colleagues have "opted out" of their historical involvement within the APA governance, with even some Past Presidents no longer attending the annual conventions—perhaps as a result of "physical challenges." Involvement in APA has historically provided meaningful social and emotional support for all of us, not to mention considerable status and societal respect. As psychologists, we **know** that this is important for one's health and well-being.

This year in Denver, long time public servant Rod Baker will discuss his evolution towards writing that novel that he had always thought he would do in retirement—finding fun and a sense of accomplishment and purpose, such that he now looks forward to spending most of his time in retirement with that activity. Walter Penk, last year's recipient of an APF Gold Medal Award and now in his 80s, continues to work tirelessly on behalf of our nation's Veterans and especially those returning to universities as students. Walter embraces three goals: reading, writing, and running. Running, because physical and mental health are essential—not just when young, but especially when older. Ellen Cole has undertaken the challenge of confronting Aging Discrimination. Still academically-based, the highlights of her journey include teaching Introductory Psychology to high school students, going back to school to earn her Master's degree in Applied Positive Psychology (her biggest adventure), and continuing her active journal involvement. Our audiences seem to enjoy themselves, suggesting additional topics for the following year (for example, the stress of dealing with major physical difficulties). From our perspective, these thought-provoking discussions touch upon foundational issues that will increase in importance for **all** professional associations, as their membership gradually ages and their next generation matures and takes center stage.

Over the years, APA has had truly outstanding individuals serving for a year in Washington, DC, under its Congressional and Executive Branch Science Fellowship program. During the 2003 Toronto convention, Fellow Neil Kirschner opined: "More often than not, research findings in the legislative arena are only valued if consistent with conclusions based upon the more salient political decision factors. Thus, within the legislative setting, research data are not used to drive decision-making decisions, but more frequently are used to support decisions made based upon other factors. As psychologists, we need to be aware of this basic difference between the role of research in science settings and the legislative world. It makes

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the role of the researcher who wants to put 'into play' available research results into a public policy deliberation more complex. Data needs to be introduced, explained, or framed in a manner cognizant of the political exigencies. Furthermore, it emphasizes the importance of efforts to educate our legislators on the importance and long-term effectiveness of basing decisions on quality research data. If I've learned anything on the Hill, it is the importance of political advocacy if you desire a change in public policy." Neil will soon be "retiring" from the American College of Physicians (ACP) on his 70th birthday.

Under Neil's guidance, the ACP Health and Public Policy Committee recently recommended: *That ACP support the integration of behavioral health care into primary care and encourage its members to address behavioral health issues within the limits of their competencies and resources. *That ACP recommend that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care. *That ACP encourage efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting. *That ACP recommend that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These must address the negative perceptions held by the general population and by many physicians and other health care professionals. And, *that physicians and other health care professionals will have to consider the behavioral and physical health of the patient if they are to be treated as a "whole person."

Another psychologist visionary, Mitch Prinstein, recently conducted a survey of psychologists for Division 53 (the Society of Clinical Child and Adolescent Psychologists) exploring their perceptions of how the field will change in the next couple of decades. There was a very impressive response rate with 619 individuals participating; 46.0% indicated they were practitioners, while 17.3% were students. Independent practice and university-research were their two top workplaces. When asked: "As compared to now, clinical psychologists will be engaged in much MORE... in 2032"; Clinical Services (26%) and Interdisciplinary Collaboration (21%) were the two top noted. When asked: "In 2032, clinical psychologists will need to be much more competent in…."; Interdisciplinary Collaboration and Psychopharmacology, Prescribing, Medical Settings, received 10% of the vote. Clinical Services received 23% of the vote; and of those votes, Technology Based Work received 16.2%, second only to Evidence-Based Practice in Psychology (EBPP) which received 30.9%. Clearly, there is the growing perception in the field that significant change is upon us.

The Next Generation

Today's champion for prescriptive authority (RxP) is Beth Rom-Rymer, a longtime member of the Council of Representatives. "Probably my greatest inspiration, as I criss-cross Illinois and our country, talking about the mounting enthusiasm for prescriptive authority, are the words, themselves, of our (more than 100) prescribing psychologists in training: 'My decision to seek prescriptive authority is part of the natural evolution in my continuing efforts to serve underserved and Spanish-speaking

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communities. It is borne from personal experience with trauma, as well as from my many work experiences in which I've seen patients wait for extended periods of time, and/or travel over 2 hours, one way, for a psychiatric appointment. In my current and recent jobs, our institutions have struggled to hire psychiatrists. However, we could not locate any candidates in over 2 years of active recruitment. I want to meet these glaring needs. As Illinois progresses, I look forward to collaborating with colleagues in other states so that prescribing psychologists become a national healthcare standard.'

"Two of the largest Illinois State Universities (with tens of thousands of undergraduate students) have added undergraduate concentrations in a 'pre-prescribing psychologist' curriculum; and more than 20 hospitals and medical centers, statewide, are working, in collaboration with the Illinois Psychological Association (IPA), to provide medical rotations for the prescribing psychologist trainee. While organized medicine and psychiatry had vociferously opposed the Illinois bill during the lobbying effort, now that the law has passed, both general medicine and psychiatry have been working hand-in-hand with us to implement the law and accelerate the integration of prescribing psychologists into the healthcare provider network statewide.

"Under the leadership of prominent healthcare economist, Uwe Reinhardt, scholars at Princeton University's Center for Health and Well-Being have been doing extensive research on the effects of healthcare providers' expanded scope of practice on health status. An article, soon to published, has been provisionally titled: 'Just What the Nurse Practitioner Ordered: Independent Prescriptive Authority and Population Mental Health.' One of the stunning preliminary results of this research (looking at mortality data from 1990 to 2013) is that states 'that grant independent prescriptive authority to nurse practitioners experience, on average, a 12% reduction in 'mental-health-related mortality' (including suicides, deaths of unknown intent, and accidental deaths). The results are more pronounced in areas with a low psychiatrist-to-population ratio and among populations with low levels of education.' These scholars will also be looking at similar health status data from states that have granted prescriptive authority to psychologists."

Additional Reflections on the Hoffman Report

Those attending the Toronto convention had to be impressed by the energy generated surrounding the release of the Hoffman Report. Dedicated and sincere colleagues were passionate about their conflicting views of what had transpired and the underlying causes/issues. Accordingly, I asked the perspective of a long-time colleague, for whom I have tremendous respect: "Discussions regarding the Hoffman report continue. In October, four psychologists named in the report issued a response that provided documentation refuting Hoffman's central conclusion, namely, that military psychologists worked to keep ethics guidelines 'loose' in order to enable detainee abuse. In fact, it appears that the very psychologists under scrutiny assisted in drafting Department of Defense policies designed to prevent detainee abuse. One such policy, which US Army COL (Ret) Dr. Debra Dunivin helped draft, was itself contained in the Hoffman report supplemental materials and prohibited the very interrogation techniques Mr. Hoffman alleged military psychologists sought to permit. In November, Division 19, the Society for

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Military Psychology, issued its own response to the Hoffman report which provided examples of what the Division felt was a deep seated anti-military bias in the report. APA has yet to respond publicly to the substantive and compelling criticisms of the Hoffman report in either of these documents. According to *The New York Times*, Mr. Hoffman has declined to comment on these points.

"In addition, the Pentagon has brought forth serious concerns about the 2015 APA policy. It seems that when they voted, many Council members did not realize the 2015 resolution would prevent military psychologists from providing psychological services to detainees. In a letter to APA, Pentagon officials pointed out that this aspect of the resolution appears to violate Common Article 3 of the Geneva Conventions. The Pentagon has asked APA to reconsider the blanket prohibition against psychologist involvement in interrogations. The plan is for APA and DoD representatives to meet soon regarding APA policy and DoD concerns. It will be critical for both sides to listen to one another carefully in order to craft policies that successfully integrate national security and respect for human rights. As it moves forward, APA will need to consider how it views the appropriate role of a member association, that is, whether the association's primary focus should be on promoting human rights, or rather on advancing the legitimate interests of all of its members."

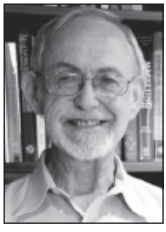
"Start Walkin'!"

Aloha.

BOOK REVIEW

Book Review of *The Human Elements of Psychotherapy: A Nonmedical Model of Emotional Healing* by David N. Elkins. Washington, DC: American Psychological Association, 2016, 155 pp. ISBN 9781433820663.

Arthur C. Bohart, PhD
Santa Clara University
Meridian University, Petaluma, CA



Currently, there is a paradigm clash between different visions of the nature of psychotherapy. The clash is not merely about what psychotherapy is, how it helps, and how it should be practiced. It is also about the nature of scientific evidence and what the evidence shows about effective practice. In the forward to this book (Elkins, 2016), Barry Duncan argues research supports the idea that the effectiveness of psychotherapy is largely due to the therapist, the client, and their relationship. By contrast, those who favor so-called empirically supported treatments argue the evidence supports the predominance of the use of specific techniques for specific disorders. Baker, McFall and Shoham (2008), have gone so far as to label the therapeutic relationship and other common factors as "marginal" scientific constructs. Could there be any clearer evidence of how polarized these different visions are?

In this book, Dave Elkins (2016) develops the relational side of the argument. I am not writing here to promote either side, although I have been identified with the relational side paradigms (Bohart, 2000). Instead, I am here to evaluate Elkins' contribution to the discussion.

Elkins' basic thesis is that there is a paradigm revolution taking place, with a relational model of healing in psychotherapy ascending. He is not the first to argue that relationships heal in psychotherapy. Others (e.g., Greenberg, 2014; Schore, 2012) have argued for the healing power of the relationship on the basis of neuroscience and attachment theory. However, Elkins is one of the first to frame the argument in the context of the empirical debate between those supporting what he calls the "medical model" (focusing on a diagnosis-treatment paradigm), and those who support a relational model (see also Wampold & Imel, 2015). The advocates of relational points of view, of which I have been one, have been so busy defending against attacks from empirically supported treatments advocates that they have not spent as much time on developing a proactive relational view. Elkins book attempts to do this.

In the first chapter, Elkins reviews the evidence for a "nonmedical model" of psychotherapy. He draws a distinction between a model emphasizing human relational aspects and the medical model. The diagnosis-treatment paradigm has been dominant due in part to the fact that those who fund health care think in its terms. In a medical model of treatment, the physician (or psychotherapist) diagnoses a condition or disorder,

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and then "treats" it with various strategies (e.g., drugs, exercise, surgery, radiation, various psychotherapeutic exercises and techniques). The *healing* aspect resides primarily in the techniques employed, with specificity of disorder and a tailored symptom-oriented treatment preferred. It is this model that underlies the development of empirically supported treatments (e.g., Chambless & Hollon, 1998) and subsequent controversy over that notion (Norcross, Beutler, & Levant, 2006).

Few in modern medicine would discount the importance of the physician-patient relationship. However, the relationship (sometimes relegated to the term "bedside manner") is seen as providing an *auxiliary* role. The good healing relationship is a context wherein the physician can most effectively diagnose and provide treatment. The relationship therefore functions primarily by helping calm the patient and enhance compliance. Although there is some evidence the relationship may also facilitate healing (e.g., Del Canale et al., 2012), the role of the relationship in medicine is still primarily that of support for what the physician does. This is the method for psychotherapists who think in terms of the medical model. Goldfried (1997), for example, has pointed out the relationship in cognitive-behavior therapy largely functions as an "anesthetic" which allows the "surgery" of effective interventions to take place.

By contrast, Elkins (2016) argues it is the relationship that heals; diagnosis of specific disorders and treatment with specific interventions is unnecessary. He cites evidence supporting the relational model over the diagnosis-treatment model. In a nutshell, Elkins relies on evidence from meta-analyses showing all approaches to therapy work about equally well for most disorders. If vastly different approaches work equally well, and there is no evidence for differential effectiveness for virtually all disorders, it becomes difficult to argue the specific techniques or interventions are "doing the work." Furthermore, the notion of underlying "common factors" accounting for effectiveness is supported (e.g., Duncan, Miller, Wampold, & Hubble, 2010; Wampold & Imel, 2015). The common factor for which there is the most research support is the therapeutic relationship (e.g., Norcross, 2011).

Elkins (2016) claims the relationship *is* the intervention; psychotherapy is an expression of healing through human connection and social interaction. He cites research showing how important relationships are in human development. He spends one chapter looking at attachment theory and social healing aspects of relationships (Chapter 2), and another exploring how humans have been "built" by evolution to develop and preserve their social and emotional well-being through social relationships (Chapter 3). He also looks at how we are neurologically "wired" to respond to one another relationally. He then reviews the 1800s practice of Moral Therapy (Chapter 4), which had among the best outcomes ever for the treatment of psychosis, and is an exemplar of a relational perspective. He concludes by exploring the implications of his thesis for therapy research, practice, and training (Chapter 5).

With Elkins' (2016) focus on the pro-relational view, this book is not a critical evaluation of research on both sides of the issue. It will not satisfy critics from the technique-oriented side of the argument. I suspect such critics would question Elkins' conclusions on the strength of the relational evidence. They might point out that most of the evidence sup-

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porting the importance of the relationship in psychotherapy is correlational. For instance, the evidence that the relationship, as rated by clients early in therapy, predicts outcome may be confounded by the possibility that those who are succeeding in therapy early may simply rate the relationship as stronger.

In making his argument, Elkins (2016) cites both attachment and neuroscience evidence, such as research on mirror neurons. While the body of research on attachment in psychotherapy is increasing, it has not been shown that the attachment relationship between therapist and client is the healing factor. In addition, critics might point out that the existence of mirror neurons has yet to be demonstrated as providing a basis for the complex interpersonal skill of therapeutic empathy, although the analogy underlying it is intriguing. In sum, if you are a believer in empirically supported treatments, Elkins' book will not convince you.

However the purpose of the book is not to rehash the debate between the different points of view, but rather to attempt to strike new ground (Elkins, 2016). It is odd in some respects, given the research on attachment and other research on the direct impact of relationships on both physical and mental health, that there is still a battle over whether a relational *healing* component is pertinent to psychotherapy, beyond the role of the relationship as support for technique-based interventions. It is valuable to have someone lay out an argument like Elkins has, independent of the issue as to whether specific interventions are useful as well.

I do have some criticisms. First, the book is short. Elkins' (2016) reviews of the research in various areas are brief and not comprehensive. He only briefly sketches out how attachment theory and neuroscience play into psychotherapy. I would like to see a follow-up in which Elkins more thoroughly examines the research on psychotherapy, documents the attachment and neuroscience literature in more detail, and then fleshes out an innovative model of how that literature supports the primacy of the healing power of the therapy relationship.

Second, I am less sanguine than Elkins (2016) about a paradigm revolution taking place. Empirically supported technique-oriented treatments remain dominant in training programs and in various practice settings. I believe it is fruitless to try to make it either/or. It is possible there are multiple ways to human healing. I have tried to hint at that possibility myself with a theory of the client as active self-healer (Bohart & Tallman, 1999). We argue that clients take whatever positive elements therapists offer and use them to self-heal—be they techniques or the relationship. It is entirely possible interventions can heal *and* that a separate pathway to human healing runs through relationships. It is even possible to imagine the two paradigms co-existing. In this case, it will be left to the future to figure out how they fit together. At any rate, Elkin's book is an important, valuable, and useful contribution on the side of articulating the argument for a relational model of healing.

Author's Note: I reviewed the initial proposal for this book for the American Psychological Association and gave it a favorable "go ahead."

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

CALL FOR NOMINATIONS

Society for the Advancement of Psychotherapy Internet Editor

The Publications Board of the Society for the Advancement of Psychotherapy is seeking nominations (including self-nominations) for the position of Internet Editor. A detailed position description is provided below.

The Internet Editor supervises and receives assistance and support from the Associate Editor for Web Content and a student assistant. To discuss the position further and to learn more about it, interested members are encouraged to contact the current editor, Brad Brenner, Ph.D. at bradbrenner@therapygroupdc.com

All nominations should include:

- a brief cover letter stating one's interest in the position,
- a description of relevant experience and skills,
- statement of one's vision for the website and the Society's online presence, and
- plans for using social media to support the Society's mission.

All nomination materials should be forwarded to the Chair of the Society's Publications Board, Jeffrey E. Barnett, Psy.D., ABPP by May 1, 2016: JBarnett@loyola.edu All interested individuals are encouraged to apply.

INTERNET EDITOR DUTIES

In digital form, the Internet Editor for the Society for the Advancement of Psychotherapy is dedicated to advancing the science, practice, and study of psychotherapy. The Internet Editor oversees the strategic implementation of website, social media, and other digital outreach.

DESCRIPTION OF COMMITMENT

Term

- 3-year term, beginning January 2017
- Starting approximately July 2016 begin shadowing and coordinating with the out-going Internet Editor to prepare to assume the role.

Time Commitment

- 10-15 hours per week

Honorarium

- $5000 per year

DESCRIPTION OF MINIMUM DESIRED WEBSITE-RELATED SKILLS AND KNOWLEDGE

Website Content Management System

- Familiarly with WordPress

Website and Social Analytics

- Familiarity with Google Analytics
- Familiarly with Facebook Insights

Content Marketing

- Familiarly with Search Engine Optimization (SEO) concepts

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FIDUCIARY RESPONSIBILITIES

Reporting Responsibilities

- Report directly to the Chair of the Publications Board of the Society for the Advancement of Psychotherapy
- Create a mid-year and year-end report of the activities of the Internet Editors

Budgeting Responsibilities

- Propose annual budget to the Publications Board
- Monitor and manage the Internet Editors' annual budget

Participation in Society Governance

- Participate in Publication Board meetings
- Participate, as needed, in Board of Directors meetings

STRATEGY

Digital Content Strategy

- Develop and oversee the implementation of strategy emphasizing publication of top-quality, engaging content
- Develop and oversee the implementation of editorial procedures to support reader engagement
- Develop and oversee the implementation of strategy to build relationships with potential contributors for original featured content
- Develop and oversee the implementation of strategy to incentivize submission of original content from Society members

Promote Printed Society Publications

- Develop active partnership with the *Psychotherapy* editor to promote recent volumes, special issues, notable articles, and trending topics
- Develop active partnership with the *Psychotherapy Bulletin* editor to promote recent volumes and publish relevant articles on the Society website

Social Media Strategy

- Develop and oversee the implementation of strategy for communication with members and prospective members via social media

Assist with Growing the Society

- Support increase of Society membership
- Support increased consumption of Society publications.
- Aim to increase involvement of graduate students and ECPs

Personnel

- Selection of personnel for support positions (e.g., Associate Internet Editor, Student Editorial Assistant)
- Management and oversight of support positions and coordination of their responsibilities and work (e.g., Associate Internet Editor, Student Editorial Assistant)

TECHNICAL AND USER EXPERIENCE

Monitor and Assess User Experience Effectiveness

- Perform monthly reviews of website and social media analytics data.
- Solicit and review proposals for on-going maintenance contract(s) and special digital/web projects, as needed
- Make recommendation of selected vendor(s) to the Publications Board
- Catalog and prioritize problems and difficulties (e.g., 'bugs') with the website

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- Address technological problems
- Minor problems to be directly handled by Internet Editor
- Significant problems referred to web developer

Refine User Experience

- Make recommendations about Information Architecture and appropriate User Experience and Website Developer vendors to the Publications Board, as needed
- In conjunction with a website development firm oversee periodic refinement of the Information Architecture (IA) of the Society's website, including reviewing site flow diagrams and site wireframes to best promote the Society's growing volumes of content.
- Select and guide development of appropriate web technology platform(s).
- Select technology/software system(s) for social media publication, engagement, and management.

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

NOTICE TO READERS

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

Michael J. Constantino, Ph.D.

I, Michael Constantino, am honored to be nominated for President-Elect of the Society for the Advancement of Psychotherapy. My engagement in Division 29 began on the Student Development Committee, and I have subsequently served as Chair of the Continuing Education Committee, Early Career Domain Representative to the Board, Chair of the Research Committee, and Contributing Editor to *Psychotherapy Bulletin*. I also serve on the Editorial Board of *Psychotherapy*. I owe the Division and its leaders a huge debt of gratitude for the positive influence they have had on my career development. I "cut my professional teeth," so to speak, in Division 29, which has served me well within APA and other sister organizations (such as my recent term as President of the North American Society for Psychotherapy Research [NASPR]). The Division has also honored me with the 2007 APF/Division 29 Early Career Award, and has awarded my colleagues and me the Charles J. Gelso Psychotherapy Research Grant, the Norine Johnson Psychotherapy Research Grant, and the 2013 Distinguished Publication of Psychotherapy Research Award. With appreciation and humility, I hope to "give back" to the organization and its constituents in the important role of President-Elect.

I am a Professor at the University of Massachusetts where I direct my Psychotherapy Research Lab, teach psychotherapy courses, supervise clinicians, and see patients. Across these roles, I am committed to integrating rigorous science with quality practice and training. Such commitment is exemplified by my scholarship, devotion to mentorship/ teaching, and substantive involvement in Division 29, the Society for Psychotherapy Research, and the Society for the Exploration of Psychotherapy Integration. My primary scientific contributions include (1) investigating patient, therapist, and dyadic characteristics/ processes that influence psychosocial treatments, (2) developing/testing therapeutic interventions that address pantheoretical principles of clinical change, (3) conducting effectiveness research in naturalistic settings, and (4) examining how basic social psychological constructs apply to clinical situations. I have published both theoretical and empirical works, and I have received extramural funding for my research (including from NIH, PCORI, and the Robert Wood Johnson Foundation).

If elected, I would approach this position much like I did my NASPR presidency. First, I would strive to uphold the tradition of successful Division 29 leadership. Second, I would attempt to simultaneously fortify strengths (and it is obvious that Division 29 is already strong) and start new initiatives. Prime examples of maintaining strength include, preserving and promoting healthy collegial exchange at professional meetings and between like organizations, and supporting the development of future generations of psychotherapy practitioners, researchers, and educators.

New initiatives would include developing work groups to translate cutting edge research findings to create newer psychotherapy training molds, fostering online and convention-based professional development mentoring on topics like practice-research network involvement/development and navigating NIH funding priorities, and creating a web-based brown bag series on psychotherapy science translation/ dissemination, including a safe place to tout "disruptive innovations" that extend the reach of psychosocial services. My hope is that such endeavors, and others, will foster Division 29's vital voice in psychotherapy theory, research, practice, and training. ■

Changming Duan, Ph.D.

Dear SAP members and colleagues,

I can't tell you how humbled I felt when being nominated to run for the president of our society. I never see myself as a leader, but always strive to be an instrumental and involved team player. I take pride and comfort in being helpful to others on my team or in my communities. The cultural values I learned while growing up in China have led to my belief that an effective leader first has to be a servant to his or her community.

I came to North America over 30 years ago for graduate school, and received a doctoral degree in counseling psychology and social psychology from University of Maryland. But I did not return home after graduation as planned because of the political unrest in China at that time. Instead, I started my professional career at University of Missouri, Columbia, at its counseling center and in its academic department, and then joined counseling psychology faculty at University of Missouri, Kansas City. Currently I am a professor of counseling psychology and the Director of Training for our doctoral program at the University of Kansas.

I have worked in various service roles within APA, including those of Council member, commissioner on the Commission of Accreditation, and SAP's program chair for APA Conventions. I also have been active in promoting the advancement of psychotherapy by establishing US-China collaborative training programs (The success of these programs is directly linked to those involved psychotherapy practitioners and schoars from the U.S.!) and by conducting psychotherapy process and outcome studies in China (We established the first China-U.S. research and training center in counseling psychology).

I asked myself "what can I do to be helpful if elected as the president for SAP?" The answer is simple: serving its members and promoting psychotherapy advancement. Being fully committed to SAP's mission, I will immerse myself in learning from and with SAP members and pursue our collective interests in psychotherapy practice, research and training and in service to our communities and society. My plan will include working to 1) strengthen member engagement to make SAP an increasingly welcoming, supportive, and attractive professional home for our members; 2) build upon previous and current SAP presidents' initiatives in furthering SAP's international visibility and efforts both in helping SAP members to make connections abroad for professional exchange and in increasing the size of SAP's non-APA international affiliate membership to SAP; 3) support members' interest in integrating diversity and social justice into psychotherapy science and practice by initiating, promoting and facilitating projects in this area; and 4) build for the future by increasing membership and member engagement among CEPs and students through mentoring. Our early career professionals and students have so much to offer to enrich our experience and enhance SAP's contributions to human health for future generations.

I deeply appreciate your taking time to read my statement.

Sincerely,

Changming Duan ■

CANDIDATE STATEMENTS
Early Career Psychologists Domain Representatives

Leigh A. Carter, Psy.D.

It is an honor to be considered to serve as the Division 29 Early Career Domain Representative. In addition to the ever-changing landscape of our field, I believe early career psychologists (ECPs) face unique challenges, and I am excited about the possibility to provide voice and representation for ECPs within the Society.

As the future of this profession, we hold a vital role in supporting and advancing the field of psychotherapy, and yet, many professional organizations face the ongoing challenge of encouraging membership and active participation among ECPs. Therefore, I am dedicated to building on the work the Society has already begun in fostering ECP participation through ongoing promotion and support of the Society's mentorship program and publication opportunities for ECP members. I also believe that increasing interconnectedness provides a greater a sense of community and shared resources among the Society's ECPs located across the country. This would include expanding the Society's virtual and in-person opportunities for ECPs to continue fostering this sense of community. Beginning in graduate school and now as an ECP I have benefitted from the resources and support of professional organizations including the Society, and am deeply committed to further enhancing what the Society can offer for its ECPs.

In addition to personal experience, my enthusiasm for serving as Early Career Domain Representative stems from my interests in self-care and professional development for psychologists and trainees. I have presented and co-authored a book and several articles on this topic. I have previously served as membership chair and liaison to the ECP Committee of the Maryland Psychological Association for Graduate Students, as the graduate student liaison within the APA Advisory Committee on Colleague Assistance, and served on the Society's selection committee for the Student Development Committee. I am currently a staff psychologist at Towson University Counseling Center. ■

Joshua Swift, Ph.D.

It is an honor to have been nominated for the Early Career Domain Representative position. I am currently an Assistant Professor at Idaho State University and a licensed psychologist. I received my Ph.D. from Oklahoma State University, completed an internship at SUNY Upstate Medical University, and held a previous faculty position at the University of Alaska Anchorage. My first experiences with the Society for the Advancement of Psychotherapy (SAP) came when I was a graduate student - in 2008 I attended SAP's social hour to receive one of the student awards. Since then, I have been an active participant in SAP, having served on the Early Career Committee, the Education and Training Committee, and as chair for the Research Committee. First as a graduate student, and now as an early career psy-

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chologist, I have always felt welcomed and valued within SAP. In serving as the representative for the Early Career Domain, I hope to be able to pass my positive experiences on to others. If elected, I plan to reach out to existing early career SAP members to see how they believe SAP can best serve them. I also hope to help these early career members become more involved in SAP's various committees and activities and maintain a place within SAP for networking and mentoring. Finally, I plan to reach out to early career individuals across the globe who are not currently members of SAP, share with them the exciting things happening in Society, and invite them to join us. ■

NOTICE TO READERS

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

CANDIDATE STATEMENTS
Science and Scholarship Domain Representatives

Andrés Consoli, Ph.D.

My name is Andrés Consoli, Ph.D., and I am running for the position of Domain Representative in Science and Scholarship of the Society for the Advancement of Psychotherapy, Division 29 of the American Psychological Association. It would be my pleasure and privilege to serve Division 29 in this capacity. If I were to be elected to this position, I would work collaboratively with our Society's leadership to advance the scientific foundations of psychotherapy and to support and promote innovative, socially responsible and responsive psychotherapy endeavors through the Society's scholarships.

I am an Associate Professor in the Department of Counseling, Clinical, and School Psychology at the University of California, Santa Barbara (UCSB). I am also a visiting professor at the Universidad del Valle in Guatemala and a licensed psychologist in California. Prior to joining UCSB, I was a faculty member at San Francisco State University for 17 years where I trained master's level practitioners. My previous leadership positions include the presidencies of the National Latina/o Psychological Association, the Interamerican Society of Psychology, and the Western Association of Counselor Educators and Supervisors. My professional and research interests involve transnational collaborations, program evaluation and community based participatory action research, multicultural supervision, psychotherapy integration and training, systematic treatment selection, ethics and values in psychotherapy, access and utilization of mental health services within a social justice framework, and the development of a bilingual (English/Spanish) academic and mental health workforce.

Please do not hesitate to contact me if you have any questions about my candidacy or qualifications. I can be reached at aconsoli@education.ucsb.edu. I thank you very much for considering voting for me. ¡Muchas gracias! ■

Susan S. Woodhouse, Ph.D.

I am honored to be nominated to run for a second term as the Science and Scholarship Domain Representative. The Society for the Advancement of Psychotherapy (SAP) has been a key intellectual home for me within APA. I enthusiastically continue to spearhead research-related initiatives for SAP, and I look forward to the opportunity to continue to move forward with these exciting initiatives. I am particularly interested in engaging and supporting early career psychologists and students, who are the future of our organization; as well as in initiatives that provide support for psychotherapy research that promises to move science forward, while being relevant to clinical service in the community.

I am a licensed psychologist and psychotherapy researcher. My research includes a focus on psychotherapy process, the psychotherapy relationship, and research on preventive interven-

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tions for families with young children. I am the PI on a $2.1 million NIH-funded study focused on basic science questions relevant to psychotherapy with diverse, low-income, underserved families with young children (and includes an applied component). I am involved in a number of additional research projects and an NIH grant application focused on psychotherapy and prevention work with diverse, low-income, underserved families. I strongly believe that that the work we do on the psychotherapy relationship, process, outcomes, client strengths, and culturally appropriate psychotherapy is important; and that the science of psychotherapy is relevant to the public good. In my own community-based research, I have worked hard to build trust with community stakeholders, engage the community in the research, and bring the results of the research back to the community. I believe those skills translate well to serving as the Science and Scholarship Domain Representative.

I received my doctorate (Counseling Psychology) in 2003 from the University of Maryland, College Park, and I am an Associate Professor at Lehigh University. ■

CANDIDATE STATEMENTS
Diversity Domain Representatives

Astrea Greig, Psy.D.

I, Astrea Greig PsyD, am a candidate for the open 2017 Diversity Domain Representative position on our division's Executive Committee. It has been a great pleasure to serve as Chair of the Diversity committee and I look forward to another rewarding experience this year. Through my position of Chair, I have been working with our current Diversity Domain Representatives and others of our division, to coordinate the delivery of informative content to you our members and represent your interests. Working with underserved and diverse populations is my passion and is fulfilled by my serving on diversity related initiatives for our and other divisions of APA and locally at health care centers in Boston. I am an early career psychologist, and am practicing psychotherapy, teaching psychotherapy, and am hoping to improve the access to psychotherapy to many who often do not have access. I understand the importance of the need to highlight how diversity intersects with the research, provision, and practice of psychotherapy. My hope is to bring this interest, experience, and perspective to the Diversity Domain Representative position. Our division has a wonderful history of promoting psychotherapy practice, research, and policy and I hope to continue to serve our division in this manner with the importance of diversity in mind. ■

Rosemary E. Phelps, Ph.D.

Dr. Rosemary E. Phelps is a professor of Counseling Psychology and the director of the UGA Preparing Future Faculty (PFF) in Psychology Program in the Department of Counseling and Human Development Services at the University of Georgia. She served as Department Head from 2006-2012 and was the first African American to hold this position in the Department. Dr. Phelps received her bachelor's degree in Psychology and master's degree in Guidance and Counseling from The Ohio State University, and her Ph.D. in Counseling Psychology from the University of Tennessee, Knoxville. She is the recipient of the 2010 American Psychological Association's Distinguished Contributions to Education and Training in Psychology Award and is an APA Fellow (Society of Counseling Psychology). She has built her 30-year career on teaching, research, and practice related to research on diversity issues and ethnic and racial identity development, examining professional issues for students and faculty of color, and mentoring students. Recently, Dr. Phelps has begun to facilitate research teams focused on the unique and varied experiences of African Americans in both personal and professional domains that affect psychological well-being. Her professional activities have included national and regional leadership positions including chairing the Ethnic and Cultural Diversity Committee and serving as Program Chair of Division 17 of the American Psychological Association (APA), chairing the Minority Interest Group of the Southeastern Psychologi-

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cal Association (SEPA), and chairing the SEPA Committee on Equality and Professional Opportunity (CEPO)/PSI CHI Undergraduate Research Program. She is also a 2016-2017 President-Elect nominee of the SEPA. "I am pleased to be nominated for the position of Diversity Domain Representative for the Society for the Advancement of Psychotherapy. I have spent my career engaged in training counseling psychologists committed to culturally responsive practice and to the advancement of psychotherapy—it would be a privilege to serve the division in this capacity." ■

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

CANDIDATE STATEMENTS

Council Representatives

Jean Carter, Ph.D.

I am Jean Carter, and I have been nominated for a second term on the APA Council of Representatives—a position of responsibility for governance of both APA and the Society. The Society needs knowledgeable and wise representation at this important time in APA's history. Council will implement governance changes (from the Good Governance Project); address policies around transparency, conflict of interest and ethics (raised by the Independent Review); and support the stability of APA financially and organizationally in a time of change. The learning curve will be steep and the issues are complex. I believe the Society would be well served by the continuity and experience my second term would offer. My reputation is as a collaborative and steady voice, bringing perspective and experience in challenging situations. In addition to serving APA, Council Representatives serve on the Society's Board of Directors and have responsibility for the well being of our division. During my presidency of the Society, I initiated the reorganization that brought us the Domain structure of our governance, which was energizing and enlivening. As a member and chair of the Publications Board, I supported the move to APA as the publisher of Psychotherapy and the selection of Mark Hilsenroth as our excellent editor. As your representative on Council and the Executive Board, I will work hard and thoughtfully to best support the needs of the Society, the enterprise of psychotherapy and APA. ■

Lillian Comas-Diaz, Ph.D.

It is an honor to be nominated to run for the position of Council Representative. I am a psychotherapist in full time private practice. I also serve as a Clinical Professor at the George Washington University Department of Psychiatry and Behavioral Sciences. As a practitioner–scholar, most of my publications are regarding psychotherapeutic issues. My main professional areas of interest are multicultural and feminist psychotherapies, social justice, international psychology, and psycho-spirituality. I believe in giving psychology away and do so through media presentations in the Spanish language.

I would like can to represent the Society for the Advancement of Psychotherapy at the APA Council of Representatives. I have extensive experience in APA governance, both as a past director of the APA Office of Ethnic Minority Affairs, as well as a past member of several governance groups. I have been Council Representative for Divisions 12 (Clinical Psychology) and 35 (Women's Issues). Additionally, I have been president of Division 42, and chair of the APA Committee of International Relations. I am a fellow of our Society and a past member of the Editor Search Committee for Psychotherapy: Theory, Research, and Practice Journal. Additionally, I have served a s a Consulting Editor for this journal, and currently, I am a member of our Society's Publication Board.

I will be honored if you vote for me. You will be voting for passion, experience, and commitment to psychotherapy. ■

Libby Nutt Williams, Ph.D.

I was honored to be asked to run for Council Representative for Division 29. I believe that the Council of Representatives has been doing an excellent job as the voice of the membership, particularly in the wake of the Hoffman Report. Thus, I take very seriously this nomination and would approach the opportunity to serve on Council as a way to ensure that issues relevant to Division 29 members (ethical and culturally competent psychotherapy practice, research, education, and advocacy) are attended to at all levels of the APA.

In my professional work, I have been a professor of psychology at a public honors college for nearly 20 years. My primary areas of research include psychotherapy process research, feminist multicultural counseling, and qualitative methodology. I have worked with Division 29 governance over the last 10 years, first as the Early Career representative to the Board of Directors in 2005, then as the Membership Domain Representative (2008-2010), and as President of the Division in 2011. I have consistently focused on a few key issues: 1) clarifying our divisional identity, 2) strengthening the link between psychotherapy science and practice, and 3) promoting tangible evidence of our commitment to diversity and multiculturalism.

I am proud to be part of the Division's history (see Williams, Barnett & Canter, 2013) as well as its bright future. I care deeply about the Division and about our flagship journal *Psychotherapy*, and I would be honored to be a Council Rep for 29. Thank you for your consideration. ■

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