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BULLETIN

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Armand Cerbone, PhD
3625 N Paulina St
Chicago, IL 60613
Ofc: 773-755-0833 | Fax: 773-755-0834
E-mail: arcerbone@aol.com

President-elect
Jeffrey Zimmerman, PhD
391 Highland Ave.
Cheshire, CT 06410
Phone: 203-271-1990
333 Westchester Ave., Suite E-102
White Plains, NY 10604
Ofc: 914-595-4040
E-mail: drz@jzphd.com

Secretary
Barry Farber, PhD, 2015-2017
Dept of Counslg & Clinical Psychology
Columbia University Teachers College
525 W 120th St
New York, NY 10027
Ofc: 212-678-3125 | Fax: 212-678-8235
E-mail: farber@tc.columbia.edu

Treasurer
Jesse J. Owen, PhD, 2016-2018
University of Denver, Morgridge
College of Education
Counseling Psychology Department
1999 E Evans Ave
Denver CO 80208
Ofc: 303-871-2482
E-mail: jesse.owen@du.edu

Past President
Rodney K. Goodyear, PhD
School of Education
University of Redlands
Redlands, CA 92373-0999
Ofc: 909-748-8800
E-mail: rod_goodyear@redlands.edu

Domain Representatives

Public Interest and Social Justice
Rosemary Adam-Terem, PhD, 2015-2017
1833 Kalakaua Avenue, Suite 800
Honolulu, HI 96815
Ofc: 808-955-7372 | Fax: 808-981-9282
E-mail: drrozi@yahoo.com

Psychotherapy Practice
Barbara Thompson, PhD, 2016-2018
3355 St. Johns Lane, Suite F.
Ellicott City, MD 21042
Ofc: 443-629-3761
E-mail: drbarb@comcast.net

Education and Training
Jennifer Callahan, PhD, 2016-2018
UNT Department of Psychology
Terrill Hall, Room 376
1155 Union Circle #311280
Denton, TX 76203-5017
Ofc: 940-369-8229
E-mail: Jennifer.Callahan@unt.edu

Membership
Jean Birbilis, PhD, 2016-2018
University of St. Thomas
1000 LaSalle Ave., MOH 217
Minneapolis, Minnesota 55403
Ofc: 651-962-4654 | Fax: 651-962-4651
E-mail: jmbirbilis@stthomas.edu

Early Career
Rayna D. Markin, PhD, 2014-2016
Department of Education and Counseling
302 Saint Augustine Center
800 Lancaster Ave
Villanova, PA 19075
E-mail: rayna.markin@villanova.edu
Ofc: 610-519-3078

Science and Scholarship
Susan S. Woodhouse, PhD, 2014-2016
Department of Education and Human Services
Lehigh University
111 Research Drive
Bethlehem, PA 18015
Ofc: 610-758-3269 | Fax: 610-758-3227
E-mail: woodhouse@lehigh.edu

Diversity
Jairo Fuertes, PhD, 2014-2016
Derner Inst. of Advanced Psychological Studies
Adelphi University Hy Weinberg Ctr Rm 319
158 Cambridge Ave.
Garden City, NY 11530
Ofc: 516-877-4829
E-mail: jfuertes@adelphi.edu

Diversity
Beverly Greene, PhD, 2016-2018
Psychology, St. Johns University
8000 Utopia Pkwy.
Jamaica, NY 11439
Ofc:718-638-6451
E-mail: bgreene203@aol.com

International Affairs
Frederick Leong, Ph.D. (2016-2017)
Michigan State University
Department of Psychology
East Lansing, MI 48824
Phone: 517-353-9925; Fax: 517-353-1652
E-mail: fleong@msu.edu

APA Council Representatives
John C. Norcross, PhD, 2014-2016
Dept of Psychology
University of Scranton
Scranton, PA 18510-4596
Ofc: 570-941-7638 | Fax: 570-941-2463
E-mail: norcross@scranton.edu

Jean Carter, PhD, 2014-2016
Washington Psychological Ctr PC
5225 Wisconsin Ave NW #513
Washington, DC 20015
Phone: 202-244-3505 x3 | Fax: 202-364-0561
E-mail: JCarterPhd@gmail.com

Student Development Chair
Maria Lauer, 2015-2016
101 Race St. Apt 111
Catasauqua, PA 18032
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E-mail: marialauer2@gmail.com

STANDING COMMITTEES

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Fairbanks, AK 99775-5580
Phone: (907) 474-7043
E-mail: trousmaniere@gmail.com

Diversity
Chair: Astrea Greig, PsyD
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780 Albany St, Rm 3107
Boston MA 02118
Ofc: 857-654-1324
E-mail: agreig@bhchp.org

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Chair: Kevin McCarthy, PhD
Dept. of Psychology / Chestnut Hill College
St. Joseph's Hall 452
9601 Germantown Avenue
Philadelphia, PA 19118
Ofc: 215 248-7115
E-mail: kevin.mccarthy@chc.edu

Education & Training
Stewart Cooper, PhD
Counseling Services / Valparaiso University
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Ofc: 219-464-5002 | Fax: 219-464-6865
E-mail: stewart.cooper@valpo.edu

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365 Fifth Avenue
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Ofc: 212-817-7029
E-mail: rhatcher@gc.cuny.edu

Finance
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Behavioral Health Consultants
3018 Dixwell Avenue
Hamden, CT 06518
Ofc: 203-288-3554 x12 | Fax: 203-281-0235
E-mail: adholzman@bhcservices.com

Membership
Ann Judge, PhD
49 Old Solomon's Island Road, Suite 200
Annapolis, MD 21401
(410) 266-8555 (answering service)
E-mail: Anniejudge@aol.com

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Program
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Dept. of Psychology & Research in Education
University of Kansas
Lawrence, KS 66054
Ofc:785 864-2426 | Fax 785 864-3820
E-mail: duanc@ku.edu

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Chair: Barbara Vivino, PhD
921 The Alameda #109
Berkeley, CA 94707
Ofc: 510-303-6650
E-mail: bvivino@aol.com

Psychotherapy Research
Chair: Joshua Swift, PhD
Department of Psychology
University of Alaska Anchorage
3211 Providence Drive, SSB214
Anchorage, Alaska 99508
Phone: 907-786-1726
E-mail: jkswift@alaska.edu

Social Justice
Chair: Hiroshi M. Sasaki, PhD
Psychology Dept. / University of the West
1409 N. Walnut Grove Ave.
Rosemead, CA 91770
Phone: 562-756-6211
E-mail: hiroshis@uwest.edu

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SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
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6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

EDITOR
Lynett Henderson Metzger, Psy.D.
Lynett.HendersonMetzger@du.edu

ASSOCIATE EDITOR
Ian Goncher, Ph.D.
idgoncher@loyola.edu

CONTRIBUTING EDITORS

Diversity
Beverly Greene, Ph.D., and
Jairo Fuertes, Ph.D.

Education and Training
Jesse J. Owens, Ph.D., and
Jennifer Callahan, Ph.D.

Ethics in Psychotherapy
Jennifer A.E. Cornish, Ph.D.

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PSYCHOTHERAPY BULLETIN

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PRESIDENT'S COLUMN

Change Is the Problem and Change Is the Solution

Armand R. Cerbone, PhD, ABPP
Chicago, IL

In my last column I reported some of the changes that our Society has made in recent years to adapt and to improve. I mentioned, too, that the winds of change are strong in APA these days. In this column I want to tell you what some of those changes are. Some of these changes affect us directly and others indirectly. For some change will be the problem; for others change will be the solution. But all agree that change is necessary for a viable APA future.

Changes to Our Bylaws

First, I want to announce an important change to our Society: ***We have a new Domain for International Affairs***! The Bylaw to establish it passed. This realizes the vision of a number of our former and current Board members. In particular, I want to thank Drs. Marvin Goldfried, Rod Goodyear, Changming Duan, Jeff Zimmerman, and Fred Leong for their efforts over the years to develop out international initiatives.

All the other proposed Bylaws were likewise adopted.

Special thanks are due to Drs. Jeff Barnett, Jean Carter, and their Bylaws Task Force members. More than capable and dedicated, they plodded through the painstaking task of drafting, reviewing, and editing versions of each proposed change until the entire Board was satisfied they were ready for your vote.

And thanks are always due to our Executive Director, Tracey Martin, who insures that we comply with our Bylaws when we unwittingly stray, reminds us of deadlines when we forget, and facilitates our work and meetings year after year.

And you deserve thanks, too. Your voice and votes always matter. Thank you!

Making Change: The Good Governance Project, or Why This Change Is Important to Division 29 Members

The problem: *too many representatives*. For several years now the Council of Representatives (COR) has been considering how to improve its functioning. The current size of Council, 173 representatives, is unwieldy for deliberations and decision-making and is expensive to maintain. Certainly, timeliness has suffered. A proposal for resolution aimed at providing psychological knowledge on important issues of the day to the public, for example, can take up to 18 months while it wends its way through a review by governance boards and committees. On the other hand, the present system provides the checks and balances that a data based profession like ours needs before informing the public on contentious concerns like end-of-life issues and healthcare disparities.

The response. APA's first strategic plan provided a mandate to maximize organizational effectiveness. The Good Governance Project (GGP) was APA's plan to take a data based approach to understanding how APA governance could be improved. In 2010 the Board appointed 15 APA members to the GGP, charged them to gather relevant data and, based on those data, to recommend actions to COR that would improve communication across APA and determine optimal

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structures and functions for accomplishing these goal. In 2013 the GGP made several recommendations, including enhancing technology to improve communication among members and governance entities and developing leadership training. Some recommendations, such as making COR an exclusively policy-making body, focused on major strategic issues for the discipline and APA, appealing to COR's need to be timely and to engage more readily the rich expertise COR members bring to the table.

Two other recommendations, however, have generated considerable controversy. These pertain to assigning to a newly organized and larger Board of Directors final authority for the budget. COR delegated that control on a trial basis for three years. It will consider the future of that GGP recommendation later this year or in early 2017. The other concerns the restructuring of Council itself.

The problem: not enough representation. Several models for reducing the size of COR have been proposed, each of which satisfies one constituency more and another less, but none has received unequivocal support. With one-third of COR changing every year it is easy to see why old arguments need repeating and new ones are presented. The aftermath of any decision will have momentous consequences for more than self-governance, potentially impacting the APA's power to protect and advance the interests of all its members. With stakes so high, COR resists acting precipitously. So, six years after the GGP made its recommendations, COR remains stuck and progress stalled.

Representation means influence. Reducing the number of representatives means reducing influence. Who wants to shrink their voices and votes when the outcome of a debate can adversely affect their interests? There is no substitute for a voting seat at the table. Multiple seats mean more influence. Having two or more members of COR translates into more, and more effective, lobbying.

This is a major concern for the underrepresented and minority members of COR, who have historically been marginalized along with their interests. It is also the concern of every division that elects one or more of its members to represent its interests. Each division has at its core a mission to advance scholarship and expertise and, based on that, the professional authority of its members. *In our case, that means promoting psychotherapy as a core discipline within psychology and pressing APA to promote psychotherapy with the public and policy makers.*

It must be remembered that, though elected by a constituency, every COR member has a fiduciary responsibility to give priority to the interests of the organization as a whole! First and foremost that representatives represent not only you, the members of the Society for the Advancement of Psychotherapy, but all of APA's loyal members. All representatives must balance the interests of their constituencies with the interests of the larger association—no easy task.

We have always been fortunate to have effective and smart representatives acting on our behalf. Some have been presidents of the APA; many have sat on the APA Board of Directors. At present, we have two exceptional representatives in COR to act on our behalf: Drs. Jean Carter and John Norcross. Ours is well-respected Division. "When our reps speak, COR listens."

However, we have had three representatives on COR. We lost our third seat as a result of the ***Apportionment Ballot*** that you receive in the fall. The number of votes, in proportion to the number of

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votes each APA member casts across all divisions or states, determines the number of seats any division is assigned. **That's why we appeal to you each year to give all or as many of your votes as you can to us. Your voice and votes always matter. And that is why the Good Governance Project is important to us. However, COR determines to structure itself, our interests will be determined with it.**

Diversity in Governance
Persons of color, persons of faith, persons with disabilities … any stigmatized minority has an understandable investment in reducing the size of COR. Will the number of voices of the historically marginalized be strong enough to repair painful injustices and insure equality?

Our Society has made tangible commitments to diversity. In addition to having two Diversity Domain seats to influence our agenda, conducting a daylong diversity workshop triennially, slating diversity candidates for Board leadership, and seeking diversity candidates for committee members and chairs, we support the biennial National Multicultural Summit (NMCS). The NMCS was founded by four APA divisions to address multicultural concerns and is now the largest such conference in psychology outside the APA annual convention.

We want to support our diversity members and our diversity colleagues on COR. We will be guided by our Diversity Domain reps and will collaborate with our diversity colleagues in COR to protect what progress we have made and to further equality and fairness.

Again, this is what makes GGP important to us.

Change of these proportions, as always, lays siege to our deepest values. It is our values that are tested most deeply and sorely. Yet, it is our core values that can and should guide our management of change … if we do not abandon them.

Commission on Ethics Processes
I have just returned from Washington, where I am serving as a member of the Commission on Ethics Processes. The Commission represents another change taking place in the APA.

As one response to the findings of the Independent Review, aka the Hoffman report, the Council of Representatives established a blue ribbon panel, composed of a diverse group of 17 psychologists and non-psychologists with expertise in ethics, to evaluate and recommend changes, where needed, to APA's ethics processes, including, but not limited to: (1) the relationship between ethics education and adjudication, (2) the efficacy and utility of the investigative and adjudication processes, and (3) the possible establishment of a Chief Ethics Officer.

The Commission is chaired by Paul Root Wolpe, PhD, and Melba Vasquez, PhD. The Commission is to consider all operations of the Ethics Committee and Office but not to address the Ethics Code or any other findings of the Hoffman report. Liaisons from the APA Board of Directors are Jennifer Kelly, PhD, and Rick McGraw, PhD. APA staff members are Katherine Nordal, PhD (Acting Director of the Ethics Office), Lindsay Childress-Beatty, JD, PhD, and Joan Freund.

The Commission met for the first of two scheduled face-to-face meetings at the APA offices during the second week of May. The plan is to complete its report to COR by the end of the year. The following is a summary of that first meeting.

After reviewing the independent report, letters, articles, and documents, as well

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as studying the current rules and procedures of the Ethics Committee and Office, the Commission established three working groups: 1) *Ethics adjudication and education* to evaluate all procedures related to managing ethics complaints and to review its education programs, 2) *Ethics Committee, APA ethics policies and procedures* to examine the role of the ethics function in the APA, 3) APA institutional culture, structure and external relationships and power influences, 4) *Benchmarking* to consider the best practices of other organizations, and 5) *Communications* to and from members and governance groups.

The goal is to create recommendations that will be broadly disseminated for feedback on a public comment site. In addition, a town hall meeting will be scheduled during the APA annual convention in Denver in August along with the Commission progress report to Council.

Getting to Know Your Board Members
I thought that you might be interested in knowing a bit more about the officers and Domain Reps you elected. For that reason I will include some brief comments about the work, achievements, and interests of one or more in my columns.

Given that I cannot include them all before I leave office, I instituted an arbitrary selection process. I wrote the name of each board member on an index card, shuffled them, and drew one. This time I drew the name of **Jesse Owen**, PhD, our Treasurer.

Now in his first year as Treasurer, Jesse is part of the Executive Committee. Prior to his election to his office, he held the position of Domain Representative for Education and Training. When not meeting his responsibilities to the Society, Jesse is an Associate Professor and Department Chair in the Department of Counseling Psychology at the University of Denver, where he teaches and conducts an impressive research program on psychotherapy. Jesse has developed and empirically tested the Multicultural Orientation framework, a transtheoretical psychotherapy driven model for working with culturally focused topics in treatment.

Jesse's research has also received the 2015 Most Valuable Paper from the Editorial Board of our journal, *Psychotherapy*, and Jesse received the Johnson Grant of $10,000 last year.

Two Final Notes
I want to remind you that the convention is coming up and to encourage you to attend. Our Program Chair, Dr. Changming Duan, with important support from Dr. Gary Howell, our Associate Chair, has coordinated and lobbied for a series of programs that will be intellectually stimulating and professionally valuable. Many appreciative thanks to both for their impressive work. Sessions include reports of current psychotherapy research and applications of evidence in the provision of psychotherapy services. We have applied for Continuing Education credits to increase the value to you.

Last of all, I will be attending the international gathering of the Society for the Exploration of Psychotherapy Integration (SEPI) in Dublin, Ireland, in June. Our Society will be well represented by present and former Board members: Dr. Marvin Goldfried (a founding member of the Society), along with Drs. Abe Wolf, Jeffrey Magnavita, Rod Goodyear, and John Norcross. Division 29 is sponsoring the CE program as well.

EDITORS' COLUMN

Lynett Henderson Metzger, PsyD, JD
University of Denver-Graduate School of Professional Psychology

Ian Goncher, PsyD
Pediatric Care Specialists
Division of Behavioral Health Services
Johnstown, PA

Welcome to our second issue of *Psychotherapy Bulletin* for 2016. We are delighted to bring you a variety of perspectives on topics ranging from transitioning to motherhood as an early career professional to providing clinical services to members of the Deaf community to conducting microprocess research in psychotherapy to using popular games as therapeutic tools … and the list goes on!

Of particular interest to Society members, this issue includes a number of announcements and the APA Convention Programming Guide (*Editor's Note: The Convention is in Denver, Colorado, this year, and I have it on good authority it will be AWESOME—join us!*). Also, make sure to take a few moments to look over Dr. Cerbone's President's Column for important information regarding changes to our Bylaws, Governance, and APA as a whole.

Finally, please visit the Society's website (http://societyforpsychotherapy.org/) for additional content, including upcoming online-exclusive book reviews, and to access past issues of the Bulletin. Our next deadline is August 1, 2016; if you have an idea for print and/or online content, we would love to hear from you! Submission guidelines may be found in the back of this volume or online.

Safe travels to everyone out and about this summer, and we hope to see you in Denver in August.

Lynett Henderson Metzger, JD, PsyD
Psychotherapy Bulletin Editor
email:
Lynett.HendersonMetzger@du.edu
office: (303) 871-4684

Ian Goncher, PsyD
Psychotherapy Bulletin Associate Editor
email: idgoncher@loyola.edu
office: (814) 244-4486

COMMENTARY

The Empirical Evidence for Psychotherapist Humility as a Foundation for Psychotherapist Expertise

Helene A. Nissen-Lie, PhD
Michael Helge Rønnestad, PhD
Department of Psychology
University of Oslo, Norway

Drawing on two comprehensive analyses of prerequisites for developing expertise in the field of psychotherapy (Tracey, Wampold, Lichtenberg, & Goodyear, 2014; Tracey, Wampold, Goodyear, & Lichtenberg, 2015), Hook, Watkins, Davis, and Owen (2015) ask an important question in a paper entitled *Humility: The Paradoxical Foundation for Psychotherapy Expertise*: "What prerequisite variable or set of variables makes the process of acquiring therapist expertise possible?" (p. 12). They suggest that therapist humility is needed in order for the specific recommendations proposed by Tracey and his colleagues (i.e., to seek accurate feedback from clients and engage in deliberate practice) to be helpful. They note, "At face value, humility may appear to be the opposite of expertise, but we argue that humility is foundational to implementing the suggestions put forth in the Tracey et al. (2014, 2015) articles" (p.12). According to Hook et al., an attitude of humility is necessary for therapists to be willing to overcome several barriers in order to incorporate feedback and engage in deliberate practice.

We fully endorse the conceptual analyses made by Hook and colleagues. Here, we aim to underscore the paramount importance of therapist humility by reporting empirical evidence supporting their view. We conducted a series of naturalistic psychotherapy studies as part of the Norwegian Multisite Study of the Process and Outcome of Psychotherapy (NMSPOP; Havik et al., 1995) on the contribution to process and outcome of a variety of therapist variables. These were assessed through the comprehensive multi-part survey instrument, the Development of Psychotherapist Common Core Questionnaire (Orlinsky & Rønnestad, 2005), and included psychotherapists' perceptions of themselves as practitioners, in-session feelings, interpersonal styles with clients, difficulties in practice, preferred coping strategies, and other components. Among these therapist variables, one particular finding stood out: Higher scores on therapist Professional Self-Doubt (PSD) in practice (e.g., therapist-endorsed items such as lacking confidence that they might have beneficial effects on clients; feeling unsure how best to deal effectively with a client) were strongly and positively linked to therapy process and outcomes. Therapists higher on Professional Self-Doubt showed stronger therapeutic alliance, as rated by the clients and, even more importantly, greater client-rated therapeutic gains (e.g., Nissen-Lie, Monsen, & Rønnestad, 2010; Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013). This finding was

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recently replicated in a German sample of therapists and their clients (Odyniec, Probst, Margraf, & Willutzki, 2016). While it appears to be robust, this finding was not expected when we began this research. Beforehand, we believed less doubt—not more doubt—would be beneficial for the client. However, this apparent paradox lends itself to speculation and interpretation, especially if we bring in the concept of humility.

That said, therapist humility in and of itself may not be sufficient to evoke constructive therapy processes and consequently a positive client outcome. In our latest study, we addressed the interplay between psychotherapist self-doubt and patient outcome by including therapists'ratings of a self-affiliative introject, based on the Structural Analysis of Social Behaviors (SASB) methodology (Benjamin, 1996). The SASB self-affiliative introject indexes the extent to which therapists treat themselves in a more or less affiliative manner (i.e., self-love versus self-attack; Nissen-Lie et al., 2015). We anticipated that therapists' level of personal self-affiliation would enhance the effect professional self-doubt has on change. We hypothesized professional self-doubt, in the context of a tolerant and self-affiliative introject, is different than in the context of a more disaffiliative introject. This hypothesis was supported: Therapists who reported more self-doubt in their work facilitated change in patient distress to a greater extent if they also reported to have a self-affiliative introject, while those who combined low scores on professional self-doubt with higher scores of self-affiliation contributed to the *least* change. The findings imply that a healthy self-critical stance is an ingredient of successful professional performance or expertise, while treating oneself as a person with care and nurturance, but lacking capacity to critically evaluate (i.e., doubt) one's therapeutic work, is not a pathway to therapeutic success. With these findings, we believe we provide empirical support for Hook et al.'s (2015) assertion that "The expert psychotherapist is foremost a humble psychotherapist" (p.13), but add a nuance that may be worth noting.

It seems likely that therapist professional self-doubt reflects the sort of humility that Hook and collaborators address (i.e., an attitude which enables therapists to remain open to feedback, and to seeing their own contribution in treatment, and a willingness to self-correct when needed). In fact, Tracey et al. (2014) reasoned that PSD may "encompass a critical evaluation of one's work from a disconfirming stance" (p. 225). A similar line of reasoning has been proposed by Rønnestad and Skovholt (1991), who suggested therapists' awareness of the complexity of therapeutic work as an attribute of optimal professional development. In a later formulation, and referring to their own studies on therapist development, as well as to studies on master therapists (e.g., Jennings, Skovholt, Goh, & Lian, 2012), Rønnestad and Skovholt (2012) wrote: "Humility appears to be a characteristic of experts across many studies … and it seems reasonable to assume that therapist humility is positively related to openness to feedback" (p. 155).

Another related perspective that may inform us is the concept of wisdom (Baltes & Smith, 1990), an analytical perspective applied to understand professional development (Rønnestad & Skovholt, 2012). Baltes and Smith suggested wisdom includes an attitude of "uncertainty," which has been understood to imply "a rejection of precisely defined realities in understanding matters of human interaction" (Rønnestad & Skovholt, 2003, p. 31).

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In conclusion, there is a converging body of knowledge from conceptions of expertise and wisdom, empirical studies of professional development, and process-outcome research underscoring the role of humility for the development of expertise. The empirical evidence adds strength to the argument that humility may indeed be the *sine qua non* for actualizing expertise (Tracey et al., 2014). Although the concept of humility and related concepts, such as Professional Self Doubt and wisdom, have nuanced our understanding of therapeutic expertise, their role in the process of being a healer is not new. It echoes its contrast from Greek mythology, ὕβρις (Hybris), and reminds us of the Danish philosopher Søren Kierkegaard (1859), who wrote more than 150 years ago, "But all true helping begins with a humbling. The helper must first and foremost humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve…[and to know that] to help is a willingness for the time being to tolerate being in the wrong and not understanding what the other understands" (p.96).

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

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Paying Attention to the Details: Conducting Psychotherapy Micro-Process Research With Clients and Therapists

Joshua K. Swift, PhD
Department of Psychology
Idaho State University

Kelley A. Tompkins, MS
Department of Psychology
University of Alaska - Anchorage

The past 100 years of psychotherapy research has sought not only to examine the efficacy and effectiveness of psychotherapy, but also to identify the causal mechanisms and processes underlying therapeutic change (Lambert, 2013; Wampold & Imel, 2015). The existing research on psychotherapy processes has provided us with a rich understanding of several variables that are linked to treatment outcomes, including attendance to the therapeutic alliance, eliciting and responding to client feedback, addressing client expectations and motivation, and collaboration (Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011; Swift & Greenberg, 2015). Yet, although significant gains have been made through this research, as a field we still do not know exactly why or how change occurs for clients.

Our limitations in knowing the exact why and how of change in psychotherapy may be partially due to the limitations in the research methods we frequently use. A large portion of the current research being conducted focuses on testing the efficacy of specific treatments or treatment techniques. Although this research plays a valuable role, therapist, client, and process variables are often suppressed or ignored in these types of studies. Much of the research focusing specifically on psychotherapy processes utilizes a global rating of the process variable for the entire session. These studies may miss details of the psychotherapy process that could help to explain the how and why of client change.

Micro-process research is one method for gaining a deeper understanding of these dynamics. This research typically involves a moment-to-moment analysis of treatment sessions, focusing on a segment of a single session, an entire session, a specified number of sessions, or the entire course of therapy for some clients. One example of micro-process research was provided in the last issue of the *Psychotherapy Bulletin*. In that issue, Pace and colleagues (2016) discussed research they are doing, examining natural language processing in the therapeutic dyad. In these studies, they are examining transcripts from psychotherapy sessions in order to identify relational/emotional processes in word usage that are associated with therapeutic change. Another example comes from a study of treatment outcomes for generalized anxiety disorder (Fluckiger, Zinbarg, Znoj, & Ackert, 2014). In this

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study, trained coders conducted minute-by-minute ratings of the fifth session for 20 different clients. While observing these sessions, coders were identifying clients' experiences of negative moods, expressions of strength, working toward goals, and positive reinterpretations of problems. In another interesting study, Altenstein, Krieger, and Holtforth, (2013) had trained coders watch a middle therapy session for a client receiving exposure-based cognitive therapy for depression. While watching, these coders used a joystick to rate the therapists' and clients' circumplex of dominant and affiliative behaviors throughout every second of the session.

Most of the micro-process research that has been conducted has used outside/neutral parties to evaluate the session content (e.g., trained researchers to code behaviors and emotions, a computer program to code text); however, it may also be valuable to have clients and their therapists provide moment-to-moment ratings of their sessions. Given their level of involvement, clients' and therapists' moment-to-moment ratings may be able to provide unique insight into the why and how questions of therapeutic change. With this goal in mind, we recently completed a study in which we asked 18 clients and their therapists to provide moment-to-moment ratings of the effectiveness of a single psychotherapy session. Specifically, we were seeking to (1) examine whether variability in the moment-to-moment ratings within sessions was present; (2) identify therapist and client behaviors associated with higher and lower rated segments of the sessions; and (3) test whether clients and therapists were congruent in their moment-to-moment ratings. Here we provide the results from one dyad as an example of this type of micro-process research.

The Client-Therapist Dyad

The client was 30 years old, identified as an American Indian female, and was married in a heterosexual relationship. She was seeking treatment primarily for concerns with depression, but also experienced some anxiety symptoms and alcohol use concerns. At the time of her participation in this study (after the fifth session), the client rated the therapeutic relationship as a 47 (of 60) on the Working Alliance Inventory-Short Revised (Hatcher & Gillaspy, 2006), and the total session effectiveness as a 32.5 (of 40) on the Session Rating Scale (Johnson, Miller, & Duncan, 2000).

The therapist was a similar-aged female (specific demographic information is not reported in order to protect the individual's identity) who was receiving training in a clinical psychology Master's program. The therapist reported working with this client from an integrated approach. The therapist rated the therapeutic relationship as a 40 (of 60) on the Working Alliance Inventory-Short Revised.

Moment-to-Moment Coding of Sessions

The client and therapist had been working together for five sessions with no knowledge of this study. Per routine clinic procedures, all sessions were recorded. The client volunteered to participate in this study after seeing a flier posted in the clinic waiting room. After informed consent for the study was provided, the client watched a video recording of the most recent treatment session. While watching the recording, she held a dial rating device with a pivoting central knob and a digital numeric display screen. She was instructed to rate every moment of the session on a scale ranging from helpful (100, dial pointing to the far right) to hindering (0, dial pointing to the far left), with 50 being neutral. The anchors (helpful and hindering) were labeled on the device and the dig-

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ital screen reported the numeric rating the knob was recording. After watching and rating the entire session, the client was asked to watch their three highest and the three lowest rated segments and describe why those segments were rated as helpful or hindering.

After the client completed her ratings of the session, her therapist was invited to come in and watch the same session and complete the moment-to-moment ratings in a similar way. At the end of the session, the therapist was shown her three most helpful and three most hindering rated segments, and was asked to describe what was occurring in each. Last, the therapist was asked to watch the client's highest and lowest rated segments, but was not told which was which. Instead, the therapist was asked to guess which three segments were rated more helpful and which three segments were rated as more hindering by her client.

Evidence for Variability Within the Session

Figure 1 displays the client's and therapist's moment-by-moment ratings for the session. One immediately notices the variability within the session. For example, the client tended to rate the session fairly neutral, but then had several segments that were rated very positively and some rated negatively. The therapist, on the other hand, tended to fluctuate more in the positive and negative ratings, and rarely identified the segments of the session as just being neutral. This finding in particular demonstrates the need for micro-process research. Based on the variability that was observed, it is clear an end-of-session global rating would not represent the many highs and occasional lows that occurred during this session. By pinpointing the highs and lows, researchers can more specifically identify the processes leading to change.

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Figure 1. Session Effectiveness Ratings

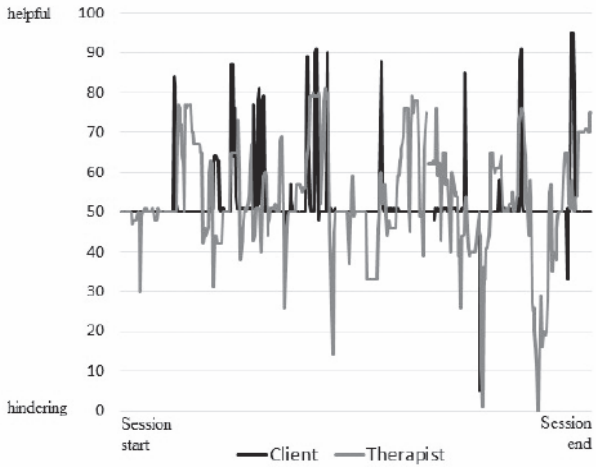

Figure 1. Client and therapist moment-to-moment ratings of session effectiveness.

Explanations for the Variability

Helpful segments. When asked to describe what was occurring in the segments rated most helpful by the client, the client indicated the therapist was helping her to become more accepting of her positive and negative thoughts; the therapist allowed her to express her own motivation for change, rather than judge her for doing something wrong; and the therapist validated her progress. When asked to describe her most helpful rated segments of the session, the therapist indicated they were characterized by when she was able to just listen and provide support while the client engaged in change talk or made her own connections leading to insight. In general, the therapist indicated all three were characterized by her feeling like she and the client were on the "same page."

Hindering segments. The client described her most hindering rated segments as characterized twice by the therapist asking a question, and once by the therapist offering advise that did not seem to her to be related to what they were talking about or the direction the session was moving. The therapist indicated her three most hindering rated segments included two times where she tried to provide validation to the client and the client did not accept the validation, and one time where there was an awkward silence where she, as the therapist, forgot the point of what she was sharing with the client.

A review of the qualitative descriptions of helpful and hindering segments provides us with some insight into clients' and therapists' opinions about how and why psychotherapy works. For this pair, the session seemed to be more helpful when the client and therapist felt like they were on the "same page." This seemed to occur when the therapist was providing support and validation to the client, allowing the client to lead, and helping the client become more accepting of herself. These segments were not characterized by the use of any specific treatment techniques or the therapist providing any specific education or insight to the client. For this pair, the hindering segments seemed to be characterized by the therapist trying to lead the client in a direction the client did not understand or was not ready to go.

Congruence between the Client and Therapist

Client and therapist ratings on the 0 (hindering) to 100 (helpful) scale were matched for time and a Pearson's correlation coefficient was calculated. A significant, but modest, correlation between the client and therapist ratings was found, $r = .13$, $p < .01$. The client's average rating of the session, $M = 52.20$ ($SD = 8.44$), and the therapist's average rating of the session, $M = 53.07$ ($SD = 13.96$), were similar, $t(457) = 1.22$, $p = .22$. By visually examining Figure 1, it appears that the client and therapist similarly recognized one hindering segment toward the end of the session. It also appears the therapist and client matched for about half of the positively-rated segments. However, the therapist rated several segments as hindering that the client felt were neutral or positive. In addition, the therapist missed several of the segments rated positively by the client. The client's three most helpful and three most hindering-rated segments were shown to the therapist and the therapist was asked to make a categorical guess as to which ones the client rated as helpful or hindering. The therapist guessed four of the six segments correctly.

The level of congruence, or lack thereof,

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between this client and therapist is interesting. One might expect, given these two individuals were providing their opinions about every moment of the session, a relatively small correlation would be found. In addition, given they had only worked together for four sessions prior to this point and that the therapist was a trainee, the significant correlation found is actually fairly impressive. However, the divergent segments (at about one-quarter and five-eighths of the way through the session, respectively) are important areas of concern. Some of these were areas where perhaps the therapist felt like she was being helpful in what she was doing, but the client did not feel like she was getting much out of what was happening. Some of these were also times when the therapist felt like things were going poorly, but the client did not feel the same way—this was seen for most of the hindering-rated segments by the therapist. These discrepancy segments would be important areas to target, because they represent clinical errors in therapist judgment, which in turn could lead to small treatment decisions by the therapist that could then lead therapy in the wrong direction.

Conclusions

The micro-process data that were gathered provided important insight into what was working and what was not working during this session for this individual therapist and client. Using similar micro-process data from several dyads, it will be interesting to see if the level of congruence within a pair is significantly related to the number of sessions the client and therapist have had together as well as their ratings of the therapeutic alliance and treatment outcomes. Future studies are needed that focus on gathering moment-to-moment evaluations of treatment sessions by clients, therapists, and outside observers. Data from these types of micro-process studies can provide a rich and detailed picture of how and why psychotherapy may be effective—an understanding that can complement findings from the other frequently used process and outcome research methods.

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

EDUCATION AND TRAINING

Domain Note: **The Role of Deliberate Practice Across the Professional Lifespan**. Starting with this issue and continuing with the upcoming issues of the next year, the Society for the Advancement of Psychotherapy Education and Training Committee is excited to be providing a series of articles on the role of deliberate practice in the development of highly effective psychotherapists. The current research indicates that such deliberate practice is the main (and only demonstrated) factor that leads to such development (see, e.g., Chow, Miller, Seidel, Kane, & Andrews, 2015). This theme, which is based on the literature on expertise and expert performance, will be illustrated across the professional lifespan. This initial article, co-written by the Division's Domain Leader for Education and Training, focuses on the role of deliberate practice in training contexts.

Stewart Cooper, PhD, ABPP
Chair, Education and Training Committee

Deliberate Interleaving Practice in Psychotherapy Training

Patrick K. Love, BS
Elizabeth C. Davis, BA
Jennifer L. Callahan, PhD, ABPP

University of North Texas

"*Do that scale again*." "*Do that fingering transition again*." "*Let me hear that again*." Even if the scale was correct, it had to be done…*again*. As a novice musician, the word, "again," became synonymous with repetitive practice. Practice for the sake of practice, because practice makes perfect.

I (voice of 3rd author; true story) had to reconsider the purpose of repetitive practice some years later, as I neared completion of the novice level. The precipitant of my reconsideration was a flushed director screaming in the middle of a full ensemble rehearsal. He was kicking at music stands and threw his baton with total disregard for the projectile's trajectory. As he grabbed his hair with both hands, his vocalizations gave way to actual language and we heard the following: "Can you AT LEAST make a NEW mistake?! I am SICK AND TIRED of hearing THE SAME mistake EVERY day!" After calming himself, the director had us play again, but this time he instructed us to perform a planned, effortful, and fully intentional error as loudly as possible.

His pedagogy was poor, but his point was cogent. Simple repetition can take on a mindless quality that facilitates rehearsing errors and really entrenching them without awareness. The remedy was to heighten awareness and have us fully engage the troublesome phrase with intentionality. He did not demand that we be perfect; rather, he demanded we be deliberate in our practice.

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What Is Deliberate Practice?

A scholarly conceptualization of deliberate practice had not yet appeared in the literature when the above event transpired, but the formal conceptualization nevertheless traces back to the instruction of music students. In studying top music students at a world-renowned music conservatory, Ericsson, Krampe, and Tesch-Romer (1993) first described deliberate practice as involving the completion of a series of activities designed to maximize skill acquisition. However, deliberate practice is more than simply practicing musical pieces repeatedly, as uncorrected mistakes made by a novice will be repeated until the student receives corrective feedback (Ericsson, 2015). Instead, deliberate practice includes engaging students in the following activities: observing their own performance, getting expert feedback, setting incremental learning goals just beyond the performer's ability, repetitive rehearsal of specific skills, and continuously assessing performance (Ericsson, 2006).

It is important to keep in mind that while similar, the process of deliberate practice is different from mastery based learning, where students are given varying levels of time to meet a predefined goal (Carroll, 1963). The key difference between the two teaching methods is that *deliberate practice requires that each student receive expert feedback on individual growth edges*, allowing for greater mastery of the skill.

Deliberate practice has subsequently been found to foster competency in a range of health care professions. For example, a number of studies have shown requiring surgical trainees to review their recorded surgeries with their supervisors significantly improves patient outcomes in later procedures (Bann, Khan, Datta, & Darzi, 2005). Similarly, radiology students who receive immediate feedback on diagnoses of digitally recorded mammograms later perform significantly better in diagnosing mammograms (Geller et al., 2014). Encouraging students to verbalize their decision-making process in vivo augments the effects of deliberate practice, likely because it allows instructors to immediately correct errors in situational appraisal and problem solving techniques (Ericsson, 2015). It also seems likely that asking students to reflect on their actions would simultaneously build competency in reflective practice. Consistent with this conceptualization, recent studies have found highly skilled surgeons, those with the best outcomes, thoughtfully revaluated their surgical approach during procedures (Craig et al., 2012; Cristancho, Vanstone, Lingard, LaBel, & Ott, 2013).

With respect to the training of professional psychologists, a conceptual map derived from a deliberate practice model appeared last year (Callahan, 2015). As shown in Figure 1 (top of next page), key to this map is the integration of sequential, cumulative, and increasingly complex training experiences with rapid and substantive feedback. However, the Callahan model expands the deliberate practice model by scaffolding psychology trainees' competency development with interleaved practice.

What Is Interleaved Practice?

Most of us are familiar with block practicing approaches. In block practice, presentations of stimuli focus on one skill at a time (e.g., remember those multiplication drills in elementary school?). You learn a skill, practice the skill to mastery, and then move to a new skill. In contrast, interleaving practice requires trainees to work on multiple skills in concert with one another. Training trials focused on one skill are interspersed with training trials of another developing skill (Szpiro, Wright, Carrasco, 2014).

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Figure 1. Conceptual Model for an Evidence-Based Training Approach

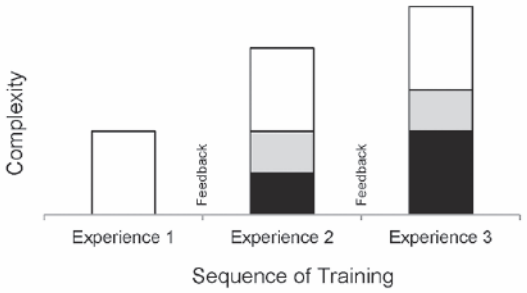

Figure 1. Each successive training experience is cumulative, with greater complexity progressively introduced by increasing load (middle band of experiences two and three) or difficulty (lower band of experiences two and three). These changes should not be made without first carefully considering whether expert feedback (supervisor) and client feedback (outcome scores) are supportive of increasing the training complexity in these ways. Reproduced and adapted with permission from Callahan, 2015.

Practice using an interleaving format has been found to be more effective than blocked practice for active learning (where participants have to discover category rules) (Carvalho, & Goldstone, 2015). In addition, recent studies have found that interleaving practice is conducive to multiple types of learning, including perceptual learning (Szpiro, et al., 2014) and inductive learning (Birnbaum, Kornell, & Bjork, 2013).

Interleaving practice is represented in the Callahan model via the different colored bands within each training experience (Figure 1). The article in which the model first appeared applied the interleaving approach to training in technical assessment skills and found deliberate interleaving practice yielded better outcomes than comparable studies relying on simple repetitive practice methods. Further, trainees' competency gains were evidenced in many fewer learning trials (Callahan, 2015). Constructive, thorough, and supportive feedback both within and between training experiences is integral to the model to foster critical thinking among trainees. A study examining interleaving practice with complex judgment found evidence to support that such critical thinking prompts increased effectiveness (Helsdingen, Van Gog, & Van Merriënboer, 2011). An added potential benefit is this model encourages active on-going reflective practice, another important functional competency necessary before emerging into one's early career (Fouad et al., 2009).

However, interleaving practice may not always be the most popular learning option. One study found participants believed blocked learning was more effective than interleaving learning, even in situations when this was empirically untrue (Zulkiply, & Burt, 2013). This misconception may stem from observation that, for any given single skill, interleaving practice can take longer than block practice by virtue of spreading out practice of specific skills across the training schedule (Helsdingen et al., 2011). In other words, trainees may find deliberate interleaving practice pushes their learning comfort zone if it is not handled delicately. Supervisors must be diligent to remember growing pains

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may occur and provide reassurance such pains are normative, transient, and addressable—with controlled stretching that takes them gently just to the edge of their current limits for the purpose of increasing the reach of their competency over time.

Why Does Deliberate Interleaving Practice in Psychotherapy Matter?
It matters because, frankly, we are not very good at training novice psychotherapists.

Unfortunately, psychotherapy outcomes in psychology training clinics, using naturalistic designs, support this admittedly provocative contention. The majority of doctoral programs in clinical and counseling psychology have affiliated training clinics. A central mission of these clinics is to lay the foundation for trainees' development of professional competencies, particularly with respect to beginning psychotherapy competencies. Yet, studies of individual training clinics (Callahan, Aubuchon-Endsley, Borja, & Swift, 2009; Swift, Callahan & Levine, 2009), as well as a relatively recent multi-site study, indicate 69 to 77% of psychotherapy clients seen in these settings do not improve (Callahan et al., 2014). We can, and should, do better.

What Does Deliberate Interleaving Practice in Psychotherapy Look Like?
After acquiring and demonstrating foundational competencies pertaining to psychotherapy, novice psychotherapy trainees should be assigned *very few cases of no more than mild distress* to develop their functional competencies (see Fouad et al., 2009; Kaslow et al., 2009; Rodolfa et al., 2005; Spruill, 2004 for nuanced elaboration regarding foundational versus functional competencies). Importantly, while training novice clinicians in psychotherapy is associated with improved client outcomes, the effect of training is moderated by client severity (Owen, Wampold, Kopta, Rousmaniere, & Miller, 2016). Given this, novice psychotherapy trainees should be assigned minimally distressed clients as their first cases to maximize the propensity for a positive trajectory during their early competency development as psychotherapists. The trainee's caseload and client difficulty level may be increased over time (as shown in Figure 1), but those increases should be made incrementally, with careful monitoring of client outcomes and supervisor feedback supporting that neither client nor trainee development is being thwarted by such increases in difficulty.

Aside from managing client difficulty and caseload sizes, other structural elements of training are important. As novice psychotherapists, beginning clinicians must have a means for recording sessions (preferably both audio and visual). Trainees need protected time and space to independently view recorded sessions in preparation for supervision to foster the development of reflective practice. Supervisors must also be provided with protected time and space to review recorded sessions in preparation for conducting supervision with trainees. A supervisor who is not regularly reviewing recordings (or, alternatively, engaging in live supervision) cannot know whether the trainee is accurately identifying and bringing to supervision the key elements of the session requiring expert feedback. Further, a supervisor cannot logically infer a trainee is ready for less intensive and/or close supervision until the supervisor has consistently observed the trainee correctly identifying their needs for supervision across a range of client presentations. Finally, trainees and supervisors should view segments of recordings together. The supervisor

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should encourage critical thinking by having the trainee explain as they review the recording just what the trainee was actually thinking in session (reflective commentary). Goals pertaining to specific skills should be identified and monitored for development across supervision sessions.

Wait. Aren't We Already Doing That?
Initially, some readers are likely to read these ideas and think they represent conventional wisdom that is surely already widespread and commonly implemented. However, we contend that is not the case. While these ideas seem straightforward, trainees, supervisors, and training clinics nationwide routinely take shortcuts that significantly undermine the psychotherapy training process.

For trainees, a common misimpression is more client contact hours are better with respect to applying for internship (Boggs & Douce, 2000). Addressing their eagerness to accrue hours, novice clinicians may be assigned transfer cases from more advanced students who are departing the training clinic as a way to quickly establish their caseload. Almost by definition, such cases do not reflect low difficulty presentations. Quickly taking on too many cases (hours tallied on internship applications), but not watching session recordings or otherwise preparing for supervision (hours that do not contribute to the hours tally) is the most efficient way to accumulate clinical hours prior to applying for internship. Perhaps not surprisingly, an empirical study of national data revealed large discrepancies between time spent performing direct services activities and trainees self-reported accrual of hours (Rodolfa, Owen, & Clark, 2007). As noted earlier, the idea that accruing more hours results in a trainee being more competitive for internship is errant and a vast over-simplification of what it takes to ready oneself for internship (Callahan, Collins & Klonoff, 2010). Close supervision significantly interacts with the accumulation of client contact hours (Callahan, Hogan, Klonoff, & Collins, 2014). In short, close supervision on a small number of cases yields more gains in preparing for internship than does carrying a large client caseload with light supervision.

For supervisors, every hour spent preparing for, or engaging in, supervision risks wasting an hour on the tenure/promotion clock. A review of my own supervision notes indicates that at times I have been required to supervise the care of as many as 30 clients a week, with some trainees arriving on my supervision team already carrying as many as 12 psychotherapy clients (for context in understanding the time constraints, being on call for a half day per week and supervising an additional 10 integrated assessment reports per semester is also required of supervisors in our training clinic). In looking at the content of my notes specifically associated with trainees in their first psychotherapy practicum, client concerns pertaining to active psychosis and/or self-harm are peppered throughout. Supervision, as described herein, should entail previewing all 30 hours of session recordings and meeting individually for an hour with each of the 6 to 8 students on my supervision team. Add in a 2-hour group supervision meeting each week, which is customary in many training clinics, and the clock is up. Hiring of adjunct faculty to serve as supervisors is unlikely to solve this problem. The typical pay structure for adjunct faculty is not sufficient to support the time required for review of every session of every trainee before meeting with them for supervision. Under the conditions

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revealed by my own supervision notes, it is clear this would require hiring a full-time adjunct position for supervision of a single practicum team. The course fees generated by those few students enrolled on that practicum team would not come close to covering the cost of hiring the adjunct supervisor. The solution, unfortunately, is starkly obvious. Supervisors, regardless of whether they are tenure-track or not, are strongly disincentivized from engaging in high quality supervision. Personal communication suggests that high quality supervisors tend to describe it as intrinsically rewarding; however, exploiting such supervisors in that regard is not acceptable. Much more needs to be done to remove barriers to providing high quality supervision.

Finally, training clinics also take shortcuts that undermine psychotherapy training. Some are pressured to cover their operating expenses via client fees, which creates a pressure to increase the volume of clients served and/or accept into treatment clients whose difficulty level exceeds the readiness of novice trainees. It also increases the likelihood the clinic will prioritize service delivery in scheduling their space allocations, thus limiting trainees or supervisors access to viewing recordings. To deal with accusations of inequity by eager trainees wanting more cases and/or overburdened supervisors wanting fewer cases, assignment of cases may be centralized. Such a practice increases the likelihood neither client outcome data nor supervisor feedback will be incorporated routinely prior to every new case assignment (see Swift et al., 2015 for suggestions on how to incorporate client outcome monitoring as a tool in training and supervision).

Is There Any Hope?

Much like the novice musicians in the ensemble rehearsal, psychotherapy trainees risk repeating the same mistakes over and over without realizing it. They may even inadvertently rehearse and entrench therapeutic errors, thereby compromising their competency development as well as client outcomes. In this article, we provide a model illustrating how incorporating deliberate interleaving practice into the training of novice psychotherapists can provide a mechanism for heightening awareness and fully engaging trainees with an efficient number of cases to advance their competencies and, we hope, improve client outcomes in training clinics. As mentioned earlier, there are supervisors who find training psychotherapists to be intrinsically rewarding, and we made an appeal that they not be exploited. We contend they should be celebrated because they give us all hope. They provide hope we will right our ship as a profession and enact what we know we need to do to be effective in training psychotherapists. So, with that in mind, we will close this article by acknowledging and dedicating this piece to Vincent J. Adesso, PhD, ABPP. Dr. Adesso found a way to do *all* of the things described for a young psychotherapist in training—one who remains forever grateful.

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

Using Popular Games Therapeutically

Mary D. Hill, PhD
Elliott City, Maryland

Play and games have different meanings in play therapy literature (Schaefer and Reid, 1986). Play is usually spontaneous, has no particular purpose, and is motivated by a desire to have fun (Csikszentmihalzi, 1976; Erickson, 1950; Garvey, 1977). Play has an unrestricted, unstructured quality, whereas games are formal and have more restrictive rules for how the game is played. Although games can also be fun, they usually involve some sort of a contest between/among the players. Avedon and Sutton-Smith (1971) call this "an exercise in voluntary control systems, in which there is a contest between powers, defined by rules, in order to produce a disequilibrial outcome (someone ends up a winner)." This competition usually results in more involvement of participants and more enjoyment for them (Holmes, 1964; Rapoport, 1966; Steele & Tedeschi, 1967).

I use games in therapy to have fun and establish a good relationship with patients. I find that I can also do therapeutic work with games I select for specific purposes. Playing games is an activity with which most children and adolescents are familiar, and it helps them relax in the therapy session and "open up" with less inhibition. Sometimes the games I use are new to children who play most of their games on computers, smart phones and tablets, or video game terminals. The tactile experience of a non-computerized game affords these children a new experience they generally like. Using games also helps patients master social skills. We talk about what it feels like to win and lose and about doing so gracefully, all of which are important social skills. Other important social skills such as learning to shuffle and deal a deck of cards can help children fit in better with peers. We talk about not cheating by trying to see another player's cards, taking turns, finishing the game, and putting the games away at the end of play. Children and adolescents who have some difficulty with reading social cues and pragmatic language tend to take communication literally and seldom understand the concept of "trash talk" during a competitive game. However, they almost universally enjoy this feature once it is explained to them. Aside from these benefits, some games lend themselves to teaching and practicing specific skills, such as impulse control, self-expression, communication skills, scanning and processing, using rules and strategies, organizing information and objects, developing better working memory skills, learning not to give up, and planning. My focus here is to share some of the games I use, therapeutically, for dealing with patients who have specific diagnoses and needs.

I seldom use "therapeutic" games like the "Talking, Feeling, and Doing Game" (Gardner, 1973) in therapy. Some children, mostly very young children, enjoy these games; but many of the children I see would rather play a store-bought or

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"real" game. Since an important reason for using games in therapy is to create a space where the relationship can develop and grow, it is essential that the games selected be interesting and acceptable to patients. I will discuss a few of the games that have universal appeal and address multiple issues.

"Pass the Pigs." One of the first "difficult" teens I saw during my pre-licensure year was a boy, Tim,[1] who lived in a group home. He was polite enough but did not really participate in the therapeutic process, only giving monosyllabic answers and being guarded about opening up. I stumbled across a game called "Pass the Pigs" (Moffat, 1977) and took it out to play with him. This game consists of rolling two little rubbery pigs onto the table and scoring points for the different positions in which they land. A turn ends when the pigs land in a "pig out" position with each one on opposite sides, and all points scored in that turn are lost. The pig out position occurs frequently. Players have the option of stopping their turn at any point and banking their points toward the winning goal of 100 before they lose their turn and points. This game can be won in one turn, and Tim gambled on this option nearly every time. I won more games than he did, but he still persisted with his gamble.

I spoke to my supervisor about how all Tim seemed to want to do was play this game and was told to be patient. Then one day Tim came in upset and said he did not want to play any game. He cried as he told me that he had disappointed his grandfather by breaking one of the rules. For the first time, we explored his experience and feelings and talked about his plans. I realized that if I had not played all of those games with him, he would not have felt comfortable opening up to me. We had established a safe space/relationship through playing the game together. We continued to play the game each week, and we talked more as we played. One day, I asked him what rule he used to play. He said he had not used any rule and asked what rule I used. I told him that I went for 20 points in a turn and then stopped my turn. He decided to take 5 chances in a turn before stopping and did much better than before. We talked a little about how rules can be helpful, and I believe he began to see rules differently, as a way of winning rather than as a restriction to be defied. Several months later, Tim graduated from the group home and went back to live with his grandfather. He called me a few months after our termination to let me know how well he was doing. Playing "Pass the Pigs" with Tim helped us to create a relationship and to work on his rule-breaking behavior. Instead of thinking of playing a game as being an adjunct to therapy or a method just to establish a relationship, I realized that playing well-selected games with patients can also *be* therapy.

"Set." I began to think of how using other games that were fun for kids and teens might serve multiple purposes as well. When I found "Set" (Falco, 1988), I immediately thought that the cards resembled items on the Wisconsin Card Sort test and wondered if this game might also address executive functioning deficits and mental flexibility. This is a card game in which each card has one, two, or three items of the same shape on it. There are three kinds of shapes possible, three possible colors, and three possible types of shading. I present the rules to patients in a way that helps them activate and use working memory. Before I even show the cards to patients, I ask them to say "color, number, shape, shading" in that order several times and to remember it. Then I show them cards with each color, number of items, shapes, and

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shadings on them. I tell them that a set consists of three cards that either are all the same or all different in color, number, shape, and shading. We then look at examples of sets. The cards are shuffled and 12 are laid on the table face up. The first person to see a set calls out "set," takes up the cards, and explains why they constitute a set, citing the color, number, shape, and shading on the cards in that order. The players are required to pay attention, scan the layout, apply the rules and relevant set definition, and curb their impulses until they find a set. Calling out "set" and being incorrect means that the player loses three cards. The player with the most cards at the end wins. This game addresses visual attention, scanning, working memory, processing speed, impulsivity, and the social skills involved in winning and losing—and it is fun! I use this game with patients who have Attention-Deficit/Hyperactivity Disorder (ADHD), Autism Spectrum traits, and with older patients who fear they are losing some of their cognitive sharpness. I have played this game with children as young as four years old. We talk about strategies for finding sets, and I often give hints to younger children about what a set I see on the table looks like.

Dorothy was a six-year-old first grader when her parents brought her to therapy to deal with her ADHD symptoms, which were beginning to cause her problems in school. The results of testing indicated that she was bright, but had significantly lower scores on tests of working memory and processing speed, a typical pattern for those with ADHD. She received accommodations at school to help her deal with slow processing speed and working memory issues. One of the games we played frequently in our therapy sessions was the "Set Game." Dorothy especially enjoyed this game; once she got pretty good at it, she no longer wanted me to give her any hints about whether there was a set on the table and what characteristics it had. Her school performance improved steadily, and I had the opportunity to test her again several years later. Her working memory scores improved, and her processing speed scores improved by more than one standard deviation. Clearly, this is only anecdotal evidence and does not constitute a valid research study, but it was encouraging to me. Currently, Dorothy is a good student in middle school and is able to finish her work on time. It seems that practicing the skills she needed to improve helped Dorothy to master them and generalize them outside of therapy.

"*Catch Phrase*." "Catch Phrase" (1994) is a universally accepted game among my patients, and I use it with individuals and families. This game resembles "Password," a television game show in which players give clues for others to guess the word or phrase on the game screen. In addition to helping to establish and enhance the therapeutic relationship, Catch Phrase also helps some children who seem to have trouble expressing themselves, such as some of those whose diagnoses fall on the Autism Spectrum. Once these children get used to talking in order to play the game, they seem to be more comfortable talking in sessions in general. It also serves as a structured and fun way to address taking things literally, since we always talk about what the phrase that is guessed actually means as opposed to its literal meaning. Frequently, players can guess syllables in the word or phrase if they are not familiar with the whole word or parts of the phrase; this encourages flexibility in thinking. Usually, I turn off the timer, because as the timer ticks away faster and faster it seems to make the clue-giver more anxious. I also seldom keep score for this game, unless with a larger group or

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family; the guessing and giving of clues is inherently fun. This game offers the therapist an excellent opportunity to observe family dynamics and for some troubled families to have fun with each other.

"*Uno*." "Uno" (Robbins, 1971) is a popular card game that follows basic card game rules but is simpler that using a regular deck of cards. Instead of four suits, there are four colors; game play consists of discarding one card at a time or drawing cards if the player cannot match the color or number of the top card on the discard pile. The object of the game is to be the first to get rid of all of one's cards. Very young children can learn to play this game, sometimes by initially playing as a team member with a parent. Patients learn how to shuffle and deal cards, how to organize their hand, how to take their turns in order, and how to deal with the ups and downs of having their turn skipped and having to take on extra cards. Once the cards are dealt, I tell the players to organize the cards in their hands by color and show them how I organized my hand. During play, we engage in trash talk like, "You rascal, I'm going to get you next time!" We also talk about scoring, some basic strategies, not revealing what's in one's hand, and not looking at other people's cards.

Jonah is a smart, four-year-old patient with problems with social skills, emotional dysregulation, and ADHD. He learned to play Uno in our session with his mother as his helper. He can organize his hand and take his turn. He initially had problems with losing, and did not understand trash talk, taking offense until I explained it to him. Now he delights in being called, and calling me, a rascal when we play. He can continue playing the game even when it looks like he will lose and understands that if he quits when he is losing, then others may not want to play with him.

"*Ungame*." The Ungame (Zakich, 1973) is a board game and resembles the "Talking, Feeling, & Doing Game" in several ways. However, this game has no winners or losers and does not require players to do silly things. Questions are geared for players of all ages. The game proceeds when players roll the die and land on spaces that either indicate that they have to draw a card from the pile and answer the question, move their pawn to a location based on how they are feeling and talk about that feeling, or make a comment or ask a question. One rule is that players may not make comments about other players' questions and answers unless they land on the question/comment space. They are given paper and pencil to write short notes to help them curb their urge to interrupt with a comment. I use this game with younger children, teens, and families. It encourages children to control their impulses, especially important for children with ADHD, begin to learn to take notes as a helpful process, open up in a structured way, and improve relationships with family members and with me. The competition aspect is removed with this game, and that can be helpful for children and families that engage in high levels of conflict and/or do not know how to win and lose graciously.

I also use other games in therapy such as "Mancala" for patients with Obsessive Compulsive Disorder and ADHD. This game helps with planning and slowing down. "Chess" and "Connect Four" are good games to encourage visual scanning and planning skills. "Rush Hour" helps patients with map-reading skills, visual scanning, putting the problem into words, and planning. "Pick up

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Sticks" helps curb impulsivity, encourages planning, and helps with concentration and slowing things down. "Skip-Bo" (Bowman, 1967) encourages patients to appreciate order and strategy. The most important thing is to use each game in a way that encourages the patient to develop and enhance needed skills.

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

[1]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

Understanding the APA Practice Organization (APAPO)

Jean Carter, PhD
Washington, DC

Barbara J. Thompson, PhD
Ellicott City, MD

Barbara L. Vivino, PhD
Berkeley, CA

Many practicing psychologists received a check early this year from the APA Practice Organization (previously called the Practice Directorate). This was part of a class action suit filed against APA for implying that psychologists in private practice were required to pay the Practice Assessment. The suit resulted in APAPO dues now being optional; however, choosing to support the APAPO may be beneficial to you and your practice. Whether you happily cashed the check or sent back a donation to the Practice Organization, we thought it would be helpful to share more directly what the Practice Organization is, and, more importantly, what it does to help those of us who practice psychotherapy.

Why is it important to support the APAPO? It is difficult for one lone psychologist or even a small group of psychologists to advocate for issues that are central to the practice of psychology. A voice representing thousands is stronger. APAPO has that big voice. APAPO has been hard at work on behalf of private practitioners. Some recent accomplishments and benefits provided for practitioners include:

- Access to the Practice Central Website with information on billing and coding, financial management, business of practice, self-care resources, licensing, CEU's and much more
- Good Practice Magazine and the Practice Update enewsletter filled with practical information
- ICD-10-CM Web Application to help APAPO members transition to the updated coding system
- Physician Quality Reporting System (PQRS) Registry, which makes quality reporting easier for psychologists who are Medicare providers
- Access to staff expertise on practice-related legal and regulatory issues
- Free listing in the Psychologist Locator
- Access to HIPAA Compliance products

According to the APAPO website (http://www.apapracticecentral.org), The Practice Organization's advocacy

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priorities and accomplishments include:

- Challenging reimbursement rate cuts
- Taking action against managed care and insurance company abuses
- Advocating for practitioners' interests in health care reform
- Affirming the doctoral standard for entry into the profession and expanding marketplace opportunities for practitioners
- Confronting assaults on scope of practice
- Fostering political action for psychology
- Advocating for higher rates and expansion in Medicaid

APA vs. APAPO: What's the difference? APA and APAPO are partners in the health of psychology as a discipline and psychologists as professionals. The missions, purposes, and structures are related but different. Understanding those differences and the partnership is important for both APA and APAPO

Per its Mission Statement, the APA's mission is "the creation, communication and application of psychological knowledge to benefit society and improve people's lives" (American Psychological Association, n.d.). The APAPO, on the other hand, serves the professional and economic interests of practicing psychologists, as a guild organization focusing on the members rather than the public.

The legal and financial structures and sources of revenue are also different. The APA has a 501(c)3 tax status, which is a non-profit designation for organizations with charitable, educational, and scientific purposes that serve the public good. The APAPO, on the other hand, has a 501(c)6 tax status, which is applied to guild and trade associations that advance the professional interests of their members through a variety of activities including direct advocacy on issues that are important to the pocketbooks of practicing psychologists. Importantly, the APAPO supports psychologists' professional interests across the spectrum of psychology, including education as well as practice.

APA's membership dues, publishing business, investments and real estate support APA's activities on behalf of psychology and the public. Its direct advocacy is quite limited. The APAPO, on the other hand, is supported entirely by membership dues (members of APA who pay the Practice Organization dues) and cannot (by law) received funding or other resources from the APA.

Supporting the APAPO is a way to support yourself. The work of the APAPO is guided by the Committee for the Advancement of Professional Practice (CAPP), whose members are nominated and elected by the full membership of APAPO and by the APAPO/APA Board of Directors. Be sure to check out the resources APAPO provides and be sure to vote for members of CAPP!

The Ethics of Scholarship: Some Words of Caution

Jeffrey E. Barnett, PsyD, ABPP
Katherine Edwards
Loyola University Maryland

The ethical conduct of research and the dissemination of its results are essential for the field of psychotherapy and for all psychotherapists. Ongoing research provides us with new insights, and expanding one's knowledge base directly impacts the clinical services provided to clients. Without ongoing research, the mental health profession would stagnate and the public served would suffer. To provide the best possible treatment services, providers must be able to continually advance understanding of what makes psychotherapy effective, which treatments are most appropriate for which presenting problems, which psychotherapist factors have what effects, which new treatments should be added to one's armamentarium, and which methods should no longer be used, among many other important issues impacting psychotherapy practice.

The Ethical Principles of Psychologists and Code of Conduct (Ethics Code) of the American Psychological Association (2010a) specifies the professional services psychologists provide should be based on knowledge derived from research, stating, "Psychologists' work is based upon established scientific and professional knowledge of the discipline" (p. 5). While many different methods of conducting research are seen as legitimate (e.g., randomized controlled clinical trials, practice networks, and qualitative research), the APA has made it clear that psychotherapy should be evidence based. It defines evidence based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 271).

Reasons for Concern

The value of evidence-based psychotherapy practice depends upon the quality of the research upon which it is based; thus, how the research is conducted and how its results are disseminated are of great importance and concern. It is essential that both the professionals who utilize research findings to guide their clinical practice and the public served by those professionals have confidence in the findings of research. To accomplish these goals, research must be conducted and disseminated with integrity, free from the influence of bias, conflicts of interest, and political or other agendas adversely impacting the scientific process.

This has been shown to not always be the case. Martinson, Anderson, and de Vries (2005) found that an alarming percentage of researchers they surveyed acknowledged engaging in a range of unethical behaviors in their work, as researchers and scholars. Examples included:

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- 0.3% Falsifying or "cooking" data
- 0.3% Not properly disclosing involvement in firms whose products are based on one's own research
- 1.4% Using another's ideas without obtaining permission or giving credit
- 6.0% Failing to present data that contradict one's own research
- 10.0% Inappropriately assigning authorship credit
- 10.8% withholding details of methodology or results in papers or proposals
- 12.5% Overlooking others' use of flawed data or questionable interpretation of data
- 15.5% Changing the design, methodology or results of a study in response to pressure from a funding source. (p. 737)

These data raise numerous concerns, to include questions about how such practices could occur. Possible explanations include a lack of ethics education and training, having one's judgment impacted by emotional distress or burnout, or having one's objectivity and judgment influenced by conflicts of interest or other pressures. Numerous authors (e.g., Pachter, Fox, Zimbardo, & Antonuccio, 2007) have documented the potentially pernicious effects of financial conflicts of interest, ranging from the influence of simply knowing one's funding source to the exercise of overt pressure by funding sources. In fact, studies suggest that research funded by the company generating a product or treatment is significantly more likely to yield positive results (e.g., Lexchin, Bero, Djulbegovic, & Clark, 2003).

Additional pressures include competition for research funding that is often performance (i.e., productivity) based, concerns about losing grant funding and contracts if one's research program does not produce advances as anticipated, productivity requirements for promotion and tenure, and other "career advancement opportunities," and ego-driven decision-making (Cleary, Usher, & Jackson, 2015, p. 612). And, as Levine and Levine (2014) suggest, one can also add "personal and professional agendas and … human fallibilities" to this list (p. 164).

Such issues raise serious concerns regarding the integrity of the mental health profession and the public's ability to have confidence in research findings. The fact that important life decisions are made based on published research results further illustrates how important these issues are. An illustrative example is Andrew Wakefield's now infamous published research linking early childhood vaccinations with the development of autism (CNN, 2011). Despite the later retraction of Wakefield's research as fraudulent and Wakefield's subsequent loss of his medical license, among other consequences, many parents of young children decided to withhold vaccinations based on their understanding of Wakefield's work; some continue to do so, highlighting the potentially profound impact published research findings can have on the lives of those influenced by the research (Haberman, 2015).

Relevant Guidance for Promoting Ethics in Scholarship

Numerous aspects of the research process are addressed in the APA Ethics Code (APA, 2010a), which offers guidance from the planning stages of research through data collection, analysis, and dissemination. Potentially relevant topics include Institutional Approval (Standard 8.01), Informed Consent to Research (Standard 8.02), Informed Con-

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sent for Recording Voices and Images in Research (Standard 8.03), Client/Patient, Student, and Subordinate Research Participation (Standard 8.04), Dispensing with Informed Consent (Standard 8.05), Offering Inducements for Research Participation (Standard 8.06) Deception in Research (Standard 8.07), Debriefing (Standard 8.08), and Humane Care and Use of Animals in Research (Standard 8.09), among many others. A comprehensive examination of these topics would be beyond the scope of this brief article, which focuses more narrowly on ethics of scholarship directly pertaining to the dissemination of the results of one's research. Specific issues to be addressed include authorship credit and order (Standard 8.12), along with the use of ghost authors and guest authors, plagiarism (Standard 8.11), duplicate publication of data (Standard 8.13), and participation in a rigorous peer review process to help ensure the integrity of all published research findings.

In addition to being familiar with the relevant standard of the APA Ethics Code (APA, 2010a), readers are also referred to the APA Publication Manual (APA, 2010b). While this book may be widely used to consult with standards for APA style in one's manuscripts, such as how to appropriately cite articles with eight or more authors, how to use a running head, and other technical details of preparing a manuscript according to APA style, its use as a resource for guidance on the ethics of scholarship should not be overlooked. Detailed and helpful information is provided on ethical and legal standards in publishing, ensuring the accuracy of scientific knowledge, protecting intellectual property rights, when and how to appropriately credit sources, the editorial process, and author responsibilities in the manuscript submission and publication process. Review of these sections of the APA Publication Manual is strongly recommended for all researchers and scholars.

Authorship Issues

Authorship issues include authorship credit and authorship order. Researchers and scholars should address such issues from the outset, in a manner similar to the informed consent process. Agreements should be reached about each individual's anticipated participation and contributions, with appropriate credit given. Agreement should also be reached on the relative importance and value of various contributions to the research project, recognizing that different activities may be of varying importance (Oberlander & Spencer, 2006). If actual contributions differ from what was originally agreed upon, the level of credit given can be changed. As with informed consent, this should an ongoing process with open discussion among collaborators.

As is highlighted in the APA Ethics Code (APA, 2010a), junior colleagues and students should not be taken advantage of or exploited. Their contributions should be appropriately credited pursuant to Standard 8.12(c), Publication Credit. Further, authorship credit should not be motivated by political factors or conflicts of interest. Guest authorship (i.e., giving authorship credit to an individual who did not earn this credit) and ghost authorship (i.e., not giving authorship credit to an individual who deserves it) are both unethical practices jeopardizing the legitimacy of published research (Barnett & Campbell, 2012).

Clearly Unethical Behaviors

While many issues discussed may represent ethical dilemmas requiring careful attention, several behaviors are so clearly unethical they can be reviewed here together. These include plagiarism, fabricating results, modifying results in response to external pressures, and the

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duplicate or piecemeal publication of research results (i.e., specifically creating multiple publications out of what would legitimately be considered one study, with the intent of obtaining an increased number of publications). While possible motivations for these practices may be understandable, prevention is of paramount importance.

Research ethics and the overarching goals of legitimate research should be addressed at every possible point in education and training. In addition to a solid grounding in research ethics, future researchers should be specifically trained to avoid each of these unethical practices. For example, learning to spot potential conflicts of interest and motivations potentially leading to impaired decision-making early in one's career may be helpful in proactively avoiding difficulties later; likewise, training in how to avoid inadvertent or unintentional plagiarism and self-plagiarism, as well as the importance of active oversight throughout each phase of the research process, may assist researchers in avoiding these pitfalls (Roig, 2008; Walker, 2008).

Publication and the Peer Review Process

Assuming the concerns detailed above have been avoided, the next hallmark of scientific integrity in research is the peer review process. Once a manuscript has been submitted to a journal's editor, if the topic falls within the purview of the journal and meets the journal's minimum standards based on an initial review by the editor, the usual process is for the manuscript to then be forwarded to an associate editor, who serves as action editor for the manuscript. The action editor selects reviewers who are experts in the areas focused on in the manuscript. The manuscript then undergoes masked review (i.e., no author information is included in the manuscript) by several expert reviewers. Based on feedback provided by the reviewers and action editor, the action editor then makes a decision about the manuscript. This can include rejecting the manuscript, providing detailed feedback, and requesting revisions and subsequent resubmission of the manuscript for further consideration, or acceptance of the manuscript.

One potential challenge might involve a pre-existing relationship between the editor, associate editor, or a reviewer and one or more authors submitting a manuscript. Editors, in this situation, should refer the manuscript to a colleague on the journal's editorial board, rather than potentially jeopardizing the integrity of the review or decision-making process. Reviewers who suspect (based on the topic, writing style, or some other information) that they may know the author(s) of a submitted manuscript should return it to the action editor and withdraw from the review process. While this system is not perfect, in general it works well and upholds the integrity of the peer review process. Of greater concern is the proliferation of online open access journals and their wide range of standards for peer review.

Understanding Online Open Access Journals

The business model for most journals is to sell subscriptions (print and electronic) to libraries, other institutions, and individual subscribers and to charge a fee to individuals who are not subscribers for the download of individual articles. While this can be a profitable business, these journals also play an important role in the dissemination of high quality research through the rigorous peer review process they generally employ.

In recent years, an alternative model has emerged: the online open access journal. Based on the rationale that restricting access to scientific findings to those who

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can pay for a subscription or afford download fees limits the wide distribution of research and limits scientific inquiry, these journals charge a publication fee to the researcher who submits the manuscript to the journal for consideration of publication. These fees may be paid by the individual researcher, the researcher's institution, through grant funding, and the like. Upon publication, the articles are available, free of charge, to all who may be interested in reading them.

Reasons for Concern and Caution

Despite its egalitarian-sounding nature, this system raises a number of challenges and causes for concern. In recent years, there has been a proliferation of online open access journals, not all of which are peer reviewed publication outlets. A large number of these online journals promise a "rapid review" process and quick publication of accepted manuscripts. While there are, in fact, legitimate online open access journals utilizing a rigorous peer review process, as Bohanan (2013) has documented, most are predatory publishing businesses motivated by collecting publication fees. Bohanan (2013) submitted a deeply flawed manuscript with meaningless results to 304 online open access journals, 157 (60%) of which accepted it for publication outright, with no actual peer review process (although a small number of journals did reject the manuscript and provide helpful feedback for improving it).

Researchers and scholars may find publication through legitimate online open access journals to be consistent with their goals of widely disseminating their research, but caution is recommended. Jeffrey Beall (2012a), a librarian at the University of Colorado, Denver, has created criteria for determining predatory open access publishers (available at: https://scholarlyoa.com/2012/11/30/criteria-for-determining-predatory-open-access-publishers-2nd-edition/); Beall (2012b) also provides a comprehensive list of potential, possible, and probable predatory open access journals (available at: https://scholarlyoa.com/publishers/). Use of these and other, similar resources is recommended to help ensure the legitimacy of the peer review and publication processes.

Recommendations

The unethical behaviors highlighted above may occur for a variety of reasons. These may include lack of education on, or awareness of, relevant issues; failure to give adequate attention to ongoing self-care and management of ongoing stresses in one's life; participating in relationships creating conflicts of interest; and personal motivations. Inadequate attention to each may contribute to impaired objectivity and judgment, potentially resulting in decision-making that is inconsistent with the highest ideals of the mental health profession. In order to maintain the public's trust and help ensure that research and scholarship are conducted and disseminated with integrity, a range of recommendations can be made. Each of these deserve attention by all researchers and scholars individually, as well as by those who educate, train, and supervise them.

Conflicts of interest and personal motivations. At a minimum, researchers and scholars should endeavor to be aware of conflicts of interest and their likely effects on objectivity and judgment. Mental health providers should also seek to be aware of personal motivations and pressures impacting objectivity, judgment, and decision-making. These are necessary, but insufficient, considerations for ensuring good decision-making

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in the face of the multiple challenges, stressors, and pressures commonly experienced, as explored below.

Self-care and the promotion of wellness. Mental health professionals face many demands in their professional and personal lives. Attention to these issues, implementing an ongoing practice of self-care, promoting wellness, and striving to develop balance and prevent burnout, are important preventative measures (Baker, 2003; Norcross & Guy, 2007). Further, a focus on self-care should be integrated into each graduate student's training and should be an ongoing focus in supervision to help promote and adequately address positive career-long habits to help prevent impaired judgment and decision-making (Carter & Barnett, 2014).

Education and self-awareness. An important first step is to include comprehensive education about ethical issues in research and scholarship in each psychotherapist's training. This should not be limited to ethics courses, but should be integrated into all relevant aspects of training, from research methods courses to supervision, throughout the professional lifespan. Pressures, challenges, and ethical dilemmas should be discussed openly and proactively through group discussions and in ongoing supervision (Pope, Sonne, & Greene, 2006). Rather than emphasizing the memorization of ethics standards and rules, a focus on ethical decision-making is recommended.

The literature on ethics and ethical conduct has emphasized the importance of self-monitoring and self-awareness. These are important, but may not be enough to ensure ethical conduct alone. Research has demonstrated quite clearly that health professionals in general, and mental health professionals in particular, are unable to accurately self-assess competence in professional functioning (Dunning, Heath, & Suls, 2004; Dunning, Johnson, Ehrlinger, & Kruger, 2003). In fact, those with the greatest impairment in their abilities are least effective in self-assessment, resulting in impaired objectivity and placing them at greatest risk of poor decision-making (Kruger & Dunning, 1999). Thus, when one's objectivity or judgment is impaired, the ability to accurately self-assess is impaired as well.

In its focus on self-awareness and reporting ethics violations after they occur, the APA Ethics Code (APA, 2010a) gives inadequate guidance to researchers, educators, supervisors, and trainers. What is needed is a focus on prevention and an acceptance of responsibility for each other's ethical conduct. As Johnson and colleagues (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012; Johnson, Barnett, Elman, Forrest, & Kaslow, 2013) recommend, mental health providers need to promote a communitarian culture within the profession, emphasizing support for one another and taking an active interest in each other's personal and professional functioning, effectiveness, wellness, and conduct. This involves a proactive approach to monitoring and supporting each other, as well as providing honest feedback and assistance in the hope of preventing and avoiding impaired decision-making and unethical conduct.

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

THURSDAY, AUGUST 4

Symposium (A): How Technology Is Transforming the Mental Health Landscape
8:00 AM - 9:50 AM • Convention Center, Room 203 • 46, 12, 27, 29, 42
Anitha Iyer, PhD

Symposium (A): *Supervision—Master Supervisors of Various Orientations Show and Discuss Their Supervision Session Videos*
9:00 AM - 10:50 AM • Convention Center, Room 304 • 17, 39, 42, 46, 49
Cochairs: Hanna Levenson, PhD
Arpana G. Inman, PhD
Participant/1stAuthor:
Joan E. Sarnat, PhD
Brian McNeill, PhD
Elizabeth Holloway, PhD
Discussants:
Hanna Levenson, PhD
Arpana G. Inman, PhD

Skill-Building Session (A): What Every Psychotherapist Should Know About Violence
11:00 AM - 11:50 AM • Convention Center, Room 109 • 12, 18, 19, 39, 42
Chair: Lynett Henderson Metzger, PsyD, JD
Participant/1stAuthor:
Michael Karson, PhD, JD
Heather Morris, PsyD

Symposium (A): Publishing Books on Psychotherapy—Insights and Strategies From Psychologist Authors
12:00 PM - 12:50 PM • Convention Center, Room 302 • 10, 42, 46
Chair: John Sommers-Flanagan, PhD
Participant/1stAuthor:
Melba J.T. Vasquez, PhD
Derald Wing Sue, PhD
John Norcross, PhD
Discussant:
John Sommers-Flanagan, PhD

Skill-Building Session (A): How to Make Love to the Same Person for the Rest of Your Life
12:00 PM - 1:50 PM • Convention Center, Room 109 • 42, 43
Chair: Armand Cerbone, PhD
Participant/1stAuthor:
Dagmar O'Connor, PhD

Thursday, August 4, continued on page 36

Symposium (A): Unequal Psychotherapies—-
Culture, Race, Ethnicity, and Scientific Equity
12:00 PM - 1:50 PM • Convention Center, Room 201 • 12, 17, 29, 42, 45
Frederick T.L. Leong, PhD
Guillermo Bernal, PhD

Skill-Building Session (A): Using Innovative Moments to Track Progress in Therapy Across Orientations and Presenting Problems
1:00 PM - 1:50 PM • Convention Center, Room 403 • 17, 39, 42, 49
Cochairs: Melissa A. Smigelsky, MA, MS
Robert A. Neimeyer, PhD
Participant/1stAuthor:
Melissa A. Smigelsky, MA, MS
Elizabeth Piazza-Bonin, PhD

Symposium (A): Measuring Outcome at a Community Mental Health Training Clinic—-Challenges and Encouraging Results
2:00 PM - 2:50 PM • Convention Center, Room 107 • 46, 49
Cochairs: Tara Rooney, PhD
William Chaplin, PhD
Participant/1stAuthor:
Tovah Weinrib, BA
Carmen Mootz, BA
Sherry Cheng
Discussant:
Michael J. Lambert, PhD

Symposium (A): Advancing Social Justice in Clinical Practice
2:00 PM - 3:50 PM • Convention Center, Room 201 • 42, 12, 29, 35, 45
Lillian Comas-Diaz, PhD

Symposium (A): Goal-Focused Positive Psychotherapy—-
A Comprehensive Positive Psychology Therapy Model
3:00 PM - 3:50 PM • Convention Center, Room 304 • 17, 42
Chair: Michael J. Scheel, PhD
Participant/1stAuthor:
Collie W. Conoley, PhD
Alexandra K. Dahl, MA
Evelyn I. Plumb, BA
Robert A. Byrom, MA
Discussant:
Brian P. Cole, PhD

FRIDAY, AUGUST 5

Symposium (A): Psychotherapist Self-Disclosure With Complications—-
Personal Problems, Sex, "Me-Too"
9:00 AM - 9:50 AM • Convention Center, Mile High Ballroom 1E • 39, 42
Chair: Randolph B. Pipes, PhD
Participant/1stAuthor:
Caroline Burke, PhD
Raina Hafftka, BA
Randolph B. Pipes, PhD

Friday, August 5, continued on page 37

Symposium (A): Reverse Engineering and Validation of Psychotherapy
10:00 AM - 10:50 AM • Convention Center, Room 404
Chair: Stevan L. Nielsen, PhD
Participant/1stAuthor:
David Erekson, PhD
Adam Scalese, BS
Stevan L. Nielsen, PhD
Brian P. Hansen, PhD
Dianne L. Nielsen, PhD
Discussant:
Michael J. Lambert, PhD

Symposium (A): Making the Invisible Risible—-Sketch Comedy As a Basis for Difficult Dialogues
10:00 AM - 11:50 AM • Convention Center Mile High, Ballroom 3B • 45, 10, 17, 29
Michael Karson, PhD, JD

Poster Session (F): Psychotherapy—-Science, Practice, and Advances—I
11:00 AM - 11:50 AM • Convention Center, Exhibit Hall ABC • 46
Participant/1stAuthor:
Elizabeth McKamy, MSW
Tim Buschmann, MS
Peter W. Sanders, BS
Joshua K. Swift, PhD
April B. Brewer, MA
Myrna L. Friedlander, PhD
William R. Taboas, MA
Alexander J. Lengerich, MS
Joanna M. Drinane, MEd
Laura E. Jimenez-Arista, MA
James F. Boswell, PhD
Heath Schechinger, MS, MEd
Lisa A. Firestone, PhD
Cheri L. Marmarosh, PhD
Shannon O'Neill, MA
Jonathan S. Kent, PsyD
Michael J. Tanana, MEd
Jean M. Birbilis, PhD
Kelly Lavin, BA
Vaughn Worthen, PhD

Symposium (A): Improving Competence for Psychotherapists Working With Older Lesbian, Gay, Bisexual, and Transgender Adults
11:00 AM - 11:50 AM • Convention Center Mile High, Ballroom 1D • 17, 18, 19, 42, 43, 44
Chair: Douglas Kimmel, PhD
Participant/1stAuthor:
Kate L. Hinrichs, PhD
Perry N. Halkitis, PhD, MPH
Weston V. Donaldson, PhD
Discussant:
Douglas Kimmel, PhD

Symposium (A): Psychotherapy Interventions, Process, and Outcome With Transgender and Gender Nonconforming Clients
11:00 AM - 11:50 AM • Convention Center, Room 405 • 18, 19, 39, 42, 44
Chair: Stephanie L. Budge, PhD
Participant/1stAuthor:
Sand Chang, PhD
Laura P. Minero, MA
Stephanie L. Budge, PhD
Discussant:
Lore M. Dickey, PhD

Friday, August 5, continued on page 38

Business Meeting: Journal Editorial Board- INVITATION ONLY
12:00 PM - 12:50 PM • Hyatt Regency Denver Hotel, Granite Room A

Presidential Address
3:00 PM - 3:50 PM • Sheraton Denver Hotel, Plaza Ballroom A

Business Meeting
4:00 PM - 4:50 PM • Sheraton Denver Hotel, Plaza Ballroom A

Discussion (A): Psychology and the Media—-Strengthening Our Voice
4:00 PM - 5:50 PM • Convention Center, Rooms 108 and 110
Daniel Reimer, MA

Social Hour
5:00 PM - 6:50 PM • Sheraton Denver Hotel, Plaza Ballroom D

SATURDAY, AUGUST 6

Symposium (A): Spirituality and Psychotherapy—-Managing Ethical Dilemmas
8:00 AM - 9:50 AM • Convention Center Mile High, Ballroom 2B • 17, 19, 24, 39, 42, 45
Cochairs:
W. Brad Johnson, PhD
Stephanie R. Brasfield, JD, MS
Participant/1stAuthor:
William L. Hathaway, PhD
Edward P. Shafranske, PhD
W. Brad Johnson, PhD
Douglas C. Haldeman, PhD
D. Fredrica Brooks-Davis, PsyD

Symposium (A): The Determination and Promotion of Expertise in Psychotherapy
8:00 AM - 9:50 AM • Convention Center, Rooms 108 and 110 • 17, 12, 29
James Lichtenberg, PhD
Rodney K. Goodyear, PhD

Discussion (A): PechaKucha 20x20—-Cutting-Edge Presentation Styles
10:00 AM - 10:50 AM • Convention Center, Room 205
Janet K. Swim, PhD

Symposium (A): Sexuality and Diverse Identities, Culturally Competent Sexual Health Assessment, and Intervention
10:00 AM - 11:50 AM • Convention Center, Room 403 • 42, 43
Chair: Linda R. Mona, PhD
Participant/1stAuthor:
Maggie L. Syme, PhD, MPH
Zyanya Mendoza, PsyD
Kyle Ortigo, PhD
Colleen Cordes, PhD
Discussant:
Rebecca P. Cameron, PhD

Saturday, August 6, continued on page 39

Skill-Building Session (A): How to Use Mobile Applications in Mental Health
11:00 AM - 11:50 AM • Convention Center, Room 205
Julia E. Hoffman, PsyD

Poster Session (F): Psychotherapy—-Science, Practice, and Advances—II
12:00 PM - 12:50 PM • Convention Center, Exhibit Hall ABC • 46
Participant/1stAuthor:

Rui Du, PharmD
Ting Lu, MD
Xiubin Lin, MA
Dalong Wei, BS
Minnah W. Farook, MS
Erin M. Van Seeters, BS
Xu Li, MEd
Julie Koch, MS
Raina Hafftka, BA
Jennifer A. Schager, BA
Whitley R. Paden, BA
Barbara M. Vollmer, PhD
Amber J. Gorzynski, BS
Joanna M. Drinane, MEd
Mengting Ying, MD
Hui Wei, MA
Yujia Lei, MS
Minnah W. Farook, MS
Kevin M. Kieffer, PhD
Hugh D. Leonard, BA
Joseph A. Ramirez, BA
Kelly Lavin, BA
Carolyn E. Meiller, BS
Maria Lauer, MEd
Jeremy J. Coleman, BA
Deepta R. DasGupta, MA
Geneva A. Polser, MEd

Symposium (A): The Human Core of Effective Psychotherapy—
Toward a More Scientific, Relational Perspective
12:00 PM - 1:50 PM • Convention Center Mile High, Ballroom 4B • 24, 42, 49
Chair:
David N. Elkins, PhD
Participant/1stAuthor
Michael J. Lambert, PhD
Barry L. Duncan, PsyD
Melba J.T. Vasquez, PhD
Lillian Comas-Diaz, PhD
Discussant
Kirk J. Schneider, PhD

Symposium (A): Promoting Sexual Health and Well-Being Among
Individuals With Mental Health Diagnoses
12:00 PM - 1:50 PM • Convention Center, Room 205 • 29, 18
Linda R. Mona, PhD

Social Hour (S): Reception With Masters
5:00 PM - 6:50 PM • Hyatt Regency Denver Hotel, Mineral Hall G

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SUNDAY, AUGUST 7

Symposium (A): Boundaries and Rituals Enhancing Resilience—-Creative and Deliberate Decisions by Therapists
8:00 AM - 8:50 AM • Convention Center, Room 107 • 39, 42
Chair: Caroline Burke, PhD
Participant/1stAuthor:
Thomas M. Skovholt, PhD
Caroline Burke, PhD
Meredith A. Martyr, MA

Symposium (A): Expanding EBPs Frontiers—- Explicitly Considering Implicit Processes and Culture in Psychotherapy
9:00 AM - 9:50 AM • Convention Center, Room 405 • 12, 49
Chair: Hector Y. Adames, PsyD
Participant/1stAuthor:
Hector Y. Adames, PsyD
Nayeli Y. Chavez-Dueñas, PhD
Martin J. La Roche, PhD

Symposium (A): Self-Care for Practicing Psychologists—Research, Educational, and Clinical Practice Perspectives
10:00 AM - 10:50 AM • Convention Center, Room 706 • 42
Chair: Patricia A. Rupert, PhD
Participant/1stAuthor:
Katherine E. Dorociak, MA
Evan Zahniser, BA
Ellen K. Baker, PhD
Discussant:
Patricia A. Rupert, PhD

Symposium (A): Ethical and Legal Aspects of Practice With Transgender and Gender Nonconforming Clients
11:00 AM - 11:50 AM • Convention Center, Room 403 • 42, 43, 44, 51
Chair: Anneliese A. Singh, PhD
Participant/1stAuthor:
Lore M. Dickey, PhD
Linda F. Campbell, PhD

Symposium (A): Science, Sexuality, and Psychotherapy—Alternative Expressions
12:00 PM - 1:50 PM • Convention Center, Rooms 108 and 110 • 42, 43
Chair: Armand Cerbone, PhD
Participant/1stAuthor:
Michelle D. Vaughan, PhD
Karen Davison, PsyD
Ryan Witherspoon, MA
Neil Cannon, PhD
Discussant:
Richard A. Sprott, PhD

CLINICAL NOTES WITH DR. J

Think Before You Tweet: Things to Consider When Posting on Social Media About Social Issues

Jonathan Jenkins, PsyD
Massachusetts General Hospital
Assistant in Child and Adolescent Psychiatry
Harvard Medical School Instructor in Psychology (Psychiatry)

The proliferation of different social media platforms provides the global community the opportunity to transmit information and opinions at lightening quick speed via countless unique venues. As we have seen in recent history, social media has not only offered an avenue for social engagement, but it has also led to cultivating tangible changes in our community, including assisting in political elections (Chang & Masunaga, 2015), promoting terrorism (Braw, 2009) or fighting it (Menn, 2015), communicating important information after natural catastrophes (Fine, 2013), and assisting with major fundraising efforts for important causes in our community (Sreenivasan, 2014). Although social media platforms do have roots in the mundane and sophomoric (read: cat videos), clinicians must appreciate and attempt to understand the ways in which our clients utilize this medium and how we can leverage it to reach prospective and current clients, while also communicating with other clinicians in a professional manner. Much media coverage and research has already been invested in the ways in which social media can have both a positive and negative effect on individual's emotions and sense of self (Hampton, Rainie, Lu, Shin & Purcell, 2015). When we work with our clients, we often speak to and assist them with problem-solving challenges both in their physical worlds and in their digital identities, in which people may be wholeheartedly invested. The same applies to clinicians. As both practitioners and brands, we often utilize social media and the internet to further our brand, communicate with other clinicians, recruit clients, and consume research. As we go about these avenues on the internet, we continuously engage with social media and we are often reminded of its tremendous impact on our daily lives and relationships.

Before I was a clinician, I tended to babble on social media and magically say a lot without saying much at all. In addition to constantly posting Facebook status updates about my beloved Boston Celtics and the mundane actions of my small social circle, many of my expressed reactions to social issues were passionate, but lacked mechanisms to inform the reader. For me, these responses to social issues were often me, "speaking to the choir," in that these posts were intended to be read, understood, and agreed with by similarly-minded peers and friends. When I entered graduate school and later began my internship, I reexamined the ways in which I interacted with social media. I not only changed the ways in which I personally interacted with this portal of the internet, but also thought about the ways in which I could utilize social media to advocate for my community. Through this process of reflecting upon social media, I grew in my ability to rec-

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ognize the true power in being "Dr. Jonathan Jenkins," instead of just "Jonathan Jenkins" or "JJ." With the recognition and social status that often came with those two letters in front of my name and the abbreviated letters behind it, I took it upon myself to leverage the ways in which I could utilize my community status as a doctor to speak for those voices that were underserved and marginalized, and galvanize others to become more aware of important social causes.

Like many clinicians, I am often asked by friends and family to weigh in on social issues, especially those related to this current voracious election cycle. In this current election, there appears to be an uptick in the degree to which social issues have become a key and volatile focus of many of the recent editorials and debates. From topics such as immigration, racial profiling, and religious freedom, to the civil rights of transgender individuals, the community as a whole has participated in an often-animated discussion on these topics, with many believing strongly in their own positions as the righteous and correct positions for the community. As inquires and requests to give my own opinion on these topics grew stronger from my peers and colleagues, I was forced to think about the ways in which clinicians *do* and *should* participate in these discussions, given our stakeholder position within the community. Outlined below are several strategies I utilize to determine how and when to respond to social causes, and how I utilize social platforms to inform my social media community.

What Do You Want to Say?

Once you have an issue on which you want to comment, the next step is to cultivate your statement. To cultivate your statement, think about members of your target audience, what you want their takeaway message to be, and also, who you are, both as a person and a clinician. For example, if I am writing about the importance of fighting recent legislation that would reduce funding for special needs children in schools, I would want my audience to focus on the impact this proposed change would have on the students' mental health, given my role as a psychologist. As both a clinician and the child of an elementary school teacher who frequently worked with special needs children, I also come with a unique perspective that I *should* capitalize on in my social media statement. When functioning as a psychologist commenting on a social issue, it is imperative to always comment from a position of *known knowledge* and not *assumptions*. When commenting via a position of *known knowledge*, one is utilizing their clinical knowledge, guidance from the American Psychological Association's Ethics code, and appropriate personal and professional experiences to inform the public. When engaged in this type of social dialogue, the clinician greatly reduces the likelihood of either operating outside the boundaries of competence or providing false or inappropriate information to the public and therefore causing potential damage to the community, current clients, and the profession. When operating from a position of *assumptions,* a person is presenting information from a perspective lacking in evidence, safety, facts, and logic. These positions often resonate purely from an emotional place instead of from a position of thoughtful reflection supported by research. *Known knowledge* provides for a stronger argument and one more capable of informing the minds of the community and assisting individuals in thinking more critically and thoughtfully regarding the particular topic, which should be the goal of any type of social media advocacy.

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Be Nice

Although it is difficult to believe, the Golden Rule STILL applies to one's life and interactions on the internet. Although the internet is known for appalling, demeaning, and truly emotionally devastating constructs, such as cyber bullying and revenge pornography, there is the potential to change the culture of the internet by engaging in and promoting more balanced and respectful interactions with others. People harbor many complicated emotions around issues of social justice, and may respond to others' experiences of lack of respect, safety, or civil rights with feelings of anger, frustration, agitation, and aggression of their own. Given this reality, it is often important to be able to recognize when one is being passionate versus when one is being disrespectful or overly aggressive. When a person crosses the line and becomes aggressive about social justice issues, the individual runs the risk of having the specific message lost in the fervor of an attack on someone else or the opposing point of view. A thoughtful and effective social commentator will be able to express a distinct point of view with facts and emotions that both inspire and enrage but do not insult. As clinicians, this is a difficult line for us to straddle, especially when we may be greatly personally impacted by these social issues. It is our responsibility to do so in order to be respectful to the entire community, even those who look to divide it. Although it might seem difficult to be respectful to those who oppose social issues we care deeply about, it is important to keep in mind that respectful does not mean that you cannot be pointed and stern in your position or response. To avoid getting caught up in responding inappropriately, always take a few minutes reviewing a response or social media post before pasting it on the internet, or ask a close friend or colleague to read the post for appropriateness.

Being nice also provides great insight into your therapeutic style for those in the community. When posting on social media, we often forget that our views and opinions are not only available to our "followers" and friends, but others who have access to the words or pictures we put online (read: almost anyone). Given this undeniable fact, a clinician will be best served mirroring the welcoming and open minded environment that operates within the clinician's therapeutic space, so as to be welcoming to prospective clients and community members. A community member who reads something from a therapist that seems ill-conceived, short tempered, hyperbolic, and offensive will understandably make certain assumptions about the therapist's ability to hold the client in a nonjudgmental space. Being thoughtful and emotionally present is not only a necessary ingredient in good psychotherapy, but also an aspect of participating with social media. By taking this time, you decrease the likelihood of passionately posting something to your account that may have soothed your initial anger, but unfortunately portrays you in a less than positive light.

Chose the Appropriate Platform for Your Response

Each social platform has its own advantages and disadvantages, and thus deliberate thought should go into deciding which social media platform to utilize for any statements or social advocacy. For example, Instagram might be a great platform to post a picture of solidarity with a particular issue or group with a beautiful picture referencing the topic, whereas Twitter might be useful to further trend a hashtag that has gained momentum in its popularity and power in its meaning. Being flexible and mobile with your social media presence allows you to be adept at communicating with

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a variety of different communities, similar to the ways in which being bi- or trilingual allows individuals to have richer and more diverse conversations and interactions, both within and outside their communities of origin. Clinicians should dedicate time to becoming familiar with these social media platforms not only for their own marketing and communication, but so they can also become good consumers of social media in order to stay on top of social movements and events that impact the community and subsequently their clients.

Be Prepared for Feedback

Expressing one's views on social issues does not occur in a vacuum, so taking a position on a certain topic often invites either support or criticism from the community, especially when this position is related to a hot-button issue. Before posting a position on social media, clinicians should think about their ability to tolerate the potential negative and positive ramifications. Given the intimate nature of psychotherapy, clinicians are often accustomed to receiving feedback from known entities, whether those persons are professors, colleagues, or clients. Given these traditional outlets for feedback, it can often feel uncomfortable to receive feedback from strangers and those not trained in psychology, given the lack of knowledge some may have on the field or on the clinician as a person. Many of us have had the mind-numbing experience of accidently scrolling through the comments section of an article on a popular media outlet such as the Huffington Post or CNN and reading comments that are simultaneously highly offensive and highly inaccurate. Before even posting the statement or picture to social media, a clinician should dedicate time to exploring the ways in which their statement could be misunderstood in order to prepare for certain critiques or to avoid those critiques altogether by making slight alterations to the statement. Conversely, a clinician must also prepare for the possibility of their post gaining incredible attention for its poignancy and ability to speak to a certain position. Overly positive feedback can be just as uncomfortable for some as negative feedback, especially if the topic shared is personal or if the clinician is, by nature, a private person and did not intend for the message to have such a wide audience. When this occurs, it is important for the clinician to rely on a support system of those with previous experience managing the "spotlight" and who can provide meaningful information to help the clinician navigate this unique and important opportunity.

The power of the internet is vast but it can be harnessed via an organized and thoughtful social media response to social justice issues. Clinicians have the responsibility to participate in the communal discussion of the issues facing our community and to provide both accurate and meaningful discourse to help filter out misinformation and combat fearmongering. We, as clinicians, have an important role to play in our community, and social media is an important tool for disseminating helpful and healthy information.

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

The Transition to Motherhood for Therapists: Examining and Reflecting on Issues of Gender and Identity

Maggie Benedict-Montgomery, PhD
Emeryville, CA

As Mother's Day approached this year, I found myself reflecting on my experiences the previous May. It was a watershed year for me, both professionally and personally, as I navigated the challenges of a postdoctoral residency in child community mental health while learning to parent. Last year, I was midway through my residency and deeply involved in both my relationships with my son and with my other "children"—the clients with whom I spent much of my time. I vividly remember the strange experience of my divided mind that day. I celebrated my new role with my family, but found myself wondering about my clients, several of whom had been separated from their biological mothers at some point. I felt guilty and grateful at the same time, and wondered how my clients were doing on this triggering day. This experience was one of many similar during my training year, a year of learning to integrate my identity of mother and therapist.

About two-thirds of all practicing psychologists in the United States identify as female (American Psychological Association; APA, 2015). Over half of these psychologists are under the age of 50, and many are, or will become, mothers at some point during their careers, often during the early career phase.[1*]

Although the field of psychology includes many mothers (and potential mothers), discrimination continues to impact female-identified trainees and therapists, despite efforts to enhance cultural competence in this area (Bertsch et al., 2014). In the workplace, female therapists may encounter gender-related events (GREs), defined by Walker, Ladany, and Pate-Carolan (2007) as relational experiences that are influenced by one's sex, gender, or social stereotypes related to gender roles. However, to date there has been little scholarly research on new-mother therapists (Waldman, 2003). In this paper, I discuss how gender discrimination and bias affect new mothers, explore the ways that identity may shift during this transition, and reflect on my own experience of becoming a mother-therapist.

New Motherhood: Issues of Bias and Discrimination

Gender discrimination and bias toward new mothers has been well documented and continues to be a major social concern (Benard & Correll, 2010; Cech & Blair-Loy, 2014; Correll, Benard, & Paik, 2007; Stone & Hernandez, 2013; Williams, Blair-Loy, & Berdahl, 2013). Mothers are seen as less competent, less trustworthy, and less committed to their jobs than their non-parent peers and fathers, which results in wage discrimination by employers (Benard & Correll, 2010; Correll & Benard, & Paik, 2007; Williams, Blair-Loy, & Berdahl, 2013). New mothers are driven out of the workforce by lack of support, hostile work environment, and perceived or experienced stigma (Benard & Correll, 2010;

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Stone & Hernandez, 2013; Williams, Blair-Loy, & Berdahl, 2013).

GREs experienced by new mothers might include discrimination at work (e.g., fewer referrals upon return from leave or lack of private spaces for pumping), negative responses from supervisors or colleagues (e.g., negative statements about needing to leave work early due to child's illness or being passed up for promotion), and, for mother-therapists, challenging interactions with clients (Baum, 2010; Dyson & King, 2008; Fallon & Brabender, 2003; Hamilton, 2013; Raphael-Leff, 2004; Shaw & Breckenridge, 2014; Waldman, 2003). For therapists with children, discrimination and bias in the workplace, if not appropriately processed and addressed, can negatively impact collegial relationships, trust for supervisors and employers, and work with clients (Bertsch et al., 2014). Because new mothers' experiences are often minimized, it is also important to explore the impact on women's gender identity and roles (Prinds, Hvidt, Mogensen, & Buus, 2014).

The Great Identity Shift

Many have described the transition to motherhood as one of the most impactful experiences in their lives, shifting their perspectives and identities in profound ways (Baum, 2010; Dyson & King, 2008; Hamilton, 2013; Laney, Hall, Anderson & Willingham, 2015; Raphael-Leff, 2004; Shaw & Breckenridge, 2014; Waldman, 2003). New mothers tend to experience a time of great personal growth, as well as an opportunity for integration of new values and meaning. The transition to new motherhood may radically alter the ways women experience their bodies, their relationships with others and themselves, and their sense of personal meaning and spiritual beliefs (Prinds et al., 2014).

While this shift in identity can bring opportunity for personal growth, it may also complicate or even disrupt women's professional identities and career aspirations. Studies have found professional women are sensitive to negative messages in the workplace, particularly around their competence and their emerging need for flexible scheduling and family leave (e.g., sick days; Stone & Hernandez, 2013; Williams, Blair-Loy, & Berdahl, 2013). Professional women are more likely to opt out of returning to work, feel less satisfied with their jobs, and are less likely to persist in their career when they face stigma and discrimination at work (Benard & Correll, 2010; Cech & Blair-Loy, 2014; Stone & Hernandez, 2013). Women tend to feel pulled between the dual roles of mother and professional, and this constant struggle can reduce their ability to engage in executive functioning tasks (Hodges & Park, 2013). It is clear that new mothers face many challenges in the workforce, but becoming a mother may present therapists with an opportunity to enhance their clinical skills in profound ways, while also enhancing their identities as mothers.

Clinical Work as a Mother-therapist

The process of developing this new identity offers enormous opportunity for growth, especially for therapists. The experience of attuning to, mirroring, and creating a holding environment for their children, hallmarks of a "good-enough" mother (Winnicott, 1971), can be applied by mother-therapists to their work with clients, which can facilitate therapeutic change (Kenny, 2014). Mother-therapists have reported they feel their new identity and experience helps them better empathize with their clients, to understand developmental issues and needs, and to utilize primitive affect and intuition in their clinical work (Fallon & Brabender,

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2003; Shaw & Breckenridge, 2014; Waldman, 2003). Therapists who choose to disclose their status as a mother to clients who also have children may be perceived as more empathic and understanding of their unique life experiences, which may, in turn, positively impact the therapeutic relationship and treatment outcomes (Hodges, Kiel, Kramer, Veach, & Villanueva, 2010). Waldman (2003) notes the transition to new motherhood allows for an expansion in the transferential relationship between client and therapist, including an ability to intuit unspoken or preverbal issues that may cause "stuckness" for clients.

Additionally, clinicians who are mothers report they are able to use their experiences in clinical work to benefit their relationships with children and partners at home (Shaw & Breckenridge, 2014; Waldman, 2003; Zur, 1994). For instance, professionals working with abused children were found to display more democratic parenting practices (Dursun, Sener, Esin, Anci, & Sapmaz, 2014) and child welfare workers utilized reflection and meaning making to enhance relationships with their children (Menashe, Possick, & Buchbinder, 2014).

On the other hand, there are clinical challenges accompanying the territory. New mother therapists may find they are, in fact, too open to clients' emotional and nonverbal experiences, which may result in a decline in objectivity (Raphael-Leff, 2004; Schmidt, Fiorini, & Ramires, 2015; Waldman, 2003). Therapists may experience diffuse boundaries, a tendency to over-identify with clients, and difficulty drawing appropriate limits during this time (i.e., going over session time or responding to out of session contacts). They may be more likely to engage in rescue fantasies, especially when working with children and families (Malawista, 2004; Raphael-Leff, 2004). They may find that the needs of their child leave them with less space and patience for those of clients (Raphael-Leff, 2004; Shaw & Breckenridge, 2014; Waldman, 2003). Mother-therapists can find themselves so burnt out by the emotional and physical needs required in both roles that they have little time or energy to care for their other relationships and attend to their own needs (Waldman, 2003).

Acknowledging Issues of New Motherhood: Cultural Competence Within the Field

It is clear that exploration of issues facing new mothers benefits the field of psychology on levels both systemic (e.g., ensuring psychologists are able to continue working in the field after becoming parents) and personal (e.g., allowing therapists to process and make meaning of critical events related to parenting status). The APA's guidelines for work with women and girls (2007) state that psychologists who work with women and girls should help their clients "understand the impact of bias and discrimination so they can better overcome the impact of obstacles that are external in origin as well as internal" (p. 963). In order to effectively explore these issues with clients, psychologists must first recognize and acknowledge their own experiences of gender socialization, discrimination, and bias, as well as how they understand these events (APA, 2007).

Agencies and organizations can promote well being and encourage cultural competence by facilitating thoughtful conversation and training about these issues. New mother-therapists report that the ability to engage in honest, open dialogue about their experiences allows them to make meaning of this transition, and to feel less conflicted in their parenting-career roles (Baum, 2010; Fallon

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& Brabender, 2003; Hamilton, 2013; Raphael-Leff, 2004; Shaw & Breckendridge, 2014; Waldman, 2003). Supervision, peer consultation, and mentoring with other mothers may be particularly helpful, and allow women to feel safe disclosing their experiences. Supervisors of new mothers should be aware of the immense shifts in identity discussed above, and should be willing to openly process gender-related experiences and challenges supervisees bring in (Bertsch et al., 2014; Walker, Ladany, & Pate-Carolan, 2007). Open and honest exploration of such issues helps therapists feel competent, supported, and satisfied with work (Bertsch et al., 2014). This is important since therapists who feel positively about their workplace are less likely to experience burnout and compassion fatigue (Thompson, Amatea, & Thompson, 2014).

Reflections on One Mother-Therapist's Experience

Despite seeking out a residency with a family-friendly agency, I experienced many of the challenges described above. During the early days of my residency, I dealt mostly with logistical issues. For example, I learned I needed to remind training personnel I would be taking breaks throughout the day during day-long trainings—and that I would need a private place to pump. Through experience, I realized I needed a childcare plan to ensure both clients, and my child, were cared for in case of a crisis at work. Tired and drained from both my new roles, I often felt like I was barely treading water.

Although my agency was highly responsive to feedback around challenges and accommodations, I soon realized it would fall on me to confidently and clearly communicate my needs. As the only new mother in my cohort, some things just were not "on the radar," even though many staff members were new mothers. Speaking directly about something as private as breast milk left me feeling exposed and uncomfortable. I often felt anxious and rude as I snuck out of trainings, but told myself firmly that I was doing what I needed to do as a parent. At times, my roles of trainee, mother, and therapist seemed directly in conflict with one another, and I struggled to balance them.

When the stress of the more practical challenges of new motherhood began to wane, I found the more existential and relational aspects of this transition ramped up for me. I began to settle into my relationship with my baby and my clients, and to notice shifts in myself. I often felt tender and vulnerable during sessions, especially when working with children who had experienced early relational trauma. I found myself more tearful and emotionally responsive than before—during supervision, during consultation with colleagues, even during sessions at times. Much of my work involved home-based therapy, and I noticed myself struggling to parse out what was mine, what was theirs, and what was ours in these sessions. As I sat with my son, I sometimes thought about my desire to offer a "good-enough" experience to repair my clients' early traumatic experiences. These responses often provided valuable insight into my clients' inner lives, but at other times I wondered whether it was normal to experience such intense emotions. In some group settings, I felt worried that talking about these experiences would make me seem less competent.

In order to cope, I found answers to my questions, solace, guidance, and support from my colleagues and supervisors who were also parents. I was lucky that almost all of the psychologists responsible for

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my training were mothers—and many of them had even had a young child during their own residency. I found "allies" within my agency—from my training director, who ensured I had a private place to pump during trainings, to my supervisors, who helped facilitate my understanding of my own experiences as a mother and how they impacted my clinical work. I found the more I shared my story with others, the more I was able to integrate my new and old identities and feel secure in my dual roles.

Supervision was particularly important over the residency year. I frequently encountered therapeutic issues related to mothering, and my supervisors encouraged me to explore these. For instance, I was able to process the ways gender stereotypes about mothers contributed to my own anxieties and fears about being a "good-enough" mother while completing my emotionally intense residency. I was later able to use this experience clinically as I worked with a mother who feared she was at fault for her child's explosive behavior, due to her mental health struggles during his infancy. Through ongoing supervision with a team of culturally competent and humble psychologists, I began to feel competent when using my own experiences and openness to attune to my clients and help them feel empowered and heard.

Discrimination, bias, and stereotypes of mothers affect many in our field, but are rarely examined critically. Furthermore, discussing the major identity and role shifts that occur when becoming a mother may be discouraged or minimized, leading to dissatisfaction and burnout for mother therapists. Exploring these issues opens the door for us to examine nuances of gender and identity, how they may affect our views of ourselves, and how they may inform our work with clients—in the early stages of our careers and beyond.

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

* Editor's Note: Given that many women who become mothers do so during the early years of their training and practice, it seems relevant to address this topic through an Early Career lens. It is important to recognize that gender discrimination impacts women of all ages and at every career stage, and that women may become mothers or be impacted by many of the issues discussed in this article at a variety of points before, during, or after their professional careers. By no means is the framing of this article meant to imply that the issues of gender and identity raised by motherhood and clinical practice are exclusive to early career professionals.

The Sign of Good Work in Psychotherapy: Deaf Practices and Customs

Garret Shelenhamer, MA
Gallaudet University

The clock reads 1:55 p.m.; it is time for your next session. You go to the waiting room and there sits your new client, head down in their phone, as is common for clients waiting to see you. As you approach, you start introducing yourself; however, the client does not look up. You raise your voice and try again. No response. Finally, you place yourself in front of the client and clear your throat. The client does not respond for a second, and then glances up and gives you a look of surprise. The client starts to sign to you. Suddenly, your mind racing, you realize: Your client is Deaf. You immediately think, "Where should I go from here?"

Sometimes it has not been communicated to the therapist that a client is Deaf and, as result, the therapist is unprepared. Other times the therapist simply does not know how to proceed. This narrative is designed to provide clinicians who may not have worked with Deaf clients previously an introduction to Deaf culture and resources for better serving members of the Deaf community.

Basic Considerations

What does it mean to be Deaf? An audiological definition means the lack of hearing or a hearing impairment. Viewing it through a medical model, deafness is the inability to hear; a disability. Still another model used to view Deaf people is a cultural model. The Deaf culture model uses an uppercase D to denote it as a formal culture. The medical model uses a lowercase d to denote they are talking about a disability. The cultural model argues that being Deaf stands alone as its own culture, with its own language, practices, customs, traditions, and community (Lane, Hoffmeister, & Bahan, 1996). Which model should you use? The answer is simple—whichever one with which the client identifies. Often, hearing psychotherapists think they know what is best and either assume Deaf clients see themselves as impaired or see themselves as culturally different, instead of asking about the individual client's identity (Lane et al., 1996). This may seem obvious, but it is one of the most overlooked aspects when working with Deaf individuals. Identity matters and, to members of the Deaf community, Deaf culture may be a salient identity. As with any client, neither identity nor cultural practice should be assumed (Gutman, 2002).

Hearing people often assume all Deaf people are able to lip read and know sign language. However, this is not true; each Deaf individual is going to be different. Sensitivity starts with knowing a little bit about Deaf culture. One can read about the culture, and there are several books (listed below) with which to start. However, the best way to learn about Deaf culture is to experience it. Most cities have resources and a welcoming Deaf community with which hearing psychotherapists can become involved. Consider taking sign language

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classes where, in addition to the language, you can often learn about culture. Continuing education classes and community classes specializing in working with Deaf clients are also great ways to expand your knowledge base. Look up professionals in your area who work with Deaf clients, take some time to get to know them (as uninformed referrals could put the client in a worse situation), and use them.

When learning about Deaf culture, you will come across a number of "do" and "do not's". First, do not raise your voice when a member of the Deaf community does not understand what you say. Deaf people tend to be visually oriented, and when you raise your voice, your facial expressions change. It is a sign of rudeness to raise your voice (Leigh, 2010). Another common problem is deciding where to look when talking to a Deaf individual. Make eye contact. Do not look down or away when speaking, even with another person in the room. Look directly at the recipient of your speech, even if that person is not looking directly at you (for example, when an interpreter is being used). Part of becoming sensitive is asking clients how they would like to communicate. Not everyone uses sign, and it is essential to find out how your client prefers to communicate. This is the most important aspect of working with Deaf individuals: Each person is different, and the importance of using the most comfortable form of communication is key to a successful interaction.

Communicating Ethically and Effectively

Although those with limited or no experience with working with Deaf clients may consider referring to a provider who is more experienced, referral is not always an option, and may not be preferred in a given situation for a variety of reasons. Remember: Asking about your client's preferred mode of communication is imperative. Clinicians with limited fluency in sign language are likely aware that, as with any language, it must be practiced consistently to be mastered. It certainly helps to know some sign language, but if you are not fluent (or not fluent in the client's language of choice), do not rely on sign based skills in a therapy session. Use an interpreter, if doing so is possible and aligns with the client's needs and wishes.

Choosing an interpreter. Finding an interpreter who is skilled in the client's particular language of choice is crucial to understanding the client. Do not let family, significant others, or friends interpret for your client. Set boundaries and empower the client to be in charge of the therapy and its content. Allowing a noncertified interpreter to interpret is both unethical and potentially harmful to the relationship and the client's growth while under your care.

Working with an interpreter. What do you do when the interpreter arrives? Sit down with the interpreter and talk about how the session will go, what communication will look like, and what happens if there is a breakdown in communication. And, what I believe to be paramount, talk about privacy and subjects that might come up in therapy and how to handle them. Remember, an interpreter is there to facilitate the language difference between you and your client—not function as a therapist or educate you in Deaf practices. One pragmatic issue to consider is room setup. Having the interpreter slightly behind the therapist and to the side allows the Deaf individual to see both parties, and allows you to connect with the client more directly, conducting therapy as you typically would. Another common

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concern is who pays for the interpreter. The short answer is: It is not always clear. However, the type of practice, service being provided, and referral source may impact funding. In private practice expenses may be covered by an insurance company, paid by the Deaf individual, or come out of the therapist's fees. This is a real problem and a limitation to seeing Deaf clients, and financial matters should be addressed proactively to prevent misunderstanding.

Issues of Competency

Providing psychotherapy services. Issues of competency may arise when inexperienced psychotherapists work with members of the Deaf community. Under such circumstances, the psychotherapist should seek supervision from a clinician specially trained in Deaf psychological processes. A good starting point is the National Directory of Deaf Trained Professionals (Gallaudet University, 2016; available on the Gallaudet University website: https://www.gallaudet.edu/clerc-center/info-to-go/national-resources-and-directories/mental-health-services-.html), which provides information regarding those who specialize in providing help to Deaf individuals. Another suggestion is to look up the Deaf-specific community resources in your area.

Providing assessment services. When performing psychological evaluations with Deaf individuals, providers need to understand underlying assessment principles, and how to apply them to Deaf individuals. Merely translating an assessment instrument does not make it valid to administer to a new culture (Brice, 2002). Many assessments are designed to answer questions about knowledge, behavior, or emotion. The types of data used may vary with the measure, but typical assessments are based on hearing norms (Fellinger, Holzinger & Pollard, 2012). Deaf individuals may differ from hearing individuals in terms of English-based reading skills, short-term memory, or in other nuanced ways that could significantly impact results, leading to an inaccurate representation of level of functioning.

Getting Started

If you are interested in understanding more about Deaf culture and working more effectively with Deaf clients in psychotherapy, a number of excellent books may help you get started: *Deaf Mental Health Care* edited by Neil Glickman (2013), *Psychotherapy with Deaf Clients from Diverse Groups* edited by Irene Leigh (2010), *Ethics in Mental Health and Deafness* edited by Virginia Gutman (2002), *Journey into a Deaf World* by Lane, Hoffmeister, and Bahan (1996). Next, I recommend you engage with the Deaf community. A quick Internet search will take you to Deaf community resources in your area. An excellent resource to know and use is the website from the National Association of the Deaf (n.d.; https://nad.org). Here you will find a list of Deaf agencies and services. Lastly, if you find this subject fascinating and want to pursue this field, Gallaudet University (2016) has the only program of its kind with a doctorate program in clinical psychology, specializing in working with Deaf and Hard of Hearing individuals.

Challenges and Rewards

Obviously there will be challenges. Sign language may not come as easily as other languages to many; it is a total communication language, using the entire body rather than simply speaking words. It requires one to practice and engage in communication that may not be intuitive to grasp (Brice, Leigh, Sheridan, & Smith, 2013). Personally, I found learning sign language to be one of the most difficult challenges of my life.

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When I become discouraged, however, I remember a favorite sign language teacher joking about starting to get the hang of American Sign Language after some nine years of practice. And fluency in the mechanics of communication is not the only obstacle. As noted by Brice et al. (2013), whenever two cultures sit down and try to come together, challenges will occur. This tension exists when I, as a hearing therapist, am working with a Deaf client. Most Deaf individuals expect to work with a hearing therapist, but long for an opportunity to work with a Deaf therapist (Steinberg, Loew, & Sullivan, 2010). We all want our therapists to be similar to us, to understand us, and to relate to our struggles on some level. It is the same for my clients when they think I am too different from them to be of service. With Deaf clients, I try to validate their concerns while exploring with them ways to work together effectively to accomplish their therapeutic goals.

With all that has been mentioned thus far, I do not mean to frighten you away from working with Deaf individuals. Quite the opposite, actually: I hope to encourage clinicians who are not engaged with the Deaf community to consider becoming more involved. Seeing Deaf clients "light up" when they can sign directly to their therapists for the first time creates feelings I will never forget. The impact that being understood, linguistically and culturally, has on a client is difficult to quantify. As a therapist, connecting with your clients on a deeper level and assisting them in understanding more about themselves through the lens of therapy is rewarding under any circumstances; when it happens for the first time with a Deaf client, the feeling is amplified. These are experiences you cannot get from reading a book. Getting to know people and experiencing their culture will build a much stronger understanding of the community. For me, one of the most gratifying moments in my professional training was being honored and integrated into the Deaf community through being given a sign name. This cultural ritual communicated acceptance and respect, and it warmed my heart to be welcomed into a small part of Deaf culture. For the record, my sign name is Bowtie.

Conclusion

This overview is by no means comprehensive, but I hope it has given you a glimpse into some of the rewards, challenges, and pragmatic considerations in psychotherapy work with members of the Deaf community. I encourage you to seek more resources and further your knowledge. The only way to understand is to learn, and the only way to learn is to invest time and interest. I wish you luck in your journey.

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STUDENT FEATURE

The Perils of Denial: An Intern's Response to the Hoffman Report

Mariya Dvoskina, MA
University of Denver
Graduate School of Professional Psychology

After reading the recent Hoffman report (Hoffman et al., 2015), I found myself wondering how respected individuals in my field could participate (even indirectly) in such horrific acts. As an intern who is soon to be an early career psychologist, I considered that, while there are many complex factors at the heart of any man-made tragedy, psychoanalytic theory might help shed light on these incidents and provide unique insights. Given the breadth, depth, and multitude of psychoanalytic approaches, I decided to narrow my focus to one of the most well-known and accepted tenants of classic ego psychology—defense mechanisms. More specifically, I will focus on a brief exploration of how the mechanism of denial can lead to a failure to see and prevent tragic events.

Psychoanalytic theory views denial as an unconscious mechanism that serves to protect us from our own anxiety or guilt and involves blocking external events from conscious awareness (Freud, 1937). As individuals, and collectively as a culture, denial may be one of the most common defense mechanisms in which we engage. Given the unconscious nature of our defense mechanisms, we fail to see not only that we may be engaging in denial, but also the subsequent consequences. Sometimes those consequences may be trivial, or only affect us on an individual level (at which point we may choose to seek individual psychotherapy (as a potential remedy, for example). At other times, the human propensity toward denial holds the potential for disaster. The findings of the recent Hoffman report are just one example of how perilous a path paved in denial can be. I will examine how denial can permeate our view of the past, our perception of the present, and our outlook toward the future—in essence, immobilizing us psychologically and preventing us from taking effective action. By looking more closely at these dynamics, I hope to suggest clear and effective steps for preventing this outcome in the aftermath of the Hoffman report.

In the wake of a tragic event, individuals may utilize denial to avoid feelings of guilt and shame. One reaction might be to blame or demonize the behavior others. Some of us engaged in this type of response after the Hoffman report was published, reacting in disbelief to the idea that the events it described could have occurred. By engaging in this type of denial, however, we create an arbitrary distinction between good and bad and refuse to see the complexity of each situation. Looking back, we may tell ourselves and others, "I could never do something like that," or, "I could never even inadvertently support torture." We engage in a similar type of denial in our future-oriented thinking as well. We be-

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lieve "it won't happen to me" or, "it won't happen here." Yet, by buying into these beliefs, not only do we deny the importance of contextual factors (i.e., that there are situations in which we *would*, in fact, engage in similar actions, such as protecting ourselves or our children, for example), but, psychoanalytically speaking, we also deny and refuse to believe in our own capacity for aggression. Of course, Sigmund Freud saw aggression as an essential human drive (Freud, 1922), while Carl Jung referred to this darker part of ourselves as the "shadow" (Jung, 1969). Both theorists would suggest aggression and the capacity for violence are inherent parts of every human being.

Although the concept of denial is historically and conceptually rooted in classic ego psychology (Freud, 1937), it is equally relevant today, and can be understood through a lens of more modern relational psychoanalytic approaches. While classic psychodynamic theory largely does not address the power of contextual factors, more modern approaches of psychoanalytic theory recognize the importance of context and situation in understanding human behavior (Mitchell & Aron, 1999). Both classic and modern psychoanalytic approaches suggest that we are all capable of deeply horrific acts given the right circumstances. To be in denial about this aspect of selfhood is dangerous, as it prevents us from engaging in preventative measures. While it would be equally impractical to be constantly focused on our potential capacity for violence, we should strike a balance and look ahead through a lens of preparedness and self-awareness.

In the present moment, I would suggest, there are two relevant types of denial responses. The first involves the difficulty of accepting responsibility and taking action. We tell ourselves, "someone else will do something about it," or we assume following direct orders from a superior eliminates any personal responsibility. Fearing embarrassment or failure leads to ignoring the warning signs of a moral slippery slope. One does not have to be a sociopath or an extremist to commit heinous acts. As mentioned earlier, we do ourselves a disservice when we underestimate our own potential for aggression and the contexts in which it presents itself. It is likely the psychologists implicated in the Hoffman report believed they were doing the right thing or, at the least, what was expected of them. I would (maybe boldly) argue that most of us would have acted in similar ways, faced with the same challenges and circumstances. This leads back to being aware of how contextual factors may affect us, and how easily we can succumb to the pull of denial. Given how difficult it is to catch ourselves in denial in real time, we should proactively place checks and balances on our behaviors. Unbiased oversight should be part of these checks and balances. Additionally, importance should be placed on being able to consult with other professionals who are not as close to the situation.

The second type of denial response in the present moment incorporates a deeper level of fear and an inability to see the humanity in others. Proponents of war and violence often play on our ability to deny the basic humanity of "them." For example, a common tactic in war is propaganda, which dehumanizes the enemy by reducing individuals to objectified caricatures. Racist stereotypes are another example of this. Dehumanization, or, to put it another way, the denial of others' humanity and humanness, naturally makes it easier for an individual to cross their own ethical and

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moral boundaries and to commit acts of violence. If you see the person in front of you as a target, you will likely have fewer inhibitions about torturing or killing them. One way to combat this type of denial is to get back in touch with our own humanity by examining our own fears. Through self reflection and acceptance of our humanity for what it is, we can develop greater empathy for others. I would agree with an existential line of thinking that posits an examination of our own mortality and our fears of death can actually revitalize our experience of life and our awareness of ourselves and others (Kaufman, 1956). A greater appreciation for the value of life—all life—is at the heart of any human rights movement.

We engage in denial effortlessly and fluidly. Even as you read this essay, I hope to tug on some of those strings of denial. It is, of course, extraordinarily difficult to catch oneself in the act of denial; after all, it operates from within the unconscious. Yet, I urge clinicians and others to partake in a deep examination of their own defense mechanisms. Psychoanalytic theory gives clinicians the tools and knowledge to explore and address defense mechanisms, including denial; unless we do so, we will simply continue to engage in the same behaviors, as people and as a community of professionals. Moving beyond this cycle requires us to engage in an examination of ourselves and our greatest fears, individually and collectively. Examining fears more deeply and confronting denial will be uncomfortable, but worth it. Whether we are thinking of past situations, addressing an issue in the present moment, or looking toward the future, we can benefit from examining our thought processes. We can create a safer environment for ourselves, and ensure more ethical decision making for our clients, if we focus on seeing and taking responsibility for our own contributions to the society we have helped to create.

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WASHINGTON SCENE

Looking Outwards for a Change: Interprofessional Collaboration

Pat DeLeon, PhD
Former APA President

Early last year, APA systematically inquired with the leadership of its divisions and state associations as to what in their view were the major issues which the discipline of psychology would be facing in the next 5 to 10 years. Seven themes evolved, the first of which was Positioning for the Future. Under this topic were: Engaging and positioning psychology in integrated healthcare settings; Globalization and Internationalizing psychology; the Role of technology; and Telehealth/Telemedicine. APA President Dr. Susan McDaniel, who recently represented APA at the British Psychological Society, has been personally involved with these issues for the past several decades and thus her election to our highest leadership office could not have come at a better time for the association. Last year, when we were both fortunate enough to have been invited to attend the Beach Boys' tribute to Barbara Van Dahlen's Give An Hour initiative—which has already provided over 185,000 hours of free care to our military and veterans communities—she passionately described her contributions to the World Federation for Mental Health Congress in Cairo. I still vividly recall from when I was serving on the APA Board of Directors former APA President Ray Fowler constantly reminding us that American psychology represented only a small subset of psychology and that those of us who were active in the APA governance had much to learn from our international colleagues.

This spring, with great enthusiasm, Susan hosted her Integrated Primary Care Alliance Presidential initiative which, by all accounts, was a major success. Co-hosted by Institute of Medicine (IOM; recently renamed the National Academy of Medicine, or NAM) member and family physician Frank deGruy, MD, the meeting occurred on the weekend of April 8th and 9th in the Tower Conference Room at APA. APA hosted a CEO and a leader in the Presidential cycle of 23 different health and mental health professional organizations that compose the integrated primary care team. This list resulted in over 80 participants (pediatricians, internists, family physicians, nurse practitioners, physician assistants, psychiatrists, social workers, clinical pharmacists, etc.). The objective for the weekend was to develop inter-organizational goals to move the needle forward on integrated primary care. Panels of 4 to 6 experts provided five-minute "lightening talks" to stimulate discussion in four areas: clinical innovation, interprofessional education, new methods of research and evaluation, and needed policy and payment methods. After each panel, participants divided into five action discussion groups to discuss what policies these organizations might collectively agree to lobby for and what projects they might want to support. The participants left energized by the opportunity to work together. To start, they already have three letters to Congress

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that all agreed to sign (e.g., one on giving psychologists access to electronic health records, or EHR). A number of other work groups have been established that need future attention.

Conference attendee Lucinda Maine, Executive Vice President of the American Association of Colleges of Pharmacy, reports: "I immediately responded 'yes' to Susan's invitation to attend the summit because I knew that 'integrated primary care' was central to our work on interprofessional education and practice. Yet it was not until I reviewed the preconference materials that I fully comprehended that it was behavioral health integration that we would be discussing. I suppose that should have been self-evident! That said, both the style and the content of the summit were powerful and the caliber of attendees was simply amazing. It will be a meeting that influences my thinking about patient care forever." As Susan reflectively summarized: "It is our hope that this effort has legs…."

An Expanding Definition of Health

Also this spring, the IOM released its report: *A Framework for Educating Health Professionals to Address the Social Determinants of Health* which highlighted that the World Health Organization (WHO) defines the social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." These forces and systems include economic policies, development agendas, cultural and social norms, social policies, and political systems. Educating health professionals in and with communities negatively affected by the social determinants of health can generate awareness among those professionals about the potential root causes of ill health, thereby contributing to more effective strategies for improving health and health care for underserved individuals, communities, and populations.

The IOM's review of the salient literature supports the need for a holistic, consistent, and coherent framework that can align the education, health, and other sectors, in partnership with communities, to educate health professionals in the social determinants of health. The outcome of its deliberations provides a framework for lifelong learning for health professionals in understanding and addressing the social determinants of health. To impact health equity requires the movement of knowledge into action, and this requires more than just accruing knowledge. Health professionals must develop appropriate skills and attitudes to be advocates for change. Governments, ministries, communities, foundations, as well as health professional and educational associations all have a role to play in how health professionals learn to address the social determinants of health. Transformative learning, together with partnerships and lifelong learning, are fundamental principles from which the IOM built its framework. We would remind the readership that one of the fundamental elements of President Obama's Patient Protection and Affordable Care Act (ACA) is the furtherance of data-based, population focused health care. Our nation's health care and educational systems are undergoing unprecedented change.

An Inspirational Vision by Our Colleagues in Nursing

Over the past several years, we have become increasingly impressed by the public policy sophistication demonstrated by our colleagues in nursing. Fellow Purdue University graduate Angela McBride, PhD, RN, FAAN, invited me to

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participate in the American Academy of Nursing's (AAN's) Institute for Nursing Leadership, which is in alignment with the Nurses on Boards Coalition (NOBC), a funded effort of the Robert Wood Johnson Foundation (RWJF). The NOBC, of which AAN is a founding member, has the express goal of placing 10,000 nurses on various policy boards, commissions, and councils by the year 2020 with the ultimate goal of positioning nurses to lead change to improve health and drive policy. NOBC's efforts emanated from the comprehensive recommendations of the 2010 IOM report *The Future of Nursing: Leading Change, Advancing Health*, chaired by former Department of Health and Human Services (HHS) Secretary Donna Shalala.

Similar to WHO, the Institute proffers a broad definition of "health," including areas that impact health outcomes and population health. Three related efforts have been articulated: Increase the appointments of their members, prepare their membership for serving, and continually evaluate the impact of these efforts. The AAN has three strategic goals: *Influence the implementation of healthcare reform with the goal of achieving the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. *Lead efforts, *in partnership with others*, to address the broad range of factors that affect the health of populations. And, *Position nurses to lead change to improve health and health care and to drive policy. Twenty-two organizations are now members of the NOBC, all working on similar efforts. One can find the latest "count" of nurses on boards by viewing the live thermometer on www.nursesonboardscoalition.org.

I was pleased to have the opportunity to serve as a reviewer last year for the follow-up IOM report *Assessing Progress on the IOM Report The Future of Nursing*. Both of these visionary reports were sponsored by the RWJF and have resulted in several impressive national stakeholder conferences held in Washington, DC. Several of the highlights of the follow-up report: The passage of the ACA will require the U.S. health-care system to expand to accommodate a significant increase in demand for services, "particularly those needed to manage patients with chronic conditions or mental health illnesses or for basic primary care." Nurses are in a unique position to take on a leadership role in helping the nation attain this goal. "Nurses have a key role to play as team members and leaders for a reformed and better integrated patient-centered health care system." With approximately three million members, nurses make up the largest segment of the nation's health care profession.

The changing climate of health care policy and practice has sharpened the national focus on the challenges of providing high-quality and affordable care to an aging and increasingly diverse population. The priorities of this changed climate will increasingly require the collaboration of health professionals to provide patient-centered, coordinated, and community-based primary and specialty care services. We would emphasize that it is important for psychology to appreciate that one element of organized nursing's response—pursuant to numerous IOM reports—has been the launching of the Campaign for Action, in conjunction with AARP, to shepherd the various recommendations toward implementation at the national, state, and institutional level. Several of the key areas to be addressed are: removing scope-of-practice barriers, implementing nursing resi-

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dency programs (a provision of the ACA), doubling the number of nurses with a doctorate by 2020, and building an infrastructure for the collection and analysis of interprofessional health care workforce data. Susan Hassmiller, Senior Advisor for Nursing at RWJF, spent two years on loan to the IOM as staff director for the initial report and currently serves as National Campaign Director:

"The Campaign has made significant progress in many aspects of this effort. In a short period of time, it has galvanized the nursing community through its work at the national level and through the 51 state Action Coalitions it has organized. The (IOM) found that the Campaign has met or exceeded expectations in many areas. However, given the changing health care culture and, in particular the increasing importance placed on interprofessional collaboration, the Campaign needs to engage a broader network of stakeholders. The present report also recommends addressing challenges in the areas of scope of practice, education, collaboration, leadership, diversity, and data. The (IOM) believes these contributions can change the impact of nurses on the health care system and on patient care and outcomes."

The original IOM report emphatically proposed that advanced practice registered nurses (APRNs) could help build the workforce necessary to meet the country's health care needs if permitted to practice to the full extent of their education and training. The follow-up report: "While there has been on-the-ground collaboration between medicine and nursing, opposition by some physicians and physician organizations has been noted as a barrier to expansion of ARPNs' scope of practice. The health care environment continues to evolve and demand greater team-based and value-based care. There is growing evidence that new models of practice in which all health professionals practice to the full extent of their education and training offer greater efficiency and quality of services. Several studies have shown, moreover, that these care models enhance satisfaction among health care providers. This is an important contextual change since the release of the (initial) report, one that offers potential common ground for that report's goals regarding scope-of-practice expansion."

A senior colleague and I were recently admiring nursing's success in obtaining support from a number of foundations. For example, the Jonas Center for Nursing and Veterans Healthcare has the impressive accomplishment of supporting 1,000 Jonas Scholars, committing nearly $25 million in grants to nurses pursuing PhDs and DNPs. This is also evident in the nearly $20 million that the Future of Nursing Action Coalitions have leveraged from additional sources, including other foundations, to match the RWJF dollars that are supporting their efforts. Our nation's health care environment is, indeed, undergoing dramatic change.

Aloha.

THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOC

REPORT OF APA COUNCIL

The 2016 APA Council of Representatives met for the first time in Washington, DC, on February 19-21. Your Society for the Advancement of Psychotherapy/APA Division 29 was represented by Drs. Jean Carter and John Norcross.

Hoffman/Independent Review
Council continued to struggle with the findings and limitations of the Hoffman/Independent Review. To correct deficits identified in that report, Council established work groups to (1) review organizational policies and procedures, (2) develop civility principles and procedures for itself, and (3) create guidelines for selecting members of future task forces.

As well, Council approved the inclusion of ethics, human rights, and social justice when APA's Strategic Plan is revised. All of this in addition to the prior staff firings and resignations, resolutions passed at Council's August 2015 meeting, and numerous changes transpiring throughout the APA governance.

The Board announced appointments to task forces to conduct the CEO search and to review Ethics Office policies and procedures.

The crisis has softened and has not yet resolved as Council and the Board of Directors seek to chart a course in which we respond to it and also try to understand the multiple perspectives that are increasingly apparent. We are still recoiling and healing, while simultaneously trying to move forward and to learn from the crisis.

Positive Actions
Council approved two resolutions: Opposing HIV Criminalization, and Data about Sexual Orientation and Gender Diversity. We also approved guidelines on the treatment of transgender individuals. You can find these resolutions and the guidelines in full on the APA website.

As well, in this meeting and the preceding one, Council approved changes to the Bylaws and Association Rules that would enlarge and democratize the election of the APA Board of Directors. If the membership approves the proposed Bylaws this November, then:

- Members-at-large of the Board of Directors will be elected by the entire membership (not by the Council of Representatives).
- One member of the Board of Directors will be an early career psychologist.
- The Board of Directors will include a public member.
- Members-at-large and Recording Secretary cannot succeed themselves in office or run for another office on the Board of Directors.

Council received a 90-minute diversity training on religious tolerance and discrimination, with a special emphasis on Islamophobia.

Financial Matters
APA finances are strong and stable, with four months of cash on hand (as required by Council). There is at least $190 million of equity in the two APA buildings. Dues account for a mere 10% of APA revenues, while publications and database fees bring in 80%.

However, cash shortages and a deficit budget have been occasioned by the

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costs of the Hoffman/Independent Review, settlement of the practice assessment class action lawsuit, and several special designations (e.g., internship stimulus funds, public education campaign). Thus, APA will curtail its spending in 2016, which includes delaying several conferences for a year.

Division 29 is strongly represented throughout the APA leadership. The last two APA presidents (Barry Anton, Nadine Kaslow), the current president (Susan McDaniel), and fully half of the members of the Board of Directors are proud Division 29 members.

Thank you for supporting the Society/Division 29 and us as we traverse these turbulent waters. We are confident that APA will emerge stronger and better from the crisis.

John

Jean

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

2016 REQUEST FOR PROPOSALS

The Drs. Rosalee G. and Raymond A. Weiss Research and Program Innovation Grants

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

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

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

About the Grants
The Drs. Rosalee G. Weiss Program and Innovation Grant supports innovative research, education, and intervention efforts that advance psychological knowledge and application in

- Understanding the connection between behavior and health.
- Reducing stigma and prejudice
- Understanding and preventing all forms of violence
- Addressing long-term psychological needs in the aftermath of disaster

Preference will be given to early career psychologists (ten years or less post-doctoral), and pilot projects that, if successful, would be strong candidates for support from major federal and foundation funding agencies, and "demonstration projects" that promise to generalize broadly to similar settings in other geographical areas and/or to other settings.

Amount
Up to $1,000

For grants and scholarships that are $10,000 or more, APF will make the award to your institution. APF does not allow institutional indirect costs or overhead costs. Applicants may use grant monies for direct administrative costs of their proposed project.

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Eligibility Requirements
Applicants must:

- Be affiliated with 501(c)(3) nonprofit organizations. APF will NOT consider the following requests for grants to support:
  - ~ political or lobbying purposes
  - ~ entertainment or fundraising expenses
  - ~ anyone the Internal Revenue Service would regard as a disqualified group or individual
  - ~ localized direct service
  - ~ conference/workshop expenses
- Have demonstrated competence and capacity to execute the proposed work
- IRB approval must be received from host institution before funding can be awarded if human participants are involved

Evaluation Criteria
Proposals will be evaluated on:

- Innovative and potential impact qualities
- Quality, viability, and promise of proposed work
- Clear and comprehensive methodology
- Practicality of budget

Proposal Requirements
Please include the following sections in your proposal (no more than 7 pages; 1 inch margins, no smaller than 11 point font):

- Description of proposed project to include goal, relevant background, target population, methods, anticipated outcomes. Format: not to exceed 5 pages (1 inch margins, no smaller than 11 point font)
- Timeline for execution (1 page)
- Full budget and justification (1 page)
- Current CV
- Please attach your organization's IRS determination letter.

Submission Process and Deadline
Please submit an application online by **September 15, 2016** at http://www.apa.org/apf/funding/weiss.aspx

Please be advised that APF does not provide feedback to applicants on their proposals. Please contact Samantha Edington, Program Officer, at sedington@apa.org with questions.

CALL FOR NOMINATIONS

Society for the Advancement of Psychotherapy
Associate Internet Editor

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

The Associate Internet Editor provides assistance and support to the Internet Editor, especially on matters of technology and social media, and works with a student assistant to help with overall workflow and production of online content.

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 and the current Associate Editor, Amy Ellis, Ph.D. at amyellisphd@gmail.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 especially as it applies to the effective use of technology in support of the Internet Editor, 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 August 1, 2016: JBarnett@loyola.edu All interested individuals are encouraged to apply.

ASSOCIATE INTERNET EDITOR DUTIES

The Associate Internet Editor for the Society for the Advancement of Psychotherapy is dedicated to advancing the science, practice, and study of psychotherapy through their online and social media skills and expertise. The Associate Internet Editor advises and supports the efforts of the Internet Editor through the strategic implementation of website, social media, and other digital outreach.

THE MAJOR DIGITAL ASSETS OF THE SOCIETY:

Website: http://societyforpsychotherapy.org
Facebook Page: https://www.facebook.com/Psychotherapy29
Twitter Account: https://twitter.com/psychotherapy29

DESCRIPTION OF COMMITMENT

Term

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

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Time Commitment
- 10-12 hours per week

Honorarium
- $2000 per year

DESCRIPTION OF MINIMUM DESIRED WEBSITE AND SOCIAL MEDIA RELATED SKILLS AND KNOWLEDGE

Website Content Management Systems
Familiarly with WordPress and CoSchedule (i.e., web authoring and content delivery systems)

Website and Social Analytics
Familiarity with Google Analytics
Familiarly with Facebook Insights

Content Marketing
Familiarly with Search Engine Optimization (SEO) concepts

Social Media
Facility with Facebook and Twitter
Familiarity with other social media platforms (e.g., LinkedIn, Reddit, Instagram)

TECHNICAL AND USER EXPERIENCE IN SUPPORT OF THE INTERNET EDITOR

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
- Catalog and prioritize problems and difficulties (e.g., 'bugs') with the website
- Address technological problems
- Minor problems to be directly handled by Associate 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 Internet Editor, as needed
- Under the direction of the Internet Editor and 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.
- Under the direction of the Internet Editor, select and guide development of appropriate web technology platform(s).
- Under the direction of the Internet Editor, select technology/software system(s) for social media publication, engagement, and management.

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FIDUCIARY RESPONSIBILITIES

Reporting Responsibilities
Assist in creating a mid-year and year-end report of the activities of the Internet committee

Participating in Society Governance
- Participate in Publication Board meetings
- Annual 1-day meeting with reasonable expenses paid to attend.

STRATEGY

Digital Content Strategy
- Assist in the implementation of editorial procedures to support reader engagement
- Assist in the implementation of strategy to build relationships with potential contributors for original featured content
- Assist in the implementation of strategy to incentivize submission of original content from Society members

Promote Printed Society Publications
- Assist in the active partnership with the *Psychotherapy* Editor to promote recent volumes, special issues, notable articles, and trending topics
- Assist in the 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
- Support increased involvement of graduate students and ECPs

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

THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY CONGRATULATES THE 2016 GRANT AWARDEES!

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

The 2016 Norine Johnson Psychotherapy Research Grant for Early Career Psychologists was awarded to Tali Boritz, PhD, for her proposal: "Therapist Characteristics, Alliance Rupture and Resolution, and Treatment Outcomes in Dialectical Behavior Therapy for Borderline Personality Disorder."

Tali Boritz is a psychologist and clinician scientist at the Centre for Addiction and Mental Health (CAMH), and an Assistant Professor in the Department of Psychiatry at the University of Toronto. She received her PhD from York University in Toronto, Canada. Her research primarily focuses on psychotherapy process and outcome, with particular emphasis on the treatment of personality disorders. Her current research program aims to elucidate mechanisms of change in personality disorders, including the successful negotiation of the therapeutic alliance. The aim of her Norine Johnson Grant study is to determine whether in-session alliance rupture and resolution processes predict clinical outcomes in borderline personality disorder (BPD), and to assess the moderating effect of specific therapist characteristics on these alliance processes. This research will be used to inform the improvement of existing psychotherapies for BPD, as well as to optimize training practices for therapists working with this population. ■

The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually by the Society for the Advancement of Psychotherapy to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three $5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome. Grant proposals are due each year on April 1. We congratulate the three individuals listed below whose proposals were selected for grant funding in 2016.

Ken Critchfield, Ph.D., Assistant Professor, James Madison University, for his proposal "Adherence and outcome in Interpersonal Reconstructive Therapy for complex cases."

Ken Critchfield received his doctoral degree (Ph.D., 2002) in Clinical Psychology from the University of Utah where he used

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interpersonal models to study psychotherapy processes and case formulation. From 2004-2014, Dr. Critchfield was director of research, and eventually become co-director of the Interpersonal Reconstructive Therapy (IRT) clinic at the University of Utah Neuropsychiatric Institute. There, he worked closely with Dr. Lorna Smith Benjamin, creator of IRT, to operationalize and test efficacy and process of change of IRT as applied with adults having severe and chronic psychiatric problems often involving comorbid personality disorder and suicidality. He joined the faculty of the Department of Graduate Psychology at James Madison University in August, 2014 and continues to work in close collaboration with Dr. Benjamin. He is a licensed clinical psychologist and now co-directs JMU's Combined-Integrated Doctoral Program in Clinical and School Psychology.

The primary goal of this Gelso grant proposal is to enable coding of the level of adherence for therapists and patients in a recently-archived psychotherapy database focused on evaluation of putative mechanisms of change in Interpersonal Reconstructive Therapy (IRT: Benjamin, 2003/2006; Benjamin, in press). The work is part of a larger study of the effectiveness of IRT in complex cases and would extend current data in new and crucial ways that speak to the validity of the underlying theory by allowing direct tests of whether variability in adherence to principles of IRT predicts change. The work represents a direct extension of methods and findings pursued for over a decade by Drs. Critchfield and Benjamin that has so far resulted in a sequence of empirical, peer-reviewed publications addressing IRT's basis in copy process theory, its case formulation method, effectiveness, and mechanisms that impact change (Critchfield & Benjamin, 2008; 2010; in preparation; Critchfield, Benjamin, & Levenick, 2015). ■

Jennifer S. Cheavens, Ph.D., for her research proposal, "Exploring potential mechanisms of change in Dialectical Behavior Therapy."

Jennifer Cheavens is an Associate Professor and the Director of Clinical Training in the Department of Psychology at The Ohio State University. She received her Ph.D. in Clinical Psychology from the University of Kansas and completed her internship and post-doctoral fellowship at Duke University Medical Center. Her research interests focus on optimizing psychotherapy treatments for borderline personality disorder and depression through both basic and applied research efforts.

With the current project, Dr. Cheavens plans to investigate the role of therapist validation and invalidation in outcomes of clients participating in Dialectical Behavior Therapy (DBT). Specifically, observer-ratings of in-session validation will be used to predict session-to-session changes in therapy outcomes, including changes in symptoms, emotion regulation, and interpersonal functioning, over the course of DBT. ■

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Rayna D. Markin, Ph.D., for her research proposal, "Psychodynamic psychotherapy for a pregnant woman following perinatal loss: A single-case study analysis of mentalization."

Rayna Markin is an Associate Professor at Villanova University and a Licensed Psychologist in part-time private practice, specializing in maternal mental health. She is also the Early Career Psychologist Domain Representative for Division 29. Dr. Markin is a graduate of the Counseling Psychology Program at the University of Maryland, where she completed her dissertation on central relationship themes in group therapy under the advisement of Dr. Dennis M. Kivlighan, Jr. During the course of her graduate studies, she was fortunate to also work with Dr. Charles Gelso on projects related to the therapy relationship and learned from him the value of therapy process research that is theoretically driven. After graduation, Dr. Markin continued her research on the therapy relationship in individual and group therapy; for example, she worked with Dr. Jacques Barber and colleagues on a study of transference and countertransference in Short-Term Expressive Therapy. She has been increasingly influenced by attachment theory and co-authored an *APA* published book on *Attachment in Group Therapy*. More recently, she has received several grants to study the effects of early trauma on the expecting mother's ability to mentalize and attach to her unborn baby and has written on the psychology of pregnancy from a mentalization-attachment perspective.

The purpose of the present study is to begin to fill in the gap in the literature on psychotherapy during pregnancy following a perinatal loss. It is proposed that psychodynamic psychotherapy is an effective treatment for the perinatal grief, depression, anxiety, and attachment problems sometimes observed during pregnancies following such a personal and devastating loss. Furthermore, this investigation will look at the future mother's capacity to mentalize as a predictor of therapy outcome, utilizing a mixed methods, single case study design. This study is an important first step in identifying effective treatments for a woman faced with the daunting task of grieving the loss of one baby while struggling to attach to the next baby. ■

Please join us as we honor these grant recipients at the Society for the Advancement of Psychotherapy Awards Ceremony, on Friday August 5th, at the APA Convention - 4:00 PM in the Sheraton Denver Hotel, Plaza Ballroom A. The Social Hour will be immediately following in Plaza Ballroom D.

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

Society for the Advancement of Psychotherapy
Distinguished Psychologist Award
Jeffrey Magnavita, PhD

Jeffrey J. Magnavita, Ph.D., ABPP has been in independent practice for over three decades and is a scholar in several areas of psychopathology and theory. Dr. David Barlow, in an endorsement for a recent volume, described Jeffrey as "…perhaps the most prominent psychologist in the broad area of mental health practice." Dr. Magnavita has published broadly in the treatment of personality disorders, personality theory, psychopathology, and family systems, and has done pioneering work toward the unification of psychotherapy and the study of clinical science. He sought to develop a framework for unifying the various approaches to psychotherapy by distilling the essential components and methods of treatment. He is the founder of the *Unified Psychotherapy Project (UPP)* and the co-founder and current Editor-in-Chief of *The Journal of Unified Psychotherapy and Clinical Science*, with Dr. Jack C. Anchin. One of his long-standing interests is the development of *psychotherapedia*™, a catalogue of techniques and methods of psychotherapy in an on-line format. Dr. Magnavita has served on the editorial boards of a number of leading journals. His latest volume with APA is entitled *Clinical Decision Making in Mental Health Practice* and he is currently completing *Incorporating Technology in Mental Health Practice*, also with APA. He has edited and written ten volumes, a number of which have been highly praised by reviewers. His approach to psychotherapy has been featured in two APA Psychotherapy videos.

Dr. Magnavita a fellow of APA and has been actively involved in advancing psychological science and psychotherapy for many years. He served a three-year term on the APA *Practice Guideline Advisory Steering Committee* and during his final year was appointed co-chair. He was president of the *Society for the Advancement of Psychotherapy* in 2010 and has served in a variety of divisional roles including the Council of Representatives. In 2014 he was nominated and ran for President of APA. He has been recognized with numerous state and national awards for his pioneering work including the APA *Distinguished Contributions to Independent Practice* (2006) and *Distinguished Psychologist of the Year Award* from the Society of Psychologists in Independent Practice (2010). Dr. Magnavita created and hosted the online series *Psychotherapists Face-to-Face* a production Division 29.

Dr. Magnavita treats individuals, couples, and families in his offices in Glastonbury, CT and Orleans, MA, as well as offering telemental health treatment when deemed appropriate. More information at www.drjeffreymagnavita.com & www.unifiedpsychotherapyproject.com

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Society for the Advancement of Psychotherapy Award for Distinguished Contributions to Teaching and Mentoring

Charles Gelso, PhD

Dr. Gelso received his doctoral degree from Ohio State University in 1970. After working at the University of Maryland counseling center for 12 years, he joined the Psychology Department as a fulltime professor in 1982 and became an Emeritus Professor in 2013. His theoretical, research, and clinical interests focus on the patient-therapist relationship in psychotherapy.

Dr. Gelso states: "I have theorized that all therapeutic relationships consist of a working alliance, a personal or 'real' relationship, and a transference-countertransference configuration. Although these components all are rooted in psychoanalytic theory, my attempt has been to theorize about and empirically investigate their operations in diverse psychotherapies. I have empirically studied all of the elements of this tripartite model and my research program along with clinical experience has allowed me to write book-length treatments of two of the components: countertransference (Gelso & Hayes, 2007) and the real relationship (Gelso, 2011). I am now beginning a book on how the tripartite model operates in the practice of psychotherapy. My other main area of interest is research training in applied areas of psychology, particularly clinical and counseling psychology. Here I have developed a theory of the ingredients of training that, when present, facilitate graduate students' interest in, self-efficacy about, and production of research during their graduate training and afterwards. The product of over three decades of research on this theory has been presented in a recent publication (Gelso, Baumann, Chui, & Savela, A., 2013). I have also conducted individual psychotherapy throughout my career, and I currently see patients through my private practice. My approach to treatment is psychodynamic, although I do integrate other theories as is indicated."

Dr. Gelso has chaired 35 dissertation committees, chaired 27 thesis committees, and chaired seven undergraduate honors theses. His teaching and research have influenced a generation of young psychologists.

Along with many other awards and honors, recently Dr. Gelso has received the Lifetime Achievement in Mentoring Award, 2011-2012, Society for Counseling Psychology; the Lifetime Contribution Award for Psychotherapy Research, 2012, Society for Psychotherapy Research; and the James Cosse Distinguished Service Award, 2013, American Academy of Counseling Psychology; and the SAP Distinguished Psychologist Award, 2003. Dr. Gelso has also served as the editor of the Society for the Advancement of Psychotherapy's peer-reviewed journal, *Psychotherapy*, and the Society has named one of its grant programs in his honor: the Charles J. Gelso Psychotherapy Research Grant.

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SAP/APF Early Career Award
Joshua K. Swift, PhD, and Christian Webb, PhD

Joshua K. Swift, Ph.D., is an Assistant Professor in the Department of Psychology at Idaho State University where he provides supervision and mentoring for graduate and undergraduate students. He is also an Idaho state Licensed Psychologist. He graduated with a degree in clinical psychology from Oklahoma State University, completed a pre-doctoral internship at SUNY Upstate Medical University, and held a previous faculty position in the Department of Psychology at the University of Alaska Anchorage. Dr. Swift and his lab conduct psychotherapy process and outcome research, primarily focusing on the client variables in psychotherapy, premature termination, and therapist training and supervision.

Christian Webb received his B.A. at McGill University in Psychology and Philosophy and his Ph.D. in Clinical Psychology at the University of Pennsylvania, working under the mentorship of Drs. Robert DeRubeis, Martin Seligman and Jacques Barber. He is currently an Instructor at Harvard Medical School and Assistant Neuroscientist at McLean Hospital. He has received several awards and fellowships for his research on the etiology and treatment of depression, including a NARSAD Young Investigator Award, a Klingenstein Third Generation Foundation Adolescent Depression Fellowship, and both an NIMH F32 National Research Service Award (NRSA) and a Career Development (K23) Award.

Most Valuable Paper (MVP) Award – 2015 *Psychotherapy*

Jesse Owen, Ph.D., is an Associate Professor and the Chair of the Counseling Psychology Department. Dr. Owen earned his B.S. from Ball State University, his master's degree from the University of Miami, and his doctorate from the University of Denver. He worked at Gannon University and the University of Louisville prior to joining the faculty at DU. He is a licensed psychologist and has had a private practice. His research focuses on psychotherapy processes and outcomes as well as romantic relationships. He is currently the treasurer of SAP. He also serves as an Associate Editor for Psychotherapy; Journal of Counseling Psychology; and the Archives of Sexual Behavior. His research has merited the 2015 Norine Johnson Psychotherapy Research Grant from the Society.

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Society for the Advancement of Psychotherapy Student Paper Award Winners

Mathilda B. Canter Education and Training Student Paper Award
"Creating a climate for psychotherapist improvement: A case study of an agency focused on outcomes and deliberate practice, " Simon B. Goldberg, University of Wisconsin

Donald K. Freedheim Student Development Award
"Clients' Perceptions of Personal Psychotherapy for Therapists," Amanda Zold, UAA-UAF Ph.D. program in Clinical/Community Psychology

Diversity Award
"White Psychologists and African American Historical Trauma: Implications for Practice," Graham Danzer, Allianz International University/CSPP

Please join us as we honor these award winners at the Society for the Advancement of Psychotherapy Awards Ceremony, on Friday August 5th, at the APA Convention - 4:00 PM in the Sheraton Denver Hotel, Plaza Ballroom A. The Social Hour will be immediately following in Plaza Ballroom D

Bulletin ADVERTISING RATES

Full Page (4.5" x 7.5") $300 per issue
Half Page (4.5" x 3.5") $200 per issue
Quarter Page (2.185" x 3.5") $100 per issue

Send your camera ready advertisement, along with a check made payable to the Society for the Advancement of Psychotherapy, to:

Society for the Advancement of Psychotherapy (29)
6557 E. Riverdale
Mesa, AZ 85215

Deadlines for Submission

February 1 for First Issue
May 1 for Second Issue
August 1 for Third Issue
November 1 for Fourth Issue

All APA Divisions and Subsidiaries (Task Forces, Standing and Ad Hoc Committees, Liaison and Representative Roles) materials will be published at no charge as space allows.

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Loyola University Maryland
4501 N. Charles Street
Baltimore, MD 21210
Ofc: 410-617-5382 | Fax: 410-617-2595
E-mail: jbarnett@loyola.edu

Laurie Heatherington, PhD, 2016-2018
Dept of Psychology
Williams College
Williamstown, MA 01267
Ofc: 413-597-2442 | Fax: 413-597-2085
E-mail: laurie.heatherington@williams.edu

Lillian Comas-Diaz, PhD, 2014-2019
908 New Hampshire Ave., NW Suite 700
Washington, D.C. 20037
Ofc: 202-775-1938
E-mail: lilliancomasdiaz@gmail.com

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Center for Psychological Studies
Nova Southeastern University
3301 College Ave
Fort Lauderdale , FL 33314
Ofc: 954-262-5714 | Fax: 954-262-3857
E-mail: gold@nova.edu

Robert Hatcher, PhD, 2015-2020
Wellness Center /Graduate Center
City University of New York
365 Fifth Avenue
New York, NY 10016
Ofc: 212-817-7029
E-mail: rhatcher@gc.cuny.edu

Publications Board, continued
Heather Lyons, PhD, 2014-2019
Department of Psychology – Loyola University Maryland
4501 N. Charles St.
Baltimore, MD 21210
Ofc: 410-617-2309
E-mail: hzlyons@loyola.edu

Soo Jeong Youn, 2013-2014 (student mbr)
311 Toftrees Ave. #37
State College, PA 16803
E-mail: sooj.youn@gmail.com

EDITORS

Psychotherapy Journal Editor
Mark J. Hilsenroth, PhD, 2011-2020
Derner Institute of Advanced Psych Studies
220 Weinberg Bldg.
158 Cambridge Ave.
Adelphi University
Garden City, NY 11530
E-mail: hilsenro@adelphi.edu
Ofc: 516-877-4748 | Fax 516-877-4805

Psychotherapy Bulletin Editor, 2014-2019
Lynett Henderson Metzger, JD, PsyD
University of Denver-GSPP
2460 South Vine Street
Denver, CO 80208
Ofc: 303-871-4684
E-mail: Lynett.HendersonMetzger@du.edu

Internet Editor
Bradley Brenner, PhD
District Psychotherapy Associates
1633 Q St., NW, Suite 200
Washington, D.C. 20009
Ofc: 202-986-5941
E-mail: bradbrenner@therapygroupdc.com

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

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

Society for the Advancement of Psychotherapy (29)
Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net
www.societyforpsychotherapy.org

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the Advancement
of Psychotherapy
American Psychological Association
6557 E. Riverdale St.
Mesa, AZ 85215

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