Psychotherapy

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

www.societyforpsychotherapy.org

BULLETIN

In This Issue

2016 VOLUME 51, NUMBER 4

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PSYCHOTHERAPY BULLETIN
Published by the
SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
American Psychological Association

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PSYCHOTHERAPY BULLETIN

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

2016 Volume 51, Number 4

CONTENTS

PRESIDENT'S COLUMN

Change Is the Problem and Change Is the Answer: A Reprise

Armand R. Cerbone, PhD, ABPP
Chicago, IL

It is November, and like the nation, we are making transitions in governance. Unlike the nation, ours is proceeding smoothly and without drama. In January Dr. Jeff Zimmerman will assume the Presidency, Dr. Michael Constantino will become President-elect, and I will move to Past-president. Dr. Rod Goodyear will be retiring from the Executive Committee but will continue his work with the International Domain. All of us are working together to insure that current initiatives continue unabated and new ones succeed. In Dr. Zimmerman you will find a president well prepared to lead judiciously, collaboratively, and with great respect for his team and, most of all, for you—our members. The ease of the transition testifies to the number of capable leaders committed to promoting the interests of the Society.

In an earlier column I reported on the many changes that have been taking place in APA and how they affect our Society. In this column I want to report the several positive changes we have implemented since January.

The National Elections and Psychotherapy

But before I do, I would like to exercise a presidential prerogative to offer some remarks on the psychological fallout from the national elections and the changes they are certain to bring. I do so, not to comment on the politics of the election or to be preemptive but to note the implications for us as psychologists and psychotherapists and for the clients and public we serve (for more on that topic, please see this issue's "Clinical Notes With Dr. J"). Even before the election the APA issued survey results, picked up by more than 2,500 media outlets, showing high levels of anxiety in more than 50% of the respondents. It affected all sides of the political divide. And what a divide it has exposed! If my practice in Chicago is like yours, then the depth and scope of the impact of the election are showing up in many of your clients. Anticipating the strains families and friends could experience during the holidays, the APA publicized suggestions for coping with divisions that might surface around dinner tables (for details, visit http://www.apa.org/news/press/releases/2016/10/presidential-election-stress.aspx).

Apart from being prepared to treat the post-election anxieties clients might be experiencing individually, it makes sense for us to be especially mindful of the implications of the cultural differences that the nation must now face. At the very least we are recognizing the extent to which Americans are feeling threatened and left out if not pushed aside by other Americans. Angry, too. Anger, I believe, springs from caring deeply; if I did not care, I would not be angry. How we will manage to avoid bitter conflict and the urge to blame and punish depends on how well we can mobilize that anger for constructive engagement. Constructive engagement, in turn, will depend on the extent to which we can listen with compassion to the narratives of each other. For those of us who have done couples or divorce counseling, this is familiar territory. And yet

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in a climate of extremes, it is too easy to commit the sins we condemn in others.

What is the point of these comments? Briefly, it is to suggest that it is for us to change what we can within our respective spheres of influence. We as mental health providers know how to meet the distress of persons in our offices. Most often it involves listening with an open ear. But here I am encouraging us to remain attuned and responsive to what the election is telling us about the frustrated dreams now so starkly before us. From years of diversity trainings, I have learned how tough it is to change entrenched attitudes and beliefs. And yet I have lived long enough to see how small changes add up to big ones. Change is the problem and change is the answer.

A Year of Change

If you read my previous columns, you will already know the more significant changes the Society has made in 2016. Here is a brief summary of those changes at year's end.

- *Establishment of a new Domain for International Affairs*. The membership approved a bylaws change to create a domain to expand our growing commitment to collaborate with international partners and together to promote psychotherapy research and practice, electing Dr. Fred Leong as the Domain's first Representative. Dr. Leong set up the Committee for International Affairs with Dr. Changming Duan as its first chair.

- Signing a partnership with Oriental Insight. Under the leadership of Past-president Rod Goodyear, Dr. Changming Duan, and Dr. Fred Leong, the Society signed an agreement with Oriental Insight (OI), a respected psychological organization in China, to collaborate in the exchange of resources. Members of OI plan to join the Society as Affiliate Members. **Note: On our website is a video of the signing ceremony recorder and edited by FIL Sibley of FSP Media** (http://societyforpsychotherapy.org/new-partner-oriental-insight-organization-chinese-psychologists/).

- *Co-sponsoring an Oriental Insight conference in Wuhan, China, in April 2017.* Several of the Society's leadership will be presenting on topics ranging from supervision and ethics to LGBT relationships and marriage and divorce.

- *Collaborated with the Society for the Exploration of Psychotherapy Integration (SEPI).* Continuing its long and productive relationship with SEPI, the Society again sponsored its CE program. Many of our Board members and researchers offered sessions at the conference held in Dublin, Ireland.

- *Co-sponsored the CE program for the North American Society for Psychotherapy Research (NASPR) Conference in Berkeley, CA*.

- *Conducted the first Domain Day.* The Domain Day offered the first day-long orientation for new and current Board members prior to the semi-annual business meeting. It aimed to develop more productive working relationships among our several Domains and review the agenda for the coming year. It was a success, and the Board voted to institutionalize the initiative. Under Dr. Jeff Zimmerman's leadership it will be dubbed *Fast Start*.

- *Increased Diversity grant funding from $2000 to $5000 in 2017*.

- *Provided funding to improve our website's user interface.* This promises to make navigating the website easier

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and more intuitive.

- *Digitizing the* Psychotherapy Bulletin. The Board voted in September to move the *Psychotherapy Bulletin* to a digital-exclusive format in July. **Note: There will be several announcements notifying members of the change and the process for the transition. These announcements will also provide details on how to access the *Bulletin* online.**

- *Random "Thank you!" calls to members.* I began making random calls as President-elect to members just to say thank you for your loyalty and support of the Division. This year Board members have joined me in making those calls. It is important to us all that you know how much we value you and your voice.

These are but the highlights of a year of change and growth. There are more to come in 2017.

Getting to Know Your Board

Each column I have been introducing two members of the Board whom you should know. In this last column I want to let you know more about Susan Woodhouse, PhD, and Barbara Thompson, PhD.

Susan Woodhouse, PhD. Dr. Woodhouse is the Domain Representative for Science and Scholarship. She is also an Associate Professor of Counseling Psychology at Lehigh University, interested in both basic and applied research that focuses how best to assess and support parenting strengths in diverse, low-income, underserved families with young children—including research on the psychotherapy relationship and process of psychotherapy with parents. She has received a $2.3 million grant from the National Institute of Child Health and Human Development to study links between parenting and later infant outcomes, including infant attachment security, physiological indicators of infant emotion regulation and stress reactivity, as well as infant mental health in low-income families. One important contribution Dr. Woodhouse is making to the Division is collaborating with other Board Members on a project focused on models for making psychotherapy more accessible to underserved people.

Barbara Thompson, PhD. Dr. Thompson is the Domain Representative for Psychotherapy Practice. She is in her second 3-year term as the Domain Representative for Professional Practice and is an adjunct professor at Lehigh University and Loyola Marymount Los Angeles teaching online masters level counseling students and providing supervision to graduate students. Dr. Thompson maintains a full-time solo practice in Maryland working with adults and couples. As much as her practice demands allow, she participates in qualitative research aimed at understanding difficult to measure aspects of psychotherapy, such as Therapist Compassion.

A Final Note

I wish I could communicate effectively what it is like to have presided over the Society this year. If I could do it well enough, I might just persuade you to come on board with us. Then you too would understand why I have the greatest respect and appreciation for my colleagues in the Society. My thanks to you and to them!

EDITORS' COLUMN

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Welcome to the final issue of *Psychotherapy Bulletin* for 2016. Please enjoy a variety of articles ranging from a proposed taxonomy for professional psychology education and training to considerations to bear in mind when working with transfer clients to a thoughtful discussion of bilingualism as a tool in psychotherapy and a call to action regarding graduate training in China in the form of this summer's Wuhan Declaration. Early (and later) career professionals may enjoy a Special Feature exploring Millennial versus Baby-Boomer expectations about psychotherapy, and, as always, we are delighted to offer several student-written pieces on topics ranging from the importance of learning to give and receive critical feedback to addressing resistance with internalizing clients to one group of students' experiences with a partially-affiliated internship consortium.

Change appears to be the theme this time of year, and this year brings unique changes. From the U.S. Presidential election (if you have not yet done so, please read this issue's President's Column and Dr. Jenkins' piece on potential mental health policy implications of the new administration) to changes within the Society and the Bulletin itself. We say goodbye, with gratitude, to the Domain Representatives, Contributing Editors, and others in governance who have helped make this year so successful for the Bulletin. We want to especially thank outgoing President Armand Cerbone, whose warmth, vision, and compassion have enhanced both these pages and our Society as a whole. We would also like to wish outgoing Internet Editor Dr. Brad Brenner well in his future endeavors, recognizing that his work, and that of his team, revitalized our online presence and created a strong virtual life for the Society. And, on a personal note, Lynett would like to extend her heartfelt gratitude to Dr. Krystine Jackson, whose tireless efforts as Editorial Assistant over the past three years have set a high standard of excellence—and, finally, to Dr. Ian Goncher, Associate Editor, who has been a bright and steady presence as we both learned our new roles: Thank you. You will be missed.

As we turn our thoughts to the upcoming year, we welcome new faces and familiar folks in new positions. In particular, we would like to welcome Dr. Jeff Zimmerman as incoming President of the Society for the Advancement of Psychotherapy, as well as incoming *Psychotherapy Bulletin* Associate Editor Dr. Cara Jacobson, who has already provided invaluable assistance during this transition time. Dr. Amy Ellis will be transitioning to the role of Internet Editor, and we welcome Kourtney Lavallee, BS, who will be the new Associate Editor for Website Content.

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In addition, we are looking forward to some exciting changes within the *Bulletin* itself, including moving to a digital-exclusive format beginning with the third issue next year (you can find details later in this issue and online at www.societyforpsychotherapy.org/bulletin-announcement), and a special "Difficult Dialogues" series for which we would be delighted to receive ideas and submissions (more on that in the next Editors' Column).

Our next deadline is February 1, 2017, and you can find the Bulletin submission guidelines in the back of this volume or online (http://societyforpsychotherapy.org/). We would love for you to be a part of next year's journey.

Wishing you and yours a safe rest of the year and start to 2017,

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ANNOUNCEMENT ABOUT THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY'S BULLETIN

The Society for the Advancement of Psychotherapy is going green! We'll be publishing and mailing two more issues of the *Bulletin* before moving to our online-only format. You will still be able to get the same great content, in the same great format.

WHEN WILL THIS TAKE PLACE? **This change will take place in September 2017 for the third issue of the *Bulletin*.**

HOW WILL I GAIN ACCESS TO THE ONLINE VERSION OF THE BULLETIN? **In September 2017, we'll be emailing you the *Bulletin* straight to your email inbox.**

HOW WILL THE BULLETIN CHANGE? **There will not be any changes made to the format or content of the *Bulletin*. The only difference is how you will receive it. Rather than having a copy mailed to your home or office, it will instead be available online.**

HOW DO I MAKE SURE I CAN STILL RECEIVE ACCESS? **If you are a paid member, student member, or affiliate, you are already signed up. You can sign up for our newsletter (for free) here:** http://societyforpsychotherapy.org/sign-up-for-our-societys-electronic-newsletter/

Also, you will still be able to access the *Bulletin* by directly visiting our website and downloading a pdf: http://societyforpsychotherapy.org/psychotherapy-bulletin-archives/

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Thank you for going green with us!

SPECIAL FEATURE

Expectations of Psychotherapy: Millennials Versus Baby-Boomers

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It is well-documented that Millennials—(those born between 1980 and 2000 ± 5 years)—exhibit behaviors and attitudes that are distinct from previous generations (Fromm & Garton, 2013; Smith & Nichols, 2015). For example, compared to the Baby-Boomers constituting their parents' generation—individuals born between 1946 and 1955 ± 5 years—Millennials are more likely to expect immediate results. While this preference for immediacy is often reflected by colloquial characterizations of Millennials as "impatient" and "needing everything fast," a body of scholarly research and formal literature has sought to document the more tangible ways in which Millennials' preference for immediacy has manifested in real-world behavior. Consumer research, for example, has shown that Millennials tend to make more frequent and impulsive purchases—a fact attributed to their tendency to make quicker decisions with less deliberation (Lissitsa & Kol, 2016; Parment, 2009). In recent years, organizations seeking to recruit Millennials have adopted faster applicant response systems and now offer such services as immediate applicant confirmation emails, "call backs" within a day, and interview decisions within days (Cahill & Sedrak, 2012).

Recent studies suggest that these attitudes have also manifested in Millennials' healthcare choices. Researchers have found that when seeking medical care, Millennials prefer faster services such as retail and urgent-care clinics at rates double those of Baby-Boomers (Parment, 2013; PNC Healthcare, 2015). This "intolerance for delays" among Millennials is a "unique characteristic that is changing the dynamics of healthcare" (Cowan, 2010, p. 379).

Psychotherapy is similar to medical services in that it offers multiple forms of treatment that differ in length and method of delivery. However, to date, there has been no research regarding generational expectations and preferences as they relate specifically to psychotherapy. Given the extent to which Millennials' preference for immediacy has begun to transform the medical care industry, psychotherapists may well benefit from understanding how generational status influences clients' expectations of psychotherapy. Thus this study investigated the respective time preferences of Millennials and Baby-Boomers as they relate to various issues regarding psychotherapy. Specifically, this study compared Millennials' and Baby-Boomers' attitudes regarding:

- The type of psychotherapy preferred (short-term or long-term);
- Expectations for when primary problems should be resolved through psychotherapy;

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- The consequences if results are not achieved when expected;
- The acceptable duration of time for waiting for psychological testing results;
- Patience levels for having to wait for therapy sessions to begin;
- Views on when very personal information would be disclosed to the therapist;
- The desired amount of "small talk" at the beginning of a therapy session; and
- The number of sessions it should take to develop a working relationship with the therapist.

In addition to generational data, we investigated the potential influence on expectations of psychotherapy of participants' race, gender, income, and previous treatment history.

Method

Participants. Participants (N = 902) consisted of Millennial and Baby-Boomer respondents who completed an online survey. The Millennial respondents (n = 453) were those between the ages of 18 and 34 (born between 1982 and 1998); Baby-Boomer respondents (n = 449) were those between the ages of 55 and 64 (born between 1952 and 1961). Of the total respondents, 476 were male (52.8%) and 426 (47.2%) were female; 58.5% earned less than $50,000 a year, and 41.5% earned more than $50,000 annually. A majority of respondents identified as "White" (82.7%), whereas 6.5% identified as "African-American," 6.1% identified as "Hispanic," and 4.7% identified as "Asian." Overall, roughly half (49.8%) of the sample reported having previously received some form of therapy.

Apart from age differences, the Millennial and Baby-Boomer respondents were demographically similar. Thus, 50.2% of the Millennials identified as male, compared to 52.8% of Baby-Boomers. Additionally, 40.4% of Millennials earned more than $50,000 annually, as opposed to 42.5 % of Baby-Boomers. With respect to race, 75.7% of Millennials identified as White, 7.2% identified as African-American, 9.2% identified as Hispanic, and 8% identified as Asian. A slightly higher percentage of Baby-Boomers identified as White (89.7%); 5.7% identified as African-American, 3.1% as Hispanic, and 1.4% as Asian. Lastly, 45.9% of Millennials reported they had been in therapy at some time in their lives, compared to 53.7% of Baby-Boomers. Only this last proportion (regarding previous therapy) yielded a significant difference, $\square^2$ (1, N = 902) = 5.43, p = .02.

Measure and Procedure. Participants completed a 10-item self-report questionnaire created for this survey, consisting of eight "attitude toward psychotherapy" questions (see above), a racial identification item, and a question regarding whether they had been in therapy previously. Of the eight "attitude" items, questions 2, 5, 6, and 7 consisted of a free-numeric response format, while the remaining questions required a multiple-choice selection. Question 1, regarding the "type of therapy preferred," required respondents to choose between Cognitive-Behavioral Therapy, typically a shorter-term therapy, and Psychodynamic Therapy, typically a longer-term therapy. The choices for "not seeing results when expected" (Question 3) were: continue with the therapy-give it more time; switch therapists; and stop therapy altogether. The response choices for Question 8, regarding "the amount of time to develop a good working relationship with your therapist," were: 1-2 sessions; 3-4 sessions; 5-6 sessions; and > Than 7 sessions.

"Google Consumer Surveys" (n.d.) was the platform used to administer the

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questionnaire. Research has shown that Google Consumer Surveys is more accurate than other probability and non-probability based internet surveys, and is comparable in many respects to surveys conducted by the Pew Research Center (McDonald, Mohebbi, & Slatkin, 2012; Pew Research Center, 2012). Data collection took place in the Spring of 2016 over a two-month period. Potential participants were only shown the survey if their age qualified them as a Millennial or Baby-Boomer. Before beginning the questionnaire, participants were informed that the survey would ask anonymous health and medical questions; they were otherwise blind to the purpose of the survey.

Results

To a great extent, Millennials and Baby-Boomers did not differ regarding their psychotherapy related expectations. When asked, "After how many sessions of therapy would you expect to see a satisfactory resolution of your primary problem," Millennials (M = 8.95, SD =11.07) and Baby-Boomers (M = 8.97, SD = 11.47) both felt that their primary problem should be resolved after about 9 sessions of therapy, t (853) = -.03, NS. When responding to, "You're waiting for your therapy appointment to begin and it's clear that your therapist is going overtime with his/her previous client. I would get impatient after ____ minutes," Millennials (M = 18.09, SD = 12.78) and Baby-Boomers (M = 18.29, SD = 10.16) both agreed that they would become impatient after about 18 minutes, t (895) = -.26, NS. There was also no significant difference regarding each group's sense of when they would begin to disclose very personal information to their therapists: Millennials (M = 3.74, SD = 6.01) and Baby-Boomers (M = 3.13, SD = 5.19) similarly reported that they would begin to make such disclosures after roughly 3 sessions, t (896) =1.63, NS. And a stepwise multiple regression showed that the number of sessions it should take to develop a working relationship with the therapist was unable to be predicted based upon the independent variables examined in this study, including gender, race, income, previous attendance in therapy, and generation. Although a significant relationship was not determined, it is notable that 78% of Millennials and 82% of Baby-Boomers thought a good working relationship with the therapist should be developed within the first 4 sessions.

There were also no statistically significant relationships found when examining gender, income, race, previous attendance in therapy, and generation, in regard to the consequences if therapeutic results were not achieved when expected. Likewise, this same group of variables did not show a statistically significant relationship in terms of the perceived acceptable duration of time waiting for psychological testing results. A stepwise multiple regression was also unable to find a significant model to predict the amount of time before an individual becomes impatient waiting for a therapy appointment to begin, based upon generation and the various demographic variables.

But some significant differences did emerge. Millennials (M = 10.47, SD =10.03) seemingly need a longer period of "small talk" than Baby-Boomers (M = 9.01, SD = 9.89) before transitioning into "big" topics, t (884) = 2.18, $p < .05$. In addition, several significant attitudinal differences were found in regression models that included generational status. A stepwise binomial logistic regression was performed to ascertain the influence of respondents' gender, income, race, previous attendance in therapy, and generation on preference for

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type of therapy. While the demographic variables alone were not predictive of the type of therapy preferred, the final model, which included "generation" and "previous exposure to therapy" as variables, did produce a significant regression equation, □² (5, 902) = 24.870. Although small, the overall model explained 4.4% (Nagelkerke R^2) of the variance in respondents' long-term versus short-term therapy preference, and correctly classified 57.8% of cases. With the Odds Ratio of 1.981, Baby-Boomers were significantly more likely to prefer shorter-term therapy (CBT) than Millennials. And with an Odds Ratio of 1.365, respondents who had not been in therapy were significantly more likely to prefer shorter-term therapy (CBT).

A stepwise multiple regression was calculated to predict, "During what session a primary problem was expected to be resolved in therapy," based upon the same variables noted above. While the generational and demographic variables were not predictive by themselves, adding "previous attendance in therapy" to the model produced a significant regression equation, F (5,849) = 6.56, $p < .000$), with an R^2 of .037. Participants' predicted expectation of when a problem should be resolved is equal to 16.69 - 3.94 (no previous experience in therapy) sessions when past experience in therapy was measured as either "yes" or "no." The number of therapy sessions needed for a resolution of a primary problem decreased by 3.90 sessions when individuals had not been in therapy previously.

While gender, income, previous attendance in therapy, and generation were not found to be predictive, race was found to have a significant relationship on respondents' perceptions as to when personal information would be disclosed to the therapist. A One-way ANOVA was conducted to examine the effect of racial identification as to when respondents reported they would begin to disclose "very personal information" to their therapist. There was a statistically significant difference between racial groups, F (3,828) = 5.14, $p < .01$). A Turkey HSD post-hoc test determined that respondents who identified as African-American reported they would disclose very personal information to their therapist during sessions significantly later (M = 5.87, SD = 11.4) than individuals identifying as White (M = 3.06, SD = 4.88), $p < .01$ Comparisons between other racial groups were not found to be significant.

Discussion

The primary purpose of this study was to examine differences between Millennials and Baby-Boomers in regard to their expectations of psychotherapy. The results of this study suggest that despite Millennials' documented preference for immediacy in many other contexts, for the most part their expectations regarding psychotherapy do not differ significantly from those of Baby-Boomers. Notably, Millennials expressed a preference for longer-form therapy (Psychodynamic) while Baby-Boomers preferred shorter-term treatment (CBT); furthermore, in comparison to Baby-Boomer participants, Millennials expressed a need for a longer "warm up" time in therapy before delving into significant material. For those weary of a generational shift in the provision of psychotherapy similar to that of medical treatments, these results may be gratifying.

Another notable, though not generationally-linked, finding was that on average, individuals identifying as African-American expect to disclose very personal information to their therapist roughly 3 sessions later than those identifying as White. Previous literature has

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explained that as a result of the discrimination and racism experienced by the Black community, African American clients do not automatically grant trust to their therapist. Rather, trust is given after the therapist demonstrates an understanding of the client's worldview and cultural experiences (Sue & Sue, 2012).

Limitations

There are multiple limitations to this study. While various racial groups were represented, the overall respondent sample was primarily White. A greater representation of minority groups would increase the generalizability of the study's findings. In addition, due to the format of the Google Consumer Survey platform used in this study, the questionnaire was limited to only 10 items, and each item contained a word limit. Furthermore, when examining whether respondents had been in therapy previously, respondents were requested to answer a "yes or no" item, with no differentiation between the various forms of psychotherapy or the extent of their experiences. Similarly, respondents were only allowed to choose between the shorter-form Cognitive Behavioral Therapy, and the longer-form Psychodynamic Therapy. These two forms of therapy were chosen to reflect large differences in treatment length but this is not necessarily the case—that is, dynamic therapy can be short-term. Moreover, it was not established in this study that respondents knew the differences between these forms of treatment, including their presumed difference in treatment duration. We also suspect that if the age of the imagined therapist in these questions was systematically varied, different results may have been obtained; that is, the stereotypical image of an older (Baby-Boomer aged) therapist may have influenced response patterns. Future investigations into this topic, then, need to incorporate other forms of therapy into the study design as well as an age-related therapist variable; these investigations also need to determine whether respondents are aware of the putative differences among forms of therapy, including presumed differences in treatment duration.

Conclusion

Nevertheless, it is certainly possible that the results obtained in this study are essentially accurate—that there are few generational differences in attitudes toward psychotherapy. There may well be expectations about psychotherapy, including essentially accurate expectations about the amount of time it takes to effect a good therapeutic alliance, obtain good therapeutic results, or speak honestly about difficult topics, that transcend generational status.

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A Bouquet of Experimental Designs in Psychotherapy Research

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A Horse Race …

Psychological treatments that are intended to be fully therapeutic and that are provided by trained professionals (*bona fide psychotherapy*; Wampold & Imel, 2015; Wampold et al., 2011) have been found to be effective compared to no-treatment and treatment-as-usual for individuals who suffer from a number of disorders, including anxiety and depression (Cuijpers et al., 2013; Wampold et al., 2011). Psychotherapy has also shown enduring efficacy for anxiety disorders in comparison to pharmacotherapy (e.g., Cuijpers et al., 2013; Roshenaei-Moghaddan et al., 2011). However, the same meta-analyses of studies with direct treatment comparisons utilizing *randomized controlled treatment designs* (RCTs) also have indicated that the effects *between* two bona fide psychotherapies are usually small. Particularly, there is little evidence that specific treatment orientations such as psychodynamic or cognitive-behavioral treatments are more *sustainable* than other bona fide psychotherapies at the *follow-up assessments* (called the sleeper effect; Flückiger et al., 2015). Overall, these results can be summarized to indicate that the effects *between* treatments are generally smaller in comparison to the variability of successful and less successful components *within* treatment packages, especially in a long-term perspective.

Due to the lack of evidence that the selection of the "right" treatment packet (selective indication) might provide the hoped exploratory power, research on more fine-grained adaptations during treatment are required (Campell, Norcross, Vasquez, & Kaslow, 2013). Rather than creating an increasing number of novel treatment packages that are tested by comparative RCTs, an additional strategy may lie in the development of research designs that can be used to formulate and test a more adaptive approach to psychotherapy.

… And a Bouquet of Designs

Outside the traditional RCT design in which usually two or more distinctive psychotherapy approaches or components of treatments are compared to each other, there are a number of experimental designs that are appropriate for investigating psychotherapy processes and outcomes.

Looking at the therapist. A landmark study that used an innovative design to test for therapist effects was conducted by Strupp and Hadley (1979). In this study researchers asked university professors that had been said to be especially warm, understanding, and empathic to participate as a control group

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of therapists. College students that met criteria for depression and psychasthenia were then assigned to either therapists with actual training and experience or this control group of therapists, depending on availability. Both groups of "therapists" were allowed to choose whatever treatment approach they wanted to use with their clients for a maximum 25 sessions. Interestingly, the degree of client improvement was not found to be different between the expert and control therapists. Although the professors had comparable success with client outcomes, the authors did note that the lay therapists had more difficulties on working toward specific treatment goals, had run out of topics to discuss with the clients, and most of them did not want to further participate as therapists.

In a more recent, but similarly innovative, research study on therapist effects, Lutz et al. (2015) examined the impact of feedback systems on outcome and treatment length. In this naturalistic randomized controlled study, a feedback condition was compared to a non-feedback condition. The therapists in the feedback condition were given feedback of the progress of their patients after a certain number of sessions. To investigate the effect of attitude toward feedback, therapists were asked to provide their satisfaction with institutionalized feedback at the end of treatment. Multilevel analyses indicated that the therapists' attitudes toward the feedback accounted for 5.4% of the variability in treatment outcome. This study provides evidence not only that therapists do differ in client outcomes, but that a specific therapist variable (therapist attitudes toward outcome feedback) may be partially explaining the differences.

Looking at the patient. As an example of another innovative RCT study, this time examining the impact of a patient variable (patient preferences) on treatment outcome, Raue, Schulberg, Heo, Klimstra, and Bruce (2009) asked patients about their preferred treatment method and let them rate how strong their preference was prior to randomly assigning them to one of two treatment conditions. Because of the random assignment, some patients had been naturally allocated to preference congruent and others to preference incongruent treatment conditions. A comparison of initial preferences revealed that 70% of the patients favoured psychotherapy over medication and that the preference for psychotherapy was, on average, stronger. More importantly, the preference congruent treatment lead to a higher percentage of treatment initiation (100%) compared to the preference incongruent treatment (74%) and preference strength was associated with treatment adherence; however, client outcome was not related to either preference congruence or preference strength.

A further selective adaptation has been tested by Cheavens, Strunk, Lazarus, and Goldstein (2012). In this study, an idiographic ranking of patients' strengths and weaknesses was developed for each client participant based on an interview at intake. Patients were then randomized either into a compensation treatment selection or a capitalization treatment selection. In the compensation selection, treatment packages were selected on the basis of the patients' relative weaknesses to build up skills. In the capitalization selection, treatment packages were chosen based on patients' strengths to activate resources and therefor foster their competences. Interestingly, patients in the capitalization condition experienced greater symptom reduction than patients in the compensation condition.

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This effect occurred especially early in treatment and differences were maintained over the course of therapy.

As an example of another study focused on the patient, Flückiger et al. (2012) investigated if patients' evaluations of the therapeutic alliance at the start of the remediation phase subsequently changed based on a brief adjunctive instruction. Demonstrating the use of a minimal intervention paradigm, patients in a university outpatient clinic received treatment as usual in both conditions, but were randomized to either receive a personal one-page letter inviting and encouraging them for direct feedback about the perceived therapeutic relationship and goal consensus with their therapist, or to a control condition in which no letter was sent. Therapists were blinded about the condition to which their patients had been randomized. In accordance with the authors' hypotheses, the results indicated that the global alliance rating in the adjunctive condition showed faster increases compared to the control condition.

Looking at the sessions. Examining changes at a session level, the effect of a brief mindfulness centering exercise for therapists was tested by Dunn, Callahan, Swift, and Ivanovic (2013). In this study therapists randomly received different exercises (centering or control) to engage in before starting the session, so that the effect of centering could be investigated between therapists as well as within different sessions of one therapist. To ensure familiarity with the concept of mindfulness centering, therapists engaged in five short manualized mindfulness training sessions. In the control condition therapists were allowed to engage in typical pre-session activities for the participating clinics, such as chatting with colleagues, checking email, or using the restroom. Rather than randomizing therapists to a single condition at the start of the study, therapist activities were randomized prior to the start of every session. A comparison of the session impacts of these different conditions showed that 5 minutes of a centering exercise resulted in the therapists perceiving themselves as more present in the subsequent sessions. Furthermore, when therapists engaged in the centering exercise compared to other exercises, patients perceived the session afterwards as more effective.

Further evidence for the relevance of session-level decisions comes from an implementation-trial design conducted by Flückiger et al. (2016; also Flückiger & Grosse Holtforth, 2008). The authors contrasted an established treatment for generalized anxiety disorder (mastery-of-your-anxiety packet, MAW) within three randomized implementation conditions. Five sequences of 10-minute peer-tutoring supervision immediately before the start of the sessions were used to set therapists' attentional focus on patients' individual symptoms and how these symptoms can be addressed into the MAW-packet *(adherence priming condition)*. Two comparable conditions deriving from a capitalization model were used to set therapists' attentional focus on patients' pre-existing strengths and functional coping skills and how these individual strengths can be used to involve the patient into the MAW-packet (*resource priming conditions*). The two resource priming conditions differed as to whether the therapists were allowed to invite a patient's helpful other (usually husband or wife) into psychotherapy sessions. The results indicated that both resource priming implementations led to faster symptom reduction compared to adherence priming condition.

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Conclusion

It is the nature of psychotherapy, and maybe of human interventions more generally, that data on treatment processes and outcomes have *super nested data structures* at multiple levels, including the in-session level, the session-by-session level, the therapy phase level, the patient level, the therapist level, the institution level, and so on (Orlinsky, Rønnestad, & Willutzki, 2004). At all of these levels, clinical decisions have to be made, resulting in a stream of interdependent frames, decisions, and outcomes. Maybe one of the most challenging tasks for psychotherapist practitioners and researchers is to obtain a coordinated view of all these levels and to carefully consider the trees as well as the woods. Classical RCT designs try to tackle this clinical complexity by precisely conceptualizing, describing, and distributing overall treatment packages at the patient level. Moving forward, future psychotherapy research should attempt to provide additional knowledge that includes all levels (from the institutional to the in-session level) to understand what makes psychotherapy as effective as it is (e.g., Norcross, 2011). Further developments of intervention designs, including experimental as well as repeated measure correlational designs, are required to address these various levels of clinical decision making.

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EDUCATION AND TRAINING

A Taxonomy for Education and Training in Professional Psychology Health Service Specialties

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In 2012, the American Psychological Association (APA) endorsed as policy, *The Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties,* hereafter referred to as "the Taxonomy." This Taxonomy was developed in response to confusing inconsistencies across education and training in professional psychology training programs that would describe offerings in their program by a variety of labels, such as "track, emphasis, concentrations," for either APA and ABPP recognized specialties or other topic areas with no consistent definition of what these terms meant. They could refer to one to three courses, course work and practicum, coursework and research requirements, etc. This inconsistency has made it difficult for trainees at all levels (doctoral, internship, postdoctoral, and post-licensure) to evaluate different programs, as well as for the public to understand psychology education and training. The benefits of using the Taxonomy have been described as akin to truth in advertising, and its adoption would assist those wishing to focus on a particular area of psychotherapy as they investigate different programs.

Professional discussions about these inconsistencies have spanned a number of years including a 1996 APA-endorsed policy on *A Taxonomy for Postdoctoral and Continuing Education in Psychology* which grew from a national conference (Reich, Sands, & Wiens, 1995); the suggestion by the first APA Educational Leadership Conference in 2001, which recommended "developing a taxonomy of the field that is understandable to the public" (Belar, Nelson, & Wasik, 2003, p. 681); an attempt by the Council of Credentialing Organizations in Professional Psychology (2004) to outline terms and principles for health psychology training; and the 2005 conclusion by the APA Task Force on Quality Assurance of Education and Training for Recognized Proficiencies in Professional Psychology that there was "a need for a clearer taxonomy of terminology in describing the structure of professional psychology, from its education and training foundations, through credentialing and practice representations to the public" (p. 1).

Understanding the Taxonomy

Hence, it is clear that the need for the Taxonomy has been evident for a long time. At this point, a definition of the term taxonomy might be helpful:

> A taxonomy is simply the orderly classification or arrangement of a set of related concepts based on their common factors. There is typically a hierarchical structure with clear rules defining components of the taxonomy and how the structure is to be organized. (APA, 2012, p.3; see also Bailey, 1994)

The benefits of clear training nomenclature impact many audiences. It will aid

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students and potential students and other trainees in being informed consumers by helping them choose programs that fit their needs and career goals. For training programs, the Taxonomy offers clarity in describing their offerings to allow better fit with admitted trainees. The Taxonomy could assist the APA Commission on Accreditation (CoA) by providing clarity for program self-study descriptions of all aspects of their programs and site visits for programs at all accreditation levels: doctoral, internship, and postdoctoral. In particular, the Taxonomy could help a program in describing and defining its program-specific additional competencies pursuant to the new *Standards of Accreditation for Health Service Psychology,* which state that:

> Doctoral programs accredited in health service psychology may require that students attain additional competencies specific to the program. If the program requires additional competencies of its students, it must describe the competencies, how they are consistent with the program's aims, and the process by which students attain each competency (i.e., the curriculum). Additional competencies must be consistent with the ethics of the profession. (APA, 2015, p. 14)

Similar requirements are outlined for internships (p. 26) and postdoctoral residency programs (p. 38). For licensed psychologists already practicing, the Taxonomy could aid in evaluating the utility of continuing education offerings and how they fit into ongoing professional development and credentialing. Lastly, using the Taxonomy for all levels of training in health service psychology could aid the public in understanding the competencies and skills of their providers and help them choose their psychologists (Rozensky et al., 2015).

The development of the current Taxonomy began with the appointment and funding of a task force by the APA Board of Directors in 2007. This task force was chaired by Drs. Elena Eisman and Lynn Rehm, and included representatives from a comprehensive array of psychologists involved in psychology training and credentialing. When the task force was not funded for a second year to continue its work, the task of completing the Taxonomy was assigned to the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). The CRSPPP process entailed consultation with multiple constituency groups and a round of public comment from which suggestions were reviewed and incorporated.

The finalized Taxonomy "provides a structure for the consistent labeling of the type, content, and intensity of training and education opportunities available in health service psychology programs" (Rozensky et al., 2015, p. 25). The Taxonomy is summarized in a four by four chart which includes four levels of intensity of training by four levels of training opportunities, i.e., doctoral, internship, postdoctoral, and postlicensure (see Figure 1). The four levels of intensity from lower to higher are Exposure, Experience, Emphasis, and Major Area of Study. It is intended that these levels of intensity be reserved for specialties that are recognized by APA, ABPP, and CoS (Behavioral & Cognitive, Clinical, Clinical Child, Clinical Health, Clinical Neuropsychology, Counseling, Family, Forensic, Police & Public Safety, Professional Geropsychology, Psychoanalysis, Sleep, School, as well as Industrial-Organizational—recognized by APA). The developers did realize that many programs also offer training in areas that are not recognized specialties (e.g., trauma, multiculturalism, commu-

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nity psychology, biofeedback, substance abuse, neuroscience, feminist psychology) and recommended that such offerings be labeled as a Focus within the program until such areas are more fully developed and recognized.

Major Area of Study. These would be in areas recognized by APA as *specialties*, termed *substantive practice areas* by CoA, and as *major rotations* by the Association of Psychology Postdoctoral and Internship Centers (APPIC). The new term of *Major Area of Study* was chosen to remove confusion among the three terms in the previous sentence, and

> should be used by programs to describe the highest level of education and training opportunity with respect to the types of knowledge, skills, and attitudes that would be developed and to the intensity and amount of involvement in training to acquire those competencies. This includes expectations for acquisition of knowledge through didactics, practical training and direct service expectations (hours, number of cases, and competencies) and research and scholarly expectations. (APA, 2012, p. 6)

So, for a doctoral program the Major Area of Study would be what CoA considers the program's traditional substantive professional area (i.e., clinical, counseling, or school). A Major Area of Study for a postdoctoral residency would require 80% of more of training time spent in that specialty area.

Emphasis. A specific definition of this level would follow the guidelines established by the particular specialty according to the level of training (doctoral, internship, postdoctoral, postlicensure). In general,

> Emphasis is the level just below major area of study, with distinctly different expectations for the type and intensity of the education and training experience. A programmatic emphasis permits a structured, in-depth opportunity for knowledge acquisition, practical experience, and scientific study in a given specialty area. (APA, 2012, p. 7)

Experience. Conceptualized as doing more than merely acquainting a trainee with the speciality,

> the experience level falls between emphasis and exposure; the type and intensity of the opportunity for learning that the program offers will be clearly distinct from the other levels, with the specific parameters of knowledge acquisition, practical experience, and scientific study defined by that specialty. (APA, 2012, p. 7)

Exposure. This "represents an education and training opportunity that is limited in type and intensity. An exposure is identified by the program as a structured learning activity and would be seen as an opportunity to acquaint an individual with that specialty area" (APA, 2012, p. 7).

Focus. As stated earlier, this term refers to "opportunities in other training areas" and the idea "that programs strive to provide explicit explanations of the type of training provided in these nonspecialty areas"; its adoption is hoped to "enhance the clarity of communication regarding educational and training opportunities across programs" (APA, 2012, p. 5).

Applying the Taxonomy

These Taxonomy guidelines are aspirational and intended to give guidance to

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education and training programs. Each recognized specialty area has been charged to develop its own training criteria for each level of intensity by level of training. This task has been coordinated by the Council of Specialties in Professional Psychology (CoS) via the individual Specialty Council members. General guidance in establishing these criteria appear in Figure 1, in which possible types and intensity of training are described in each level. For example, for a doctoral program the Major Area of Study might be defined as two to three years of didactics, supervised practica, and dissertation or research project; Emphasis might include at least four courses and two practica in a specialty; Experience could be at least one to two courses and practica; and Exposure might be one to two courses. An exemplar for a website describing a particular doctoral program could read: "In our APA-accredited doctoral program at Our University, we offer a *Major Area of Study* in Clinical Psychology with at least three years of didactic coursework and supervised clinical training in that Major Area of Study, which includes a dissertation or research project. We offer students an *Exposure* to Clinical Neuropsychology, with one course in that

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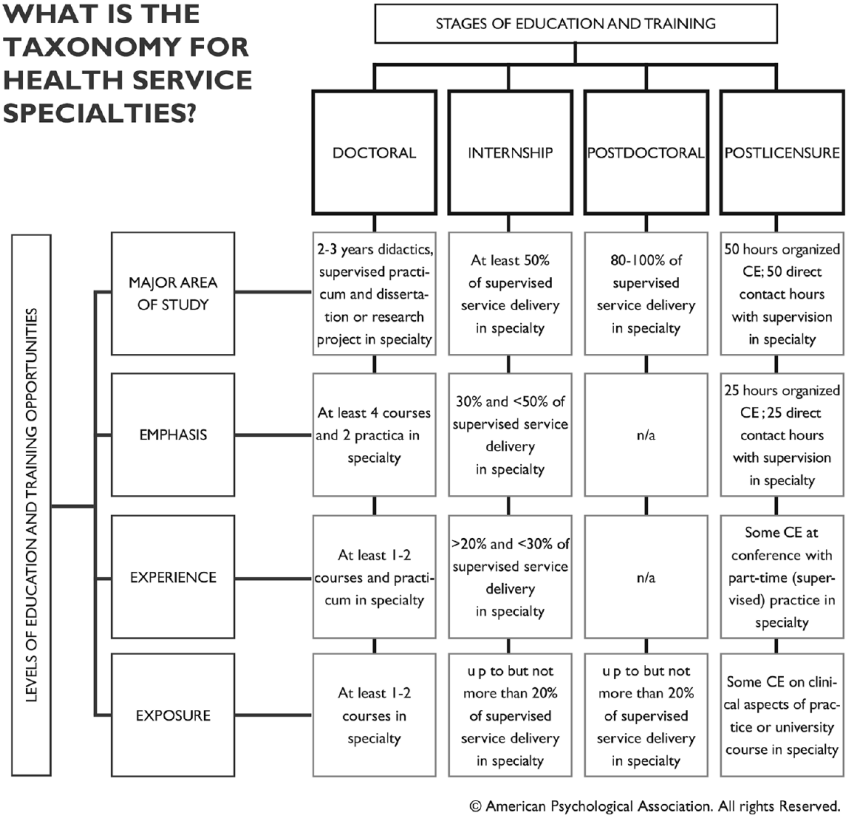
Figure 1



area, and an *Experience* in Clinical Child Psychology, with two courses and two semesters of supervised practicum in that area. We offer a *Focus* in personality assessment as part of our advanced practicum, wherein an advanced assessment course and two additional practicum semesters are available" (Rozensky et al., 2015, p. 30). For an internship program, the website might read: "Our internship program is accredited in professional psychology by the APA and offers a *Major Area of Study* in Counseling Psychology at our University Student Health Center. At least 75% of trainee time will be devoted to training in our Center in direct counseling activities and services. There is an optional *Experience* in Clinical Health Psychology at our Clinic. This Experience would involve up to 25% of supervised time working with medically ill students and health promotion services" (Rozensky et al., 2015, p. 30). For specific recommendations for a given specialty, inclusive of the various areas of psychotherapy practice, education, and science, the reader is referred to the work of each Specialty Council within CoS in populating exemplars for its specialty training.

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Working With Transfer Clients: Four Important Considerations

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It is ironic that while most therapists champion the role of the therapeutic relationship in the success of therapy, there has been little research on how the transfer process and prior therapy relationships may have an impact on the therapeutic relationship. Clients are often transferred from one therapist to another in clinics when therapists-in-training leave at the end of their training, or when therapists retire, can no longer help a client, or take a leave due to health reasons (Penn, 1990; Super, 1982; Wapner, Klein, Friedlander, & Andrasik, 1986). Clients also stop working with therapists when they have achieved their goals, move or have financial issues, or do not feel a connection to or find the therapist helpful. In my adult practice (BT), over half of my clients have had at least one prior therapist, with several having had as many as four prior therapists.

In our recent study of therapists-in-training working with transfer clients (Marmarosh et al., in press), almost all of the trainees reported that they had been provided little to no training in how to work with clients who have had prior therapists. This is consistent with our personal training experiences as well. The purpose of this short article is to identify some potentially important considerations for both new and experienced therapists working with clients who have had prior therapy relationships.

There has been some research indicating a dropout rate as high as 69% following a transfer (Tantam & Klerman, 1979; Wapner et al., 1986). Keith (1966) coined the term "transfer syndrome" to describe the difficult emotions and behavioral changes experienced by clients who end treatment with one therapist and begin treatment with another. Others describe clients' feelings of abandonment, grief, and loss when transferred (Clark, Cole, & Robertson, 2014); anger/rage towards the transferring and new therapists (Penn, 1990); and feelings of unworthiness (Penn, 1990). Despite the literature describing negative client experiences after being transferred, studies by Clark, Robertson, Keen, and Cole (2011) and Wapner et al. (1986) found that clients with a long prior therapy relationship or prior experience of being transferred were less likely to drop out of therapy after a transfer compared to those who did not. In essence, the prior therapy relationship and the experience of surviving a transfer can bolster clients through the transfer process.

The way the new therapist helps the

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client cope after the transfer can also minimize negative effects. In a qualitative study, Clark et al. (2014) found that clients often reported feeling anxiety, fear, sadness, and anger about the transfer. These clients also reported that it was helpful when the new therapist and clinic helped them cope with these feelings. Clients who felt their transfers were "successful" reported that their therapists had helped them deal with their reactions to the transfer.

Not only do clients struggle through the transfer; therapists, too, can experience challenges working with transfer clients. There is some indication that therapists have difficulties dealing with clients' emotions about their prior therapists. Boyer & Hoffman (1993) found that while some therapists reported being able to tolerate clients' experiences of termination and loss, other therapists, specifically those who had prior personal losses, struggled with the termination process.

In a study looking at psychiatric residents' experience of transfer clients, Schen, Raymond, and Notman (2013) found that some transferring residents felt guilty, sad, anxious, and even relieved to transfer their patients. In contrast, transferred-to residents felt badly about being compared to prior residents, felt overwhelmed when patients were grieving the loss of their prior clinicians, and feared transfer patients' negative emotions about repeating an intake, rehashing the past, or starting over.

In our qualitative study (Marmarosh et. al., in press) many important aspects to the transfer experience emerged that were different from seeing a client for the first time, and trainees revealed factors that both hindered and facilitated the transfer process. These factors included client past experiences of being transferred, client characterological issues, and termination of the prior therapy (e.g., whether the ending was processed). When trainees were more comfortable themselves discussing loss issues and more secure about their own competence as therapists, it seemed easier to help the client through the transfer process. When the new therapist felt the termination with the prior therapist was addressed and processed, the new therapy relationship developed more smoothly than when it had been avoided. Other practice issues such as unclear or inconsistently followed clinical policies and payment policies seemed to also impact the transfer process. For example, when there was a large debt accrued in the prior therapy, it impacted the new therapist, who had to start off the new relationship addressing issues about payment. In addition, therapist race, class, gender, and cultural background had an impact on the new therapy relationship, especially if client expectations or preferences for certain therapist characteristics were not met.

Based on our own experience as therapists, our research, and other research findings, we offer four important considerations that may facilitate working with clients who come to you after having had a prior therapy relationship. While there is likely some difference between immediate transfers versus delayed transfers (i.e., when a client ends treatment and starts again at a later date), we believe that there are enough common characteristics to warrant similar considerations.

Important Considerations in Working With Transfer Clients

1. *Recognize that the relationship with the prior therapist will likely influence the client's expectations about you and the therapy you will have.* For some clients, the loss of the prior therapist may

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have been experienced as a significant loss, even abandonment. These unresolved feelings will impact the development of the new relationship with you. For other clients, negative experiences with the prior therapist or treatment (e.g., therapist falling asleep in the session, not remembering pertinent information, having unclear or overly strict boundaries, no change in symptoms) will likely influence expectations of you. Positive past experiences will also influence the new relationship. In our experiences, positive prior therapy experiences helped clients be more open and able to trust us and the therapy and work through issues. Given the prior relationship is alive in the new relationship, it is important to explore this with the client, including the experience of loss or absence of loss toward the prior therapist, expectations (both positive and negative) about how you might be similar or different from the prior therapist, and to openly clarify expectations and differences in styles and practice up front.

2. *Be aware that client history, psychopathology, and interpersonal style will likely influence how the client reacts to a different therapist, mourns the loss of the prior therapist, and compares you to the prior therapist*. Although the research on attachment style as it relates to therapy relationships ending is minimal, some preliminary findings indicate that attachment style might influence how a client "attaches" and "detaches" from therapists (Mallinckrodt & Jeong, 2015). We know that therapist attachment style is related to their perceptions of ruptures in the new treatment after a transfer (Marmarosh et al., 2014) with more anxious therapists noting more ruptures and more effort in repairs compared to less anxious therapists. We also know that clients with different diagnoses may experience endings or transitions differently. For example, clients with borderline personality disorder or severe histories of interpersonal trauma are more likely to struggle with abandonment or emotional deregulation during and after a transfer.

3. *Be willing to initiate the conversation about the prior therapy experience with the client*. Rather than waiting for clients to bring up feelings of loss from their prior therapy—which they may be hesitant to do—invite clients to share their thoughts and feelings with you. For example, consider initiating the discussion of the transfer by asking clients what was helpful and less helpful about the prior therapy. Over time, as you learn more about the prior therapy, it may be important to delve more deeply into the past therapy and therapy relationship. If there are signs that the loss of the prior therapist was difficult or challenging to the client or the client's history identifies potential loss or abandonment issues, it is often helpful to gently push the therapy toward what the client may be avoiding or minimizing. If you sense the client is struggling with gender or cultural differences between you and the prior therapist, you may need to slowly introduce conversations about race, ethnicity, gender, class, or religion. For beginning therapists, this may mean overcoming insecurity about being a "new" therapist, saying the "right thing" or not being "good enough" when comparing themselves to the prior therapist. The more comfortable and secure you are as a therapist, the easier these discussions will be.

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4. *Periodically check in with the client about how things are going between the two of you as the new relationship is developing.* If the client expresses concerns about some aspect of the prior therapy (e.g., the client didn't like that the other therapist didn't challenge enough), it can be beneficial to use this information directly to get feedback on how the client is experiencing that in you. Do not assume that "givens" in your practice will have been the same givens in the client's prior experience. For example, therapists may differ around abuse reporting practices, payment of fees, keeping secrets, and missed sessions. When certain issues surface, it is useful to ask about prior therapy experiences around those issues to allow you an opportunity to explain or address those differences directly. It is also important to pay attention to what clients do and do not say. If the client comes late to sessions, cancels sessions, or does not show up to appointments, it is important to wonder with the client about how the client is experiencing the new relationship with you. Many times, clients will avoid difficult conversations and it is important for therapists to openly talk about these issues to prevent premature dropout.

Conclusion

The reality seems to be that as therapists we will all work with clients who have had experiences with other therapists. This can be challenging, yet this factor can also lead to potentially valuable therapeutic opportunities. Clients can address their experiences of loss, ways of coping with transitions, and implicit relational strategies that protect them from being hurt. Therapists can also gain something from these experiences. They learn to tolerate their own feelings of insecurity, cope with feelings of competition, and become more comfortable sitting with uncertainty and loss. Being aware of and addressing the possible positive and negative influences of prior therapies will likely help you become a better therapist, improve your work with the client, and help your client develop more satisfying relationships.

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INTERNATIONAL SCENE

Necessity and Urgency of Increasing Graduate Training in Chinese Clinical and Counseling Psychology: Wuhan Declaration

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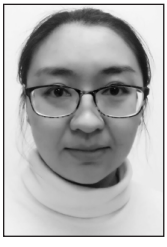

There have been several articles published in English describing the development of clinical and counseling psychology in China (e.g., Chang, 2005; Hou, 2007; Qian & Chen, 1998; Qian, Smith, Chen, & Xia, 2001). The authors consistently argue that one of the greatest needs in further developing the discipline is increasing graduate education for practitioners. Although in the past three decades, there has been significant development in the number of graduate training programs in applied or professional psychology, it is still far from sufficient to meet the mental health care needs of China, and graduate training has yet to become the main path of training for the next generation of mental health practitioners (Chang, 2005; Duan et al., 2014; Hou, 2007; Liu, 2013).

China faces the problem of not having clear and reasonable entry criteria for becoming a mental health provider or counselor. Many scholars argue that a minimum educational degree should be required for clinical and counseling practice (Chen, Qian, Zhang, & Zhang, 2010), but this is not a reality. According to a survey conducted in 2008, less than 50% of practitioners, who received certification that permits practice of mental health counseling, have a master's level or higher education background (Qin et al., 2008). Liu (2013) found only 32% of the 1193 surveyed practitioners had a graduate degree. At the present time, the threshold of academic qualification for becoming a practitioner in China is quite low. The only requirement for anyone who wants to practice counseling is to pass an examination and obtain a certificate issued by the Ministry of Labor and Social Security. Prior to the examination, the person only needs to complete a three months of training in basic psychological and counseling knowledge. Scholars have expressed serious concerns that lack of adequate training makes the practitioners prone to clinical errors that may lead to harm, and increasing graduate training is an important and urgent solution. At this time the

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number of graduate training programs in clinical and counseling psychology is extremely limited, with fewer than 100 active master's level training programs and no more than 10 doctoral programs (all PhD).

In addition to quantity, the quality of the existing graduate training programs is an area of concern. Even for those with a postgraduate diploma, there is no guarantee that they have received sufficient training in clinical work to become competent clinicians. Not all trainers (faculty or supervisors) have appropriate credentials and clinical experience from formal, professionally accredited training institutions (Hou & Zhang, 2007). When the trainers' qualifications are in doubt, it is hard to ensure that the trainees acquire sufficient competency for clinical practice. Furthermore, even some of the universities that have faculty with appropriate credentials have insufficient clinical training resources. Most high-level colleges and universities in China focus on quality research and paper publishing, and often neglect the need for solid clinical training for professional disciplines. According to a survey concerning how Chinese colleges foster the clinical competence of clinical and counseling psychology students, a lack of internship and practical training was identified as a severe and prevalent problem (Chen, Zhao, Gao, & Qian, 2009). Even with less than adequate clinical training resources, however, many colleges and universities still keep the admission level up. Some programs are not even able to offer the basic core courses in clinical and counseling psychology, not to mention needed clinical training resources.

To address the urgent issues related to mental health provider training, a historical and important meeting was held in Wuhan on June 13th and 14th, 2016, to discuss how to enhance the quality and quantity of masters' education in order to promote the professionalization of clinical and counseling psychology practice in China. The meeting was hosted by Chinese National Applied Psychology Graduate Education Steering Committee, which is authorized and charged by Chinese Ministry of Education to promote the construction of applied psychology as a discipline, help to build the educational criteria of the discipline, and organize teachers' training, academic seminars, and information communication. At this meeting, all participants who represented higher education systems in most of the provinces reached a consensus that in order to enhance the professionalization of clinical and counseling practice in mainland China, the most effective route is strengthening graduate education. With a shared vision, all representatives came to an agreement (the "Wuhan Declaration") on how to enhance the quantity and quality of graduate training in clinical and counseling psychology.

Text of the Wuhan Declaration

We, participants of the 2016 National Seminar on Chinese Applied Psychology Graduate Education in Wuhan, China on June 13th and 14th, 2016, make it known to the public and the leading bodies of higher education in China that we believe that either the quantity or quality of existing postgraduate programs in clinical and counseling psychology in China is insufficient at this time to meet the mental health care needs of Chinese citizens. We believe that the following steps toward improvement are necessary and urgent.

1. *Graduate education should be required for practicing mental health clinicians, including counselors or clinical and counseling psychologists*. All participants agree and emphasize that

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graduate education should be the main path for clinical and counseling psychology practitioner training. This requirement is necessary in order to ensure practitioners are competent in providing the public professional and quality mental health services.

2. *Clinical and counseling psychology should be recognized as an independent specialty area in psychology*. All participants agree that clinical and counseling psychology may be categorized as under applied psychology, but applied psychology as a name of the discipline doesn't reflect the nature of clinical and counseling psychology. It is noted that due to insufficient emphasis on discipline specialty, criterion and training requirement for clinical and counseling psychology has been treated haphazardly.

   Therefore, The participants recommend: 1) under the leadership of National Applied Psychology Graduate Education Steering Committee, a special professional task force be formed to develop a "clinical and counseling psychology post graduate program training guideline", stipulating the basic standard of master degree programs. The guideline should be distributed to all colleges and universities that have or intent to have such graduate training programs; 2) facilitating the separation of clinical and counseling psychology from Applied Psychology, and recognizing clinical and counseling psychology as an independent secondary subject.

3. *Training goals and training models in clinical and counseling psychology should be specified and implemented*. All participants agree that at the present time, most existing master degree training programs in clinical and counseling psychology experience confusion in terms of training goals and training models. This problem is expressed in two ways. Some universities with good training staff and facilities are often one-sided in pursuit of academic research and publication that leads to systematic bias disadvantaging the faculty staffing, performance evaluation, curriculum development, and training activities in the field of clinical and counseling psychology. Scientific research is emphasized and clinical training devalued. Another expression of the problem is that those universities that do not have adequate training staff and facilities would experience a lack of clear training objectives, have confusion regarding appropriate curriculum, and lack crucial training processes. These two conditions both lead to lack of clinical competence when students leave the programs and face the real-life clinical situations.

   The participants recommend: 1) allow two types of master training models in clinical and counseling psychology, with one being focused on producing practitioners with scientific literacy and the other training practitioners with professional literacy. 2) Clinical and counseling psychology professional graduate degree programs should be built in accordance with the required competencies for clinical and counseling practitioners in mainland China and engage corresponding training processes.

4. *Human resource for training staff is to be improved*. All participants recognize that both the quantity and quality of clinical and counseling psychology faculty members are insufficient.

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The participants recommend to: 1) strengthen on-job training; 2) expand the clinical and counseling psychology PhD program enrollment to train more qualified faculty and staff for the future; 3) invite overseas professionals to do teaching in selected subject areas; 4) employ outstanding practitioners to teach clinical courses in graduate programs.

All participants agree that the need to strengthen on-job training is the most urgent task at the present. They suggest, under the leadership of Chinese National Applied Psychology Graduate Education Steering Committee, that a "promotion of special clinical and counseling psychology faculties training program" task force be formed. Meanwhile those universities or institutions with resources be encouraged to offer on-job training programs.

5. *Clinical internship and practicum training are necessary components of training*. All participants agree that clinical training in clinical and counseling psychology graduate programs such as including practicum, internship, and supervision need to be strengthened. The clinical training should be clear in goals and processes, and be reflected in program design, curriculum, and clinical training and outcome assessments.

All participants expect that under the leadership of the Chinese National Applied Psychology Graduate Education Steering Committee, "The Guideline of Counseling Psychology Graduate Student (Master Level) Training Program Design" will be implemented to accelerate the development of Chinese clinical and counseling psychology and enhance the training culture and conditions, reducing the gap between developed countries and China in the field of clinical and counseling psychology, as well as cultivate more competent professionals with international and native cultural perspectives.

This declaration was issued on 14th June 2016 by all the participants who attended the 2016 National Seminar on Chinese Applied Psychology Graduate Education.

2016.6.14 at Xiongchu International Hotel, Wuhan

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ETHICS

The Importance of Learning to Give and Receive Critical Feedback

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"When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved."
(American Psychological Association, 2010, Standard 1.04)

Given this emphasis on personal accountability for ethical transgressions, it is surprising the American Psychological Association's requirements for accreditation of professional psychology programs do not include mandatory training in providing feedback to peers (2006). Ideally, negative outcomes in future ethical conflicts are diminished by coursework in ethics; however, being informed of the principles of the field does not preclude "grey area" situations from arising in the course of education and training or as trainees ultimately enter the field as licensed clinicians.

The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2010) requires psychologists to address ethical problems with colleagues via communication of feedback in an appropriate manner. In a health service profession with layers upon layers of relationships—supervisor to supervisee, practitioner to patient, professor to student—individuals are constantly collaborating in a shared experience of understanding one another. Given the value program directors who structure clinical psychology training likely place on fostering the community of growth and self-determinism that emerges from peer engagement, it could be considered an oversight when psychologists enter practice without formal preparation in providing and accepting feedback.

In light of the wealth of publications calling for regimented feedback programs in higher education (Cushing, Abbott, Lothian, Hall, & Westwood, 2011; Jonsson, 2012; Al Wahbi, 2014) and the fundamental necessity of receiving and giving feedback effectively as a competent practitioner (Hook, Watkins, Davis, & Owen, 2015), the question then turns to why this valuable learning opportunity is not routinely incorporated in the training of clinical psychologists. While some programs may incorporate formalized opportunities for peer feedback, this aspect of training is left up to the discretion of individual programs; standardization of such an evaluative process and opportunity for professional growth is not enforced by the accreditation requirements overseeing the competence of training programs (American Psychological Association, 2006).

Understanding Feedback

A simplified model of information processing borrowed from cognitive psychology (Groome, 1999) provides an apt

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metaphor to understand how challenges arise at different stages in the process of peer evaluation. Sense data extant in the environment is processed and integrated for the purpose of turning around output that feedback into the context (p. 2). On the input side, characteristics of the evaluator might impede the process or diminish its value. Social anxiety and fear of public speaking might be some barriers of this type (American Psychiatric Association, 2013; Boelen & Reijntjes, 2009), to say nothing of personal factors influencing feedback quality, such as tone, negativity of content, etc. Alternately, aspects of the environment might hinder availability of input. For example, a training program in which administrators resist formalized evaluative processes might undermine participation in informal processes spearheaded by students.

Barriers to Receiving Feedback

One of the fears many students harbor in providing feedback to their peers is the risk of it backfiring should feedback be poorly received (Morran, Stockton, & Bond, 1991). Studies on the dynamics of members in small group therapy may shed light on what is driving that apprehension; these include concerns over being misunderstood, of offending, of losing status in the group, and of receiving punitive action for expressing one's opinion (Morran et al., 1991; Robison, Stockton, Morran, & Uhl-Wagner, 1988). Those suffering from social anxiety may particularly fear negative evaluation from others. Whether these anxieties are well-founded or not, the impact is clear: There are many obstacles that hinder the ability to give and receive critical feedback.

Quality of feedback can often be an impediment to receptivity. Bald criticism may be minimally helpful—only a rare human enjoys hearing "you're doing it wrong" with no further explanation. Unclear feedback may be equally problematic. Imagine being told, for example, "Your glasses are ugly and probably distract your clients in session." The ambiguity of this statement leaves the receiver to ruminate over the broad range of possible interpretations, many of which may be more difficult (or even more painful) than the sentiment from which the initial opinion was born. The pull the receiver feels to dismiss feedback of questionable quality may inhibit subsequent evaluations of substantive content from being taken into full consideration ("Someone who criticizes something as trivial as my glasses probably doesn't have much to say of value"). Of course people are unreceptive when no opinions are voiced at all, but weaknesses in relevance, appropriateness, specificity, and tone can negate the value of feedback provided and similarly shut down the receiver.

The processing and integration step represents another obstacle to the feedback process. The problem might occur amongst the internal variables of the recipient, wherein personal attributes of the person receiving feedback undermine receptivity. Examples might include arrogance, lack of self-reflective insight, or even language barriers. Another challenge may arise in the interaction between evaluator characteristics and traits of the evaluated wherein perceptions of questionable credibility of the evaluator undermine receptivity to the feedback produced (Bing-You & Paterson, 1997). In this manner, processing feedback is also at the mercy of both parties' capacities to effectively navigate interpersonal dynamics of identity (e.g., race, gender, class) and power, as implicit biases may attribute unequal weight to feedback from some sources over others.

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Finally, the output manifests in the response to the evaluation and poses its own challenges as it feeds back to the original contributor. Different types of responses to evaluation may undermine subsequent willingness to participate in evaluative experiences. Such damaging experiences might include the program's punitive action in response to well-intentioned but misguided feedback, or negative verbal responses when personal offense is taken by the individual being evaluated. Obviously, there is a wide array of factors prone to exacerbate the clumsiness of the process in the absence of formalized training on how to give feedback in the first place.

Implications of Lack of Feedback Training

With all of these person- and context-dependent obstacles to overcome, it is not surprising that peer evaluation may meet resistance by students and faculty alike. However, the failure to make use of this learning opportunity may lead to specific deficits in effective practice within the field of clinical psychology. Beyond the gap in preparatory training, there are best practice implications for therapists, too. To the extent clinicians "preach" giving and receiving feedback effectively as valuable tools for living, it behooves them to "practice" these skills in their own lives. Failing to do so in training represents a missed opportunity to model assertive communication skills therapists often work on honing with clients.

Additionally, a skill requisite to almost all forms of psychotherapy, regardless of orientation, is the ability to challenge one's clients. Cognitive-behavioral therapists confront cognitive distortions; psychodynamic therapists work toward providing corrective emotional experiences to counter engrained maladaptive organizing principles; behaviorists utilize exposure therapy, literally requiring clients to experience uncomfortable stimuli to systematically desensitize excessive stress reactions. People rarely seek treatment to cope with an overwhelming love of life, expressing no desire for change. To paraphrase the wise words of Cozolino in *The Making of a Therapist*, "sophisticated and effective practice requires the therapist to be what the client needs, not what she wants (2004, p. 174).

Advantages of Feedback Training

One area that may be overlooked is the potential benefit that providing and receiving positive peer feedback can have on training. Again using the information processing model, variables at each stage can promote self-efficacy, personal and professional growth, and peer culture. On the input side, the peer evaluator is in a unique position to provide insight in the context of a relationship without an inherent power hierarchy, such as is an inherent part of supervisor-supervisee relationships. Sometimes people are more receptive to critical evaluation from their peers than authority figures (Avent, Wahesh, Purgason, Borders, & Mobley, 2015). If there is an access route to increase receptivity, pragmatism suggests its use without requiring identification of mechanisms of change or etiology of the original problem.

As to the processing stage, individuals who perceive systemic and peer support are more likely to be goal-directed and high-achieving, leading to enhanced self-efficacy, which reinforces progress (Onyishi & Ogbodo, 2012). It seems shortsighted to deny opportunities that might elevate long-term confidence in professional convictions and investment in the field because of initial discomfort with the process. Regardless of whether

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feedback ultimately improves performance, positive feedback is a desirable part of learning (Hattie & Timperley, 2007), and negative feedback is associated with development of expertise (Finkelstein & Fishback, 2012). Engagement in peer culture promotes a "sense of safety, shared intent, high levels of positive interaction, the effective management of conflict, and support for exploration" and leads to better outcomes for the group as a whole (West, 2001, p. 270).

The output stage provides the opportunity for improvement at both individual and systemic levels. While this opportunity inherently promotes professional growth, participation also enhances peer culture, which then fosters more favorable conditions for critical self-evaluation in a nonthreatening environment. In other words, when feedback is accomplished well, it is an educational opportunity for all parties involved. Comfort with receiving and internalizing feedback through a formalized process may prepare practitioners to re-examine their clinical formulations and biases in the therapy, a self-reflective process shown to yield better outcomes for clients (Macdonald & Mellor-Clark, 2015).

Studies of learning have shown long-lasting changes in behavior to be more readily reinforced when met with reward than punishment (Nakatania, et al., 2009; Guitart-Masip, et al., 2012). Studies have also shown peer support to be associated with positive outcomes across several different measures of success and satisfaction; thus, researchers are calling for use of this aspect of graduate life to facilitate the learning experience (Chui, Ziemer, Palma, & Hill, 2014). As psychologists in training, the failure to capitalize on the power of positive reinforcement as a tool of learning is an ironic omission. While the American Psychological Association does not specifically require peer feedback for doctoral program accreditation, throughout its guidelines professional training programs are encouraged to "ensure appropriate peer interaction, support, and socialization" (American Psychological Association, 2006). Capitalizing on this opportunity is at the heart and soul of the field's virtue ethics.

Conclusion

As both an ethical and educational concern, the value of peer feedback is irrefutable, but there is also a humanistic need for this process; in the words of Diana Leafe Christian, "like rocks polishing one another in a rock tumbler, our mutual feedback and requests for change can lead to our each becoming kinder, more aware, more considerate versions of ourselves" (2001, p. 57). To refuse, avoid, or limit the collaborative endeavor of professional growth through interpersonal meaning-making is to refuse to honor one's potential to receive, internalize, and adapt to that feedback. Thus, the absence of peer feedback opportunities deprives individuals and the field of better informed and more sophisticated practitioners.

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CLINICAL NOTES WITH DR. J

The Politics of Mental Health: Potential Policy Implications of the 2016 U.S. Presidential Election

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On January 20, 2017, Donald Trump will be inaugurated as the 45th President of the United States due to his overwhelming Electoral College victory over Hilary Clinton in November 2016. Throughout this long and seemingly never-ending election cycle, the ferocity of the primary battles and the eventual bedlam between the two major party candidates left large numbers of people experiencing significant stress and heartache over the race itself and its eventual outcome. According to a *New York Times* article by Lesley Alderman (2016), as many as 52% of surveyed adults attributed recent tension to the presidential election, with more Republicans (59%) acknowledging this tension than Democrats (55%). Additionally, data from this aforementioned study conducted by the American Psychological Association (APA) also highlighted the additional negative impact that social media has had on people's ability to safeguard themselves from the stress of the election (APA, 2016). Given the popularity of social media outlets such as Facebook, Instagram, etc., it was increasingly difficult for individuals to avoid these "triggers," and it placed much responsibility on the individual to seek appropriate social or clinical support when needed. The Alderman article (2016) spoke about how many have utilized psychotherapy as a safe place to discuss various emotions associated with the current political rhetoric and the ways in which the election and its aftermath have emotionally impacted them personally, as well as affecting their relationships with others. Similar to other seminal national events that reverberate throughout the collective consciousness of Americans and those abroad, the results of this election have caused many to feel unsettled and unsafe, especially with regard to the issues raised by Trump while campaigning for president (Alderman, 2016).

The Importance of the Election Outcome

As close as one week prior to Election Day, most polls estimated that former Secretary of State Hillary Clinton held a commanding lead. FiveThirtyEight (Silver, 2016) for example, placed her chance of becoming the next (and first female) U.S. President at 75.6%, with Donald Trump's chance of winning being estimated at 24.4%. Another poll found on the *New York Times* website predicted that Ms. Clinton had an 88% chance of winning the White House, due in part to the demographics of the Electoral College and her ability to capture states that traditionally vote Democrat (Katz, 2016). It seems fair to say that, for many, the outcome of the election came as a surprise, and mental health professionals are likely no exception. Given how strange the election cycle was and

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the unexpected outcome of a Donald Trump presidency, it is important to examine his positions as they relate to important topics impacting the country in general, both to predict how a Trump administration may govern and to assist in the discovery of creative solutions to longstanding issues facing the U.S. and the world. In the midst of this election cycle, much attention was given to important topics such as trustworthiness, allegations of corruption, foreign policy, immigration, and the use of "enhanced interrogation techniques," or torture, by the U.S. government. Although these were all important topics with clear implications for the field, healthcare also received tremendous attention due to President Barack Obama's implementation of significant national healthcare reform in 2010, which is officially known as the Patient Protection and Affordable Care Act but commonly referred to as "Obamacare" (U.S. Department of Health and Human Services, 2015). To address broad policy implications would be beyond the scope of this article; however, it is worth examining a few issues raised during the campaign that relate specifically to mental health and President-elect Trump's apparent positions on them.

Potential Implications for Healthcare

As a psychologist and medical professional, I am significantly interested in the policies through which Donald Trump plans to address healthcare concerns in this country, especially those concerns related to mental healthcare and reducing the stigma of mental illness. This focus is not only related to the direct ways in which legislation might impact my career and my service delivery of therapy. In my eyes, gaining perspective on his understanding of how to care for those with mental healthcare challenges speaks to the President-elect's ability to understand the needs of the various members of the community, whether they face temporary struggles or are profoundly impacted by severe and intractable mental illness. In order to better understand the ways in which our healthcare system might change with Donald Trump as President, I researched each of the major candidates' positions on mental healthcare in order to collate this information to foster further discussion and hold him eventually accountable for his suggested improvements or lack thereof.

When exploring the views of the various candidates in this election, it was clear that each took a particular approach to addressing mental health concerns. While some focused on specific steps to improve the mental healthcare structure and service delivery in this country, others focused on addressing systemic stressors that often impact someone's emotional wellness or resilience, such as poverty, violence, physical health and wellness, and access to education. For example, Donald Trump's official campaign platform for mental health offers no specific policies but instead is a three-sentence aspirational statement:

> Finally, we need to reform our mental health programs and institutions in this country. Families, without the ability to get the information needed to help those who are ailing, are too often not given the tools to help their loved ones. There are promising reforms being developed in Congress that should receive bi-partisan support. (Trump, 2016b)

In addition to these remarks, mental healthcare reform is also mentioned during his comments on gun control and the need for more thorough background screenings before gun purchases (Trump, 2016a). In this section, he again does not mention particular changes

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that he would like to make but instead speaks to a desire to expand care and coverage for those impacted by mental health concerns. The inclusion of mental healthcare reform in this section has the potential to do more harm than good, as many may see this connection drawn between people with mental health challenges and mass shootings as further stigmatizing individuals with mental illness or disability. Additionally, his statement on this subject suggests these steps are designed to protect the general public from the "mentally ill" because they are "dangerous," as opposed to adopting a more compassionate approach that could acknowledge the dangers posed by a small minority of significantly violent people obtaining guns with an element that humanizes those impacted by mental illness who have no desire to harm anyone and never will. This, combined with his previous comments about how soldiers with Posttraumatic Stress Disorder are mentally and emotionally weak (Angenend, 2016) does not suggest an interest in promoting compassion and sensitivity toward those we serve in the mental healthcare field. This presents a significant blind spot for a Trump presidency that would need to be addressed through appropriate lobbying and support by mental healthcare advocates and practitioners who can educate the President-elect on how to formulate empowering healthcare for those with mental illness.

Valuable input might be gained by incorporating aspects from the proposed policies of other candidates. For example, Hillary Clinton had a substantial amount of information on her official website regarding the ways in which she sought to improve mental healthcare. In contrast with Donald Trump's 54-word policy position regarding mental health, Ms. Clinton's policies regarding mental healthcare reform contained nearly 15 times more words, with several tangible plans for addressing mental healthcare and assisting those with mental illness in this country. Her mental healthcare plan sought to address the known stigma regarding mental illness while providing real world changes to the healthcare system to reduce barriers for services. Included in these potential changes were increases in clinical and technological research to support treatment delivery and diagnosis (Clinton, 2016). Additionally, a Hillary Clinton presidency presumably would have focused on increasing the number and availability of mental healthcare providers to meet the needs of the population, as many clinicians are overworked and underfunded to meet the demands of the community (Christie, 2014). Like Donald Trump, Green Party candidate Dr. Jill Stein, and Libertarian candidate Gary Johnson, Ms. Clinton was similarly focused on addressing systemic challenges in this country that lead to decreased quality of life and, in more severe situations, potential mental illness (Clinton, 2016). The final major area that Ms. Clinton hoped to address with regard to mental healthcare was improving the ways in which health insurance companies allow customers to seek out mental healthcare, to increase the ease and fluidity of this process (Clinton, 2016). This would have helped ensure that those in need are able to find local, competent, accessible, and engaged therapists to assist them with addressing their cognitive, emotional, social, and behavioral mental health challenges.

Given his lack of direct political involvement prior to his Presidential campaign due to his career as a businessman and the dearth of precise policy positions on his website, it is difficult to predict how the new administration might respond to key mental healthcare legislature, and no clear estimations can be made about likely policy changes. It is

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perhaps reasonable to assume that, like past U.S. presidents, Donald Trump would surround himself with well-respected mental health advisors and clinicians in order to more formally outline his mental healthcare policies; thus, it is possible that many of his policies could end up being similar to or better than those more thoroughly outlined by Hillary Clinton and others. However, given the lack of concrete information provided by his transition team and lack of focus on mental healthcare during his recent speeches, that is more of a possibility than a fact.

Looking Toward the Future

One open question is how willing the new administration will be to work with others, including former rivals. For example, although Dr. Jill Stein lost and has been criticized for remarks that seemed to connect vaccines to autism (Watkins, 2016) despite research refuting that claim (Scott, 2015), she did present creative visions for addressing the clinical, educational, employment, and financial concerns of those living with autism and other developmental disabilities (Stein, 2016). To ignore the contributions that she made to a worthy conversation about the rights of individuals with autism because of her significantly low poll numbers in the election would be a disservice to that population and would not be in the spirit of democracy and community action. As outlined above, Ms. Clinton offered potentially workable solutions and ideas for addressing mental healthcare challenges. Every political player in the presidential race possessed some valuable knowledge to share with the community in order to make the country a better place, and it is up to President-elect Trump and the community to listen for these moments and break party affiliation to acknowledge and recognize creative ideas.

Donald Trump faces the challenge of dealing with the aftermath of the electoral stress that many in this country faced during this past election cycle while also helping to mend a country fractured by "us" versus "them" divisive rhetoric. To address this stress, the President-elect must work toward unifying the country under common goals, such as improving mental healthcare, in order to galvanize attention and energy productively instead of sustaining dissention over the outcome of the election and his upcoming presidency. My hope is that this great country of ours can demonstrate its true collaborative spirit and work towards assisting the President-elect with continuing to make the nation prosperous and safe for all of its citizens—and that Donald Trump works terribly hard to mend the fences that he broke on the way to this historic crossroads.

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Bilingualism as a Tool in Psychotherapy

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"…the one point that the emigrant feels so particularly painfully is—one can only say—the loss of the language in which one had lived and thought and which one will never be able to replace with another for all one's efforts at empathy."
(Freud, as cited in Urdang, 2016, p. 156)

Psychotherapists live and work in an increasingly globalized world in which people move between countries for a variety of reasons and bring with them their native cultures and languages. The makeup of the United States (U.S.) is becoming more diverse, with 60.6 million of 291.5 million people aged 5 and over (21% of this population) speaking a language other than English at home, according to U.S. Census data (Ryan, 2013). Thus, psychotherapists are not only likely to encounter bilingual clients in their practices, but may in fact be bilingual or immigrants themselves. It is this interplay between native and adopted cultures and languages in the therapy room that is gaining more interest in the field of multicultural psychology. However, it is still largely missing from the training of psychotherapists, given that most theories and therapies covertly assume that both parties come from the same linguistic standpoint. Language is a particularly important aspect of therapy as it is one of the main means of communication. It seems important for psychotherapists, therefore, to consider what role language plays in the therapeutic dynamic for bilingual people, as well as to understand how to use it as a tool in therapy.

I am one such psychotherapist, both a bilingual immigrant myself and someone who works with clients who speak a native language other than English. Sometimes our common language, the one we use in therapy, is English. Other times it is Russian. I often find myself reflecting on the role that language plays in my work. I know first-hand that some words cannot be translated or have a different affective salience depending on the language in which they are spoken. For example, words like *pain*, *grief*, *anger*, when uttered in Russian (*боль, печаль, злость*) touch me much more deeply; in English they feel like mere translations of the feelings at a superficial level. Other words have no equivalent in English at all, and may require multiple terms to approximate; for example, *тоска* is some combination of melancholy, longing, and heartache, with a possible connection to homesickness or nostalgia.

Furthermore, as I shift between languages, I also notice changes in my sense of self, with each language bringing a certain set of historical and cultural experiences. Because I moved to the U.S. as a pre-adolescent, for example, my maturing through adolescence and into adulthood happened largely in English, the language I spoke at school, with my peers and significant others, and in society at large. Russian was the language

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I used with my family, and thus I remained a child within that system of familiar relationships when speaking my native language. As I progressed through my psychology training, therefore, I began to wonder: How do these two cultural identities play out in psychotherapy through the use of two languages?

The following is not meant to be an exhaustive review, as the study of psycholinguistics is an already extensive subfield, and bilingualism has gained more attention in multicultural literature in recent years. Since the formulation of the Sapir-Whorf hypothesis (Sapir, 1929; Carroll, 1956)—that language influences one's worldview—psychologists have recognized that languages affect our cognitive processes, organization of the world, and sense of self. Researchers have studied such phenomena as assimilation and integration of identity through the use of language, the brain structures involved in storing and processing linguistic material, and memory and language (Clauss-Ehlers, 2006). Nonetheless, I hope that the following overview will help summarize some of contemporary thinking around the role of bilingualism in therapy and provide some ideas of how to use it as a therapeutic tool.

Mechanisms of Bilingualism

Bilingualism is one's ability to be fluent in two languages (Clauss-Ehlers, 2006). Although we cannot actually see where language is stored in the brain, neuroimaging techniques have helped us construct a pattern for the storage and retrieval of linguistic material as it pertains to our understanding of concepts (Santiago-Rivera & Altarriba, 2002). One language acquisition model by Kroll and Stewart (1994) suggests that bilingual individuals have a large word store for their first language and a smaller one for the acquired second language. A third store is conceptual and is linked to the first language. As one learns a second language, words in the new language are connected through lexical links to words in the first language store. This leads to the formation of direct conceptual links from the second language store to conceptual memory. Thus, this model suggests that as individuals become more proficient in a second language, they are able to directly access conceptual memory from a word in the second language. Conceptual storage then expands as one learns more words and creates new links between languages.

According to Santiago-Rivera and Altarriba (2002), although little is known regarding the encoding and storage of emotion words (e.g., love, hate, fear) in bilingual memory, researchers have identified differential patterns of usage as a function of language proficiency. It has been suggested that when individuals learn emotion words in their first language, those words are stored at a deeper level of representation than their second language synonyms. Because emotion words in the first language are usually experienced in many more contexts and have been applied in varying ways, encountering an emotion word in the second language is not likely to activate as many different associations.

Psychologists have also posited that learning a second language is a process of not only acquiring the knowledge of new words, but also developing the ability to think and feel using new words and concepts (Leavitt, 2010). This may then lead to a change in one's worldview and identity. These mechanisms of bilingualism may be at play for both the client and the therapist, creating a certain dynamic in the therapy room. The next sections discuss the influence of bilin-

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gualism on the therapeutic process, as well as possible techniques to address it.

The Bilingual Client

The phenomenon of the bilingual client has been discussed from the start by early psychoanalysts, as Freud was a native speaker of German and later used his second language, English, in his work with patients. In one case (as described in Clauss-Ehlers, 2006), early psychoanalysts discussed working with a woman whose native language was German but who fled to the U.S. during World War II as an adolescent and acquired English as a second language. In therapy she spoke only English and refused to speak German. It was later discovered that when she was finally able to speak German, she was able to access many more feelings of childhood anxiety and the trauma of experiencing the war. This showed that different self-experiences are organized by language and pointed to the idea that it may be useful for bilingual individuals to switch between languages in order to access those different experiences and feelings.

This process of changing between languages is called code switching. Any switch away from one language to another may hold therapeutic significance, especially if it follows a consistent pattern for the bilingual client. As described in the case example above, the switching can have a distancing or defensive function, as the client attempts to veer away from the deeper emotions one experiences when using the native language. Studies have also found that talking about taboo or embarrassing topics is easier in one's second language, further suggesting that code switching to one's second language can serve as a defense (Santiago-Rivera & Altarriba, 2002). It is important then to pay attention to the pattern of language switching in therapy, and discuss the meaning it might have for a particular client depending on context, topic of discourse, and conceptual and emotional relevance.

The Bilingual Therapist

A significant aspect for the bilingual therapist is the development of an integrated professional and cultural identity as it may pertain to working in two languages with bilingual clients. The therapist's experience of oneself as a bilingual individual follows a developmental trajectory, the successful completion of which enables the development of a more complex, integrated, and professional identity (Burck, 2004). Additionally, in a study of bilingual psychotherapy, Kokaliari and Catanzarite (2011) reported that language was found to be a factor that influenced the therapeutic alliance, as it triggered clients' issues of trust, idealization, and hostility towards the psychotherapist. Furthermore, the same study reported two major themes of countertransference: White monocultural bilingual therapists tended to engage intellectually and were more concerned with boundaries, whereas bicultural bilingual therapists tended to engage relationally and were more concerned with self-awareness. Therefore, the therapist's cultural awareness plays an essential in the therapeutic dynamic.

Bilingualism as a Tool in Therapy

In summary, it is important to consider the function that the first and second languages play for bilingual clients in communicating and understanding their emotions and experiences. It is also essential for bilingual therapists to reflect on their own cultural identities and assess their level of comfort with using both languages in therapy.

Bilingualism can be a powerful psychotherapeutic tool. When working with bilingual clients, the clinician should

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pay attention to language-related phenomena and bring attention to them. For a language-matched dyad (when the therapist and client speak the same two languages), the clinician may acknowledge and analyze the client's pattern of code switching and further discuss whether there is a consistent switch to the second language for emotionally salient material or taboo topics, for example. The clinician may encourage the use of both languages in therapy in order to assist the client with achieving integration.

For a non-matched dyad, the therapist, recognizing the benefits of using a dual language system to process feelings and experiences, can encourage clients to express themselves in their native language first, then translate what had been said; subsequently, the dyad can explore the meaning of uttering emotional material in the first language. Another important factor when dealing with the issue of bilingualism in therapy is sensitivity to and clarification of the client's identification with the native culture and language, including asking about the preferred language.

Overall, the increasing number of bilingual people in the U.S. calls for an increase in bilingual psychotherapists who are able to speak and understand the language through which the client experiences the world. This, in turn, calls for more research and training, through formal means and supervision or consultation, by which clinicians can learn techniques for utilizing their bilingualism as the powerful psychotherapeutic tool that it can be.

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STUDENT FEATURE

Stop, Drop, and Roll (With It): Addressing "Realistic" Resistance With Internalizing Clients

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Psychological resistance refers to patients' conscious or unconscious opposition to aspects of the therapy process. When not skillfully addressed, resistance can lead to therapeutic alliance ruptures, "deteriorations in the relationship [indicated by] patient behaviors or communications that are interpersonal markers indicating critical points in therapy for exploration" (Safran & Muran, 1996, p. 447). While ruptures differ in a) their intensity, duration, and frequency, and b) on a case-by-case basis, most courses of treatment (regardless of outcomes) contain at least one or more instances of this kind of relational disjunction (Safran, Crocker, McMain, & Murray, 1990). Alliance ruptures precipitated by resistance engender emotional disconnection, interfere with client engagement, and ultimately thwart therapeutic progress. Ample literature demonstrating the link between weakened alliances and poor outcomes across various treatment modalities (Martin, Garske, & Davis, 2000) and patient populations (Castonguay, Constantino, & Holtforth, 2006), signifies the clinical imperative of understanding the path leading from resistance to rupture.

Despite their treatment-interfering potential, ruptures are not considered to be problematic by many therapists and clinical scientists. Rather, they are seen as vehicles that may be used to deepen the therapeutic bond and promote growth by allowing patients—and their therapists—to practice skills needed for interpersonal conflict resolution (Muran et al., 2009; Safran, Muran, & Eubanks-Carter, 2011). Indeed, rupture repair may foster a particular kind of therapeutic change that would be unlikely to occur within unruptured relationships. The resolution process often provides compelling and experiential disconfirmation of clients' long-held, maladaptive interpersonal schemata (Safran et al., 1990). However, unresolved ruptures may contribute to a continuation of maladaptive relational patterns and obstruct treatment (Ackerman & Hilsenroth, 2001). Given the potent nature of these transactions, identifying and understanding the nature of resistance is critical to facilitate constructive therapeutic action when ruptures occur.

Although resistance is often considered a unitary construct, literature has identified particular subsets of resistance which seem to require different therapeutic interventions. Rennie's (1994) exploration of various forms of "realistic"

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resistance (i.e., clients' conscious, deliberate opposition to therapeutic initiatives that they fail to understand or accept) revealed that one type of realistic resistance in particular—resistance to a therapist's general approach—was associated with unfavorable therapeutic outcomes. In their review of factors negatively impacting the alliance, Ackerman and Hilsenroth (2001) describe how ruptures stem from instances in which the therapist actively engages in techniques that do not resonate with the client, as well as when the therapist does not do what the client *does* want. These authors eschew rigid adherence to treatment guidelines that preempt the formation of a collaborative relationship between therapist and client.

Clients with internalizing disorders characterized by overcontrolled temperaments (e.g., refractory anxiety and depression) may be especially prone to resistance that goes unnoticed by their therapists, as these clients may be inhibited in their interpersonal style and reluctant to overtly challenge or confront their treaters (Hill, Thompson, Cogar, & Denman, 1993; Lynch, Seretis, & Hempel, 2016). Given the difficulties these clients often have directly expressing their dissatisfaction when "feeling misunderstood, and/or experiencing the treatment as not relevant for their unique issues" (Lynch, in press), resistance in this population is frequently expressed via covert behaviors (e.g., withdrawal, distancing, avoidance; Ackerman & Hilsenroth, 2001; Hill et al., 1993). Therapists must be highly attuned to even subtle signs of such resistance in order to effectively address it and both repair relationship ruptures before they fester and enhance collaboration on therapeutic tasks.

To provide an example of the ways in which internalizing clients may experience or reveal their realistic resistance, we offer a brief clinical vignette drawn from the first author's early experience as a psychology trainee.

Case Illustration

"Roger"[1] was a 45-year-old Caucasian male referred to our clinic for ongoing depression, anxiety, and unresolved grief following his father's death two years prior. Heeding my supervisor's recommendations, I had loosely structured the first several months of treatment, integrating both cognitive-behavioral and client-centered approaches. After beginning my spring intervention course—a rigorous entrée to manualized cognitive-behavioral therapy (CBT)—I felt I would be negligent if I did not implement some of the newer strategies we were learning. I asked if my client would be amenable to trying out a highly-structured CBT format in one of our sessions. Though I did not notice anything peculiar in that session—and despite my client's reassurance that this technique was "more efficient"—I subsequently sensed a qualitative shift in our relationship. Roger seemed less talkative in session, more distant, and missed a series of sessions subsequent to the transition. Although he had legitimate excuses for the cancellations—he had recently taken on a third shift position—I wondered about the timing of these changes. Concerned that the session format change had been irresponsible, I inquired several sessions later about his experience of it. At this time, he was more forthcoming and stated that he was not particularly enamored with the structured approach. Only then did I realize I had inadvertently prioritized my agenda (experiential learning) above his needs. While my therapeutic intent was certainly to help my client, he ultimately felt overlooked, unheard, and misread.

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Discussion

Therapists' failure to pay attention has been cited as the most consistent precipitant to alliance rupture (Safran et al., 1990), underscoring the need for in-session mindfulness on the part of the therapist. Verbal indicators of resistance may include client statements such as "I'm fine," "I suppose," "I guess so," "It's not a problem," or "I'll try" (Lynch, in press). Due to internalizing clients' people-pleasing tendencies and deferential nature, it is perhaps more essential to recognize subtle, nonverbal changes in the movement, speed, or flow of in-session behavior suggestive of non-engagement. These signs often manifest clinically via gaze aversion, frozen, excessively pro-social, or disingenuous facial expressions, eye rolling, shrugs, constricted gestures, and changes in vocal volume/intonation (Lynch et al., 2016). In retrospect, Roger may have felt too much pressure and/or anxiety in the moment to respond frankly regarding his discomfort with the increased therapeutic structure; perhaps he needed time to downregulate between sessions before he could share his honest feedback. The first author recognizes that being more attuned to the presence of her client's in-session micro-expressions might have increased her cognizance of his realistic resistance.

Successfully navigating incidents of resistance also requires the therapeutic relationship to take precedence over specific interventions. In this regard, collaboration is key. As realistic resistance functions as a reaction against the clinical focus, it necessitates that therapists change their direction and/or listen more carefully (Miller & Rollnick, 2013). Indeed, Aspland et al. (2008) observed that successful conflict resolution and alliance repair in CBT was facilitated only by therapists modifying their stance to focus on issues more salient to their clients. Similarly, Lynch (in press) recommends that therapists who suspect a potential alliance rupture immediately slow the pace, drop their in-session agenda (i.e., technical intervention), and shift their attention to the relationship. This is similar to the "stop, drop, and roll" with resistance strategy espoused by Motivational Interviewing (Miller & Rollnick, 2013).

It is worth noting that overt (i.e., verbal) identification of realistic resistance may be counterproductive. Especially among internalizing clients, a more laidback approach is often preferable, as it takes the "heat off" (Lynch, in press). Others have described the importance of "striking while the iron is cold" by holding off comments about a client's experience in the room until the client is emotionally ready to metabolize such a comment (Pine, 1984). Further, therapists may want to consider the degree to which they are physically leaning in toward their client and back off slightly when attempting to repair a rupture—a stance signaling non-dominance. Therapeutic approaches recognizing the need to target physiology as a mechanism of change (e.g., Jaycox, Zoellner, & Foa, 2002; Lynch et al., 2016; Ogden, Minton, & Pain, 2006) suggest that therapist behaviors like reclining in one's chair or removing eye-contact temporarily may be especially useful during these times.

Established clinicians also recommend strategies to *avoid* when working with resistance among internalizing clients. The use of "collusive resistance" (i.e., avoidance of painful topics due to countertransference reactions; Fox & Carey, 1999) is problematic on a number of different levels. It is not uncommon, however, for certain internalizing clients who present as psychologically fragile

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to pull for this kind of reaction in their therapist. Therapists should take care not to reinforce clients' desires for nurturance but rather to foster growth by encouraging the client's agency. This can be done in many ways, including: 1) allowing the client to develop the client's own ways of using skills or addressing problems in everyday life, as internalizing clients may acquiesce to, rather than agree with, a therapist's recommendations; 2) asking open-ended questions to enable the client to explore personal experience without being unduly influenced; 3) letting the client to sit in moments of silence and experience emotions, even if the they are uncomfortable. Skilled clinicians learn to navigate this tension between accommodating or reinforcing operant avoidant responses, which function to block dialogue about resistance, while remaining sensitive to the discomfort clients often feel about addressing the topic directly.

Conclusion

As illustrated, incongruities between patients' and therapists' understanding of presenting problems and the manner with which to approach them can lead to therapeutic impasse. It is important to attend to this issue on a macro-level, as the specific practice of managing resistance can be considered to constitute a therapeutic operation. Orienting clients ahead of time to such therapeutic operations (including soliciting their feedback about them as well as preemptive troubleshooting) may aid in circumventing undesirable outcomes. The inherent power imbalance in therapy compounded by submissive client characteristics means that it is the clinician's responsibility to encourage patient collaboration in developing a treatment plan. At the same time, a therapist's capacity for mindful awareness is essential to allow for the swift identification of nascent resistance arising from disagreements regarding particular therapeutic approaches.

We realize that much of the way in which therapists may facilitate rupture repair is in attending to their own interpersonal attitudes, recognizing their own contributions to alliance ruptures, and remaining open with clients' suggestions as to how to proceed with therapy (Hook, Watkins, Davis, & Owen, 2015). Soliciting client feedback via alternative means, such as treatment outcome monitoring protocols utilizing written or online self-report (versus direct communication) can also offer internalizing clients another "less-threatening channel for communication and an alternative forum for disclosure of highly sensitive and personal information" (Youn, Kraus, & Castonguay, 2012). Competent management of ruptures resulting from realistic resistance can ultimately foster deeper exploration of relational patterns, strengthen the client-therapist bond, and foster therapeutic growth.

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

STUDENT FEATURE

Student Experience of Partially Affiliated Internship Consortia: A Case Study

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Introduction

To complete a doctoral degree in Clinical or Counseling Psychology, a year-long internship during the final year is required (American Psychological Association [APA], n.d.). Yet, the process to obtain an internship accredited by the APA is competitive, with many students needing to relocate to other states across the country due to historical imbalances between available internships and student applicants. In 2011, only 52% of students in accredited doctoral programs nationwide matched to an accredited internship through the Association of Psychology Postdoctoral and Internship Directors (APPIC) national match (Doran & Cimbora, 2016). Despite APA's and APPIC's efforts to improve the internship crisis by increasing the number of accredited internship sites, in the most recent match, 14.6% of students from accredited doctoral programs and 72% of students from non-accredited doctoral programs matched to internships that were not accredited (APPIC, 2016). According to Doran and Cimbora (2016), one proposed way of increasing more sites is for doctoral programs to create affiliated internships through the program's mental health clinic or through affiliated practicum sites.

An affiliated internship is an internship that selects students from a specific doctoral program. Although these internships are closely associated with their home programs, as with all internship programs, they are independently accredited by the APA Commission on Accreditation. According to current listings in the APPIC Directory Online, of the 770 total internship sites, 17 are partially and 10 are fully affiliated (APPIC, n.d.).

Internships affiliated with doctoral programs may elect to create a consortium of sites. An internship consortium consists of multiple independently-administered sites that have agreed to pool resources to provide a training or edu-

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cational program (Illfelder-Kaye & Knauss, n.d.). A consortium model can provide a variety of training opportunities for interns. In an affiliated consortium, the doctoral program selects sites from the community, and pools their resources to create a training program (Erickson Cornish et al., 2005).

The University of Denver Graduate School of Professional Psychology (DU GSPP) established an APA accredited exclusively affiliated internship program in 1998. This program was developed to meet the needs of GSPP doctoral students who wished to remain in the Denver area for internship (Erickson Cornish et al., 2005). Initially, the program was affiliated solely with the Counseling Center at DU. However, to meet the needs of students who sought specialty training, the program decided to move to a consortium model in 2001. The internship training director recruited additional sites to join the consortium, resulting in the conglomeration of six sites and ten internship positions (Erickson Cornish et al., 2005).

The DU GSPP Internship Consortium follows the "sun model" of internship consortia, a model in which the sites are the "rays" and the academic program is the "sun" (Erickson Cornish, personal communication). Interns apply to and are matched to specific sites within the consortium during the APPIC matching process, and work exclusively at that particular site. Interns come together to meet at DU on Fridays for didactic seminars focused on professional issues, research, multicultural issues, and psychological assessment. These seminars take place either on the DU campus or at one of the eight sites within the consortium (two university counseling centers, a large community mental health center, a health maintenance organization, a residential treatment facility, a police psychology agency, an agency focused primarily on assessment and treatment of autism spectrum disorders, and an agency assessing and treating sex offenders).

The current format of the DU GSPP Internship Consortium consists of eight internship sites with 13 internship positions. In 2015, the DU GSPP internship consortium matched only six of the 13 internship positions during Phase I of the APPIC match, leaving six spots vacant, with one site declining to participate. For the first time since becoming exclusively affiliated in 1998, the DU GSPP Internship Consortium opened the remaining spots to the Phase II National Match. Following the Phase II National Match, five additional consortium spots matched with doctoral students from clinical and counseling psychology PhD and PsyD programs across the United States. The 2015-2016 internship cohort marked the first year since 1998 in which the internship class was partially rather than exclusively affiliated with GSPP.

The idea for the current paper originated from the 2015-2016 intern cohort of the DU GSPP Internship Consortium during the weekly research seminars, which require the development of a shared project. As part of the first cohort blended from various doctoral programs in clinical and counseling psychology, we were curious about our own experiences and whether those might help inform similar programs. Thus, the aim of this paper is to capture the varied experiences from the members of the internship class and to provide future recommendations for other exclusively affiliated programs who may open their programs up to the national match in the future.

Methods

Participants. Data were collected from 11 pre-doctoral interns from the DU GSPP Internship Consortium. Six participants

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(54.55%) were from the DU GSPP doctoral program and five participants (45.45%) were from PsyD or PhD programs across the United States. The sample was composed of eight females and three males, ranging in age from 26 to 37 years ($M = 30$ years, $SD = 3.74$). All participants (100%) self-identified as White/Caucasian. Nine participants self-identified as heterosexual, one participant self-identified as gay and one self-identified as lesbian.

Materials. An author-derived questionnaire was created for all participants that contained demographic questions and open-ended prompts for participants to write narratives. These prompts included the best and worst aspects of consortium, diversity, group cohesion, and novelty and added value of didactics compared to program of origin.

Procedure. Questionnaires were distributed to participants who were instructed to respond to prompts on the questionnaire. Participants were instructed to not include their names on the questionnaires in order for the data to remain anonymous. After data collection, the narratives were analyzed for common themes.

Results

Given that the data were phenomenological in nature (i.e., involving a description of a phenomenon), the goal was to arrive at an understanding of the essential themes of each participant's subjective experience. We reviewed the narratives and highlighted significant statements, key words, and quotations that were relevant to understanding each participant's experience. Upon examining the narratives, we developed clusters of keywords and statements based on the themes (Creswell, Hanson, Plano, & Morales, 2007; Sandelowski & Barroso, 2003).

With regard to positive aspects related to our partially affiliated consortium year, themes included having a strong support system of peers (6), interpersonal diversity (6), and professional diversity (11). Many students commented on how much they enjoyed spending the Friday consortium time together with their peers and viewed this as supportive. As one person wrote,

> Coming together at the end of the week to share in each other's experiences, whether suffering or celebrating, has been both a pleasant way to end my week and feel connected to others during a year which seems to universally be viewed as difficult.

The two other common themes focused on the diversity brought both by the mixed consortium group and the exposure to the diversity of different sites and seminar topics. In regards to interpersonal diversity and the richness it brings, one person wrote, "I have loved having folks from different programs, as it exposes me to totally different ways of thinking about psychology." Another stated, "It has been especially nice to have some new students in the group from programs other than GSPP. They have brought a diverse and interesting perspective that would likely be missing if the group consisted only of GSPP students." Students also commented on the diversity of the training experience provided by different speakers and sites. For example, one student described enjoying the "exposure to different theoretical orientations, interventions and training experiences with the mixed cohort. Site visits provide exposure to new psychological positions and jobs" and another commented, "one of my favorite parts has been the exposure to different topic areas not covered at my internship site, such as sex offense treatment or risk assessment."

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There were also some negative themes that stood out from the student narratives. In particular, the majority of the students (6) commented on the experience of "forced intimacy," especially during the diversity seminar, which included experiential "target journeys" focused on sharing personal experiences in order to better understand oppression and privilege. The varying levels of familiarity with one another seemed to bring about a sense of artificial bonding, or a superficial intimacy, which many students found uncomfortable. This also may be due to the fact that some individuals come from less "process oriented" programs and were unfamiliar with the procedures associated with target journeys. As one student wrote, "It is uncomfortable to listen to people divulge such intimate information about themselves because I feel as though many of these stories require a significant amount of vulnerability that I haven't earned because I am essentially an acquaintance." Another student commented:

> Some of the same aspects that make the mixed consortium a positive experience may also contribute to some negative components. For example, since we are a mix of different cohorts there does not exists the same group cohesion and relational history that was shared with other GSPP students. This may create a sense of a false intimacy between the group members, who may feel more pressured to disclose something but not feel fully comfortable.

Some students, including those from both GSPP and outside programs, commented that their sense of not belonging might be due to the fact that they are alone at their sites, which made it more difficult to bond with other consortium members. The importance of having other GSPP interns with whom to bond seemed particularly true for students from outside programs.

Discussion and Recommendations

There were varied program affiliation among the students, and these differing affiliations may have had an influence on the themes that stood out in the narratives. Due to the nature of this project, it is difficult to say which themes may be truly unique to a mixed consortium group, and which arise regardless of whether the consortium is composed of a group from mixed universities or only DU. Due to the small number of participants and the fact that students would be reading each others' comments, the nature of this project may have made the participants particularly self-disclosing or self-filtering. Further, some students were alone at their individual sites, while others had opportunities to bond with as many as three other interns at their site. Some of the GSPP students came from the same cohorts. This unique compilation of people allowed for many of the positive aspects to be brought forth, but in some cases also lead to some negative experiences.

We have several recommendations for future consortia. Overall, our results endorse the general notion of having a partially affiliated consortium; however, there are several considerations to keep in mind. First, our results indicate that the ratio of affiliated and non-affiliated students is important; a cohort with only one or two non-affiliated interns could prove difficult for those from outside programs. If the ratio of affiliated and non-affiliated interns is not balanced, we hypothesize that the ratio should be in favor of a larger proportion of non-affiliated interns. In the event that the match process does not produce a balanced ratio, we recommend employing some of the strategies listed below, such as the "buddy" system.

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Second, our results imply that it may be important to expose national candidates to the culture of the affiliated doctoral program before the internship year starts. Comments from non-affiliated students described how their programs were less process-oriented, how they were unfamiliar with some of the psychotherapy theories taught at GSPP but not in their home programs, and how the concept of "target journeys" was completely foreign to them. Additionally, something as small as calling professors and seminar leaders by their first names and not using the prefix "doctor" was unfamiliar to many non-affiliated students. It may have been helpful to provide these students with information about how the affiliated doctoral program curriculum includes studying the science of marginalization, and how students have historically explored their own marginalization through target and non-target journeys. This background would have provided context for the non-affiliated students, and likely decreased the feelings of being "outsiders." Some non-affiliated students also commented how they expected a more didactic experience based on the description in the training handbook. Students commented on being surprised at the amount of experiential learning in the diversity seminar. Again, being provided materials at the beginning of internship describing the culture and "what to expect" would likely be beneficial. Additionally, more team-building events at the beginning of internship would help build group cohesion.

Third, regardless of whether a consortium is fully or partially affiliated, we recommend that no student be the sole intern at a site. Interns tend to make the strongest connection with other individuals at their same sites, and interns who are alone may miss out on this important sense of connection. Feeling less close to other students likely contributes to the sense of "forced intimacy" about which several participants commented. If students feel more genuinely connected, they more likely to believe they have "earned the right" to hear other people's deeply personal experiences. Similarly, we recommend that individuals are not required to share comments after intense experiential exercises, (such as the journeys) as this may also contribute to a feeling of disingenuousness and "forced intimacy."

Another possible adaptation to increase cohort cohesion, particularly between affiliated and non-affiliated students, would be to match affiliated with non-affiliated interns in a "buddy" system. Providing non-affiliated students with a liaison who is intimately familiar with the affiliated doctoral program and its system and culture and would help these students more quickly feel part of the community and would provide them a contact person for any questions or concerns the non-affiliated student may have. Matching of non-affiliated and affiliated students could be done based on clinical interest, theoretical orientation, past life experience, or a number of other factors.

Conclusion

Overall, interns reported varied experiences with a mixed cohort. Our results indicate that partially affiliated internship consortia may be beneficial, but future research is needed to clarify how they should be organized to provide the best training experience possible for interns during years that include both affiliated and nonaffiliated interns.

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

WASHINGTON SCENE

"Why Don't You Let Me Go Home?"

Pat DeLeon, PhD
Former APA President

The Importance of Pursuing One's Passion

It is exciting to reflect upon the challenges which dedicated colleagues have willingly embraced, especially when they are serving the "public good." Two of our true RxP pioneers, who from the beginning have been on the front-line treating those in need of appropriate psychopharmacological care, have recently joined forces to promote global mental health. New Mexico's Drs. Elaine LeVine and USAF (Ret.) Elaine Foster, who are among our earliest prescribing psychologists, have partnered to take on a weighty challenge indeed—global mental health.

According to the RxP International website (2015), citing the World Health Organization (WHO), half of all countries in the world have less than one psychiatrist per 100,000 people, and a third of all countries have no mental health programs at all. Access and quality of care are extremely critical within the U.S. and are even more striking in middle- and low-income countries. Our colleagues are well known for taking an unconventional slant on traditional medicine through their Psychobiosocial Model of Care. They emphasize psychological factors in all aspects of evaluation and treatment; the more traditional medical school "biopsychosocial" model typically emphasizes body over mind (the physical over the psyche).

WHO outlines the evolution of integrated care for mental health providers through a concept called "task shifting." This is a process of expanded training for the healthcare workforce. The goal is to empower health workers to better assist those in need. In many countries there are few medical practitioners and the populations they serve are so vast that they are often not able to provide day-by-day services to their patients. Task shifting allows a mental health worker to make recommendations to a primary care doctor regarding treatment options, based on augmented training in psychopharmacology from a psychobiosocial perspective.

Our dedicated colleagues have moved beyond the theoretical concept of task shifting by launching a nonprofit organization, RxP International. The organization's mission is to provide training in psychiatric medications as an adjunct to the many types of therapies that can be used in place of medicine. In order to make rational recommendations about when medications should be avoided or discontinued, a mental health provider must understand when, how, and why they are used in the first place. Helping practitioners gain the information and skills of this psychobiosocial model so that they consult effectively with medical personnel who are prescribing psychotropics is clearly a social justice concern since the focus is teaching people, many of whom are traditionally underserved, to better help themselves.

In order to reach the broadest popula-

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tion, RxP international has designed courses that can be offered through distance learning and an open communication forum. The courses target the most commonly diagnosed conditions, such as anxiety, depression, and psychosis, along with special populations, such as the elderly and children. The online forum is actively managed to help student-providers share their unique experiences and needs from their place in the world. In addition to providing a more personalized educational experience, the information from this forum will be used by the course developers to gain a better understanding of mental health needs and interests around the globe. The RxP International signature course is a one-hour presentation on social justice, explaining the philosophy behind the movement and case studies on the New Mexico-Mexico border.

In many ways, this vision is targeting the need of those front-line practitioners who are addressing society's real needs (i.e., those within the VA, DoD, state mental health systems, and federally qualified community health centers, or FQHCs). The underlying goal is to provide readily available *quality* psychopharmacological expertise for dedicated public servants who need access to *practical* information, regardless of whether or not they receive a formal credential. "We want to create a dynamic learning environment where anyone, regardless of their formal professional discipline, who wants to expand their clinical skills anywhere in the world can join this social justice movement" [Elaine Foster]. Current faculty include psychologists Drs. Elaine Foster, Elaine LeVine, Mark Muse, John Preston, ABPP, and Mitchell Simson, MD. RxP International will be enlarging their number of offerings as the curriculum undergoes future iterations; for more information visit t heir website (www.rxpint.org).

One of psychology's first RxP training programs was developed by former Division 55 (American Society for the Advancement of Pharmacotherapy) President Bob McGrath at Fairleigh Dickinson University. Bob is currently the Director of Integrated Care for the Underserved of Northeastern New Jersey, pursuing his passion for furthering psychology's involvement in serving those "most-in-need" by working closely with FQHCs. When I enquired about enrollment in light of the recent legislative success in Iowa, Anne Farrar-Anton, the new director, reported they have 38 to 45 new students each year, which is quite impressive. Recall that in Denver, Bethe Lonning pointed out that although it did take Iowa a decade to enact RxP legislation, since 2011 they had only needed to raise $3,535.50. The key to their success was grassroots campaigning and believing that their agenda was important for the citizens of Iowa. Accordingly, we would suggest that as the number of practicing psychologists obtaining this specialized training continues to increase *and* as the media continues to focus upon the pressing needs for quality mental health care (such as the much-publicized VA report that every day 20 Veterans commit suicide; Shane & Kime, 2016) more and more states will achieve legislative success.

A Fascinating Training Opportunity

"The Military Contingency Medicine (MCM) course, which includes the field training exercise called 'Bushmaster', epitomizes the mission of USUHS: preparing health care providers to operate in any environment around the world. There are two phases to the exercise and each phase is important. The first phase is a two-week didactic experience that ranges from dental emergencies in the field to the United States strategic goals of Global Health Engage-

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ment. The practical knowledge imparted is important, but what will last personally is an epiphany moment of recognizing 'Military Health' as its own unique specialty, a conceptualization of both the population I will treat and the role I will fulfill. The second phase of MCM is Bushmaster, which lasts six days at a military installation in Pennsylvania. I participated by providing mental health expertise and support to the main body of troops training. It was an impressive operation and some of the highest-quality training in my military career. More than that, it had the unbeatable quality inherent to much of military life, camaraderie and fun of being part of a large group of people with a shared goal. However, the truly lasting effect of Bushmaster will be the exchange of ideas and the relationships built between our graduate nursing students, international participants, medical students, faculty, USUHS alumni, and practicing providers from across the country. People I am guaranteed to cross paths with again, both stateside and across the world on any given mission" [Doug Taylor, USUHS mental health DNP student].

Evolving Approaches to the Future

With the enactment of President Obama's Patient Protection and Affordable Care Act (ACA), the delivery of health care services within our nation is steadily evolving towards *integrated systems* of care, rather than maintaining our historical reliance on independent practice models. The federal government, and particularly the Departments of Defense (DoD) and Veterans Affairs (VA), have been on the cutting-edge of this movement. This was evident at the town hall meeting hosted last year by then-FPA President Lori Butts during the Florida Psychological Association's 2015 Annual Convention, as her VA colleagues described their ongoing successes *and* challenges in meeting the mental health needs of their beneficiaries utilizing the maturing VA telehealth capabilities.

Licensure mobility is one of the new challenges facing practitioners of all disciplines who are interested in providing care in the 21st Century. Why should the locus of where one practices—especially in today's virtual lifespace—continue to be a determining factor of one's scope of practice? In October 1998 the Pew Health Professions Commission, chaired by the former Senate Majority Leader George Mitchell, recommended: "Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement" (Romig, 1999, p. 260). This summer the VA proposed to permit full practice authority for its Advanced Practice Registered Nurses (APRNs) relying upon its federal supremacy authority. By the close of the public commentary period, an extraordinary 223,000 comments had been received approximately 60% supportive. Under the leadership of APA immediate Past-President Barry Anton and President-Elect Tony Puente, 16 former APA Presidents submitted a letter in support of the VA's proposal. The APA Practice Organization signed on to a similar statement as a member of the Coalition for Patients' Rights, along with the American Physical Therapy Association. The American Association of Colleges of Pharmacy and the Federal Trade Commission also submitted highly supportive comments. It is significant that this proposal would only impact federal nurses working within VA facilities.

From a public policy perspective, the issue of licensure mobility becomes sig-

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nificantly more complex when one contemplates providing federal reimbursement to private sector clinicians for serving the health care needs of federal beneficiaries via telehealth. The Senate Fiscal Year 2017 National Defense Authorization Act (S. 2943) would authorize the military's TRICARE program to reimburse for telehealth, including mobile health applications. One aspect of this proposed authority, however, provides that for purposes of reimbursement, licensure, and professional liability relating to the provision of telehealth services, providers shall be considered to be furnishing such services at their location and not at the location of the patient. In response, the AMA and the American Association of Family Physicians (AAFP) expressed the concern that this approach would essentially create a workaround to medical licensure and lead to physicians who are not accountable to any medical board, as the board in the patient's state would not be able to regulate an out-of-state physician and the board in the physician's home state could not regulate an interaction with a patient in another state. The AMA: "This provision would deprive TRICARE beneficiaries of essential protections by fundamentally subverting and undermining existing state-based patient safety protections that are currently in force, and remove an essential mechanism used by states to ensure medical care provided to patients in their state meets acceptable standards of care." (See Comstock, 2016). They both urged reliance upon the interstate licensing compact of the Federation of State Medical Boards as a viable alternative.

The Association of State and Provincial Psychology Boards (ASPPB) has now established the Psychology Interjurisdictional Compact (PSYPACT) which is an interstate compact designed specifically to facilitate telehealth and the temporary face-to-face practice of psychology across jurisdictional boundaries. Thanks to the vision of ASPPB CEO Steve DeMers, this effort has been endorsed in principle by the APA Council of Representatives. The next step: Having our State Associations appreciate the importance of "Catching the Wave" and enacting timely legislation— "So hoist up the John B's sail."

Aloha.

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BOOK REVIEW

Book Review of *Art-Based Group Therapy Theory and Practice* (2nd ed.) by Bruce L. Moon. Springfield, IL: Charles C Thomas, 2016, 234 pp. ISBN: 9780398091163.

Alexia C. Electris, PhD, L-CAT
New York, NY

Although the existing group art therapy literature focuses on identifying art therapy directives and describing the root of group psychotherapy as being geared toward verbal therapy (Liebmann, 2004; Steinbach, 2014), there has been a gap in the literature when it comes to describing the healing components of art in group work. The second edition of Bruce Moon's (2016) text *Art-Based Group Therapy Theory and Practice* fills this gap. Moon's focus on art-based group therapy theory and practice is intended for use as a textbook for graduate level art therapy programs, but it is also useful as a supportive resource and source of inspiration for practicing art therapy clinicians.

This book successfully guides the reader on how to use intuition and supports clinical growth through instruction on the use of continuous reflection, learning, and experience in becoming an effective art therapist in the group format. Most importantly, Moon shows how art-based therapy groups help clients, and may be advantageous in treating clients who have not been able to make progress or respond well to traditional talk therapy. Moon's understanding of group dynamics is influenced by the writings of Corey and Corey (2010) and Yalom (2005); however, the root of his theories lies in art making. While some similar texts are filled with exercises to use in specific situations, Moon remains a challenging professor, encouraging his students to grow and trust in the transformative process of art-making, which might be constrained by such exercises. Instead of using a cookbook approach, he describes and encourages ways to increase one's intuition and discover what works with particular clients and particular groups.

In this well written and easy to follow text, Moon discourages formulaic approaches to group leadership, instead encouraging readers to be open to the process of discovery. In fact, in response to student feedback, Moon moved the chapter on art-based group leadership in this second edition to the beginning of the book to highlight important personality characteristics of art therapy group leaders. These include "a sense of personal power and self-confidence" and serving as artistic role models, demonstrating "a willingness to take both personal and creative risks" (Moon, 2016, p. 15). He also insists that the group leader constantly work to foster artistic contagion, and describes ways to facilitate a dialogue with group members and their artworks. For example, Moon's excitement about making art remained strong despite a threatening remark from a new 20-year-old client, mandated to a residential treatment facility by court after being charged with assault. Rather than respond to his threatening and hostile start to the group and falling into an enactment of distancing the group from him, Moon enthusiastically commended this client's expressiveness and helped him find a

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way to express his current emotional state by painting a "shit brown" canvas and covering it in jagged lines. Moon was able to honor the client's feelings and include him in the group, showing him how powerful painting out his anger for all to see could be (pp. 55-60).

The author illustrates group practice that is based in art therapy theory and eloquently describes the powerful and transformative experience of making art with others. Here, Moon describes art therapy basics, such as how art-based groups help clients, and the 13 "therapeutic essentials" (pp. 8-9). For example, "making art in a group setting creates a sense of ritual that provides psychological safety and promotes interpersonal emotional risk-taking"; it also "reduces isolation and creates a sense of community" (p. 8). Moon raises useful points about the group leader's struggle to learn artistic and relational self-disclosure, suggesting that art therapists must decide where their styles fall on the continuum by both experiencing "the emptiness of a missed opportunity when they unnecessarily withhold information" as well as "the pain of being hurt by the client who was not ready or able to respond positively to the gift of the group leader's vulnerability" (p. 17). Therefore, the text is a good primer for novice group psychotherapists practicing with and without artistic elements.

However, Moon's writing can also feed and inspire the more experienced art therapist. Based on over 40 years of experience running art therapy groups in inpatient hospitals, adolescent residential programs, and graduate art therapy classrooms, Moon's vivid descriptions are engaging and performative. Ultimately, this is the greatest strength of the book. While motivating and teaching experienced art therapists about group therapy practice, he is simultaneously demonstrating how to write about the work in a dynamic and beautiful way. His passion for, and trust in, the powerful qualities of art-making shine throughout the text. Moon describes writing the second edition of this text as an "act of love" (p. xvii) and his passion and advocacy for art therapy are contagious.

Most valuably, Moon added a number of new vignettes from clinical and educational settings to bring theories of art therapy to life. He also added chapters exploring ethical issues related to group practice as well as another related to the power of being seen and heard (witnessed) by peers in groups. There are several poignant examples of patients and students demonstrating resistance to the process of psychotherapy. Moon included an example of a relatively new graduate class of art therapists who were relating to one another superficially, insisting that this was a class and not therapy. He assigned them a group task of covering mural paper with blue and green chalk. In an attempt to move beyond the surface and into the depths, he asked each student to draw and portray themselves as an element or character in this underwater world that represented how they experienced themselves in the group. In discussing the images, the conversation remained light with humor until one woman spoke about the puffer fish she drew and members remarked on its "cuteness." She quickly reacted, "Well, I may be cute, but you better watch out for those spines. They will hurt you if you get too close" (p. 105). Moon then remarked on how "puffed up" the fish was and the student spoke about how this represented a response to danger, eventually revealing how scared of the class she was because "this ocean felt fake" (p. 105). She went on to insist that the group learn to be real and vulnerable with one another. Moon's empathic and open stance, as well as his deep passion

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and belief in the healing property of art-making, helps clients and students quickly make progress through nonverbal work. Identifying resistance as problems with engaging and connecting, Moon strongly and confidently guides individuals to go deeper into expressing themselves through their art, even if the words are not found. He utilizes all creative expression, including movement, poetry, music, and theater to help clients gain deeper self-understanding. Ultimately, Moon's descriptions of the process of art psychotherapy are deeply inspiring. He helps art therapists learn to take what they love about creation and art and use it to help others connect and transform themselves in a natural way.

Importantly, Moon argues that art therapy is more effective than is often widely recognized, and may have advantages over verbal therapies. When used in psychotherapy, art can yield transformative mental health outcomes, working to engage resistant clients and students alike. Moon articulates how the unique powers of art and creation can reach clients who cannot easily verbalize their problems. Although Moon describes traditional group therapy theory, he differentiates art-based group therapy theory and highlights advantages to working nonverbally. For instance, art psychotherapy groups are process oriented and engagement in the creative process is the mechanism of change.

The work of art therapy groups differs from that of traditional talk-therapy groups because clients must find a way to engage in the creative process, which can reduce feelings of isolation and foster connection with others by their art being witnessed. This can happen without a verbal discussion. For example, Moon described an angry 35-year-old on an inpatient psychiatric unit who was loud, offensive, and intimidating. He criticized the art therapy group, questioning what "play(ing) around with crayons" would do for him. One member shared as she checked in that she felt like Sisyphus, a figure of Greek mythology, who was condemned to the repeated meaningless task of pushing a rock up a mountain. Moon assigned the group a task of draw their own version of a metaphorical rock in their lives. The angry client was resistant, but with much encouragement from the entire group, he drew a stormy background with a monolith. Rather than have the group discuss their pieces, Moon had members move their pieces around as if they were in an exhibit. This allowed members to relate to the angry client, and appreciate the sense of the loneliness and pain he was encountering in a safe and non-threatening way. Over time, this group member created subsequent images symbolizing his "fears, regrets, and inadequacies" (p. 113). He rarely spoke about the images and would retreat into a defensive machismo if the discussion moved from the safety of the imagery toward the feelings they depicted as his own. In maintaining a noncritical and nonjudgmental therapeutic presence, practitioners can utilize the powerful and transformative process of art-making to help clients and students achieve a deeper sense of self-actualization by starting to understand the emotions they often work hard to defend against.

In his epilogue, Moon concludes his text by cautioning and empowering art therapists not to imitate other approaches or professions "in order to be taken seriously" (p. 219). Art therapy is its own unique, legitimate, and powerful profession, and Moon also calls for proper recognition by other professions. He explains this by pointing out the bias in assuming that only talking cures, which he

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attributes to verbal treatments having a considerably longer history than art therapy. Art therapy may not be as valued within the existing health care hierarchy in part because other disciplines do not fully understand the potential for change through art making.

Although Moon's text is written for an art therapy audience, it is applicable to all therapists, students, and educators interested in deepening their understanding of the process of psychotherapy. Furthermore, many of the techniques described, such as having a ritual for the beginning and closing of groups or helping members articulate meaningful goals in response to their conflicts, are applicable with patients and students, alike. Moon's ideas are also helpful for training non-art therapists or talk therapists who want to learn about vulnerability and exposure, which are inherent in the process of making art. Finally, the emphasis on process is applicable across all disciplines. Moon encourages experimentation and learning while reminding readers that psychotherapy is not exclusively about the alleviation of distressing symptoms. Instead, the emphasis here is on helping clients who struggle to verbally identify and express inner states gain a deeper understanding of the self and connection with others. Reading about the powerful impact of art therapy is a useful challenge for other disciplines, as they would certainly benefit from learning how to integrate or translate nonverbal techniques into verbal interventions.

Moon clearly states that this book is tailored primarily as a textbook for graduate students, and ultimately it does seem to reach its full potential when paired with graduate courses and practica. Although inspiring, it may be somewhat difficult for a non-art therapist to know *how* to integrate nonverbal communication in their groups in a comprehensive way. Although Moon emphasizes that clinicians should learn how to trust their own intuition and inner voice, he does not address some more basic information such as knowing which materials are most clinically appropriate to use for clients. Moon also recognizes in a short chapter towards the end of the book that the art materials he relied on were somewhat limited, as they did not include more current materials of media, photography, video, technology, or found objects (p. 194). A more in-depth explanation of the thought process behind suggesting art materials for clients would improve an otherwise comprehensive book on art-based group therapy. A beginning art therapist may not yet understand the issues of control and vulnerability associated with various materials. In addition, while he presented a number of vignettes with resistant clients, explaining a little more as to why he recommended some materials or including how to handle frustration with materials and the process of art making could add to this. This is something that develops over time and may come more naturally for experienced art therapists who already trust their therapeutic voice. For the sake of therapists early in their careers, it could be helpful to elaborate on these themes.

In conclusion, Moon encourages personal growth in new art therapists as they learn to rely on their intuition and experience exploring their own artwork rather than formulaic interventions. Although he describes therapeutic essentials and characteristics of a group leader more tailored to the novice therapist, Moon's beautifully written descriptions of group work are inspiring and can help more experienced art therapists find the language to honor their

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work. Moon argues that artmaking has unique therapeutic qualities that allow art therapy to reach a population of more resistant clients who would not respond well to verbal interventions. This text adds a robust perspective on the transformative theory and practice of art therapy in groups, and will be a source of inspiration and knowledge for therapists, educators, and students focused on psychotherapy.

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PRESIDENTIAL CITATION AWARDED

Outgoing Website Editor, Brad Brenner, PhD, receives a Presidential Citation from SAP President Armand Cerbone and Publications and Communications Board Chair Jeff Barnett, in recognition of Brad's many outstanding contributions that have advanced SAP's mission on behalf of our members in his role as Website Editor.

In appreciation for exemplary service as Website Editor from 2013-2016. Your creativity, dedication, technological sophistication, and leadership enabled the Society to achieve and exceed its vision for our website and internet presence.

2017 CHARLES J. GELSO PSYCHOTHERAPY RESEARCH GRANTS

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

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

Submission Deadline: April 1, 2017

REQUEST FOR PROPOSALS: CHARLES J. GELSO, PH.D. GRANT

Description
This program awards a $5000 grant for a research project in the area of psychotherapy process and/or outcome.

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

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

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

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

Proposal Requirements for All Proposal
- Description of the proposed project to include, title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on

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research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within two years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows
- **Graduate students, predoctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.**

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

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

Submission Process and Deadline
- All materials must be submitted electronically at the same time
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.
- Deadline: April 1, 2017

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

2017 NORINE JOHNSON PSYCHOTHERAPY RESEARCH GRANT FOR EARLY CAREER PSYCHOLOGISTS

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

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

Submission Deadline: April 1, 2017

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

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

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

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

Eligibility Requirements
- Early Career (within 10 years post earning the doctoral degree), Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
- The selection committee may choose not to award the grant in years when no suitable nominations are received
- Researcher must be a member of the Society for the Advancement of Psychotherapy. Join the society at http://societyforpsychotherapy.org/

Evaluation Criteria
- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area

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- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals

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

Additional Information

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

Submission Process and Deadline

- All materials must be submitted electronically at the same time
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.
- Deadline: April 1, 2016

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

DIVISION 29 PSYCHOTHERAPY
Of the American Psychological Association (APA)

CALL FOR NOMINATIONS

Distinguished Psychologist Award

The APA Division of Psychotherapy invites nominations for its 2017 *Distinguished Psychologist Award,* which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

Deadline is January 31, 2017. All items must be sent electronically. Letters of nomination outlining the nominee's credentials and contributions (along with the nominee's CV) should be emailed to the Chair of the Professional Awards Committee, Dr. Armand Cerbone, at arcerbone@aol.com

CALL FOR NOMINATIONS

Division 29 Award for Distinguished Contributions to Teaching and Mentoring

The APA Division of Psychotherapy invites nominations for its 2017 *Award for Distinguished Contributions to Teaching and Mentoring*, which honors a member of the division who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists.

Both self-nominations and nominations of others will be considered. The nomination packet should include:

1) a letter of nomination describing the individual's impact, role, and activities as a mentor;
2) a vitae of the nominee; and,
3) three letters of reference for the mentor, written by students, former students, and/or colleagues who are early career psychologists. Letters of reference for the award should describe the nature of the mentoring relationship (when, where, level of training), and an explanation of the role played by the mentor in facilitating the student or colleague's development as a psychotherapist. Letters of reference may include, but are not limited to, discussion of the following behaviors that characterize successful mentoring: providing feedback and support; providing assistance with awards, grants and other funding; helping establish a professional network; serving as a role model in the areas of teaching, research, and/or public service; giving advice for professional development (including graduate school postdoctoral study, faculty and clinical positions); and treating students/colleagues with respect.

Deadline is January 31, 2017. All items must be sent electronically. The letter of nomination must be emailed to the Chair of the Professional Awards Committee, Dr. Armand Cerbone, at arcerbone@aol.com

CALL FOR NOMINATIONS
ROSALEE G. WEISS AWARD

The Rosalee G. Weiss Award is a joint award, bestowed by the Divisions of Psychotherapy(29) and Independent Practice (42) in alternate years and administered by the American Psychological Foundation. It was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee. The lecturer receives $1000 honorarium.

The Awards Committee shall employ the following guidelines for the selection of the recipient of the Rosalee G. Weiss Award:

1. Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology; or,

2. Outstanding leaders in any of the special areas within the spheres of psychology.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 200X Awards Chair: Dr. Armand Cerbone arcerbone@aol.com. The applicant's CV would also be helpful. Self-nominations are welcomed. Deadline is January 31, 2017.

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