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BULLETIN

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PRESIDENT'S COLUMN

Jeffrey Zimmerman, PhD, ABPP

The privilege of serving as your 2017 President was capped off by the amazing work that your Board of Directors did at its final meeting for the year. The commitment, thoughtful deliberation, mutual respect and creativity was a pleasure to witness and be a part of. I'd like to share some examples with you and update you about some of what's happening in your Society for the Advancement of Psychotherapy (SAP). I don't have the space to cover everything, so instead I will just highlight some initiatives.

Publications Board: Our journal *Psychotherapy* is doing very well. Mark Hilsenroth and his team are intent on continuing to grow the journal and have it provide content that is pertinent to *both* researchers and clinicians. This is a difficult task, but something that you can see routinely by just scanning the table of contents of any recent issue. Our *Bulletin* edited by Lynett Henderson Metzger is now provided electronically. This can enable us to expand the offerings without concern for printing and mailing costs. Please feel free to submit articles you think may be of interest to our members. Our website editor Amy Ellis is continuing to develop the site. Keep an eye on it as you will see that soon it will become easier to find content. We are also considering having forums to allow for special interest discussions that you can join if interested without receiving multiple emails about things that do not appeal to you.

Budget: Jesse Owen presented the Board with a balanced budget (which was approved). Our reserves have continued to grow and the Board decided on two major initiatives (see below) to spend the overage of the reserves cap ($500,000) recommended by the Finance Committee.

50th Anniversary Research Grant: - In honor of our 50th anniversary (2018), the Board decided to offer a research grant of $30,000 (from our reserves surplus) to more substantially fund psychotherapy research. Keep an eye out for the call for proposals. Or, contact Susan Woodhouse for more information.

Interdisciplinary Think Tank to Help the Underserved: Susan Woodhouse who chaired my task force on bringing psychotherapy to the underserved, proposed that the Board fund a think tank to further address this issue. The Board approved the concept subject to a more detailed plan being brought before the Board in the future. If you are interested in getting involved in this project please contact Susan. The funding for this will also come from the reserves overage.

International Domain Initiatives: Keeping with the intention of expanding our reach internationally, Fred Leong has reached out to our colleagues who are organizing the 2018 International Congress of Applied Psychology. They are excited about SAP having a presence at the Congress (similar to our role at the World Congress of Psychotherapy earlier this year). Stay tuned for more information on this, or contact Fred if you are interested in being part of the planning group.

There is so much more great work being

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done by the other Domains as well. The Board also approved many new awards as recommended by different Domains (keep on the lookout for the calls for nominations).

But, what most pleased me was the Board working together. Many initiatives discussed incorporated thought and action plans from different domains as the Board took on the tone of a team working together, regardless of individual interests. This was such a great pleasure to be a part of.

It was also a pleasure to see the Executive Committee (EC) recently responded to a situation in which a difficult dialogue, or what is sometimes called a "courageous conversation" was needed regarding the process at APA Council. The EC acted quickly on the input from Lillian Comas-Diaz and Libby Nutt Williams (our Council Representatives) by sending a letter requesting that attention promptly be paid to avoid micro-aggressions and increase inclusiveness in Council and its process.

By the way, if anything above, or elsewhere in the Bulletin is of interest to you, and you want to be a part of it, or you just want to discuss it, please contact me and I will put you in touch with the right person. None of the above could have been done without the hard work and thoughtful deliberation of our Board and Committee Chairs and Members. Thank you all.

Some of Board is departing after many years of service. Rosie Adam-Terem, Jeff Barnett and Barry Farber will be stepping down from their positions. Armand Cerbone, will also be completing his term on the Board. As immediate Past President. Armand has been a particularly special mentor and role-model to me. Thank you all for all your contributions—too numerous to mention here. You will be missed. I hope you always think of SAP as your home.

I'd also like to welcome our newly elected 2018 officers Nancy L. Murdock (President-Elect), Rebecca M. Ametrano (Secretary), Frederick T. L. Leong (Domain Representative - International Affairs) and Lavita I. Nadkarni (Domain Representative - Public Interest and Social Justice). The Board also appointed Laurie Heatherington as the new Chair of the Publications Board. Welcome to all of you. You are joining a wonderful Board.

I am so pleased that Mike Constantino will be your President during our 50th year. I am sure the Society will be well served by Mike's leadership, focus and caring. And, stay-tuned for his Presidential initiatives.

As my term comes to a close I am so grateful for having this year to serve as your President and for all the support I received. I am especially grateful to Tracey Martin for all her help. SAP is so well served by her contributions large and small.

Thank you all for a wonderful year, and more importantly thank you for all you do for the Society for the Advancement of Psychotherapy.

EDITORS' COLUMN

Lynett Henderson Metzger, JD, PsyD
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Welcome to the final issue of *Psychotherapy Bulletin* for 2017. This is a rich issue, and includes the final pieces in our "Difficult Dialogue" series, on powerful topics ranging from microaggressions in psychotherapy to self care and the difficulty of saying "no" to navigating politics in therapy sessions to responding to genocide; make sure and check out Dr. Daniel Jose Gaztambide's "Heroes of the Heart" piece at the beginning of this issue and online (societyforpsychotherapy.org/heroes-of-the-heart/). For more on moving from "Difficult Dialogues" to Courageous Conversations," please see Associate Editor Cara Jacobson's Column in this issue.

Other topics of interest to our readership include pieces on intern wisdom, graduate stress and cohort cohesion, tips for preparing high quality manuscripts, social justice advocacy in early career, and an article on ethical practice for members of the "millennial" generation by Maria Hochuli and Dr. Jeff Barnett.

Speaking of Dr. Barnett, please take a moment to read Dr. Jean Carter's tribute in this issue ("Thank You, Dr. Barnett"), and feel free to add your own comments to the article online (http://societyforpsychotherapy.org/thank-you-dr-barnett//). We would also like to thank all of our outgoing Domain Representatives and governance members, with a special expression of gratitude to outgoing SAP President Jeff Zimmerman for his support and service over the past year.

We anticipate 2018 holding many opportunities, changes, and challenges—and we hope you will be a part of our journey here at *Psychotherapy Bulletin*. Our submission guidelines can be found online (http://societyforpsychotherapy.org/publications/bulletin/about/), and we would love to hear from you!

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ASSOCIATE EDITOR'S COLUMN

From Difficult Dialogues to Courageous Conversations?

Cara Jacobson, PsyD
Loyola University Maryland

Over the summer, I attended the American Psychological Association Annual Convention. There, I listened with enthusiasm to a talk by Dr. David Rivera entitled *Perspectives and Strategies for Addressing Resistance in Multicultural Psychology Courses*. During this talk, Dr. Rivera made the point that perhaps in approaching interactions around multiculturalism, our field should replace the commonly used expression, "Difficult Dialogues" with the also popular term, "Courageous Conversations." This got me thinking about how our language impacts our worldview, our thoughts, our behaviors, and even our interpersonal interactions. Once Dr. Rivera made that point, I was reminded of learning about the concept of linguistic relativity, which states that the structure of language affects its speakers' cognitions. With this concept in mind, I began to wonder… if we frame a conversation as "difficult," does it feel unappealing to join? Could the term "difficult" influence people to want to avoid these conversations of such great import?

These dialogues are, and should continue to be, *difficult*. They will elicit painful emotions that are necessary during the process of self-reflection, growth, and hopefully, change. I believe that the most impactful growth moments I've had throughout my career, and frankly, my life, were interactions and conversations that pushed me far outside of my comfort zone. I recall these conversations as being difficult and as certainly requiring courage. I also credit these tough dialogues with being the cause of more growth than any "easy" conversation would be capable of eliciting. Of course it is difficult to acknowledge and honestly examine implicit or explicit biases, to make mistakes, to realize that you have hurt others, and it takes courage to own up to and to treat these experiences as learning moments.

We are at a point in history where these dialogues are crucial. They are difficult and it takes bravery and courage to initiate and to engage in these conversations. It is my hope that with a reframed focus on courageousness, more people will be willing to take the opportunities to self reflect, to talk about difficult topics, to make mistakes, to grow, and to be courageous.

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SPECIAL SECTION: DIFFICULT DIALOGUES

PUBLIC INTEREST AND SOCIAL JUSTICE

Heroes of the Heart: A Reflection on Professional and Personal Identities

Daniel Jose Gaztambide, PsyD
New York, NY

Prologue:

"When are you going to stop splitting like this?"

I almost spilled my coffee. I often wondered why shrinks talk like this—using words like "splitting" and "distortion" and "automatic thoughts" as if they were a part of everyday language. They're not. But we do it anyway, I always figured, because deep down we're all a bunch of nerds.

What's that you say? That's just me? I'm projecting? Overgeneralizing? *You prove my point*.

I pivot in my stool to face my friend Kira, "What do you mean?"

"When are you going to stop living *two lives*?" she asked, pointedly.

"When I don't feel like it'll put my career in jeopardy?" I responded coyly. *It still might*, I think to myself as I'm writing this essay. Then again, I'm probably catastrophizing.

Point taken, reader. I prove my own point.

"You need to start integrating these parts of yourself," Kira insisted, "Isn't that what we try to nurture in our work? For people to be true to themselves, and not hide who they are?"

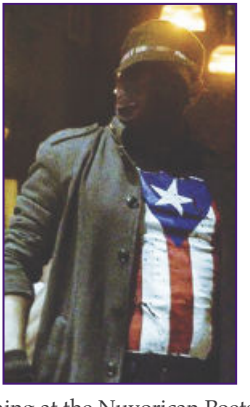
"Wearing a mask is pretty cool though." I retorted. Brilliantly, I might add (my friend disagrees).

"But do you always have to wear a mask when you perform?" she pressed further.

I used to think I did. In the beginning, at least. You see, my friend Kira, or more formally, Dr. Chakira Haddock-Lazala, is not only a clinical psychologist, but an artist and poet in New York City—much like me. It is a very generative combination of hobby and profession, one which mutually enriches both sides. The difference between Kira and I is that I took things a little… too far.

I am a clinical psychologist, professor, supervisor, and scholar.

I am also a superhero.



Performing at the Nuyorican Poets Café.

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Flashback: The Lie

I'm fond of saying that,
Poets are like superheroes,
They have an origin story,

A long, long time ago,
At a Cuban restaurant far, far away...
(Well not that far away, more like,
116th and Broadway, New York City)
A woman I'd been dating for about a month,

Asks me,
"Hey, You're Puerto Rican, right?"
I wondered, quizzically,
Was she not sure?
Did I not look, Puerto Rican?
I thought the simplest answer,
was the best, "Yes, yes I am,"

"Oh," she paused for a moment,
pensively, then responded
"Do you do slam poetry?",
I reply, "Yes, yes I do,"
"I'm a regular at the Nuyorican Poets Cafe, I spit rhymes from Boogie Down to Bushwick,
From Brooklyn to Shaolin,
I've been here and there,
And everywhere,
Known throughout,"

And then she said, "Oh, that's pretty cool,"

And then I said, "Yeah, I'm pretty cool,"

To this day I still wonder if this partner somehow read my being Puerto Rican as short-hand for "being urban," "street wise," associations which were then followed by the curious question—Do I engage in slam poetry, an art form born from the intersection of Beats and Negritude, working class jazz and multicultural blues? In New York City, at least, a practice of expression among inner city African-American and Latino communities. Was this a microaggresion? A stereotype? Or, to give a different perspective, did her attunement help her perceive some other traits and predilections that led her to intuit that I had artistic leanings? Perhaps neither. Possibly both. I don't really know.

As to her question of whether I *did* slam poetry, my answer was yes. But this, my dear reader, was a lie.

A simple, and very problematic lie.

It was the first mask

I would wear as a poet. Ironically, the mask of a poet.

I had never written a poem,
I had never performed behind a mic,
I was new to New York,
And was geographically illiterate,
I thought Boogie Down was,
A bar in Bushwick,
Not the birth place of hip hop,
In the Bronx,
I thought Staten Island,
Was as close to Manhattan,
As it is depicted in the MTA Subway Map,
(I thought what's the problem,
That's right around the corner!)

I just wanted her to like me,
And I thought,
What's the big deal?
It's just a teeny wheenie,
Big humongous lie,
What's the worst that could happen?

Little did I know that a week later she would invite me to an open mic—a gathering where artists and performers were expected to showcase their craft. And I thought,

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Oh shit,

I better come up with something quick,

So I put pen to paper,
And pulled a poem right,
Out of nothing,

You may be curious as to what the topic of that initial poem was, or the theme—But I don't really remember. I just remember sitting in the audience the night of the open mic. Anxious, afraid, unsure of just *what the hell was I doing*.

And when my name was called,
I made my way toward that mic,
holding my poem thinking,
I can't keep standing,
I need to sit down,
Cause if they see me standing,
With my piece of paper,
They gonna see me shaking and sweating,
And see that I'm nervous,
And when I get nervous,
I start to freak out,
They'll see me for the a freak and fraud
I am
Now the next three minutes are kind of a blur,
I just kind of tuned out,
And read my poem,
Not really paying attention,
To the audience,
Not really making eye contact,
I looked just above people's heads,
So other people would think I'm making eye contact with people,
But I'm not,
I finished my poem,
And I braced for what,
tomatoes, oranges, drinks,
Maduros,
Anything, really anything coming my way,
And for a hot second,
there was silence,

And then the crowd explodes in laughter, and joy, and love,
And I'm thinking
Who just walked into the building?

Realizing they were applauding for me,
I walked away from that mic,
Thinking,
Hey, I can write.

Flashforward: The Mask

This lie had transformed something in me—for good and for ill. For a couple of years, I wrote poetry and performed throughout New York City. And although the relationship that served as a catalyst for this change ended, it clearly left an imprint on my own development. All of this went on hold, however, when I moved to New Jersey to begin my doctoral studies in Clinical Psychology. Poetry, art, and performance took a backseat to clinical work, research, and academics. For a time, I put down that mask and forgot about these experiences. Until three years later.

Being "all but dissertation," I had the freedom to live wherever I wanted in completing my program, and so decided to move back to New York City (I later matched with a New York City-based internship). In returning to the Big Apple, I found myself drawn once again to the world of art, poetry, and the spoken word. As I considered performing again, new issues arose. When I performed in the past, was I not just per-

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forming for the sake of another, in order to garner their love? Did this not mean I was basically a fraud? Could I do this with any integrity? Furthermore, I was completing my training as a clinical psychologist. What would my colleagues and supervisors think? At times I also felt that being a clinical psychologist and psychotherapist also meant being part of a contemporary form of clergy—to be "neutral," chaste, and professional in all aspects of life. And then came the "big one," the fear of many a neophyte clinician—*What if I bump into my patients?* What if they were to see me performing in the community? What would this introduce into the therapeutic relationship? Would it disrupt my treatments?

One could say I had a bit of anxiety.

How did I resolve this tension for myself? What creative compromise formations did I come up with? Naturally, I wore a mask. A literal one.

I figured the best way to re-enter the world of poetry, and maintain a sense of anonymity and boundaries, was to produce some attire that would sufficiently hide my identity. It was the Winter season at the time, so I donned a scarf which I wrapped around my face, a hat that would peel just over my eyes, and a heavy coat. I thought it wouldn't be noticeable in any particular way, given the weather. However, I also needed a stage name. Something engaging and recognizable, yet also enigmatic and nondescript. Once I decided on it, the stage name itself became part of my performance.

My name….
Is Daniel
Jose G. Nuñez Arrillaga Acosta
Suarez Ceija…
Bird
But you can call me…
D. Bird

Performing for Amnesty International's "Slamnesty" Event.

I decided on this nom-de-guerre as an amalgamation of my first name, the various last names that made up my family history, traditionally as well as not often recognized Latino and Spanish (Basque, Galician) names, as well as the odd duck of the bunch—*Bird*. This last name in particular I'm told is derived from a British, possibly Irish, extraction from our predominantly Caribbean and Iberian family. This play of names, heritage, and culture tied into the themes that textured much of my artistic writing and performance. Race, belonging, identity, heritage, and the masks we wear in our search for love and acceptance became central to my artistic work, one which resonated with the predominantly Latino and African-American audiences I performed for.

However, something happened which I did not quite expect. People resonated to my performances, but also to my attire and demeanor.

"Who is that mysterious poet?"
"He suddenly arrives on the scene,
performs, and seemingly
disappears into the night."
"Who is that masked vigilante?"

Audiences were responding not just to a message, but an optics—the image of a

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masked superhero of color brandishing the Puerto Rican flag on his chest, swooping in and delivering laughs, entertainment, and food for thought. Even more striking were the reactions of young people, especially children, adolescents, and their parents. I wasn't sure what to make of this, but decided to lean into it. My art style shifted into a new mode—one in which I used the language of comic books and superheroes to talk about race, identity, and politics. It was fun. A more fundamental shift took place, however, in the act of just listening to my fellow poets and their work, a series of truths that built up to a crescendo.

> Truths that dash lies and
> demand that masks
> come off.

To be transparent about my clinical work and scholarship, I write a lot about cultural competency, race, psychotherapy, and the therapeutic alliance. In my clinical work, I focus on treating people from vulnerable communities with complex trauma histories and comorbid personality disorders, substance misuse, and self-harm, drawing on Exposure Therapy, Transference-Focused Psychotherapy, and Dialectical Behavior Therapy, depending on the needs of the case. These perspectives hovered in the back of my head, as I heard poem after poem exploring histories of child sexual abuse and neglect, drugs, sexual assault, invalidation, love, loss, and communal trauma. At times, especially when I participated in workshops and heard my peers' work out loud, it was overwhelming. Initially, I was taken off guard in the way so many themes and stories that regularly came up in my work, were also finding a home in the art scene. As a trauma therapist navigating his own self-care and burnout, it felt like drowning.

I learned to see art and poetry as windows looking into the wounds of my community. Something about it moved me, and pushed me further and further into letting go of some of my fears. I let myself get closer, and make new friendships and relationships in the community. Through these friendships I let myself be more comfortable, and over time talked openly about my profession as a clinical psychologist. This opened up new opportunities for advocacy and consciousness raising, as I began performing with friends who disclosed their own struggles with mental health, and wrote pieces and skits exploring psychotherapy, therapeutic relationships, and what it is like for people of color to seek mental health treatment. Sometimes I performed as a "persona" of different kinds of therapists—the abstinent Freudian, the empathic Rogerian, the dialectical Behaviorist (I've channeled my inner Kernberg and Linehan at times). Other times I wore the mask, and performed as D.Bird fighting against the forces of stigma and social injustice.

Mind you, I am still a clinician with firm boundaries, and a clear understanding of the role of "the frame" in developing an effective treatment. Nevertheless, the neatly divided lines between personal and professional—lies I had spent so much energy setting up—were beginning to cross.

The Truth

Illustrations by artist Rammer Martinez Sanches. Right, the spoken word artist D.Bird. Left, his secret identity as Dr. Gaztambide, delivering an academic presentation.

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"Would you be comfortable performing for the big meeting?"

I looked around the table at my expectant colleagues.

"No pressure if you're not comfortable. But it would add a different dimension to the meeting."

This was essentially my nightmare scenario—performing poetry in front of other psychologists, leaders, and members of APA governance at a professional meeting. I think I had an anxiety dream related to this at some point. Except this was real, and mere minutes away. A couple of years of self-initiated exposure therapy had brought me to this point.

"Sure," I swallowed my anxiety, "I'd love to."

I performed a poetry piece in front of my colleagues, to make sure they could vet it and give feedback on anything I should adjust for the larger meeting. And afterward it was fine. No cataclysmic catastrophe fell upon me. No one lashed out in a rebuke. All I could hear was just the sound of two worlds colliding.

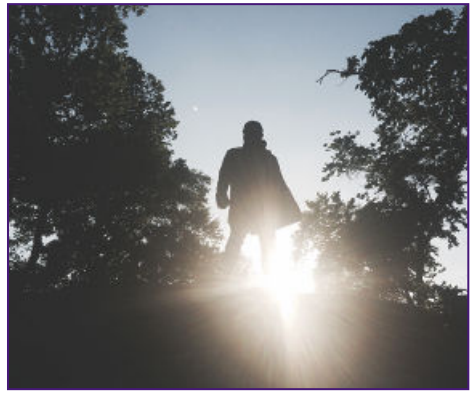
I continue to be a clinical psychologist, professor, supervisor, and scholar.

I also just happen to be a superhero.

Not quite integrated, but always in some state of tension, always informing and enriching one another. I continue to write and perform poetry, raise awareness, and when needed, help connect people in the community to services.

But is the hero
The one that
wears the mask?
Or
The one that
takes them off?

Whether it is through our
clinical work and research,
our advocacy and activism,
We psychologists and
psychotherapists,
Are heroes of the heart.



Editors' Note: Please visit society-forpsychotherapy.org/heroes-of-the-heart/ to experience the piece in its original format and hear Dr. Gaztambide read his words.

SPECIAL SECTION: DIFFICULT DIALOGUES

DIVERSITY

Microaggressions in Psychotherapy

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Microaggressions have been linked to reductions in psychological and physical health (Sue, 2010). The term racial microaggression is a term first utilized by Pierce (1970) to describe the subtle, jarring, typically automatic or unconscious, verbal and nonverbal exchanges; often perceived as understated, insulting "put downs" directed at people of color. Sue et al. (2007) did extend this definition and determine the various types of microaggressions. The American Psychological Association (2003) stresses the importance of being aware of oneself as a racial and cultural being, as well as being aware of the cultural worldviews of one's clients. Unfortunately, reinforcing stereotypes that endorsed or influence microaggressions tend to evade these recommendations (Sue et al., 2007). The extant literature explains that when microaggressions occur, it can be difficult for the individual perpetrating the microaggression to hear, understand, and empathize with the person they have offended (Sue et al., 2007). The consequences befalling the victim of the microaggression is then twofold (Sue, 2010). First, the victim is struck by the initial insult caused by the microaggression, then by invalidation accompanying the denial of the insult by the perpetrator (Sue et al., 2007). Frequently, the perpetrator behaves in a manner that reverses roles, leaving them as the perceived blameless victim in the situation when this is not the case at all (Sue et al., 2007).

The perpetrator mistakes the lack of purposeful ill intention for innocence in the situation, regardless of the reality and damage caused by the actual transgression committed (Sue, 2010; Sue et al., 2007). Lack of intentionality to do harm when committing microaggressions does not remove culpability, nor does it erase the real harm that has been done to the actual victim (Sue, 2010; Sue & Sue, 2003). This is a confusing scenario for the victim of microaggressions to traverse under any circumstance, but when it occurs within the therapeutic relationship, there can be lasting harmful effects (Sue, 2010; Sue & Sue, 2003). This damage can be seen when the psychotherapist commits the microaggression or when the client commits the microaggression, due to the deeply interpersonal nature of the insult (Sue & Sue, 2003). Additionally, microaggressions may lead to lasting effects on other aspects of life that should not be minimized (Sue & Sue, 2003). This article will briefly review the literature related to the effects of microaggressions within

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the context of psychotherapy. Furthermore, this article will briefly discuss effects of microaggressions on the client when the psychotherapist is the perpetrator of these insensitivities, as well as challenges to the psychotherapist when the client perpetrates microaggressions.

Microaggressions have been explained as subtle, everyday exchanges and insults—often automatic or unconscious—that send degrading messages to a target on a behavioral, environmental, verbal, or institutional level (Sue, 2010; Sue et al. 2007). This means the individual committing the microaggression is often unaware of the offense and often becomes defensive, even hostile verbally or behaviorally, when informed of the slight (Sue, 2010; Sue et al. 2007). Despite clear evidence to the contrary in the literature (see, e.g., Bonilla-Silva, 2003), there is frequently denial due to a total lack of belief that entire harmful construct of covert racism even exists. This constant invalidation leaves some victims of microaggressions questioning the validity of their own experiences, confused, hurt, angered, and further marginalized (Sue, 2010; Sue et al. 2007; Sue & Sue, 2003). This may even lead some to seek the support and assistance of psychotherapy. Unfortunately, even psychotherapists have inherent biases, and these are not always kept secret from the client. They arise through microaggressions, even in the therapeutic setting, with similar denial patterns replaying, potentially leaving the client feeling paranoid or betrayed by the therapeutic process (Sue, 2010; Sue et al., 2007).

Microaggressions Directed at the Client

A client or patient is a necessary component of psychotherapy, yet the client's contribution to the therapeutic process is underestimated as essential for change to occur (Bohart & Tallman, 2010). It is typical for psychotherapists to embody the role of expert within the context of psychotherapy (Sue & Sue, 2003). It is when this expertise is applied to the client's experience and perception of oppression that this expertise removes autonomy from clients of minority group membership who are better experts at recognizing oppression than the psychotherapist (Sue & Sue, 2003). More importantly, the failure to consider the client's perspective can further heighten the level of distress, distrust, and frustration associated with minority status, which causes the client to feel misunderstood (Sue & Sue, 2003). Clients may feel as though their experiences have been invalidated by the psychotherapist, again fostering a sense of marginalization (Sue & Sue, 2003).

The Myth of Meritocracy is the belief that a society is based on equal opportunities and access to social mobility (McNamee & Miller, 2009). Endorsement of this myth will typically involve difficulty identifying an unjust or unfair system (McNamee & Miller, 2009). Clinicians who endorse this belief may find it difficult to self-identify microaggressions. Because of the power differential placed on the client by the implied structure of psychotherapy, microaggressions can jeopardize and potentially destroy the therapeutic relationship (Sue & Sue, 2003). Although the psychotherapist must establish credibility with the client, credibility is undermined when microaggressions are committed (Sue et al, 2007; Sue & Sue, 2003). It is not reasonable to assume that the client is responsible for policing the perpetration of microaggressions committed by the psychotherapist in psychotherapy. Given that the psychotherapist is in an elevated power role, the client may not feel comfortable addressing the situation. Aside from the power differential, hostility is the typical reaction clients receive when

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they identify microaggressions in the psychotherapy (Sue et al., 2007).

Psychotherapy is generally thought of as a safe and nonjudgmental place for the client to address a given therapeutic concern. Yet microaggressions communicate that the client is unwelcome and will receive inappropriate treatment, thus leading to an underutilization of services (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006; Zane, Hall, Sue, Young, & Nunez, 2004) and premature termination (Sue, 2010). Prejudicial attitudes have a negative impact on therapeutic outcomes (Beutler et al., 2006; Brondolo, Ng, Pierre, & Lane, 2016; Poussaint, 2002), even when the expressed attitude is implicit or unintentionally expressed. This is likely due to significant ruptures in the therapeutic alliance. Failure to attend to microaggressions in psychotherapy reveals a lack of awareness, introspection, and empathy on the part of the perpetrator. A study by Bohart, Elliot, Greenberg, and Watson (2002) found that when clients feel empathy within the therapeutic environment as a whole, significant positive change outcome is more likely ($d = 0.68$). Likewise, when there is a lack of empathy or perceived bigotry is present, the relationship's level of trust and therapeutic outcomes plummet (Brondolo et al., 2016). Instead of responding with denial, anger, and ridicule, psychotherapists should simply listen to the client's reality so that growth, learning, and acknowledgment of experience may occur.

Within professional and interpersonal contexts, the psychotherapeutic relationship may be the only place clients find the safety to challenge microaggressions and normalize their life experiences. As professionals, psychotherapists have the responsibility to be multiculturally competent (APA, 2003; Sue, Zane, Nagayama-Hall, & Berger, 2009b). Competency involves the ability to self-assess and reflect on how one's own view of the world, attitudes, beliefs, and behaviors can differ and affect clinical work involving culturally diverse individuals (Comas-Díaz, 2012). Some recommendations to improve clinician's competency related to microaggressions and psychotherapy include: avoiding immediate offense when confronted with the notion that a microaggression has been committed (Sue et al., 2007; Sue & Sue, 2003); acknowledgment and awareness of self-biases; avoiding assumptions; being open to other worldviews; considering every encounter as multicultural; increasing contact with culturally diverse individuals; empowering the individual clients, and having conversations about difficult topics, beginning in graduate programs (Comas-Díaz, 2012; Sue, Lin, Torino, Capodilupo, & Rivera, 2009a; Sue & Sue, 2003).

Microaggressions Against the Psychotherapist

Professionalism and empathy are critical skills for psychotherapists to embody. In general, psychotherapists are expected to behave in an ethical manner. While this is always the goal, there are times in which self-compassion must be considered for the sake of the therapeutic relationship as well as for the wellbeing of the psychotherapist. Literature focusing on cross-racial psychotherapy dyads often emphasized the therapeutic relationship between a psychotherapist who is a member of a majority population conducting psychotherapy with a client who is a member of a minority group (Turner, 2012). Hence, studies of dyads with psychotherapists who are members of a minority group conducting psychotherapy with clients who are members of majority groups are minimal to nonexistent. Even multicultural courses are structured to educate psychotherapists who identify primarily as members

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of the majority group—as if the courses are preparing the majority group member for what they may encounter when entering the therapeutic workforce. Assisting trainees who are members of majority groups to begin to have some perspective on the reality of the marginalized client is necessary and important; however, mental health professionals who have marginalized identities are not provided with many resources to help them navigate confronting microaggressions by their own clients.

There is limited literature that is available examining the dynamic of an opposite interaction (minority psychotherapist with majority identity client; Turner, 2012). The lack of literature may implicitly reiterate the complexities and discomfort that may be involved with having a difficult dialogue about race (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Sue et al., 2009a). Literature has shown that African-American psychologists experience microaggressions outside of psychotherapy and within professional settings, which further adds to their level of stress (Clark, Anderson, Clark, & Williams 1999; DeLapp & Williams, 2015). Therefore, racial minority psychotherapists may find it difficult to provide services to a client who continues to commit microaggressions, as a result of the relentless nature of the exposure to microaggressions, both within the psychotherapy room and without. Clients may not be aware that their behavior is causing tension to arise in the session. Psychotherapists are products of their surroundings and family belief system, just as all humans are. However, clients may not have been introduced to differing beliefs, which makes it difficult to understand the minority culture perspective; this lack of understanding may manifest as microaggressions (Sue et al, 2007; Sue, 2010; Sue & Sue, 2003). In these situations, it may be beneficial for the psychotherapist to provide some psychoeducation to help clients better understand the consequences of their actions.

Given that majority culture, clients may not be exposed to the minority culture, clients from the majority culture may possess a fear of being misunderstood. Thus, clients may be tempted to question the psychotherapist's credentials or ask questions related to stereotypes (Turner, 2012). Although these questions may arise from lack of familiarity with others, it can be perceived by the psychotherapist as a microaggression (Sue et al., 2007). Several factors may impact the psychotherapist's perception of the client's intent, including the location of the clinical setting. In our personal experience, each region of the United States has its own set of cultural norms that govern the behavior of most individuals. For instance, the Southern culture has an extensive history of segregation and viewing non-White individuals as inferior (Hale, 1999). Although segregation has legally ended, there are lingering effects (Hale, 1999). In a qualitative study conducted by Knox and colleagues (2003), a Black male participant confirmed this perspective and described the South as a "hostile environment" (p. 471). Thus, microaggressions may evoke a more emotional response from the victim depending on that region's cultural history. This regional effect is present in psychotherapist's experiences as well. Regional factors may influence the rate, and intensity to which microaggressions occur and or impact the psychotherapist, especially if the environment is perceived as "hostile."

Implications for Psychotherapists

Confronting a client's microaggressions may be a difficult process to navigate. Many clinicians may worry about being perceived in a negative manner or even

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confirming a stereotype about their racial or ethnic membership groups (Knox et al., 2003). For some psychotherapists, this can be an anxiety provoking situation. Finding the correct words to portray how the microaggressions impact the psychotherapist is a particularly daunting task. Thus, many psychotherapists choose not to address the microaggression in fear, aware that the client may demonstrate some defensiveness in the therapeutic relationship (Knox et al., 2003). Developing and implementing training which incorporates skills to specifically address microaggressions may be helpful. Microaggressions typically begin below the conscious level. Motivational interviewing can provide valuable therapeutic techniques by which the client is able to recognize the behavior, as well as move toward dialog with less defensiveness (Hall, 2006).

The implications for experiencing microaggressions can be detrimental, which requires constant self-reflection by the psychotherapist. The literature encourages psychotherapists to establish networks that could provide support during times of difficulty (Constantine, Smith, Redington, & Owens, 2008). Additionally, it may be necessary to establish boundaries within the clinical setting to allow for safe processing of microaggressions and decompression (Kelly & Greene, 2010). The client's well-being is an important component, but it can be problematic when their behavior is impeding the process of psychotherapy. The goal remains competent, ethical practice in which the client and the psychotherapist are respected and feel safe.

It should also be noted that microaggressions may occur during any phase of a mental health professional's career. While professionals with more established professional networks may have trusted individuals with whom they comfortably consult and process such incidents, student trainees and early career professionals may not have access to such resources. When student supervisees experience microaggressions and present these experiences within the context of supervision, supervisors sometimes communicate invalidation and lack of empathy toward the supervisee's experience, rather than support and knowledgeable guidance. These invalidations by the supervisor can result in the perpetration of further microaggressions against the trainee, potentially causing damage the supervisory relationships and trainee efficacy. The same awareness, knowledge, and skill required for multiculturally competent psychotherapists (Sue, Arredondo, & McDavis, 1992), should be present within supervisory relationships. Remaining aware of personal bias, beliefs, and attitudes, as well as associated behaviors helps to promote competence (Sue et al., 2009b), as well as guide improved reactions to trainee's experiences with microaggressions. The compounding effects of microaggressions take a toll on the mental health professional, self-compassion is an especially pertinent to employ as the effects can sometimes be confusing (Sue, 2010). Due to the widespread occurrence of microaggressions, psychotherapists at every stage of development should consider addressing microaggressions within the context of their own personal psychotherapeutic relationships as a form of self-care and competence maintenance.

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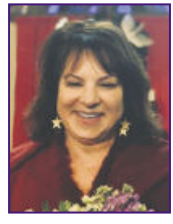
PSYCHOTHERAPY PRACTICE

Navigating the Minefield of Politics in the Therapy Session



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If, indeed, the personal is political and the political is personal, where does that leave psychotherapists—whose profession is intensely personal—when clients voice strong political views counter to ours or when their political stress resonates with our own sense of a rending of the civic and cultural fabric of the country? In the aftermath of one of the most contentious presidential elections in recent U.S. history, many of us have noted a marked increase in our clients' expressions of anger, anxiety, and depression. At the same time, we have been challenged by managing our reactions to the election results and subsequent heightened societal tensions.

In the weeks surrounding the November 2016 election, many clients came to therapy fearful and angry about what the future would bring (Panning, 2017; Stosny, 2017), whereas others came in with joy, vindication, and excitement about a new direction for the country. According to a March 2017 survey ("New Study Shows," 2017) more than half of Americans (59%) were anxious because of the November 2016 election results. Half (50%) of Americans were looking for ways to cope with the negative environment and more than a quarter (26%) were engaging in negative behavior such as drinking or smoking more often, eating unhealthily, or arguing with loved ones more frequently as a result of their election-induced anxiety. The months of acrimony since the inauguration have precluded a return to political or cultural normalcy. Instead, our citizenry has grown more polarized, with greater public visibility of extremist views (e.g., Charlottesville), a marked increase in civic activism and protest (e.g., the Women's March), and a general sense of unease, anxiety, and fear. A *Washington Post*-University of Maryland poll conducted nine months into the new administration found that 7 in 10 Americans believe the current political divisions in the country are as least as severe as those during the Vietnam War and that the current climate

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likely represents a "new normal" rather than a temporary state (Wagner & Clement, 2017).

Psychological distress arising from the current sociopolitical tumult is being brought into the therapy session, and the factors informing this fraught clinical material are as diverse and nuanced as our clients. In keeping with the theme of difficult dialogues, we focus here on four of those factors: cultural competence as it relates to client and psychotherapist political identity, how political differences and similarities may affect the therapy relationship, managing countertransference related to political views, and ethical concerns. In this unprecedented time, we have as many questions as we do observations and insights. Our goal in writing this article is to contribute to the growing pool of resources and to stimulate further discussion.

Political Cultural Competence

Political analysts have noted that party or candidate affiliation has become a primary component of identity for many Americans, a phenomenon that psychotherapists may be unsure of how to address in session. The sense many individuals have of not being represented, not mattering, or not being heard by the governing class was reflected in J. D. Vance's stark memoir, *Hillbilly Elegy* (2016), and the public response to it. The sense of being politically overlooked is believed to have formed the core of a backlash against perceived "identity politics" in the 2016 election. Psychotherapist multicultural training has rightfully focused on ethnicity, age, gender identity, sexual orientation, nationality, ability, socioeconomic status, and religion as essential components of client and therapist identity. But few training programs address political affiliation as a component of culture or identity or how it may inform treatment or affect the therapy relationship. When clients bring differing political views into the therapy room, it can cause us unease, a sense of not knowing the way forward. Yet, as psychotherapists, we can and must enter the world of the other openly, curiously, and compassionately. Indeed, this is what multicultural understanding and competence rest upon. We have found that working with clients with political identities different from our own has engendered a deeper understanding of our clients' issues as well as the factors that drove the 2016 election results. It requires us to bracket our views and our privilege and dive beneath political opinions contrary to our own to find the human being and the experiences at the source of these opinions. Working with difference helps us to grow in understanding and compassion. Outside of therapy, it is incumbent upon us to step outside our own political, cultural, and professional "bubbles" to gain awareness and knowledge of the cultural and political influences (e.g., news and social media) underpinning our clients' intersecting identities and concerns.

Impact of Politics on the Therapy Relationship

Although many clients have readily brought into session their concerns about the current political climate, others may be unsure of the appropriateness of discussing such concerns or whether it is safe to do so. If anxiety about the country's political state is a client's primary presenting issue, we must cultivate a sense of relational safety. Some psychotherapists suggest opening up the topic for discussion from the outset of treatment, either via optional intake questions or an open letter placed in the waiting area stating the psychotherapist's openness to concerns from anywhere on the political spectrum (Doherty, 2017).

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Given an offer of openness, clients may expect reciprocity, which compels psychotherapists to consider how much of their own views they should make known. If a client tacitly or overtly asks for your political views, when is it appropriate to disclose them? General caveats are that self-disclosures should be clinically relevant and that the psychotherapist should not disclose about unresolved issues. If clients ask about our political views we should, as with any disclosure, consider their reasons for doing so, which presents an opportunity to process the therapy relationship. We may ask why it is important for the client to know and then carefully consider the response. Will it help the client to feel safer, closer, or more supported? Or, is it an attempt to enmesh with us or induce collusion on other issues? What was the status of the therapy relationship prior to the question and what are our own reasons for disclosing or not? Feeling our own unmanaged distress about the political climate may speak to not disclosing. On the other hand, is it fair to our clients not to disclose our beliefs and biases so that the client is informed about our values?

Even if a client does not ask about our views, the books on our shelves or artwork on our office walls can reveal our values without us speaking a word. Within the current climate of general cultural divisiveness and mistrust, political self-disclosures—whether overt or unwitting—can potentially lead to ruptures. How, then, to address such ruptures? Are the methods for repair different when divergent political views are at the root of the sundering? Psychotherapists who in other situations might turn to immediacy to facilitate repair may feel there is risk of further damage with a politically induced rupture. If the client views the psychotherapist as an intractable other—as another source of political, public, and personal stress—how can the relationship be restored? If the therapy relationship is well established and the client has felt safe in the past, despite the discovery of "otherness," we can use the differences to foster growth both in our clients and ourselves. A qualitative study (Williams & Levitt, 2007) on personal values in therapy indicated the majority of a sample of eminent psychotherapists viewed psychotherapy as inevitably values laden, that they attempted to remain aware of values in the therapy room, that they generally deferred to clients' values, and that they encouraged clients to evaluate their values. By maintaining our empathic stance and providing space for clients to feel they are heard and their values understood, we can provide an opportunity to ease their anxieties and model a way for them to humanize the political "others" in their daily lives.

Managing Politically Based Countertransference

Although society has been growing increasingly polarized over the past two decades, the 2016 election was a tipping point for many. Until that point, unresolved anxiety about election results was not an obvious source of countertransference for most psychotherapists. We as psychotherapists are as subject to the political climate as any member of society. In managing any countertransference, gaining awareness is the first step, specifically by recognizing our political hot button topics and the triggers for them. Are there particular topics that rile? Does denial of global warming or scientific methods in general set you off? Or are questions about voter fraud likely to be a focus of unresolved material? Whatever the issue, awareness that it *is* a trigger is important, as is understanding the underlying source of the coun-

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tertransference. Many of us have family members or friends across the political divide with whom we have broken or grown more distant over issues similar to those presented by clients. Understanding these complications helps us to manage behaviors in session and enables us to be more open to our clients' beliefs. Consulting with colleagues or bringing the issue to peer supervision is obviously a useful resource. In addition, just as we have recommended that clients minimize their exposure to social media and newscasts, we may consider spending less time plugged into the negativity and divisiveness currently saturating all media.

Ethical Dilemmas

Perhaps the most perplexing aspects of the election fallout are ethical. Our role as psychotherapists is to help clients explore their values and beliefs and to use these values to help clients solve their problems. Yet the current climate and our clients' responses to it present us with some ethical dilemmas. What do you do when a client states as fact something heard on talk radio or seen on social media that is verifiably false? What is our role in educating clients about politically related facts? Is this a question of identity or culture or is it evidence of the need for reality testing? If the client came in and stated something as true about something nonpolitical that you knew was untrue (e.g., the earth is flat; it is impossible for people to change), would your response be different?

As mental health professionals, we are charged with following a code of ethics. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA Code of Ethics; 2017) states that psychologists must exercise reasonable judgment and take precautions to ensure that their potential biases do not lead to misuse of their influence. We must try not to impose our political views on clients and we must respect their right of self-determination. Yet, psychologists are also charged in Principle E of the Code of Ethics to "not knowingly participate in or condone activities of others based upon such prejudices" as age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2017). Similarly, regarding personal values, Standard A.4.b of the 2014 Code of Ethics for the American Counseling Association (ACA) states,

> Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

Thus, while we may not impose our own views, we must not condone others' prejudicial activities. The dilemma arises when a client presents a bigoted view that is integral to the client's political identity. There is an opportunity to explore the basis for such beliefs and to provide data from the client's own experiences to counter these views, thus ideally enabling us to adhere to both seemingly conflicting principles. But we do not practice in an ideal world; we may be faced with the dilemma of a client's intransigent bigotry or misogyny. If political views in session become irreconcilable, is it ethical to refer a client to another psychotherapist? Would it be unethical not to refer the client on? Only the individual psychotherapist can judge (or someone with whom you consult)

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whether these differences are enough to qualify as interfering with therapy.

Looking Forward

Our nation, our clients, and we ourselves have experienced profound changes in the past year that have propelled us into uncharted territory. Many of us have struggled to find a way forward not only clinically, but in our larger societal role as mental health professionals. Since the election, thousands of psychologists, psychiatrists, psychotherapists, and counselors have spoken out to question the president's fitness for office and to express concern about the toll the political climate is taking on the mental health of our citizens (Karlamangla, 2017; Lee, 2017). New resources and associations have developed to provide support around these issues. For example, Dr. William Doherty has founded an online association of psychotherapists with the mission to spread ways to practice therapy that address clients' public stress, help individuals within their communities to maintain their values and emotional balance, and to engage publicly to resist antidemocratic ideologies and practices (https://citizenpsychotherapists.com). We can address the politically informed clinical needs of our clients by relying on such resources, as well as on our training and values, and by remaining open to change in ourselves. As the political turmoil continues, there will be further challenges in negotiating our professional roles and responsibilities in the public sphere and in navigating how these may integrate with clinical work. Looking to the future, if this is in fact our new normal, what is our responsibility with regard to political issues and speaking about them both to clients and in a public forum? As we engage in these difficult dialogues with our clients, it is also important to expand the dialogues among ourselves, in our training programs, and in our associations about best practices in this new era.

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CLINICAL NOTES WITH DR. J

The Genealogy of My Guilt Towards Self-Care and Saying "No"

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At times, I can be really bad at asking for help. This trait, for better or worse, is most likely a byproduct of a variety of factors in my life, most notably playing sports, my history of asthma, and my identity as a young Black professional. As athletes, we are conditioned from an early age to persevere and ignore thoughts of quitting or "taking a break" in order to be successful in our sport. Sport psychologists often highlight this athletic resilience as a tremendous quality for athletes to possess in order to progress in their sport and not get overly discouraged by injury or errors (Solomon, 2017). This athletic resilience has served me well by assisting me in accomplishing great goals throughout my life, including playing collegiate lacrosse and running the Boston Marathon in 2014, though this type of resilience has also caused challenges in my life. Sometimes for me, as I am sure with other athletes, this resilience crept into the realm of "athletic bullheadedness," which caused me to over-train and accidentally expose myself to either injury or emotional distress. The pull to be successful in my given athletic activities is a significant motivator for my perseverance when playing sports and this is something that can sometimes get overwhelming when I am dead set on accomplishing particular athletic tasks as the cost of injury or overtraining are high. Overtraining can have a huge impact on not only one's physical health, but also on emotional wellbeing, causing lethargy and a lack of pleasure in activities similar to symptoms found in clinical depression (Kreher & Schwartz, 2012). As I have aged, I have grown in my ability to distinguish between resilience and bullheadedness, but I still struggle at times with this difference when I am heavily invested in an athletic activity or goal. To address this concern, I rely heavily upon peers, trainers, and other athletes to assist me with maintaining proper perspective on my progress and both my physical and mental health. Over time, I have grown to trust their perspectives to make necessary changes, which has assisted me with fine tuning my own perspective of self so that I am now more competent with making more of those decisions independently. In addition to battling on the field with competitors, I had another opponent in my life, one that would challenge me every day: asthma.

Dangers of "Not Rocking the Boat"

Like many children with asthma, my life was an often-chaotic mixture of inhalers, "breathing machines," and

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countless asthma attacks that would trigger trips to the hospital at all hours of the day and evening. I remember learning about the diagnosis from my pediatrician and being constantly reminded of my limits throughout my childhood. Having asthma makes the individual feel perpetually out of control, given the fear of the next upcoming asthma attack and the incomparable discomfort of being able to inhale but not being able to exhale, which is what people experience during an asthma attack (Van Lieshout & MacQueen, 2008). As expected, these experiences are often scarier and more emotionally stressful for children when compared to adults, as children have fewer coping mechanisms to deal with these situations. I too was greatly impacted by my asthma diagnosis and the symptoms of asthma that I experienced as a child and continue to experience as an adult. The depression and lowered self-esteem explored in the research by Van Lieshout & MacQueen (2008) certainly was familiar to me, as I would remember thoughts and feelings that supported a sense of inferiority to my peers and shame over having a "broken body." Even in the midst of an impending attack, I would frequently neglect telling my parents or teachers out of fear of missing out on an activity or being seen as "too needy." Children like myself may also feel uncomfortable alerting adults and caretakers about an impending asthma attack due to the stress that the incident causes for everyone. The child may instead avoid triggering the expected chaos initiated by signaling for help and attempt to deal with the symptoms, whether significant (or even in fact dangerous), alone. Unbeknownst to me, this was a common experience for many with asthma as many children experienced the mixture of anxiety about impending asthma attacks mixed with occasional defiance towards taking medication and having to miss out on celebrated childhood activities such as recess, gym, and so forth (Pemment, 2014). Additionally, I foolishly believed either I could manage the attack or it would fade before becoming serious, and this flawed logic exposed me to ferocious and dangerous asthma attacks. Either through my own ignorance or misinformation, I admittedly never knew or internalized that people could actually die from an asthma attack until I was in college and a friend lost a loved one to an unmanageable asthma attack. This part of my identity cultivated a sense of not wanting to disrupt things or "rock the boat," which has been a part of my personality ever since. This trait, mixed with the bullheadedness from sports, created a unique response to stress that requires me to be acutely aware of my circumstances and myself when stressful events occur.

When the Word "No" Is a Difficult Dialogue

Lastly, my identity as a young Black professional also contributes to my distinctive reaction to stress and the need for self-care. As I have previously discussed in other articles and venues, John Henryism and tokenism play major roles as influences in my life and experience of self. John Henryism, or the tendency for minorities to demonstrate almost back-breaking perseverance and positivity in order to "overcome" racism and find joy and status within society, is something that many Black males experience and something that has a significant impact on our mood. For many who are impacted by this mindset, giving into rest is considered surrendering to prejudicial stereotypes that label Black people lazy and incapable of having talent. This creates a situation where the person will avoid internal and external cues to engage in self-care and thus expose them-

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selves to more opportunities for negative affect and physical consequences (Angner, Hullett, & Allison, 2011). When I believe that I am in a state where John Henryism is corrupting my health and interfering with my workflow, I rely on perspective taking and being increasingly careful about analyzing irrational thoughts. Similarly, feelings of tokenism, where someone feels alone due to being the lone member of a community in an otherwise homogenous group, can promote Imposter Syndrome, or the feeling that one's position at work or in the community was awarded, not because of the one's talents, but because of one's ethnic status and the need to fill a quota. There are times when these two societal stressors have a significant impact in my professional life. Although this impact has decreased in frequency and severity as I have been able to establish myself professionally at the hospital and experience more of the open minded humanity of my colleagues and coworkers, I still will on occasion get surprised by the return of these feelings at especially critical junctures, such as performance reviews or significant presentations. These stressors can make it difficult to ask for help from others because asking for help is perceived as a sign of weakness and incompetency when Imposter Syndrome and John Henryism are influencing your mind and self-care habits (Weir, 2013).

When preparing to write an article for the last edition of the *Psychotherapy Bulletin*, I was in a similar place of need. Events in my family had caused much stress and that stress was causing writers' block the likes of which I had never experienced before. I would spend hours at the computer blankly staring at the screen waiting for words to pour out as they usually did, but nothing would happen and the computer screen would stare back at me, the blinking icon in Microsoft Word awaiting my keystrokes. During this period of time, I felt pressure from myself to continue producing articles for the Bulletin and a fear of letting my colleagues down who gave me the awesome opportunity to write for this periodical nearly two years ago. The fear of disappointing these colleagues was tangible and it put more pressure upon me to produce a great article in the midst of my mind being a barren landscape where normally accessible mental, emotional, and intellectual resources had been sent to help cope with this family stressor and maintain my professional clinical obligations to my clients. But what was I to do? I could not disappoint my colleagues but I also could not produce an article out of thin air. Reflecting back on this experience a few months ago, I can now see how my various identities and experiences combined to create a sense of guilt for needing to say "no" and engage in the self-care of taking time off to be with my family. The bullheadedness that I developed as an athlete combined with how asthma contributed to a learned fear of being in a position of need further eroded my confidence to make me more susceptible to an episode of Imposter Syndrome and John Henryism. Contrary to conventional wisdom, I ended up allowing myself to struggle more than I needed to and I delayed enacting a self-care plan in regards to the article, which only served to cause further stress.

This experience allowed me to learn much about my apparent guilt of saying "no" and how I must be aware of how this tendency can continue to show up in my life. When I was able to finally convince myself to take a break, I felt an initial rush of guilt and then a flood of relief when I realized that I was now able to manage my stress at a reasonable

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and appropriate cadence. This situation provided me with the chance to take this stressor and convert it into a learning opportunity. To deal with the initial discomfort and guilt of saying "no," I sought out articles on self-care and I spent time speaking to mentors and peers about stress management. This proactive reaction to this hectic incident not only proved to be beneficial due to the great information gained, but it also positively reinforced my own confidence in my abilities to be compassionate towards myself during times of need. This recalibration continues to today where I have revised my schedule in order to provide more time for consistent and meaningful self-care to maintain a more consistent level of balance as opposed to only primarily engaging in significant self-care when in times of stress.

This was a difficult article to write because speaking about your own self-care and how you needed help is not an easy topic for Type A people like myself (and you, too) to discuss publicly. Besides using this article as a method of further healing by speaking about my own experiences with stress and frustration, my additional hope is that this article can encourage us all to continue to have open and honest conversations about our own self-soothing and self-care. So, do not fear saying "no" if you really need to, no is often seen as a negative word in today's society but it can also be one of the most compassionate words you can use towards yourself as it protects you from allowing physically and emotionally dangerous things into your life.

Editor's Note: I want to again express my appreciation for all the contributions Dr. Jenkins has made to the Bulletin down through the years, and especially for this piece. It also feels important to acknowledge how much people with racial privilege, including myself, benefit from contributing to a culture in which it is difficult for a person of color to say "no." Power disparities can lead to people of color and those with less privilege bearing a disproportionate load of the essential (but often unacknowledged) work within academia, scholarship, and other fields. *Psychotherapy Bulletin* and I welcome discussion of these imbalances—when we are part of the problem, we must be part of the solution.

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INTERNATIONAL SCENE

Meaningfulworld's Response to Suffering in Armenia: Offering Healing and Continuing the Difficult Conversation of the Ottoman Turkish Genocide of Armenians

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The landscape of the world is becoming increasingly connected and globalized. It is difficult to exist, even in the United States (U.S.), without hearing about the events happening across the globe: hurricane in Puerto Rico, earthquake in Haiti, war in Syria, mudslides in Sierra Leone, to name a few. Many of us living and practicing in the U.S. are also immigrants ourselves, with connections, emotional or practical, to our countries of origin. Many of us have and hear stories of fleeing, escaping trauma, and survival. We also have a deep desire to contribute to the well-being of those who remain in disaster areas and dire circumstances. The purpose of this article is to share the work of one such mental health humanitarian relief organization, the Association for Trauma Outreach & Prevention (ATOP), Meaningfulworld. This organization was founded by Dr. Ani Kalayjian and provides an example of humanitarian action applied to a community affected by trauma. Established in 1990 and affiliated with the United Nations (UN) Department of Public Information, Meaningfulworld has been committed to the service of humanity, fostering healing, instilling peace and justice, and transforming generational pain and suffering. Meaningfulworld's Humanitarian Outreach Programs have worked in over 46 countries around the globe in seven regions: Africa, Asia, North and South Americas, Caribbean, Europe, The Middle East, and the Caucuses, transforming the lives of over a million people. This article will focus on the work in Armenia, a country that has suffered from both a sizeable natural disaster and continuous human-made conflict with neighboring countries.

Relevant Background

Armenia is a small landlocked country in the Southern Caucasus region of Eurasia that has withstood several devastations (e.g., Ottoman Turkish Genocide of Armenians, 1988 earthquake, independence from the Soviet Union in 1991, and border ongoing conflict with Azerbaijan) and is currently experiencing aftermaths from the wars in nearby Syria and Iraq that continue to negatively impact to its residents. Exposure to traumatic events is well documented to negatively impact one's psychologi-

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cal wellbeing (Kendall-Tackett, 2009; Perry, 2008; Wu, Schairer, Dellor, & Grella, 2010). Some level of post-traumatic stress is common following a traumatic event, with individuals presenting with disruptions in sense-making systems, loss of faith, and feelings of anger (Carver, 1999; Frankl, 1962; Park & Ali, 2006). These can develop into syndromes such as depression, anxiety, acute stress disorder, horizontal violence, and post-traumatic stress disorder (Deschenie, 2006; Kalayjian & Eugene, 2010a,b; Kessler, Sonnega, Bromet, & Hughes, 1995).

During the last decade, the conflict between Armenia and Azerbaijan over the Artsakh territory has led to more than 20,000 casualties, large numbers of refugees moving away from both Armenia and Azerbaijan, and expulsions of ethnic Armenians and Azeris from both sides (Geneva Academy of International Humanitarian Law and Human Rights, 2012). Starting in 2001, Armenia saw an increase in Iraqi refugees and then after 2010, Syrian refugees, as affected people began to relocate to Armenia as a result of the U.S. invasion of Iraq and civil war Syria. The settling of refugees in this contested territory is likely to lead to future political clashes, as well as increases in horizontal violence from one community to a neighboring one. Since the collapse of the Soviet Union, the economic status of Armenia has been unstable, with many groups of native as well as refugee communities competing for limited resources. Often when a country experiences an economic crisis, the population's psychological wellbeing decreases as people face feelings of anger, desperation, uncertainty, anxiety, depression, and suicidal ideation (Hong, Knapp, & McGuire, 2013; Lee et al., 2010).

Additionally, although the Armenian Constitution states that men and women are equal and Armenia has historically treated women as equals (for example, granting women voting rights long before women were granted such rights in the U.S.) mechanisms to ensure equality in the daily life of Armenian society are now nonexistent. Women face domestic violence and poverty, and are often solely responsible for children and elderly parents. They are typically employed in all professions, while their average monthly wages represent only 64% of men's, giving Armenia one of the largest gender pay gaps in all of Eastern Europe and Central Asia (Barsoumian, 2016).

Central to healing from trauma is the ability to find meaning in the traumatic event and cultivate a sense of meaning and purpose in one's life (Frankl, 1962; Kalayjian & Eugene, 2010a,b). Meaning-making can be defined as the forming of mental representations for the relationships between things and events and what connects representations to each other (Baumeister, 1991). Meaning-making has been linked to better adjustment following stressful life events (Collie & Long, 2005; Skaggs & Baron, 2006) and lower severity of post-traumatic stress symptoms (Kalayjian, Shigemoto, & Patel, 2010). Those who are able to process and make personal sense of often incomprehensible and atrocious events are able to experience healing following a traumatic event. A less well-understood variable is forgiveness. Forgiveness has been identified as a way of coping with the effects of perpetrated, human-made trauma (Chapman, 2007; Kalayjian, 2010; Schaefer, Blazer, & Koenig, 2008; Staub, Pearlman, Gubin, & Hagengimana, 2005; Worthington, 2006), including in post-conflict societies (Swart, Turner, Hewstone, & Voci, 2011). Forgiveness is described as shifting from the automatic ego reaction of hitting

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back (revenge, hurting back) to a conscious empathic response considering that the perpetrator is also human and perhaps not acting mindfully (Kalayjian, 2010), thereby increasing one's sense of peace and decreasing incidents of anger, retaliation, and depression. Researchers have shown that forgiveness leads to lower levels of post-traumatic stress (Friedberg, Adonis, von Bergen, & Suchday, 2005; Peddle, 2007; Stein et al., 2008; Toussaint, Kalayjian, & Diakonova-Curtis, 2017), while failure to forgive one's perpetrators exacerbates psychological suffering (Worthington, 2006).

Humanitarian Outreach in Armenia

With great excitement, the Meaningfulworld humanitarian team arrived in Yerevan, the capital of Armenia, in April 2017 to begin the vital work. From the moment we arrived we were privileged to observe many of the traditions and customs of the rich Armenian culture, one that reflects Armenia's long history and carries with it great meaning into the present. These traditions give the Armenian culture its unique character and essence. We experienced it through kneading dough and observing the baking of flatbread in a Lavash bread factory, as well as lighting candles at the oldest Cathedral in the world, the impressive Echmiadzine Cathedral. We were blessed with banquets of traditional Armenian food prepared by our gracious hosts, with many ingredients grown and harvested in their own garden. Cultural foods included homemade organic yogurt, a variety of fragrant greens, cheese, apricot jam, sour cherry juice, sausages, and eggs hatched by the chickens in the back yard. Driving through the streets of Yerevan brought to view the stark contrast of the rich history of Armenia with a modern business and shopping center, and a bustling subway system. There is also a palpable energy brought by a growing number of young Armenians determined to return to their roots while tending to new creative growth.

During our meetings and consultations with people from a variety of organizations and some in high-level positions, we learned that while most governmental funding for education throughout the world is at a 20% level, only 3% of the governmental budget in Armenia is allocated for education. The majority of the budget is allocated for defence to secure the borders blockaded by Turkey and Azerbaijan. We also learned that people in Armenia struggle with the challenges of unemployment at 30%, and in some towns as high as 50%. This level of poverty has resulted in the exodus of many Armenian men to Russia and other European countries to find employment, with the women left alone to care for children and the elderly. This devastating reality made us feel the heavy weight of responsibility for the work that we came here to do.

The goals of our mission to Armenia included promoting emotional healing and wellbeing, working towards the transformation of the generational trauma of genocide, transforming horizontal violence, and training professionals in the 7-Step Integrative Healing Model which incorporates and promotes self-care, self-healing, mindfulness, emotional intelligence, empathy, forgiveness, and meaning-making. In addition to these goals was the team's commitment to follow up on the initiative that Meaningfulworld started during our 2014 mission, which was to help create a suicide prevention lifeline. The need for a suicide prevention lifeline was clearly evidenced in the steady increase in frequency of death from suicide and attempted suicide for adolescents and adults, fuelled by the

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challenging socioeconomic climate and the presence of generational trauma, horizontal violence, and other daily stressors faced by the Armenian people. We worked with 12 organizations, children in orphanages, Syrian Armenians dealing with the challenges of resettlement while struggling to survive in a country dealing with severe economic hardship, professionals who are working with them, and university students suffering from drafts to the army where death tolls continue to rise along the border with Azerbaijan. We conducted workshops on empowering young girls and boys, teaching the UN Declaration for Human Rights, the UN Sustainable Development Goals, discussing mindfulness techniques, assertiveness, meaning-making, and forgiveness.

The Ottoman Turkish Genocide of Armenians Remains a Difficult Conversation

Furthermore, our team had the privilege of being in Yerevan on April 24, 2017, during the centennial commemoration of the 1.5 million of Armenians who were slaughtered during the Genocide by the Ottoman Turks. On this day every year people in Armenia and the Armenian diaspora around the world celebrate Genocide Remembrance Day. In Yerevan, thousands of people gather at the Genocide Memorial complex to climb the hill upon which the Memorial sits, lay flowers, and mourn the millions of ancestors who perished during the Genocide. The path up the hill symbolizes the road travelled by Armenians who were brutally forced into their death march along the Syrian Desert. The Armenian people were persecuted for their ethnicity and religion, being Christian in a largely Muslim Ottoman Empire. Men, women, and children were beaten, raped, starved, hung, burned, and abandoned in the desert. In addition to the millions of people killed during the genocide, Armenia lost much of its territory during the conquest, including 12 provinces now in present-day Turkey. Only 29 countries have acknowledged the Ottoman Turkish Genocide of Armenians, including: Brazil, Canada, France, Germany, Italy, and Russia. However, local governments have called on other nations to officially recognize the Genocide; the U.S., and, most notably, the government of Turkey, have not officially recognized the Genocide. This contributes to the continued trauma felt by generations of Armenian people across the diaspora, as many still struggle to move toward healing from the atrocious events perpetuated against their ancestors.

Two events stand out as evidence for this continued trauma. First, during a workshop with university educators in Yerevan, our team presented evidence that forgiveness, even in circumstances where no apology was issued for a wrongdoing, helps one release anger and find healing after a human-made traumatic event. This idea was met by vehement rejection and disagreement from the audience of Armenians. Participants entered into a heated discussion and refused to entertain the idea of forgiveness until the Genocide is, at the least, officially recognized by the Turkish government and the global community. The anger, hurt, sadness, and self-destruction that still exist 102 years later are evidence for the level of generational trauma and need for reparations and healing. In fact, any time Dr. Kalayjian presented the idea of forgiveness in Armenia, she received angry reactions, threats, and personal attacks, even though she is an in-group member with parents who were survivors of the Genocide. We realized that much work remains to be done to mitigate the negative emotions connected to the Geno-

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cide in order to move toward a meaningful and productive conversation on the matter.

On the other side, back in New York, our team encountered opposition for an open discussion and recognition of the Genocide. From October 23-27, 2017, we had organized a photography exhibit, entitled "Transforming Suffering into Resilience," in honor of UN's founding. Photos from our humanitarian missions in six countries, including Armenia, were to be displayed inside the UN. However, after the photos were approved and hung, we received a call urging us take every photo from Armenia down, as our sponsor, the Haitian Mission to the UN, received threats and pressure from the Turkish Mission to the UN, forcing them to withdraw their sponsorship on the grounds that the Armenian photos were offensive to the Turkish people. This response by the Turkish Ambassadors, and the UN's subsequent long delay to our organization's urges to resolve this incident, were extremely disappointing and characteristic of the reason for continued feelings of anger, hurt, and shame around the issue of the Genocide.

As psychotherapists and mental health professionals, we are in a unique position to help communities find peace and healing after traumatic events, due to our understanding of the emotional processes involved in surviving trauma. We are trained to assess and mitigate negative emotions, and teach the tools for reducing their effect. We are familiar with the roles that forgiveness and meaning-making play in decreasing the influence of external wrongdoings. We can apply this knowledge at the individual level, when working with people living in or fleeing adversity, at the community level, by presenting information, research findings, and workshops, as well as at the policy level, by educating governments on these issues affecting people in disaster areas and urging them to move toward reconciliation and peace-building.

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SPECIAL FEATURE

Thank You, Dr. Barnett

Jean Carter, PhD, Former President, Division 29, and Other Admirers of Dr. Barnett

In awarding Dr. Jeffrey Barnett a Presidential Citation on August 4, 2017, SAP President Jeffrey Zimmerman described Jeff as "an active and vital member of the Society for the Advancement of Psychotherapy, Division 29 of the American Psychological Association, serving in many important roles including its President and its Publications Board Chair" and noted his contribution to mentoring, advising, inspiring and supporting members of the SAP community. It is with sadness that we also note that Jeff's role on the Board came to a close at the end of 2017.

As Jeff transitions out of service in the Society, we have the opportunity to reflect on the lasting impact he has had as President and Pub Board Chair. He has been transformative in a myriad of both obvious and subtle ways. The Society will never be the same after Jeff. Those who have had the opportunity and privilege to work closely with him won't either.

I feel like I've known Jeff forever, which of course isn't true. Our lives intertwined in Division 42, as associate editors of *Professional Psychology: Research and Practice* and in the Association of Practicing Psychologists. After having shared the presidency of Division 42 (he was president-elect as I was president), I knew exactly who I wanted to follow me as president of this wonderful Society—it had to be Jeff. We were embarking on big changes in the Division as we created the domains and developed stronger opportunities for members to engage with and participate in the activities of the division. He brings a wonderful combination of broad perspective, attention to detail and generosity of spirit that draw people into his vision. He engages them in supportive collaboration that leads to grand successes. But he wasn't looking for a new challenge. I thought about offering him my firstborn child, but he already had one of those and wasn't looking for another! So I offered him something even better—the opportunity to make a real difference in something he is passionate about—the science and practice of psychotherapy and how we communicate that knowledge. He took the bait, and this Society started a new era.

We reorganized the Division, creating Domains, re-energizing committees and committing to clear focus on diversity. I was president that year, but it was in the partnership and continuity across time that real change happened. Jeff continued his involvement in the Division, ultimately becoming chair of the Pub Board, and the changes we began together were cemented. Two most noteworthy were the support he offered Mark Hilsenroth in building the journal as a premier resource for the field, as well as for the Society, and the leadership he brought to Brad Brenner as we built a first class website.

Jeff's impact is felt in a thousand ways, large and small and goes way beyond the Society. I will share a few that are exemplars. He chaired the APA Board of

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Convention Affairs when the decision was made to meet in New Orleans the year after Hurricane Katrina; he organized the collection of backpacks with supplies to help many impacted kids return to school. He chaired the APA Ethics Committee and continues to write and present about ethics in a way that is respectful, responsible, complex and deeply understanding of the realities of being human. As a past president of Division 31, he undertook organizing and presenting the Heiser Awards for advocacy when it became homeless within APA; he did this for many years, quietly and generously. He is a professor at Loyola College of Maryland where he delights in being paid to think, and write, and work with students; what could be better for him?

His sense of humor is gentle, subtle, fun and always kind. His mentoring is legend, as many can attest. I knew how much he would quickly find a good match in the friendships and warmth of this Society, just as we have with him. Jeff's warmth, supportiveness, wise counsel and humor transform the work into partnership and friendship that make it easier and far more fun to accomplish big goals. We have all accomplished big goals under his leadership. Thank you, Jeff.

Editors' Note: Below are just a few reflections from members of SAP governance on Jeff and what his involvement with SAP has meant to them.

On Hope, Change, and Jeff Barnett

The first time I spoke to Jeff Barnett was on November 4th 2008. It was historic night, and like so many millions of people throughout the country my wife and I were eagerly awaiting Barack Obama's victory speech to the crowd at Grant Park in Chicago. In that growing anticipation, the phone rang. My wife and I looked at each other in ways that communicated several related thoughts nonverbally and with accompanying facial or bodily expressions, "Should we get it?" "Should we not?" "May-be…?' "It's late-ish "We don't want to miss any of the speech." "We're tired, do we really want to talk to anyone?" "Who the heck is calling us after 8pm?" After the second ring, a soft rustling sound emanated from the baby monitor transmitting from my 3-month old daughter's room. Prior to the third ring I picked up the phone, and stated "hello" in a soft, tentative, tone. "Hi Mark, this is Jeff Barnett calling on behalf of the Division 29 Executive Board. I've got some great news!" And while perhaps not so auspicious as the other election news that evening, he informed me that I had been selected as the next Editor of *Psychotherapy*. Great news indeed, and news that would change my life. Although, knowing my newborn daughter could be on the verge waking up I keenly felt the dread of not wanting that to happen, along with my desire to jump up and down with all the excitement and joy that came with this news. I realized I was a little tongue tied and acting very odd, because my wife kept giving me her "What's going on?" look with increasing intensity until I smiled and quickly whispered "Editor" to her with a "thumbs up" sign. Then I quickly moved down to the basement where I was able to more fully express my energy and passion about this position to Jeff. Jeff and I spoke for a while, deeply, not only about our hopes for the journal, but also how these related to both the future of Division 29 as well as the

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field of psychotherapy. Our shared attitude about these hopes was, fittingly, "Yes we can!" This was my first experience of Jeff's warmth, encouragement and engagement, something that would be a constant over the many conversations we would have in the years to come.

The second time I spoke to Jeff Barnett was a few years later, when he agreed to take on the position of Publication Board Chair. Very soon after he was elected to this position we spoke on the phone again. Our conversation very quickly and easily picked up where it had left off regarding the synergistic goals of the journal, division and the field at large. Again, covering where we had been, where we were and where we hoped to go the sentiment continued to be one of "Yes we can!" Also of note, I remember us discussing even then how I was mentoring our journal Associate Editors for their own eventual roles as editors someday, an important issue we would return to regularly across the time we've worked together. I think this highlights one of the key aspects of Jeff's leadership style, planning for the long term and the value of mentoring others well. He recognizes it's easier to have hope for the future and facing the eventual change that is inevitable, when you are well prepared for it. And at the heart of this preparations is facilitating relationships.

I've spoken with Jeff regularly over the last seven years in his role as Chair of the Publication Board. He has been a great partner and provided valuable support through this time. I can say without doubt the journal success has benefitted from this relationship, involvement and his leadership of the Publication Board. As such, I feel a good bit of ambivalence about his departure from the Publication Board. This change has come with quite a bit of preparation, most importantly his mentoring of several individuals on both the executive and publications boards in the process and functioning of the division. Our entire organization is better off because of his many years of service and have confidence in the environment he helped develop. I hope the best for him as he transitions into his new primary support role as a grandfather. I believe he will be up to the task at hand.

I plan to call Jeff one last time in his role as Publication Board Chair at the end of December to again express my thanks for all he has done for myself, the journal and our organization. To say "Yes we did!" And express my sincere hope that someday in the future we may find another project to work on together.

—Mark Hilsenroth

I have served on the board of Division 29 with Jeff for almost 10 years and I feel confident that I speak for everyone who has worked with him in this capacity over the years that he will be badly missed. Jeff stands out as someone truly committed to not only the organization but to the individual persons that comprise it. He always goes above and beyond in his efforts for the division. He has made me and every other new member feel welcomed and valued. Thank you Jeff for all that you have done!

—Rayna Markin

I first met Jeff when he was leading the ethics workshop for the Mary-

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land licensure exam. He was clear, helpful, and, frankly, calming. In fact, he has continued to be a clear, helpful, and calming presence in my life for 20 years. Having served with him on the Division 29 Board, both when he was president and when I was president, I can say with great confidence that Jeff has expertly mentored me in my professional volunteer roles. Some of what I learned from Jeff was taught by him directly (such as in the ethics workshop). Some of what I have learned from Jeff has been through observing him (such as his incredibly positive and always diplomatic responses, whether in person or in email). Some of what I have learned from Jeff has been through conversation with him (such as his supportive and helpful suggestions when I took on the presidency of the division). In every instance, those moments of learning have stuck with me. His impact on me has been both immediate (and practical) and long-term (and highly influential). I hope I have learned to be a little bit like Jeff in all that I do - competent, ethical, trustworthy, kind, and dedicated. Thank you, Jeff, for being you and for improving the lives of the people around you.

—Libby Nutt Williams

It is difficult to put into words how influential and inspirational Jeff Barnett has been to me both professionally and personally. As small examples, I would have never been a member of the APA Ethics Committee, or been promoted to full professor without Jeff's exceptionally generous support and mentoring. Despite his incredible accomplishments, Jeff always makes time for anyone who needs his guidance. He is the consummate ethical professional and scholar, outstanding leader, exemplary role model, and legendary in the field yet also refreshingly modest. Thank you, Jeff, for everything you have done for psychology, APA, Division 29, your colleagues, your students, and me. We all owe you a huge debt of gratitude.

—Jenny Erickson Cornish

Again, this is just a small sample of the many stories and expressions of gratitude we have heard down through the years for Jeff and his contributions to SAP and the field of psychology.

We will be posting this article on the SAP website (http://societyforpsychotherapy.org/thank-you-dr-barnett/), and we invite anyone who would like to share thoughts to do so in the Comments section.

EDUCATION AND TRAINING

Intern Wisdom: Things We Know Now and Wish We Knew Then

Karen W. Tao, PhD
University of Utah

April Krowel, PhD
Ball State University

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University of Utah

Division 29 Education & Training Committee

Although a number of printed materials or professionals provide great tips on how to land an ideal psychology predoctoral internship, we at Division 29 were lucky to gather "real time" and valuable insider information. Current and recent psychology predoctoral interns from across the United States were recently asked to share their insights about the internship application, interview experiences and notes about their first few months on the job. Here is a summary of their words of wisdom, which we hope will help current and future applicants gear up for this major endeavor.

The Application, aka "AAPI"

Your challenge, should you choose to accept: Enthusiastically communicate who you are, stand out among numerous other applicants, and cogently describe all the clinical and research experience you've gained over the past several years while appearing humble in 500 words or less. Overwhelmed? You're not alone. Although the thought of the AAPIC Application for Psychology Internships (AAPI) essays commonly elicits a flight response, frequent and early exposure is critical. The AAPI essays are comparable to an "elevator speech"—your moment to dazzle the internship selection committee with who you are and why you're the ideal applicant. Here are a few guidelines on how to get started.

Prioritize the cover letter. This is your first impression; it sets the tone and is an opportunity to convince an internship selection committee why they should interview *you*. Describe what you want to accomplish and how the specific site will help you reach these goals. There is a fine balance between showcasing your expertise and conveying your openness to learning. Although there will be a temptation to reiterate what you wrote in your essays, attention to developing a distinct cover letter demonstrates your conscientiousness.

The personal statement and essays. The personal statement should be exactly this—

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personal. This essay distinguishes you from other applicants. It is your story; so write with intent to really draw readers in with a narrative that makes you stand out. The diversity essay is designed to demonstrate how you approach multicultural competence. Highlight an experience in which you were able to work through a cultural challenge, including the process through which you learned something new about the interplay between your social identities and those of your clients'. And finally, the research essay provides a succinct overview of how you bridge science and practice. Anecdotes in all of your essays offer readers a clearer sense of you and what you're like as a therapist.

Although each essay should stand on its own, make sure there is a common thread throughout your materials so sites are able to envision how you would fit within their organization. This will only be accomplished by customizing your application for each site, which will demonstrate your attention to what they have to offer and how it meets your professional goals. Accordingly, invite supervisors, recent interns, *and* family members to read your materials. Their feedback will lead to more concise, more personalized, and clearly written essays and cover letter. Don't forget to check your spelling and grammar!

Letters of Recommendation

Your letter of recommendations will bolster your application by delivering three primary messages, including: (a) you have something valuable to contribute to a site; (b) you are well-prepared for the internship year; and (c) you are likeable. Do not be afraid to ask potential recommenders if they are able to write you a "strong letter." If someone hesitates, do not pursue it and ask someone else. Relatedly, request letters from people who can really speak to your various clinical, research, and academic skills. These may typically include your academic advisor, a mentor, and one or two clinical supervisors. Also include reviewers who can speak to your interpersonal style and professional development.

The next step is to set one due date for all of your letter writers, preferably several days earlier than your first official deadline. This will prevent confusion. It is also a courtesy to prepare an outline for each letter writer using the standardized recommendation form. Include some information about what you would like each letter writer to highlight regarding your skills and your future professional goals. Briefly describe your experiences and areas of expertise as well as areas you would like to develop while on internship. Recommenders often have a number of supervisees, so it is helpful to give them a "refresher" on things you accomplished while working with them.

Your Hours

Do not fall behind! From day one of your first clinical practicum experience, you have been accruing valuable hours. Keep up with tallying and saving your hours in an organized way, as it will be difficult to recall the specifics later. Some interns suggest the Time2Track system, which corresponds with the AAPIC application; however, there are other easy methods (e.g., Excel spreadsheets). As you begin to tally your hours, it's important to be honest, but do not pore over every minute. For example, sites expect 45-minute sessions to be rounded to an hour. Consult with your program training director or advisor if you are confused about how to categorize your hours (e.g., direct, assessment, or indirect).

Selecting Your Sites

As a graduate student, you have been encouraged to identify the types of sites,

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training, and populations in which you are interested. Perhaps you have received a breadth of experiences and opportunities to work with a variety of populations in diverse contexts. The internship year is your opportunity to receive intensive training from one site. The thought of committing to one place for 12 months, however, can be quite daunting.

Interns recommend first identifying sites which offer training opportunities that fit your goals, followed by narrowing your list down to approximately 12 to 15 sites based on personal priorities. In addition to all of the amazing training opportunities, you know what you need to be successful during the year. Perhaps you are heavily influenced by weather or know distance from family or job opportunities for a partner take precedence. It is critical to consider a number of these factors as you select sites to which you will apply. On the other hand, it will be tempting to base your decision purely on geography. Think warm and balmy Hawaii or cool and misty Seattle. Current interns remind us all this is the year to receive the exceptional training you need and want for your future career, and advise not to lean too heavily on the geography factor.

Finally, it is common to have a number of "maybe" sites, about which you are ambivalent and need more information. The interview may move them up or down on your list, so remain open to all possibilities. The person-environment fit will be something about which you learn more as the application process continues. Each interaction with each site will provide valuable insight into the right match for you.

Interviews

Take a deep breath and savor the moment. You have made it to the next big application milestone and should feel good. You've received your several interview invitations. Depending on the site, you will have options for a phone, in-person, or open-house type interview. Although preparation will be quite similar across interviews, we offer a few guidelines for each type below.

Phone and online interviews. Test, test, 1, 2, 3. Find a location where you will have quiet, privacy, and clear cell phone reception and/or internet connection. Ask a friend to test it out with you. If at all possible, conduct a dress rehearsal, asking a classmate to act as an interviewer who can subsequently provide you feedback on how you sounded or appeared.

On interview day, here are a few unanticipated items for which to be ready. First, you may be interviewed by multiple individuals during the phone call or Skype meeting. This will mean fewer nonverbal cues and minimal encouragers. Either prior to or during the interview, jot down the names of the people with whom you are speaking. You can easily reference this list while interacting.

Unlike in therapy, interviewer silence or a lack of facial expression does not always mean something, as interviewers may be jotting down notes or preparing their next question. On your end, offer the interviewers some nonverbal cues, including occasional nods or minimal encouragers (e.g., uh-huh) to let them know you are listening. Keep a list of your questions and comments in front of you and refer to it when it's your turn to ask them about their site.

In-person interviews. Lights, camera, action! The interview starts the moment you walk in the door. Talk to everyone you can, including current interns and non-

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clinical staff. Engage with other intern applicants, as interviewers are observing group dynamics and determining the ideal cohort composition.

If possible, spend some time checking out the local area and nearby communities. Current interns will have the best information on cost of living, transportation, and so forth. Ask yourself, "Will I enjoy living here for a year or possibly even longer if I am offered a postdoctoral or position after internship?"

All interviews. For all interviews, preparation is key. Do your research by getting to really know your sites and their staff. Remember to think about why you want to be at this internship site, and to be clear about why you are a good fit and vice versa. The interview is a two-way street, so observe organizational dynamics, including how staff communicate and collaborate with one another.

You will have many chances to ask interviewers questions. Come prepared with questions tailored to each site, staff, and specific opportunities. The questions you ask also give interviewers some insight into who you are and what you might be like as a colleague. It is okay to ask about work-life balance, how staff get along, intern experiences, and opportunities you did not see described in their materials. In a group interview, bounce off questions others are asking and keep track of what's been asked to avoid redundancy.

Practice quick thinking skills, as you may be asked to discuss how you might approach a sample assessment or therapy case. Be prepared to speak to views on the state of psychology and where you see the future of psychology. You may also be asked to describe what you do outside of work. It's all right to talk about things outside of your clinical experience. Be yourself while maintaining professionalism. Finally, eat and sleep well the night before! Dress in business attire for all interviews (even the phone ones)—no jeans or t-shirts.

Scheduling interviews. You are going to start receiving interview invitations as early as October! Prior to these invitations, create a calendar ahead of time with all possible dates and times for site interviews. Develop a "pre-rank" list of sites in case there are scheduling conflicts. This will enable you to prioritize specific interviews. Keep this calendar available with you until all interviews are scheduled.

If there are conflicts, attend highly preferred sites in-person (if offered) and request phone interviews for others. Most sites are willing to accommodate this request. A note of caution: You are generally at a disadvantage if you interview by phone instead of in-person (except for sites that only conduct phone interviews).

Interview travel. Interviews are often held in November through late January. This may mean missing classes and days at your clinical sites. To minimize days you are gone, try to schedule flights regionally, if possible. Although it can be quite exhausting, be open to scheduling a phone interview on the same day as an in-person interview, especially if you value both sites. This may mean being interviewed in your hotel room.

Ranking Sites

You are almost there! Interviews are done. Frequent flier miles accrued. Now, it's time to pull out your notes and decision matrices and start ranking your sites. This is easier said than done and it is absolutely typical to waver from one day until the next and to feel flooded.

How should you rank your site? You

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won't like our answer. Like with nearly every question you've ever asked throughout your graduate career, it depends! Whether you create a spreadsheet or rely on Likert-type scales, there is no one way to go about this. Here are some questions to reflect upon (in no particular order):

- How did you feel during the interview? If you found it hard to connect with staff on interview day, it will be harder during the full internship year. The interview day is when everyone is on their best behavior.
- How will the training opportunities enhance or broaden your current clinical skills or strategically position you for the job market?
- What was the surrounding community/city like? Can you see yourself living there longer than a year? What is the cost of living?
- What does your gut tell you? For sites with similar training opportunities, trust your intuition about where you'd fit the best.

Finally, you don't have to rank every site. There may be sites with whom you were unable to schedule an interview or missed due to flight delays. You may still want to throw your hat into the ring with these sites—or you may decide to exclude these sites from your final list.

First Months on the Job

Congratulations, you successfully matched with your top site and have your own office with a name plate on your door! You know the quickest bust route to your site and where to grab a strong cup of coffee on the go. Your real life as an intern has begun.

Okay, so the first tip: Remember when your advisor used to say, "The best dissertation is a done dissertation"? This cannot ring more true than when you are internship. It can be extremely stressful to have to come home after an eight-hour day of clinical work five days per week to then face the unfinished dissertation. It detracts from the fun you could be having during the year. Plain and simple: Get it done ahead of time.

At the outset, it is not uncommon to be exhausted. There will be numerous trainings and orientations, moments when you feel like an "impostor" (e.g., I don't belong; I didn't learn enough in school). Remember this. You are well-prepared and this is your time to soak up as much as you can. Be open to all experiences and also set some limits around what you are able to commit to, which means setting clear boundaries and making time for self-care.

All eyes on you. Your clinical supervisors and training director want you to grow. The way they do this is by giving you LOTS of feedback. For some internships, you may have as many as five supervisors during one rotation. That's a lot of evaluation and potentially differing opinions on your clinical skills. Humility will take you a long way. At the same time, the internship year is also your springboard toward independence and concretizing your own therapeutic style.

Finally, this may be your final opportunity to take advantage of clinical supervision with numerous wise clinicians, participate in lively case consultations with a multidisciplinary team, develop a new group, engage in community outreach, meet amazing clients, learn a new kind of therapy, and hang out with cool colleagues. The days may feel long at times, but the year will definitely fly by. Have fun. You've earned it!

Acknowledgement: Thank you to all of the interns who took the time to share your wisdom with Division 29 members.

PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

Publishing Psychotherapy Research: Suggestions From Editors and Associate Editors for Preparing High Quality Manuscripts

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Throughout 2017, the Psychotherapy Research Committee and the Scholarship Domain have been providing *Psychotherapy Bulletin* articles with recommendations for sharing our research with others. In the first Bulletin issue of the year, we included suggestions for sharing our research with policy makers. In the second issue, we focused on sharing our research with psychotherapy clients. In the third issue, we discussed sharing research with the media. In this issue, we would like to provide recommendations for sharing research with the professional field. Specifically, the focus of this article is on preparing manuscripts for publication in peer-reviewed psychotherapy research journals.

In preparing our comments, we sought input from the editors and associate editors of three journals that publish psychotherapy research—our society's journal (*Psychotherapy*), the Society for Psychotherapy Research's journal (*Psychotherapy Research*), and the Society for the Exploration of Psychotherapy Integration's journal (*Journal of Psychotherapy Integration*). These editors were asked to provide their opinions about how to write a high quality manuscript. They were asked to not focus on the actual quality and contribution of the research study, but rather, aspects of the written manuscript itself. Here we provide a summary of their suggestions, split by sections of the article, including the abstract, introduction, method, results, and discussion.

Before we get to those sections though, one of the editors strongly recommended researchers start their manuscript preparation by taking a few minutes to read the instructions to authors on journal websites. The journal websites often have information about the scope and aims of the journal that can guide authors in how to tailor their manuscript to the audience of the journal. In addition, the instructions to authors often include information about page lengths, abstract word count and format, style, and additional items that should be submitted with the manuscript (e.g., clinical significance statement, ethics statements that should be included in the cover letter). When some of the basic requirements of the journal are not addressed, the peer-review process will likely not start off on the best foot.

Second, the Journal Article Reporting Standards (APA Publications and Communications Board Working Group on

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Journal Article Reporting Standards, 2008) provide detailed guidance on what specific information should be included in each section of the manuscript. These recommendations cover everything from what words to include in the title to the proper description of the recruitment method. Authors should familiarize themselves with these standards for the field prior to beginning the manuscript.

Abstract

The editors and associate editors all emphasized that clarity is a priority when writing an abstract. Having an opening sentence describing the value of the study in a straightforward but attention-grabbing way is essential. The abstract should not cover the background literature extensively; a brief statement showing the need for the current study is sufficient. That way, the abstract can focus on the main aims of the manuscript, the methods used to study those research questions, and the primary results. Authors should also pay careful attention to abstract word limits. It may not be possible to cover all of the findings in the abstract. Rather than highlighting only the statistically significant results, an abstract should present the results most relevant to the main objectives of the study.

Introduction

When it comes to the introduction of the manuscript, the editors and associate editors that were surveyed discuss the importance of "hooking" readers. One editor suggested that authors should attempt to answer the question, "Why is the paper worth reading?" in this section of the manuscript. In addition, the introduction should have a clear focus and remain on topic throughout.

The introduction should be organized like a funnel, starting with the general problem and moving to a more detailed review of the research directly related to the study on which the manuscript is based. Several editors and associate editors talked about giving sufficient information in the introduction so that the study makes sense in the context of the background literature. The introduction should provide enough evidence to support why the study needs to be done. Describing what has been done and the gaps in the literature the current study fills is necessary, but not sufficient, in building a case for the study. For example, just because no one has studied what color shoes psychotherapists wear when providing treatment doesn't mean that a study on that is needed. Instead, focus on the actual contribution and generation of knowledge from the study. One editor suggested that, in providing a convincing rationale for a study, "the strongest introductions make an argument, present a counter-argument, and then counter the counter-argument."

Several of the editors and associate editors stated the introduction section should always end with the hypotheses—be specific and don't leave the readers guessing. The hypotheses should not be a surprise to readers; rather, the literature reviewed throughout the introduction should provide a rationale for the hypotheses made. There should also be sufficient information so the introduction makes sense in the context of the method section—reviewers should also not be surprised once they get to the methods.

In preparing the introduction it is also important to pay attention to the style formatting required by the journal. This is particularly important in the introduction, as it provides the first impression for the manuscript. One associate editor stated, "The more mistakes, the

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more it detracts from understanding the substance." Another editor explained, "Reviewers notice little errors (regardless of whether they take time to comment on each individual error or not) and have a subjective tally running in their heads as they read the manuscript. When too many errors add up, reviewers form an unfavorable impression that often appears (to me in the editor role) as generalizing about the entire study." This is true not just for grammatical errors, but also for the general organization and flow of the introduction.

Method

The surveyed editors and associate editors emphasized that the methods section of a manuscript is not the place to be creative. Although creativity may have played an important role in the design of the study, the description of the Method should be straightforward, detailed, and follow the standards of the field. Remember, the goal of the Method section is to allow readers to know exactly what was done with enough precision that, if they would like to reproduce the study, they would know exactly how to do so. Given this goal, details are essential.

When describing the measures, it is important to include an assessment of internal consistency with the present sample, as well as clinical and nonclinical benchmarks; however, one associate editor commented that authors "usually do a pretty good job of describing measures, but the procedures are where information is lacking." This statement was echoed by several others. The exact information needed in the procedures section differs somewhat depending on the design of the study and likely includes details about the assignment of participants to conditions, the treatment/experimental conditions themselves (e.g., manualized or not, treatment length, format, prohibited content), an assessment of fidelity, and the setting in which the study was conducted. It is important to remember the procedures not only cover how the study was conducted, but they also cover the methods for data collection. Given this, information needs to be provided about how observational coding or coding of qualitative data were performed. Whenever these types of coding take place, statistics regarding interrater reliability should be provided. In addition, information about the timing of data collection is critical. Along these lines, authors should provide a rationale for the procedural decisions that were made. For example, if the researchers chose to analyze data from the third and eighth treatment sessions, the authors should provide a rationale for why those sessions were chosen over the fifth and tenth.

In most psychotherapy research studies, the participants include both clients and therapists, and an adequate description should be provided for each. The client description should include demographics as well as information about diagnosis, symptoms, level of distress at the start of the study, and previous experience with treatment. Inclusionary and exclusionary criteria, if present, should be carefully spelled out. The therapist description should also include demographics, experience level, type of degree, theoretical orientation, a description of the training and ongoing supervision received while providing the intervention. Given the nested nature of the data in most psychotherapy research, appropriate statistical techniques should be chosen.

One associate editor also suggested that the methods section should include a subsection on the data analyses. This section should clearly tie the planned statistical techniques to the hypotheses presented at the end of the introduction.

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As with the procedures section, a rationale for the specific data analytic procedures should be given and enough detail should be provided so it is reproducible. In this section, the authors should also state which analyses were planned versus exploratory.

It seems in the methods section, reproducibility is of paramount importance. This was perhaps best reflected in the comments of one editor who stated, "When you think you are done, read this section again but with the question looming in your mind….could I replicate this study on the basis of the information provided?" It may even be helpful to have colleagues outside your particular area of study read through the methods section and see if they believe they could replicate the design. Related, the editors and associate editors emphasized if the manuscript provides a secondary analysis from a previously published study, that fact should be explicitly stated, though the methods of the initial study should still be described in enough details so readers will not have to look up the initial study to see what was done. Many readers will not have access to the initial publication and most won't take the extra time to find it.

Results

In keeping with the theme of clarity, the editors and associate editors surveyed recommended that the results be presented in a straightforward and clear manner. Several of them suggested the results should be organized by hypotheses. First, remind readers what the hypothesis was, present the descriptive data (e.g., means, standard deviations, correlations between measures), then state what statistical tests were used to test the hypothesis, and present the results. Then move on to the second hypothesis, the third hypothesis, and so on.

When writing the results section, authors should take an impartial stance. One editor recommended authors "write the results section as if you were writing up someone else's findings. Would you be inclined to interpret someone else's findings as 'approaching significance' as you would your own?" Similarly, another editor suggested authors "present only findings which are there, and not what you wish for."

Several of those interviewed stated specific statistics that should be included in the results section, such as confidence intervals (particularly necessary when plotting means), raw means and standard deviations, and common effect sizes (*d*, *g*, or *r*). Those interviewed also highly recommended using tables and figures to display detailed information, then reviewing the aggregate data and the results of the statistical tests in the text. While many researchers do not use enough tables and figures, some include too many. Tables and figures may not be needed when the results can be presented simply in written form.

Discussion

Some of the editors and associate editors shared that reviewers often make up their minds regarding the quality of the manuscript before making it to the discussion section. If the introduction does not build a case for the study or the method and results sections are written poorly, even the best discussion section cannot change the reviewer's perception. However, the opposite may be true—a manuscript with an adequate introduction, methods, and results section may be rejected if the discussion section is not well thought through.

The primary concern emphasized was that the discussion stick to the results of

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the study. That is, the discussion should not make statements or conclusions that over-reach the results found. This may be seen when authors make causal claims that do not fit the design or discuss clinical implications that were not actually tested in the study. At the same time, authors should not simply restate the study's findings. One editor commented "remember, you wrote an introduction with relevant context. Wrap the manuscript in that context by revisiting how the study enriches that literature." While not overreaching the findings, this may be the place to, as one associate editor said, "Take some risks with the explanations/implications." This same associate editor mentioned getting bored when reading the obvious in the discussion section, such as, "alliance is related to outcome, therefore pay attention to the alliance."

The editors and associate editors also emphasized the need for a thorough section covering the limitations, future research, and clinical implications. Authors should spend a good amount of time thinking about the limitations of their work. One associate editor stated, "No study could cover the whole territory," emphasizing a study can still have merit even if it is not perfect. However, if major limitations are not recognized by the authors, reviewers may question the objectivity and expertise with which the study was conducted. Also, the limitations discussed should be meaningful. For example, most manuscripts discuss the limits in generalizability based on the demographics of the participants; but, is there some reason to believe different results would be observed in different samples? The future research section should also not simply state the obvious. Of course, every study could be replicated in a different setting or with a different sample, but what are the important next steps? One associate editor said, "A discussion should leave the person feeling inspired to drop everything and follow up your research." In concluding the manuscript, authors should help the readers see the contribution of the study to the field. For psychotherapy research, this contribution should have direct clinical applications to the practice of psychotherapy. These applications should be stated explicitly. However, authors should still remember not to overstate. In the end, as one editor put it, "We ought to be more invested in discerning what is true than in proving our original ideas to be right."

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Social Justice, Advocacy, and Early Career Practice

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Colin Kaepernick kneeling for Black Lives Matter. Protests at Standing Rock. Fighting against the elimination of Deferred Action for Childhood Arrivals (DACA). #MeToo. Social justice movements are abundantly present in our current political/cultural climate. Where is psychology's role in these movements? What are our personal roles, as early career practitioners? How do we help those we serve as they struggle with uncertainty and feelings of helplessness? How do we maintain self-care while harboring those same concerns?

Psychology and the American Psychological Association (APA) was slow to embrace social justice (see Leong, Pickren, & Vasquez, 2017, for historical review). However, through acknowledgement of the importance of advocating for clients—often from oppressed, marginalized, and vulnerable populations—the presence of advocacy and social justice efforts in psychology have grown and widely expanded. From institutional policy changes to local policy to the United States Supreme Court *amicus curiae* briefs, psychologists and other mental health professionals have played important roles in instrumental social changes.

Advocacy and Social Justice as an Ethical Obligation?

As an early career psychologist, I have asked myself: Ethically, do professionals in the field have an obligation to involve themselves in such advocacy and social justice efforts? As always, we consult with the APA's Ethical Principles of Psychologists and Code of Conduct (Code of Ethics; 2017) to provide guidance. Although Section 3 (Human Relations) of the enumerated Code describes avoiding discrimination and harm to the public, there are no explicit ethical guidelines addressing psychologists engaging in advocacy and social justice work. Thus, examining how advocacy fits into the General Principles of the Code of Conduct may provide clarity. For instance, Principle A: Beneficience and Nonmaleficence reads,

> In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research … Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.

Safeguarding the welfare and rights of the clients we serve is fundamental. Essentially, psychologists should not cause harm to others; in some cases, this may require them to advocate for the well-being and rights of individuals. For example, solitary confinement for adults and juveniles is a burning issue in corrections currently. Despite the wealth of knowledge throughout the last decade

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describing the harm caused by those in solitary confinement (e.g., Kaba et al., 2014; Metzner & Fellner, 2010; Whitley & Rozel, 2016), paired with the push for trauma-informed care and treatment, segregation and isolation continue to be common practices. Fortunately, mental health providers have been in the forefront of shifting policies surrounding isolation, as psychological research has been used to support policy change.

Principle B: Fidelity and Responsibility suggests adherents to the Code of Ethics should be "aware of their professional and scientific responsibilities to society and to the specific communities in which they work." Clients often discuss psychosocial difficulties they're facing—economic burdens, employment struggles, and neighborhood struggles. Those who provide mental and behavioral health care to a community develop a sense of the pulse of that community via their clients. In addition, watching the local news or reading your local paper (or social media) helps identify community social problems. In our roles as advocates, we should feel empowered to address these problems as related to our areas of competency. Writing an Op-Ed or Letter to the Editor about critical topics is one way to insert psychological and scientific knowledge into the public sphere. For example, after a viral video reached the Internet depicting problematic cheerleading practices, colleague Dr. Brian Gearity (Clinical Assistant Professor at the University of Denver's sports coaching program) discussed coaching certification and proper sports coaching with local news station (Bolton, 2017; watch the video here). This is an excellent example of using acquired knowledge from our field and advocating for others and better practices.

The most fitting Principle related to advocacy and social justice is Principle D: Justice, which challenges us to "recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists." What does this mean for an early career clinician? Simply, psychologists should advocate for equality for their clients. In working with vulnerable populations, clients often do not have the privilege and platform mental health practitioners have in their roles. Therefore, it is an underlying mission for providers to help promote those populations to advocate for themselves, while advocating for them as professionals. We can begin to incorporate these values as part of our own professional development during training and continuing into our early career practices.

Advocacy in Psychotherapy

How does advocacy fit into psychotherapy? Are your clients discussing the events outlined above? How are they coping with the present uncertainty regarding those social issues?

Advocacy counseling has a long history in field of psychology and psychotherapy (see Kiselica & Robinson, 2001, for a review). Advocacy counseling, or social justice interventions, involves "helping clients challenge institutional and social barriers that impede academic, career, or personal-social development" (Lee, 1998). Becoming involved in an advocacy organization may help clients feel more in control in situations affecting themselves, their families, and communities. In psychotherapy, advocacy counseling can be used to increase a client's sense of personal power. Discussing self-advocacy skills and providing a space to discuss important social issues in treatment can empower clients to become advocates for themselves and their communities. For example, Savage, Harley, and Nowak (2005) discuss employing

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social empowerment strategies in counseling with gay and lesbian clients as a means of self-advocacy. These strategies help clients to develop a positive identity while becoming empowered enough to advocate for themselves and their communities and simultaneously pushing against systems of discrimination and marginalization. Their model serves as an effective approach for assisting clients in becoming their own social justice advocates and getting involved in creating change.

Systems-Level Change

Social justice movements need psychology, and especially the engagement of those early in their careers. Mallinckrodt, Miles, and Levy (2014) note that social justice advocates rely on social psychology literature about perception, prejudice, and attitude changes, as well as the negative consequences of oppression, such as chronic stress. Systems advocacy involves the therapist assuming roles to facilitate systematic change. Many early career professionals are or will soon become involved in administrative and leadership roles; in these roles, we can leverage our awareness and enthusiasm to influence our organizations and to facilitate change.

Regarding psychology's involvement in social justice, Vasquez (2012) noted, "One of our tasks is to determine what our psychological theories, scientific research, and clinical experience have to say about the grand challenges that profoundly affect our daily lives, our society, and our world." (p. 342). One identified barrier to engaging in advocacy efforts identified by psychologists was a lack of awareness of public policy issues and perceived lack of enough knowledge to discuss such issues competently (Heinowitz et al., 2012). However, as a field we can translate our knowledge, expertise, and research into policy change. For instance, research regarding families and same-sex couples, along with several APA Council resolutions, greatly impacted the United States Supreme Court's decision for *Obergefell vs. Hodges* (2015), which found the Defense of Marriage Act (DOMA; 1996) unconstitutional under the Fifth Amendment. What is your niche? Think of ways you can use your knowledge, skills, and expertise to influence policy.

Future Directions

APA Benchmarks include advocacy as a competency for clinical training in the practice of psychology. The Benchmarks defines advocacy as "actions targeting the impact of social, political, economic or cultural factors to promote change at the individual (client), institutional, and/or systems level" (American Psychological Association, 2011). Despite being identified as a benchmark for clinical training (American Psychological Association, 2011), advocacy in psychology is not universally taught or discussed in graduate programs in psychology. According to a 2005 survey conducted by the National Council of Schools and Programs of Professional Psychology (NCSPP), 62% of faculty and student respondents reported advocacy training was not offered (Lating, Barnett, & Horowitz, 2009). In order to develop and fill a pipeline of professionals involved in advocacy, public policy, and social justice efforts, graduate training programs must expose students to these arenas. For example, within the Graduate School of Professional Psychology at the University of Denver, a course entitled *Psychology, Public Policy, and Advocacy* is offered to graduate students across graduate psychology programs. The course introduces students to political advocacy, as well as connects students with current and former legislators, nonprofit agencies, and grass-

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roots organizations to examine how psychology trainees and mental health practitioners can impact various systems. Recently, students also attended Colorado Mental Health Hill Day, which connected them with mental health advocacy groups and legislatures from across the state. In order to properly prepare students for this important area of the workforce, it is essential they have exposure to advocacy in their training.

As a mental health practitioner, are you aware of current legislation impacting your practice? Your institution or employer? Professional advocacy is "a synthesis of both public policy and social justice advocacy" (Heinowitz et al., 2012). Heinowitz and colleagues (2012) note, "Professional advocacy in the field of professional psychology demands that clinicians advocate not only for fair access to appropriate services but also for the important legislative changes necessary to enhance the quality of life of patients and at-risk populations" (p. 373).

In order to properly advocate for our clients, other members of our communities, and ourselves, we must remain up-to-date with current state and federal legislation. Providing legislative testimony, writing letters to your state representatives, and building coalitions are all great ways to become involved. Many state, provincial, and territorial psychological associations (SPTAs) have divisions or leaders dedicated to local public policy issues related to the field, and can provide direction on how to approach certain legislation as a collective unit. In sum, get involved!

Conclusion

Psychology has a longstanding history in advocacy and social justice movements. Although mental health practitioners may not be directly involved in advocacy efforts in their day-to-day work, perhaps they should—including at the client-level. The power of the field is greater than its individual parts: As students, clinicians, educators, researchers, administrators—and, yes, as early career professionals—each of us can be agents of influential social change.

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Slowing it Down: Assisting Millennials to Practice Ethically

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Acting in an ethical manner requires careful consideration, deliberation, consultation, and reflection (Knapp, VandeCreek, & Fingerhut, 2017). Answers to ethical dilemmas cannot be found through a quick internet search or superficially sought through queries on professional listservs. When faced with ethically ambiguous and challenging situations for which there appears to be no readily evident "right" course of action, psychotherapists and psychotherapists-in-training must take the time to consider their clients' best interests, to seek ethical guidance from a range of sources, to consider their own values and the values of the profession, and to apply an ethical decision-making model or process to assist them to determine the most appropriate course of action in that situation (Barnett, 2017). In short, ethical practice can require considerable time, thought, and effort. In a culture that seems to continually speed up, how do we get emerging generations to slow down and engage in this deliberate process to promote ethical practice?

Millennial Culture

From "trophy kids" to "generation tech" to the more popular, "millennials," there has been a wide variety of terms used to describe individuals born between 1980 and the early 2000s. Distinguished by both positive and negative stereotypes, the reputation of millennials seems to be a relatively controversial topic of conversation with little consensus. Research on members of this generation mainly focuses on their role in the workplace and their workplace interactions, yet there appear to be some overarching generational traits worthy of mention.

Millennial culture has been associated with greater education, multicultural and diversity awareness, and affluence (Howe & Strauss, 2009). Greater exposure to cultural diversity has led to the development of increased empathy for populations of lower socioeconomic status and increased advocacy for social justice issues (Fox, 2012). Not only does the literature describe and discuss a generation engaged in, and motivated by, social activism, millennials are argued to be more competent and comfortable when interacting with individuals from diverse cultural backgrounds (Thompson & Gregory, 2012).

In terms of personality traits, individuals in this generation are defined as being generally collaborative and achievement-oriented, having strong multitasking abilities, and as being modest and philanthropic (Howe & Strauss, 2009). Yet, despite these positive generational at-

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tributes, millennials have also been identified as being over-indulgent, self-obsessed, competitive, sleep-deprived, arrogant, and entitled—traits not limited only to millennials in the United States (Alsop, 2008). Millennials have a tendency to seek career advancement based on performance, rather than experience or seniority, and can be impatient when it comes to traditional career tracks (Ott, Blacksmith, & Royal, 2008). Poor job retention, often described in the literature as a lack of loyalty, is cited as the leading problem for employers of millennials. Millennials tend to seek early employment to develop marketable skills, or make money to support their social life, rather than to establish a career (Thompson & Gregory, 2012).

The need for ongoing and frequent positive feedback to foster confidence and feelings of security is also associated with this generation (Gursoy, Maier, & Chi, 2008). Difficulty with decision-making and in resolving ambiguous tasks are said to result from a preference for receiving explicit directions and the use of checklists (Alsop, 2008). The ability to multitask is another defining characteristic of this generation, particularly as it relates to the use of technology. Millennials prefer to engage in multiple experiences at once and are ever-connected to others through social media, smartphones, and other forms of technology, which can lead to high expectations for information exchange (Stein, 2013). In this age of technological speed and growth, millennials are frequently focused on determining the best, most efficient course of action, and time is regarded as a valuable currency that is not be wasted (Marston, 2016). Each of these qualities and characteristics have implications for how they may approach and practice psychotherapy, especially when confronted by ethical dilemmas.

Ethics and the Practice of Psychotherapy

Ethical dilemmas are those situations in which no clearly appropriate or inappropriate course of action is readily apparent. While there exist some situations and actions by psychotherapists that are clearly ethical or unethical, many of the challenges psychotherapists face in the conduct of their professional work constitute ethical dilemmas. The American Psychological Association (APA)'s Ethical Principles of Psychologists and Code of Conduct (Ethics Code; APA, 2017) sets minimal expectations in a number of areas of practice (e.g., it is never appropriate to engage in sexually intimate relations with a current client), yet the Ethics Code is not designed to tell us what to do in every situation that might arise. As the Ethics Code states in the Introduction and Applicability section, the Ethics Code is intended as one source of guidance for psychologists, and it should be utilized along with a decision-making process that includes consultation with colleagues.

When confronting an ethical dilemma, the most appropriate course of action may not be initially evident, so an immediate response or solution is not always necessary or appropriate (Barnett, 2017). In fact, quick and impulsive decision-making in these situations is generally the opposite of what will likely lead to the best possible outcome. It is important for psychotherapists to take the time needed to reflect on the situation, seek consultation, and engage in a deliberate and thoughtful decision-making process. In contrast to the preferences of many millennials that Alsop (2008) describes, there is no comprehensive checklist to consult to quickly find the appropriate course of action, and a rapid resolution that seems to be the most efficient use of time possible may not be

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the preferred approach to take. Ethical dilemmas are most frequently ambiguous situations, requiring careful thought and adequate time to reach the best possible decision.

When confronted with an ethical dilemma, the General Principles of the APA Ethics Code (APA, 2017) should be reviewed as an initial source of guidance. These aspirational principles form the foundation of all ethical practice and may prove helpful in shaping our approach to the dilemma (Barnett & Behnke, 2012). A first step may be reflecting on whether our considered course of action is consistent with these aspirational principles. For example, for beneficence, a psychotherapist might ask, "Will acting in this way result in benefit to my client?" Similar questions may be asked regarding each of the other General Principles of the APA Ethics Code. Of course, one should also consider the enforceable Ethics Standards in the Ethics Code to find whatever clear guidance on the matter might be in the Ethics Code. Then, we must consider our own values and how the guidance available in the Ethics Code (as well as in relevant laws and regulations) might be interpreted and applied, while keeping the client's best interests in mind.

The next step is to engage in a thoughtful and deliberate decision-making process. A number of ethical decision-making models are available. One useful resource that describes many of them is the website of the Markkula Center for Applied Ethics, which may be accessed at https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/. Ethical decision-making models can provide psychotherapists with a systematic, step-by-step process for working through ethical dilemmas. Common steps in ethical decision-making models include: Clearly define the situation and the conflict/dilemma, determine who all will be impacted and how different decisions might impact them; review and consider available guidance or direction from relevant the laws, regulations, and guidelines; reflect on your relevant competence and countertransference; consult with trusted colleagues to obtain feedback on the plan you are considering as well as to be exposed to alternative views and perspectives; consider all reasonably available possible courses of action; identify the potential risks and benefits likely to be associated with each course of action; after careful deliberation make a decision and implement it; then monitor the impact of the decision made on the client and make any necessary modifications based on outcomes achieved (Barnett, 2017).

Consultation with trusted colleagues or mentors provides new insights or differing perspectives that might not ever have been considered otherwise (Sears, Rudisill, & Mason-Sears, 2006). Consultation can be also be useful for challenging unconscious biases or highlighting competence issues unknown to the decision-maker (Caplan & Caplan, 1993). Thus, consultation is an essential element of all ethical decision-making processes. Professional isolation and making decisions in a vacuum can be significant contributing factors to poor decision-making and further reinforces the need to consult with colleagues when addressing an ethical dilemma (Younggren & Gottlieb, 2004).

As mental health professionals, psychotherapists have a fiduciary responsibility to their clients (Jorgenson, Hirsch, & Wahl, 1997). This means that we are entrusted with our clients' well-being and that we should not take any actions

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that are inconsistent with this obligation. Our clients are trusting us to do so and we have an obligation to take all reasonably available actions to achieve these objectives, only acting in ways that are consistent with our clients' best interests.

Tying it all Together for Millennial Psychotherapists (and Others)

Further research is needed to define millennial culture and determine the potential personality traits specific to individuals in this generation. However, based on the current literature, it seems there are some common characteristics worth discussing in the context of emerging psychotherapists. A number of millennials possess some generational characteristics that could enhance the therapeutic relationship, such as greater multicultural awareness and competence, empathy for diverse populations, and affinity for philanthropic engagement. These are all crucial strengths when working with individuals in the context of a psychotherapy relationship.

However, the importance of efficiency and expediency associated with millennials could lead to an impatience for taking the necessary steps to act ethically. Ethical dilemmas tend not to have readily available answers. Following an ethical-decision making model is not as fast as asking a supervisor what to do or "Googling" for an immediate, definitive answer. As has been highlighted, ethical dilemmas have no easily identifiable correct or right courses of action. These situations are characterized by ambiguity, which is not conducive to speedy resolution, and which may present unique challenges for a group shown to have increased difficulty with decision-making and problem-solving in unclear situations.

So, should millennial psychotherapists be viewed as potentially less ethical than other generational cohorts? The answer is a clear and emphatic, "No!": As a group, they bring valuable strengths and a unique perspective to the field. However, it may be important for millennial psychotherapists-in-training to challenge learned or reinforced values of speed and efficiency, as they contradict the values of ethical decision-making. Immediate responses to ethical dilemmas are often not needed, and may, in fact, contribute to poor decision-making. Not only can psychotherapists themselves face consequences for ethical and legal violations, such as license revocation, but they can potentially harm their clients. Failure to exercise due diligence when facing ethical dilemmas may result in neglect of fiduciary responsibilities, which in turn can weaken the individual clients' and the community's trust in mental health professionals. Having a step-by-step guide, such as an ethical decision-making model, seems to be a great compensatory tool for individuals of this generation to utilize to assist them in slowing down and thoughtfully determining the most appropriate course of action in the many challenging situations and ethical dilemmas that will undoubtedly arise in the practice of psychotherapy throughout their careers.

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STUDENT FEATURE

What Are We Missing? An Investigation of Graduate Stress and Cohort Cohesion

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I presented my first research poster at the 2016 American Psychological Association (APA) Conference in Denver, Colorado. My name had been on other posters in previous years, but never as first author. I was especially excited about this opportunity. The research I presented was about graduate student stress and how it may be important for programs to measure this construct so as to better help their students and possibly reduce attrition. As a third year doctoral student in clinical psychology, I was fully experiencing all stressors that came with graduate school: classes, homework, dissertation, practicum, finances, family, friends, meetings, jobs, and all while trying to maintain some semblance of a social life. To me, examining the topic of graduate student stress seemed logical, especially given that in graduate school for psychology, self reflection is all but required to do effective work. However, my experience during the poster presentation elicited significantly different opinions.

As I watched the students around me talk with fellow conference colleagues about their research, I could not help but wonder why was no one stopping at my poster to talk to me; what was different about my research topic? At the end of the session, I had only two individuals that stopped to talk to me. One conversation in particular stood out to me, as it seemed to explain my experience. The attendee read my poster, questioned why I was looking at this topic, and then proceeded to tell me my research was somewhat unnecessary and nothing can be done about graduate student stress. The underlying message I received was that stress is just part of the process. As my poster hour came to a close, I rolled up my poster, put it in my tube, and left feeling defeated.

I would like to say that I continued my research on graduate student stress, but I instead abandoned it. Why research something no one cares about? Although I knew that was not true, I felt discouraged. After the conference, I shifted my focus to another related topic that I felt might get better traction: cohesion among graduate student cohorts. Due to the demands graduate school places upon us, it is not unreasonable to guess that we as students spend more time with our cohort members than anyone else in our lives. I know that for me personally, my

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cohort was a major source of support after I moved from California to Kentucky to attend graduate school. With no friends or family other than my husband and my cat, I needed my cohort members to help me acclimate to this new life with all new demands and expectations. As my cohort progressed through the program, we leaned on each other in times of need and supported one another both academically and personally. When comprehensive exams came around, we helped each other study and shared materials; when someone's home flooded, we donated money and toys to the family; when I had surgery, I received text after text asking if I needed anything. From these examples, you can see that my cohort is highly cohesive. Even if we do not hang out every day or have classes together, we are there for each other in times of need. And interestingly (read: thankfully), we have not had a single person drop out of the program since our first year. However, not every cohort is like this. Students have told me their cohorts feel disjointed, and students are surprised to hear about how my cohort supports one another. This left me wondering: Why do cohorts differ? What contributes to cohesion, and what hinders it? How does this impact the graduate school experience and a student's stress level? Through these conversations, research, and my personal experience, I found a question that still addressed the topic of graduate student stress, yet in a more nuanced and complex manner.

Pilot Study

While research has evaluated social interaction (Goplerud, 1980) and perceived social support (Cohen, 2004; Dunkley, Blankstein, Halsall, Williams, & Winksworth, 2000; Lepore, Evans, & Schneider, 1991) in relation to positive outcomes for students, there is little information in the literature regarding the impact of a graduate school cohort or how the cohesion of that cohort relates to program and overall life satisfaction. Cohesion is an important relational construct that involves both relationship structure and relationship quality (Burlingame, McClendon, & Alonso, 2011). Research has identified social support, especially peer support, as an important coping tool, including in post-secondary settings, yet it is unknown how the structure and quality of those relationships affect a graduate student's reliance on that tool.

To find out if cohort cohesion was something that even mattered to students, I conducted a pilot study to assess student perceptions of and experiences with cohort cohesion. An online survey questionnaire was sent to a national sample of doctoral students in APA-accredited programs from around the country. A total of 55 doctoral students in clinical psychology responded. Fifty participants identified as White, three as Black/African American, one as Hispanic/Latino/Latina, and one as Multiracial. Self-identified gender included 45 women and 10 men. The majority of participants were in a relationship (60%) and in their first or second year of practicum (40%). Measures included demographic questions, the Depression, Anxiety, and Stress Scales (DASS-21; Lovibond & Lovibond, 1995), Therapeutic Factors Inventory–Cohesion Subscale (TFI-C; Lese & MacNair-Semands, 2000), Individual Cohesion Questionnaire (ICQ; Gallagher et al., 2014), Inventory of Interpersonal Problems–Short Circumplex Form (IIP-SC; Soldz, Budman, Demby, & Merry, 1995), and Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). Additionally, we asked qualitative questions regarding the

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importance of cohesion, what contributes to or hinders it, how students' programs contribute (or do not), and what they wish their programs did to facilitate cohesion among cohorts.

Quantitative Results
Our survey yielded interesting, yet not surprising results. Quantitatively, cohort cohesion importance was rated higher than actual perceived cohort cohesion. Although students rated cohort cohesion as significantly important to them, they did not report experiencing it to the degree one might expect, given that importance. Per the students' reports, programmatic efforts to facilitate cohesion were positively correlated with perceived cohort cohesion, indicating students may feel it is helpful for programs to be actively engaged in fostering cohesion among their students. We will address more specific ways of "how" below. Finally, doctoral clinical psychology students with higher interpersonal problems reported significantly lower life satisfaction.

Qualitative Results
Qualitatively, several themes emerged from questions related to students' experiences of cohort cohesion. Themes included: What specifically facilitates cohesion, what hinders it, and whose responsibility it is to make it happen. The following is a description of each theme.

What facilitates cohesion? Students identified social gatherings, classes, and studying together as the best ways to develop cohesion. One student stated,

> *I think studying together and hanging out socially [is] important to cohort cohesion. Even more so, I think having support for personal reasons (i.e. family problems, relationship issues, etc) is important for cohort cohesion. Having this type of support is especially important when one is away from their primary support network.*

Such responses connect to the *quality* dimension of cohesion—it is not just about studying together, but being there in a time of need or providing support for sensitive issues. Multiple responses reflected how fellow graduate students, who could understand what it is like to be in graduate school and experience similar unique stressors to this time in their lives, validated respondents' personal experiences.

Students noted that having classes together and studying helps with feeling connected to their cohort, especially in courses that are highly interactive: "*[the program] encourages talking to each other, working together, and facilitates group discussions and working together in class.*" One student noted that seminar-style and supervision courses specifically helped with cohesion, likely because of the discussion and engagement these types of course formats allow. However, many students reported that, as they progress in their program, they have fewer courses with cohort members due to selecting specific specialty tracks. As this happened, students felt less connected to their cohort: "*We were very cohesive in the beginning of the program, but less as training continued...classes and life circumstances changed.*"

What hinders cohesion? Overwhelmingly, students cited cliques, competition within the program, and time constraints as constructs that hindered the development and maintenance of cohort cohesion. While students may naturally divide into friend subgroups within the cohort over time, it seems that when interpersonal issues enter the picture, cohesion may be harmed. One student

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described: "*As of this past year, my cohort has divided into cliques and there have been many hurtful comments spread about many of our cohort members.*" It is noteworthy that the students used the word "cliques" rather than something more benign (e.g., groups)—that is, "clique" possesses a negative connotation and implies exclusivity, both of which impede cohesion quality.

Competition was also cited as an issue in fostering cohesion. Many students stated they felt their programs did a good job of discouraging competition, which in turn made cohesion easier to develop. A student noted, "*Our program does not hinder cohesion because they do not encourage intense competition between students.*" Others echoed this sentiment, stating that their programs intentionally discouraged competition. This suggests that programs with less competitive environments may have higher rates of cohesion among their students. For another student in a PhD program, competition was especially salient: "*Competition between graduate students is a large contributor to difficulty within cohorts. We are often fighting for the same funding, clinical[s] (e.g. internship, practicum), and teaching positions.*" For this student, competition was cited as a barrier to creating meaningful relationships with others given the resources each were vying for in the program.

Time constraints were also identified as hindering cohort cohesion; however, respondents normalized that these were natural and unchangeable in graduate school. Students noted that graduate school is both time and labor intensive, which is emotionally taxing. Given the stressful nature of graduate school, cohort cohesion may be even more important, as students do not feel they have the time to invest in these or other relationships:

> *I think the biggest thing that gets in the way of cohort cohesion is free time ... as time goes on, there is less and less time to hang out with other members of our cohort unless we are studying or doing something school related.*

One might categorize these as relationships of convenience due to the time spent together. Further, students have demands outside of school that require their time such as employment or family obligations. One student summarized it well: "*It never feels like there is enough time to bond.*"

Whose responsibility is it? Among student responses, there seemed to be uncertainty as to who is responsible for fostering cohort cohesion. Some viewed cohort cohesion as happening organically through student interactions: "*Cohesion comes from voluntarily deciding to be closer.*" From this perspective, programmatic efforts would not be useful. Some suggested that programs do not really have a role in the cohesion process: "*I don't think there is much to do from the program side. I think a majority of cohesion comes from the students.*" Others felt more strongly, noting, "*If they tried to force cohesion, it would backfire and just make us not want to hang out.*" In this camp of thought, students are the ones responsible for building cohesion, and any programmatic efforts would only hinder that organic process.

Other respondents had a different, more moderate perspective. Many expressed a need for more opportunities to build cohesion: "*I wish they had more planned gatherings or opportunities for cohorts to work together outside of school.*" This is where, respondents felt, a program could play a role in organizing such events. Students noted that although they spend time together in courses, "*the program itself does not have anything in*

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place to encourage cohesion." Respondents suggested that "*the program can encourage activities that are in a group and that involved individual cohort members to get to know each other one-on-one*." Although they feel a program is not responsible for cohort cohesion, they do see a role for the program to provide opportunities for cohesion to happen organically among the students.

In sum, responses suggested fostering cohesion is a balancing act between providing opportunities for graduate students who want it, while not forcing experiences upon those who do not. Students identify natural places for cohesion to happen, such as in the classroom or when studying together, yet as they progress through the program, it becomes difficult for cohorts to be their main source of socialization. By offering additional social hours or events, programs could extend opportunities to socialize that otherwise might not occur. With such busy schedules, it is difficult for graduate students to find time to socialize with peers outside the classroom. If social hours or events are scheduled by the program with student schedules in mind, it may increase the opportunity for students to be able to attend and interact with one another.

After aggregating my pilot data, I once again unrolled my poster and hung it up on the board to present it at the 2017 APA National Convention in Washington, DC, to see what others in the field thought about these findings. Given my previous experience presenting data about graduate students, I did not expect to have much engagement. Surprisingly, I had significantly more attendees stop at my poster, and many attendees reported being able to relate to the survey results. Several students expressed frustration with the formation of cliques in their cohort, and how challenging it is to find time to socialize with others outside the classroom. Some even noted that the isolation experienced later in programs caused additional stress or dissatisfaction with their programs. Many student attendees stated they wished their programs at least offered opportunities for more socialization within and between cohorts. A professor from a PsyD program noted her students talk about this topic all the time, yet her program was unsure of what to do to help.

Now What?

By narrowing the topic of graduate student stress to a specific issue, an honest dialogue began to take place. While the broad statement of "students are stressed!" did not garner attention, people recognized and related to the specific issue and need to have connection and cohesion within a graduate program. After all, we are spending four to six years of our time with peers; why would it not be an important factor in the journey? After researching this topic and obtaining feedback, I found myself asking this question: In a field of individuals who are supposed to care about the wellbeing of one another, why is it so difficult to talk about the wellbeing of our future professionals? A response on my survey reflected this well: "*One would think psychology students would be able to foster a positive environment, but there have been times when the cohort is so split (which it will naturally) that you can feel the tension within the room*." How can we do better?

First, programs need to ask the questions. Given the survey results, students are willing to share their experiences and ideas if programs are

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willing to ask and genuinely listen. Part of the responsibility is on the students themselves, and cohort cohesion is undoubtedly affected by individual differences; however, the overwhelming feedback from students surveyed indicates it would be helpful for programs to offer more opportunities for cohesion. This could be offering study groups, events scheduled after common class end times, or monthly events involving both student to student and student to faculty interactions. Given the comments regarding environments of competition, programs may wish to assess the current climate and make intentional steps towards fostering a supportive and collaborative environment. The more we discuss the stressors graduate students face and are intentional about offering opportunities for support, the better we may be able to support them in becoming competent, self-aware clinicians.

If you are interested in the topic, have questions or comments, or would like to collaborate on future projects, please do not hesitate to reach out to continue the dialogue. You are welcome to contact Jen Schager, M.A. at: jschager@spalding.edu.

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"This Country Will Not Be a Permanently Good Place for Any of Us . . ."

Pat DeLeon, PhD
Former APA President

Developing a Visionary Perspective

After nearly four decades of involvement at the federal policy level, we have come to appreciate how those who serve in higher office (whether within the Congress, the Administration, or their national professional associations) often develop an intuitive understanding of the "waves of change" and how their interests and expertise must continue to evolve in order to remain relevant and "cutting edge." Former APA Presidents Suzanne Bennett Johnson and Susan McDaniel emphasized the importance of psychology affirmatively embracing interprofessional integrated care. Psychologist Peter Kaufmann, former Acting Director of the Office of Behavioral and Social Sciences Research at the National Institutes of Health and former President of the Society of Behavioral Medicine, recently transitioned to the University of Colorado's College of Nursing as Associate Dean of Research. He finds that nursing faces challenges similar to those of psychology with respect to research and practice, yet both can learn from one another. Colleagues invested in mental and/or behavioral health must appreciate the fundamental importance of regularly interacting with the other disciplines (e.g., nursing, clinical pharmacy, social work, physician assistants, and medicine) which are essentially working with the same patients or systems/organizations—notwithstanding our different professional training backgrounds. Fundamental change evolves from collective past experiences and challenges.

Two of Dr. McDaniel's 2016 Presidential Initiatives exemplify this commitment to increasing psychology's role in interprofessional integrated care.

"The first initiative took a year to accomplish: developing a meeting of Presidents and CEOs or Government Relations people of all the primary care and mental health professional associations (including family medicine, pediatrics, general internal medicine, psychology, psychiatry, social work, nurse practitioners, nurses, physician assistants, etc.). We called it the Integrated Primary Care Alliance. Eighty-three leaders from 28 associations met at the APA Tower Conference Center in April for two days, to work on inter-professional approaches to integrated primary care with regard to: advocacy, education, research methodologies, team-based care, and healthcare disparities. Many of these leaders had never met each other, and few had been to APA. More than a handful said this was the best meeting they had ever attended!

"My second Interprofessional initiative was to develop a curriculum for an Interprofessional seminar for integrated primary care that will be taught early in the graduate training of all health professionals. Psychology often does clinical train-

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ing and research with other disciplines *after* receiving foundational education. Other health professionals often have *early* seminars or classroom training together. We typically get on the Interprofessional train a bit late. Integrated primary care seems a perfect vehicle for such a seminar for psychology graduate students to learn with other health professionals about issues such as population health, healthcare financing, collaboration, the science of teamwork, etc.—topics that all disciplines need to learn and would usefully be learned together.

"To accomplish this task, we convened a group of talented expert educator psychologists who know integrated primary care and were already involved in Interprofessional teaching at the early graduate level. This crackerjack group was co-chaired by Ron Rozensky and Jeff Goodie, with the able assistance of Catherine Grus from the Education Directorate. We met once, but had many phone calls and emails before and after the meeting. Once the curriculum was in solid draft form, we sent it to members of the Integrated Primary Care Alliance for feedback. After incorporating their suggestions, the curriculum was posted to the APA web-site for anyone to access free of charge. Check it out! (http://www.apa.org/education/grad/curriculum-seminar.aspx). I wish all psychology students (practice, science, applied) were required to have an Interprofessional seminar early in their career, before applying any of it in practice or on research teams." The era of perhaps comfortable, but unfortunately isolated, professional silos is rapidly passing. Those fortunate to work within visionary systems of health care delivery and/or educational institutions will find themselves increasingly exposed to exciting challenges and unprecedented opportunities.

Exciting Opportunities to Contribute

Under the leadership of Dean Carol Romano, former Chief Nurse Officer for the U.S. Public Health Service, the Daniel K. Inouye Graduate School of Nursing (GSN) at the Uniformed Services University (USU) of the Department of Defense has recently initiated graduate student clinical placements in American Samoa. Located in the South Pacific, midway between Hawaii and New Zealand, this site was chosen in 1872 as a coaling station for the U.S. Navy. After the attack on Pearl Harbor on December 7, 1941, naval activity there increased significantly. On January 11, 1942, a Japanese submarine surfaced off the coast of Tutuila and fired 15 shells from its deck gun at the Naval Station, most landing harmlessly in the bay. This fire was not returned and it turned out to be the only Japanese attack on American Samoa during World War II.

American Samoa is a U.S. territory, covering seven islands and atolls. Its current population approximates 55,500 with a land mass of 76.8 square miles, slightly more than Washington, DC. It is noted for having the highest rate of military enlistment of any U.S. state or territory. Today, health care is provided by the Department of Health (DOH), the Lyndon B. Johnson tropical medical center, a VA clinic, and a federally qualified community health center. Traditional private practice is essentially non-existent. With an extreme shortage of health professionals of all disciplines, as is all too common throughout rural America, health disparities are rampant.

"Lt. Christopher Johnson (U.S. Navy) and I, Major Douglas Taylor (U.S. Army), were the first Graduate School of Nursing students from USU to complete a clinical rotation in American Samoa. It was a three-and-a-half week rotation,

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the first of a new partnership between the USU and the Department of Health of American Samoa. Professors Jill Schramm, Eric Pauli, and several other faculty members recognized the military and healthcare educational value of this experience. They worked with American Samoan partners, Sandra King-Young, DOH Director Motusa Tuileama To'atolu Nua (retired US Army), and others to establish a Memorandum of Understanding (MOU) signed personally by the Governor of American Samoa and the President of USU. Lt. Johnson is a Women's Health and Family Nurse Practitioner student and I am a Psychiatric Mental Health Nurse Practitioner student. Interestingly, Mrs. King-Young served as an American Samoan Fellow in the office of the late U.S. Senator Daniel K. Inouye. In our judgment, this clinical experience was critical to our military mission, health education, and without a doubt, our personal growth.

"The mission of a military health officer is ensuring a Ready Medical Force and a Medically Ready Force. The medically ready force ensures our Service Members are ready for combat, but the ready medical force ensures that, as a health professional, I am ready to deploy and engage in medical care anywhere in the world. Our clinical rotation to American Samoa expanded our ability to effectively meet the mission of a ready medical force. The United States projects its presence in many ways and one such way is supporting, building, and contributing to the health stability of a region. I have to be ready to engage local leaders, local media, and local health providers. American Samoa provided a real-life testing of these skills.

"On our first day, jet lag in full force, we met with the Governor and Lt. Governor (a Veteran himself) and were surprised to find both news reporters and camera crew waiting to interview us [http://samoanews.com/visiting-medical-practitioners]. My training from Army Captains Career Course and media training from Operation Bushmaster (a field training exercise at USU) kicked in, and Lt. Johnson and I successfully navigated a media event, redirecting questions like 'Will the U.S. military do anything about the supply shortages on the island?' back to our clinical mission. Lastly, each day on the island, we engaged with local health providers, providing education and mentorship—ensuring that our presence had a lasting change to island health care.

"As a health professional, cultural competence is essential to providing relevant mental health treatment. On this trip, I learned that major depressive disorder can present incredibly similar in American Samoa as it does in my practice at home. I also learned about differences, such as how the American Samoan culture emphasizes the 'We' instead of 'Me' and that multiple members of the family will show up for an appointment. I'm thinking specifically of Joan (not her real name) who was brought in by her two younger sisters for being 'forgetful.' When she was called into my office, her sisters came in with her. At first, I assumed that it would be more culturally appropriate to include her family in the interview with her. However, this assumption proved wrong and, in fact, Joan opened up much more when we were alone. I learned that I had to be careful not to impose my beliefs of privacy, but also not to overcompensate by acting on misunderstood cultural norms. I definitely still have much to learn in the practice of identifying cultural similarities and differences in the therapeutic relationship. However, I

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know I am better at it for having served even so briefly in American Samoa.

"Lastly, I grew as a person while in American Samoa and this can only be attributed to the people I met. In particular, one person stands out as both an inspiration and hero. Mrs. Mara Brown is the director at the Juvenile Detention Center. I had the opportunity to meet her and the three counselors who work at her facility. Prior to her arrival, the youth who passed through the detention center cells rarely completed high school. Since she took over, 100% of the youth graduate from high school. She turned the detention center from a focus on punishment to a focus on rehabilitation and recovery. Two of her youth have gone on to join the military, one the postal service in Hawaii, and others have become productive members of the American Samoan community. Often times, she and her counselors will work twelve-hour days or over the weekend without compensation. It was amazing to see how one dedicated individual attained the right job, built the right team, and accessed the right resources to help the most vulnerable in our society. I was able to share some of my knowledge with her and her staff during a two-hour education session on suicide assessment and prevention. It was by far the most important work I did on the island and one of the most fulfilling moments of my professional life. I am beyond thankful for the opportunity to practice in American Samoa. I know I am better for it and I am confident that the people we met valued our presence." Hopefully, the psychology, public health, and other medical school specialties at USU will soon follow the leadership of the GSN.

Substantive Change Takes Time

In 1982, the Institute of Medicine called for: "(G)reater interdisciplinary collaboration within the scientific community and more communication between it and clinical practitioners…. Interdisciplinary collaboration is not an end in itself; rather, it is a means to a higher goal – solving a problem…. (I)t should be possible to construct a reasonably unified biobehavioral science pertinent to health and disease, with major applications in all the health professions and by the public at large."

" … to live in unless we make it a reasonably good place for all of us to live in." – speech by President Theodore Roosevelt, Chicago, Illinois, June 17, 1912.

Aloha.

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PSYCHOTHERAPY BULLETIN

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

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

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