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OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

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1968 2018
50TH ANNIVERSARY

Society for the Advancement of Psychotherapy

2018 VOLUME 53, NUMBER 1

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PRESIDENT'S COLUMN

2018 President's Column: Turning Points and Turning 50!

Michael J. Constantino, PhD
University of Massachusetts, Amherst

Eight short years ago I wrote my final *Psychotherapy Bulletin* column as SAP Early Career Domain Representative. In re-reading this piece, I was reminded of my reflections on our various career "crossings," often over imaginary lines that somehow (at least through the field's lens) render us objectively more accomplished or even more expert (despite not feeling subjectively different from the day before!). At that time, I was specifically crossing the line from early to mid-career, and trying to accept and embrace all that the transition entailed. Fast-forward to today, and I am back on the SAP Board of Directors, but this time as its President. I suppose as one's career progresses, it becomes less about *crossings*, and perhaps more about *turning points*. Leading an organization like SAP is indeed a personal turning point, as one is entrusted both to serve its mission and to help it evolve. Moreover, the organization itself and our field of psychotherapy have their ever-present turning points; thus, it is fitting that such turns will be the overarching theme of our *Bulletin* content this year.

Having just returned from our mid-winter board meeting, I am amazed at how many SAP initiatives reflect genuine turning points and relentless attempts to be on the cutting edge of psychotherapy research, practice, training, and professional development. It is clear that this is an exciting time for SAP, and as I noted at our meeting, I accepted the gavel for 2018 with gratitude, humility, and excitement. I am honored to be in this position, as SAP has supported my career both indirectly in terms of its mission, and directly in the form of grants, awards, and a place to call home professionally. As your President, I hope to give back to SAP not only in serving to keep a well-run organizing humming along, but also with several new initiatives related to my Presidential themes. I am also thrilled to do this in the context of a meta-turning point, as this year SAP celebrates it 50th Anniversary!

With our birthday in our background, we have an opportunity both to honor those who have come before, and to begin to shape the next 50 years of psychotherapy. In this spirit, I will give here just a quick note of thanks to Dr. Jeffrey Zimmerman, as the most immediate Past-President to come before, as he has been an inspirational leader of our organization and a personal "Presidential Trio" mentor to me. Also, regarding the short-term future, congratulations to Dr. Nancy Murdock on beginning her term as President-Elect. I know that I will pass the gavel in 2019 into extremely capable hands! And, of course, a huge shout out of thanks to the person who most connects past to present to future, Tracey Martin (our super-human administrator!).

Presidential Themes and Initiatives

My Presidential themes are summarized in our Convention programming call: *Establishing and refining personalized mental health care: Promoting disruptive, evidence-informed innovations to psychotherapy training molds and methods*. Regarding personalized mental health care, I am referring (broadly) to a movement away

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from fitting patients into particular therapy molds based on a categorical diagnosis, toward fitting treatments to patients in a personally responsive manner. This can be about fit, attunement to individual needs, responsivity to momentary process, ways of training beyond the faithful application of evidence-based protocols, and so forth. The term 'disruptive innovation' comes from the business world, referencing the reframing/reshaping of a typical way of doing business to be more efficient and more accessible. For psychotherapy, this could mean things like boiling treatment down into its most common and effective elements, developing new treatment delivery formats (e.g., Internet, peers), using outcome monitoring data to inform continuous quality improvement, better understanding and harnessing *therapist* vs. *treatment* effects, etc. I have invited several Convention presentations that speak to these themes, and how they would reflect disruptive turning points, and other presenters responded to the call on their own accord. Stay tuned for the release of SAP Convention programming, and we hope to see everyone in San Francisco in August!

Outside of Convention, I have listed below just a few initiatives that I will spearhead that relate to the above themes directly or indirectly, and that support SAP's mission in general.

- My team conducted an original meta-analysis on the association between patient-perceived credibility of therapist/ treatment and outcome for the forthcoming book, *Psychotherapy Relationships That Work* (3rd ed.); I had already signed on to update our meta-analysis on the patient outcome expectation-outcome link, but agreed to conduct the second meta-analysis as a Presidential initiative.

- I have organized a Presidential symposium for SAP programming at APA Convention, with three presentations (to be delivered by Drs. Jesse Owen, Zac Imel, and me) and expert discussion (by Dr. Nancy Murdock) related to my multilayered Presidential theme.

- I will create a web- or newsletter-based 'brown bag' series on psychotherapy science translation/ dissemination, including a safe place to tout disruptive innovations that extend the reach of psychosocial services (consistent with our "turning points" theme).

- I will create a task force on translating cutting edge research findings to create newer psychotherapy training molds, including member's only web content, especially for continuing education purposes.

- I have created two mid-career awards, one centered on scientific contributions and one centered on practice contributions; my reasoning is that although mid-career often gets overlooked in the career arc (in terms of awards and honors), it is perhaps a time when acknowledgement is most needed/ appreciated to reinforce good work, combat burnout, etc.

- I have created two new SAP poster awards to be given annually at Convention.

- I will represent SAP at the May 2018 meeting of the Society for the Exploration of Psychotherapy Integration (SEPI) in order to raise awareness of SAP and to increase the active connection between these two organizations who share many overlapping missions and philosophies for advancing psychotherapy.

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- I will represent SAP at the Penn State Conference on Psychotherapy, for which its current "think tank" topic and book project centers on psychotherapy training.

Spotlighting Current Board Initiatives
To borrow Jeff Zimmerman's words from last year, "So much is happening in the Society for the Advancement of Psychotherapy!" Below I have chosen to spotlight just a few initiatives that have been front and center during the past year or so since I have re-joined the Board. As there are many more, please do not read into any omissions. The fact that I can only spotlight a few here underscores how vibrant our Society is, and how tirelessly our Board members and general members work to advance psychotherapy. Also note that I simply use the term "we" to indicate SAP enterprises. As there is such a collaborative spirit among our Board members, it would be too challenging to list all of the associated names behind our creativities.

- We continue, and plan to extend, our successful partnership with Oriental Insight, and we remain devoted to the internationalization of SAP.

- We are producing companion videos to the chapters in the aforementioned book, *Psychotherapy Relationships That Work* (3rd ed.); these videos, which will be cross-listed on our website and the Oxford University Press website, will be a series of interviews with contributing authors discussing the training implications of their original meta-analyses on factors that contribute to psychotherapy improvement.

- We are developing a routine outcome measure that represents psychotherapy outcomes more dimensionally and consistent with the current funding climate.

- We continue to engage in several projects to help bring psychotherapy to the underserved community.

- We are interviewing private practitioners to better understand their unique needs and ways in which SAP can be responsive.

- We continue to cultivate respect for diversity, and our Board recently completed our mandated training, which centered on ally building.

- We are developing an early career psychologist (ECP)-specific listserv, as well as ECP-relevant web content.

- We will soon roll out a newly developed advocacy and mentoring program for diversity.

- We have developed a workgroup to explore avenues for childcare at SAP meetings, Convention, etc.

- We have developed and advertised two new student awards, the Student Excellence in Practice Award and the Student Excellence in Teaching/Mentorship Award.

- We are pursuing a bylaw change to allow undergraduate students in psychology to be affiliate members of SAP.

- We continue to disseminate cutting-edge empirical, conceptual, and integrative material via our print journal, *Psychotherapy*, and our online outlets—the *Psychotherapy Bulletin*, our newly remodeled (and beautiful!) website, our newsletter, and our listserv.

- *Psychotherapy* will release two special issues this year: (1) *Cultural Processes in Psychotherapy* (organized by Associate Editor, Jesse Owen); and (2)

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Group Psychotherapy: Using Member Feedback to Enhance Clinical Practice (organized by Associate Editor, Cheri Marmarosh).

- *Psychotherapy* has a call for another special series, *International Perspectives on Psychotherapy Training and Practice*, so please consider submitting your relevant work!

50th Anniversary Activities

We have several initiatives planned for commemorating our 50th anniversary:

We have created a one-time request for proposals for the 2018 Society for the Advancement of Psychotherapy 50th Anniversary Research Grant, which will provide $30,000 toward the advancement of research on psychotherapy process and/or outcome that will help shape the field for the next 50 years.

Our anniversary has prompted us to give our SAP logo a facelift, and I have convened a workgroup to this end.

We have convened a workgroup to plan special events, especially at convention (e.g., social hour, lunch with the masters, award ceremony), to celebrate our birthday. At a minimum, there will be cake! Stayed tuned, though, for things beyond sugar.

Final Comments (for now ...)

To our Board members, thank you, again, for all that you do for SAP! To all SAP members, thank you, again, for entrusting me to lead our organization this year. We have many wonderful mission-relevant initiatives, programs, and awards, both old and new, of which we should be proud, and I am committed to helping SAP reach its goals for this year and beyond. Let's make some important turns together.

EDITORS' COLUMN

Lynett Henderson Metzger, JD, PsyD
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Happy Spring, and welcome to the first issue of *Psychotherapy Bulletin* for 2018! We would like first thank outgoing Editorial Assistant Dr. Elizabeth Coyle for her excellent service to the Bulletin, and to welcome new Editorial Assistant, Cory Marchi, MA. We would like to wish an especially warm welcome our new Domain Chairs, Representatives, officers, and other members of Governance, including our new Publications Board Chair, Dr. Laurie Heatherington, and SAP President, Dr. Michael Constantino. Finally, please join us in welcoming Dr. Terence Tracey to the Publications Board (and please see more about Terry in "Meet Your Newest Publications Board Member" in this issue).

As Dr. Constantino notes in his inaugural President's Column (found at the beginning of this issue and online at http://societyforpsychotherapy.org/category/news-announcements/presidents-column/), 2018 marks the 50th anniversary of the founding of APA Division 29. We at the Bulletin will be celebrating this milestone with a variety of special articles and online content—including a "digital scrapbook" where you can post your own memories and comments (www.societyforpsychotherapy.org/sap-50th-anniversary-digital-scrapbook). On a small celebratory note, we will be featuring the humorous artwork of Dr. Ragnar Storaasli in each of our issues for 2018; you can learn a little bit more about Dr. Storaasli and his work later in this issue ("Meet the Cartoonist" and online at www.societyforpsychotherapy.org/meet-cartoonist-dr-ragnar-storaasli).

Our Special Focus for this year is "Turning Points," a theme that invites us all to reflect on moments when things changed for us—perhaps during our training, while conducting research, or in our practice. Sometimes these moments are big, flashy signposts taking us in an obviously new direction; sometimes they are more the quiet whisper of a corner we did not realize we were turning at the time.

For the field of psychotherapy, 1968 was perhaps a little bit of both. That year, under the leadership of our first President, Dr. Fred E. Spanner (1967-1968), Division 29 was founded. Sadly, co-founder Dr. Ronald Fox died on March 14, 2018; his Remembrance can be found in this issue and at http://societyforpsychotherapy.org/esteemed-national-leader-dr-ronald-fox/.

Fifty years, and innumerable other turning points later, this organization (renamedthe Society for the Advancement of Psychotherapy in 2014) remains strong.

Our current mission statement reads:

A strong voice for psychotherapy

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and home for psychotherapists, the Society for the Advancement of Psychotherapy is committed to preserving and expanding the theoretical and evidentiary base for psychotherapy and psychotherapeutic relationships, supporting life-long learning of psychotherapeutic skills, as well as making the benefits of psychotherapy accessible to all. The Society is an international community of practitioners, scholars, researchers, teachers, health care specialists, and students who are interested in and devoted to the advancement of the practice and science of psychotherapy. Our mission is to provide an active, diverse, and vital community and to generate, share, and disseminate the rapidly accumulating evidence base in clinical science and practice.

After five decades, our commitment to psychotherapy remains strong, and this mission is carried out, day by day, across vast geographical spaces, in multidisciplinary settings, by SAP members and readers who come from different backgrounds, embrace different theoretical perspectives, and hold different intersectional identities. In this complex, diverse, and inclusive web lie both our strength and our future. We hope you will be a part of all that SAP is, and will help us shape what can be (for more thoughts on the future of psychotherapy, please see the Associate Editor's Column, "**http://societyforpsychotherapy.org/psychotherapy/**").

Our next deadline is May 1, 2018; the remaining deadlines for the year are August 1 and November 1. Please consider joining the conversation through an article (submission guidelines and the online submission portal can be found at http://societyforpsychotherapy.org/bulletin-about/), comment, or suggestion.

We look forward to celebrating SAP's 50th with all of you,

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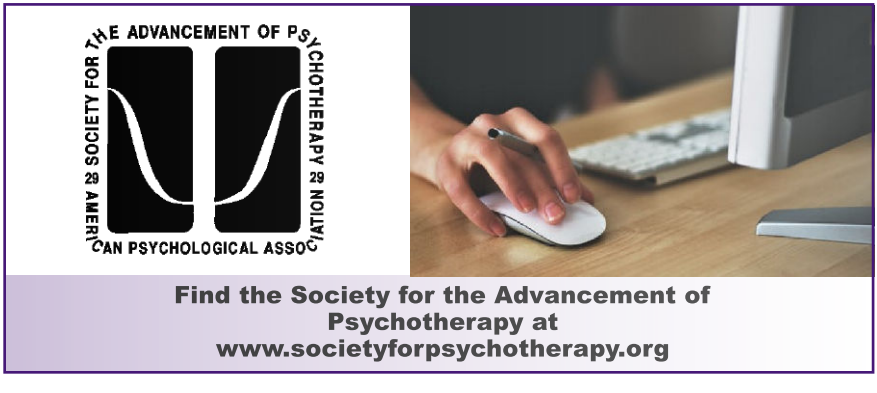

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ASSOCIATE EDITOR'S COLUMN

Psychotherapy: The Next 50 Years?

Cara Jacobson, PsyD
Loyola University Maryland

It's the year 2068 and a client is seeking therapy. What will this process look like? What will psychotherapy look like? Will it be completely unrecognizable? As I reflect on the future of psychotherapy, I feel simultaneously exhilarated and terrified about the future of our field. Will people continue to seek therapy through internet research, word of mouth, and referrals from other professionals? Or will there be some new technological database or app that we cannot even yet imagine that will promise to match clients with their perfect therapist by swiping left or right?

I have many high hopes regarding where psychotherapy will be in in 50 years. My hope for the future is that our field will continue to advance in research and advocacy around equity and inclusion … that we can increase the efficacy of treatment and reduce premature dropout rates of marginalized populations … that the therapists available to treat truly represent and look like the people who could benefit from treatment … that therapy is widely available, accessible, and affordable for everyone … that the stigma around mental health continues to dissipate and that people talk openly and with pride about the therapy they are seeking.

While hopes of the future fill me with excitement, I have to admit that I also have a good amount of fear and dread related to what could happen. In my private practice, I highly value sitting directly across from my clients, putting away our phones and devices, and creating in-the-room human connections. When I'm engaged in video or telephone psychotherapy sessions, I often feel that some important factor is missing. I miss the in-person interactions that make me feel more connected to my clients. I also notice that my ability to feel and demonstrate accurate empathy decreases a bit when I'm not seated directly in front of my clients. And yet, as I reflect on telehealth, I am painfully aware of the convenience, increased accessibility, and new opportunities for care that it offers our clients.

I acknowledge that we have entered a time period in which our interpersonal relationships have shifted due to the intimate relationships we have created with the small devices we constantly have next to us. We have become enmeshed with these devices to the point that it has become anxiety provoking to be without them, even in private spaces like the bathroom. On one hand, these devices have afforded us increased interpersonal connections, in that the physical space between us and our loved ones feels less threatening when we can FaceTime and text at any hour of the day. Paradoxically, the same technology that reduces geographical distance from loved ones creates emotional distance and disconnection in in-person interactions. How often have we felt ignored or triangulated by our friends' or our partners' phones?

I think this use of technology has become, and will continue to be, our new normal—and of course that will affect

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the way in which we conduct psychotherapy sessions. My greatest fear is that technology will continue to progress and that clients will end up with robot therapists that are programmed to say the perfect empathic statements but who will be poor substitutes for interpersonal connections. Or that perhaps scientists will create some Black Mirror-esque implant for the brain, rendering people happy and well-adjusted all the time so that psychotherapy becomes irrelevant and outdated. My hope is that we can find ways to remain current with the changing times; to both utilize the convenience and benefits of telehealth while continuing to value our unique ability to connect so deeply with our clients.

In 1968, could any psychotherapists have predicted what our field would look like in the year 2018? Would the changes that have been made related to empirically validated treatments, changes in best practices, ethics, and technology in these past 50 years feel futuristic, unfamiliar, and unfathomable? Or is psychotherapy really that different at all? Do the common factors related to the importance of the therapeutic relationship and the basic tenants of what is helpful in the treatment room still stand strong? And will they continue to do so 50 years in the future?

Contributors to *Psychotherapy Bulletin* will be exploring these questions over the course of the next year—we would love to hear your thoughts, as well. Feel free to comment on this piece or submit an article for the Bulletin at: https://sapwebsite.wufoo.com/forms/psychotherapy-bulletin-sap-author-submission-form/

Society for the Advancement of Psychotherapy International Research Grant for Students and Early Career Professionals—
DEADLINE EXTENDED TO JUNE 15

Consistent with the goals of the Society for the Advancement of Psychotherapy (SAP) and its International Domain, the International Research Grant for graduate students and early career professionals was established in order to promote more international and cross-cultural research within SAP and within the profession of psychotherapy.

The International Research Grant is expected to be used to support the completion of a research project. The grant may be used to fund:

- supplies used to conduct the research;
- training needed for completion of the research; and/or
- travel to present the research (such as at a professional conference).

The Society may award this $1,000 International Research Grant to a graduate student or early career professional (within 10 years of receiving the doctoral degree). The applicant must be a member of the Society. This grant is available to all graduate students including U.S. citizens, permanent residents, and international students and affiliates. The recipient of the grant will be expected to present their research results in a scholarly forum (e.g., presentation at an APA Annual Convention, the Society journal, Psychotherapy, or other refereed professional journal) and the Psychotherapy Bulletin.

A complete application must be submitted by email to the International Domain Representative: Frederick Leong (email: fleong@msu.edu) by midnight, June 15. Incomplete or late application packets will not be considered. For more information, visit: http://societyforpsychotherapy.org/international-research-grant-students-early-career-professionals-ecps/

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May 11, 1936 – March 14, 2018

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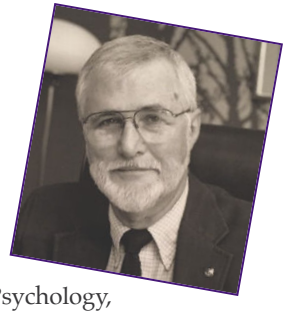
Former APA and Division 29 Presidents



Those of us who passionately believe in the mission of Division 29, and the importance of an autonomous psychological profession for the wellbeing of our nation, lost one of our most beloved and visionary leaders with the passing of Ron Fox on March 14, 2018. Ron served as APA Recording Secretary for two terms and as President in 1994. Over the years, he held an incredible number of leadership positions within the Division (co-founder and President in 1981) and throughout the APA governance. He served on, and often Chaired, the APA Insurance Trust, Council of Representatives, Finance Committee, Education and Training Board, Committee on State Legislation, Committee for the Advancement of Professional Practice (CAPP), and the Association for the Advancement of Psychology (AAP). He was an ABPP Diplomate. Our Division honored him numerous times for his Outstanding and Distinguished Service. A rare visionary, Ron was always thinking ahead. For example, today, our nation's healthcare system is emphasizing interprofessional and integrated care. In the early 1980s, Ron and another former APA President, Dr. Nick Cummings, established the National Academies of Practice, with Ron servicing as the Founding Chair of the Psychology Academy.

As the first member of his family to attend college, our leader became a mentor to generations of clinicians, educators, and those who eventually became leaders of the APA. As Dean of the Wright State University School of Professional Psychology, he set the standard for quality professional education. He served as a mentor for numerous Deans of Professional Schools, including Nova Southeastern University, where his wisdom was greatly appreciated. One of the founders of the Association of Psychology Postdoctoral and Internship Centers (APPIC), he was instrumental in convincing our professional schools and internship sites to appreciate that they should not view themselves as independent entities, but should instead take the broader view of the profession as a whole and coordinate their efforts for the benefit of their students. Personally, we were particularly impressed by Ron's sensitivity to the unique stresses and aspirations of the profession's women—this was one of his most cherished Presidential initiatives and, once again, he was way ahead of the times.

APA's immediate Past President, Dr. Tony Puente, was able, as his last official act, to personally present Ron with his Presidential citation within days of his passing. Quoting in part:

> From humble beginnings to being President of our great association, Ron Fox has been driven with a vision of making our world a better place through making the profession

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of psychology a central change agent. His long and illustrious career has spanned several decades and various settings including as a clinician, a professor, and an advocate for the profession of psychology. Starting early in his career, Dr. Fox stood firmly for ethnic-minorities, for women, and for the poor, when such advocacy was considered unimportant …. Ron Fox has been a calm, steady, and reasoned voice for all of psychology for almost half a century. For his efforts, his resiliency, his vision, and the many results that have made the profession of psychology what it is today, on this last day of APA's 125th anniversary, let it be known that Ronald E. Fox is presented this APA Presidential Citation.

We shall deeply miss our leader—his smiles, his "fox-isms," his vision. He could break through impasses with comments like "That's like trying to put smoke in an envelope." He was always a step or two ahead of us—creating the Practice Directorate, supporting APA's newest reorganization, urging all of us to contribute to political action. He helped create the "Wild Card Plan" that reorganized Council to seat all State, Territorial, and Provincial Psychological Associations who heretofore had been consigned to non-voting liaison status. Everyone who interacted with Ron always came away knowing that he deeply cared about us as individuals and psychology as a profession. He was a courageous person. Those of us who were active within the governance over the years were so happy when Ron and Judy were married almost a decade ago. They were the perfect couple.

We shall all miss you Ron. Aloha.

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

SPECIAL SECTION: TURNING POINTS

EARLY CAREER

On the Search for Meaning: Reflections on My Early Career Turning Point

Leigh A. Carter, PsyD
Towson University

This year's *Bulletin* theme focuses on the notion of turning points in psychotherapy training, research, and practice. Turning points can be considered an alteration in direction or course, a response to a need for advancement or change. Such turning points are not only present and significant in the field at large, but also exist within our own professional journeys. These turning points can range from small changes to significant milestones and can occur throughout the professional career. Having recently experienced my own professional turning point, I thought I would take this opportunity to reflect and share on my experience.

My own recent turning point was a response to the professional development challenges I was experiencing over the last year. Having completed graduate school several years ago at this point (although sometimes it feels like just yesterday), I find myself approaching the middle stage of the early career lifespan. My first few years as an early career psychologist (ECP) were largely defined by settling into my role as a staff psychologist at a university counseling center and having more time to devote to my personal life. So used to the graduate school experience of having hurdle after hurdle to complete, it felt like the pace was finally slowing down. I was coasting and very much enjoying it.

Fast forward to this past year: I started to notice that this sense of coasting had turned into a void. At first, it was barely noticeable; I thought perhaps it was due to increased demands and stress at work, but even when the stress subsided, the void was still there and grew over time in size and shape. I found myself having less energy and enthusiasm. Knowing that I had worked so hard and for so long to reach this point of my career, it was difficult for me to initially accept these feelings. Sharing my experience with colleagues and in my own personal psychotherapy helped me to understand that this void represented feelings of both boredom and stagnation in my clinical work. Though I wear many hats in any given day as a university counseling psychologist (supervisor, therapist, case manager, administrator), working at a site that primarily practices short-term psychology, I felt frustrated by the limitations in what I could and could not achieve within a short-term model. I also felt restricted at times by the age and limited life experiences of the clients with whom I was working. Additionally, I noticed myself feeling clinically "stunted": Although I was using the tools I had learned and trying to be as helpful as I could be for clients, at times it felt like I was reaching the limit of my professional skills thus far. I felt aware of how much more there was for me to learn and of a desire to advance my clinical skills. What surprised me most was not so much the

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idea that I was feeling this void, but rather that I was feeling it so early in my career. Wasn't this something more common among mid-career psychologists? Apparently not.

Research suggests that my experience as an ECP may not have been as unique as I had imagined. ECPs report lower job satisfaction and greater intent to leave their current job position than more seasoned psychologists (Dorociak, Rupert, & Zahniser, 2017). Additionally, ECPs report more professional stress, including greater emotional exhaustion and less personal accomplishment, than more seasoned colleagues (Dorociak et al., 2017). The same research indicates that in contrast to late- and mid-career psychologists, ECPs also report relying less on professional self-care practices such as professional support, engaging in professional development, work-life balance, cognitive awareness, and daily balance. Thus, not only are ECPs more at risk for symptoms of burnout, but we are also less likely to be engaging in the practices that can help us reduce our risk (Dorociak et al., 2017).

In my own experience, I believe I was missing a greater sense of meaningfulness in my professional work. While for me this desire for meaning-making was predominately reflected in my clinical work, this is not the case for everyone. For example, some ECPs may feel a void in not being able to participate in training or supervisory roles. Those who work predominately in clinical work may desire to return to opportunities for research or teaching and vice versa. Others may experience a desire to give back, to the profession or to the community at large. Such experiences, like my own, can provide exciting opportunities for turning points, if one is willing to seek them out.

Below are just a few of the many professional development opportunities ECPs may consider when facing their own sense of a professional void:

Seek Consultation

Many ECPs, especially once licensed, no longer have access to ongoing supervision or consultation compared to their time in graduate school. While some work environments may offer formal or informal peer consultation groups, for many ECPs the experience of increased isolation can be a significant shift (Green & Hawley, 2009). No longer still in training but not yet a seasoned professional, I also find that as an ECP it can sometimes feel intimidating or even anxiety-provoking to seek consultation. I have wondered, "Is this something I am already supposed to know?" Opportunities for consultation can include joining a pre-established peer consultation group at your work or in your community, seeking out a psychologist who offers paid consultation hours, or more informal consultations with colleagues. Several colleagues of mine have started an online peer consultation group with former classmates now located across the country. If appropriate, you can also consider taking the lead in advocating for the establishment of peer consultation at your place of employment or establishing one in your community.

Develop Mentoring Opportunities

Consider seeking out formal or informal mentoring opportunities. Mentors can provide guidance and support for ECPs on such topics as career decisions, networking, student debt and finance issues, balance and self-care, and leadership (Green & Hawley, 2009). Other ECPs may not be searching for a mentor, but looking for ways to become one. Recently I met with a friend who has transitioned into private practice, and she

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shared that she missed being involved in training, which had been a significant part of her previous job. As a result, she volunteered to become a mentor to a graduate student through a mentoring program organized by her local state psychological association. For ECPs who may not have opportunities in their places of employment for involvement in training or advising, consider serving as a mentor to those just starting their professional journeys, including undergraduate and graduate students.

Pursue Advanced Training

The early career phase of one's professional development can be a great time to begin thinking about advanced training or working towards developing a particular clinical niche. For those who work for institutions or organizations, consider inquiring if your place of employment offers funding to support such professional development opportunities. For those not ready to commit to advanced training in a particular area, consider seeking out CE opportunities in areas of potential interest to help you decide.

Expand Your Role(s)

One of the aspects of being a psychologist that I was most drawn to is the notion that psychologists can wear many hats and are not limited to just one type of work. Consider exploring additional roles that may be available to you as a mental health professional. This can be anything from starting a private practice to teaching a course, providing supervision, increasing your engagement in research, or becoming more involved in professional organizations—the list is endless. It also does not have to be a significant commitment, and instead can involve a series of one-time opportunities such as offering a seminar to a local community group or graduate training program.

Set Goals for Yourself

My first day of employment my boss asked me, "So, what is your five-year plan?" I realized at that moment that I had given so much thought and energy to getting to the point of having this job that I had not seriously thought much beyond it. Establishing short- and long-term professional goals for yourself, drafting a plan for the next five, 10, even 15 years, may sound daunting at first. However, this can not only provide you with an opportunity to reflect on your professional values, needs, and aspirations, but also help you get started in determining a path to get there.

My own turning point came in the form of three main changes I made in my professional life. The first was taking the leap and establishing a part-time private practice. Always a dream of mine, this provided me with increased autonomy, greater clinical diversity, an opportunity to return to longer-term psychotherapy, and allowed me to engage in new professional activities such as marketing and finance. Secondly, I contacted a former supervisor and sought out regular consultation to help me expand my clinical repertoire and gain additional support regarding my professional development issues. And finally, I chose to become more engaged in professional organizations, including Division 29. More than I even anticipated, it has been a great experience connecting with other professionals, has afforded me many opportunities for informal mentoring, and has felt extremely rewarding in being able to give back to the profession.

It feels important to clarify that none of these changes happened overnight. Nor am I suggesting one needs to engage in all of the items on the list above in order to address professional development challenges. Turning points can come in

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all shapes and sizes. More than ever before I am aware that my own recent turning point is likely one of several I will encounter during the course of my career. I have become more open to seeing the early career phase as a time of great exploration, openness, and flexibility as I continue to mold my ever-changing professional identity.

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Clinical Impact Statement: This articles provides information on professional development issues relevant to early career psychologists and those who train and support them.

Keywords: Early career psychologist, professional development, mentoring, consultation

Meet the Cartoonist

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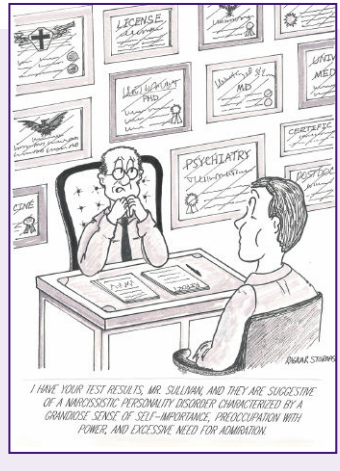

Ragnar Storaasli is an applied behavior analyst, recognized trainer in Acceptance and Commitment Therapy, and research methodologist with a long association and commitment to teaching, training and supervising doctoral students at the University of Denver's Graduate School of Professional Psychology, where he serves as a clinical associate professor. He is known to be thought provoking and entertaining while passionate and committed to helping others achieve their very best. Ragnar brings that same kind of energy, commitment and passion to his clinical work where he is devoted to helping individuals heal the past, empower the present, and achieve a future that is vital and lived according to their personal values. His approach is real, pragmatic, honest, and fully directed to helping people live the life they really want—no gimmicks, therapist shtick or psychobabble. In a very deep sense, Ragnar believes that all human beings are in the same boat. What unites us can trap us all, but every human being has the ability to live a life that truly matters. He has published in several areas of psychology and has also done cartooning work for books on Marital Psychology, Money and Marriage, and Sex Education.

SPECIAL SECTION: TURNING POINTS

PUBLIC INTEREST AND SOCIAL JUSTICE

Ripple Effects: One Psychologist's Post-Election Journey

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Argosy University Northern Virginia

The day after the 2016 election dawned cloudy and rainy in Washington, DC. As I awoke from a few hours of fitful sleep to drive to work, I felt shocked, disoriented, and confused. The long election season had intensified political divisions, information silos, alternate worldviews, extreme partisan attacks, and disrespect and disgust for the other side (Kaplan, Gimbel, & Harris, 2016). How was my job as a training director for students of clinical psychology relevant to what was happening in our country? That afternoon, I was scheduled to lead 40 first-year doctoral students in a meeting to prepare them to apply to next fall's practicum. I was supposed to support and encourage my students—but I was feeling awful. I wandered into the offices of several fellow faculty members for support. I also reread our five Ethical Principles in the APA Ethics Code: Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity (American Psychological Association, 2017). As I read, I was reminded that in this confusing time, what psychology stands for—what we as professionals stand for—was still worth standing for, even fighting for.

But what I had been doing professionally—Director of Clinical Training, and a small private practice—no longer felt like enough. I needed to do more, at least for a little time each week. But how and where to get involved? What could I, as a psychologist, contribute towards healing sociopolitical divisions? I started by asking one of my communities, my graduate school's alumni listserv.

> Fellow alums, In the aftermath of the election, with all the fears, anger, and divisions going on in our country, I want to do something to contribute to healing the divides. Our skills in listening, facilitating groups, and helping people to understand their reactions to others and learn from a process of dialogue, seem to be very much needed. How can we help most directly in these times? …What have others been doing and finding useful? Let's support one another in skillful action. (D. Sacks, personal communication, November 17, 2016)

I didn't know what to expect from my post, but I was heartened by the ensuing lively online discussion; six alums ranging from 1981 to 2014, and living in New Jersey, Connecticut, and DC, soon joined me for an impromptu conference call.

We shared several reactions to the current situation post-election: fear, vigilance, anger, sadness, hopelessness, grief, paralysis. Some expressed a need to escape "echo chambers" so as to understand why Trump's supporters voted for him. Some expressed a desire to

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build skills in conducting dialogues, whether among groups of more like-minded people, or, more ambitiously, across the political divide. Most expressed concern and alarm about what Trump's election would mean for advocacy around important psychology-related issues such as climate change, immigrants and refugees, race and justice, and police violence.

And we had many questions for one another. How could we as clinicians "work on ourselves" vis-à-vis our own reactions to the political atmosphere, as well as the reactions of our patients? How could we help current clinical psychology students? Could we promote dialogues around post-election feelings and concerns, in families, schools, religious organizations, psychology organizations, advocacy organizations, training programs, supervision/consultation groups?

Since the call, I have continued email and Skype exchanges with three of the participants, each of whom has defined a personal-professional path of activism. And I have tried two avenues of activism myself: reflective structured dialogue, and nonviolent active bystander training.

Bridging Divides?

Encouraged by the warmth and mutual support on the conference call, I resolved to attend a three-day training with Essential Partners, a Boston-based consulting and training organization working to foster constructive dialogue. Its consultants had a compelling history and a powerful methodology. In the 1990s, when controversies over abortion in the Boston area had culminated in deadly shootings at a Brookline medical clinic, they had facilitated a dialogue between leaders of pro-life and pro-choice movements, leading to lowered tensions and a growth of respect and civility in relationships between opposing sides. Reflective Structured Dialogue had subsequently been utilized in schools and universities, faith communities, and civic groups, in the United States and internationally (Chasin et al., 1996; Herzig, 2014). In the training, I learned and practiced how to design and facilitate conversations in which participants from various "sides" in a conflict can share their personal lived experiences, address deep concerns, acknowledge their uncertainties, listen to others with curiosity and respect, and find strength and new possibilities for working together (Essential Partners, 2018).

I returned to DC enthusiastic to convene dialogues of my own across the political divide. At first, I saw signs of interest. Van Jones had been holding his "Messy Truth" conversations (Jones, 2016, 2017). There was a spate of newspaper stories and online guides about how to discuss politics with family members over holiday dinner tables (e.g., Showing Up for Racial Justice, 2016). In late November and December, I noticed a distinct upsurge in interfaith activities, and attended a "walking pilgrimage" in DC from a synagogue to a church to a mosque featuring prayers on the theme of "Choosing Unity Over Extremism." I joined some 300 singers from various congregations in a musical rally on the steps of the Lincoln Memorial. In January, I participated in a workshop on connecting across differences that exemplified the benefits of structured political conversation (McMahon, Likanasudh, & Solomon, 2017).

On my campus, there was much interest in convening a post-election discussion. In late January 2017, the clinical Student Government Association announced "an open discussion about how the mental health field may be impacted; our personal experiences post-election;

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our hopes and fears; and where to go from here – collectively moving forward as psychologists in training." I met with the student and faculty organizers to help refine ground rules: "Allow others to speak. Say what you feel. Share the time with others. Treat each other with compassion, and a non-judgmental attitude. Listen deeply. Be respectful of others' statements whether you agree or disagree. Focus on the topic." Over 40 students and faculty attended. Individuals spoke solemnly, thoughtfully, seriously, sharing personal stories and beliefs. Some of the themes included fears about increased discrimination, divisiveness, intergroup polarization, violence, and deportations; concern over rollbacks in mental health and other services; and a disregard for facts in public conversations. This forum was a step towards a campus culture more open to hearing one another's personal stories, which I have come to understand is a crucial, perhaps the crucial, ingredient in changing people's beliefs about "other" people. Nationally, many of my faculty colleagues in other programs of the National Council of Schools and Programs of Professional Psychology (NCSPP) report similar sorts of discussion forums on their campuses.

Nonetheless, my efforts to convene a more formal, sit-down dialogue across political divides were unsuccessful. Why? As I reached out to friends, relatives, and neighbors, I found several "liberal" individuals willing to participate, but I failed to enlist a co-sponsor from any conservative group. Republican party officials did not answer my email inquiries. I had a telephone exchange with one Trump-voting neighbor who was willing to talk to me about his opinions, but unable to make time to meet. Another neighbor wrote me long emails complaining about how liberals in the community had for years said offensive and insulting things about his religion and politics; he had had enough, and was planning to move to a community more compatible with his views. And a local businessman well-known for his philanthropy also turned down my invitation, fearing that if his political convictions became publicly known, his business would face a boycott. On the plus side, I met a notable champion of bipartisanship, former Congresswoman Connie Morella.

Around the country, others were making some efforts to bridge divides, including the Bridge Alliance, Living Room Conversations, Better Angels, Hi From the Other Side, and the National Coalition for Dialogue and Deliberation. I discovered a rich literature discussing political, economic, and social divides in the United States (Anderson, 2016; Haidt, 2012; Murray, 2012; Putnam, 2007; Wagner, 2016). Overall, it seemed to me that that serious dialogue would occur only when significant numbers of people experienced the conflict as carrying too high a price. In 2017 at least, I observed that people were more energized by continued conflict: on the left, by "resistance," and on the right, by a feeling of triumph.

Becoming an Active Bystander

During the first week of January 2017, I got a notice forwarded by Dr. Luisa Saffiotti inviting people to a training-of-trainers in Nonviolent Active Bystander Intervention. I had heard Luisa, a former President of Psychologists for Social Responsibility (PsySR) speak eloquently to students on my campus about PsySR and liberation psychology (Watkins & Shulman, 2008). That snowy Saturday, I showed up at a nearby church social hall which turned out to be buzzing with activity. Sixty articulate, energetic people from various communities gathered in a

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big circle. Kit Bonson and her colleagues from the Montgomery County Civil Rights Coalition introduced the training, along with its audacious objective: to train between 1,000 and 2,000 people by January 19. We trainers were asked to pair up with a co-leader, find large meeting spaces throughout the DC metropolitan area, and lead trainings for residents and visitors to town for the Women's March on January 21. I was ready to be asked to do a lot, and energized to be part of a large group effort.

Why Nonviolent Active Bystander Intervention? At that time, there was a nationwide spike in hate speech and incidents of harassment in schools, on the street, on public transportation, in stores, and on university campuses (ProPublica, 2018). Nonviolent Active Bystander Intervention Training is a 3-hour, hands-on workshop that gives participants skills to respond to a situation happening in a public space when someone is being targeted, especially based on a perceived difference from the "attacker" (race, nationality, sexual orientation, gender identity, etc.).

Many psychologists wonder how they can do more to help with the vital sociopolitical issues facing us now. So many people—immigrants, people of color, members of the LGBTQ+ community, women, kids in school, and others—are seeing more harassment, bias incidents, and hate crimes. Nonviolent Active Bystander Intervention Training helps ordinary citizens prepare themselves to actively, yet safely, respond to such incidents—to stand up for others, and make a difference. Psychologists are especially well suited not only to learn the techniques, but to teach them to others on campuses and in our communities. These trainings will increase our collective capacity to spread nonviolence and create unity.

What kind of problematic situations call for active bystander intervention? Some examples:

- A man harassing a woman with a hijab on public transportation
- Verbal attacks on the street (from a moving car or a pedestrian)
- A person harassing a Latino man who is speaking Spanish with a store clerk
- A woman at a bar (or social situation) being pressured or maneuvered for sex
- Scenarios at a demonstration: activists being cat-called by opposition; witnessing civil disobedience; harassment going through a security checkpoint.

In these situations, bystanders are often unsure of how to get involved, feel intimidated, don't want to make a situation worse, or are unsure how their help will be perceived by the victim of the attack. We also know that the "bystander effect" suggests that the more people are around, the less likely anyone is to take action. But when one person acts, others often follow. This training focuses attention on de-escalation, not confrontation. Active bystanders are trained to focus on the person being attacked, not the attacker, and implement solutions that bring an incident to a close peacefully and quickly. The training is grounded in the same principles of nonviolence that the Reverend Dr. Martin Luther King, Jr., and Mahatma Gandhi used as the basis of their nonviolent protests. That is, we do not hate people; we work to change bad behavior and unjust systems.

At the end of our training-of-trainers, Luisa and I worked together and offered the training on January 20 at the Washington School of Psychiatry, an institute providing post-graduate education to mental health providers and the com-

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munity. We had 41 attendees—part of a larger effort that trained 1,700 people that day.

After the January training, Luisa and I discussed where else we could offer it. On August 2, 2017, NCSPP and George Washington University's PsyD program co-hosted a morning training, and APA Division 48, the Division of Peace Psychology, hosted an evening training. A combined 22 trainees attended the sessions. One of the attendees subsequently offered the training in her community in Michigan. At last count, bystander intervention training has been provided to over 2,500 people. Training materials are offered online, at no charge (Montgomery County Civil Rights Coalition, 2018).

Bystander intervention is one of many ways to fight hate. The Southern Poverty Law Center urges people to join with churches, schools, clubs, and other civic groups; show active support for victims of hate crimes; educate ourselves about hate groups, hate crimes, and bias incidents; hold a unity rally; pressure political leaders to take a stand; teach inclusion and acceptance at our schools and university campuses; and examine our own biases and stereotypes (Southern Poverty Law Center, 2018).

Many psychologists think that advocacy or social justice must be big. My personal journey of action and learning has been more like a series of small actions—with, I hope, ripple effects. There are many ways to become more active, based on one's skill set, personality, location, and social and organizational connections.

Editors' Note: For an Early Career perspective on this topic, please also see: Alexander, A. (2018). Social justice, advocacy, and early career practice. *Psychotherapy Bulletin*, *53*(1), 51-55.

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Clinical Impact Statement: This manuscript describes some ways in which mental health clinicians can involve themselves in urgent sociopolitical issues. Some ways to become active and make a difference include networking with fellow professionals and in our local communities; utilizing our skills in group facilitation to design dialogues on political issues; and teaching and training fellow professionals in bystander intervention.

Keywords: Social justice, self-care and development, dialogue, nonviolence, bystander intervention

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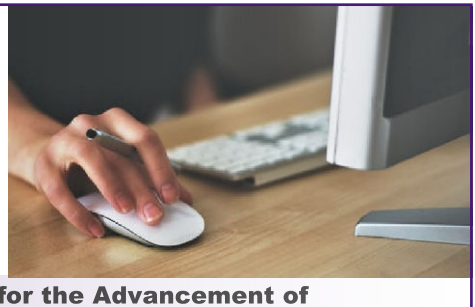

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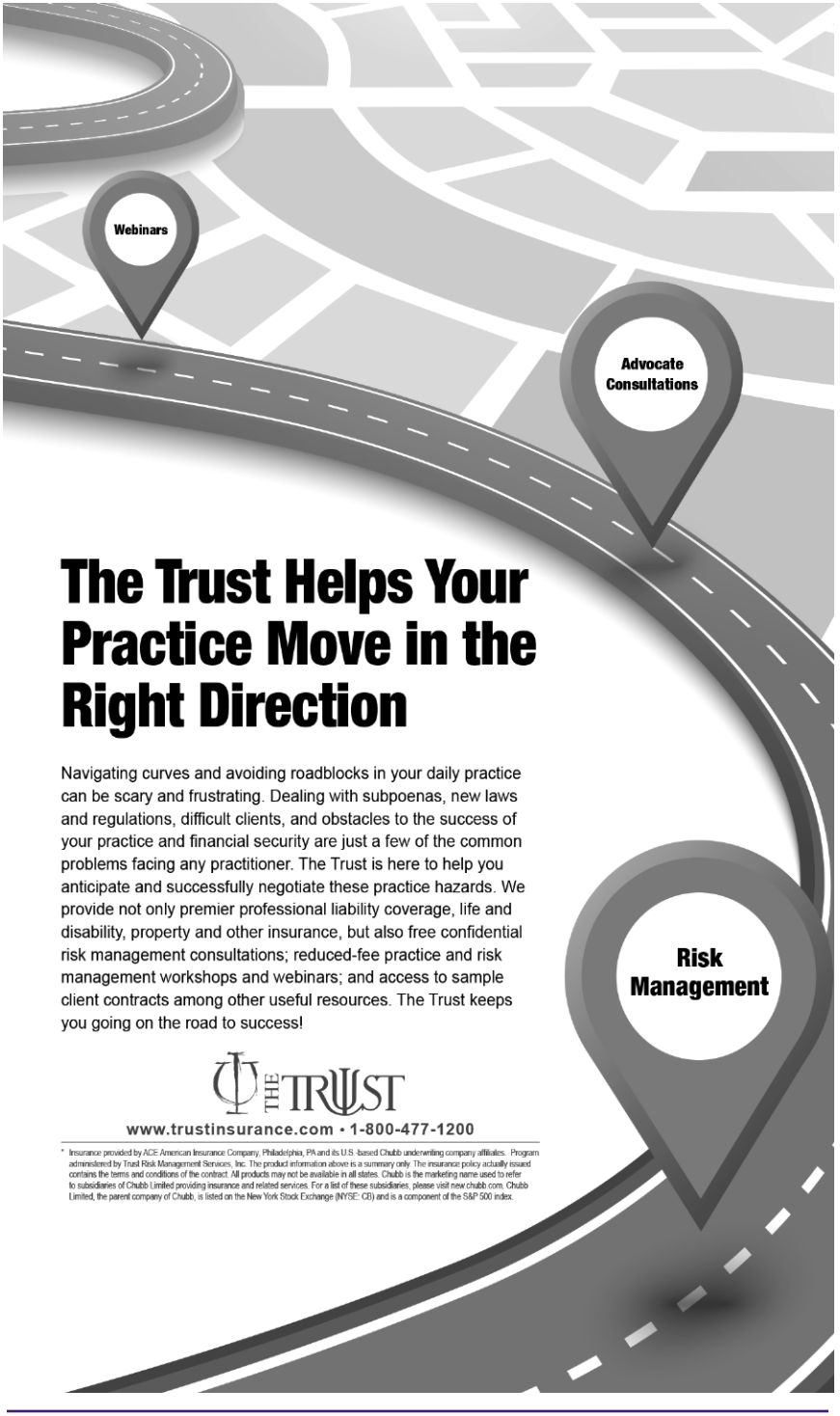

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SPECIAL SECTION: TURNING POINTS

EDUCATION AND TRAINING

Turning Points in Training: Self Reflection, Growth Edges, and Strengths

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I am writing this article as a counseling psychology doctoral student who still has much training left to do. Nevertheless, throughout my training I have already come to realize that learning to be a good psychologist requires a ruthless examination of yourself. This examination must include a willingness to explore one's weaknesses and vulnerabilities. However, I have also come to realize that this self-reflective stance must include an ability to identify and reflect and make use of one's strengths. Below I share several "turning points" that helped me learn the importance of reflecting on my strengths and weaknesses.

My first therapy client during my master's program was also a graduate student working on a psychology degree at another university. Throughout the intake, she was generally soft-spoken. Although she described her mood as good, her affect was somewhat constricted. Initially, she seemed detached/distant, and provided vague responses to questions. By the end of the intake, although I had managed to cover a wide range of topics, each area had only been discussed at surface level.

Following the intake, I attempted to formulate a case conceptualization and diagnosis. However, I found myself confused about my client's dynamics. I decided to seek help from my supervisor, who had already watched the videotape of the session. I reminded my supervisor of my client's main traits: perfectionistic, rigid, and overly conscientious. My supervisor offered a few tips for parsing out the possible diagnoses, and then stated that I should explore my negative countertransference. My supervisor noted that I seemed distant in the interview and wondered as to whether my own behavior suggested that I disliked my client and felt angry at her.

I immediately felt criticized by my supervisor's comments, which triggered my fears of being a bad trainee and future therapist. Reluctant to admit these fears, I concluded that my supervisor must be mistaken. I made a conscious decision to appear present and compassionate during my next session with the client in order to appease the situation. However, as my client spent the majority of the session voicing concern for her grades and expressing shame for previous grades, I found myself extremely annoyed.

A few days later, I watched the tape of the session and reflected on my own affect and behaviors more closely. As I watched the tape, I noticed that I sat with a rigid posture throughout the session and conveyed disinterest in her problems. Most importantly, I noticed the glaring similarities between my

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client and myself. After deeper reflection, I realized that the very qualities with which I struggle were shared by my client. Consequently, working with her had triggered my own fears of failure, fraudulence, and inadequacy. I realized that these feelings had greatly impeded my clarity and empathy for her problems.

During the next session with my client, I decided to address my countertransference. I verbalized to the client that I felt badly for keeping my head down and writing for the majority of our first session. I then requested feedback from her regarding her feelings about our first few sessions. The client explained that although she did feel that I appeared preoccupied during the initial intake, she felt that I had "made up for it" during the last few sessions. To my surprise, the client also revealed feelings of inferiority and competitiveness toward me because we were both aspiring therapists.

Once she shared her own transference, I realized that every countertransference reaction is accompanied by a transference reaction. I now view transference and countertransference as inevitable parts of the therapeutic process that, when addressed properly, can help develop a sustainable therapeutic working relationship. Thus, I came to understand that my supervisor's observations were not intended to be hurtful, but instead were offered as valuable information from which to learn. Indeed, I have come to learn that part of becoming a therapist is having one's aspirations of perfectionism constantly challenged. Even more importantly, that the process is not about "doing it right"; it is about finding your way with another person and "making sense together" (Buirski & Haglund, 2001, p. 27). This collaborative stance requires openness to reflecting on one's areas of struggle. Over the next few years I honed this skill of continuously exploring my growth edges.

Fast forward several years later, I am sitting in Dr. Candice Hargons' social justice consultation and evaluation class at my current university. We were delegating tasks to each member of the class. This process involved a discussion about who would be best for each role (e.g., focus group leaders, individual interviewers). In order to facilitate this discussion, Dr. Hargons asked each of us in the class to name something we are good at that would be of value to the consultation process. The room fell silent and everyone immediately appeared uncomfortable, myself included. I even began to conceptualize my struggle to reflect on my strengths as a weakness in it of itself. Dr. Hargons seemed surprised that we were unable to identify and state our own strengths. At this point, she went around the table having each one of us verbalize what we bring to the consultation team. Perhaps what stood out the most during this event was that she even challenged our use of qualifiers. My classmates and I left class feeling more confident in our ability to work together and be effective. We also felt a sense of empowerment, as most of the time we wait to be informed of our strengths.

The irony of this event is that a primary defining value of counseling psychology is a focus on people's assets and strengths (Gelso, Nutt Williams, & Fretz, 2014). Indeed, it is now widely accepted that identifying strengths should be a routine part of clinical assessment and case conceptualization (Gelso et al., 2014). Yet it is not uncommon for therapists to report feelings of anxiety and embarrassment when asked to reflect on their strengths (Haarhoff & Thwaites, 2016). If one of our primary aims is to help others identify their strengths, it

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seems important that we be able to identify our own. Engaging in regular strength-identifying dialogue likely increases confidence in one's abilities as a counselor. Research demonstrates that receiving positive (strength-based) feedback enhances counselor self-efficacy (Barnes, 2004). Nevertheless, it seems possible that we come to rely on others to identify and affirm our strengths (Morrison & Lent, 2014). Perhaps the push to be self-aware leads us to focus on our deficits without acknowledging our strengths.

I think this aversion to identifying our own strengths arises from multiple sources. For example, trainees are often showered with information about the harm that can come from not being aware of one's weaknesses. A lack of awareness can lead to errors in clinical judgments and a lack of therapeutic effectiveness (Knapp, Gottlieb, & Handelsman, 2017). Being modest, self-critical, and receptive to negative feedback reduces complacency and the likelihood of making errors in clinical judgement. However, there is some research indicating that too much self-awareness about one's shortcomings can serve as a distraction within the therapeutic setting (Thériault, Gazzola, Richardson, 2009). Thus, I think we have to learn to use all of who we are, both strengths and weaknesses.

I think a focus on using strengths and weaknesses should be emphasized early in training. A few months ago, I was supervising a first-year student in the counseling psychology program at my current school. She asked if I could help her with an assignment asking her to list her strengths as a helper. My supervisee had listed numerous growth edges but had nothing written down for her strengths. I fought the urge to start rattling off her many strengths. Instead, I used the same strategy that my professor used that day in my consultation and evaluation course: I verbalized my belief in her ability to identify her own strengths. I believe we need more assignments that push trainees to identify their own assets in order to help them strike an appropriate balance between humility and self-confidence.

Reflecting on and verbalizing our strengths becomes uncomfortable, as it feels somewhat incongruent with the general idea of being open and receptive to feedback. Similar to the first time I received difficult feedback from my supervisor, I initially met this idea with extreme discomfort. Over time, however, my turning point has been an increased awareness of the importance of developing a level of comfort with my own capabilities. I am working harder to integrate components from the same strength-based approach with myself that I strive to use with my clients. That is, I am working to increase my comfort level with expressing my belief in my own abilities, so that I can better model a strength-based attitude with my future clients.

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Clinical Impact Statement: This article uses personal experience to highlight the importance of helping psychotherapy trainees identify their strengths and weaknesses. The training and clinical implications of implementing this more holistic approach to self-reflection are discussed.

Keywords: strengths-based, training, counseling psychology, reflection

Meet Your Newest Publications Board Member

Terence J. G. Tracey, PhD, ABPP

Terence J. G. Tracey is an academic nomad, having received his BA at Cornell University in 1974, his master's at University of Kansas in 1977 and his PhD from the University of Maryland, College Park, in 1981. He then was employed as a Counseling Psychologist at the University Counseling Service at the State University of New York at Buffalo from 1981 to 1983. He then joined the faculty of the Counseling Psychology Program at the University of Illinois at Urbana-Champaign. He moved to become a Program Head of the Counseling and Counseling Psychology Programs at Arizona State University in 1999.

He is a fellow of the American Psychological Association (APA), The Association for Psychological Science (APS), and the American Educational Research Association (AERA). He has served as the Editor of the *Journal of Counseling Psychology*. He is also certified by the American Board of Psychological Practice (ABPP). His scholarship has focused on the topics of client-therapist interaction in psychotherapy and its relation to outcome, interpersonal models of personality and psychotherapy, the structure and development of vocational interests, and minority student academic success. He has published over 200 refereed empirical studies and book chapters in these areas.

Ethnic-Racial Socialization, Cultural Identity, and Perceived Stress Are Related to Mental and Physical Health in African Americans

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Background

Health disparities have been gaining attention in recent years (Centers for Disease Control and Prevention, 2013). Many health disparities have been related to social and cultural factors. The CDC has indicated that identifying population-specific precursors to health outcomes are necessary to reduce health disparities. To gain a comprehensive understanding of these disparities, racial socialization and cultural identity must be taken into consideration.

Cultural Identity and Ethnic-Racial Socialization

Culture is the set of behaviors from a group of people reflective of shared values, social experiences, norms, attitudes, and beliefs. Culture is passed down from generation to generation, and changes over time (Eshun & Gurung, 2009). African/Black psychologists assert that every person operates out of some group's concept of reality, whether consciously or unconsciously (Baldwin, 1984, 1985; Baldwin & Hopkins, 1990; Kambon, 1992). It is this perception that is shared with other members of an identified reference group. Therefore, one's cultural reality is dependent upon the culture with which one identifies. Racial and ethnic identity are vital processes in psychological development (Williams et al., 2012).

Racial socialization denotes the process through which individuals learn about specific cultural beliefs and values pertaining to their ethnic, racial, and/or cultural group memberships (Berkel et al., 2009; Hughes et al., 2006; Umaña-Taylor & Fine, 2004). It is an important socialization process that prepares individuals for a racially and ethnically diverse society. Ethnic-racial socialization practices focus on teaching children their cultural origins in order to inculcate a sense of ethnic and racial pride. Ethnic-racial socialization can encourage ethnic-racial identity formation, moderate the negative effects of discrimination, and increase cognitive and social-emotional outcomes (e.g., Brittian, Umaña-Taylor, & Derlan, 2013; Caughy, Nettles, & Lima, 2011; Neblett, Hammond, Seaton, & Townsend, 2010; Neblett, Rivas-Drake, & Umaña-Taylor, 2012; Neblett et al., 2008). In addition, ethnic-racial socialization and ethnic-racial identity offer individuals a sense of community and belonging when ostracized by other groups.

A consensus in psychology, sociology, and epidemiology is that racial discrimination against African Americans is

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linked to damaging mental health outcomes, including distress, negative affect, anxiety, depression and depressive symptoms, and other psychiatric symptoms (Brondolo et al., 2008; Pascoe & Richman, 2009; Pieterse, Todd, Neville, & Carter, 2012; Williams & Mohammed, 2009). Gaylord-Harden and Cunningham (2009) report that racial discrimination was positively correlated to anxiety and depression among African American adolescents in lower income communities. These findings, along with comparative analyses, have led some researchers to suggest that racially based stressors may be experienced more deeply than nonracially based stressors (Utsey, Giesbrecht, Hook, & Stanard, 2008).

Racial pride and socialization are vital communal coping mechanisms for dealing with the reality of racism and discrimination. Theorists and researchers in the development of racial identity argue that psychological well-being requires the affirmation of one's ethnic, racial, cultural identities. Bynum, Burton, and Best (2007) found parental messages that emphasized racial and cultural pride were shown to reduce race-related stress and showed a negative correlation to psychological distress.

Cultural socialization has been shown to be positively associated with psychological well-being (Bannon, McKay, Chacko, Rodriguez, & Cavaleri, 2009) and negatively associated with depression (McHale et al., 2006). Racial socialization, for example, buffers the negative effects of racial discrimination, psychological distress, and chronic stress (Bynum et al., 2007; Harris-Britt, Valrie, Kurtz-Costes, & Rowley, 2007; Neblett et al., 2008) in both adolescents and young adults. Racial socialization buffers the relationship between anxiety and mental health risk factors in much the same way that it defends against race-related stressors (Bannon et al., 2009). Children who received higher rates of racial socialization reported less anxiety in spite of exposure to mental health risk factors (e.g., exposure to domestic violence/substance abuse). Affirmative outcomes related to preparation for biases and strong cultural socialization amongst African American youth are associated with: (a) development of a sense of self-worth or pride, (b) feeling efficacious, and (c) positive identity, all of which can be advantageous across contexts.

Stress and Mental Health in African Americans

Historically, stress and coping models have posited that environmental stressors, role strains, and daily hassles, in the absence of adequate coping resources, potentially disrupt an individual's psychological equilibrium and cause psychological and physiological distress. Psychosocial resources (e.g., optimism, ego resilience) may reinforce and strengthen a person's psychological equilibrium and emotional stability, thus reducing the likely onset of possible distress. Such resources are seen as having both a deterring and a coping function, helping to maintain positive self-identity and self-esteem, reduce distress, preserve psychological and social equilibrium, and reduce the likelihood of encountering stressful experiences.

Stress and coping theories emphasize cognitive facets of the stress process or external environmental factors. In the early 2000s the conservation of resources (COR) theory (Hobfoll, 2001) suggested that one's conceptualization of stress should be based on the "individual nested in family nested in tribe." Focus on the individual, with no reference to the individual's placement in relation to the greater whole, will provide limited

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insight for social systems and groups. An encounter with stressful situations involves social consequences and is embedded within the greater social context. Much of the historical research that has been conducted on stress and coping has been greatly influenced by the conceptualization of stress as being an outcome of personal appraisal. Although the literature supports this, Hobfoll (2001) argued that this tactic provides little insight into why certain appraisals are made and the extent to which these appraisals are socially and culturally shared. Individuals also make appraisals and select coping responses within a group of personal strengths and social attachments, along with a sense of cultural belonging (Scott, 2003). The appraisals (and experiences) of race-related stress among African Americans are embedded in a larger historical, social, and legal context that lays the foundation for shared racial interactions.

Although stress has been extensively studied for decades, more recent research has contributed to the understanding of the effects of "minority" stressors and race related stressors to physical, psychological, and emotional outcomes among people of African descent. A meta-analysis (Pieterse et al., 2012) revealed a positive relationship between psychological distress and racial discrimination for African Americans. Depression, psychiatric symptoms, and anxiety were the strongest mental health outcomes related to discrimination among all of the variables incorporated in the overall relationship between psychological distress and racial discrimination.

The extent to which African Americans affiliate and identify with members of their own ethnic and/or racial group is identified as a healthy coping mechanism to racial discrimination (Brondolo, Brady ver Halen, Pencille, Beatty, & Contrada, 2009). Brondolo and colleagues recognized three related factors that may be connected to discrimination-distress—ethnic identity, racial identity, and racial socialization—and concluded that these factors may influence whether discriminatory occurrences are appraised as being stressors, consequently determining the occurrence of discrimination-distress. Brondolo and colleagues (2009) advanced that ethnic identity, racial identity, and racial socialization mediate the impact racial discrimination has on mental health. Advocates argue that socialized individuals who more strongly identify with members within their own ethnicity/race are sheltered from negative effects of racial discrimination. This connection provides individuals with awareness that discriminatory experiences are a result of societal injustices as opposed to personal deficits (Pascoe & Richman, 2009). This awareness, in turn, prevents one's self-concept from being negatively affected when threatened by varying forms of discrimination. In addition, ethnic identity, racial identity, and cultural socialization offer individuals a sense of community and belonging when ostracized by other groups.

Stress and Physical Health

Members of various "minority" groups reported overt and subtle stressful discrimination experiences as being a part of their daily lives (Myers, 2009; Sue et al., 2007). Numerous investigators focusing on the relationship between perceptions of discrimination and mental health outcomes, have reported that higher perceptions of discrimination are consistently linked to poorer mental health (Kessler et al., 2010; Lee & Ahn, 2011a; Pascoe & Richman, 2009; Williams & Mohammed, 2009). In several notable reviews and cross-sectional studies, discrimination has been found to be linked

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with indicators of poor physical health and chronic health conditions (Mays, Cochran, & Barnes, 2007; Smedley, 2012; Williams & Mohammed, 2009). Meta-analyses (Lee & Ahn, 2011a, 2011b; Pieterse et al., 2012) presented evidence that racial discrimination has adverse effects on the participants' mental health.

Research shows evidence of early health deterioration among minorities, specifically African Americans (Chae et. al., 2014; Singh & Siahpush, 2014). To account for early health deterioration among African Americans, the "weathering" hypothesis posited that African Americans experience early health deterioration as a result of the cumulative impact of repeated experiences with economic or social adversity and political marginalization. The weathering effects of living in a race-conscious society are expected be greatest among African Americans who engage in high effort coping, meaning coping with more intense stressors and for longer periods of time (Geronimus, 1992).

High-effort coping with acute and chronic stressors can have a profound effect on physiological health (Lewis et al., 2013; Pascoe & Richman, 2009; Williams & Mohammed, 2009). For example, high effort coping has been found to increase blood pressure and heart rate, impacting cardiovascular and overall physiological health (Geronimus, 1992). The stress that is inherent in living in this race-conscious society, which stigmatizes and disadvantages African Americans, may cause disproportionate physiological deterioration, such that an African American may show the morbidity and mortality typical of a White American who is significantly older (Deuster, Kim-Dorner, Remaley, & Poth, 2011; Duru, Harawa, Kermah, & Norris, 2012). Because the response to stress disrupts the regulation of several systems throughout the body, including the cardiovascular, metabolic, and immune systems, the concept of weathering encompasses multiple systems and includes impacts that may not yet register clinically.

In a longitudinal study, Duru and colleagues (2012) investigated whether allostatic load (i.e., the cumulative physical effect of prolonged exposure to stress) among middle-aged adults at baseline was associated with racial differences in mortality rates. It was postulated that after adjusting for socioeconomic (SES) measures, health insurance status, and health behaviors, allostatic load would significantly reduce disparities in African-White American mortality. Furthermore, differences in allostatic load scores have the ability to partially explain the disparities. These findings indicate that at baseline, racial disparities in physiological irregularities (e.g., metabolic markers, cardiovascular markers, inflammatory markers, and a marker for organ dysfunction), measured by biomarkers of allostatic load, assist in explaining African-White American disparities in mortality.

Additionally, numerous epidemiological studies validate that acute and chronic trauma is related to increased risks for adult psychiatric disorders (Benjet, Borges, & Medina-Mora, 2010; Green et al., 2010; McLaughlin et al., 2010). Individuals strongly identifying with other members of their race are assumed to be protected from the negative effects of racial discrimination. This prevents adverse effects on their self-concept when challenged with race related stressors (Pascoe & Richman, 2009); decreasing the likelihood of the onset of the aforementioned stress-related physical health outcomes.

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Method
We conducted research to examine relationships among racial socialization, cultural identity, and perceived stress with mental and physical health; as well as to explore possible predictors of health in African Americans. Once IRB approval was obtained, 229 college students (128 women, 101 men) were administered a 35- to 45-minute battery of measures of: racial socialization (Stevenson, Cameron, Herrero-Taylor, & Davis, 2002), cultural identity (Baldwin & Bell, 1985), perceived stress (Cohen, Kamarck, & Mermelstein, 1983), and mental health and physical health (Ware et al., 1997).

Results and Conclusions
The results of the current investigation of African American college students showed that higher racial socialization and higher cultural identity were significantly related to better outcomes on measures of mental health.

The current study provided much insight into possible predictors of mental health. The degree to which participants identified with and internalized race, ethnicity, and/or culture was shown to significantly impact emotional well-being, with more developed knowledge and awareness of cultural heritage/identity correlating with better mental health. This is consistent with previous research that found African self-consciousness was associated with a reduction in mental illness (Baldwin, 1984). Knowledge/practice of African traditions, rituals, and ideologies apparently serves as a protective buffer for people of African descent (Akbar, 2004; Kambon, 2012). This validates the idea that there are other factors aside from socioeconomic status and health behaviors that impact the health of African Americans.

In keeping with research suggesting that parental endorsement of reinforcing cultural pride messages moderates the relationship between child anxiety and risk factors associated with child mental health (Bannon et al., 2009), cultural socialization in this study was positively correlated to psychological well-being. This emphasizes the need for culturally specific mental health protective factors for people of African descent, as African self-consciousness and racial socialization have demonstrated important protective effects in African Americans.

African self-consciousness and ethnic-racial socialization accounted for an increased percentage of variance within the mental health of the participants. Bannon et al. (2009) found that cultural socialization was positively related to psychological well-being. The significant relationship between racial socialization and African self-consciousness suggests that there are intersecting characteristics between the two. This also suggests that ethnic-racial socialization may influence the development of African self-consciousness. It is promising that ethnic-racial socialization and African self-consciousness showed such a strong relationship. Because these two variables encompass the internalization of one's ethnic, racial, and cultural values, the finding makes sense in light of previous research in this arena.

Taken together, these findings yield important implications for parenting, education, social development, and mental health outcomes for individuals of African descent. These findings are particularly critical in efforts to move from therapy-centered to patient-centered psychotherapy and interventions (including parenting and similar educational programs). The current study adds to previous research suggesting that knowledge, awareness, and identification with one's race, ethnicity,

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and/or culture both support and predict improved mental health. It is reasonable to conclude that race congruent cultural identity results in healthier outcomes compared to non-congruent identity. In summary, awareness, knowledge, and connection to varying aspects of their history, cultural norms/practices, race, and ethnicity are all vital to mental health in African Americans.

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Clinical Impact Statement: This manuscript provides information to mental health clinicians, clinicians in training, and those who educate and train them to assist them to better meet the mental health needs of African Americans. Information is provided to assist mental health clinicians to design and implement culturally relevant services and interventions for African Americans.

***Keywords*:** mental health, perceived stress, cultural identity, racial socialization, ethnic-racial socialization, African Americans

To Share or Not to Share: Current Research and Thoughts About Therapist Self Disclosure

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My Confusion About and Interest in TSD

As I begin to establish my private practice, I have been reflecting on the evolution of my thoughts about and use of therapist self-disclosure (TSD), which I am using here to mean "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2002, p. 256), and which does not include immediacy, or "here-and-now" discussions about the therapeutic relationship. In my first psychology course, we read several articles that caused me to become intrigued by TSD. In a study of the effects of therapist response modes in psychotherapy, Hill et al. (1988) stated that although they occurred only 1% of the time in their sample of therapy sessions, TSDs received the highest client helpfulness ratings and led to the highest client experiencing levels of all therapist responses. In a qualitative investigation, clients described the positive effects of TSDs from therapy (Knox, Hess, Petersen, & Hill, 1997). Finally, Barrett and Berman (2001) experimentally manipulated TSD levels and found that the condition with higher (but still moderate) levels of TSD resulted in lower levels of symptom distress and increased liking of the therapist. These authors concluded that TSD might improve the quality of the therapeutic relationship and the outcome of treatment.

Given the role TSD plays in establishing intimacy in most interpersonal relationships, and the fact that the literature pointed to such positive effects, it was fascinating to me that TSD is such an infrequent occurrence in therapy (accounting for about 3.5% of interventions; Knox & Hill, 2003). Furthermore, as a beginning trainee, I was flummoxed when my Basic Practicum instructor *strongly* discouraged us from using it. I understood the need to focus on the client, but I couldn't quite make sense of being encouraged to be authentic and real as a therapist, but not self-revealing. What harm could it possibly do to share a little something with a client? These seeming contradictions led me to study, among other TSD-related subjects, what factors influence therapists' use of TSD, how TSD is used in therapy, what characterizes a therapeutic TSD, what differentiates successful from unsuccessful TSD, and what recommendations experienced clinicians have for trainees and early career practitioners.

Disclosure in "Real Life" Versus in Therapy

The lack of TSD is one of the key factors that most distinguishes psychotherapy from other relationships. Self-disclosure research findings in social psychology suggest that sharing feelings and thoughts with others is an important skill for developing and maintaining close relationships (Altman & Taylor, 1973; Berscheid & Walster, 1978; Cohen, Sherrod, & Clark, 1986), and that failure to disclose suggests attempts to avoid inti-

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macy (Mikulincer & Nachshon, 1991).

In typical interpersonal relationships, self-disclosure seems to facilitate development of intimacy, mutual understanding, validation, and caring (Berg & Derlega, 1987; Chelune, 1979; Laurenceau, Barrett, & Pietromonaco, 1998; Reis & Shaver, 1988). The most common responses to self-disclosure in social psychology research are liking for the discloser and disclosure reciprocity (Berg, 1987; Berg & Derlega, 1987), which is the tendency to disclose something about oneself at a similar level of intimacy to something someone else shared with you. In contrast, a therapeutic relationship is extremely intimate, but also professional, and lacking in the reciprocity that so often characterizes self-disclosure in relationships outside of therapy.

Historical Debate and Contemporary Literature

On one side of the historical debate about using self-disclosure in therapy, traditional psychoanalysts argued that TSD shifts the focus away from the client, hinders the therapist's ability to act as a mirror or "blank screen" onto which the client projects emotional reactions, and undermines the therapist's credibility, thereby damaging trust (Curtis, 1982; Freud, 1958; Greenson, 1967). On the other side, humanists maintained that TSD has a positive impact on treatment because it facilitates client exploration, encourages honesty as a foundation for building a stronger therapeutic relationship, and lays the groundwork for cultivating client trust (Bugental, 1965; Derlega, Hendrick, Winstead, & Berg, 1991; Jourard, 1971; Kaiser, 1965; Strassberg, Roback, D'Antonio, & Gabel, 1977).

Contemporary literature indicates that therapists and theorists of various orientations are converging on the beliefs that: a) TSD can have a variety of beneficial effects if used intentionally and judiciously, and b) avoiding disclosure in all circumstances may have harmful effects for both the client and the therapy (Eagle, 2011; Farber, 2006; Henretty, Currier, Berman, & Levitt, 2014; Henretty & Levitt, 2010; Hill & Knox, 2002; McWilliams, 2004). Indeed, current thinking is that the appropriateness and effectiveness of TSD depend heavily on therapist skill (Hanson, 2005) and situational and contextual factors (e.g., the moment-to-moment interaction of a specific dyad within the context of specific presenting issues and a unique therapeutic relationship, TSD type and timing, information shared, and client's expectations and preferences; Henretty & Levitt, 2010).

Factors That Influence Therapists' Use of TSD: Training and Personal Therapy

In a recent investigation of 13 experienced therapists' perceptions and use of TSD (Pinto-Coelho et al., in press), participants had typically been encouraged during training to be open to using TSD and also instructed not to self-disclose (all participants had seen more than one supervisor). Participants reported having supervisors, co-therapists, and other colleagues who discussed and modeled appropriate use of TSD; they also reported receiving feedback that you "didn't reveal yourself at all" and having a supervisor "horrified" by TSD.

Consistent with Hanson's (2005) finding that clients preferred disclosure to nondisclosure, therapists in the Pinto-Coelho et al. (in press) study reported the beneficial effects of disclosure in their own therapy. For example, one participant described having put the therapist on a pedestal and stated that "every

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time the therapist would disclose that helped humanize" him. Participants also reported negative feelings related to nondisclosure by their therapists (e.g., feeling "deprived a lot" or feeling their therapists were "cold" or "withholding"), which supports the growing literature suggesting that avoiding disclosure entirely may be ill-advised.

How TSD Is Used in Therapy

Given the recommendation in the literature that therapists should be prepared to disclose *something, some of the time*, I set out to study: "What do therapists actually do?" To answer this question, my colleagues and I investigated TSD occurence in 16 therapy cases from a psychodynamic training clinic (Pinto-Coelho, Hill, & Kivlighan, 2016). A total of 360 sessions were reviewed looking for TSD events. Approximately one disclosure occurred every other session, yielding 185 TSDs in 115 sessions. Doctoral student therapists initiated three-quarters of disclosures, and the focus of the session almost always returned to the client afterward. Disclosures fell into four primary categories, with disclosures of facts occurring most frequently (facts–59%, feelings–23%, insight–15%, and strategy–3%).

Consistent with recommendations in the literature, these therapists disclosed with low to moderate levels of intimacy. Certain TSD types (feelings and insight) and characteristics (challenging, and both reassuring and challenging) were rated by judges as significantly higher in intimacy than others (factual TSDs that were neither challenging nor reassuring), and higher-intimacy disclosures were associated with stronger client ratings of the real relationship and the working alliance. Feelings TSDs were positively related to strong client-rated real relationship and insight TSDs were positively related to strong client-rated working alliance; factual TSDs were more likely to occur in the context of a weak relationship.

Judges' rating of TSD intimacy and quality were positively associated. Feelings and insight TSDs were significantly higher in quality than factual TSDs. Similarly, challenging, reassuring, or both challenging and reassuring TSDs were significantly higher in quality than disclosures that were neither reassuring nor challenging. Although these findings were correlational, not causal, and the therapists were all trainees, these results suggest that further study of different types of TSDs and their outcomes and correlates is warranted.

Characteristics of Therapeutic TSDs

Pinto-Coelho et al. (2016) indicated that therapists may wish to use their urges to self-disclose as a gauge for what is happening in the relationship. For example, if a therapist feels pulled to disclose facts, this may be an indication that the relationship needs strengthening. Similarly, the association of factual disclosures with weaker client ratings of the therapeutic relationship suggests that therapists should think twice before using factual TSDs once a strong therapeutic relationship has been established.

In interviewing clients, Audet and Everall (2010) also discoverd a link between TSD and the working alliance, indicating that TSD affects clients' willingness to disclose and consider therapeutically relevant information. Clients' confidence in therapists and in the working relationship was related to clients' sense of therapists' attunement to clients' issues, as reflected by therapists' TSDs, and TSD content relevance affected clients' levels of engagement. These authors highlighted that TSD of inappropriate or clinically irrelevant ma-

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terial could harm the working alliance.

Hanson (2005) interviewed clients about their perceptions of disclosure and nondisclosure. Participants in this study indicated that therapist nondisclosures were likely to be unhelpful and to damage the therapeutic alliance, whereas TSD was likely to be helpful, contributing to the real relationship by providing clients with a sense of increased egalitarianism, warmth, and trust. Clients perceived TSDs that were brief, well-timed, directly relevant to their own material, and designed to highlight similarities between the dyad members to be skillful. Unhelpful disclosures were described as lacking in technical neutrality, oversharing, and poorly timed.

What Differentiates Successful From Unsuccessful TSD?

Pinto-Coelho et al. (in press) compared actual instances of successful and unsuccessful TSD and found that helpful disclosures were directly relevant to clients' issues. These were not simply instances of therapists sharing a little about themselves to build rapport with clients, but were personal experiences that were meaningful and intended to help clients overcome negative emotions and feel hope about their circumstances. For example, one therapist disclosed an experience from his own childhood, conveying that it was possible to get past the effects of having a difficult father.

Successful and unsuccessful disclosures were remarkably similar in terms of antecedents, intentions, and content, with the exception that in some cases therapists identified no intention for unsuccessful TSD. In successful as compared with unsuccessful TSDs, clients were more often experiencing negative emotions and therapists were less often experiencing personal or professional concerns (countertransference) before the TSD. Also importantly, in successful TSDs, content was accurate and relevant, whereas in unsuccessful TSDs, therapists often misjudged similarities or learned following TSD that they were not attuned to clients' experiences.

Perhaps most importantly, the consequences of successful versus unsuccessful TSD differed remarkably. Clients reacted positively to the former, with one client stating it was the most helpful thing that had ever been said to the client. Successful TSDs alleviated clients' negative feelings, deepened the work, improved the therapeutic relationship, and even led to client changes outside of therapy. In contrast, unsuccessful TSDs resulted in negative client reactions and therapist regrets and self-doubt. Two therapists thought the poorly delivered TSD led to premature termination. Thus, it seems clear that an ill-considered TSD can, indeed, cause harm. That said, when delivered effectively, TSD can be an extremely powerful therapeutic tool, and its outcomes are more likely to be beneficial than harmful (Hill, Knox, & Pinto-Coelho, in press).

Experienced Psychologists' Recommendations for TSD Use

Experienced therapists recommend that practitioners consider the following guidelines when trying to decide whether or not to use TSD (Pinto-Coelho et al., in press):

- Be thoughtful and strategic, and have a clear intention.
- Proceed with caution when feeling an urge to disclose or when the client requests TSD.
- Disclose in the context of long-term therapy or a strong relationship.
- Ensure that the focus is on the client rather than on the therapist's needs.

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- Establish and abide by clear guidelines for how to approach TSD with clients and monitor yourself for any temptation to deviate from your standard procedure.
- Do not disclose with clients who cannot tolerate knowing about the therapist (e.g., because of presenting issues, difficulty with boundaries, or personal preference).
- Disclose when not disclosing violates the basic social contract (e.g., if you're wearing a cast or if there's unusual noise that disrupts the treatment that should be explained).
- Do not disclose material that is too personal, emotional, or unresolved.
- Get training, supervision, and consultation about using TSD.
- Evaluate the effects of TSD by observing the client's reaction, and adjust accordingly (e.g., be aware that some clients have difficulty tolerating knowing too much about their therapists, while other clients may crave TSD as a way of blurring professional boundaries or feel TSD is outside the realm of appropriate behavior in therapy).

Conclusion

TSD should be viewed as a complex and multifaceted intervention for practice, research, and training purposes. TSD is not one therapeutic intervention, but many, and should be treated as such. Different types serve different functions and have different effects on clients. Even within a given type, quality levels, intimacy levels, and outcomes may vary from one TSD to the next. Accordingly, it follows that each type of TSD should be taught and researched separately, with attention paid by type to differing intentions, characteristics, and impacts. All TSDs are not created equal.

My main takeaway from years of studying TSD is that it is difficult to disclose in a way that is therapeutic and meaningful for clients. My Basic Practicum instructor knew what she was talking about! Even experienced therapists who have been in practice for 30 years sometimes have a hard time choosing the right moment and accurately assessing clients' readiness, openness to, and likely responses to TSD. The more I study TSD, the less inclined I am to use it in my own clinical work. Based on the research, I expect that trend will shift with time. Until then, I am content to resist my urges to disclose, to respond to clients' requests for TSD with caution, and to use other methods, such as empathic attunement, immediacy (as distinct from the self-revelatory TSD being discussed in this article), and reassurance and support to be real and genuine with clients.

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Clinical Impact Statement: This manuscript provides information for mental health clinicians, mental health trainees, and those who educate them to assist therapy practitioners to consider and improve their use of therapist self-disclosure. Specific recommendations based on recent research are provided to enable clinicians to disclose more effectively.

Keywords: therapist self-disclosure, psychotherapy process, practice guidelines, therapist development

Making Psychotherapy Scalable by Teaching Nonprofessionals to Deliver Treatment to Each Other

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Decades of psychotherapy outcome research and countless meta-analyses show that psychotherapy works. Unfortunately, psychotherapy is a luxury afforded to few. Only a minority of people with mental illness receive treatment (Kessler et al., 2005), due to both attitudinal barriers (e.g., stigma, desire for self-reliance) and structural barriers (e.g., cost, provider availability; Mojtabai et al., 2011). And psychotherapy is not particularly efficient, typically involving an hour per week across multiple, if not many, weeks with a trained professional. To improve public psychological well-being, "disruptive innovations" are needed that make treatment more efficient by overcoming these barriers (Rotheram-Borus, Swendeman, & Chorpita, 2012).

The current project preliminarily tested one such innovation, funded partly by the Society for the Advancement of Psychotherapy through a Charles J. Gelso, PhD, Psychotherapy Research Grant. We developed an intervention, called "Crowdsourcing Mental Health" (CMH), in which individuals with some level of psychological distress seek a "partner" who is already known to them (e.g., friend or family member) to participate with them. This partner may or may not also be experiencing distress; regardless, each partner has the opportunity to both provide and receive care. Both dyad members take an online course that teaches "talking" and "listening" skills. The talking skills guide the speaker through the process of exploring a stressor and making a coping plan. The listening skills, which are the focus of this report, include a suite of active listening attitudes and behaviors, including mindfully attending, taking a nonjudgmental attitude, making reflections, asking open-ended questions, and avoiding attempts to influence the speaker. After completing the course, the partners meet weekly face-to-face to discuss current stressors, taking turns in client-like and therapist-like roles.

CMH was inspired by two sets of psychotherapy findings. First, nonprofessional mental health practitioners appear to be effective at delivering simple treatments, and at times may not perform any worse than professional caregivers (Berman & Norton, 1985; van Ginneken et al., 2013). Second, although there is clearly some benefit for sophisticated mental health interventions, simple supportive psychotherapy does appear to reduce symptoms, and results can be comparable to more complex interventions for those with lower symptom severity (Cuijpers et al., 2012;

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Cuijpers, van Straten, Andersson, & van Oppen, 2008). Thus, an efficient intervention in which laypeople provide only psychotherapy's simplest elements could cause at least moderate improvement, which could have a substantial public health impact when disseminated widely.

CMH circumvents structural barriers to treatment-seeking because of its near-universal accessibility through a free online course. It also overcomes attitudinal barriers: We surveyed over 1,000 Internet users to assess public interest in the intervention and about 60% of respondents indicated that they would try CMH (Bernecker, Banschback, Santorelli, & Constantino, 2017). Importantly, interest in CMH was nearly as high among respondents who stated that they would not use psychotherapy or medication. Further, CMH was appealing across levels of psychological distress and demographic characteristics. Thus, peer-delivered psychotherapy could be a viable vehicle for disseminating psychotherapy ingredients to the public.

However, prior to the current study, we know of no rigorous test of whether nonprofessionals can learn psychotherapy skills from an online course, particularly one that lacks interaction with an instructor. Therefore, this study assessed whether nonprofessionals who completed the CMH course changed their observable helping behaviors in mock counseling sessions recorded before and after the course. Because this was a test of the course's *teaching* efficacy, participants were not required to meet with each other to engage in the intervention after they completed the course, and we did not assess effects on mental health of repeated interactions with one's partner while using the skills. However, as a proxy for psychological benefits, we measured the perceived helpfulness of the sessions.

Method

Participants. Thirty pairs of friends, roommates, romantic partners, or family members (60 individuals) were recruited "to learn ways to manage stress and feel closer to another person" via flyers, Web advertisements, and listserv announcements in western Massachusetts. Approximately two-thirds of the participants were local undergraduate students.

CMH Course. The CMH course design is based on behavior modeling training, a well-supported method for learning behavioral skills (including counseling skills) that consists of four components: instruction, modeling, practice, and feedback (Taylor, Russ-Eft, & Chan, 2005). In the course, each skill is introduced with an instructional video with slides and audio lecture and a written review exercise. Learners then watch videos of actors modeling the skill. Finally, participants practice engaging in the skill, then complete self-evaluation questionnaires as feedback on whether they engaged in the necessary behaviors. The types of practice increase in complexity in order to scaffold progress, from written exercises (e.g., typing replies to videos of actors), to telephone practice with a "mentor" (anyone who has already taken the course; for this study research assistants served as mentors), to in-person practice with one's partner. Including all exercises, the course takes approximately 20 to 25 hours to complete.

Procedure. Pairs were randomly assigned to an immediate training group or a waitlist group. Pairs in the immediate training group were video recorded completing a mock counseling session in the laboratory in which they were asked to take turns discussing a stressor in the way they ordinarily would. They

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then took the online course over a period of 4 to 8 weeks before returning to the lab to complete a second mock counseling session in which they were asked to take turns using the skills they learned in the course. The waitlist group was included to account for the possibility of changes due to repeated testing or other confounds, and participants in this condition completed two "pre-training" mock counseling sessions spaced approximately 4 weeks apart. The waitlist participants also completed a third session after taking the course, in the same format as the immediate training group, in order to increase the sample size available for testing pre- to post-training change.

Measures. Session transcripts were coded by trained research assistants (RAs), who were blind to group assignment and time point, and by the first author. Each sentence received a mutually-exclusive code: restatement, open-ended question, closed-ended question, self-disclosure, miscellaneous sympathetic utterance, or other. In addition to its main category, any sentence could also be marked as "influencing" when it included an attempt to influence the speaker (e.g., through advice-giving or reassurance). Two RAs coded each session and resolved any disagreements through discussion with each other and, if necessary, the larger coder group. Participants were considered to have achieved full competence to deliver the intervention if they met six criteria (all of which were dichotomous cutoffs based on the coded behaviors).

Additionally, participants rated the helpfulness of the mock CMH sessions with the CMH Session Reaction Scale (CSRS), a modified version of the Revised Session Reaction Scale (RSRS; Elliott, 1993), an instrument used for clients to rate psychotherapy sessions. The CSRS has two subscales, task reactions (progress towards problem resolution through insight, emotional relief, or problem-solving, coefficient α .86-.92) and relationship reactions (feeling understood by, connected to, and supported by one's partner, coefficient α .84-.95).

Data analysis. For each outcome variable, we used Bayesian multilevel models to (1) estimate the amount of change in each behavior from pre- to post-course (aggregating across participants from both groups) and (2) test whether the amount of change between the first two sessions was different for the training group and the waitlist group. Multilevel modeling was necessary to account for clustering of data. A Bayesian approach was used because of its flexibility for modeling different forms of outcome variables, and because models would have been unidentified under frequentist maximum likelihood estimation. Due to space considerations, we present only the more easily-interpretable descriptive statistics and simply describe the conclusions implied by the Bayesian models (which will appear in a forthcoming article) in the text.

Results

Nine dyads (30% of participants) withdrew from the study prior to completion, primarily because one partner of each pair was concerned about time demands; sensitivity analyses suggest that attrition did not substantially bias these results.

Table 1 displays means, standard deviations, and within-person effect sizes for change in each outcome variable from before to after taking the course, aggregating across both the immediate and waitlist group. There was evidence that participants changed their listening

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behaviors in the desired directions from pre- to post-training for most variables, and that this change was a consequence of taking the course. Specifically, the course caused a substantial decrease in the number of sentences uttered; an increase in the proportion of sentences classified as attempts to influence the speaker, as self-focused talk, and as "other" (mostly off-topic); and an increase in the proportion of sentences classified as restatements. The effect of training on open-ended questions was less clear: There was evidence for change from before to after taking the course, but the magnitude was small enough that there was no "significant" difference between the training and waitlist groups. There was no evidence of an effect of training on closed-ended questions or miscellaneous sympathetic utterances. None of the participants were deemed competent to deliver CMH prior to taking the course, whereas 18 participants (30.0% of the full sample, 42.8% of completers) achieved competence after the course. In terms of perceived helpfulness, sessions that took place after training were viewed as more productive, but there was no change in how participants felt about their relationships with their partners.

Table 1. Descriptive Statistics for Pre- to Post Training Change

Variable	Pre-course *M (SD)*	Post-course *M (SD)*	Within-person *d*
Number of sentences	163 (82)	35 (36)	-1.5
Influencing	33.4% (17.9%)	8.5% (13.8%)	-1.6
Restatement	2.7% (3.9%)	25.0% (22.1%)	1.0
Open question	3.2% (3.0%)	9.2% (7.7%)	0.8
Closed question	13.4% (8.7%)	15.9% (11.9%)	0.2
Self-disclosure	18.2% (14.2%)	4.3% (8.8%)	-0.8
Miscellaneous sympathy	14.2% (10.8%)	11.9% (12.1%)	-0.1
Other	48.3% (15.2%)	33.7% (18.9%)	-0.8
Task reactions	5.3 (1.5)	7.0 (1.6)	1.1
Relationship reactions	6.7 (1.5)	7.1 (1.9)	0.3

Discussion

These results indicate that a massively scalable online course, at least one that is designed with evidence-based pedagogical techniques in mind, can substantially change non-professionals' helping behaviors. For the most part, participants displayed strong active listening skills throughout post-training sessions, as measured through direct observation of objective criteria. Participants also reported that their post-training sessions were more productive in resolving their concerns, which suggests that the behaviors prescribed in the course could have positive effects on psychological well-being.

However, this course will require refinement before launching access for the general public. In order to decrease attrition, we plan to reduce its length and use participants' qualitative feedback to make the course more engaging. Additionally, we hoped that 80% of completers would achieve competence, but only about half of that proportion met all competence criteria. In examining the reasons for failure, we found that most participants only missed one criterion; in hindsight, that criterion may have been too stringent, given that qualitatively, their behaviors appeared acceptable. The course's only moderate success in promoting full competence may be,

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then, less of a concern than it initially appears, but we still plan to make some adjustments to the course in order to further improve learners' post-training performance.

More broadly, by demonstrating that nonprofessionals can learn therapeutic skills from an online course, this study opens the door for a variety of strategies for using this vehicle to improve public health, increasing access to low-level care at essentially no cost. Versions of the course could be developed for different target populations, and lessons targeting specific symptoms or concerns could be tested and added. Courses like this could also be used to increase the efficiency of training for professional psychotherapists, counselors, social workers, and certified peer specialists.

Such large-scale, peer-delivered interventions also have the potential to advance psychotherapy research. Although perhaps the most rigorous method for investigating change mechanisms is to directly manipulate a putative mechanism, component treatment studies often produce null results (Bell, Marcus, & Goodlad, 2013), probably because the small effect of adding or removing a component is drowned out by noise in small samples. Once CMH or similar courses are launched to the general public, large component studies can be performed on the user base through "A/B testing," in which users are randomized to different versions of the training course website. Thus, Internet-delivered peer trainings can eventually act as a "laboratory" to test psychotherapy change mechanisms.

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Clinical Impact Statement: This article describes a study that tested the efficacy of a new Crowdsourcing Mental Health intervention, designed to train laypeople in the use of basic psychotherapy skills. The preliminary results suggest that a brief online training may be a useful way to teach helping skills to the general public.

Keywords: crowdsourcing mental health, helping skills, laypeople, training

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Revisiting Dr. Martin Luther King, Jr.'s, Address: Cultural Humility and Ethics

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April 4, 2018, marked the 50th anniversary of the assassination of Dr. Martin Luther King, Jr., in Memphis, Tennessee. One of the nation's most prominent civil rights advocates and leaders left a long-lasting impact on the world with his messages of civil disobedience and social change. His legacy prevails as society continues to strive towards equality across sociodemographic categories.

In September 1967, Dr. King provided an address at the American Psychological Association (APA) Convention summoning social scientists to be involved in the Civil Rights Movement (King, 1968). He believed social science was a domain which sought answers and truth in addressing social problems. His address acknowledged the need to avoid economic discrimination, religious bigotry, and racial discrimination. Though the term had yet to be formally coined—Dr. King's ideology that was quite *intersectional* in nature.

Cultural Competence and Ethics

Providing culturally competent care is one of the major competencies and values within psychology. Cultural competence is embedded throughout our ethical guidelines. In reviewing the APA's Ethical Principles of Psychologists and Code of Conduct (Code of Ethics; APA, 2017a), Principle E (Respect for People's Rights and Dignity) addresses the importance of respect to client's individual and cultural differences. The code reads:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, and consider these factors when working with members of such groups. (p. 4)

Additionally, psychologists should aspire to eliminate their biases related to the identified factors. Currently, there is much dialogue occurring regarding implicit biases within the scientific community and public. Practicing psychologists should continue to use the extant literature to engage in their own self-analysis of prejudice and bias.

In addition to the APA Code of Conduct, the APA recently released the updated version of the *Multicultural Guidelines* (APA, 2017b), which provides further insight into how to engage in culturally-sensitive practice. The update was warranted given the "need to reconsider diversity and multicultural practice within professional psychology at a different period in time, with intersectionality as its primary purview" (APA, 2017b, p. 6). Intersectional theory evolved from Black scholar-activists identifying the complexities of intersecting identities among Black women and

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their experiences in social contexts (see Collins, 1990; Crenshaw, 1989). APA's definition of intersectionality "incorporates the vast array of cultural, structural, sociobiological, economic, and social contexts by which individuals are shaped and with which they identify" (APA, 2017b, p. 19). This definition provides a broad lens of both the visible and invisible identities a person maintains. Indeed, the *Multicultural Guidelines* cite identity as being shaped by "cultural influences including age, generation, gender, ethnicity, race religion, spirituality, language, sexual orientation, gender identity, social class, ability/disability status, national origin, immigration status, and historical as well as ongoing experiences of marginalization, among other variables" (APA, 2017b, p. 8).

Another aspect of examining work from an intersectional framework is a psychologist's understanding of self and personal intersecting identities, as well as the intersecting identities of their clients. The *Multicultural Guidelines* note this self-disclosing and exploring of identities of both parties requires vulnerability, which is why some clinicians may shy away from having important conversations about how their own identities and the identities of their clients contribute to their therapeutic relationships and working alliances. Given the salience of intersectionality for both members of the therapeutic dyad, it is important for clinicians to incorporate this framework early in their work with clients.

Multiculturalism Across Contexts

Intersectionality and ethical principles related to multiculturalism should be applied across all professional psychology contexts, including practice, research, training, and consultation. Although cultural competence is often discussed in therapeutic contexts, it should be embedded across all areas of professional practice.

Even within psychotherapy, concerns regarding cultural competence still emerge. In the most recent issue of *Psychotherapy Bulletin* (52.4), Williams, Shamp, and Harris (2017) described how microaggressions can crop up in psychotherapy, indicating a continued need for reflective practice amongst clinicians. Although some have argued for the rewording of the term "microaggression" (Lilienfeld, 2017), the perception of discrimination in the psychotherapy context remains. With existing barriers to care and stigma surrounding mental health access, psychologists must both acknowledge and address their biases as they arise.

Intersectional approaches to research are largely absent. Despite awareness of these important aspects of identity, how frequently are multiple social, personal, and demographic factors evaluated in peer-reviewed research? Researchers note psychologists have historically been slow to incorporate an intersectional perspective in research because there are no established guidelines (Cole, 2009). Too often researchers note the lack of ecological validity of their research to representative samples in their study's limitations. Reliance on convenience samples result in much research being conducted on dominant groups, limiting the applicability to marginalized populations. What can researchers do to alleviate this approach? Cole (2009) poses three questions that should be addressed when applying an intersectional conceptualization in their research:

1. Who is included within this category? (i.e., defining social categories, sampling which includes neglected groups, not interpreting group find-

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ings to represent a normative/universal experience);

2. What role does inequality play? (i.e., attending to social and historical contexts of inequality, testing both similarities and differences among groups);
3. Where are there similarities? (i.e., including groups connected by common relationships to social and institutional power, taking an interest in research not limited to differences)

Although the absence of an intersectional framework in research might be unintentional, the perception of bias can remain. A component of providing ethical and competent care is addressing our limitations, even when unintentional, and identify the root of such biases. "Discrimination explains a great deal, but not everything" (King, 1968, p. 183).

Cultural Competence or Cultural Humility

Many models of multicultural competence have primarily emphasized three components:

1. Self-awareness, which refers to developing an understanding of one's own cultural background and the ways in which it influences personal attitudes, values, and beliefs;
2. Knowledge, which refers to learning about the worldviews of individuals from diverse cultural backgrounds; and
3. Skills, which refers to utilizing culturally appropriate interventions (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2012)

Though each component is important in conceptualization, there is often an assumption of mastery. Rather than a focus on achieving cultural competence, discourse has shifted to *cultural humility*. In psychology, cultural humility has been defined as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client" (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 354). Hook and colleagues note that culturally humble therapists "rarely assume competence," but rather strive to understand the client's intersecting identities and how those identities affect the therapeutic alliance. Cultural humility is a lifelong process of self-exploration and openness of understanding others. Thus, some theorists have added cultural humility as a component of multicultural orientation (Owen, 2013). Dr. King stated, "For social scientists, the opportunity to serve in a life-giving purpose is a humanist challenge of rare distinction. . . Social scientists, in the main, are fortunate to be able to extirpate evil, not to invent it" (King, 1968, p. 180).

Future Directions

One goal remains improving undergraduate and graduate training in multiculturalism. There is continued concern that mental health practitioners are trained in theories with a Eurocentric, heteronormative bias (Burnes, Singh, & Witherspoon, 2017; Mindrup, Spray, & Lamberghini-West, 2011). Further, Section 7.03 (Accuracy in Teaching) of the APA Code of Ethics emphasizes the importance of presenting "psychological information accurately" in teaching and training (APA, 2017a, p. 9). However, there is a tendency to avoid "taboo" topics in training programs, despite many of these topics having importance in the lives of our clients. For example, in a study of 25 counseling psychology doctoral programs, only

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16% reported offering a course on human sexuality—all but one offering it as an elective (Burnes et al., 2017). Additionally, four programs covered sexuality only on an as-needed basis in practicum supervision.

Similarly, although many clients endorse religion and spirituality as being an important aspect in their lives, a survey of 340 psychologists assessing attitudes toward inclusion of spirituality and religion in graduate education revealed that 65% took the position that spiritual and religious issues should be included in graduate training (Crook-Lyon et al., 2012). What about the other 35%? In order to fully embrace an intersectional framework and provide culturally-sensitive practices, all facets of a person's identity need to be addressed.

In graduate education in clinical and counseling psychology, improving the cultural competency/humility of educators and supervisors is also important. Culturally-informed and humble supervisors can help scaffold and model skills for clinicians in training. Supervisors can communicate cultural humility through modeling having dialogues surrounding culture directly in supervision and owning their limitations in understanding when difficult cultural issues arise (Hook et al., 2016). Several guidelines and have been developed outlining culturally-related supervision competencies (see Falender, Burnes, & Ellis, 2012; Fouad et al., 2009).

Continuing education focusing in this area would also beneficial for practitioners. For instance, individuals licensed in psychology in Washington, DC, are required to complete three hours in ethics and cultural competency and two hours of LGBTQ continuing education every two-year period (District of Columbia Municipal Regulations, 2017). Last year, I provided a continuing education workshop on cultural competence in working with individuals who have engaged in sexual offending, and one person in the audience stated they attended the workshop in order to fulfill their state requirement. This was an excellent opportunity to utilize continuing education at a niche conference in order to learn about cultural competence in a specific population. It is recommended that in addition to self-initiated continuing education on multicultural issues, other states follow suit in order to assist practitioners in their cultural humble practices.

Conclusion

As we reflect on the words and teachings of Dr. Martin Luther King, Jr., and honor his APA address to social scientists, we must also reflect on our own limits in understanding of self and others in a culturally humble stance. Incorporating an intersectional framework into all components of professional practice—therapy, assessment, research, training and supervision, and consultation—is a much-needed perspective in cultural humility. His address ended with:

> And so with this faith, we will be able to hew out of the mountain of despair a stone of hope. We will be able to transform the jangling discords of our nation into a beautiful symphony of brotherhood. This will be a great day. This will not be the day of the white man, it will not be the day of the black man, it will be the day of man as man. (p. 186)

Dr. King's address should continue to facilitate dialogue on areas of growth within professional psychology training and practice. While acknowledging social science has not found all the answers to social change, Dr. King believed social science could address some based

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on psychological principles of behavior change—including our own.

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Clinical Impact Statement: In September 1967, Dr. Martin Luther King, Jr., provided an address at the APA Convention summoning social scientists to be involved in the Civils Rights movement—noting the field's focus on "maladjustment." The article reflects on this address to examine the ethics in cultural competence. Definitions of intersectionality, cultural competence, and cultural humility are provided, and the integration of these concepts into professional psychology practice as a lifelong commitment to being other-oriented and engagement in one's own self-reflective practice in relation to multiculturalism is addressed. Lastly, future directions, such as embedding cultural humility into continuing education, are discussed.

Keywords: culture; intersectionality; cultural competence; cultural humility; ethics

Meet the New Editorial Assistant

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Cory Marchi is a second year master's student in Forensic Psychology at the University of Denver and will be attending the doctoral program in the fall. He enjoys hiking, playing music, and spending time with his dogs. Clinically, he is interested in trauma and resilience and passionate about working with children and adolescents.

WASHINGTON SCENE

"Never Doubt That a Small Group of Thoughtful, Committed Citizens Can Change the World . . . "

Pat DeLeon, PhD
Former APA President

The very last event which APA President Tony Puente presided over was to personally present the Presidential Citation to former Division 29 President Ron Fox. "On the closing of the American Psychological Association's 125th anniversary, I, Antonio E. Puente, as President of our venerable society bestow upon Ronald E. Fox this APA Presidential citation on December 31, 2017. From humble beginnings to being President of our great association, Ron Fox has been driven with a vision of making our world a better place through making the profession of psychology a central change agent. His long and illustrious career has spanned several decades and various settings including as a clinician, a professor, and an advocate for the profession of psychology. Starting early in his career, Dr. Fox stood firmly for ethnic-minorities, for women, and for the poor, when such advocacy was considered unimportant.

"Within APA, he has held numerous governance positions from committee member to being President, and a trustee of the Insurance Trust. Dr. Fox has been a pioneer in so many venues that it is impossible to list them all. But here are some important illustrations: key in establishing the APA Practice Directorate, Division 29 (Psychotherapy), Division 55 (Psychopharmacology), and the Association of Psychology Postdoctoral and Internship Centers (APPIC). He advocated in Ohio for the founding of one of the first Doctor of Psychology programs in the U.S. Dr. Fox was instrumental in establishing one of the first psychology licensing boards in the U.S. (Ohio). In addition, he is considered the 'grandfather' for prescription authority in psychology.

"Ron Fox has been a calm, steady, and reasoned voice for all of psychology for almost half a century. For his efforts, his resiliency, his vision, and the many results that have made the profession of psychology what it is today, on this last day of APA's 125th anniversary, let it be known that Ronald E. Fox is presented this APA Presidential Citation."

Prescriptive Authority (RxP):
From the very beginning, Ron Fox has been a visionary leader in psychology's quest for prescriptive authority (RxP). Michael Schwarzchild was one of the first colleagues to respond to Ron's call. Although the State of Connecticut was not initially successful, CPA President Anne Klee reports they have once again returned to this important policy agenda. Former CPA President and RxP committee chair Barbara Bunk: "I am writing with surprising but good news re the RxP effort in Connecticut. Our Department of Public Health (DPH) has recently informed CPA that our request for review of our scope of practice to include prescriptive authority for appropriately trained psychologists has been accepted. DPH is now forming a Com-

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mittee to review and evaluate the request, and to make subsequent recommendations to the Public Health Committee of the Connecticut General Assembly for the 2018 Legislative Session. The Committee is comprised of the six healthcare organizations that submitted impact statements regarding our request; each organization gets two seats on the Committee, as do we (CPA). Notably, the Connecticut Psychiatric Society did not appropriately submit, though the DPH Commissioner can indeed appoint additional Committee members if he so chooses—which he subsequently decided to do.

"The six organizations were CTAPRNS – Connecticut Advanced Practice Nurse Society; CCACP – Connecticut Council of Child and Adolescent Psychiatry; CCAAP – Connecticut Chapter American Association of Pediatrics; CHA – Connecticut Hospital Association; CNA – Connecticut Nurses' Association; and CSMS – Connecticut State Medical Society. The Committee is scheduled to convene two or three times after Thanksgiving." Anne: "CPA has now had three review meetings with our DPH. At the table were various medical groups. As expected, they brought up issues of quality and safety. They made mention to an article about psychologists not prescribing with the underserved as expected in New Mexico. We are well represented by Barbara, Sharif Okasha, and David Greenfield. Sharif spoke directly to the underlying issue of access. He and his father operate an established mental health practice in the New London region. For two years they have attempted (unsuccessfully) to recruit a psychiatrist or advanced practice nurse to join their practice. On a personal level, he is very interested in pursuing his masters in psychopharmacology in order to continue working with an underserved area of the state."

The States of Hawaii and Oregon have the unique experience of having their earlier RxP legislation vetoed by their Governors. This year Mental Health America of Hawaii listed Prescriptive Authority for Advanced Trained Medical Psychologists (RxP) as its *first* Access To Care Advocacy Priority. Kelly Harnick, HPA RxP Chair: "Hawaii is determined. Fortitude and an unwavering commitment best describes the nature of our RxP Committee. The Aloha State truly is filled with Aloha in our hearts for our communities. In Maui country, which includes the islands of Maui, Molokai, and Lana'i, we have an estimated 41-43% psychiatrist shortage. This is unacceptable for our communities that need access to care. RxP was re-invigorated in 2015 when the previous Speaker of the House introduced House Bill 1072, after two community advocates and myself met with him in a little coffee shop in Central Maui. Amazing how an entire movement can ignite over a cup of coffee. At first, being very green at advocacy, I was shocked that the Speaker even agreed to meet with us. Politics occurred and our beloved HB 1072 made it through every hurdle until the last 30 seconds of the legislative session of 2016. Today, we soldier on. We now have HB 2734 introduced yesterday by the Health and Human Services Chair, Rep. Mizuno. Our goal is steadfast, and I am beyond grateful for my Committee and their dedication to getting RxP passed for our patients.

"Hawaii is obviously a bit different than other states because we are an island state. If you live on a neighbor island you can't just drive to the big city, you have to take a flight. This means that if you need care that is unavailable, you have to somehow find a way to fly over to Honolulu in order to get the care you need. As the RxP Chair living on Maui, this is unacceptable for our community.

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The legislature opened last week Wednesday, and we are going to work harder than ever before to finally get the RxP bill passed for the people of Hawaii.

"To get a bill passed, it is very important to understand the parliamentary procedures in your state legislature. It is also very important to empower the people on your committee that are looking up to you for leadership. It can feel quite pressured because when it comes down to it, you know that you are responsible for advocating for a bill that could save lives. As the RxP Chair, I always remind myself when it's very easy to get wrapped up in the noise of politics and power, why we are doing this in the first place—because there are people suffering, going without care. Our suicide rates are amongst the highest in the country. Most people would be shocked by learning that. A common myth is that we simply live in paradise so what is there to be depressed about? However, psychopathology such as clinical depression, bipolar disorders, anxiety disorders, and PTSD to name a few, don't discriminate even if coconut Palm trees are swaying in the trade winds. The people of Hawaii are not immune to needing both integrated psychological and psychopharmacological care because they live in 'paradise.'

"Prescribing Medical Psychologists have a value system and clinical approach that the patients are absolutely yearning for: to work with a Doctor who knows them well while engaging in therapy, as well as one who encompasses the medical expertise being able to prescribe medication safely, as well as taper them off medication. One of the myths and arguments of the opposition that bothers me the most is that RxP is about wanting to prescribe *more* pills. It simply is not!

"As a psychologist, our training is very special. We not only are astute on understanding the therapeutic relationship and the healing power it has; but also therapists with the additional medical knowledge that a prescribing medical psychologist has. I believe it intimidates the opposition because patients want this kind of treatment from a Doctor they feel truly cares and actually knows them well. Here in Hawaii, we are now beginning to gear up again, working towards getting this RxP bill through the legislature for yet another time, and as we've heard many times before "If we don't stop we will win" [Louisiana's Jim Quillin]. Hawaii will not stop and we will win for our very special island communities. As the RxP Chair, I personally will not stop and I feel grateful to have a Committee that is as dedicated as any Chair could ask for."

Investing in Our Future

I have just completed two terms of service on the Board on Children, Youth, and Families of the National Academy of Medicine (NAM). This has been an exhilarating experience, working with dedicated colleagues from a broad range of disciplines, addressing issues directly impacting the wellbeing of our nation's children and their families. Many of these are fundamental to President Obama's landmark Patient Protection and Affordable Care Act, with its emphasis upon prevention, wellness, and population-oriented approaches to healthcare. According, it was perhaps surprising to realize, in retrospect, that many of the absolutely critical issues raised during these discussions are ones that previously I only might have superficially contemplated—emphasizing the intellectual limitation of working within comfortable, although isolated, "professional silos." Psychology is especially fortunate that former APA Congressional Fellow Natacha Blain currently serves as Director for the Board, having recently

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taken over from another visionary psychologist Kimber Bogard.

Last year the Board, under the auspices of the National Academies of Science, Engineering, and Medicine, released its consensus study report, *Promoting the Educational Success of Children and Youth Learning English*. A long-time friend and colleague, Ruby Takanishi, served as Chair of that Committee. Ruby was formally President and CEO of the Foundation for Child Development. She has also served as Director of the APA Office of Scientific Affairs, as well as Executive Director of the Carnegie Council on Adolescent Development. Highlights:

Educating Dual language learners and English learners effectively is a national challenge with consequences both for individuals and for American society. Despite their linguistic, cognitive, and social potential, many English learners—who account for more than 9% of enrollment in grades K-12—are struggling to meet the requirements for academic success, and their prospects for success in post-secondary education and in the workforce are jeopardized as a result. A defining characteristic of these two groups is their demographic diversity. They are members of every major racial/ethnic group and include both youth born in the U.S. and internationally. Most come from Latin America and Asia, with Mexico being the leading country of origin. Relative to other U.S. children, they are far more likely to live in poverty and in two-parent families with low levels of education. Nevertheless, those that become proficient in both a home or primary language *and* English are likely to reap benefits in cognitive, social, and emotional development and may also be protected from brain decline at older ages. In addition, the cultures, languages, and experiences of English learners are highly diverse and constitute assets for their development, as well as for the nation.

Both society at large and many educational and health professionals hold competing views about whether dual language learning should be supported early in a child's development and later in school. Some believe that learning two languages early in life is burdensome, while others believe that young children are "hardwired" to learn one or more languages easily and that nothing needs to be done to promote their language development. Scientific evidence clearly points to a universal, underlying human capacity to learn two languages as easily as one, and the available evidence is mixed as to whether there is a critical period for learning a second language. Research shows that it can take from five to seven years for students to learn the English necessary for participation in a school's curriculum without further linguistic support. Native language revitalization is an urgent matter for Native American communities. Some, however, unfortunately see this as being in direct conflict with school's efforts to promote English language learning.

It is important to appreciate the long-term consequences for the nation of the reality that a high educational achievement and attainment gap exists between English language learners and their monolingual peers. For example, the reading achievement gap is 36 points at the 4th -grade level and 44 points at the 8th -grade level. The high school graduation rate comparison is 63%—far lower than the rate for students living in low-income families at 75%—and the overall national rate of 82%. Language lies at the center of all human development!

Never forget, as this Column's title reminds us: In the words of Margaret Mead: " . . . Indeed, it's the only thing that ever has."

Aloha.

Meet the Publications and Communications Board Chair

Laurie Heatherington, PhD
SAP Publications and Communications Board Chair

Editors' Note: Dr. Heatherington was asked to reflect on the "Turning Point" that led her to becoming the Publications Board Chair. Please visit http://societyforpsychotherapy.org/meet-dr-laurie-heatherington/ to learn more about Dr. Heatherington.

Careful, these people are good!! Friendly people (Jeff Barnett, Past-Chair of the Publications Board) cleverly engages your agreement to serve on the Publications Board by dropping the names of highly competent people that you already know, and that you already know are working very hard themselves on behalf of Division 29 (Mark Hilsenroth, *Psychotherapy* Editor). Yearly meetings in beautiful Washington, DC, in autumn are dangled before you. Once at such meetings, you meet new people—very interesting, enthusiastic people—with fresh ideas and lots of enthusiasm for bringing psychotherapy research and writing to the Division membership: Lynett Henderson Metzger, *Bulletin* Editor, Amy Ellis, Internet Editor, and the other Publications Board members. Having never been involved in divisional activities, you feel a bit confused as names and references to past decisions and future goals are tossed around, but you are assured not to worry, that there is someone that knows all, remembers all, keeps track of all (Tracey Martin, APA, Division Administrator). Thus when you get a call from the incoming Division 29 President, a friend and colleague with whom you've worked closely on other adventures (Mike Constantino), that Jeff Barnett's hugely successful terms as Pub Board Chair are ending, and they need someone to step in, what can you say??! Like I said… be careful!

All kidding aside, I am very happy for the opportunity to be a member of this team, and now to begin serving as the new Chair and Cheerleader-in-Chief. I look forward to all the good times ahead as this team continues to bring great publications to its readerships.

Congratulations to the 2018 Society for the Advancement of Psychotherapy Distinguished Psychologist Award Winner

Dr. Jacques Barber

Jacques P. Barber, Ph.D., ABPP is Professor and Dean, Gordon F Derner School of Psychology formerly the Institute of Advanced Studies in Psychology at Adelphi University. He is professor of psychology in the Department of Psychiatry and in the Psychology Graduate Group at the University of Pennsylvania. He is also Adjunct Professor of Psychiatry at New York University School of Medicine. He is past president of the International Society for Psychotherapy Research and was a recipient of its early career award in 1996 and its Distinguished Research Career Award in 2014. He has been visiting professor at the Department of Clinical Neuroscience of the Karolinska Institute in Stockholm. He is a licensed clinical psychologist in New York and Pennsylvania.

His research focuses on the outcome and process of psychodynamic and cognitive therapies for depression, panic disorder, substance dependence and personality disorders. He has been funded by NIMH and NIDA to conduct randomized clinical trials involving psychodynamic and cognitive therapy. Guided by conceptual models emphasizing both relational and technical factors, his psychotherapy process research examines the impact of the therapeutic alliance and of therapists' use of theoretically relevant interventions on the outcome of different therapies. Outside of treatment research, he has also conducted research on individual core conflicts and metacognitiion in different populations including Children of Holocaust Survivors. He has published more than 250 papers, chapters and books in the field of psychotherapy and personality. He is mostly proud of the students and post docs he has mentored during his career.

Among his recent books are "*Psychodynamic Therapy: A Guide to Evidence-Based Practice*" and "*Practicing Psychodynamic Therapy: A Casebook (2014)* both with Richard Summers*; Visions in Psychotherapy Research and Practice: Reflections from the presidents of the society for psychotherapy research edited with Bernhard Strauss and Louis Georges Castonguay. "Echoes of the Trauma: Relationship Themes and Emotions in the Narratives of the Children of Holocaust Survivors"* co-authored with Hadas Wiseman, and *The Therapeutic Alliance: An Evidence-Based Approach to Practice, co-edited with Christopher Muran.*

SAP SCHOLARSHIP WINNERS

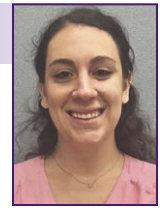
As one of Dr. Michael Constantino's President-Elect initiatives, the Society for the Advancement of Psychotherapy (SAP) administered a scholarship competition to support three student SAP members' attendance at the North American Society for Psychotherapy Research (NASPR) Science-to-Practice Workshop, *An Introduction to Dyadic Data Analysis in Psychotherapy Research*, on October 28, 2017 in Lake George, NY.

Given SAP's close connection to NASPR, this scholarship program was initiated to support students ($200 each) for whom dyadic analyses are pertinent to their clinical and research training. After reviewing proposals, the SAP Student Development Committee selected the following winners:

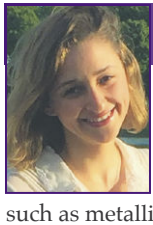
Katie Aafjes-van Doorn
Yeshiva University

Katie Aafjes-van Doorn is a Clinical Psychologist and psychotherapy researcher. She received a master's degree in clinical psychology and psychological research and completed her doctoral training at University of Oxford, United Kingdom. She received clinical psychoanalytic training at Access Institute, San Francisco and just completed a one-year postdoctoral research fellowship at the Derner Institute for Psychological Services, Adelphi University, New York. This summer she joined the faculty at Ferkauf Graduate School of Psychology, Yeshiva University, New York. Her teaching and research interest is in evidence-based psychodynamic psychotherapy, as well as its potential moderators and mediators of change. She has written several empirical papers on the process and outcome of experiential dynamic therapy, co-authored an introductory book on clinical psychology, and chapters on process-outcome research. She hopes to contribute to the evidence-base of psychodynamic therapy by operationalizing psychoanalytic concepts such as defenses, affect experiencing, countertransference, and reflective functioning.

Carly Schwartzman
University at Albany



Carly is a second-year doctoral student in clinical psychology at the University at Albany, working in Dr. James Boswell's Psychotherapy and Behavior Change Research Lab. Following graduation with a B.A. in psychology from the University of Miami, she worked as a research assistant at Butler Hospital in Providence, RI in the Obsessive-Compulsive Disorder Research Program. Her research interests include mechanisms of change in psychotherapy, intervention and therapist effectiveness, dissemination of empirically-supported treatments, and the use of technology in the delivery of psychological treatment.



Nili Solomonov
Adelphi University

Nili Solomon is an advanced doctoral candidate for clinical psychology at the Derner School of Psychology, Adelphi University. She currently works as a Clinical Psychology Intern at Jacobi Medical Center, The Bronx, NY. Her research focuses on mechanisms of change in CBT and psychodynamic therapies for mood and anxiety disorders, such as metallization and misinterpretation of bodily sensations. Her studies also focus on the role of the working alliance and use of specific therapeutic techniques in process and outcome of different psychotherapies. She is particularly interested in studying longitudinal therapeutic processes using quantitative methods, such as multilevel modeling and structural equation modeling.

SAP congratulates these deserving scholars!

Jennifer Callahan, PhD

I am honored and humbled by the nomination to serve the Division in the role of president. Before I get into my qualifications and experiences, I would like to lead with my intentions. If elected, my presidential initiative will center on resource development and dissemination. I want our members to benefit from resources that facilitate increasing psychotherapy expertise. To that end, I will foster bringing those who are in primarily research roles to work collaboratively with those in practice roles to identify, generate, and distribute needed and effective resources. While my intention is to serve our membership with this initiative, my hope is that our society will infuse resources beyond ourselves to advance psychotherapy more broadly. If this initiative is something the membership wishes to endorse, then my qualifications and experiences to lead that initiative become relevant.

I am a Professor of Psychology at the University of North Texas, where I serve as the Director of Clinical Training for an APA-accredited doctoral program. I view quality training to be a systems level intervention with lasting effects across the career lifespan. Those effects may be particularly impactful in underserved areas where few providers exist. As such, my research primarily centers on improving psychological services and client outcomes among underserved and disadvantaged populations via careful inquiry elucidating client and therapist variables, as well as the contributions of training and supervisors.

The quality of my work is implied via multiple awards for mentorship and selection for the NIH Loan Repayment Program for Individuals from Disadvantaged Backgrounds. I have also been awarded grants from the American Psychological Foundation as well as the Association of Psychology Postdoctoral and Internship Centers (APPIC) to facilitate work on assessment of competencies. I was also co-PI on a Norine Johnson Psychotherapy Research Grant for work on improving psychotherapist effectiveness. To date, I have authored more than 100 publications and am the current Editor-in-Chief for the *Journal of Psychotherapy Integration*. I am also an Associate Editor for the journal *Training and Education in Professional Psychology* and a Consulting Editor for the journals *Psychotherapy* and *Practice Innovations*. I am board certified in Clinical Psychology and an APA Fellow.

My experience with resource development and dissemination includes spearheading a program (in my role as the Society's Education and Training Domain Representative; see my publications in the Society's Bulletin here) that identified all mental health providers in the most financially disadvantaged zip codes (according to US census data) to provide complimentary journal subscriptions to our Society's journal, *Psychotherapy*. In my role as the Editor in Chief for a different journal (*Journal of Psychotherapy Integration*), I began having every published article translated at the level of title, abstract, and keywords into both Spanish and Chinese to expand the reach of the published scholarship. Those translations are indexed in the major database for our field (psycINFO) and, more importantly, disseminated throughout mental health systems of care in developing countries internationally via the World Health Organization's Hinari program. I am deeply committed to infusing resources into systems of care via resource dissemination to providers of psychotherapy.

Thank you very much for considering this initiative and allowing me to serve the Society. ■

Rayna D. Markin, PhD

Division 29 is a home for people who love psychotherapy. These are the words that I vividly remember reciting to a room full of eager Early Career Psychologists (ECP) at Division 29's annual "Reception with the Masters" mentoring event held at APA convention, in my novice role as ECP chair almost 10 years ago. Since that time, I have had the privilege of occupying multiple consecutive leadership roles in the Division, including: ECP Chair, ECP Domain Representative, and Education and Training Chair. In these roles, I have planned and organized various mentoring programs and events, chaired or participated in numerous committees, reviewed award proposals, contributed to the *Psychotherapy Bulletin*, and, most recently, planned an on-line video series for the Division's website consisting of interviews with experts on how to apply psychotherapy relationship research to training and supervision. I have also been nominated to run for Council of Representatives. Moreover, I was fortunate to receive both the Charles J. Gelso Psychotherapy Research Grant and the APF/Division 29 ECP Awards. Lastly, I serve on the editorial board for the Journal *Psychotherapy*, for which I have served as guest editor for two special sections on the Psychotherapy Relationship and Psychotherapy for Pregnancy Loss. Across all these various leadership and service experiences that I have been privileged to occupy over these many years, the original words I first uttered at the very beginning of my Division 29 career still ring true, and, I believe, comprise the very foundation of this Division, which is truly a place for people who love psychotherapy.

As psychotherapy researchers, clinicians, and educators our common commitment to psychotherapy is presumably rooted in our identification with the values that this process encapsulates. These values often include a focus on issues and special populations that are somehow typically unacknowledged or invalidated in the larger society. Through my active program of research and clinical practice on psychotherapy for pregnancy loss, a unique kind of loss which is often both "silent" and "invisible" in Western Society, I have come to appreciate how psychotherapy can acknowledge and validate patient experiences that are typically dismissed or ignored, and, moreover, serve as a vehicle for social change through putting words to experiences typically considered too taboo to talk about. If given the honor of serving as President, I would focus on initiatives that bring to light both those issues that patients often present with that are typically minimized in Society, as well as diverse marginalized populations whose experiences are often silenced or unheard. I would seek to fulfill this initiative through working collaboratively with other board members and Divisions, focusing the call for proposals for APA convention around this topic, creating related webinars, and updating our web site to include information on various salient topics for the public and for professionals. In essence, as President, I would seek to promote initiatives that tap into the very heart of psychotherapy, the capacity to shed light on experiences that are all too often left in the dark. ■

Jesse Owen, PhD

Experience: Dr. Owen is an Associate Professor and Department Chair in the Counseling Psychology Department at the University of Denver. He is an APA Fellow for the Society of the Advancement of Psychotherapy (SAP; Div 29), and he has been awarded the Early Career Awards for SAP and Division 17 (Counseling Psychology). He has been an Associate Editor for Psychotherapy since 2009, and he has been an Associate Editor for two other top-tier journals. He has also served as SAP's Domain Chair and Representative for Education and Training, and currently serves as the Treasurer. He has published over 125 peer-review publications, books, and videos most of which are focused on psychotherapy process and outcomes. He has a small private practice in Denver which focuses on individual and couple therapy as well as psychological assessment.

Statement: I have truly enjoyed my time over the past eight years serving the members of SAP. During my time as Treasurer, we have enjoyed great success with journal revenue and membership initiatives. These efforts have made our Society financially healthy, which has resulted in our ability to increase funding for our members. For instance, over the past three years we have increased grant funding for innovative projects, including larger scale projects. Additionally, we have been able to increase funding for our student, early, mid, and senior career awards. We have been able to achieve these goals while maintaining fiscal responsibility (e.g., not significantly impacting our reserves). I am very passionate about promoting the future of SAP, and I hope you will support my reelection as your Treasurer. ■

Joshua Swift, PhD.

I am deeply touched to be considered for the Treasurer position for SAP. SAP has played an important role in my career and in my professional identify, and I would look forward to the opportunity to serve the members of the society in this manner. My first interactions with Division 29 came early in my graduate training. I was attending the APA Convention in order to receive a division award. I was impressed by how welcoming members of the division were to me, even though I was just a student.

I am now an Assistant Professor at Idaho State University. At ISU I teach within our Clinical Psychology Ph.D. program and conduct my research focusing on client preferences and premature termination in psychotherapy. SAP has been an integral part of my growth over the past ten years. I frequently publish in the Society's journal and newsletter, I have received grant funding from SAP, and SAP's meetings have always been a place where I have been able to network and build collaborations with others. Over the past five years I have served in SAP's Education and Training and Early Career committees, and as the Chair for the Psychotherapy Research Committee. This service has provided me with an invaluable opportunity to observe the good that SAP and its members have provided to the field. I feel fortunate to have been part of that. I would be truly grateful to be able to now offer my service in the Treasurer role. ■

CANDIDATE STATEMENTS
Diversity Domain Representative

Manijeh Badiee, PhD

Dear colleagues, I am humbled and honored to be nominated for the Diversity Domain Representative on the Division's Executive Committee. I am currently an Assistant Professor of Psychology at California State University, San Bernardino. In this role, I teach undergraduate students as well as graduate students in our clinical counseling Master program. The courses I regularly teach are relevant to psychotherapy (e.g., Advanced Clinical Seminar and Counseling Theories) as well as to diversity (e.g., Psychology of Women and Cross-Cultural Counseling). Additionally, I provide therapy services in a private practice setting. I have over ten years of experience counseling clients of various backgrounds and currently specialize in women of color, LGBTQ individuals, and/or adolescents.

As I have grown in my professional identity, I have realized I must never forget my roots. Growing up as a first generation Iranian American immigrant woman in Texas shaped who I am. Diversity has always been central to my identity, and this emphasis has only strengthened as I have progressed professionally. My research is on women's empowerment, with a focus on Iranian and Latina women. I routinely provide presentations on diversity-related topics to community members, students, and faculty. When I was a graduate student, I served as the student representative for Counseling Psychology, Division 17, International Section and facilitated networking among counseling psychology students interested in international issues. My immigrant background has also made me passionate about social justice and the delivery of multiculturally competent services to all clients, especially those from marginalized and vulnerable groups. If elected, I will strive to consider these groups in the decisions that I make. In sum, I am excited at the possibility of expanding my diversity emphasis in teaching, research, and community service to the Diversity Domain Representative position. Thank you for the consideration! ■

Astrea Greig, PsyD

I am honored to be a candidate for Diversity Domain Representative. I am It has been a great pleasure to serve as Chair of the Diversity committee for the past 3 years and I wish to continue serving the division in this capacity even further as Domain Representative. Working with underserved, socially marginalized, and diverse populations is my passion. I completed my graduate training at University of Hartford, completed my internship at Yale, and finished my post-doctoral fellowship with the VA. I am currently at a community health center that solely serves the homeless population in Boston. I strive to bring psychotherapy to this population that does not easily access health care. I understand the importance of the need to highlight how diversity and multiculturalism intersects with the research, provision, and practice of psychotherapy. I am currently also on the APA Office of Socioeconomic Status task force to develop guidelines for working with

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persons with low socioeconomic status. Additionally, I am co-chair of the diversity committee in Division 18, public service. My hope is to bring this passion, experience, and perspective to the Diversity Domain Representative position. Division 29, the Society for the Advancement of Psychotherapy, has a wonderful history of promoting psychotherapy practice, research, and policy and I hope to continue to serve our division in this manner with the importance of diversity in mind. ■

CANDIDATE STATEMENTS
Education & Training Domain Representative

Ken Critchfield, PhD

Associate Professor, Director, Combined-Integrated Clinical and School Psychology Program, James Madison University (JMU), Harrisonburg, Virginia

I am thrilled to be nominated to be Domain Representative for the Education and Training Committee. I deeply value SAP as a "trusted place" that actively supports practitioners and nurtures student and early career voices. I am a former E&T committee member who chaired the group in 2010. I think it would be a wonderful professional homecoming, a delight, to become directly involved there again.

This nomination is timely for me. In 2014, I joined the faculty of James Madison University's Combined-Integrated Doctoral Program in Clinical and School Psychology. A cherished role there is teaching psychotherapy skills through direct supervision of our students. I am now Director of this program, as well as Chair-Elect of the Consortium of Combined-Integrated Doctoral Programs in Psychology (CCIDPIP). This context brings psychotherapy training into focus for me daily, from the needs of individual trainees to those of organizations focused broadly on training of health service psychologists.

I received my doctoral degree from the University of Utah, interned at the San Francisco VA Medical Center, and received post-doctoral training focused on personality disorders at Weill-Cornell Medical School and the University of Utah Neuropsychiatric Institute. I stayed on at Utah for over a decade and became co-director of the Interpersonal Reconstructive Therapy (IRT) clinic, which had the three-fold mission of service, research, and training for treatment of patients with comorbid psychiatric disorders, chronic suicidality, and personality disorder. I love seeing patients make profound changes in their lives, as well as researching how change may come about. I also love seeing psychotherapy trainees come into their own as they increasingly internalize principles of intervention that make lasting change possible.

Thank you for considering me as a candidate. I hope I receive your vote. I'm a fellow-traveler in any case and will be working to advance psychotherapy education and training wherever possible. ■

Marilyn Cornish, PhD

It is an honor to have been nominated to run for the Domain Representative for Education and Training position for the Society for the Advancement of Psychotherapy. Serving as an educator and supervisor of future psychologists is a large part of my professional identity. I also believe that learning and growth must continue throughout one's career as a psychologist.

I am an assistant professor and co-director of training for the APA-accredited PhD program in counseling psychology at Auburn University in Auburn, AL. In that role, I teach courses such as Counseling Supervision, Advanced Practicum, and Group Counseling. I similarly provide individual, group, and supervision of supervision to doctoral students, and I coordinate the practicum placement process for our students. In terms of related professional service, I am a member of the Division 17 (Society of Counseling Psychology) Continuing Education Committee and I have served as an Editorial Board team member for *Journal of Counseling Psychology*. My research lab has a central focus on psychotherapy process and outcome, with interests branching out to other types of positive relationships and effective interventions (including teaching and supervision). For example, I coordinated a year-long campus dialogue initiative in 2017 on creating culturally-inclusive university classrooms.

With this set of experiences, I feel well-positioned to serve as the Domain Representative for Education and Training. If elected, it would be a privilege to serve the education and training agenda for the Division, particularly with regard to evidence-based practice and culturally-sensitive care. ■

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

CANDIDATE STATEMENTS
Membership Domain Representative

Jean Birbilis, PhD

It has been a highlight of my professional life to be involved in the governance of Division 29, particularly as Membership Domain Representative, and it would be an honor to have the opportunity to continue. One of the focal points of the Board that I have appreciated is consistent, proactive efforts to diversify the membership of Division 29, with overall improvement resulting from those efforts. At the same time, there is room for improvement. For example, members were added with events like "Lunch with the Masters" that was provided for several years at APA Conventions, but conversion rates to permanent membership were low. Dr. Rosemary "Rosie" Adam-Terem, the incoming Chair of the Membership Committee, and I, as the Domain Representative for Membership, have identified strategies for not only recruiting, but also retaining and mentoring new members who will represent the vast diversity of potential members. As such, we are or plan to be implementing the following:

- Increasing the number of students and graduates (particularly of Psy.D. programs which are now graduating more doctoral level psychologists than Ph.D. programs and yet are underrepresented in Division 29 membership) by locating and directly contacting graduate psychology student organizations
- Creating and sharing methodology with other committees to develop succession plans for leadership in order to engage and retain more students and Early Career Psychologists while also increasing the continuity of committee activities
- Developing strategies for enhancing the geographic diversity of members who become involved in governance of Division 29
- Continuing to explore opportunities for Division 29 to offer continuing education via webinars and other venues to add value for members who are maintaining licenses
- Seeking new opportunities for collaborations with other organizations that have similar missions to Division 29

I would appreciate being given the opportunity to follow through on these strategies for recruiting and retaining members for Division 29, the Society for the Advancement of Psychotherapy, as the Membership Domain Representative. ■

Jonathan Jenkins, PsyD

Since joining the Division in 2016, I have been thankful for the manner in which the Society continues to reach out to early career psychologists while also continuing to seek the sage advice of well-traveled clinical "rock stars" in the field. Through this community of clinicians of various backgrounds and experiences, we are able to both be the teachers and the students in various discussions that touch upon our unique roles as clinicians in our communities and our unique seen and unseen identities. Division 29 has the unique opportunity to continue to grow its membership through a variety of means and I hope to be a part of that change. Membership growth is crucial to the overall health of the Division because increases in the breath and scope of its members will help cultivate more nuanced discussions about the ways in which we, as therapists, can continue to grow as individuals and clinicians. Increased membership also has a financial benefit as it therefore allows for the Division to be more fiscally buoyant and capable of changing with the needs of the field and its members. As a larger and more comprehensive group, Division 29 can better galvanize our efforts towards collective advocacy on critical mental healthcare topics and lend our voice to those underserved populations in the community. Investing in membership retention and member acquisition are two essential tasks to preserve the value and strength of the Division. To take Division 29 to the next level, we need to dedicate a strong push to empowering our broad membership base to help promote the Society for the Advancement of Psychotherapy and how we can help the community be emotionally healthier. ■

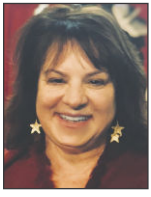
CANDIDATE STATEMENTS
Psychotherapy Practice Domain Representative

Angela Ferguson, PhD

I am honored to be considered for the position of Domain Representative for Psychotherapy Practice for Division 29. Although I am new as a member of Division 29, I am not new to serving in APA governance. I have served on the executive committee of the Council of Counseling Psychology Training Programs, the executive committee of Division 44 – Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues; the Committee on Lesbian, Gay, Bisexual and Transgender Concerns Committee (CLGBTC); and I'm currently serving on the executive committee of Division 45 – Society for the Psychological Study of Culture, Ethnicity, and Race. I have also served on the Editorial Board for *The Counseling Psychologist* (2009-2012), and currently serve on the Editorial Board for the *Journal of Counseling and Development*.

Throughout my career, I have been involved in various aspects of psychotherapy, either through direct service delivery, scholarship, or supervision and training. During my early career, I was a staff psychologist and thoroughly enjoyed working as a clinician and supervisor. I am currently an associate professor at Howard University in the Counseling Psychology Program. In all aspects of my work, I have focused on the multiple intersections of an individual's identities. My research, supervision and academic work infuses a cultural perspective relative to the ways in which the sociopolitical and historical experiences of oppressed, marginalized groups influences social, emotional, and sociocultural aspects of psychological functioning and development, and personal and group identity. I use an intersectional lens in theoretical conceptualization, psychological assessment, and didactic content. Therapists need to be culturally aware and competent, and it has been my hope that my work will inform therapeutic interventions to meet the unique needs of diverse and marginalized clients, and help ensure access to effective treatment. I am excited to add to Division 29's discourse and leadership of promoting the importance of cultural competency in psychotherapy and supervisory work. Membership Domain Representative. ■

Barbara Vivino, PhD



I, Barbara Vivino, am honored to be nominated for Domain Representative for the Professional Practice Committee for the Society for the Advancement of Psychotherapy (Div. 29) of the American Psychological Association. As a long time APA member, I took on the role of Chair of the Professional Practice Committee of Division 29 in 2013. During the past five years, I have learned to deeply appreciate and embrace the mission of The Society for the Advancement of Psychotherapy. Its goal to provide an active, diverse, and vital community has been successful with me, as it has become my home within APA.

I have been a psychologist in private practice in Berkeley, California, since 2000. I am strongly committed to the intersection of research and practice and feel passionate about representing the voice of professional practitioners. During my tenure as Chair, the Professional Practice Committee has developed and conducted a qualitative research study on the Needs of Therapists in Private Practice. Findings from this study will be presented with an international panel of psychotherapists and psychotherapy researchers at the Society for Psychotherapy Research conference in Amsterdam in June of 2018. The Professional Practice committee developed this study as a way to more fully understand and potentially meet the needs of professional practitioners. We plan to use our qualitative findings to develop and distribute a survey to a nationwide sample of therapists in private practice. I am also a regular contributor to the Psychotherapy Bulletin and have elicited a wide range of other contributors for the Bulletin as well.

I received my Ph.D. from the University of Maryland and completed a clinical postdoctoral fellowship at the University of California, Berkeley. I worked as an Associate Professor at The California Institute of Integral Studies from 2000 to 2007, where I also served as Director of Clinical Training.

I will be honored if you vote for me. I will work hard and thoughtfully to best support the needs of the division and of professional practitioners. I believe the Society for the Advancement of Psychotherapy would be well served by the continuity, experience, and passion that I would bring to this position. ■

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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.

Psychotherapy Bulletin welcomes articles, interviews, commentaries, letters to the editor, book reviews, and SAP-related announcements. Please ensure that articles conform to APA style; graphics, tables, or photos submitted with articles must be of print quality and in high resolution. Complete Submission Guidelines and the online submission portal can be found at http://society forpsychotherapy.org/bulletin-about/ (for questions or additional information, please email Lynett.HendersonMetzger@du.edu with the subject header line *Psychotherapy Bulletin*). 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.societyforpsycho-therapy.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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