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BULLETIN

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Society for the Advancement of Psychotherapy

2018 VOLUME 53, NUMBER 2

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PRESIDENT'S COLUMN

Into the First Turn

Michael J. Constantino, PhD
University of Massachusetts, Amherst

As I write my second Presidential Column, the Kentucky Derby is fast-approaching (for those unaware, it is always the first Saturday in May!). As a big fan of the event, I feel compelled to use horse racing lingo. Thus, whereas my first Presidential column was my personal post time at the SAP leadership helm, this second column represents the three-quarter pole of my term (distance is in reference to the finish line). Stated differently, I am well into the first turn (a figuratively literal *turning* point).

As time tends to do, four months on the job have gone by quickly! During this time, SAP not only continues to have its annual rhythm of events, programs, awards, and publications, but its leaders also put new initiative balls in the air to be juggled. I am happy to report that SAP continues to juggle with skill and precision, which allows for an exciting blend of the norm and the new. In this column, I provide an update on several of the Presidential and Board of Director initiatives that I laid out in my previous column, and that have been successfully launched or furthered. I also provide a brief look ahead to important transitions and SAP's next major event—APA Convention in San Francisco.

A Few Updates

As a reminder, SAP engages in numerous initiatives reflecting the cutting edge of psychotherapy research, practice, training, and professional development, and that in many ways connect to my presidential themes of *personalized mental health care* and *disruptive innovations to psychotherapy training molds and methods*.

In a few short weeks, 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. In my role as guest to SEPI (though I am also a member), Tracey Martin, Catherine Eubanks, and I will meet to discuss in earnest concrete ways to grow the SAP-SEPI collaboration and bidirectional support system. My colleague, Dr. James Boswell, and I will also present the results of the two meta-analyses that we conducted for Dr. John Norcross's forthcoming book, *Psychotherapy Relationships That Work* (3rd ed.)—a project co-sponsored by SAP. Respectively, our meta-analyses focused on the prediction of patient posttreatment outcomes from their pre- or early treatment outcome expectation and perceived credibility of therapist/treatment. We are excited to share our results, and to raise consciousness around the relevance of attending to pandiagnostic and pantheoretical patient belief variables as a central form of evidence-based practice (EBP)—a disruptive movement, for sure, away from conceptualizing EBP solely as elements of therapist actions in concert with a treatment protocol. We will also present both of these works at APA Convention in August.

Also relevant to the *Psychotherapy Relationships That Work* (3rd ed.) project,

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Dr. Rayna Markin and I have begun production on companion videos to the book's chapters. These videos, which will be cross-posted on the SAP website and the Oxford University Press website, involve Dr. Markin asking focused questions to the authors on the training implications of their original meta-analyses on factors that contribute to psychotherapy improvement. I was fortunate to be Dr. Markin's first interviewee, discussing our outcome expectancy chapter, and we look forward to featuring these videos in the near future. Be on the lookout for these companion pieces!

We have now received nominations for two new student awards: The Student Excellence in Practice Award and The Student Excellence in Teaching/Mentorship Award. I am excited to present these awards to our inaugural winners at the SAP Award Ceremony at Convention.

Commemorating our 50th anniversary, we have also now received proposals for the 2018 Society for the Advancement of Psychotherapy 50th Anniversary Research Grant, which will provide $30K toward the advancement of research on psychotherapy process and/or outcome that will help shape the field for the next 50 years. I am also excited to present this award to our winner(s) at our Award Ceremony.

I have convened a workgroup, including Nicholas Morrison, Dr. Lavita Nadkarni, and myself, to develop the administration and evaluation process for the two new SAP student poster awards, which will be granted this year at Convention. Our group looks forward to reviewing abstracts, listening to oral summaries during the poster sessions, and selecting the inaugural winners. These winners will be announced at SAP's popular "Lunch with the Masters" at Convention.

We will formally extend our successful partnership with Oriental Insight at Convention, and we remain devoted to the internationalization of SAP.

Finally, in response to SAP Fellow and Past-President, Dr. Marvin R. Goldfried, being awarded the 2018 APA/APF Gold Medal Award for Life Achievement in the Application of Psychology, our Student Development Chair, Nicholas Morrison, interviewed Marv. This piece, for which Marv reflects on his illustrious career, will be published in this edition of the *Psychotherapy Bulletin*. It is well worth the read. Congratulations, again, Marv! We are all very proud.

Transitions

Speaking of time flying, Dr. Mark Hilsrenroth, our *Psychotherapy* Editor extraordinaire now enters what is akin to the stretch run of his second and final term as Editor. Dr. Hilsenroth's term will end in 2020. Thus, the SAP Publications and Communications Board Chair, Dr. Laurie Heatherington, and I have begun working with APA on a transition plan. Please see an advertisement for the position in this issue, and we encourage those interested and qualified to apply. The Journal has been immensely successful under Dr. Hilsenroth's leadership, and we look forward to continued excellence with the selection of his successor.

Convention

The SAP Convention program has been released. Please visit our website to see the full program. I highlight here just a few events:

- Division 29: Poster Session I (ID: 1229)
  Thursday (8/9/18): 11am-11:50am
  Location: Moscone Center - Halls A, B, C
- Division 29: Poster Session II (ID: 1231)
  Friday (8/10/18): 11:00am-11:50a

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Location: Moscone Center - Halls A, B, C

- Presidential Symposium: *Personalizing Mental Health Care Through Disruptive, Evidence-Informed Innovations to Psychotherapy* (ID 1187)
  Saturday (8/11/18): 8am-9:50am
  Location: Moscone Center - Room 206

Also, you are cordially invited to the following SAP special events (all of which will incorporate a celebration of SAP's 50th anniversary):

- Division 29: Award Ceremony (ID: 1233)
  Friday (8/10/18): 4pm-4:50pm
  Location: Marriott Marquis - Yerba Buena Salons 5 & 6
- Division 29: Social Hour (ID: 1234)
  Friday (8/10/18): 5pm-5:50pm
  Location: Marriott Marquis - Yerba Buena Salons 5 & 6
- Division 29: Luncheon with the Masters (ID: 1235)
  Saturday (8/11/18): 12pm-1:50pm
  Location: Marriott Marquis - Golden Gate Room C2

See you in San Francisco!

In Memoriam

As most of you are aware, SAP lost an esteemed member, co-founder, and Past-President on March 14, 2018 when Dr. Ronald Fox passed away. We were fortunate to have Drs. Pat DeLeon and Ron Levant write a touching obituary, which can be read here.

A Repeat of Gratitude

It bears repeating from my first column: to our Board members, thank you, for all that you do for SAP. To all SAP members, thank you, for entrusting me to lead this fine organization in 2018. And for those of you who take in the most exciting two minutes in sports, enjoy the Kentucky Derby, Preakness Stakes, and Belmont Stakes, as well as a mint julep, black-eyed Susan, and Belmont breeze, respectively (if you are into those sorts of things)!

EDITORS' COLUMN

Lynett Henderson Metzger, JD, PsyD
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We hope this issue finds our readership well, and winding up summer activities/beginning to look toward Fall.

In this issue, we have two Special Features you won't want to miss. First, an interview with Dr. Marvin Goldfried, 2018 APA/APF Gold Medal Award for Life Achievement in the Application of Psychology, by Nicholas Morrison, Chair of our Student Development Committee. In addition, Dr. Ben Johnson has written an informative piece on the business of psychotherapy.

In keeping with our Special Focus of "Turning Points," we have pieces regarding transitioning into fatherhood as a clinical psychologist, as well as early career turning points working in correctional systems and community health center settings. Early career professionals should also not miss a submission by our ECP Committee Chair, Dr. Kimberly Arditte Hall, on assessing our ECP members' needs and interests. Student readers at every stage of their training may find this issue's "Guide to Gaining Relevant Skills for Acceptance to Clinical/Counseling Psychology Doctoral Programs" useful. All of our readers will want to take time to learn about practice recommendations for gender diverse clients and ethical considerations around professional competency. Finally, don't forget to check out the upcoming events, announcements, and member-specific information and updates included in this issue.

Our remaining deadlines for the year are August 1 and November 1, 2018. Please visit us at http://societyforpsychotherapy.org/bulletin-about/ for our submission guidelines and portal. As always, feel free to contact either of us, using the contact information below.

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SPECIAL FEATURE

Reflections From an American Psychological Association/ American Psychological Foundation Gold Medal Award Recipient for Life Achievement in the Application of Psychology: An Interview with Marvin Goldfried

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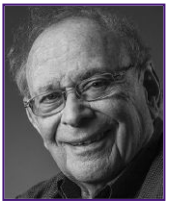

Nick: You've been selected as the recipient of the 2018 APA/APF gold medal award for life achievement in the application of psychology, which recognizes a distinguished career and enduring contribution to the advanced application of psychology through methods, research, and/or application of psychological techniques to important practical problems. So, as you look back over your career, where do you believe the field has developed or grown most in those areas and conversely, what are the biggest challenges in these areas for the next generation of psychologists?

Marv: Let me start by referring very specifically to my experience with Division 29, which started I guess around 30 years ago. I was on the board and sat in on executive committee meetings, and one of the things that was really striking was the split between research and practice among many of the members. Even the word "clinical," which connoted Division 12—and at the time connoted research and an anti-clinical attitude—was very evident at the time, and was a remnant of what had been going on for many years. The field of therapy started not from research but from clinical experience of Freud and his colleagues, and there was an antipathy—and still is in some circles—toward research.

Nick: For sure.

Marv: I think Division 29 has changed considerably. It's very obvious and there is no opposition toward the need for research. There may be some tension between researchers and practitioners and I think that continues to exist. So, while in certain circles the gap between research and practice has been closed somewhat, I think it`s still a major challenge.

Nick: Right. That makes a lot of sense.

Marv: So that is a continued challenge. To a great extent one of the problems with the field is that all professionals were people before they were professionals! We know that human behavior is not always logical, so there is bias and distortion that exists, and there are personal stakes that one needs to protect. I think this personal and professional bias continues to exist and continues to inform, or perhaps at times misinform, the field.

Nick: That makes a lot of sense. That ties nicely to my next question. The closing of the research and practice gap has ob-

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viously been an important issue for you and for the field of psychotherapy. When you consider the current state of the field, what recommendations would you have, specifically for trainees and/or training programs to foster a spirit of equal emphasis at the outside of training?

Marv: Well, let me use Stony Brook University as an example. We have faculty supervising the graduate students who work in our clinic. We set that up years ago when we started the clinical program back in the late [19]60s, because we believed in the scientist-practitioner model, which sounds good, need a lot of work to implement practically.

Nick: For sure.

Marv: But I think at an early stage, students need to see that it's not research *versus* practice, but the complementarity between the two. There are very good scientific reasons for this. One is that when good research is conducted in a science, there are usually two stages. There's the context of discovery, where you informally look for a phenomenon. And then there's the context of justification or verification, when you control the conditions and do research to demonstrate that yes indeed, the phenomenon exists.

Nick: Right.

Marv: And good researchers, creative researchers in the field—like Neil Miller of Dollard and Miller fame—who won awards for his research has acknowledged the importance of these two phases. For example, Miller said that he wasted a lot of time with elegant designs to study something that wasn't there. And his point was you've got to have good reason to believe that the phenomenon is there. Only then should you carry out the research to demonstrate to your colleagues that the phenomenon is there. This is a roundabout way of saying that clinical practice is the context of discovery. We see things clinically and those are the things that need to be researched. Part of the clinical-research gap in psychotherapy is that researchers are not making good use of the context of discovery—clinical observation. For the context of discovery, researchers need to talk to clinicians more. And certainly, there exists work that's being done by contemporary researchers that recognizes that. But there are still people who blindly follow the rules of research. Research is often based on what is fundable at the time, rather than what might be needed clinically. And it's also because clinicians and researchers live in different worlds. And there are different reinforcers. The clinician gets reinforced by referrals. The researcher gets reinforced by citations.

Nick: Right.

Marv: The clinician gets reinforced by reimbursement from third-party payers and the researcher gets reinforced by grants. So even though they may have started out in the same place and in the same classroom, their worlds begin to differ. I think that's part of the problem. And the potential solution is to have graduate students become keenly aware of this at the early outset. Research is flawed by its constrained methodology. Clinical observation is flawed by bias and misinterpretation. Which is precisely why both approaches are needed. And if both approaches, with all their flaws can come up and say there is a phenomenon here, then you can be pretty sure that there is a phenomenon there; it survived the distortion of the differential biases that are inherent in each of the methodologies.

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Nick: So, when you think about graduate students at the outset of their training, are there any explicit recommendations that you would have for addressing this gap and helping more clinically oriented students to see the research side of things and vice versa?

Marv: Well, it depends on the model of the program. It used to be that this was the goal of the scientist-practitioner program. I can speak from my Stony Brook, which of course is my bias. When I do supervision, these are the same students that were in my research and theory of therapy classes. They've read the research, and then in clinical supervision a couple of years later, we not only talk about the consistency between the two, but also acknowledge that much of the research doesn't address the issues that they're grappling with clinically.

Nick: Right.

Marv: And one of the things that happens if the supervision is right on, there are recommendations that are made that come from clinical observation, rather than clinical trials. The students try it out and it works. And then you can address the issue: "Well, there's no research on this." And this is what researchers need to do. So there needs to be a way that when you do clinical work, to convey this information to researchers. Or if you become a researcher, that you go and get the clinical observation. I think the attitude toward clinical work and research has to be a broad one. And an open one from early on in one's professional training—from day one.

Nick: That makes a lot of sense. The next question that I have is moving beyond the scope of training. How do you think that Division 29 psychologists can increase awareness of the research-practice gap in their research and clinical communities and take steps toward closing that? I would imagine that's probably harder once psychologists are entrenched in whatever their views are, so how do you see that playing out?

Marv: I see that as something that needs to involve *people*. The people behind the professionals. There needs to be direct contact, and we have lots of evidence that prejudice can be overcome by having people come into direct contact with people that are different from themselves. I think there needs to be contact between clinicians and researchers. Operationally, I think there needs to be ongoing liaison and dialogue between members of Divisions 29 and 12, and particularly, section 3 of Division 12, Society for a Science of Clinical Psychology (SSCP). In my experience, these are the people who need to have the dialogue most, because there is this bias, and there's much that they can learn from clinical observation.

Nick: What would you see as the most effective way…so does that mean that researchers at the university level are meeting with adjunct professors? Does that mean they're meeting with folks of professional organizations, like SEPI or Division 29? How do you see that contact getting to occur more frequently?

Marv: It could occur at all of those venues and in a wide variety of ways. Divisions 29 and 12 have yearly meetings, and at some of these meetings, there are often presentations on issues that are important. So, presentations on diversity are presented at some of these meetings of the executive committee. There can also be presentations of talking with people from the other camp. Particularly, from the other camp from which they want to learn something. And what is important is the spirit of the venue and the spirit of what's done. SEPI is a

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good example of that. When we established SEPI back in the [19]80s, the goal was not so much to do what was typically done at conferences, where you get people from different points of view to dialogue and where the goal is to convince the other person that they are wrong. The goal of SEPI has been to get people from different points of view to learn something from the other person. That's a significant change.

Nick: Yes, and that makes sense.

Marv: I think the issue of the clinical-research gap has become much more serious over the years. The National Institute of Mental Health (NIMH) funding priorities of the Research Domain Criteria (RDoC) are particularly relevant here. I've documented this in an article appearing in the 2016 issue of *Professional Psychology*, pointing out that the goal of RDoC is to develop biomarkers so that drug companies can develop new medications for the treatment of psychological disorders. The profession of psychiatry depends on new and better medications for its existence, not on therapy.

Nick: Right.

Marv: The future of psychiatry depends on good meds and this is what is being funded, rather than psychotherapy research. And while there's some hope and there's some lobbying to get them to expand this mandate, I think that this is basically a threat from the outside of psychotherapy, and that therapy researchers and therapy practitioners need to get together to deal with this threat.

Nick: Are you optimistic that if the two branches, the practice-oriented folks and the research-oriented folks are able to come together, that the RDoC criteria will expand?

Marv: That's a good question. It's very hard to predict what happens. I mean, nobody could have predicted the last presidential election. We don't know. But I've got to tell you this, a lot of people that use social media have been able to make dramatic changes in the world. Revolutions. Elections. Protests against assault weapons. I think a lot depends on younger professionals who see some of the difficulties in the field of psychotherapy, people such as yourself and other students of Divisions 29, 12, and other divisions. If they believe that the field needs to move in another direction, they have considerably more power than they can imagine. It's not a prediction, but an observation.

Nick: Right. I think that, something that you really kind of see even in training programs is either an emphasis on clinical work or an emphasis on research, and in some cases an equal emphasis, but it seems like there's very little emphasis on training psychologists to be involved at the systemic level and becoming involved in either political issues or policy issues related to the field. Do you think that that has any bearing on either where we are now or where the field is going?

Marv: I think you've hit on a very important point. The interesting issue is that you're a student, but you're also a future professional, which is a little bit different from being "just a student." You are being trained to work within a profession and dedicate your time and energy to that profession, so you have some right in saying what that profession should look like. Graduate students do not realize how much potential power they have, because they're beholden to the faculty for lots of things. Letters of recommendation, all kinds of other things. But believe me, faculty are

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very concerned about what students believe and want. When graduate students come from integrity and state their opinions, they become the leaders in the field.

Nick: Right.

Marv: Essentially, I've put the ball in your court and that of your fellow students.

Nick: (Laughs) I'll do my best with that! So, to kind of pivot a little bit, you talked a little bit at the outset about the founding of SEPI, and you're recognized as one of the driving forces behind the psychotherapy integration movement. As an advocate for psychotherapy integration, what do you regard as the most critical aspects of integrative best practices, and as a follow up to that, how would you encourage current trainees to develop competencies in psychotherapy integration?

Marv: Right. Let me start with worst practices and then move on.

Nick: Fair enough!

Marv: There are the things to be avoided. When we started the whole integration awareness, which eventually became a movement, one of the ultimate goals was to stop the proliferation of different schools of thought and to come up with principles and processes that are common. That's been hard to achieve. As I said before, it's because behind every professional is a person, and there are some people who are more interested in starting a school than in advancing the field. And schools of therapy are particularly problematic, even schools of integrative therapy. It adds to the proliferation.

Nick: And are there any particular aspects that you would see as best practices that you would like to see the field engage in?

Marv: I am particularly drawn to those that have a basic research foundation. One example of basic research has been that carried out on attribution or misattribution of motive. You get angry at a partner, not because of what they did, but because what you think the motive was behind it.

Nick: Right.

Marv: The attribution of motive is a mediating variable between what your partner says and your emotional reaction. If you misinterpret the motive, you may be angry. If you interpret it correctly, you may be sympathetic to your partner. This has been a replicable phenomenon experimentally. Moreover, it is a therapeutic heuristic that is extraordinarily useful when doing clinical work. When your client is angry at somebody else and you think of it in terms of a misattribution of motive, we have an evidence-based guideline on what to do clinically.

Nick: Right.

Marv: It also happens to be the premise on which behavior therapy was developed years ago as an extrapolation of basic findings. In the case of behavior therapy, it was classical and operant conditioning, and how that can be used to change people in a therapeutic situation. In many ways, I do think that that is the kind of evidence, which is far more valuable from my point of view than the evidence of randomized trials, that speaks to the clinician.

Nick: I'd like to kind of open it up for you if you have any more thoughts that we didn't touch on related to randomized controlled trials (RCTs) and where you think the field needs to move in terms of expanding beyond the RCT.

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Marv: Well, historically when the RCTs came about, which was in the '80s, there was a shift at the NIMH. And I know this through my colleague, Barry Wolfe, who spent 22 years as a staff member at the NIMH. His monitoring of research was on anxiety disorders. He met with me before I submitted a renewal and he said there's been a major change at the NIMH, which had become much more medically oriented. This was in the '80s. He told me that the NIMH was no longer going to fund my research on how to reduce examination anxiety or how we can get people to become more self-assertive. He said, "We can't fund you anymore because the NIMH wants real patients with real disorders." The model was the medical model. What you now needed to do is diagnose a disorder by looking at the pattern of symptoms that formed a DSM syndrome. And once you've made the diagnosis, you then needed to develop a treatment package to treat the disorder. A problem with this was the heterogeneity within the categories, which is (finally) now recognized as being problematic. So, someone can be socially anxious because they can't urinate in a public bathroom, and someone else with the same disorder is unable to speak to somebody interpersonally. Or someone who has difficulty speaking in front of a group. These are all diagnosed with the same disorder, so rather than treating the specific problem, you're treating a conceptual disorder or a category.

Nick: Right.

Marv: Also, using a heterogeneous intervention, you don't know what within the intervention may be working with what aspect of the clinical problem that is composing the disorder. This is not the way therapists work. However, this is where the field's systemic issues become very important. Allen Frances, who was the chair of the DSM-IV, once had a dialogue once with Barry Wolfe. Barry said, "Doing the RCTs doesn't really parallel the way clinical work is done in real practice," to which Frances said, "Don't worry Barry. One day clinical work will catch up, and that's the way clinical work will be done in the future—the same way as in RCTs."

Nick: I think that's a really amazing point. When you see the work that's been done with the RCT and the shape that's had on the field, where would you like to see research really begin to focus over the next decade or so?

Marv: I think on psychological processes. It's kind of interesting; I mean, this is the way it was in the [19]70s and the early '80s. It's interesting that within RDoC, they are now talking about mediators and moderators, and they're talking about target behaviors, rather than DSM disorders. In the '70s we didn't talk about mediators and moderators, but we did talk about variables and target behaviors. Perfectionism, procrastination, unassertiveness. Characteristics that you see clinically and are a part of cognitive-affective-behavioral functioning that humans have. However, with RDoC, you can't get biomarkers without having psychological phenomena. So even though the goal may be to get biomarkers, research also needs to focus on psychological phenomena. It's interesting that we are going back to a pre-DSM model. The focus on mediators or moderators was once called "determining variables"—which is essentially the same. The language has changed. Essentially, what is being said is that, after three decades, we're going back to that pre-DSM model. So, ironically enough, there may be something coming out of that.

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Nick: So as a field, the pendulum is kind of moving back?

Marv: Yes, except it's being done for a different purpose. It's being done for finding biomarkers and eventually developing presumably more effective psychoactive drugs.

Nick: Right, okay. That makes sense.

Marv: But I do think that the basic processes are very important. It's called "translational research." We used to call it "extrapolation of basic research." It's the same empirical strategy.

Nick: It's the same kind of principle you see across theoretical orientations. The words shift a little bit, but how frequently are we looking at different phenomena?

Marv: Exactly, yes. And of course, that creates a major problem in the field when words change. Because when you do a literature search, you do it with words. If you use the contemporary words, rather than the earlier words, you're going to miss a lot of work that's been done on a given topic.

Nick: Yes, definitely.

Marv: There's been an enormous amount of clinical and research work on assertiveness and assertiveness training. But nobody searches that anymore, of course they don't use those terms.

Nick: Right. When you think about the current state of the field of psychotherapy, what are you most excited about and/or most optimistic for, maybe in the coming decade in terms of clinical research, practice, and/or training? Do you have any thoughts on all three of those or any one in particular?

Marv: I do think that the principles or processes of change are not owned by any school of thought. Clearly, that's where the excitement is. All schools of thought, I believe, make use of the patient's ability to step back and observe what is going on with themselves. We call it different things. We call it de-centering, we call it metacognition, we call it mindfulness, we call it observing ego, we call it reflective functioning. There's probably a few other labels that I'm missing. Interestingly, Freud said that the observing ego has an alliance with the analyst, and both observe the neurotic aspects of the person's functioning. So, the ability to step back and observe yourself, this increased awareness of seeing things from a more objective point of view, is a key element in lots of forms of therapy. Now, what are the mediating and moderating variables associated with that? This is where the research should go. If you find a commonality across different schools of thought, that can be distorted by virtue of their different theoretical premises but nonetheless comes through, then that is a robust phenomenon that should be researched.

Nick: Right, right. Any other areas in which you're, maybe even beyond basic processes that you're excited about?

Marv: Well it's not so much the areas, but it's more the generation of psychologists. Psychologists who see the bigger picture. These are beginning people, starting in graduate school, who can think outside the box, who can see if the nature of the system may be interfering with what needs to be done. I think those individuals should vow to take steps to make a difference in the field.

Nick: Yes, I think that gets back to those areas where I feel like there hasn't been

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enough attention. Like to recognize in training what it's like to disrupt the field or to be able to move forward or to make a comment on policy or how funding priorities are shifting.

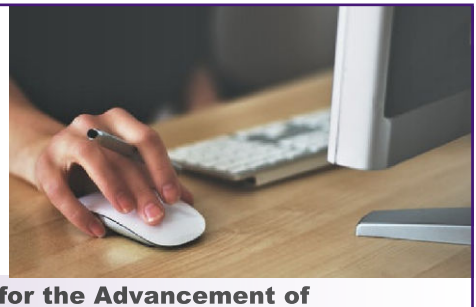
Marv: Yes, yes. As opposed to asking the question, "How high shall I jump?"

Nick: Right, yes. Well, you know, it feels in a lot of ways, that's how I feel like we're trained. To respond to the benchmarks in place and here's how to meet those, and you see that in your own program and probably across different programs.

Marv: Well, historically in my own development, this started when I received my degree in January of 1961. This is when John F. Kennedy was inaugurated as president. He said something to the effect that "The torch is being passed to a new generation," which I kind of liked. It resonated with me. And then he went on to add, "Any person can make a difference, and every person should try." And that was very inspirational for me. One of the things I saw as a graduate student was this huge gap between research and practice. The clinical books, whether they're on therapy or on the use of projective techniques, had no citations of evidence. Whereas, my readings on learning and perception did. It's like… this is not right. This should not be. I remember that as a graduate student.

Nick: So, in closing, I'm wondering if there any other areas that you wanted to touch on or when you think of this life achievement and the application of psychology, either where you recognize where the field still has yet to move or when you think about what's been most meaningful for you in terms of any shifts. I just want to open the floor to you aside from the questions that I generated, if there are any thoughts you have, I'd love to hear them.

Marv: How to end? Perhaps there is one more thing I'd like to underscore. The last point is: Make a difference. I think that's because maybe this is what my role should be; more inspirational at this point. I'm not going to break through any barriers at this point in my career, so if I can inspire students and professionals to think a certain way and to think outside the box, and to try to make a difference, then that's probably a good justification of my award.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SPECIAL FEATURE

The Business of Psychotherapy Practice: Reflections and Lessons Learned in the Trenches

Benjamin Johnson, PhD, ABPP
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Clinical Associate Professor, The Warren Alpert Medical School of Brown University
Clinical Psychologist & Director, RICBT Cognitive Behavioral Therapy and Coaching

I direct a psychotherapy practice in the northeastern United States with about 30 providers focused on providing cognitive behavioral therapy. We have two locations and treat a wide range of adults, teens, and children. I ended up in this role because I fell in love with the fields of psychology and psychotherapy almost three decades ago.

In this article, I would like to offer some lessons I have learned about the business of psychotherapy. I am going to imagine writing this as an advice letter to graduate students and early career professionals who are curious about business-of-practice issues. I also hope that my comments may be of interest to others who care about the dissemination and development of psychotherapy practice. There is so much that isn't taught in graduate school about practice-relevant business attitudes and skills that could lead to much greater success.

Business Is a Team Sport

I tend toward the independent side and feeling like I need to figure everything out myself. However, I have found that the business of psychotherapy is best considered a team sport. You will do best if you have many different players on your team. You will need a good lawyer, a great accountant, a computer firm, a web design firm, and someone trustworthy to clean the office. You may need a financial advisor, an insurance agent, and consultants of various types. Most of these players will be central, even if you are in solo practice and certainly if you have multiple providers in your group. I want you to think about building this team as a central component of the business of psychotherapy and crucially-linked to delivering excellent patient care. If you are spending tons of time trying to balance your books, clean the office, or figure out how to design a website, you are not taking care of patients or working "on" your business (versus "in" your business, as the saying goes). Trust me—my wife and I have spent lots of time running these experiments and learning the hard way. I have spent silly numbers of hours dealing with computer issues and website issues—which were probably quite far above my head, despite the fantasy that I could do them well. For years when our children were young, my wife (and practice manager) would stay late into the night every Thursday doing many tasks which we only eventually learned to "sub out" to others.

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Customer Service Is Key

Customer service is a basic concept in business and a central focus in most industries. My sense is that it is almost never discussed in graduate school and other training programs. It means trying to make it easy, pleasant, and reinforcing to receive services from you. We try to provide excellent customer service in many, many ways. We have carefully hired and trained intake coordinators who answer phone calls live and help patients to feel glad they reached out for help. We provide coffee and water in all of our waiting rooms. We accept credit cards and keep them in a secure online vault, so that patients don't need to present the card at each session. In all of our dealings with patients we try to be flexible, accommodating, and treat people with kindness and empathy. If we make a mistake, we apologize and try to make it right. I've sometimes sent people gift cards when our office has given a wrong appointment time or made a scheduling mistake. I encourage you to think about what kind of experience you want someone to have finding, signing up for, and receiving your services. Make it easy for them. Make sure you return messages promptly or have someone reliable answering calls and messages from patients. Don't be shy about amazing people with positive touch-points beyond what you do in the treatment room (e.g., establishing a good therapeutic alliance and providing proven strategies). How can you amaze and delight your patients?

Long-term Relationships Are Central to Business—and Life

Another key idea that is central to business thinking is to develop long-term relationships with your customers. I remember when I first read about this idea. Now it seems obvious. However, it was new a point-of-focus for me at the time. Businesses typically succeed in the world because they develop loyal customers. It works much better for businesses to provide services to their existing customer base than it does to keep bringing in new customers. There is often a significant cost to customer acquisition, such as in marketing dollars. Businesses with little repeat business will usually struggle.

I take and encourage a "primary care doctor" metaphor in providing psychotherapy. I convey that I am taking responsibility for the patient's mental health care. Much like a primary care doctor, I will propose we meet more frequently at first and then taper off gradually. Once someone is doing much better, I will see them monthly or quarterly—until we go to a call-me-when-you-need-me plan. I rarely do hard terminations with patients. The nature of life, depression, anxiety, and stress is the recurrence of issues, stress, and problems. It is much better healthcare to remain a resource for patients, within ethical boundaries, and we want to avoid forcing on clients the difficulty of feeling ashamed when they need our help again. We want to de-shame and normalize seeking support and wise counsel. So, I want to encourage you to think about forming long-term relationships with patients—even if you are trained as a short-term, problem-solving kind of clinician. I consider myself very much working from a CBT point of view. This does not preclude me from having been there for my patients over many life stages. I have helped people cope with their teenage years, college, dating, marriage, and parenting. Indeed, seeing someone through a crisis if I haven't seen them in a few years is one of the most gratifying parts of my work as a psychotherapist. As you develop your practice, plan for

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what you want your relationship with patients to be over time. Discuss explicitly that you hope to be a resource for them in an ongoing way, regardless of the length of any treatment episode.

Trust Your Value—Deep Listening and Wise Counsel Are Crucial and Rare

For a business to succeed it has to have an excellent product or offering in which the people running the business truly believe. Great customer service can't make up for a lousy product. So, in general, how valuable is the service we are trained to offer? There are many pieces of evidence that suggest to me that it is highly valuable. First, decades of research and many meta-analyses have shown that psychotherapy is generally effective, that differences between active treatments are difficult to show, and that many patients find it an acceptable service to receive. Indeed, stress and anxiety appear to be at all-time highs—just ask high school or college students about how stressed their peers seem to be, or how many mental-health related issues they encounter in school. Shame and stigma about both having emotional problems and receiving help for them appear to be decreasing. My sense is that is far more common now to share that you are seeing a therapist than it was 30 years ago. With the advent of the smartphone age, it seems that having someone give you undivided attention for 45 minutes is increasingly uncommon in the real-world. We can no longer expect most people to have the kind of friends who will listen to them well for significant lengths of time and who have the availability and knowledge to discuss issues and guide them skillfully. So, I want you to trust your value to your patients, even if you don't fully feel competent yet. Show up, be unbelievably genuine, focus in and help patients organize and clarify issues, and work collaboratively on a game plan for progress. If you are offering psychotherapy, you are likely offering something increasingly valuable. It may not feel like it all the time, because you know there are many things you don't know and your sense of confidence and competence may still be forming. However, we also know from decades of research that if you can form a strong therapeutic alliance, in which you help the patient feel warmth from you and trust in you, and you seek agreement on the goals and tasks of therapy, you will likely help them feel and function much better in their lives.

Don't Be Cheap About Training

In the business world, successful companies keep innovating and improving their products. They put significant resources toward research and development. They upgrade the food and appearance of the restaurant, the look of the website, or the speed and power of the iPads they sell. If Apple, Google, or 3M hadn't kept improving their products and inventing new services, they would have been long defunct. In the strange industry of psychotherapy, you are largely your product. So, I want you to spend heavily on your training, workshops, and professional development. Buy and read large numbers of books on the field. Go to an embarrassing number of continuing education events. Develop areas of expertise. Pay for supervision and consultation. It is okay if it is a bit scary and feels indulgent. That is the price tag of your research and development. I also want you to keep investing in making your personal life as pleasant and growth-oriented as possible. Try never to be a hypocrite: If you are pushing your patients to keep growing and improving, you need to as well. You have my full doctor's permission to

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experiment with traveling, going to a gym, getting a house cleaner, hosting a party, and changing your hairstylist. It is all part of the field. You can't really help people improve their self-care and growth if you aren't also pushing yourself out of your comfort zone.

You Can Care Deeply and Charge Appropriately

Successful businesses price strategically and seek high margins on their products and services. They look to differentiate what they sell from what their competitors sell. They try to avoid pushing commodities in which the consumer is focused only on obtaining the lowest price. Businesses with low margins and poor business models often fail. Then, they don't serve any of their customers. Successful businesses need to make reasonable profits for many reasons. As discussed previously, they need to keep improving their products and services. That takes money. They need to have a stockpile of cash to weather inevitable upturns and downturns in the market. They need to have money available to seize unique opportunities that emerge. If they sell too cheaply to current customers, they are harming potential future customers. In the industry of psychotherapy, there are several challenges. For many of us, the fees we charge don't matter much because insurance companies dictate reimbursement amounts so heavily. Some clinicians, myself included, find it so easy to care about people, and they love work they do so much that they wish they could do it for free. It feels like it is hardly about the money. Others get a sense that if they charge patients a significant fee, it means that they don't really care about them. I want to encourage you to learn to feel good about charging high fees. Stick to them and raise them periodically. Your caring and expertise are valuable and worth significant remuneration. The more you can just broadly accept this equation, the better off both you and your clients will be. Being deeply caring doesn't mean you should be paid less! It means you should be paid more—it is your natural resource and you are offering it for someone else's gain. Furthermore, it is a terribly limited resource. There are only so many hours in the day and only so much emotional energy you have to give to others. You also have a unique voice and life experience that informs your work. No one else comes from precisely the same point of view. In terms of the restrictions put on what you get reimbursed by insurance companies, it is tricky. You can try to develop a strong niche and either go out-of-network, or you can try your hand at negotiating with them. Both scenarios are possible. You can also develop some services that don't count as medical procedures and for which you can set fees at the level you choose. For instance, offering a workshop on the psychology of money might be a good non-insurance service.

Identify Your Ideal Customers and End Relationships With Your Worst Customers

Successful businesses figure out the profile of their ideal customer. Then, they seek out those customers and try to over-deliver value to them. Businesses that don't know which market segment they are trying to reach will struggle. Mercedes and Hyundai are trying to please different segments of the car market. If businesses try to please everyone, they will likely get spread too thin, confuse the marketplace, and dilute their brand message. Apple makes it clear that they are trying to deliver a premium product. They are not trying to reach customers seeking the cheapest device possible. Businesses

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can also get caught up trying to accommodate their most difficult and demanding customers. This can take time and energy away from dealing with your main customer base. So, I want to encourage you to think deeply about your strengths and who is so easy for you to treat that it feels like cheating. The picture of this client will differ greatly between clinicians. My usual example is that some clinicians don't like treating angry men. It makes them nervous and stressed much more than it might make someone else. Thus, we don't give these psychotherapists angry men to treat, if we can possibly help it. We encourage them to frame the evaluation as an evaluation and to feel empowered to send them to a colleague who loves that kind of work, if the match isn't right. Keep asking yourself which of your clients make you feel energized. Notice patterns among them and seek them out as much as possible. I know some clinicians who love college students and some who don't. Your preferences are unique and okay. And if it time to stretch those growth areas, invest in the personal therapy, training, and supervision to do so ethically and effectively (see above!).

One to five percent of a busy clinician's caseload can be consuming much of their emotional energy and contribute disproportionately to burnout. Though I have learned much from working with that sliver, I would tell my younger self and other colleagues coming up that it is okay to set limits and to refer more readily. You need to protect your whole caseload by protecting yourself some times. Go the extra mile for patients, but know when to bring in other providers on a case.

For a small business example, let's say an accountant had a general practice and was preparing taxes for dozens of individuals and small businesses. This is their bread-and-butter work and not too difficult. If they also had a large medical practice they were trying to serve, that demanded tons of time from them, created lots of stress, and made it difficult to stay on top of the bookkeeping of the rest of the client portfolio, we would have a major problem. It would likely make sense for them to refer the medical practice to a specialist in that area of accounting—or perhaps refocus their own efforts on that niche. Whether for accountants or psychotherapists, stress matters and must be carefully monitored.

I encourage you to keep learning about the business of practice. The better we get at the business of psychotherapy, the more people we can reach. One of the best ways of disseminating therapy to those in need is to disseminate business-positive attitudes and skills that make it easier to succeed.

CLINICAL NOTES WITH DR. J

From Psychologist to "Whose Father is This?": Transitioning Into Fatherhood as a Psychotherapist

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One of the main components of my job as a psychotherapist is helping my clients navigate transitions in their lives, such as relocating, marriage, death, and starting new jobs. Whether expected or not, life transitions are often seen as opportunities for mental and emotional stress as worry, insecurities, and fear can develop in that empty space between the familiar and the "new." Many clients put a tremendous burden and stress on themselves to navigate these transitions impeccably, especially given the ways in which society places great social cache on the appearance of flawlessness (thanks, Beyoncé). Not only are we supposed to flawlessly transition through these key "checkpoints" in our lives, but we are also are supposed to do so without a hint of consternation or fear as these are "welcomed" events and we should be "happy" about achieving these cultural milestones. But with this pressure comes real world fears and worries about our abilities to both fully appreciate and be successful in these new places. We all want to be successful parents, partners, and employees but to do so takes much work, most of which occurs between the ears.

An aspect of this potential for emotional stress lies in the very nature of a transition or change. Life transitions represent deviations from the norm and situations where a person is required to use either new or different skill sets to overcome an important challenge or to manage a significant life event. When we ask ourselves to be resourceful and mentally or emotionally flexible it can illuminate some of our shortcomings and the ways in which we may hold negative opinions of our fitness to assume titles such as parent, boss, partner, or others. Transition also has the potential to show us much about ourselves, with some of these observations welcomed while some only serve to confirm irrational negative thoughts about our capabilities or ourselves. For example, our experience of growing up may positively or negatively influence our feelings regarding assuming the role of parent and how a parent should act in order to cultivate a healthy family. As a clinician, my responsibility is to assist the client with being both present and agile during transition. This position allows the client the opportunity to be better aware of irrational or inappropriate thoughts and also more attuned to the various necessary aspects of this change. Successful management of a transitional period in someone's life is varied but it can often be defined as the client being able to achieve or come close to an optimal outcome while also not assuming any unnecessary residual negative thoughts, feelings, or behaviors.

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There are many factors that contribute to the current stress associated with getting married, getting that next great job, or having children, with aspects of this being associated with the proliferation of social media. Our expectations of parenting, marriage, and other life transitions can be artificially augmented by how we view others in our social circles presenting their successes and challenges on social media. What we may fail to remember is that social media is often a one-sided window into a person's life where their true struggles or difficulties are often glanced over in favor of projecting a sense of fluidity, control, and mastery to the outside community. Research has also consistently demonstrated the potential negative impact of emotional over-reliance on social media and the ways in which it can pose genuine mental health risks to both the individual and those who read the posts (Fagan, 2015). As psychotherapists, we too must be aware of the impact of social media on the expectations that we may consciously and unconsciously place on our clients. Given our exposure to examples of members of our community navigating these life events on social media, we may lose sight of the often-real challenges that exist when someone is in the midst of a transition and attempting to do so with a present focus and with authenticity. We also run the risk of experiencing the same or similar challenges as our clients when it comes to the negative impacts of social media (Middleton, 2015). Clinicians themselves are not immune to the challenges of managing transitions. Often times, some of the most vulnerable times for a clinician to provide efficacious care can be during these expected and unexpected times of great joy or sadness in their lives.

I am going to be a father in September. My fiancée and I discovered at the beginning of the year that we were going to be parents and we were both elated. The thought of bringing a child into our relationship was one that was met with joy and happiness for our entire community and us as a couple. To understand the depth of the emotions surrounding my fiancée's pregnancy, one would require greater understanding of my own unique familial experience and narrative surrounding parenthood and pregnancy. When my parents were young and in love, they, too, decided to embark on parenthood and attempt to have children. Without getting too much into the specifics of their situation, they had to endure approximately seven years of unfruitful pregnancy attempts in order to receive clearance to seek professional medical assistance. After seeking this assistance, my parents were able to conceive both my brother and I, with one miscarriage occurring in between. This story about the difficulties my parents endured on their quest to become parents has been a story that has always been a part of my life narrative and an aspect of my later thinking as my fiancée and I seriously considered having biological children. Some of the stress and anxiety that my parents felt in their experience seemingly traveled across space and time to land here in my own experience of this transition. My experience of their pregnancy in my life narrative has had a tremendous impact on my view of family, parenting, and pregnancy. One obvious way in which this narrative contributed to my experience of this life transition was in my awareness of infertility and the difficulties that some experience when attempting to conceive. When we were able to confirm my fiancée's pregnancy, my heart skipped a beat, but my mind also went to those in our social circle who have struggled to become parents. The questions as to

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why we had been so lucky with our conception while others have struggled and endured tremendous stress caused me to think about how to communicate our joy to those members of our community that might find this news exciting but also reinforcing of their own pain. This significantly influenced how we communicated this news to friends and family while wanting to be sensitive to those we knew and did not know were coping with fertility challenges. One example of this has been the lack of the typical Facebook or Instagram playful baby announcement as we are aware of the unintended pain that has caused some of our friends in the past. This struggle to celebrate this news but also be mindful of others was difficult and something that I struggled with and continue to explore. Another example where my specific life narrative impacted my transition into fatherhood has been the joyful response of my parents to our pregnancy. Beyond being excited for us, it seems as though there is a palpable sense of relief that we were not subjected to similar challenges with having children, given how my parents understand how impactful that can be to a relationship and to an individual's psyche. Their joy brought us happiness and we were well aware of how they reveled in our joy and how they were excited about being grandparents.

In addition to this providing me with the opportunity to better understand my adult clients who are going through similar transitions in their lives, my entry into fatherhood has also helped me better understand some of the stressors of parenting. Although some speak about parenting as something that happens once the baby is born, the act of parenting and the emotional connection with your child starts much earlier. During my fiancée's pregnancy, we have encountered both the usual pregnancy stressors and several that were unexpected. Encountering the unexpected was challenging, as this was uncharted territory for us and we were surrounded by similar pregnant couples who were experiencing stress-free pregnancies according to social media. But this was not necessarily true. As we began to confide in close friends, we realized how common pregnancy medical stress was and how many of our friends experienced similar sleepless nights and concerned looks from doctors. In this case, we fell victim to similar misleading information from social media in terms of adopting the assumption of a carefree pregnancy and not having a sense of the normal bumps in the road that many face while pregnant. When speaking to my father about these events, I remember telling him about all of the times he and my mother told my brother and I that we would not understand certain things until we were parents. During this recent conversation, I playfully joked to my father by telling him, "I get it. I get it. I get it. I get it now." With that declaration, I both thanked him and my mother for the tireless efforts they selflessly dedicated to raising my brother and I, while also acknowledging the arduous road ahead in terms of growing into the father my child needs me to be—and the father I want to be for my child. This experience then helped me better understand the level of love and dedication that most parents have for their children, especially the children I have the pleasure of working with in therapy.

Becoming a father may also help me better appreciate the ways in which parenting is similar to being a good psychotherapist. According to Firestone (2010), there are numerous commonalities between successful parenting and guiding a client through the therapeutic process. Dr. Firestone highlights several

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commonalities, including equality, good listening, and investment in creating a fair and balanced atmosphere for growth and frank communication (Firestone, 2010). Reviewing this article made me realize how building a healthy therapeutic alliance is similar to building healthy family connections as a parent. Although parenting and therapy differ in many noteworthy and important ways, the ability for the two identities of parent and psychotherapist to positively influence each other is something that I am looking forward to enjoying. Similarly, I am confident that my experiences as a psychologist will better prepare me for my role as a father. Besides the academic knowledge regarding developmental stages, moral development, and learning disabilities, psychology has taught me how to focus on relationships and quiet the noise around me that may distract from that human moment between two people. My hope is that I can incorporate those same skills to help me target my full and undivided attention toward our child as the child grows and develops. Similar to how I want my clients to feel like they have my full attention from the time they are in my office until they leave, I also want my child and my partner to feel like time spent with them is intentional and purposeful as opposed to just circumstantial and inconsequential.

So, as I embark on a journey filled with dirty diapers and sleepless nights, I look forward to this life transition with both nervousness and joy. There has been no greater joy in my life than finding my partner and beginning to start my family and I cannot wait to add the title of "dad" to my list of names.

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SPECIAL SECTION: TURNING POINTS

PUBLIC INTEREST AND SOCIAL JUSTICE

A Personal Perspective on Systemic Change

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I have approached life and my career with a genuine enthusiasm for adventure. I have also found my richest experiences in life to come from learning to be comfortable with the uncomfortable. Being asked to write about my career turning points as a relatively new psychologist evoked this uncomfortable feeling. Do I really have something to write about that others care to read? My desire to end human suffering and promote values of equality and justice is a widely shared goal among many in the field. However, I am grateful for this opportunity to share my thoughts on the need for larger systemic change within criminal justice and behavioral health settings.

Thus far, my most significant career turning point was matching for pre-doctoral internship at NYU Bellevue Hospital as part of the Forensic Track. It was one of the best training years of my life, and I was fortunate to be surrounded by arguably one of the top intern cohorts Bellevue has ever seen. Obviously, I am a bit biased, but the rigorous training year was somehow muffled by the laughter and support. Unlike many of my colleagues, I chose to apply for jobs after internship rather than a postdoc. I was fortunate and accepted the position as the Team Leader for the Brooklyn Forensic Assertive Community Treatment (FACT) team at the Center for Alternative Sentencing and Employment Services (CASES). This mobile-based mental health team was designed to help individuals with severe mental illness and criminal justice involvement live sustainable lives in the community. Our clients were some of the Brooklyn's most vulnerable and marginalized members. Each one of them had seen the inside of a psychiatric hospital, emergency room, prison cell and/or courtroom far too many times. Many struggled with primary psychotic illnesses with co-occurring substance abuse disorders. Their lives were laden with trauma, ruptured relationships, and homelessness. As you can imagine, it was a steep learning curve- overnight I went from an intern to a manager, administrator, and clinical supervisor. Fortunately, I was starting with a strong foundation of training and experience coming from Bellevue and the University of Denver's Graduate School of Professional Psychology.

Like many things in this world, my first job was a mix of *privilege, timing*, and *luck*. I mention *privilege* given my ability to train at Bellevue and live in New York City with the support of family, despite large student loan debt. An internship at Bellevue Hospital afforded me exceptional clinical training and an expanded network of clinicians and mentors. *Timing* in sense of right place, right time. New York City wanted to build five

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borough specific FACT teams and a former Bellevue graduate was looking for eager psychologists to staff the teams. Lastly, I say *luck* because I will always believe in non-scientific based things such as luck or karma. Yes, there were years of hard work and perseverance leading up to it, but in that moment, luck, karma, or something bigger showed up and helped me get my first job as a clinical psychologist.

The Need for Change

As the Team Leader for the first Brooklyn Forensic ACT team, I felt connected to something much greater than just my team, our clients, or CASES. I felt connected to the movement in New York City to end mass incarceration, to stop the rotating door between psychiatric hospitals and correctional facilities, and to increase access to mental health treatment for marginalized community members. It was life changing- challenging, of course, but the type of challenging that motivated me to do better, work harder, and learn more. I worked alongside deeply inspiring, passionate people from all disciplines and backgrounds. Together we were fighting for a solution, determined to see change within the system. However, it did not take long to feel hindered by the slow bureaucratic issues that made change feel almost impossible

In order to lead a group of eager and relatively new social workers, I had to first bring my attention to the here and now—distract my mind from wandering to the aspirational intersection of mental health and criminal justice. As a team, we needed to work together to get through each day. We encouraged each other to take joy in every win, no matter how small or seemingly insignificant. We focused on supporting one another, creating a place where people's strengths were utilized, and searching for ways to improve how we delivered treatment to our clients. We did the best we could with what we were given. We stressed the importance of self-care and work /life balance, as part of our job entailed living and reliving the traumas endured by many of our clients. In order to continue showing up for them, we needed to first show up for ourselves. It was our job to meet our clients where they were at in their recovery with hope, compassion, and enthusiasm.

From working this population, I have developed some strong opinions. To me, it is pretty simple: People managing mental health issues get better in the community, not in jail or prison. It is a widely known that for years our criminal justice system has functioned as a series of ill-equipped psychiatric treatment centers- not designed to treat and heal, but rather to punish and supposedly deter. Our criminal justice system is disproportionally harsh on communities of color, especially those with mental illness, substance abuse, and lower socioeconomic backgrounds. For many, there are traumas associated with incarceration and extreme psychological difficulties when reentering the community. Within the bubble I choose to live, psychologists, social workers, psychiatrists, and those passionate about this topic are well-versed in the layers of systemic atrocities—numbed, outraged, and deeply saddened, though not surprised, when horrific stories like Kalief Browder are brought forth in the news.

From my experience working in New York City, change is happening. The movement for mental health treatment behind locked doors and barbed wire is improving, but the rate of victimization within the criminal justice system is still too high. Many of our clients shared the traumas they endured while awaiting

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sentencing at Rikers Island or serving time upstate. These are stories filled with violence and abuse. The number of young Black men who endured their first psychotic break while in segregation was far too many. I heard about the experiences of men who would never wear the color green [one of the prison jumpsuit colors] because it brought back vivid memories of events they would prefer to forget forever. I listened to the experiences of women who endured physical, psychological, and emotional trauma while losing their children to the system, uncertain if they would ever be able to hold them again. People's lives were forever changed by incarceration, which exacerbated their mental illnesses and made reentry into life in the community much more difficult.

What Can We Do?

As a nation, we need to intervene sooner, strengthen our diversion programs, and increase access to mental health for all community members. We need to expand our mental health, drug, and specialty courts systems and give juveniles and adults an opportunity for recovery sooner. I will never forget the day I witnessed our first mental health court client be un-handcuffed and released to our program. I was fortunate to bear witness to this many times, and for those who were able to manage life in the community with their available supports, it was remarkable to see their progress and positive interaction with the legal system. They felt the judge cared about them and their lives. They also felt pride and a sense of accomplishment once they finished. After observing the different mental health court systems in New York City, I became aware of the politics and the dance that occurred in and outside of the courtroom, between courtroom players, advocates, and judges. There were politics behind the cases that were accepted, the cases that were rejected, and conditions for sentencing. There were also strong opposing viewpoints and variable levels of understanding about mental health among legal professionals. To me, this intersection is the perfect place for psychology to influence change, if we are willing to develop the necessary skills. We need to learn to speak the language and participate in the dance. We need to learn to articulate the challenges and overlap between mental illness, criminogenic risk, and risk assessment. We need to learn to explain dynamic and static risk factors through a clinical lens, the role of strengths and protective factors, and how risk can be mitigated through appropriate community based intervention. Simply, we need to continue educating our court systems and legal professionals on mental health and community-based treatment.

On a united front, we need to increase access to all mental health services for our community members. Intervention needs to happen as soon as possible and we need to be creative and dynamic in our approach. This requires qualified, trauma informed professionals in these positions to change an individual's first experience with the mental health system. Our clients had years of negative experiences with mental health, and it was our job to change that. We were given service dollars and told to be imaginative. We viewed our clients through a person-centered lens and met them where they were at in their recovery. Assertive Community Treatment (ACT) changes the walls of treatment and awards individuals a different experience with mental health. Why does it take repeated hospitalizations, patterns of not taking psychiatric medications, and criminal justice involvement to get a FACT team? Might some people need a mobile team from the beginning?

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I wonder: Can we identify the needs of our community members and develop treatment around those points, rather than having people mold to the model of mental health we most commonly know?

We need to open more discussions between corrections and mental health and push through the resistant barriers to change through platforms, discussions, and trainings. We need to improve how we communicate with and understand one another. The movement is alive and well, and change is slowly happening but we must keep talking. On our team, we witnessed insignificant parole violations with short-term incarceration jeopardize a client's place of residence, after years of living in the shelter system and working toward stable housing. We observed parole officers who were understanding and compassionate towards the ebb and flow of stability, and those who were not. If you have never been to a New York City shelter, pay a visit to one, and try to put yourself in the resident's shoes. How are individuals with severe, complex trauma backgrounds, managing severe mental illness and substance abuse, supposed to see hope in treatment if they don't have a safe environment in which to live? How are they able to meet every demand the criminal justice systems puts on them while living in the community in such conditions?

Developing peer support models. Additionally, we need to grow the peer movement. Peers are individuals who share background experience of mental health, substance abuse, or criminal justice involvement with the people they serve. They are able to provide support, validation, and empowerment through a different lens than medical personnel, psychologists, or social workers. Peers bring a valuable perspective to the discussion, one that I believe needs to be heard more often. I will never forget when my team was grappling with the thought of a client returning to jail due to a parole violation related to smoking marijuana. The parole officer agreed to substance abuse treatment; however, our client wanted to serve time. We as a team had blinders on, only focused on the re-traumatization that might occur by returning to jail. My staff searched, advocated, and fought for a place to accept our client, believing he would change his mind. It wasn't until the peer specialist on our team shared his perceptive that we understood how this choice could be empowering. How at some point you are simply exhausted from running and you just want the chase to be over. Within this movement, we also need to learn how to best support our peers, through supervision and workload expectations. I watched too many peers come through our team, struggling to manage their own hardships, while giving a large part of themselves to others.

Working effectively with other support systems. We need to continue the conversation between hospitals and community based treatment. To be honest, I was struck by my own learning curve, and how much I did not know until I ran the Brooklyn FACT team. I want to challenge hospitals to reevaluate their approach to medication and think about what happens after a client leaves those hospital walls. Discharging a homeless patient from a psychiatric hospital with a bag of oral medication, required to be taken multiple times a day, without discussing the option of injectable medication seems ineffective and potentially harmful. I have spoken to psychiatrists about this particular concern. They reassure me that these conversations are happening, and the case I am referencing is an outlier. Injectable medication not only decreases risk for the client, but

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also for the community. I believe that one's approach and choice of words can empower an individual in making a decision about a medication regimen that works for them. It is also important to see what might be lost in the dialogue. For example, I had a client who required a translator during our sessions. Despite my experience working with translators and attempts to explain this concept, I was flabbergasted when I realized he was refusing injectable medication because he believed he would be stuck with a needle every day. I could have sworn I did a good job explaining it—clearly something was being missed.

The challenges that accompany hospital systems are complex, and I recognize I have only been exposed to few. However, I see the importance of more discussion on complex topics such as medicating substance abuse, traumatic brain injury, and trauma with antipsychotics and mood stabilizers, occurrences that were far too common among our clients.

Conclusion

Now more than ever, strong leadership within behavioral health, criminal justice, and state government is paramount in this movement for change. I want to challenge reformers to understand the issues of front line staff and stakeholders by bringing them to the discussion before developing and implementing programs. Ask questions, listen, then ask some more. They are filled with knowledge and a unique perspective. It is one thing to develop a program that sounds good on paper, and another to do it by knowing what works and what does not. By excluding these voices from the discussion, I believe we do a disservice to our community, wasting time, money, and effort in the process. At every level we can be working for change, but our leaders sent the tone. Long-term change occurs from the top and works its way down.

Lastly, we need to shift the culture within mental health to one which prioritizes staff wellbeing. By valuing staff, we are taking better care of our institutions, agencies, and clients. Culture within public mental health needs to support both productivity and wellness. Let's face it; I don't think there will ever be a time when the workload will evenly match the allotted timeframe. The culture needs to value the individual employee and promote growth, similar to how Assertive Community Treatment (ACT) takes a person-centered approach. Within this culture, we need to increase lines of communication, acknowledge individual efforts, and offer employee programs that promote a healthy work/life balance, from physical to mental health, to social, financial, and spiritual wellbeing. I witnessed how burnout and compassion fatigue at every level can lead staff to look for a different job. It eventually got the best of me. I recently left my job as the Brooklyn FACT Team Leader for some time to reflect on my next steps … Time to figure out how I can reenter the system in a way that supports larger change in alignment with my viewpoints.

SPECIAL SECTION: TURNING POINTS

DIVERSITY

Choosing to Work for a Community Health Center: A Career Turning Point

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Like everyone else I worked hard to get to where I am today, so why decline an offer from a prestigious hospital with an academic appointment to work at a community health center? There are a number of reasons why someone may want to work for a community health center including interest in working with serious or chronic mental health needs, interest in working with people experiencing poverty and racial and ethnic minority groups, interest in working for a small non-profit organization, and the ability to use state and federal loan repayment programs, among others.

Why a CHC?

Community health centers (CHCs) and community mental health centers were developed in the late 1960s and 1970s through a federal initiative. CHCs are designed to cater to the community in which they are located. Furthermore, they provide care to underinsured and uninsured persons, provide care to communities with a shortage of health care options and act as a health care safety net, and have a governing board where a majority of members are clients of the CHC (Taylor, 2004).

The majority of clients who seek health care from community health centers are uninsured and fall within lower socioeconomic status brackets. CHCs serve underserved populations and are located in federally designated medically underserved areas or serve a federally designated medically underserved population. As such, CHCs make up part of the United State's health care safety net. For many CHCs, Medicaid is the most often used insurance payer and persons are seen regardless of ability to pay (Taylor, 2004). For psychologists interested in providing care to persons with lower access to care and/or to persons with low-income or who are economically marginalized, CHCs offer a means to work with these populations. Before working at a CHC, I was mostly interested in serious mental illness and psychosis. Meanwhile, through this work, I began to come across more instances of my clients' struggling with poverty. This germinated my interest in economically marginalized populations. In addition, CHCs provide services for a racially, ethnically, and linguistically diverse client population. More than half of CHC clients are persons of color and a third are provided services in languages other than English (Taylor, 2004). Aside from my interest in serious mental illness, I've also always had interest in diversity and racial and/or ethnic discrimination. Given that many persons of color also experience economic marginalization, this was another way that I naturally developed interests in the mental health sequelae of living in poverty.

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Often, persons experiencing poverty withstand multiple life stressors and adversities and have a high prevalence of mental health disorders (American Psychological Association, 2017). Sometimes, as is often the case with serious mental illness, one's symptoms can lead to economic hardship and therefore low-socioeconomic status (Stansfeld, Clark, Rodgers, Caldwell, & Power, 2011). Other times, the stressors of poverty correlate to the development of mental health symptoms later in life (Javanbakt et al., 2015). Given this, community health centers are a great way to work with persons with serious mental illness and/or chronic mental health needs, a number of whom would go unserved in other settings. While working at a CHC I have been able to witness firsthand how societal inequities influence people's physical and mental health. Many of my clients are painfully aware of these inequities, often voicing their frustration with how the lack of financial security or stable housing worsens their mental health status.

Benefits and Challenges of Working for a CHC

CHCs may be relatively small in scale in comparison to other health care organizations such as hospitals, with the benefits that working for a smaller organization can offer, such as a close-knit community, the ability to easily communicate and collaborate with others, and the ability for psychologists to integrate their training and liaison with other disciplines. As CHCs are required to have comprehensive primary care, this is an opportunity for psychologists to work closely with those providers and establish high quality integration between behavioral health and primary care. While working at a CHC I have had the ability to learn much about primary care and even communicate with my primary care colleagues more regularly than with my mental health colleagues.

Many community health centers, if not most, qualify for National Health Service Corps (NHSC) loan repayment programs. The NHSC offers non-taxed loan repayment to psychologists and other mental health professionals who work in federally qualified health professional shortage areas. These health professional shortage areas are defined by the U.S. Health Resources and Services Administration and are often CHCs. NHSC provides up to $50,000 dollars in loan repayment funding for two-year contracts which can be renewed afterward on a yearly basis. For early career psychologists and other health care professionals, this is a great way to manage the costs of education. I am extremely grateful that this program exists; visit https://nhsc.hrsa.gov/ for the most up-to-date information on the NHSC.

While being drawn to community health centers due to my interests in serious mental illness, economically marginalized populations, racial and ethnic diversity, and for the loan repayment opportunities, I have struggled with the lack of an academic focus at CHCs, and have noticed myself missing the rich educational opportunities and experiences that could help expand my career if I worked for an academic institution. However, this is not the case for all community health centers. Some community health centers have a partnership with local hospitals and academic institutions. It does not hurt to try to forge partnerships like this in order to get the best of both worlds. I am fortunate that my current organization is partnered with a large hospital where I have a clinical appointment and can therefore use resources like their medical library and grand rounds for continuing education.

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Moreover, I get to participate in enriching activities like membership in various committees and networking opportunities with others with similar interests. Psychologists and mental health professionals can additionally partner with local colleges and universities to obtain academic appointments and work on research and teaching activities. Likewise, psychotherapists working at CHCs can partner with nearby doctoral and masters level psychology, social work, and mental health counseling graduate programs to foster supervision experiences and provide practicum and internship training to future generations of psychotherapists.

Psychotherapists at CHCs can contribute their unique clinical experiences to initiatives focused on research and/or policy. Community health centers also benefit from having psychologists as part of their multidisciplinary team. Psychologists' training offers a skill set that benefits the clientele of community health centers. Psychologists are trained not only in evidence based interventions and psychological testing but also likely have training and/or experience in leadership roles (Carr & Miller, 2017).

My Decision to Stay

Despite all of the rewards of working in community health centers, I began to struggle with inadequate salary and feeling like my CHC did not fully understand or value my skill set as a psychologist. So, even though I loved the population, I took time to interview elsewhere to keep my options open. Meanwhile, using my leadership and communication skills, I worked to inform my CHC of both my career needs and how being able to get these needs met would benefit the organization. Though I was blessed to be given offers at nearby well-known organizations with academic affiliations and related benefits, I ultimately chose to remain at my CHC for two main reasons. First, NHSC loan repayment is a compelling factor. Second, my CHC and I were able to work together to address the aspects of my experience that I felt were lacking.

This was a difficult decision. Some of my colleagues to this day do not understand why I chose to remain with the CHC, and others reading this may feel the same. This highlighted another issue I have experienced when sharing with others that I work at a CHC. I have felt a negative bias directed towards myself and other psychologists and psychotherapists who work at CHCs. I feel at times that others judge my training, my knowledge, and my capabilities as a psychologist based on the fact that I work at a CHC. It feels as if others assume that I may be poorly trained or unable to make the cut to work at a more prestigious organization. But why should I let unfounded assumptions from others deter my career choices and divert me from my interests? This was my turning point. When examining my needs and wants, I decided that, as long as I am able to follow my passion in terms of my clinical and research interests, obtain adequate career development opportunities, and get my loans paid off, then I am fine. In the end, many of these items would have been met in my current position or in a new setting; however, NHSC loan repayment tipped the balance. It has truly been a lifesaver for me as I entered graduate school during the height of the recent economic recession. When I obtained student loans during this time, interest rates skyrocketed to all-time highs. However, in the past three years I was able to wipe out half of my loans! To me, that is definitely worth dealing with the occasional negative judgment from peers who have biases about CHCs. Now, I plan to retire

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the rest of my loans while working with a highly underserved population with mental health needs that fascinate me, all the while working for a cause that I find highly rewarding.

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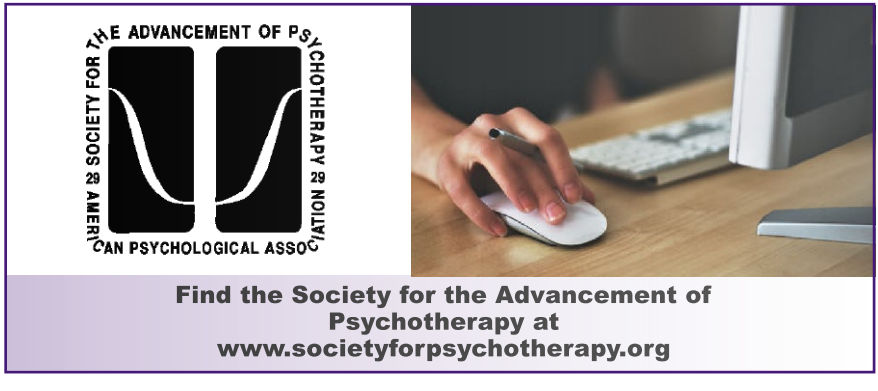

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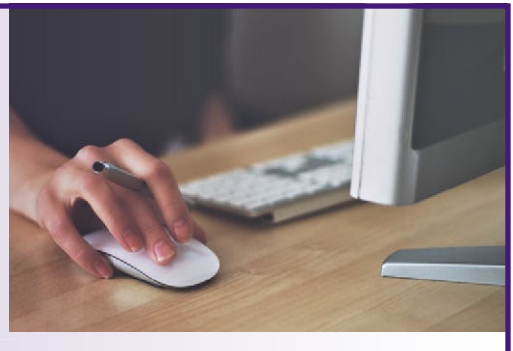

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The Uphill Climb: A Student's Guide to Gaining Relevant Skills for Acceptance to Clinical/ Counseling Psychology Doctoral Programs

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This article details the authors' experiences pertaining to applying to counseling and clinical PhD programs, and offers advice for students, particularly those coming from smaller undergraduate institutions or institutions lacking clinical psychology programs, who may be considering a similar training path.

Introductions

Heather Muir graduated with a BA in psychology from the University of New Hampshire in 2014. She then worked as a research coordinator in a social psychology lab. Subsequently, she worked as a behavior technician and program manager for children with diagnoses on the Autism Spectrum before applying and accepting admittance to a clinical psychology PhD program at the University of Massachusetts Amherst.

Alyssa Clements-Hickman graduated with a BS in psychology from Augusta University (formerly Augusta State University). Immediately after earning her bachelor's degree, she enrolled in the Clinical Psychology Master's Program at Augusta University. She worked at the university counseling center and as a research assistant after earning her master's degree. She worked for two years with her master's degree before applying for and accepting admittance into the Counseling Psychology PhD Program at the University of Kentucky.

Undergraduate Years

As students pursue their undergraduate educations, there are a number of steps they can take to help position themselves on a career trajectory that includes doctoral-level training in counseling or clinical psychology. A few suggestions are outlined below.

Join psychology clubs/organizations.

Heather: Getting involved in psychology clubs or organizations is something students can do early in their undergraduate careers to determine pathways for success. Clubs such as Psi Chi Honor Society, a psychology club, Active Minds, and other psychology related organizations on campus are helpful in learning about psychology careers and making connections with more experienced students. These student mentors can guide newer students to specific research labs and classes, as well as offer suggestions on topics ranging from how to do an

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honors thesis to how to apply to graduate school. Making connections with other students is valuable in orienting yourself to a specific program.

Join labs. **Heather:** Getting involved in research is one of the best things you can do to increase your chances of getting into a doctoral program (Littleford, Buxton, Bucher, Simon-Dack, & Yang, 2018). However, locating research opportunities at a smaller university is a challenge we both experienced. We recommend being open to opportunities that may be outside of your area of interest. For example, to gain research experience I worked in a social psychology lab studying celebrity worship throughout my undergraduate program. While the research was clearly not clinical in nature, working in this lab helped me learn how to plan and execute a study. Working in this lab also helped me obtain my first poster presentation for a professional conference, where I was able to meet several clinical and counseling psychologists.

Find a good mentor. **Alyssa**: It is also important to form close relationships with professors and professionals in the field. Mentors can have a strong impact on our future career paths. Mentors serve several psychosocial functions, including role modeling, acceptance, and guidance. I was fortunate to have several great mentors who guided me through the process of applying to doctoral programs. The best mentors with whom I have worked provided me with unwavering support and encouragement to help me reach my goals. They also provided me with honest feedback about my standing, which helped me make informed decisions throughout the process. This honesty should be bi-directional in nature. That is, it is important to find a mentor with whom you feel comfortable being open and honest. Additionally, I have found that a good mentor is available and dedicated to helping students achieve their goals. One of the mentors I appreciate the most met with me weekly, and helped me make crucial decisions about my career options, such as whether to pursue a master's degree.

Postbaccalaureate Years

Some students may matriculate directly into doctoral programs; for those who do not, there are a variety of options available to make good use of the time in between earning a baccalaureate degree and applying to a doctoral program. We will each share our own experiences with this process below.

Obtain a master's degree. **Alyssa:** After completing my bachelor's degree in psychology, I was unsure whether or not I wanted to pursue doctoral training. I also knew that I had not yet acquired the credentials to be a competitive candidate for doctoral programs and felt unsure regarding the best path to take. I ultimately decided to enroll in a clinical psychology master's program. In my experience, taking the master's route has the potential to strengthen an application, but the time and energy spent earning the degree must be used wisely.

Master's degrees are generally viewed positively by doctoral programs (Littleford, et al., 2018). Nevertheless, it seems important to mention that obtaining a master's degree is more likely to increase the chances of being admitted into a counseling PhD program compared to a clinical program (Littleford et al., 2018). Yet, both clinical and counseling PhD programs value research experience (Pashak, Handal, & Ubinger, 2012). Attending a master's program that cultivates positive attitudes toward research has the potential to increase confidence and future research activity.

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Thus, I recommend that prospective applicants look for a master's programs that will provide plenty of opportunities to obtain formal research experience. My master's program offered a research sequence, which focused on helping students learn to plan and execute an empirical study. We were also encouraged to assist with faculty research projects and attend research conferences. These experiences during my master's program allowed me to narrow down my research interest, which was helpful for applying to doctoral programs.

On the other hand, acquiring additional debt prior to starting a doctoral program can be a hindrance to future plans. Thus, a potential downside to earning a master's degree is the additional cost. Some master's programs offer funding, which I believe should be an important factor for people considering this path. The program I attended offered various research and teaching assistantships that covered tuition and included a stipend. I was able to work as a teaching assistant for assessment courses, which allowed me to gain additional professional experience.

I was also able to transfer several of my courses from my master's program, which has saved me time and money throughout my doctoral training. Importantly, not all doctoral programs are willing to transfer credits; thus, I recommend that prospective students keep this in mind when considering this route.

Taking time "off" to get research experience. **Heather:** Taking time to work after completion of one's bachelor's degree, if utilized with intention, can serve as one way to make oneself a stronger applicant for clinical or counseling doctoral programs. I took three years to work before going on to my PhD. The first year I worked as a research coordinator in a social psychology lab researching relationships. This was the same lab in which I had volunteered during my undergraduate career. Although it was not a clinical lab, I earned a few co-authorships on publications and learned much more about psychology research. Ideally, before applying to a clinical program, one would have clinical research experience. If this is not a possibility, psychology research of any kind can only strengthen your application. Research experience is vital to getting into a clinical or counseling PhD program.

After working as a research coordinator, I felt satisfied with my research experience and wanted to switch my focus to gaining more clinical experience before applying to a clinical program. I spent two years working with children with Autism Spectrum diagnoses. First, as a lead behavior technician working one-on-one with children providing applied behavior analysis therapy, then as a program manager in the same clinic utilizing more clinical oversight skills. Working with a clinical population can help you determine if you are still interested in clinical psychology and will add to your application.

Taking time "off" to get clinical experience. **Heather:** Although, it has been found that PhD programs place less importance on prior clinical experience than PsyD programs, attaining some background in clinical work prior to applying to doctoral programs in clinical or counseling psychology can help make for stronger applications (Pashak et al., 2012). "Clinical experience" is a broad term. This can range from working as a secretary in a psychological services center, to working in a research lab using a clinical population as participants (e.g. an ADHD lab), to working as a behavior technician, to working with a clinical homeless population as an assistant case

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SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY • APA DIVISION 29
2018 Convention Program Summary

THURSDAY, AUGUST 9TH

Symposium: RCT Data on Psychotherapy With Transgender Clients—Feasibility, Outcomes, and Minority Stress
8:00 AM - 8:50 AM • Moscone Center Room 160 44

Chair
Stephanie L. Budge, PhD

Participant/1stAuthor
Stephanie L. Budge, PhD
Morgan T. Sinnard, MEd
Ezra Mauk, BS

Discussant
Elliot A. Tebbe, PhD

Symposium: Supervision—Master Supervisors Show and Discuss Their Supervision Session Videos
9:00 AM - 10:50 AM • Moscone Center Room 215

Cochair
Arpana G. Inman, PhD
Hanna Levenson, PhD

Participant/1stAuthor
Laura S. Brown, PhD
Joan E. Sarnat, PhD
Beatriz Craven, PhD

Discussant
Daniel Marom, PhD

Poster Session: Psychotherapy—Science, Practice, and Advances—Session I
11:00 AM - 11:50 AM • Moscone Center Halls ABC

Participant/1stAuthor
Daniel Lydon, MA
Karen L. Steinberg, PhD
Cara L. Solness, BS
Jeremy J. Coleman, MA
Brian TaeHyuk Keum, MA
Cheri L. Marmarosh, PhD
Brett L. Opelt, MS
Hannah K. Muetzelfeld, MEd
Chelsea Atlas, MEd
Daniella M. Vasquez, MA
Kathryn McGill, MA
Yourim Kim, BA
Ashley C. DeMarco, PhD
Stacy J. Kim, BA
John H. Diepold, PhD
Derek D. Caperton, MS
Keoshia Harris, BA
Michael J. Tanana, PhD
Jade Clemons, MS
Alyssa Clements-Hickman, MS
Christina S. Soma, BA
Amy D. Smith, BA
Kelley Quirk, PhD
Pressley A. Chakales, BS
Jean M. Birbilis, PhD
Bediha Ipekci, MS
Jennifer A. Schager, MA
Craig A. Warlick, MS
Jansey Lagdamen, BS
Michelle A. Blose, MS
Barbara L. Vivino, PhD
Len Jennings, PhD

Thursday, August 9th, continued on page 37

Symposium: Existential-Humanistic Therapy As a Basis for Effective Therapy—Are Training Directors Listening?
12:00 PM - 12:50 PM • Moscone Center Room 216
Cochair
Kirk J. Schneider, PhD
Orah Krug, PhD
Participant/1stAuthor
Kirk J. Schneider, PhD
Orah Krug, PhD
Gilbert Newman, PhD
Discussant
Nadine J. Kaslow, PhD

Invited Symposium: Keeping Psychologists in the Driver's Seat—Multiple Perspectives on Quality Improvement
1:00 PM - 1:50 PM • Moscone Center Room 104
12, 17, 42, APA Committee on Early Career Psychologists, APAGS
Chair
Caroline Vaile Wright, PhD
Participant/1stAuthor
Caroline Vaile Wright, PhD
James F. Boswell, PhD
Tony G. Rousmaniere, PsyD
Discussant
Carol D. Goodheart, EdD

Symposium: When Faith Matters More Than Sexual Orientation—Challenges in Ethics, Training, and Psychotherapy
2:00 PM - 3:50 PM • Moscone Center Room 159
12, 17, 44, APA Committee on Sexual Orientation and Gender Identity
Chair
Armand R. Cerbone, PhD
Participant/1stAuthor
Armand R. Cerbone, PhD
Joshua Wolff, PsyD
Jeffrey Paul, MA
Discussant
Judith Classgold, PsyD

Symposium: Clinical Supervision Around the Globe—Culture, Values and Best Practice
3:00 PM - 3:50 PM • Moscone Center Room 214
Chair
Carol A. Falender, PhD
Participant/1stAuthor
Fatima R. Al-Darmaki, PhD
Maria del Pilar Grazioso, PhD
Keeyeon Bang, PhD
Yelda Kagnici, PhD
Xiaoming Jia, PhD
Discussant
Rodney K. Goodyear, PhD

Conference Program Summary, continued on page 38

FRIDAY, AUGUST 10TH

Symposium: Psychotherapy Relationships That Work—Translating Meta-Analytic Results Into Clinical Practices
8:00 AM - 9:50 AM • Moscone Center Room 104
Chair
John C. Norcross, PhD
Participant/1stAuthor
Myrna L. Friedlander, PhD
Michael J. Constantino, PhD
Paul R. Peluso, PhD
Alice E. Coyne, MS

Symposium: Self-Care in the Seasons of a Psychology Career—Ethics and Best Practices
9:00 AM - 9:50 AM • Moscone Center Room 216
12, 17, 42, APA Ethics Committee
Chair
Jeffrey E. Barnett, PsyD
Participant/1stAuthor
Jeffrey E. Barnett, PsyD
Erin E. Ayala, PhD
W. Brad Johnson, PhD
Debbie Joffe Ellis, DPhil
Gerald Corey, EdD

Skill-Building Session: Deliberate Practice and the Expertise—Development Model of Supervision and Consultation
10:00 AM - 11:50 AM • Moscone Center Room 152 13
Chair
Rodney K. Goodyear, PhD
Participant/1stAuthor
Michael V. Ellis, PhD
Tony G. Rousmaniere, PsyD

Poster Session: II—-Psychotherapy: Science, Practice, and Advances—Multicultural and International Contributions
11:00 AM - 11:50 AM • Moscone Center Halls ABC
Participant/1stAuthor
Na Fu, PhD
Hui Xu, PhD
Feihan Li, PhD
Linyuan Deng, PhD
Xiang Zhou, MA
Dong Xie, PhD
Akshay Kumar, PhD, MA
Mirela A. Aldea, PhD
Kayoko Yokoyama, PhD
Yuye Zhang, MSW
Jazmin M. Gonzalez, MEd
Xiubin Lin, MA
Jennifer A. Schager, MA
Nour M. Abdelghani, MA
Sang-Hee Hong, MA
Minnah W. Farook, MA, EdS
Tania Valente, MA
Patty B. Kuo, MEd
Jarice N. Carr, PhD
Keoshia Harris, BA
Amy D. Smith, BA
Jean M. Birbilis, PhD
Beilei Li, PhD
Shitao Chen, PhD
Ha Yan An, PhD
Adijat Bola Adams, PhD, MEd

Friday, August 10th, continued on page 39

Symposium: Case Formulation As a Tool for Individualizing Psychotherapy
11:00 AM - 11:50 AM • Moscone Center Room 306
Chair
George Silberschatz, PhD
Participant/1stAuthor
John T. Curtis, PhD
Lorna S. Benjamin, PhD
Discussant
Hanna Levenson, PhD

Business Meeting: Journal Editor Invited Luncheon
12:00 PM - 12:50 PM • San Francisco Marriott Marquis Hotel
Pacific Room B

Business Meeting: Awards Ceremony
4:00 PM - 4:50 PM • San Francisco Marriott Marquis Hotel
Yerba Buena Salons 5 and 6

Business Meeting: and Awards Reception
5:00 PM - 5:50 PM • San Francisco Marriott Marquis Hotel
Yerba Buena Salons 5 and 6

SATURDAY, AUGUST 11TH

Symposium: Personalizing Mental Health Care Through Disruptive, Evidence-Informed Innovations to Psychotherapy
8:00 AM - 9:50 AM • Moscone Center Room 206
12, 17, 42, APA Committee on Early Career Psychologists, APAGS
Chair
Michael J. Constantino, PhD
Participant/1stAuthor
Michael J. Constantino, PhD
Jesse Owen, PhD
Zac E. Imel, PhD
Discussant
Nancy L. Murdock, PhD

Symposium: Pulling Psychotherapy Into the Big Data Research Era
10:00 AM - 10:50 AM • Moscone Center Room 307 43
Chair
Stevan Lars Nielsen, PhD
Participant/1stAuthor
P. Scott Richards, PhD
David M. Erekson, PhD
Mindi N. Thompson, PhD
Philip Brownell, PsyD
Tyler Pedersen, PhD
Discussant
Raymond DiGiuseppe, PhD

Saturday, August 11th, continued on page 40

Social Hour Luncheon With the Masters
12:00 PM - 1:50 PM • San Francisco Marriott Marquis Hotel
Golden Gate Room C2

Symposium: Client-Focused Psychotherapy Research—Advancing Our Understanding of Process and Outcome in Therapy
4:00 PM - 4:50 PM • Moscone Center Room 206
Cochair
Jairo N. Fuertes, PhD
Elizabeth Nutt Williams, PhD
Participant/1stAuthor
Jairo N. Fuertes, PhD
Changming Duan, PhD
Zac E. Imel, PhD
Craig N. Shealy, PhD
Discussant
Charles J. Gelso, PhD

Symposium: Evidence-Based Responsiveness—Personalizing Psychotherapy to the Individual Patient
5:00 PM - 5:50 PM • Moscone Center Room 214
12, 17, 42, APA Committee on Early Career Psychologists, APAGS
Chair
John C. Norcross, PhD
Participant/1stAuthor
Kenneth N. Levy, PhD
Paul Krebs, PhD
Satoko Kimpara, PhD
Alberto Soto, PhD
Laura E. Captari, MA

40th Annual Running Psychologists "Ray's Race" 5k Run & Walk

Register NOW!! for the 40th Annual Running Psychologists "Ray's Race" 5k Run and Walk This year's race will be held at Crissy Field on Saturday, August 11, 2018 at 7 a.m. You won't want to miss this run along San Francisco Bay, complete with iconic views of the Golden Gate Bridge, Alcatraz, and the Marin Headlands!

The Annual Ray's Race is an APA tradition started by, former APA President and CEO, Ray Fowler, over 40 years ago! It's a great opportunity to get some exercise during the convention, network with likeminded colleagues, and see a beautiful part of our host city.

Registration is $40 for APA Members, Family, & Friends; $30 for Students. A shuttle will be provided to and from the race site. All participants will receive a t-shirt. Prizes will be offered in all age categories for runners and walkers. This year's race also features awards for the *fastest* Division and the Division *with the most participants.*

To register, click on the following link: https://register.chronotrack.com/r/38749

HAPPY RUNNING!

SUNDAY, AUGUST 12TH

Symposium (A): Considerations for Providing Excellent Supervision—From Social Justice to Deliberate Practice
8:00 AM - 8:50 AM • Moscone Center Room 307
Chair
Robert Jeff Reese, PhD
Participant/1stAuthor
Carolyn Meiller, MS
Douglas A. Spiker, MA
Todd Ryser-Oatman, MS
Alyssa Clements-Hickman, MS

Symposium (A): Social Class in Psychotherapy Research—Considerations for Measurement, Design, and Analysis
9:00 AM - 9:50 AM • Moscone Center Room 207
Chair
Mindi N. Thompson, PhD
Participant/1stAuthor
Simon B. Goldberg, PhD
Rachel Nitzarim, PhD
Anna Fetter, MEd

Symposium (A): Hope in Psychotherapy—Therapist and Client Perspectives
9:00 AM - 9:50 AM • Moscone Center Room 208
Chair
Theodore T. Bartholomew, PhD
Participant/1stAuthor
Eileen E. Joy, MA
Huaying Li, BA
Ellice Kang, BS
Discussant
Michael J. Scheel, PhD

Conversation Hour (A): Did That Just Happen? Responding to Microaggressions Committed by Psychotherapy Clients in Session
10:00 AM - 10:50 AM • Moscone Center Room 2005 45, 56
Cochair
Marilyn Cornish, PhD
Melisa Martinez, MA
Participant/1stAuthor
Melisa Martinez, MA
LaVarius Harris, BS

Symposium (A): Multicultural Psychotherapy Research in College Mental Health
11:00 AM - 11:50 AM • Moscone Center Rooms 310 and 311 45
Chair
Allison J. Lockard, PhD
Participant/1stAuthor
Theodore T. Bartholomew, PhD
Allison J. Lockard, PhD
Andres E. Pérez-Rojas, PhD
Discussant
Benjamin D. Locke, PhD

manager. Although it may seem daunting to find one of these positions without a master's degree, it is possible. Any formal interaction you have with a clinical population, including volunteer work, may strengthen your application, if you are able to highlight the skills and insights you gained. Sometimes such positions are not listed on job sites and it is wise to reach out to directors to ask if any jobs or volunteer positions are available. It is possible that a volunteer position could be created for you; it never hurts to ask! Be proactive.

Application Preparation

When the time comes to apply to a doctoral program, it is important to keep a few useful strategies in mind.

Be realistic. **Heather & Alyssa:** Counseling and clinical psychology PhD programs are extremely popular. This makes them more difficult, statistically, to get accepted into than other psychology programs (Norcross, Ellis, & Sayette, 2010). It was important for us to remain optimistic yet realistic about our chances of getting in directly after graduation from our respective undergraduate institutions. Many who apply to these programs will have high GPAs, relatively good GRE scores, ample clinical research experience, outstanding letters of recommendation, and clinical experience of some sort. Being strategic while considering when to submit applications is important, because completing testing, applications, and interviews can be emotionally and cognitively taxing and financially burdensome. Both of us spent a few years between our undergraduate careers and our PhD programs ensuring that we met these standards *before* applying. It is definitely possible to get accepted right out of your undergraduate program, if you have a competitive application. Coming from a smaller undergraduate institution or a research institution without a clinical program meant it took a bit longer to "check these boxes" for us. There are various routes one could take to achieve the needed credentials and competencies, including pursuit of a master's degree or obtaining research and clinical experiences other ways.

Prior to applying, we also recommend doing some research about the programs in which you are interested to be informed about your likelihood of being accepted. The *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Norcross, Mayne, & Sayette, 2018), which provides in-depth profiles on hundreds of programs, is a good resource.

Prepare for the GRE. **Alyssa:** The Graduate Records Exam (GRE) is a requirement across most clinician and counseling doctoral programs (Littleford et al., 2018). Unfortunately, it is also a frequently cited barrier to being admitted into a doctoral program (Littleford et al., 2018). Programs typically post average GRE scores of successful applicants, which can be useful for knowing what scores for which to aim. I took the GRE numerous times before earning a score that would make me competitive for doctoral programs. It was difficult for me to find a study method that worked for me. I found Magoosh's GRE prep course and Manhattan Prep's GRE flash cards to be the most helpful resources. It seems important to mention that these materials will likely not work for everyone, and I recommend researching the numerous test materials that are currently available. Additionally, test prep programs such as Magoosh should not be a substitute for working through actual Educational Testing Service problems. Finally, some schools require or recommend that applicants take the

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GRE psychology test. Unlike the general GRE, which is offered regularly, GRE subject tests are only offered three times a year (i.e., September, October, and April). Thus, it is important to plan ahead for this test.

Connect your experiences. **Heather:** When I applied to clinical psychology doctoral programs, I had no clinical research experience due to the opportunities I had been given during my undergraduate career and after graduation. I was aware that this would be a negative aspect of my application when applying, especially when many of the other applicants had these credentials. With this in mind, I was strategic with my essays and in selecting the professors to which I applied for mentorship. I had ample research experience in the romantic relationships realm of social psychology. I was interested in relationships in general and interpersonal factors in clinical psychology. I applied to programs that housed faculty whose research examines the therapeutic relationship. My experiences in romantic relationships research had some overlapping features with the work these labs were pursuing. It was important for me to highlight these overlaps and explain why the skills I had would add to the research these faculty were already doing. Fitting my social psychology background with a specific clinical psychology lab is likely one aspect of my application that counteracted the fact that I had only social psychology research experience. Homing in on specific faculty, reading up on their research, and writing your cover letters in ways that tailor your experiences to fit their particular interests, are important ways to stand out to clinical and counseling psychology PhD programs.

Conclusion

However a student gets there, the path to a successful clinical or counseling psychology admission is a long and challenging one. By thinking strategically about the process, students at each stage of their educational journey can set themselves up for future success. Our hope is that these suggestions will help students pursuing graduate clinical training in achieving their career goals.

References

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Norcross, J. C., Mayne, T. J., & Sayette, M. A. (2018). *Insider's guide to graduate programs in clinical and counseling psychology* (2018/2019 ed.). New York, NY: Guilford Press.

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Practice Recommendations for Psychotherapy With Gender Diverse Clients

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Department of Psychology
Southern Illinois University—Carbondale

Recently, the population of people who identify as transgender or gender diverse has become more visible in U.S. society. Likewise, there have been calls by psychologists and counselors for more research and scholarship related to gender identity and issues that people who identify as gender diverse might face or present with in therapy. Psychotherapists have a number of guidelines and resources to assist in providing affirmative work with gender diverse clients. For example, the American Psychological Association (APA) published the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015). The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) developed their Competencies for Counseling Transgender Clients in 2009. The World Professional Association for Transgender Health (WPATH) published its Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People in 2011 (SOC 7.0) and is currently working on making revisions for SOC 8.0. A number of helpful articles and books to assist therapists have been published in recent years, such as Hendricks and Testa's (2012) framework for clinical work with transgender and gender nonconforming clients; Singh and dickey's (2017) text on affirmative counseling and psychological practice, as well as their instructional video on the topic (2018); and Budge's (2015) article on writing letters for transgender clients.

It is beyond the scope of this article to provide a thorough, extensive review of the literature that is available. Instead, we pull from our own clinical experiences working with gender diverse clients and discuss some of the common themes and issues we frequently see. A caveat is that this article is based on our own experiences, which are limited to clients we have seen in the last approximately 10 years in rural, suburban, and urban areas of the Midwest and Southwest regions of the U.S. Our experiences have included private practice, college counseling centers, medical/hospital settings, public schools, and local LGBTQ centers. Therapists in regions such as the east and west coasts or who practice in different settings may have different experiences, and clients may need different types of resources, or may

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have better access to resources than our clients have. This article is based on our own professional opinions, is not exhaustive, and we are sure we have missed some things—we welcome others to share their own unique experiences in future publications.

To us, one of the first and most important things for therapists to understand is the importance of language when working with transgender or gender diverse clients. As recently as 2015, when the APA Guidelines were developed, the term *gender non-conforming* was used. More recently, it seems that the term *gender diverse* may be preferred as an umbrella term for anyone who does not identify as *cisgender*. The term cisgender refers to an individual whose sex assigned at birth is congruent with their gender identity. The term *non-binary* also appears to be more frequently used now than it was five years ago. However, some individuals may find terms like *non-binary* and *non-conforming* to be problematic, given that they define populations in relationship to societal expectations or based on who these individuals are not, as opposed to who they are. Thus, it is important for therapists to invite their clients to self-identify, and for therapists to share their own identities as well. Simple steps such as beginning to refer to *gender identities* rather than to *gender identity* provides verbal confirmation that the therapist views gender as reaching beyond fixed, binary categories.

Sensitivity to gender diversity has many implications for clinical practice. For example, clinical paperwork may need to be reconsidered. Having an open space on an intake form such as "Gender: _____" rather than offering choices might allow a client to use the language that is most appropriate. We prefer this to offering choices such as Male/Female/Other because this can be "othering." Therapists should also initiate discussions about gender to fully understand how their clients identify rather than simply what terms their clients use to express their gender identities. We suggest that therapists self-educate and interact with transgender communities to stay current and competent. For example, simply watching online videos by transgender bloggers may provide valuable insight and growth. A great resource for therapists to keep up with terminology is the National Center for Transgender Equality (transequality.org). We also really like FORGE, which is based in Wisconsin but provides wonderful resources and publications that are applicable across the U.S. (forge-forward.org). The book *Trans Bodies, Trans Selves: A Resource for the Transgender Community* is also a valuable resource for clinicians wishing to gain insight and understanding about many dimensions of transgender experience (Erickson-Schroth, 2014).

Another issue that therapists should be aware of is the use of pronouns. Throughout this article, we use the pronouns "they/them/their" to refer to a singular client in examples. Again, we recommend that rather than assuming that a client who identifies as female would use she/her/hers pronouns, the therapist ask the client what the preferred pronouns are. This may also be included on an intake form with an open-ended response option such as "Pronouns: _____." We also encourage therapists to offer their own pronouns at the beginning of a therapeutic relationship with a client. Demonstrating awareness that the clinician's own pronouns are salient (and may not be assumed) communicates to the client that the therapist is thoughtful about the salience of gender identities in the therapeutic process.

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Use of pronouns seems to vary by geographic area, current trends, and age of the client. We have found that our older clients tend to prefer more traditional he/him/her, she/her/hers, and they/them/their pronouns. Younger clients, and clients in larger cities or on the east or west coasts, may use pronouns such as ze/zim/zirs or ey/em/eirs. The websites we mentioned previously also have great charts and fact sheets about pronouns. Therapists may worry about getting pronouns "right," or may accidentally use incorrect pronouns. Like any error made in therapy, we believe it is best to have a transparent conversation about this, apologize, and make a conscientious effort to do better next time. We strongly advise against the use of terms like "preferred" or "chosen" gender or pronouns; this implies that gender identity is chosen in some way. As we know from transgender scholarship, gender identity is not a choiceand implying that it is may create considerable fractures in the therapeutic relationship.

Another term that therapists may hear in relation to this population is *transition* or more accurately *transitions* because the singular form of this word assumes that one type or process of transition applies to all transgender populations. It is important to know that while people who identify as transgender may choose to transition, many do not. Also, transition is a completely individual experience: No two transitions are alike. As part of transition, some clients may change their names. Whether a legal name change has happened or not, it is important that the therapist use the client's identified name and offer a place on the intake form for this information. We understand that for some legal purposes, such as insurance billing, it may be necessary to track two names simultaneously; we do not feel this is an undue burden for the therapist. We have worked with clients who have wanted to experiment with how different names "felt" over time, and who have asked us to use multiple different names over time. We reflect this in our case notes and refer to clients using their current, identified name and pronouns.

For many clients who transition, it is helpful to put together a timeline or plan, including financial cost or resources. It is important to remember that transitions may occur on a variety of levels or within a variety of life domains. Social transitions may occur interpersonally between transgender people and their loved ones, family, and friends. Legal transitions involve name and gender marker changes on government documents. Some transition-related actions may include coming out to family members, friends, or coworkers; legal name change; gender marker change on identification and government documents; wardrobe change; and therapy, if required for hormone replacement therapy or for gender affirmation surgery. For clients who identify as male, other aspects of transition could include *binding* or *packing*. For clients who identify as female, transition might include removal of body hair through electrolysis, practicing voice (sometimes through coaching), or wearing breast prosthetics. Within the context of clinical work, therapists may benefit from knowing the extent to which a client has transitioned or plans to transition. Therapists may feel the need to ask deeply personal questions about aspects of physical transition. We encourage therapists to recognize how invasive these questions may be and how trusted and privileged therapists are as they engage in these conversations. Such questions should *never* be made out of personal interest or outside of the therapeutic interaction, and these conversations should be led by the client.

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For any client who is transitioning, being misgendered is a frequent source of frustration, hurt, sadness, and anger. In our experience, clients are more forgiving of strangers who might misgender them (although this, too, is frustrating), while being misgendered by their close family and friends is particularly hurtful and rejecting. Family members and friends often misgender, either deliberately or by accident, even after multiple reminders. When a client tells a therapist about an experience of being misgendered and the hurt related to this, it is important for therapists to validate this experience. These clients may get messages such as "you're making a big deal of this," or "you will always be my little boy/girl," or "don't be so sensitive," so it is crucial for therapists to listen and empathize. On the other hand, we have also had clients who have attempted to diminish these experiences in therapy, and for whom it took a while to recognize the pain these experiences were causing.

Therapists may wonder what therapy should actually look like. The approach that therapists take does not need to differ from the approach they may take with other clients, but should be affirmative in nature. We recommend that any therapist who works with gender diverse clients fully familiarize themselves with the APA guidelines, the ALGBTIC competencies, and the WPATH standards of care, at a minimum. It is important to note that clients who identify as transgender or gender diverse may present with other concerns, and gender identity may not be their foremost concern. The therapist should work collaboratively with the client in a client-centered manner. For example, if a client transitioned years ago, and presents with concerns related to her current romantic relationship, then the therapist should focus on the romantic relationship as the presenting concern, rather than the transgender identity. On the other hand, if a client states that they want to work toward transition and are hoping for a letter of recommendation from the therapist, it is important for the therapist to assist with that. Therapists who are unable to write letters of support or to aid the client in transition-related actions must be upfront about this at intake. We have heard stories from clients and community members who saw therapists for months before discovering that their therapists would not provide supporting letters. This can be devastating for a client because it has the possibility of setting their transition back and may separate them from necessary and/or life-saving services.

Consider this example of affirmative therapy: Imagine that Sam is your client. Sam is a 22-year old male-identified client who was assigned female at birth. Sam uses they/them/their pronouns. Sam tells you that they reached out to make an appointment with you because they are feeling frustrated with their previous therapist. Sam tells you that they are limiting and controlling food intake. Sam has periods of depression and suicidality and uses substances to cope. Sam also states that they are experiencing high levels of gender dysphoria. In this case, how would you proceed with the client? Would you focus on the disordered eating? Would you focus on the depression and suicidal thoughts? The client states that they think about dying or suicide more days than not. Does the client need treatment for substance abuse before going forward with psychotherapy? Would you recommend the client receive hormone therapy?

Clearly, it is important to consider the client's safety. If a client is imminently in danger, then appropriate steps/precau-

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tions have to be taken. However, in our clinical judgment and experience, approaching the client as someone who is autonomous and who knows themselves as a gender diverse person should be foremost in the therapist's mind. Budge (2015) provides an excellent discussion about the gatekeeping role that therapists are currently asked to play and whether this fits with our ethical code and moral principles.

With this client, as you explore issues related to gender, you learn that they are limiting food intake because experiencing menstrual periods heightens gender dysphoria and, subsequently, depressive symptoms. You learn that Sam's family has rejected them completely so they are working 30 hours per week while maintaining a full course load at college. We recommend working with the client to explore gender, the current living situation, and to put gender first as a priority, while also doing frequent check-ins regarding suicidality and eating. WPATH (2011) guidelines strongly establish that being allowed to transition, and starting hormone replacement therapy, reduces depressive symptoms and improves mental health. Furthermore, starting hormone replacement therapy could reduce or halt menstrual cycles, which could also diminish gender dysphoria experienced by this client.

Though we have only been able to brush over the many themes and presenting concerns that may arise in work with gender diverse communities, we hope that this brief overview will provide a first step for therapists who wish to increase their competence with gender diverse clients. The body of literature regarding transgender and gender diverse affirmative practice is growing exponentially and therapists have the opportunity to reach this community in informed and thoughtful ways like never before. We hope you will choose to incorporate transgender affirmative awareness into your own practice.

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EARLY CAREER

Assessing the Needs and Interests of Our Early Career Psychologist Members

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This year marks the 50th anniversary of the *Society for the Advancement of Psychotherapy* (Division 29). I must admit, however, that my own experience with the division has been much briefer. Indeed, this is my first year as a member. My limited history with the division precludes me from reflecting much on its history, but as an early career psychologist (ECP) and Chair of the ECP Committee, I am better positioned to consider its future.

Over the past few months I have had the privilege of hearing from other new and more longstanding members about the goals, initiatives, and future directions they have for the division. These conversations have helped to shape my own thoughts, particularly regarding our ECP members, their engagement with the division, and the roles they will play as the division moves forward. Through these conversations I have also realized that in order to develop a plan for where we are headed, we must first take stock of where we have been and what we already know. In this article, I offer a brief review of previous research examining ECPs as a population. I also report on two studies from other APA Divisions that sought to better understand the perceptions, needs, and interests of their ECP members. I discuss the lessons learned from this previous research and offer an update on the goals of this year's ECP Committee. It is my hope that the work we accomplish this year will help to usher in the next 50 years of Division 29.

Traditionally, psychologists within seven years of their doctoral degree have been classified as "early career," though more recently the classification has been expanded to include anyone within 10 years of graduation (American Psychological Association [APA], 2016). ECPs are an increasingly diverse group of individuals. We come from a variety of different backgrounds, have trained in a variety of different programs, and work in a variety of different professional settings. Despite this diversity, there are several themes that have emerged from research on ECPs. As a group, we are well-resourced when it comes to the latest professional knowledge, our familiarity with technology, and our enthusiasm and energy (Dorociak, Rupert, & Zahniser, 2017). However, we also face several challenges. Many ECPs have high levels of educational debt, which may cause us to delay milestones, such as marriage, buying a house, or having children, or lead us to take on multiple professional roles in an attempt to increase our income (Arora, Brown, Harris, & Sullivan, 2017; Green & Hawley, 2009). Evidence also suggests that ECPs are more likely to struggle with work-life balance and less likely to engage in regular self-care as compared to our more senior colleagues (Arora et al., 2017; Dorociak et al., 2017). Perhaps due to these factors, ECPs appear to be at

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increased risk for burnout. Indeed, Dorociak and colleagues (2017) found that, as compared to later-career psychologists, ECPs were more likely to endorse emotional exhaustion and less likely to endorse personal accomplishment related to their professional lives. These challenges are further complicated by the fact that they occur at a time when ECPs are transitioning from students to professionals and thus still discovering who we are and what we want our careers to be.

Understanding the resources ECPs bring to the table, as well as the unique challenges we face has important implications for APA and its divisions, including Division 29. ECPs have, historically, been underrepresented within APA membership, and particularly within division membership (Arora et al., 2017). Previous research found that only 12% of ECPs endorsed participating in a subspecialty division of APA (Westefield, 2011), though there is also reason to believe that rates of division membership among ECPs may be on the rise (Forrest, 2012). The value of recruiting and retaining active ECP members into Division 29 is undeniable. As we look toward the next 50 years of the organization, we can expect those of us who are currently ECPs to have a large role in shaping its future. Increasing the engagement of ECPs is a worthwhile endeavor for Division 29, but it will also require us to develop an understanding of what our ECP members are looking for and the ways in which we can best serve them.

Since starting my position as Chair of the ECP Committee, I have talked with Division 29 colleagues about the possibility of developing a systematic assessment of our own ECP members. Through these discussions, I quickly realized how little I knew about the topics we were trying to assess. So, doing what I normally would do, I decided to turn to the literature. Though relatively little research on the perceptions and needs of ECPs exists, multiple APA Divisions have undertaken similar needs assessments and there is much we can learn from their efforts.

Perhaps the most comprehensive ECP assessment that has been conducted and published, to date, was the one conducted by Smith and colleagues (2012). This assessment included 70 ECP members of APA's Society of Counseling Psychology (Division 17). Results revealed that perceptions of Division 17 differed quite drastically between ECP members with primarily academic appointments and ECP members with primarily clinical appointments. As compared to members with clinical appointments, members with academic appointments reported division membership to be more useful to their careers and more helpful for finding mentors and networking with professional peers. In contrast, members with clinical appointments were more likely to report that they did not have time to be involved with the division. Though somewhat disheartening for our clinical colleagues, results of the survey informed several specific recommendations put forth by the authors to promote the needs of *all* of the division's ECP members. These recommendations included: developing a more formal mentoring program, dedicating conference hours to early career programming, highlighting activities of ECP members on the Division's website, creating additional awards in nontraditional areas, and dedicating at least one ECP seat on each committee.

More recently, Arora and colleagues (2017) published their own survey of

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ECP members within APA's Division 16: School Psychology. In contrast to the study by Smith and colleagues (2012), which focused primarily on ECPs' perceptions of division membership, this survey focused on the professional development needs and training interests of its ECP members. Across members, the most commonly endorsed developmental needs were short- and long-term career development planning, cultivating mentors, publishing, licensure, and self-care/work-life balance. Not surprisingly, however, differences emerged between ECP members with primarily applied versus primarily academic appoints. For example, when asked about their training interests, ECPs with primarily applied positions were most likely to endorse developing a specialization, navigating interpersonal and/or political issues in schools, and ethical issues, whereas ECPs with primarily academic positions were most likely to endorse developing research collaborations, training in methodology and statistics, obtaining research funding, and teaching. Both groups identified supervision of trainees as an area of interest.

What can we take away from these studies? Some professional development needs and interests appear to be shared among ECPs and, for many people, participating in an APA division can be a fruitful way to receive training and mentorship in these areas. It is also important to remember that our divisions represent a diverse group of people and to provide training and resources that meet the needs of ECPs from a variety of backgrounds and who work across many professional settings. In particular, it seems that greater emphasis needs to be placed on resources that are relevant to ECPs who are in applied clinical settings.

This year, one of the Division 29 ECP Committee's primary goals is to conduct our own needs assessment for our ECP members. As is, hopefully, clear, we have been hard at work, reflecting on the goals of the survey and the gaps in our knowledge. We have begun building the anonymous survey, and anticipate circulating it through the Division's listserv sometime in the coming months. Results will be compiled and shared at the subsequent Division 29 board meeting. We hope that this assessment will be an important first step into the next 50 years of the division. It will inform our understanding of how the division recruits and retains ECPs and will guide us as we look to serve all our ECP members better. So, if you identify as an ECP, keep an eye out for the survey in your inbox–we want to hear from you! What attracted you to join Division 29? What would you like to see from the division over the coming years? What division resources would be most helpful to meeting your professional development goals and interests? What are the biggest challenges you face at this stage of your career? Is there support—practical or emotional—that could help you navigate these challenges more easily? Your voices are not only essential to the ECP Committee and its future endeavors, but also to Division 29 as a whole.

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Knowing What You Don't Know: Addressing Professional Competence

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Recently in one of my courses, I lectured on ethics in forensic psychological assessment. A case example was provided involving a psychologist who provided testimony citing non-existent risk and risk assessment literature in a death penalty case, which later resulted in the case being overturned. One of my students inquired about the repercussions of psychologists providing false expert testimony in forensic contexts—especially having read the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (Code of Ethics; 2017) and articles on the implications of high-stakes testing at the beginning of the course (Sackett, Borneman, & Connelly, 2008; Sackett, Schmitt, Ellingson, & Kabin, 2001). Was there a state licensing board complaint? Follow-up intervention? Was the person's license revoked? What happens to the prior cases in which this person provided testimony? Professional competence is a critical discussion topic in professional ethics in psychological practice.

Professional Competence

Competence has been defined as the knowledge and skills, and attitudes, values, and judgment needed to perform the work of a psychologist (Barnett, Doll, Younggren, & Rubin, 2007; Rodolfa et al., 2005). Epstein and Hundert (2002) further expand "[professional competence is] the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 227).

Competence is considered both an aspirational and enforceable standard. The APA began requiring ethics in doctoral curricula in 1979 (Bashe, Anderson, Handelsman, & Klevansky, 2007). Education in psychology shifted to competency-based education and training (Kaslow et al., 2004). However, obtaining a graduate degree in psychology is presumed to be entry-level competence (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012). Indeed, board certification exists for psychologists to demonstrate a higher level of competence in different specialties within psychology, although only 3% of psychologists have board certification (Johnson et al., 2012).

Boundaries of Competence

Psychologists are encouraged to practice within their areas of competence. Standard 2.01 (Boundaries of Competence) of the APA Code of Ethics (2017) states,

> Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. (p. 4)

For instance, if a psychologist in private practice has spent her early career working primarily with adults with severe

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and persistent mental illness, shifting to child custody cases could potentially be working outside her area of competence. Therefore, this person would need to receive training (i.e., further graduate courses, professional seminars) and supervision and consultation prior to engaging in such professional activities.

Practicing within boundaries of competence is particularly important in high stakes contexts where the implications and potential for harm is heightened (Sackett et al., 2001; 2008). High stake contexts could include educational assessments, civil and criminal forensic treatment and assessments (e.g., child custody, death penalty, sexual harassment litigation), and dangerous practice settings. Practicing outside areas of competence can lead to significant financial, personal, emotional, and physical consequences.

Problems in Professional Competence

Elman and Forrest (2004) coined the term *problems of professional competence* (PPC). Many factors can contribute to PPC, including deficits in current education, training, and experience, personal distress or illness, or cognitive decline (Johnson et al., 2012). Further, career-related stressors such as compassion fatigue and vicarious traumatization can further contribute to PPC (Johnson, Barnett, Elman, Forrest, & Kaslow, 2013). Practicing while impaired can result in harm to both psychologists and to their clients. Standard 3.04 (Avoiding Harm) of the APA Code of Ethics (2017) notes that psychologists should "take reasonable steps" to minimize foreseeable harm with their clients and others. Noticing PPC in oneself requires a great degree self-reflection. Bashe et al. (2007) note, "Students and practicing professionals need to reflect actively and decide how much of their own personal morality can be adapted to their growing knowledge and appreciation of the ethical culture of psychology" (p. 61).

Much of the literature regarding impaired professional practice focuses on students and trainees, and there is guidance on how to address PPC from graduate training to the post-doctoral level (Bamonti et al., 2014; Forrest, Shen-Miller, & Elman, 2008; Johnson et al., 2008; McCutcheon, 2008; Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004; Wester, Christianson, Fouad, & Santiago-Rivera, 2008). Interestingly, in a study assessing ethical violations, *students endorsed PPC among their faculty* (January et al., 2014). Students cited practice issues such as lack of skill-based competence and lack of cultural competency/multicultural sensitivity. Therefore, it is important for students, faculty, and supervisors to assess their professional competence across all areas of professional work—teaching, supervision, research, and clinical practice.

Psychology and the General Public

Problems in professional competence can have a broader impact. There are numerous myths about psychological science in the general public and media. It is the role of a psychologist to uphold a scientific and professional standard when interacting in public spaces. Here is a case example loosely based on recent testimony I witnessed:

> A state is considering legislation that would prohibit LGBTQ parents from adopting children. A licensed psychologist testifies that allowing LGBTQ parents to adopt would be harmful to the child (stating "research says…") and would limit adoption agencies in exercising their religious freedom.

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Standard 2.04 (Bases for Scientific and Professional Judgements) of the APA Code of Ethics (2017) notes work should be based upon "established scientific and professional knowledge of the discipline" (p. 5). In this case example, this standard is not being met. In 2004, the APA adopted a policy resolution providing a summary of research supporting adoption for gay and lesbian parents and citing literature noting no adverse impact of their parenting on their children when compared to children with opposite-sex parents (Paige, 2005; Patterson, 2005). Therefore, personal biases may be impeding on scientific knowledge, which is detrimental when providing testimony regarding public policy. This example also elucidates the importance of remaining current on professional practice standards and literature.

Psychologists should be cautious about how they disseminate psychological knowledge and research to the general public. Accuracy and completeness of language and information, avoidance of being overly confident, highlighting limitations to research and outcomes, and avoidance of pseudoscience should all be noted (Cederberg, 2017). Again, Standard 3.04 (Avoiding Harm), as well as Principle B (Fidelity and Responsibility) of the APA Code of Ethics (2017) discusses avoiding harm and being aware of the "professional and scientific responsibilities to society and to the specific communities in which they work" (p. 3). Cederberg (2017) notes it is impossible for a psychologist to be an expert in all facets of the profession. Professional judgement, self-awareness, and humility are important in maintaining professional competence and ethical practice.

How do you address a colleague? According to Johnson et al. (2013), the APA Code of Ethics does not require psychologists to assist when another psychologist in the community suffers from PPC. Further, the authors indicated that many psychologists reported being reluctant to intervene when they notice an impaired colleague. Some jurisdictions have Colleague Assistance Programs; however, some have been discontinued due to mandatory reporting concerns and psychologists not seeking help in fear of being labeled impaired or incompetent (Barnett & Hillard, 2001). Some may want to be more direct but need more guidance on how to do so sensitively, respectfully, and professionally. Brodsky and McKinzey (2002) offer sample letters to address an unethical colleague when such a scenario arises. These samples facilitate a dialogue with the person that is polite, respectful, and devoid of shame. However, the authors ultimately note that complaints may often best be handled by the state licensing board in order to be effective.

Continuing Education and Competence

Self-assessment of competence should begin early in training and continue through the lifespan. Roberts, Borden, Christiansen, and Lopez (2005) outline a model for the assessment of competence which can be used at different stages throughout one's trainee and career. Standard 2.03 (Maintaining Competence) notes psychologists "undertake ongoing efforts to develop and maintain their competence" (APA, 2017, p. 5). Both maintaining and enhancing one's competence is essential (Barnett et al., 2007).

How do you know what you don't know? Barnett et al. (2007) note that self-assessment requires a personal awareness that one has a deficit in education, training, and self-directed learning. This is particularly challenging, as it is often

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difficult for individuals to identify their blind spots. The reason why issues of professional competence are often discussed during graduate-level training is students are under the watchful eye of their supervisors, professors, and mentors. However, psychologists often do not have that luxury of oversight and support. Peer consultation may be an arena in which this work can continue. Continuing professional education is also essential. Continuing professional education has been defined as a "loosely federated assortment of professional activities, roles, and responsibilities that provide opportunities for psychologists to engage in new learning and to keep pace with the increasingly rapid changes in their fields" (Neimeyer, Taylor, & Cox, 2012, p. 476). At the time of their writing, Neimeyer and colleagues noted 44 jurisdictions in the United States have mandated some continuing education requirement for licensure renewal. In addition, some have proposed further education and credentialing as a potential solution to ensuring professional competence (Kaslow et al., 2004; Nelson, 2007), which could be in the form of certifications and board certification. However, as previously stated, only a small percentage of psychologists have board certification (Johnson et al., 2012).

Personal stressors can also impact professional competence. Trainees and psychologists are not immune to the stressors of life and illness. Bamonti and colleagues (2014) suggest self-care should be an aspect of professional competency, citing Standard 2.05 (Personal Problems and Conflicts) and Principle A (Beneficence and Nonmaleficience) of the APA Code of Ethics (2017) as rationale.

Conclusion

Psychologists are held to a high standard of professional competence given the sensitive nature of their work and the potential for high-stakes impact. Problems in professional competence not only impact direct service to clients but can impact the public's perceptions of the field of psychology. Professional competence requires regular self-assessment and self-reflection on acquisition and maintenance of the skills, abilities, and training needed to perform effectively as a psychologist throughout one's training and career.

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1968 2018
50TH ANNIVERSARY
Society for the Advancement of Psychotherapy

WASHINGTON SCENE

"Rockin' Pneumonia"

Pat DeLeon, PhD
Former APA President

Advancing Practice Together

Just prior to the last winter blast striking our nation's Capital, I was very fortunate to be able to attend the 35th annual APAPO Practice Leadership conference, along with former APA Presidents James Bray and Carol Goodheart. These gatherings are always the highlight of my professional year and it was especially exciting this year to experience the genuine enthusiasm generated by so many first time attendees and APAGS students. Katherine Nordal will be leaving APA after a decade of service, not to mention serving in a variety of roles, including as an APA Congressional Fellow. The 350 attendees were constantly expressing their gratitude for all that she had accomplished and her willingness to strategically "disrupt" our thinking so that collectively, we could seek greater heights. As Katherine would say during the Opening Reception, psychology can make a real difference to so many people and we should appreciate that we *do* save lives. It was a particular delight that President Jessica Henderson Daniel presented long-time state association advocate Mike Sullivan with an APA Citizen Psychologist Presidential Citation. This is a well-deserved tribute. Dan Abrahamson and Susan Lazaroff did an outstanding job. The future *is* bright.

Integrated-Interprofessional Health Care

One of the foundations of President Obama's Patient Protection and Affordable Care Act (ACA) was a visionary emphasis upon fostering team-based interprofessional care, with behavioral health being increasingly integrated into primary care. Linda Campbell was one of the original architects of a quality psychopharmacology training program for those interested in obtaining prescriptive (RxP) authority. She worked closely with her pharmacy colleagues at the University of Georgia—a training model that continues to serve psychology admirably. Linda's report on her most recent initiative: "In 2016, I joined with Dr. Edward Delgado-Romero and Dr. Linda Logan who are faculty at the University of Georgia to begin an integrated behavioral health practicum at Mercy Health Center in Atlanta, Georgia. Dr. Delgado-Romero and I are counseling psychology faculty members and Dr. Logan is a School of Pharmacy and College of Education faculty member. Prior to the inception of this integrated training experience, we worked together in the department's training clinic for 10 years, developing an integrated training model for doctoral and masters students. The department training clinic includes advanced nursing students from the Augusta School of Nursing. This program is still growing and is a popular rotation for pharmacy and nursing students.

"Mercy Health Center is a health care clinic for the underserved populations who have no insurance; no Medicare, Medicaid, or any other means of paying for health care. Except for a small employee staff, over 70 physicians, dentists, and other medical specialists devote pro

continued on page 60

bono time to serve the population. We took our model from the department training clinic to Mercy where we work with Kristi Gilleland, the Whole Person Health Coordinator, and Tracy Thompson, CEO. Together, we have developed an integrated staffing of pharmacy, social work, legal consultation, nutrition, and specialty medical services. The training model includes individual behavioral health services, chronic illness groups, and pre- and post-therapy groups to ensure health promoting behaviors are secured before termination. All patients are rural and low SES (socioeconomic status), but additionally about 30% are Spanish speaking patients who are seen by Spanish speaking doctoral students supervised by Dr. Delgado-Romero. Dr. Logan provides consultation for all patients seen in the model training program and I provide supervision for English speaking patients primarily and focus on the low SES population.

"Our program is a win-win because hundreds of patients are receiving behavioral health services, students are being trained in an integrated model, and the faculty are collecting data to determine the added effectiveness of behavioral health within primary care services. The clinical training program and the research training program are called IMPACT. The faculty, Mercy staff, and students are totally committed to make this impact happen."

APA appreciates the significance of this evolution for education and practice. Jim Diaz-Granados: "The Education Directorate recognizes the value of interprofessional education and training. This is evidenced by our active participation in a number of interprofessional organizations. The APA is a liaison member on the Federation of Associations of Schools of the Health Professions that serves as a forum to encourage effective collaboration among health professions in education and practice. The Directorate is also a member of the National Academy of Medicine's Global Forum on Innovations in Health Professions Education, an ongoing convening activity that brings together stakeholders from multiple nations and professions to network, discuss and illuminate issues within health professional education with a focus on interprofessional education. In 2016, APA joined the Interprofessional Education Collaboration (IPEC). The IPEC was formed in 2009 by six organizations committed to advancing interprofessional learning experiences and promoting team-based care. In 2016, IPEC appointed 14 additional members, including the APA. Our CEO Arthur Evans and APA Presidents Tony Puente, Susan McDaniel, and Jessica Henderson Daniel have accompanied the Education Directorate leadership to the IPEC biannual council meetings.

"Similarly, in April 2017, the APA Commission on Accreditation joined the Health Professions Accreditors Collaborative (HPAC). The HCAP was founded in 2014 by the accreditors for medicine, pharmacy, nursing, dentistry, and public health and expanded in 2017 to include 17 additional organizations committed to working together to advance interprofessional education, practice, and quality. In addition to membership in key interprofessional groups, under the leadership of then APA President Susan McDaniel, the curriculum for an Interprofessional Seminar on Integrated Primary Care (IS-IPC) was developed. The IS-IPC is a resource that can be used to develop educational experiences for an interprofessional group of learners about the competencies needed to work together in a successful and integrated healthcare team.

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The next opportunity on the horizon is that of interprofessional continuing education. Currently, the Joint Accreditation for Interprofessional Continuing Education offers organizations to be simultaneously approved to provide medical, nursing, pharmacy, and optometry continuing education. In the Education Directorate we are currently exploring the possibility of adding psychology to the mix."

Prescriptive Authority (RxP)

As psychology becomes more involved in integrated and interprofessional care, we are confident that the movement towards obtaining RxP will increasingly mature. At the APAPO Practice Leadership conference Beth Rom-Rymer chaired the concurrent workshop "The Revolution in Health Care: Prescribing Psychologists" where the five successful state associations described how each of their approaches reflected unique needs and circumstances. Subsequently, Armand Cerbone reflected upon their journey in Illinois: "In 2004 when I became President of the Illinois Psychological Association (IPA), the RxP initiative was languishing. Having already obtained his authorization in New Mexico, former IPA President Marlin Hoover was the RxP chief advocate. Yet he found little traction among our Council representatives. He indicated he was losing his enthusiasm. Believing that RxP was important, even critical, to the future of psychology, I met with Marlin to bolster his commitment and to plot to advance his proposal and to encourage him to press our Council further.

"Together we engaged the IPA Council in debate over a motion to adopt as its #1 legislative priority seeking RxP for Illinois psychologists. There was considerable resistance among Council members citing negative changes to the profession and its values and concerns for the medicalization of psychology. There were anxieties that prescribing would open the door to abuse of prescriptive authority by unprincipled psychologists interested only in financial gain. Those who favored such an initiative noted remedies for persons not able to afford or access psychiatric care, improved care stemming from the advantages of consulting with a psychologist with similar training than with a medical doctor, and improving competitiveness in the marketplace. One proponent of RxP argued that prescriptive authority would broaden a 'safety net of care' for clients and patients.

"Given that in 2005 our Council was composed of middle- to late-career professionals, I polled our IPAGS representative for his opinion. His support for RxP was clear. RxP would provide opportunities for new psychologists and strengthen professional credibility in medical settings. In remarking that there was already considerable emphasis on the biological bases to behavioral health he said it seemed smart to consider how RxP could open doors to the future. I believe the voice of young people, new to or entering the profession, swayed the fence-straddlers among the representatives. When the vote was called, the motion carried by a clear majority. IPA was now committed to RxP.

"Over the next few years Marlin developed a video of interviews with psychologists who had or were pursuing RxP and one Illinois psychiatrist who supported the movement for psychologists. While the video captured important arguments, it lacked production values that reduced its effectiveness. More importantly, psychologists of color were noticeably absent. Much was learned from those initial efforts. It would require more financial and political resources than IPA had at the time.

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And passing RxP legislation in the AMA's backyard would be daunting.

"When Beth Rom-Rymer assumed the leadership of IPA, she provided the determination and political savvy the initiative needed. IPA's commitment hadn't wavered but needed the single-minded energy Beth brought. Beth was also able to pull together from sundry sources the essential financial resources to hire well-established and respected lobbyists to work exclusively for the passage of RxP legislation in the Illinois legislature. I remember one fund-raising event at her home for the reelection of a Democratic Governor who was likely to sign any RxP legislation that passed the legislature. Traveling around the state, Beth met with anyone who would meet with her to garner support for RxP and to calm the dubious and rebut the opposed.

"That RxP is law in Illinois is a measure of Beth's skill as a resourceful and effective leader. Illinois would not be among the states with prescriptive authority were it not for her efforts. Adding Illinois to the roster surely provides encouragement and momentum to the national movement. Beth was able to capitalize on ground that had been tilled. What resistance she encountered was from the rank and file who needed the education and leadership she provided. Several important factors emerged from Illinois' experience. As much as vision, unwavering commitment, and capable leadership are critical, it is equally important – at times even more important – to have a grasp of local politics and the financial resources adequate to the objective. Setbacks happen; movements can stall. Keep your eyes ever on the prize."

Investing in Our Next Generation
During this year's deliberations on the FY 2018 Appropriations bill for the Department of Health and Human Services increased funding was provided for two programs within the Health Resources and Services Administration which should be of particular interest to those colleagues concerned about our nation's children. Ten million dollars was included for a *new* initiative to expand access to behavioral health services in pediatric primary care by developing pediatric mental health care telehealth access programs. And, $22.3 million was provided for EMSC. On its 10th anniversary, C. Everett Koop noted: "I am pleased to remember that in 1984, while I was U.S. Surgeon General, the United States Congress passed legislation to improve emergency medical services for children (EMSC). It received my full support and that of many of my colleagues, because critically ill and injured children were not receiving the same high quality of emergency health care we provided for adults. But this is not unusual; throughout history children have not been our first priority." Neither initiative was in the Administration's budget.

On March 24th my wife and I joined a surprising number of neighbors at a local senior retirement community marching on behalf of the next generation ("March for Our Lives"). It was inspiring to see the number of elderly walking with their canes and/or a bit slower with their walkers, many with proud grandchildren alongside them. The signs were clear "Protect children, not guns!" As we went along a major thoroughfare, an impressive number of passing cars enthusiastically expressed their support. "Roll over Beethoven."

Aloha.

CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY 2018 AWARD WINNERS AND GRANT RECIPIENTS!

2018 Professional Awards

Distinguished Psychologist Award
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*. ■

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SAP/APF Early Career Award
Tony Rousmaniere

Tony Rousmaniere is Clinical Faculty at the University of Washington and has a private practice in Seattle. He hosts the clinical training website www.dpfortherapists.com, and is the author/editor of four books on clinical training: *Deliberate Practice for Psychotherapists*, *The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training*, *Using Technology to Enhance Counseling Training and Supervision: A Practical Handbook*, and the forthcoming *Building Psychological Capacity: A Deliberate Practice Handbook*. In 2017 Dr. Rousmaniere published an article in *The Atlantic Monthly* ("What your therapist doesn't know"). Dr. Rousmaniere provides workshops, webinars, and advanced clinical training and supervision to clinicians in the United States, the United Kingdom, Europe, Asia, and Australia. Dr. Rousmaniere supports the open-data movement and publishes his aggregated clinical outcome data, in de-identified form, on his website at www.drtonyr.com/outcome-data. Dr. Rousmaniere is an active member of the Society for Advancement of Psychotherapy (SAP), the Society for Psychotherapy Research (SPR), and the Society for Exploration of Psychotherapy Integration (SEPI). He was previously Associate Director of Counseling and Director of Training at the University of Alaska Fairbanks Student Health and Counseling Association. More about Dr. Rousmaniere can be found at www.drtonyr.com ■

SAP/APF Early Career Award
Catherine Eubanks

Catherine F. Eubanks is Associate Professor of Clinical Psychology at the Ferkauf Graduate School of Psychology of Yeshiva University. She also serves as Associate Director of the Mount Sinai-Beth Israel Brief Psychotherapy Research Program. Dr. Eubanks's research interests are in the area of psychotherapy process and outcome, in particular negotiating therapeutic alliance ruptures with patients with personality disorder features. The goals of her research program are to identify therapist skills and characteristics that are linked to effectiveness across various theoretical orientations, and to explore how therapists' skills can be enhanced through training.

Dr. Eubanks received the Dissertation Award from the Society for the Exploration of Psychotherapy Integration (SEPI) in 2007 and the Outstanding Early Career Achievement Award from the Society for Psychotherapy Research (SPR) in 2015. Dr. Eubanks currently serves as President-Elect of SEPI, and recently completed a five-year term as Executive Officer of the North American chapter of SPR. Dr. Eubanks is an Associate Editor for two journals, the *Journal of Consulting and Clinical Psychology* and *Psychotherapy Research*. She also serves on the editorial board of the *Journal of Psychotherapy Integration*. ■

Distinguished Award for the International Advancement of Psychotherapy
Rod Goodyear

Rod Goodyear, PhD., Counseling Psychology, University of Illinois at Champaign-Urbana) is a Professor at the University of Redlands as well as Emeritus Professor of Counseling Psychology, University of Southern California and was the 2015 President of the Society for the Advancement of Psychotherapy where his Presidential initiative concerned more fully internationalizing the Society. His scholarship has focused primarily on processes and outcomes in supervision and training, and secondarily on professional identity in counseling psychology. His book with Janine Bernard (Fundamentals of Clinical Supervision), in its sixth edition, is arguably the most widely used supervision book. His recent work has focused on the potential of deliberate practice for therapists (see Rousmaniere, Goodyear, Miller and Wampold's The Cycle of Excellence).

He was a member of the American Psychological Associations' task group that developed the Association's clinical supervision guidelines; and he received the American Psychological Association's 2015 award for Distinguished Lifetime Contributions to Education and Training. In the past five years his work has become increasingly international, with collaborations and training projects in Latin America, China, South Korea, and the U.K. ■

2018 Student Awards

SAP Student Diversity Paper Award
Katherine Morales

Katherine Morales is a rising third year doctoral student in the Counseling Psychology program at the University of Maryland, College Park. She and her advisor, Dr. Dennis Kivlighan, Jr., have collaboratively developed research projects that integrate his expertise in process and outcome of psychotherapy and her interests in the experiences of racial ethnic minorities. Her research interests include the study of the therapeutic alliance, cultural humility, and multicultural competency. In her leisure time, she loves to read, explore new foods, and travel. ■

SAP Donald K. Freedheim Student Development Paper Award
Brian TaeHyuk Keum

Brian TaeHyuk Keum is a PhD candidate in Counseling Psychology at the University of Maryland-College Park studying under Dr. Matthew J. Miller. Prior to beginning his PhD program, he received his MA in Counseling Psychology from Teachers College, Columbia University. His research interests include contemporary issues of discrimination and mental health correlates (such as online racism and gendered racism), stigma re-

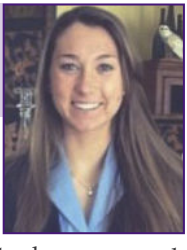
continued on page 66

duction and promotion of psychological help-seeking, psychotherapy process and outcome research on clients of color, and group perspectives in counselor training. Brian started his counselor training during his Master's at a community outpatient agency in lower east side of New York City serving primarily low-income immigrant clientele. Since then, he transitioned to providing counseling to college students and community-based clientele in the DMV area for the past four years. Brian is applying for his pre-doctoral internship this upcoming academic year. ■

SAP Jeffrey E. Barnett Psychotherapy Research Paper Award Michael Katz

Michael Katz is a rising fourth year doctoral student in Clinical Psychology at the Derner School of Psychology, Adelphi University. Michael began his research training with a focus on LGBTQ mental health as an MA student at the Academic College of Tel Aviv-Yaffo, under the supervision of Dr. Ofer Fein. His current research, under the mentorship of Dr. Mark Hilsenroth of Adelphi University, focuses on psychotherapy process and on the relationship between technique use, flexibility, and outcome within psychodynamic psychotherapy. Michael divides his time and attention between his growing second home in New York and his close family and friends in his home country, Israel. ■

SAP Mathilda B. Canter Education and Training Paper Award Taylor Groth



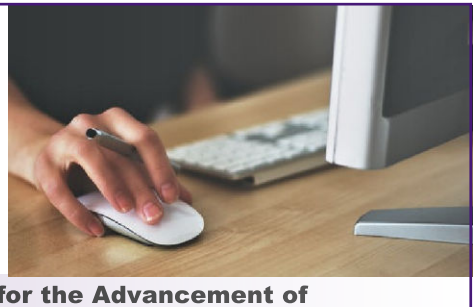
Taylor Groth will begin her third year in the Doctoral Program at the Derner School of Psychology at Adelphi University in the fall. Her Master's Thesis assessed psychologists' willingness to treat suicidal clients, and her dissertation will look at treatment outcome of adolescents with eating disorders. In the future, Taylor hopes to work with children and adolescents, as well as continue to do research. Aside from psychology, in her free time she likes to play soccer and spend time with her dog and family. ■

SAP Student Excellence in Practice Award
Mariafé Panizo Jansana

Mariafé Panizo is a doctoral student in the Combined Integrated Clinical and School Psychology program at James Madison University, Virginia. She is writing a dissertation on the Interpersonal Reconstructive Therapy (IRT)'s conceptualization and treatment of personality disorders, under the supervision of Dr. Ken Critchfield. During her doctoral training, Mariafé has practiced at several clinical sites, including Western State Hospital, where she is developing an IRT curriculum for group therapy with patients with severe mental disorders. In the future, she wishes to continue working with severely mentally ill adults and other vulnerable populations. Mariafé is originally from Perú, where she obtained a Bachelor's degree in Philosophy. In 2010, she moved to the USA to pursue a Master's in Psychological Sciences at James Madison University. ■

SAP Division 29 Student Excellence in Teaching/Mentorship Award
Alice Coyne

Alice Coyne is a rising fifth year graduate student in Clinical Psychology at the University of Massachusetts Amherst. Since beginning graduate school, she has worked in Dr. Michael Constantino's Psychotherapy Research Lab. Alice's research focuses broadly on psychotherapy process, outcome, and integration, common treatment factors, dyadic analysis of the patient-therapist relationship, therapist effects, psychotherapy training, and interpersonal theory. This work has been disseminated at several professional conferences and in empirical peer-reviewed publications. During her time as a graduate student, Alice has served as a teaching assistant for two undergraduate and two graduate courses. She has also served as a co-mentor for four undergraduate honors students who completed empirical projects focused on psychotherapy process and outcome research. Alice has also served as a methodology consultant for the Center for Research on Families at the University of Massachusetts Amherst. ■



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

2018 Grant Recipients

50th Anniversary Grant
Simon Goldberg

Dr. Simon Goldberg completed his PhD in counseling psychology at the University of Wisconsin - Madison under the mentorship of Drs. William Hoyt and Bruce Wampold. He completed his clinical internship at the Seattle VA and received postdoctoral training in health services research at the Seattle VA and the University of Washington. Simon will begin a position as assistant professor in the Department of Counseling Psychology at the University of Wisconsin - Madison in August, 2018. Simon's work focuses on factors common across psychotherapies, with a particular emphasis on therapists' contribution to outcome. He is also interested in the effects of mindfulness- and meditation-based interventions and military veteran mental health.

Dr. Goldberg will be using the 50th Anniversary Grant to examine correlates of therapist differences (i.e., therapist effects) in naturalistic psychotherapy. His study will involve assessment of a variety of candidate therapist characteristics, including administering several non-self-report behavioral and performance tasks. These measures will be used to predict the outcomes of patients treated by these therapists. He hopes to provide information regarding therapist factors that are associated with superior outcomes in psychotherapy that can be used to inform personnel selection and training. ■

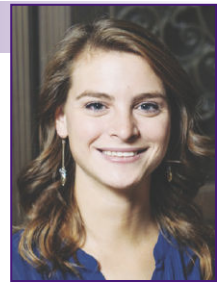
2018 Norine Johnson Research Grant
Sigal Zilcha-Mano

Sigal Zilcha-Mano is a licensed clinical psychologist, Associate Professor of Clinical Psychology at the Department of Psychology, University of Haifa, and a Visiting Associate Professor at the Healthy Aging and Late Life Brain Disorders Program, Columbia University. She heads the Psychotherapy Research Lab at the Department of Psychology, University of Haifa. She is Associate Editor of the Journal of Counseling Psychology, and on the editorial board of Psychotherapy, and of Psychotherapy Research. Her research focuses on active ingredients in psychotherapy and in the placebo effect, which bring about therapeutic change, including the working alliance and the expectancy regarding treatment progress. She investigates the distinct roles these active ingredients may play in different treatments and for different patients, with the aim of laying the foundation for evidence-based, patient-tailored treatment.

Dr. Zilcha-Mano is the recipient of the International Society for Psychotherapy Research Outstanding Early Career Achievement Award, and the Dusty and Ettie Miller Fellowship for Outstanding Young Scholars. She has received several research grants to support her work, including the Fulbright Fellowship (working with Jacques Barber at Adelphi University), as well as research and equipment grants from the Israel Science Foundation and from the U.S.-Israel Binational Science Foundation (BSF). The Norine Johnson, PhD, Psychotherapy Research Grant gives her the opportunity to investigate the effects of therapist's use of techniques to counter and complement the patient's attachment orientations, and to examine its potential contribution to optimizing the efficacy of treatments for depression. ■

2018 Charles J. Gelso, Ph.D., Psychotherapy Research Grants
Three recipients in 2018

Elizabeth Demeusy



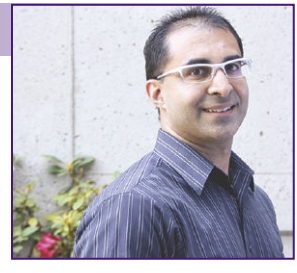
Elizabeth Demeusy, M.A. is a doctoral candidate in the Clinical Psychology program at the University of Rochester. Her research interests broadly focus on evidence-based prevention and intervention programs for high-risk youth, specifically those impoverished and with experiences of trauma. In particular, she is interested in child maltreatment prevention and the development of externalizing behavior problems in young children.

With this grant, Elizabeth plans to conduct a follow-up study on a multi-component preventative intervention designed to prevent child maltreatment and support healthy development in newborns of young mothers, for her dissertation. Following graduation, she hopes to continue this line of research by pursuing a career that focuses on the dissemination and implementation of evidence-based practices for disadvantaged children and families. ■

Sigal Zilcha-Mano

Please see bio on page 68.

Robinder (Rob) P. Bedi



Dr. Robinder (Rob) P. Bedi is an associate professor of counselling psychology In the Department of Educational and Counselling Psychology and Special Education at the University of British Columbia. He has been designated a Senior Research Fellow of the Indian Council of Cultural Relations and a University of British Columbia Leading Edge Scholar. Dr. Bedi's current research interests include multicultural and cross-cultural counselling and psychotherapy, particularly in India or with individuals of Asian Indian descent and he conducts research both in India and in North America. ■

International Research Grant for Students and Early Career Professionals

Yuye Zhang

Yuye Zhang is a third-year doctoral student in counseling psychology at Ball State University. Originally from China, she is interested in the counseling process with Chinese clients, especially the Chinese cultural influences on clients' emotional experience in psychotherapy. She is keen on bridging the research-practice gap. ■

Diversty Research Grants

Shondolyn Sanders

Shondolyn is a fourth year Counseling Psychology doctoral student at the University of Memphis. She received a M.S in Counseling (Clinical rehabilitation) from the University of Memphis and a B.A. in Psychology from the University of Arkansas at Fayetteville. She was born and raised in West Memphis, AR and is the oldest of 5. Her research areas of interest include multicultural supervision and training, chronic illness adjustment, the transitioning of children with disabilities to adulthood, and health disparities specific to ethnic/racial minority individuals. Her dissertation focuses on the supervision experiences of ethnic minority psychology graduate students. She is currently a pre-doctoral intern at the University of Oklahoma Health Sciences Center-VA track. Her favorite pastime is being the best aunt ever. ■

Joey Sergi

Joey Sergi is a fourth year Clinical Psychology doctoral student at Ferkauf Graduate School of Psychology, Yeshiva University. She holds a Master's degree in Clinical Psychology from Ferkauf and a Bachelor's degree in Anthropology from Wagner College. She is currently a pre-doctoral extern at the Manhattan Veterans Affairs Medical Center where she is working on developing an integrative approach to treatment that balances the common factors across therapeutic approaches. Joey's research interests include the therapeutic alliance, therapeutic rupture and repair, and multicultural and cross-cultural psychotherapy, especially with individuals who identity as sexual minorities. Her dissertation will explore the impact of therapist-committed microaggressions on the therapeutic alliance for LGBTQ individuals. Through this project, she will examine the effect of therapist attempts to acknowledge and resolve these difficult moments when they occur in session. Ultimately, Joey hopes that the findings of her study will contribute to enhancing therapeutic outcomes for clients of diverse backgrounds by allowing her to develop an empirically-supported and culturally sensitive rupture-repair framework to aid clinicians in working cross-culturally. ■

APA Division 29 (Society for the Advancement of Psychotherapy) has opened nominations for the editorship of the Division journal, *Psychotherapy*

The Editor would lead a very active and able group of Associate Editors and ad hoc reviewers.

Qualifications include:

- Open-mindedness and respect for contributions from all facets of (training, practice, theory, research) and vantage points on (e.g., theoretical orientation, treatment modality, patient population) psychotherapy
- Extensive experience with the peer-review process at different levels of administration (e.g., ad hoc, editorial board, associate editor)
- Creative vision for the journal's short- and long-term future
- Strong leadership, staff selection, and communication skills
- Member of Division 29, in good standing throughout the term of the contract

This will be a 5-year term. Candidates should be available to start receiving manuscripts as the Incoming Editor on January 1, 2020 to prepare for issues published beginning 2021, when their editorial office will assume the masthead. The current editorial office will be responsible for publishing the 2020 volume (57).

The new editor will receive manuscripts through December 31, 2024, publishing in the years 2021 (volume 58) through 2025 (volume 62).

Editorial responsibilities take 15–20 hours/week.

An honorarium, office expenses, and APA support are provided.

Please note that the Society for the Advancement of Psychotherapy encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations are also encouraged.

Laurie Heatherington, PhD, Division 29 Publication Board Chair, will chair the search. Please address inquiries to her.

Please go to APA's Editor Search website to enter the candidate's name and a brief statement of support.

The deadline for accepting nominations is August 1, 2018, when initial reviews will begin.

The search committee will contact nominees to assess interest and request additional materials by mid August, Skype interviews will be conducted at the end of the second week in September, and, if needed, in-person interviews will occur in February.

Final decisions will be announced by March 1, 2019.

ABOUT THE JOURNAL

Psychotherapy is a highly ranked clinical psychology journal, published quarterly. It publishes a wide variety of articles relevant to the field of psychotherapy.

Encompassing the many essential elements of psychotherapy, the journal strives to foster contributions from and interactions among individuals involved with training, practice, theory, and research. Thus, articles in Psychotherapy include theoretical contributions, original research, novel ideas, and examples of practice-relevant issues that would stimulate dialogue and/or debate among theorists, therapists, and researchers.

The journal includes the widest scope of orientations to inform the readership. See the Psychotherapy website for more information.

http://www.apa.org/pubs/authors/call-for-nominations.aspx

Society For The Advancement Of Psychotherapy

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY

MEMBERSHIP APPLICATION

The Society meets the unique needs of psychologists interested in psychotherapy. By joining the Society for the Advancement of Psychotherapy, you become part of a family of practitioners, scholars, and students who exchange ideas in order to advance psychotherapy. The Society is comprised of psychologists and students who are interested in psychotherapy. Although the Society is a division of the American Psychological Association (APA), APA membership is not required for membership in the Society.

JOIN THE SOCIETY AND GET THESE BENEFITS!

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DIVISION 29 PROGRAMS

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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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