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PSYCHOTHERAPY BULLETIN

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PRESIDENT'S COLUMN

Thank you, Division 29 Friends and Colleagues

Michael J. Constantino, PhD
University of Massachusetts Amherst

My plan was to write this third Presidential Column immediately after APA Convention, so that I could report, first hand, on what was sure to be a satisfying, productive, and festive set of events for our Society. Instead, I am writing with a heavy heart, having had to miss the Convention when my dear cat became ill. In an interesting coincidence, I was having her euthanized at the exact time that I would have been delivering my Presidential talk. Although this is, of course, profoundly sad for me, what I want to discuss here is how fortunate I feel to be part of the tremendous family that is our Society.

Although I have often referenced Division 29 as a *professional* home, I am now keenly aware that my connection to it is so much more expansive. On a *personal* level, I felt so incredibly supported and helped when I broke the above news to my Division friends and colleagues. Thank you, all, for your well wishes and expressions of sympathy. They have meant so incredibly much to me. I would also like to thank individually a few people who went above and beyond to cover my varied responsibilities in my absence.

Thank you, Tracey Martin (our extraordinary SAP administrator), for telling me with compassion and certainty that the "shows" would go on without me, and for coordinating every detail to ensure that they did. Thank you, James Boswell (my long-time friend and collaborator), for delivering my presidential talk and helping to coordinate and administer the Society's inaugural student poster award competition. Thank you, Alice Coyne (my graduate student), for delivering another one of my talks, and Nick Morrison (my graduate student), for announcing the student award winners. Thank you, Jeff Zimmerman and Nancy Murdock (my Presidential trio friends and colleagues) for helping to host the highly successful award ceremony and special 50th anniversary social hour. I hear that the slide show, swag, and cake were all hits! Also, thanks to Leigh Ann Carter, for adjusting the "master's" lunch on the fly (and for raffling off a symbolic 29 books—what a great event!), and to Jean Birbilis and Barbara Vivino, for stepping up as poster award evaluators. I'm sure I am missing others, but suffice it to say that I have widespread appreciation and affection for my entire Division 29 crew allowing me to focus solely on my crisis at home.

Of course, I was tremendously disappointed to miss the Convention, as I was looking forward to it for quite some time. I feel that some of the most exciting tasks as Division 29 President are to MC the award ceremony, host the social hour, and lead the Presidential symposium. It was such a shame to be unable to carry out these functions (as well as others), but I now have a chance to congratulate some well-deserving members in this column. I am pleased to have this space to do so.

First, although this may now be "old news," I would like to congratulate again the following winners of this

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year's election cycle for positions within our Society's governance:

Jennifer Callahan, President-Elect

Jesse Owen, Treasurer

Manijeh Badiee, Domain Representative for Diversity

Marilyn Cornish, Domain Representative for Education and Training

Jean Birbilis, Domain Representative for Membership

Barbara Vivino, Domain Representative for Psychotherapy Practice

I would also like to thank *all of the candidates* for their willingness to run, which is a major service to our Society in itself. And thank you, members, for voting!

Additionally, I would like to acknowledge our outgoing governance members; that is, those whose terms are up at the end of this calendar year:

Jeff Zimmerman, Presidential Trio

Barbara Thompson, Domain Representative for Psychotherapy Practice

Jennifer Callahan, Domain Representative for Education & Training

Tony Rousmaniere, Continuing Education Committee Chair

Barbara Vivino, Psychotherapy Practice Committee Chair

Gary Powell, who did double duty as both Domain Representative for Diversity, serving out the remainder of Beverly Greene's term, and as Program Chair for the past 2 years.

Much gratitude for all that you have done for this organization, and we hope that you will stay involved in other new and exciting ways (and for those just voted into a position, you have no choice!).

Second, a big, heartfelt congratulations to all of the following 2018 award and grant winners:

Distinguished Psychologist Award: Jacques Barber

American Psychological Foundation/ Society for the Advancement of Psychotherapy Early Career Awards: Catherine Eubanks and Tony Rousmaniere

Distinguished Award for the International Advancement of Psychotherapy: Rod Goodyear

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

Mathilda B. Canter Education and Training Student Paper Award: Taylor Groth

Diversity Student Paper Award: Katherine Morales

Jeffrey E. Barnett Psychotherapy Research Paper Award: Michael Katz

Division 29 Student Excellence in Practice Award: Mariafé Panizo Jansana

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

SAP Student Poster Award Winners: Alyssa Clements-Hickman and Jazmin Gonzalez

The *Psychotherapy* Most Valuable Paper Award: John Norcross, Barrett Zimmerman, Roger Greenberg and Joshua Swift

The Norine Johnson, PhD, Psychotherapy Research Grant: Sigal Zilcha-Mano

Charles J. Gelso, Ph.D. Psychotherapy Research Grants: Elizabeth M.

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Demeusy, Robinder P. Bedi, and Sigal Zilcha-Mano

Society for the Advancement of Psychotherapy 50th Anniversary Grant: Simon Goldberg

Diversity Research Grants for Pre-Doctoral Candidates: Shondolyn Sanders and Joey Sergi

International Research Grant for Students and Early Career Professionals: Yuye Zhang

Finally, congratulations to our new Fellows, Andres Consoli, James Boswell, Timothy Anderson, and Barry Wolfe!

I hope to see many of you next year in Chicago, if not beforehand. And, of course, my circumstances should be much happier then, in part because of all of the good thoughts and sentiments being sent my way during this difficult time.

Thank you, again, Division 29 Friends and Colleagues.

EDITORS' COLUMN

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Welcome to the penultimate issue of *Psychotherapy Bulletin* for 2018!

As you will see in this issue, the Society for the Advancement of Psychotherapy was well represented at the APA Convention in San Francisco this year, and we enjoyed seeing many of you there. Make sure to read SAP President Mike Constantino's Column for Convention "thank you"s and highlights, including SAP Award Winners, as well as Governance election results.

This issue of the Bulletin has a little something for everyone, from students (don't miss pieces by our two Student Excellence Award winners), to Early Career professionals, to those at later stages of their careers. First up, a Special Feature on disclosure and concealment among court-involved adolescents. In addition, we are pleased to offer a variety of submissions related to our Special Focus of "Turning Points," including an excerpt from an upcoming web-exclusive piece in which Dr. Philip Friedman reflects on 50 years of psychotherapy practice emphasizing practice-based evidence and effectiveness, as well as a Psychotherapy Practice article with pragmatic tips on closing a private practice (and, if you find that helpful, please check out *next* issue's piece on retirement myths). As always, don't miss the announcements, Domain updates, and other SAP business found throughout the Bulletin and on our website (http://societyforpsychotherapy.org/).

Of course, some turning points are harder than others. We would like to thank Dr. Lisa Wallner Samstag for this issue's thoughtful Remembrance of Dr. Jeremy Safran, and offer our condolences to the many SAP members, readers, and countless others whose lives he touched.

Please consider contributing your work and ideas to *Psychotherapy Bulletin*. The deadline for the final issue of the year (and the last deadline for our "Turning Points" theme) is November 1, 2018. Submission guidelines can be found on the website (http://societyforpsychotherapy.org/publications/bulletin/about/).

We look forward to hearing from you!

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SPECIAL FEATURE

Disclosure and Concealment Among Court Involved Adolescents: A Case Study

Daniel R. Samost, MA
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From Freud to present, clinicians and researchers have consistently viewed honest disclosure as an essential component of a patient's therapeutic process (Baumann & Hill, 2016; Farber, 2003). However, despite practitioners' best efforts to emphasize the importance of honest dialogue, client concealment has been found to be a common occurrence (Baumann & Hill, 2016; Farber, 2003; Kelly, 1998; Kelly & Yuan, 2009). Client concealment can be defined as any active or passive effort made by the client to avoid disclosure of significant information and can be manifest in many ways, including outright lying, minimization or exaggeration, and secret-keeping or omission of key information..

Despite the growing number of studies on client concealment, there has been limited focus on identifying populations who might be more prone to concealment, and for whom such concealment could be harmful. Thus, the purpose of this case study is to highlight one potentially vulnerable high-risk population—that of court- involved adolescents—as a means to provide a deeper understanding of how to best approach the challenge of disclosure with this group.

Case Presentation

L is a young black male in his late teens currently on parole and enrolled in a mandated harm-reduction therapeutic group for court-involved adolescents. While L meets the criteria for impairments in interpersonal functioning required for a diagnosis of Antisocial Personality Disorder (APD), much of his personality and behavior can be understood by considering the influence of his socioeconomic and sociocultural environment. L lives in a poor urban neighborhood, and is currently unemployed. L never met his father and, since losing his mother to an overdose early in his life, has lived with his abusive and aloof male relative. Due to a lack of parental supervision, L quickly became involved in gang and criminal activity. After being arrested, he spent a year in prison before being released on parole and enrolling in the group. L adheres to a heteronormative, homophobic masculine image and is aggressive in retaliating to any challenge of his masculinity. Within the group environment, L is competitive and routinely claims his superiority to other members due to his capacity for physical violence and the quantity of his sexual relationships.

A few months after joining the program, L was arrested. After getting released on bail, he returned to group. When questioned by his program counselor (PC) about the incident, L provided a particular version of the story in which he painted his physical altercation with an intoxicated individual as self-defense. The PC had already been informed by L's parole officer and lawyer that there was evidence indicating differently, but chose not mention the communications

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to L. Aware that L was concealing the truth, the PC did not press for further information, but rather attributed L's deception to lack of trust in the therapeutic relationship. Because L had repeatedly told the PC in group that he had difficulty trusting, the PC knew that honest disclosure would only occur if L believed that the PC was trustworthy. In an effort to strengthen their therapeutic relation, the PC decided to attend L's court date. While it was not unheard of for a PC to attend court if a participant were re-arrested, it was not routine as a PC's presence had no real effect on the outcome of the case. Regardless, the PC went to demonstrate his support for L. When L's case was finally heard, the only individuals in the courtroom to support L were the PC and L's lawyer.

Following the hearing, the PC met up with L. In response to the PC's unexpected support, L acknowledged how grateful he was that the PC "had [his] back." Following some discussion of the court proceedings, the conversation returned to the arrest incident. Without any prompting by the PC, L provided a different story of incident. He revealed that he had initiated the physical altercation following a particular insult and an "invasion" of personal space. The PC noted that L's willingness to disclose previously concealed information was likely due to the support felt during the court hearing. In the sessions that followed, the PC experienced a more open dialogue L and saw him participate more in group. The PC was even able to utilize the new details of the story to start a conversation about identifying triggers that could lead L to impulsive and dangerous behavior.

Application and Analysis

As seen in this case study, and consistent with the findings of Farber and Hall's (2002) research, the strength of the therapeutic alliance had a positive effect on L's willingness to disclose. However, the particular importance of this case study lies not in the disclosure per se, but rather achieving it with a participant from a highly vulnerable, clinically guarded population. Thus, it becomes important to examine all influences that led to the original concealment, as well as what actions influenced the change in the client's willingness to disclose.

Motivation for Concealment

When investigating L's motivation for concealment, several key factors should be considered: the subject matter of the concealed information, the influence of adolescence on concealment, and the relationship between incarceration and concealment.

The information that L concealed was the criminal activity that led to his new arrest. Among studies that have investigated client motivation for concealment, shame has often found to be the primary motivation (Baumann & Hill, 2016; Farber, 2003; Han & O'Brien, 2014; Hook & Andrews, 2005; Kelly & Yuan, 2009). One of the major ways that the criminal justice system attempts to deter individuals from pursing criminal activities is by promoting strong public stigma against criminal activity (Funk, 2004). However, this means of social control becomes a double-edged sword that can bring disproportionate and overwhelming shame to those who are in involved with the criminal justice system (Kohm, 2009). Thus, a clear pathway linking concealment, shame, and criminal activity becomes visible; that is, the strong social stigma associated with criminal behavior could have been a factor that initially made disclosure (to an "establishment" figure) too shameful for L to consider.

As Church (1994) notes, "Because of their desire for autonomy, adolescents

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may be very sensitive to situations where they believe others are asserting their power or authority" (p. 105). Because of a therapist's position of power within the relationship, adolescents may view the therapist as an enemy. Such assumptions can have negative effects on trust and the therapeutic relationship, two factors that have been shown to influence disclosure and concealment (Kelly & Yuan, 2009; Farber & Hall, 2002). Given L's age, his concealment can be seen as a somewhat normative means of maintaining autonomy and preventing authority-based action against his personal freedoms (Church, 1994). Moreover, adolescents rarely engage in treatment on their own accord; rather, therapy is often mandated by some authoritative power such as parents/guardians, school counselors, parole officers, or judges (Oetzel & Scherer, 2003). Without choice, adolescent clients lack genuine intrinsic motivation, making participation and honesty potential issues (Sommers-Flanagan & Sommers-Flanagan, 1995). In mandated cases, adolescents can feel that there is no need to be in treatment (Oetzel & Scherer, 2003) and often retaliate with disruptive or manipulative behavior (Sommers-Flanagan & Sommers-Flanagan, 2014). Given this, L's mandated attendance in group may have been another factor that prompted his concealment.

Much like adolescents, forensic populations are known to distrust clinicians (Marlow, White, & Chesla, 2010). In an investigation into formerly incarcerated individuals' perceptions of clinical services, Marlow et al. (2010) noted that there exists a strong distrust of the health care system, one often stemming from experiences of discrimination that arose after their criminal history was revealed. L's concealment becomes more understandable when viewed in this context. Additionally, among court involved populations, social evaluative concerns in relation to masculinity have been found to influence concealment and disclosure (Cruddas, Gilbert, & McEwan, 2012; Larson, Chastain, Hoyt, & Ayzenberg, 2015). Due to the unique power structures within prison, a strictly defined heterosexual masculinity plays a major role during social interaction, social positioning, and identity formation (Iwamoto et al., 2012). One of the key aspects of this masculine persona is dissociation from perceived feminine qualities, including help-seeking behaviors. Prisoners who seek mental health services are perceived as feminine and can become targets within prisons due to their vulnerability. In order to protect themselves, prisoners often conceal issues and avoid disclosures that could be misconstrued as weakness (Iwamoto et al., 2012). Thus, L's concern with the social evaluation of his masculinity, stemming from his history of incarceration, could have also influenced his initial decision to conceal the details of his arrest.

Achieving Disclosure

When analyzing the disclosure, another focus should be on the PC. First, the choice by the PC to not reveal awareness of the concealed information was a calculated decision. The PC felt that contradicting or confronting his client could have been perceived as spying or a challenge to his independence, in turn weakening the therapeutic relationship (Sommers-Flanagan & Sommers-Flanagan, 2014). Additionally, the PC's choice to increase trust building following an incident of known deception reflects a preparedness to expect concealment and demonstrates the temperament needed to work with this often volatile population. Because it has been found that therapists hold a number of negative attitudes towards deceptive clients (Curtis & Hart, 2015), individuals working

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with clients prone to concealment should be aware of such tendencies and do their best to remain unbiased.

Given that L chose to only disclose after his court appearance, it can be argued that whatever action the PC took was a major cause for the change in L's behavior. Thus, it seems that the PC's initial acceptance of L's story as well as his active support positively affected the therapeutic relationship and made L feel comfortable enough to disclosure. Given L's lack of parental support and distrust of service providers, the PC was most likely aware of the significance that his voluntary appearance would have on L, recognizing this as an opportunity to display his trustworthiness. The PC planned this nontraditional "intervention" as a means to increase engagement, and did so with L's specific history and needs in mind.

Increasing Disclosure

In the case example, the PC focused on demonstrating trustworthiness as a means of strengthening the therapeutic relationship, which in turn resulted in a significant disclosure followed by more open dialogue in subsequent sessions. Maintaining a supportive presence, as the PC did, is just one example of a technique that can strengthen the therapeutic alliance and increase honest disclosure. In discussing a client who was sexually abused, Balmforth and Elliot (2012) concluded that therapists can play an active role in disclosure through the use of appropriate responsiveness following potentially concealed information. Oetzel and Scherer (2003) found that the therapeutic alliance with adolescents can be strengthened by deconstructing stigmatized beliefs and allowing the client to choose what is discussed. They argued that giving adolescents such autonomy could lead to a decrease in treatment resistant behaviors, including concealment. Specifically for court involved adolescents, several researchers have developed lists of simple strategies and techniques to help increase engagement and build trust, such as learning the culture unique to the adolescent or avoiding clinical labels and/or professional language (Hanna, Hanna, & Keys, 1999; Sommers-Flanagan & Sommers-Flanagan, 2014). While these techniques will not be effective with all adolescents, insight into a client's specific needs can help narrow down which techniques may be helpful in strengthening the therapeutic alliance and increasing disclosure.

Future Directions

Despite the fact that concealment is common in clinical work with formerly incarcerated adolescents (Sommers-Flanagan & Sommers-Flanagan, 2014), there has been little research investigating this phenomenon within this population. While this single case study attempts to bring together relevant knowledge from studies on concealment, adolescents, and incarceration, further steps must be taken to confirm some of the hypothesized relationships drawn from this case and supporting literature. Similarly to how Han and O'Brien (2014) examined concealment and disclosure in therapy within Korean culture by using a sample of Korean clients, future studies conducted on concealment and disclosure in therapeutic environments by court involved adolescents should also utilize appropriately representative samples. Additional studies comparing concealment among court involved and non-court involved adolescents could further identify the unique challenges of achieving disclosure with court involved adolescents as well as for population-specific interventions.

Author's Note: The author received client's (L's) permission prior to the

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writing of the case study. In addition, efforts have been made to ensure that all personal details have been de-identified.

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SPECIAL SECTION: TURNING POINTS

PSYCHOTHERAPY PRACTICE

Closing a Private Practice

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Introduction

Although I'm a good ten years away from retirement (I hope), I've had occasion to talk with and listen to several colleagues who are facing this developmental milestone in the more near future. I've pulled together some information for psychologists to consider as they plan for the closing of their practice, whether because of retirement, relocation, illness, or transitioning to other professional activities. Some of the examples given pertain more directly to retirement; others are relevant to decisions to close a practice for other reasons as well. This article does not address the transition of selling a practice, which requires many other considerations. (I would like to acknowledge that several of the ideas discussed below were shared at a Maryland Psychological Association workshop on closing a practice, presented by Richard Bloch, Esq., Dr. Christine Courtois, and Dr. Pat Savage, and a version of this article is on the MPA website, in our Professional Practice Toolkit.)

When closing an independent/private practice, it is important to plan ahead and be aware of the practical and ethical issues regarding such duties as notice to current and former clients, maintenance of records, and attending to such "housekeeping" issues as purchasing "tail" liability coverage and notifying insurance companies. It is important to have a professional will in place and to be aware of the ethics regarding professional record keeping in general. In addition, attending to the emotional aspects of closing a practice is essential, as this represents a major transition for most psychologists who take this professional step.

The following presents guidelines and suggestions that psychologists may want to consider when closing a practice. In some sections, questions are raised for psychologists to consider; there may be more than one route to take when navigating such decisions as notice to clients or future contact with former clients. For many of the decisions to be made, there are no hard and fast rules to follow; some decisions are a matter of personal preference. The work involved in closing a practice has been compared in scope to that of starting a practice. Psychologists who practice in organizational settings should be aware of the institutional requirements for closing a practice as well.

Notice to Current and Former Clients

When to stop taking new clients? While not always feasible, many psychologists are able to plan ahead in closing a practice, and may decide to stop taking new patients at some point, for example, a year or two before retirement is planned. One psychologist with whom I am familiar decided to stop taking patients with complex trauma/dissociative disorders for the five years preceding his planned retirement. Other providers may decide to no longer take other types of clients

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(e.g., children with attachment issues). Another psychologist began informing any new clients of her plans to close the practice during her last year, thus giving them an informed choice. If one is accepting new referrals after a date has been set to retire, this fact should be discussed with new patients and other referral options given. Discussing these decisions, as well as other aspects of closing a practice, with colleagues may be helpful. One of the benefits often available to independent practitioners, finances allowing, is cutting back to part-time before planning to retire full-time. For more sudden closures of a practice, such decisions are moot, for example, in the case of sudden illness or accepting a new position.

How much notice to give current clients? While this too, is a matter of personal preference, I found a consensus that psychologists, when possible, liked to give their current clients at least three, but preferably six, months notice leading up to their retirement. In general, at least 60 days, if possible, would be a minimum amount of time to give. Some of this will depend on clinical features of the populations one is serving and the nature of one's transition. Some clients may be in a position to plan ahead to a successful termination. Others requiring more ongoing care will need to be transferred to another provider (see below). Notifying referral sources at some point prior to practice closure should also be considered.

Notice to former clients. Different states may have different statutes regarding whether notice needs to be given to former clients that one is closing one's practice. In Maryland, where I practice, former clients must be notified of the closure of a private practice **if** the psychologist plans to transfer the records to another provider or destroy the records; notice is not required if the psychologist will be maintaining the records themselves. (In Maryland, notice can be given via a notice published in a daily newspaper for two weeks, letting former clients know how they are to access their records, or by sending a letter to all clients who have been seen within a specified period, for example, within the past two years, regarding access to their records.) While not required to do so, some psychologists choose to send a letter to all clients seen within a relatively recent time period (e.g., over the past one to two years) to let them know about the closure of the practice.

Finding referrals for current clients. It is incumbent upon the psychologist closing a practice to assist current clients with finding referrals and transferring to new providers, if applicable. This process can often be a catalyst for the psychologist to provide feedback about client progress, and for clients to express their feelings about the ending of the therapeutic relationship. The retiring psychologist may want to approach colleagues at the same time that they begin to notify clients to arrange for colleagues to accept their patients. (Over the past year, I have had three colleagues ask me to accept some of their patients as they retired, and I tried to accommodate them when possible.) Some clients understandably may be resistant to this process, which is why taking adequate time to prepare them is crucial. Providing at least three different referral options to current patients is customary, and written releases will need to be obtained. Checking the availability of referral options is recommended, and considering other sources of referrals, such as psychiatrists or pediatricians, may be warranted.

Future contact with clients. Some clients may ask if it is possible to have occa-

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sional future contact with the therapist, for example, to let them know of significant life events. While this is a matter of personal preference, consideration of legal and ethical issues is important. One psychologist with whom I spoke said she told clients they could feel free to let her know how they were doing, but she could not offer them any professional advice; she was advised to take this tack by her malpractice carrier. Checking with one's malpractice carrier seems prudent. (See below regarding voicemail, email, and websites.)

Records

How long must records be retained? Again, the answer to this may be different in different jurisdictions. State law in Maryland requires that records be kept for 5 years for adults, and 5 years or 3 years after reaching age 18 for minors, whichever is later. Medicare requires that medical records be kept for 5 years, unless a patient is in a Medicare managed care program, in which case records must be kept for 10 years. HIPAA requires that administrative records be kept for 6 years, but defers to state law for medical records. Checking the applicable law where one practices is essential.

Paper versus electronic records. Paper records must be stored in a secure manner, and directions for accessing such records must be included in one's professional will. Periodic shredding is advisable. One psychologist scanned in all her paper records prior to retirement, and is keeping them in electronic but not paper format. For records that are part of an Electronic Health Record (EHR), an understanding of the features regarding maintenance and destruction of records is vital.

Write transfer/termination summaries for current clients? Not all clients being transferred to another provider will require a written transfer summary, although some psychologists, for purposes of continuity of care, may prefer to do this. Other practitioners will prefer to transmit information verbally, obviously with written consent. In any case, it is advisable that clinicians prepare a termination summary for current clients' charts. In lieu of this, another psychologist developed her own termination checklist to be filed in each client's chart. It is a matter of personal preference and communication between the referring and new clinician whether copies of the full chart are shared, again, with appropriate written permission. (Copies of the original chart should stay with the referring clinician.)

Business and Housekeeping Matters

Buy a tail from malpractice carrier. Perhaps one of the most important actions a retiring psychologist can take is the purchasing of a "tail" policy from one's malpractice carrier. A "tail" policy is one that provides coverage for claims based on events that occurred while the practice was open.

Maintaining one's license. The decision to maintain one's license after closing a practice depends on the types of professional activities (if any) the psychologist plans to engage in, as well as, perhaps, on the emotional attachment one has to being licensed. Psychologists with whom I have spoken planned to maintain their licenses for a very short period of time to indefinitely. Licenses may be placed on "inactive" status. In Maryland, psychologists may pay a fee to have their license placed on inactive status for a two year period that can be extended with a new request and fee. In this case, psychologists must meet the current continuing education requirements.

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Have a professional will in place. This is extremely important, both for psychologists who remain in practice and those who are transitioning out. It places undue burdens on surviving colleagues and family members if steps have not been taken to plan for the maintenance of records and closing out of other aspects of practice. At some point in the future, if the practice has been entirely closed and all records have been destroyed, it may no longer be necessary to have a professional will.

Notify third party payers and de-activate NPI. Psychologists who participate on insurance panels may want to notify them in writing that one's participation will no longer be active. In some cases, written termination of the contract may be necessary; check with the contract for proper notice of termination. When one is no longer practicing, one may also decide to de-activate one's National Provider Identification number. This may be done by calling the National Provider Identifier Enumerator Call Center at 800-465-3203 or going to https://nppes.cms.hhs.gov.

Maintain voicemail, email, and website? Many psychologists who are closing a practice may want to allow themselves to be reached by past clients in the future. Some may choose to shut down their office phone/voicemail, but maintain their email indefinitely. Maintaining an outgoing message for 60-90 days on voicemail or email notifying persons of the closure of the practice is one step that can be taken. Depending on any future professional activities, practitioners may wish to take down or change their websites. It is important to think through what will work best for oneself and to notify current clients of one's future ability to be contacted, if applicable. Becoming inactive on professional directories may be considered, depending on one's future professional activities and continued membership in professional organizations and societies.

Emotional Aspects of Closing a Practice

The emotional reactions to closing a practice will be as individual as each psychologist and his or her situation. One psychologist was surprised by her reactions to retiring, and found that the emotional preparation required was not as difficult as enacting the actual mechanics of closing her practice. She found that many clients, when told of her retirement, began to focus their work in preparation for termination and move toward goals in an accelerated way. Helping clients work on their feelings, which could include grief and loss, can be a big part of the work as practice closure approaches. Loss of the trusted therapist may resurrect certain issues for traumatized clients in particular. One decision that several psychologists who were retiring made was to share with clients a note, card, letter, or small but meaningful gift as they said their goodbyes. They found that this enhanced the transition for clients.

It behooves psychologists, of course, to be aware of their own emotional reactions to multiple goodbyes. To the extent that one's self-worth is tied to one's professional role, the change in identity and loss of ready validation of competence that can occur with retirement may be challenging. Talking with colleagues and working out one's emotions away from the client is advised. Careful maintenance of the treatment frame is essential. Uncertainty about financial issues may add to the stress of closing one's practice if one is not continuing in a professional capacity.

Cultivating outside interests in preparation for retirement (making sure one

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"has a life") is one idea to consider. Staying connected to the field if one is interested may mitigate against the sense of loss that can occur. On the other hand, one psychologist who was retiring was very aware of a sense of being emotionally freed up when no longer responsible for maintaining a private practice, an unexpected and welcome reaction. One issue for retiring psychologists is that there may be no ritual — no retirement party or other more formal event — to mark this transition. It might be useful to anticipate this, and plan, as I did last year for a colleague, a special dinner, for example, to publicly acknowledge this turning point in one's professional life.

In Conclusion

Talking with colleagues who have undergone this transition has been essential for me in brainstorming about steps to take to prepare for retirement. Since I am a decade away from closing my practice (again, knock wood), I have been listening for ideas that are most relevant to me now. One such idea, suggested by a colleague, is to give serious consideration to transitioning to an EHR system, which I have not done yet, as, in ten years, I would have fully transitioned away from a paper-based system and would have an easier time storing records. Another idea, mentioned above, but seeming more urgent to me now, is to complete my professional will, and to have thought through what might happen if, due to illness or another reason, I needed to close my practice more abruptly. I feel much more prepared now, and can let the experiences of colleagues guide me as I contemplate this eventual stage in my professional life.

Resources

Several resources available to psychologists who are closing their practices, for whatever reason, are included below.

http://nationalpsychologist.com/2015/03/closing-a-practice-practical-ethical-clinical-dimensions/

http://www.apa.org/monitor/feb03/howtoclose.aspx

http://www.apapracticecentral.org/ce/self-care/retirement.aspx

PUBLIC INTEREST AND SOCIAL JUSTICE

Conversations and Turning Points in the Life of a Major Policy Change in Colorado

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Background

In the spring of 2016, a highly debated Colorado bill came across the desk of Governor Hickenlooper, forcing him to make a tough decision. The piece of legislation, Senate Bill 16-269 (SB16-269), set out to solve a specific regulatory concern for hospitals regarding their ability to accept individuals brought to their door on an involuntary 72-hour mental health hold, commonly called an M-1 in Colorado. The legislation quickly gained attention from hospitals, law enforcement agencies, and the mental health community, and, as the conversations grew more complex, so did the language in the bill. Of the many policies embedded in SB16-269, one in particular lead to its eventual demise: The bill extended the time in which a jail could hold an individual on an M-1 hold without any legal charges.

The extension of this timeline was, in many cases, the first time that many individuals found out Colorado engages in this practice at all, and, furthermore, that we were just one of six states to still allow it. Policy makers from across the state all acknowledged this policy was not ideal, but not knowing what other resources were available for those Coloradans most in need, it was included in the bill. When it came time to sign the legislation, it was widely supported by lobbyists and advocacy groups across the state despite the time extension. Ultimately, the governor made the choice to veto the bill despite its support with the message that Colorado can do better to uphold the rights and safety of citizens (Hickenlooper, 2016).

Steps Toward Change

In the months following the veto, policy makers and advocacy groups worked to understand the meaning of that decision. The governor followed up on his veto with several actions, including an announcement in his veto letter of plans to convene stakeholder groups from across the state to examine the key issues behind his decision. First, the governor specifically convened a taskforce of influential Coloradans to focus primarily on mental health holds and how to modernize Colorado's process. Second, a letter was sent to the Colorado Commission on Criminal and Juvenile Justice (CCJJ) encouraging them to examine the issue of individuals with mental health disorders in jail. Meanwhile the Equitas Project, a Colorado-based advocacy group with the mission of disentangling mental health and criminal justice, hosted a large convening of over 200 stakeholders to develop systemic recommendations.

Through the summer and fall, all three groups held passionate discussions on how to best address the issues that Colorado was facing. Rising to the top were concerns about transportation for individuals in need, especially in Colorado's

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many rural communities. Rural law enforcement members stated strongly that their options in managing individuals in acute behavioral health crises were limited and that jail was the only resource available to them. Justice partners across the state felt strongly that the expectations on them to identify, understand, and manage behavioral health crises should be handled by mental health professionals. Mental health advocates alongside individuals with lived experience educated stakeholders on the traumatizing nature of the justice system and why additional options were critically necessary. Throughout the entire discussion, stakeholders agreed that a new approach had to be developed and that now was the time to act. Although many recommendations were communicated by the three groups, one was prevalent across all of them: Completely end the use of jails as a placement option for individuals on an M-1 hold.

In 2013, Colorado took a bold move to formalize the state's expansive crisis-response services with legislation that infused additional resources as well as coordination of those services on a regional basis. Since then, Colorado's crisis services system has gradually grown to better understand and serve the unique needs of the various regions and communities. Understanding the importance of this investment, many of the members of the various groups began to ask how this system can be leveraged to help address *how* Colorado can end the use of jails in the M-1 hold process. Surely, many thought, a coordinated crisis system has a role to play in providing modern, productive options for communities who are responding to an acute behavioral health crisis. Stakeholders felt strongly that, with collaboration, a better way could be developed. A turning point arrived when a small workgroup convened by the CCJJ taskforce proposed writing into statute a new intervention; instead of giving law enforcement only the two options of commit or arrest, provide for a third option of transporting individuals to a nearby mental health professional.

The new proposal was met with no shortage of skepticism. How will communities be able to transport an individual when locked, secure mental health treatment facilities are so few and far between? Will mental health providers, operating in outpatient settings, be able to assist individuals in an acute crisis? Will an involuntary transportation escalate the crisis? How will Colorado be able to meet the needs of these individuals once they have been transported? These questions were all critical in igniting conversations between partners who had not traditionally talked before. Representatives of people with lived experience met with providers and law enforcement officials to discuss just how a process like this might be helpful and effective. Quickly, it became clear to all involved that Colorado would need to rely on large-scale communication and collaboration if the mission were to be achieved.

As the dialogue continued to unfold, it became clear that meticulous coordination would need to be at the heart of whatever solution were pursued. Stakeholders began to closely examine the crisis system as a potential host for this coordination. At the core of all the conversations was a desire to bring communities together to find a solution that made sense for their needs. Coordinated across four regions, the Crisis Service Organizations that manage the services within the crisis system were especially well positioned to facilitate dialogue and enhance opportunities for collaboration. In acknowledgement of this, the CCJJ group agreed on a legislative recommendation to infuse resources to the cri-

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sis system directly related to these policy issues. The stakeholders on the group felt so strongly that this system was instrumental in answering the "how" of the mission that it was decided to reverse the order of the recommendations by addressing enhanced crisis services first and ending the use of jails second.

Working Together and Looking Ahead

In December of 2016, as policy makers and advocates prepared for the start of the 2017 legislative session, votes were taken on the recommendations that were finalized in prior months. Discussions were once again opened to a wider audience, which was quick to express hesitations and concerns. At the root of the skepticism were several key questions. Will the resources be in place in time to make this work? Will the crisis system be able to handle new demands? Will law enforcement partners be on the hook for potential disasters? And, finally, are the stakeholders confident that the consumer and peer communities believe in these policies? Unfortunately, the groups were working against the clock and recommendations became finalized before these questions could be answered. In January 2017, when the legislative session started, advocates of the recommendations had to act fast to prepare for bill drafting.

Throughout the bill drafting process, three groups were primarily engaged for their feedback: law enforcement, consumers, and providers. All three groups needed to trust that however the bill were shaped, it had to represent their concerns and provide them with the confidence that this process would be beneficial for all Coloradans. As a primary lobbying group behind the not-yet introduced bill, the Colorado Behavioral Healthcare Council (CBHC) took steps to engage partners individually as well as together to check for blind spots and missed opportunities. The importance of listening in individual stakeholder meetings could not be overtated. As language began to gel and finalize, lessons of communication were critical, and CBHC took extra measures to facilitate direct conversations between the various entities who would be impacted. Following months of drafting, discussing, re-drafting and collecting feedback, Senate Bill 17-207 (SB207) was formed and introduced.

Far from perfect, SB207 had a way to go before it was supported enough and prepared for the legislative process. Advocates and legislators knew that it would be critical to show all the key stakeholders presenting a united front about the importance of the legislation to achieve success. Time and again, conversations across sectors proved powerful in cultivating trust in the belief that all the stakeholders were in this together. Open, honest communication was of absolute importance in empowering the various partners to communicate what they would need from each other to make this bill, and the policies within it, successful.

Eventually, the time came for SB207 to be heard in legislative committees. Throughout the many hearings and debates, the power of having law enforcement, consumers, and providers all agree on a policy suggestion was evident, and in the spring of 2017 the bill was written into law. In July of 2018, Colorado statues no longer allowed for individuals on an M-1 hold to be held in any jail across the state.

Although this overview only scratches the surface of the months of work, countless conversations, and stakeholder dedication that went into this historic achievement, at the core of this turning point was the impact of opening conversations between the various key

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stakeholders. Those entrenched in the mental health and criminal justice systems may often take for granted the barriers that exist between them, despite the strides that have been made to break them down. Further, it was evident that policies were too often created with the systems' needs prioritized over those of the individuals being served by those systems. Despite its challenges, and the ongoing challenges of implementation, SB207 created a space in Colorado where those barriers could be examined more critically and discussed more openly.

A major turning point through this process was the deliberate inclusion of individuals with lived experience across every step. The voice of consumers and peers, when empowered, can elevate the mental health system to be greatly more aware of and effective within its blind spots. As with any industry, the mental health system is susceptible to the trap of system-protection over consumer needs. While this impact is acutely felt in the clinical setting, when the consumer perspective is not deliberately considered in policy decisions, the effects can ripple to thousands across countless communities. While mental health advocates have long championed the importance of peers and consumers in policy decisions, the story of SB207 also demonstrates their strength and impact in achieving a change.

Lessons Learned

Of the many lessons learned from this story, perhaps the most impactful is the establishment of a clear process to engage various stakeholders in an open dialogue about their perspectives on a systemic issue. Stakeholder engagement will only go so far unless key individuals are invited to participate. Furthermore, the power of having diverse audiences communicate with each other can create long-term trust and collaboration, which has helped Colorado's communities in the success of their policy and beyond. The success of 2017 has resonated throughout the 2018 legislative session as partnerships continued to strengthen and partners understood each other better. The story of SB207 is one of a transformation that could not have been achieved without communication, trust, and genuine shared responsibility.

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SPECIAL SECTION: TURNING POINTS

EARLY CAREER

The Stories We Tell Ourselves

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We all tell ourselves stories regarding who we are, who others are, and how the world works. This is no different in psychotherapy, both for the client and the psychotherapist, and for a psychotherapist, this "story" is called theoretical orientation. In the consulting room, it is expected (although often times implicitly), that the client's story will be challenged, either directly or experientially, in order for "story" to become more adaptive to novel encounters. Little is spoken, however, of the need for the psychotherapist's "story," or theoretical orientation, to be challenged, despite the near guarantee that novel clinical encounters will occur, risking experiential dis-ownership through cognitive dissonance (Cole, 2016).

What I find evocative about this year's *Psychotherapy Bulletin* theme on "turning points" is that it directs attention into the psychotherapist's mirror. In other words, reflection on the practice of psychotherapy—and, by extension, the psychotherapist—is an essential component of any "turning point." In this article, I would like to discuss some developmental factors in the creation of psychotherapists' "stories" (i.e., theoretical orientations) that may have inadvertently served to inhibit their openness to challenge. In turn, I will offer some reflections and challenges from the lens of existential-phenomenology that may help to avoid these potential pitfalls and provoke future dialogue and directions.

The Importance of Explanation

In many Western societies, scientific reasoning is one of the main systems of thought used to understand "the way things work" in the world (O'Barr, 2001, p. 317). This reasoning is especially powerful in its ability to explain and predict phenomena, giving precedence to "why" something is rather "what" or "how" it is. Following in the footsteps of this Western knowledge ideal, Freud (1962) originally conceptualized psychoanalysis as a new science. Trained as a neurologist, Freud was likely influenced by his mentors Charcot and Brüke, whose pivotal work in describing all organisms as energy systems undoubtedly impacted his conceptualization of the human mind as a "psychic energy" system. In applying this model to mental states that were once seemingly inexplicable, Freud was able to give a meaningful account of, or explanation for, behavior through the causal mechanism of unconscious mental processes. For Freud, shifting the study of psychoanalysis into the realm of science was essential to establish its credibility in Western dominated culture.

Continuing this lineage, providing modern day psychotherapeutic explanations through the use of theoretical orientations, ostensibly from a scientific viewpoint, dominates current discourse in

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public and academic domains to the point it may be deemed essentially unethical to not do so (Westen, Novotny, & Thompson-Brenner, 2004). Indeed, many psychotherapists, along with their clients, assume the task of psychotherapy to be that of uncovering the influences of past experiences on present day functioning, so that conflicts that have arisen from, or been aggravated by, the past may be resolved. This process, of course, necessitates an explanation, which conveniently lends itself to the measurement of change through outcome variables defined by the associated theoretical system. This not only gives psychotherapists a sense of control over their practices by highlighting the value of their knowledge, but also serves to concretize the explanation into skills that can be taught to novice practitioners who view may view problem "stories" similarly.

As attractive as this approach sounds, it is not without its shortcomings. As Kaye (1995) has discussed, the process of quantifying concerns to study (or treat) "necessitates either the reduction of the phenomenon . . . or the selection of study only those aspects of the phenomenon which can be converted into measurable terms." This, in turn, "can only result in a partial picture . . . one which also misrepresents its holistic, contextual nature" (p. 46). Stated another way, from the moment an experience is operationalized to fit into a theoretical framework, an immediate mutative bias is imposed that limits the range of experiential possibilities. As such, greater identification with and security in a given theoretical "story" may actually increase the likelihood of selectively attending to certain "story elements" that hinder experiential challenges to and adequacy of the continued viability of that "story" in the context of the psychotherapeutic endeavor.

Existential-Phenomenological Challenges

Given the limitations of an explanatory approach, what alternatives remain? One option, among many, that I wish to highlight, is existential-phenomenology. Existential-phenomenology, at its heart, is an approach to experiences of living that involves an investigation and illumination of "meaning." Meaning, as a broad term, describes "the whole gamut of both explicit and implicit beliefs, assumptions, biases, attitudes, and values, together with their concomitant affective and behavioral components, that are maintained by a person" (Spinelli, 2006, p. 2). While this broad definition may seem consonant with aspects of other approaches listed above, what differentiates existential-phenomenology is not only its "goal" with respect to meaning, but its method in addressing it.

Rather than seek to offer an explanation for problematic experiences, an existential-phenomenological approach concerns itself with offering a description. In seeking to describe experiences, the goal of the clinician shifts from operationalizing and "honing in" on certain "story elements" from clients' reports to exploring and clarifying these report with an ever increasing degree of experiential adequacy. Rather than condense experiences, requiring the rejection or favoring of certain pieces of data over others, a descriptive approach urges multiple, if not limitless, definitional possibilities. Thus a descriptive approach remains value-neutral (i.e., not advocating for problem removal, reduction, or amelioration), and the task of the psychotherapist is to provide clients with the means to examine, confront, and possibly reassess their reflective experiences of change (Spinelli, 2016).

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A related concern centers on how one views the person of the psychotherapist in relation to the client. By this I mean, how does the "story" of the psychotherapist fit with or impact upon the client? By seeking to provide an explanation, unique priority is given to the psychotherapist's "story," not least in providing the meta-framework through which the client's experience is viewed, even if it is the client providing the "story elements" (i.e., verbal data). Unlike the explanatory approach, which presupposes two subjects impacting upon one another, existential-phenomenology assumes an indissoluble and co-constituting relationship between the psychotherapist and client. Similar to a figure/ground perception, each individual is a necessary constituent to the creation of that psychotherapeutic "story," which shifts the grounding of this relationship from one that is subjective to one that is inter-relational. As the psychotherapist is implicated in the creation of, rather than mere impact upon, the phenomenally-derived relationship, it no longer makes sense to speak of a difference between the psychotherapist's and client's "stories"—rather, they share *a* story.

A natural consequence of viewing a shared story as such is that it opens psychotherapists to hearing their contributions to it more readily. In attending to their clients with the goal of "staying with" their experiences as they present themselves and examining what emerges experientially in the immediacy of the encounter, the psychotherapist expresses flexibility and openness to those self-same experiential challenges. This better allows the psychotherapist to bracket personal meanings and interpretations so as not to directly or inadvertently suggest who or what the client should/should not be. Of course, this goal is never fully achieved; however, similar to the goal of clarifying the client's experiences with increasingly greater degrees of adequacy, the psychotherapist may simultaneously achieve greater self-awareness in identifying the potential "self-storied" pitfalls that decrease openness to novel therapeutic encounters.

Conclusion

Both client and psychotherapist enter psychotherapy with a "story" about the workings of the presented problem, each other, and the world. Historically (and presently), despite clients telling their "stories," the psychotherapist's "story" was/is given precedence as the meta-narrative through which client problems and solutions are illuminated. The concern with this approach is that it limits novel therapeutic encounters as delimited by the psychotherapist's view. Incorporating insights from an existential-phenomenological lens upends this approach, valuing description over explanation and experiential widening over theoretical reduction. From this approach, the goal is to nonjudgmentally facilitate helping the client disclose lived experience as "what is there in the way it is there." In this way, the psychotherapist may help create a context in which the client feels willing and courageous enough to confront all manner of worldview concerns that have provoked current problems of living; in addition, this attitude helps the psychotherapist remain open to what presents itself through experience and attempts at bracketing, including theoretical biases and blind spots.

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SPECIAL FEATURE

Excerpt From: Reflections on 50 Years of Integrative Psychotherapy Emphasizing Practiced-Based Evidence and Effectiveness

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This article, focusing on integrative practiced-based evidence and effectiveness, was inspired by three articles in the Society for the Advancement of Psychotherapy's *Psychotherapy Bulletin* (Jacobsen, 2018; Lambert, 2016; and Savela, 2015), plus an online course by Daryl Chow on "Reigniting Clinical Supervision" (2018) and Paul Clement's classic article on "Practice Based Evidence: 45 Years of Psychotherapy Effectiveness in a Private Practice" (2013). It is the companion piece to a much more extensive exploration of these topics found on the Society for the Advancement of Psychotherapy's website (societyforpsychotherapy.org/).

Background

In 1968, I received my PhD from the University of Wisconsin. In September of 1968, I came to Philadelphia on a National Institute of Mental Health post-doctoral fellowship to study with the behavior therapists Drs. Joseph Wolpe and Arnold Lazarus. After three months I was asked to choose between them. I chose Lazarus, who was already focused more on cognitive-behavioral therapy, multimodal therapy, and the person of the therapist. However, both were interested in empirical assessment of change, which appealed to me, as I had been trained in behavioral approaches at Columbia and the University of Wisconsin and had a prior background in math and engineering.

Influenced by Lazarus, Beck and Ellis, I wrote an early published article on cognitive-behavioral therapy (1970); two dissertation-based articles on modeling, roleplaying, and assertive behavior in 1971 and 1972; and several published articles on marital and family therapy (MFT) throughout the 1970s (my first job from 1969 to 1973 was on Ivan Boszormenyi-Nagy's family psychiatry unit in Philadelphia).

Early Turning Points

The year 1977 was a personal turning point when I became actively involved with a meditation/yoga group and also *A Course in Miracles* (Foundation for Inner Peace, 1975), which focused heavily on forgiveness of self and others. Professionally, 1980 was a turning point. I wrote an early article in the field on "Integrative Psychotherapy" (1980) and created an integrative meta-model, followed closely by articles on integrative family therapy and integrative marital therapy (1981, 1982).

These turning points influenced the trajectory of my practice and research substantially. I have published several articles and books on the topics of well-being and forgiveness (1989, 2010), as

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well as creating the Friedman Well-Being Scale (1992). In addition, throughout my career, I have remained interested in technology, evidence-based practice, and tracking the effectiveness of what goes on in the psychotherapy room. In 1982, I wrote an article on "Assessment Tools and Procedures in Integrative Psychotherapy," which was the beginning of my published articles using clinical measures to track change in psychotherapy, an evidence-based therapy approach. I wanted to see empirical measures of progress and change session by session. So I used, or developed, a variety of scales that were easily administered and scored every session.

Forgiveness and Well-Being

In 1984, I published my first article on forgiveness (followed years later in 2010 by my book *The Forgiveness Solution*) and an early article on the use of computers in marital and family therapy (1985). My first book. *Creating Well-being* (1989), based on 12 principles of well-being, was followed three years later by my first published scale, the Friedman Well-Being Scale (1992) which consisted of 20 bipolar adjectives and five subscales.

Psychotherapy Outcome and Tracking Change

I became interested not only in tracking change session by session, but also the outcome of psychotherapy. I have tracked changes using the Personality Assessment Inventory (see Morey, 1996); plus various measures of well-being and life satisfaction; and I regularly use the Hopkins Stress Symptom Checklist (Derogatis, 1973), an 83-item measure of anxiety, depression, anger, interpersonal sensitivity, and so forth.

Daryl Chow and Effect Sizes in Five Studies Over Time

As previously mentioned, I recently took an online course on reigniting clinical supervision by Daryl Chow, who now resides in Australia and works closely with Scott Miller. Chow's 2014 dissertation focused on "supershrinks," and course participants were encouraged to measure change session by session and calculate effect sizes for their own and their supervisees' practices. I went back to mostly published data (1995, 2006, 2013, and 2018) and calculated the effect size for my practice over four time periods. In all four time periods clients were given the Friedman Well-Being Scale (1992) before every session. The effect sizes overall were comparable to the "supershrink" effect sizes in Chow's 2014 dissertation.

Like Clement (2013), I found no overall changes in my effectiveness between 1995 and 2018. However, unlike the Clement study, my data suggested an improvement overall in my effectiveness between the initial data collected in 1992 and the four other time periods (1995 to 2018). Puzzled by that finding, I realized that I first learned energy psychology therapy techniques (tapping, breathing, and affirmations) in 1995 from Fred Gallo (2002). I have since incorporated them into my current model which I call the ICBEST (integrative, cognitive, behavioral, energy and spiritual therapy) model (2015). This model also strongly incorporates my integrative forgiveness model (Friedman, 2010; Friedman, 2013; Friedman, 2015).

There is a real possibility that the energy therapy techniques learned in 1995 were a significant contributing factor to the enhanced effectiveness in my practice from 1995 to 2018. Personally, I believe that is the case, although others might disagree (and, of course, it is an N of 1).

Current Practice

Last year, I developed a 67-item adjective scale. On two occasions, clients

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filled this out about me. In April 2018, the top adjectives were as followed: Understanding, supportive, peaceful, calm, attentive/ focused, open-minded/hearted, trusting/trustworthy, positive attitude/outlook, dedicated, committed, accommodating, helpful, happy, respectful, bigger perspective, centered, patient, persistent, cheerful, intuitive, curious, intelligent/smart, wise, straightforward, loving, caring, devoted, loyal, accepting, non-judgmental, spiritual, enthusiastic, warm, kind, gracious, compassionate, and forgiving.

Clients also rated the top eight positive behaviors to describe me**:**

- Inspiring teacher/healer
- Very good listener
- Professional
- Very good at isolating and analyzing problems
- Very good at finding solutions or helping you find tools, exercises, processes, to find them.
- Very good at giving advice and feedback
- Storyteller (very good with stories that are instructive and helpful)
- Very good writer (all clients receive a copy of my book *The Forgiveness Solution* to work with at session three)

Clients currently receive a relatively new 20-item Client Feedback Questionnaire before every session. The range on this scale is from 0 to 100. My current average is 97.6 across 11 private clients with a range of 92 to 100. However, the client feedback score does increase over time. The last two new clients went from 75 to 95 and 92 to 98 over four to five sessions. Although this is a new scale, the client feedback scores appear to correlate with the FWBC (1992) or the outcome rating scale (ORS, 2003). Any significant change session by session, even sometimes in one item, is worth a collaborative dialogue.

I have used a variety of other measures to track change over the years. I also started using three new scales I developed and published this year called the Friedman Life Balance Scale, the Friedman Mini 5 Factor Personality Scale, the Friedman Spiritual Awakening Scale (2018), and the unpublished Friedman Benefits of Therapy Scale.

Reflections and Conclusions

Over the 50 years of my professional career (36 in private practice), I have developed an expanding integrative therapy approach. I started out (1960s and 1970s) with a strong interest in cognitive, behavioral, and systems approaches (marital and family) and fairly early on (1970s and 1980s) developed an interest in spiritual and well-being approaches (now called positive psychology), as well as the use of technology in psychotherapy. Later (1990s) I added the energy psychology approaches.

At the beginning of my career I developed a strong interest in tracking change session by session and a practice-based evidence approach. I have summarized decades of practice data as follows:

I was able to calculate my effectiveness using effect sizes over 5 time periods from the early 1990s until 2018. The effect sizes overall were comparable to the "supershrink" effect sizes in Chow's 2014 dissertation. There appears to be no overall improvement over time in my effectiveness from 1995 to 2018.

However, there appears to have been obvious improvement from 1992 to 1995 and thereafter. I attribute this to energy therapy techniques I learned and began applying in 1995.

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I have used quite a number of measures to track change session by session. I have consistently used the Friedman Well-Being Scale (FWBC) and have used the Hopkins Stress Symptom Checklist (HSCL) for a long time.

Change typically occurs rapidly in the first five sessions. Clients come in demoralized and the early sessions are in part a remoralization and reeducation process. (Frank, 1961).

I have also used relationship and alliance measures, focusing on the perceived relationship between the therapist and the client.

I am now semi-retired in private practice in the Philadelphia suburbs. My personal interests and development over 50 years in many ways parallel the development of the field, although often ten or more years earlier than the consensus of the field (making me an early adopter). I have found this process invaluable, and would encourage other practitioners, at whatever stage of their careers, to consider implementing a process of active self-reflection and evidence-based tracking measures in their own practices.

Editors' Note: Please visit our website at societyforpsychotherapy.org/ for Dr. Friedman's complete article, including References and more detailed information about his tracking measures, outcome data, and clinical practice.

Does Having Clients and Therapists Practice Mindfulness Together Have a Positive Impact on Psychotherapy Sessions?

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Over the past decade, the practice of mindfulness has received a significant amount of attention in the psychotherapy research literature. The existing research on mindfulness has demonstrated that it can produce positive health and mental health benefits for psychotherapy clients (Davis & Hayes, 2011). A smaller body of research has also demonstrated that the practice of mindfulness can also positively impact therapists, resulting in enhanced health and well-being, reduced stress and burnout, and the development of professional skills and attributes associated with effective therapeutic work (Aggs & Bambling, 2010; Martin-Asuero & Garcia-Banda, 2010; Shapiro, Brown, & Biegel, 2007).

Research has also suggested that the practice of mindfulness by therapists can have a positive impact on their treatment sessions and client outcomes (Grepmair, Mitterlehner, Loew, & Nickel, 2007). For example, in one study (Dunn, Callahan, Swift, & Ivanovic, 2013) therapists were asked to engage in a five minute mindfulness exercise prior to a random set of their psychotherapy sessions. Sessions that were preceded by the therapist mindfulness practice were rated by clients as more effective compared to sessions where therapists were allowed to complete routine activities (i.e., check email, go to the bathroom, talk to other clinicians) immediately prior to the session. More recently, others (Stone, Friedlander, & Moeyaert, 2018) found that a similar pre-session mindfulness practice for therapists can have an impact on client-rated empathy and the real relationship.

Given that research has shown benefits for both psychotherapy clients and therapists who practice mindfulness, the question that follows is whether having clients and therapists practice mindfulness together can also produce positive results. In one qualitative study (Horst, Newsom, & Smith, 2013), therapist/client dyads were asked to discuss the benefits of using mindfulness in their treatment. The themes that emerged from this study indicated that the dyads believed that the mindfulness helped with the clients' presenting problems, helped with in-session transitions, facilitated conversations, and helped bring a

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calm slower pace to the sessions. However, it is unclear in this study whether the mindfulness was therapist-guided or was actually practiced by the client and therapist together in the sessions. Further, given the study design, it is unclear whether the mindfulness actually caused the benefits that were reported. Thus, further research is needed to empirically examine the session impacts of having clients and therapists engage in mindfulness exercises together in psychotherapy.

Having clients and therapists engage in mindfulness exercises together in session might be beneficial for a number of reasons. First, it has been strongly suggested that therapists who encourage their clients to practice mindfulness should incorporate a "practice what you preach" model (Davis & Hayes, 2011). This demonstrates to clients that the therapist personally believes in the benefits of mindfulness. Second, practicing mindfulness together may foster a stronger therapeutic relationship. As clients and therapists engage in this type of activity together, clients may perceive a stronger sense of collaboration and connection in treatment. Third, practicing together may help both parties be more present-focused in sessions, which could lead to more positive treatment outcomes.

Method

This study was conducted in a psychology department training clinic, with 16 therapists-in-training and 39 of their clients participating. All treatment sessions ($k = 156$) for these dyads were randomized to begin with either a 5-minute mindfulness centering exercise or 5-minutes of psycho-education about general healthy living topics (e.g., sleep hygiene). In the mindfulness exercise condition, the therapists were instructed to play a guided audio of the exercise while the clients and therapists listened to and engaged in the practice together. The psycho-education material was scripted and led by the therapists. After engaging in the mindfulness or control exercise, therapists were instructed to conduct their sessions as usual. At the end of the sessions, clients were asked to complete a measure of perceived therapist presence (Therapist Presence Inventory-Client; Geller, Greenberg, & Watson, 2010), a measure of the session alliance (Session Rating Scale; Johnson, Miller, & Duncan, 2000), and a measure of session effectiveness (Session Evaluation Questionnaire; Stiles, Gordon, & Lani, 2002). Additional details regarding the therapist and client demographic information, the mindfulness and control exercises, and the data analytic procedures can be obtained by contacting the first author.

Results

The primary goal of this study was to test whether sessions that were randomized to begin with a joint mindfulness exercise would be rated more positively by clients compared to sessions that began with a psycho-education control. The average therapist presence scores (TPI-C) for sessions that began with mindfulness was $M = 19.92$ and the average for control sessions was $M = 19.70$. A multi-level-modeling analysis (sessions nested within clients who were nested within therapists) indicated that this was not a significant difference, $t(1.57) = 1.20$, $p = 0.38$. The average alliance scores (SRS) for sessions that began with mindfulness was $M = 37.64$ and the average for control sessions was $M = 37.27$. MLM analyses indicated that this was also not a significant difference, $t(17.74) = 1.03$, $p = 0.37$. Similarly, significant differences between mindfulness and control sessions were not found in clients' ratings of session depth (SEQ-Depth), $t(57.78) = 0.32$, $p = 0.75$; session smoothness (SEQ-Smoothness), $t(14.54)$

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= 1.36, $p = 0.20$; or the clients' experience of the session as positive (SEQ-Positivity), $t(21.59) = 0.20$, $p = 0.95$. Thus, the results from our experimental study suggested that sessions were not perceived by clients as being better if they started with the client and therapist practicing mindfulness together, compared to starting with psycho-education.

Discussion

The purpose of this study was to empirically test whether having clients and therapists practice mindfulness together during treatment would have a positive impact on treatment sessions. Contrary to our hypotheses, the results indicated that compared to control condition sessions (sessions that began with psycho-education), beginning treatment sessions by practicing mindfulness together had no added benefit in terms of clients' perceptions of therapist presence, the alliance, or session effectiveness.

The results of this study seem to contradict earlier research findings indicating that client and therapist mindfulness is related to positive treatment outcomes (Aggs & Bambling, 2010; Davis & Hayes, 2012; Dunn et al., 2013; Grepmair, Mitterlehner, Loew, & Nickel, 2007; Horst, Newsom, & Smith, 2013; Martin-Asuero & Garcia-Banda, 2010; Shapiro, Brown, & Biegel, 2007; Stone et al., 2018), but there may be several reasons for the difference. First, this was the first study that we are aware of in which clients and therapists were asked to engage in the mindfulness exercises together. Perhaps practicing together is not as effective as having either party engage in mindfulness alone. This hypothesis could easily be tested by conducting a study with four different conditions—client practices mindfulness alone at the start of the session, therapist practices mindfulness alone at the start of the session, client and therapist practice together, and control. Second, it is possible that psycho-education was not the most appropriate control condition for the study. Although it provides a control in terms of starting the session with a structured activity that deviates theoretically from mindfulness, previous research has indicated that psycho-education alone can have a positive impact on depression, anxiety, and psychological distress (Donker, Griffiths, Cuipers, & Christensen, 2009). Thus, the results of this study may indicate that beginning sessions by practicing mindfulness together is just as effective as starting the sessions with another effective brief intervention—in this case, psycho-education. Third, there may be limitations with studying session-level impacts. Although this type of design does have its advantages (Stone et al., 2018), it is possible that the benefits from practicing mindfulness together in some sessions carried over to the sessions where mindfulness was not a component. Finally, it is possible that mindfulness may not be an appropriate intervention for everyone. While some clients and therapists may respond positively to mindfulness practices, others may believe that it is a waste of their valuable session time. In this study, condition assignment was based on randomization, but in real world settings it is important for treatments to be tailored to the individual client.

Although this study failed to find significant results, further research is needed to explore different ways for using mindfulness in psychotherapy. This research should focus on both the clients' and therapists' use of mindfulness. In addition to studying session level impacts, future research should also further study for potential effects on treatment outcomes.

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2019 NOMINATIONS BALLOT

Dear SAP (Division 29) Colleague:

The Society for the Advancement of Psychotherapy (APA Division of Psychotherapy, 29) seeks nominations of creative individuals and great leaders! We would like both new and experienced voices to advance our increasingly important work on behalf of psychotherapy. The SAP Board encourages candidates from diverse backgrounds to seek nomination.

NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY (APA DIVISION 29)

The offices open for election in 2019 are:

- President-elect
- Domain Representative for Science & Scholarship
- Domain Representative for Diversity
- Domain Representative for Early Career Psychologist
- Representative to APA Council – Two seats

All persons elected will begin their terms on January 2, 2020

A Domain Representative is a voting member of the Board of Directors. The open positions will be responsible for initiatives and oversight of the Society's portfolio in the respective Domains. Candidates should have demonstrated interest, expertise, and investment in the area of their Domain.

The Society's eligibility criteria for all positions are:

1. Candidates must be Members or Fellows of the Society.
2. No member may be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for a position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.
5. All terms are for three years, except President-elect, which is one year (and then proceeds to President for one year and Past President for one year).

The deadline for receipt of all nominations ballots is December 31, 2018.

As per the Society's Bylaws, you may email your nominations to: assnmgmt1@cox.net. Please put SAP/DIVISION 29 NOMINATIONS in the subject line the email You may also mail your nominations to Society for the Advancement of Psychotherapy, 6557 E. Riverdale St., Mesa, AZ 85215

If you would like to discuss your own interest or any recommendations for nominations, please contact the Society's Chair of Nominations and Elections, Dr. Jennifer Callahan at Jennifer.Callahan@unt.edu

Sincerely yours,

Michael Constantino, PhD	*Nancy Murdock, PhD*	*Jennifer Callahan, PhD*
President	President-elect	Chair, Nominations & Elections

NOMINATIONS

President-elect

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Domain Representative Science & Scholarship

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Domain Representative for Diversity

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Domain Representative Early Career Psychologist

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Council Representative

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Division29
Central Office
6557 E. Riverdale St.
Mesa, AZ 85215

Society for the Advancement of Psychotherapy Distinguished Award for the International Advancement of Psychotherapy

Description
Concurrent with the mission of the Society for the Advancement of Psychotherapy and its International Domain and International Affairs Committee, this award was established in 2017 in recognition of individuals who have made distinguished contributions to the international advancement of psychotherapy. Award recipients receive an honorarium of $1,000 and an award certificate from the Society at the Society's awards ceremony at the APA Annual Convention.

Eligibility
The criteria for receipt of this award are broadly defined as significant and sustained contributions to the international advancement of psychotherapy which is consistent with the international dimension of the Society's mission, i.e., the Society is an international community of practitioners, scholars, researchers, teachers, health care specialists, and students who are interested in and devoted to the advancement of the practice and science of psychotherapy. Given below are the specific requirements in order to receive the award:

1. Membership in the Society for the Advancement of Psychotherapy (including International members who are non-APA Member Affiliates).
2. Sustained and significant contributions to the international advancement of psychotherapy in practice, research and/or training in psychotherapy.
3. These contributions must be in the international arena and a significant part of the contribution must be within the division OR the contributions should represent a significant collaboration with individuals from the international community and promotes the ideas and practices of that community.

How to Apply
Application materials should include:
1. A nomination letter outlining the nominee's contributions to the international advancement of psychotherapy (self-nominations are welcomed).
2. Two or more supporting letters
3. A current Curriculum Vitae.

Submit applications to Michael Constantino, at mconstantino@psych.umass.edu, by midnight, January 31, 2018. Incomplete or late application packets will not be considered.

$1,600 APF/Division 29 Early Career Award

This program supports the mission of **APA's Society for the Advancement of Psychotherapy (Division 29)** by recognizing Division members who have demonstrated outstanding promise in the field of psychotherapy early in their career.

Nominees should be a member of Division 29, be within 10 years post-doctorate, and will be rated on:
- Accomplishment and achievement related to psychotherapy theory, practice, research or training

Nomination Requirements:
- Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable)
- Current CV
- Nominations must be submitted online at https://www.grantinterface.com/Home/Logon?urlkey=apa&

Please see our website for more information: http://www.apa.org/apf/funding/div-29.aspx

Completed nominations should be submitted online by **January 31, 2019**. For questions, please contact the SAP/Division 29 Awards Chair, Michael Constantino, at mconstantino@psych.umass.edu

APF welcomes applicants with diverse backgrounds with respect to age, race, color, religion, creed, nationality, disability, sexual orientation, gender, and geography.

Spending Behaviors, Cultural Identity, and Mindfulness of African American College Students: Implications for Financial Stress and Depression

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Increasing numbers of students pursuing college and graduate degrees may face financial challenges, with 85% of students in higher education receiving some form of financial aid through grants and student loans (National Center for Education Statistics, 2015), and many graduating with a minimum of $25,250 in debt (Javine, 2013). As traditional college students are typically in young and middle adulthood, they are likely to encounter varying degrees of stressors, such as financial stress, which can result in negative health conditions (Catalano et al., 2011; Wrosch, Heckhausen, & Lachman, 2000). African American college students are particularly vulnerable to these outcomes due to overrepresentation of low income students, discrimination in applying and using credit cards, and lack of financial knowledge to practice skillful financial planning (Javine, 2013; Lyons, 2004; Mimura, Koonce, Plunkett, & Pleskus, 2015). Thus, there is a need to investigate the impact of the variables mentioned above on the financial stress and adverse psychological well-being of African American college students.

Spending Behaviors of African Americans

As the United States economy remains in a state of flux, there are ramifications for the consumption behaviors of minorities. According to Robb and Pinto (2010), 84% of undergraduate students have credit cards and, although findings from several studies show the majority of the students pay their full credit card balances, this does not account for students already at risk of accruing credit card debt, including African American students and others from low socioeconomic backgrounds (Lyons, 2004). Given that credit card debt is related to school dropout and heightened risk for suicide (Roberts & Jones, 2001), it imperative to investigate the impact of African American students' spending behaviors in an effort to combat adverse psychological health outcomes for members of this group.

Cultural Identity of African American College Students

As behavior is often guided by the racial background of an individual, it is impor-

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tant to take one's identity into account. According to Lukwago, Kreuter, Bucholtz, Holt, and Clark (2001), cultural identity refers to the positive regard, involvement, commitment, and social integration one has achieved in association with one's own racial group. In addition, cultural identity is inclusive of racial attitudes and values that are congruent with the ethnicity of the individual. It also describes the different cultural values and strengths of racial groups. The current study primarily uses the materialism subscale of the Cultural Misorientation Scale (Kambon, 1997), which shows a significant positive correlation with mental illnesses and has the highest internal consistency among the subscales (Rowe, Robinson, & Li, 2018). The present study utilizes the term "materialism" rather than "cultural identity" in subsequent sections to be representative of this aspect of cultural identity.

Mindfulness Among African American College Students

Mindfulness has gained popularity as an intervention strategy for stress-related issues affecting physical and psychological health. There is a plethora of studies that support mindfulness-based interventions as a strategy for well-being for experiences of chronic pain, generalized anxiety, panic disorders, and depression, among other mental and medical disorders (Baer, 2003). However, the racial demographics of previous studies are either largely neglected (Baer, 2003) or typically consist of White participants (Reibel, Greeson, Brainard, & Rosenzweig, 2001; Teasdale et al, 2000). Despite the few mindfulness studies with African American participants showing improvements in anxiety and psychological health, as well as lower self-concealment behaviors and blood pressure (Graham, West, & Roemer, 2013), the literature inclusive of African American participants has been sparse.

Stress and Psychological Well-Being among African American College Students

There is evidence that spending behaviors have a significant impact on financial stress and depression (Åslund, Larm, Starrin, & Nilsson, 2014; Jessop, Herberts, & Solomon, 2005; Wichianson, Bughi, Unger, Spruijt-Metz & Nguyen-Rodriguez, 2009). According to Åslund and colleagues (2014), financial stress is the persistent inability to afford the basic necessities of life, which is related to a variety of factors that can include debt accumulation and credit card usage. The persistent lack of stable finances and financial stress contributes to poor physiological and psychological well-being, with research suggesting that these factors have implications for poor sleep patterns, poor diet, lack of exercise, smoking, and alcohol consumption (Dooley, Fielding, & Levi, 1996; Hudd et al., 2000; Lee, Crombie, Smith, & Tunstall-Pedoe, 1991; Pierce, Frone, Russell, & Cooper, 1996; Wichianson et al., 2009). Furthermore, there is a well-established relationship between general stress and the onset of depression (Moreno et al., 2011). Overall, college students are at a higher risk of developing depression which makes it especially important that African American students be assessed for their risk and coping capabilities.

Methods

Participants. The participants included a convenience sample of 217 African American college students. There were 182 (83.9%) women and 35 (16.1%) men from a Historically Black College and University (HBCU), which is located in the southeastern region of the United States.

Measures. **Demographic Questionnaire**. The demographic questionnaire included questions on classification, age,

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ethnicity, gender, major, grade point average, parents' educational background, and annual family income.

Spending Behavior Questionnaire. The spending behavior questionnaire is an 8-item, self-report of money management.

Materialism Orientation Subscale (from the Cultural Misorientation Scale, Kambon, 1997). The Materialism Orientation contains statements that indicate participants' value of material things.

Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003)**.** The MAAS allows participants to respond to statements regarding their everyday experience of mindfulness.

Financial Strain Survey. The Financial Strain Survey requires participants to indicate the statements that describe them (Aldana & Liljenquist,1998).

Beck Depression Inventory-II. The Beck Depression Inventory-II contains statements that indicate participants' particular characteristics and the severity of depressive symptoms (Beck, Steer, & Brown, 1996).

Data Analyses

Pearson Product-Moment correlation analysis was used to evaluate the relationship between spending behavior, materialism, mindfulness, and financial stress and depression. A median-split was done to separate materialism and mindfulness into high and low categories to examine the effects of each level on financial stress and depression. General linear univariate analyses were conducted to examine the moderating effects of materialism and mindfulness on financial stress and depression.

Results and Discussion

Financial stress and depression were found to have a moderate positive correlation. The positive correlation between financial stress and depression but not with spending behavior suggests that students may not see an issue with their spending habits. It also suggests that students may not yet have experienced tangible consequences of their spending behavior that would manifest as symptoms of depression. Yet, they are likely to view their financial capability negatively, which is associated with their depressed mood. It is likely that one way students cope with the daily stressors of college such as school performance, peer relationship, and potential overt or implicit racial discrimination is to spend money regularly.

There was a positive relationship between materialism and financial stress, especially given that those who reported higher levels of materialism also endorsed higher levels of financial stress, not depression. Therefore, financial stress may be more problematic for students who overemphasize the possession of material things such as nicer (or more expensive) clothing, jewelry, technology, and so forth.

Based on previous literature, materialism is negatively associated with individual well-being (Kasser & Ryan, 1996; Richins, 2004). When a person is preoccupied with acquiring superficial things, it is difficult to set limits on spending, leading to living above one's means and causing undue stress. Moreover, materialism may have undergone a shift in operationalization given that college students, many of whom are part of the Millennial generation, may be absorbed in a culture of evolving technology in which social media provides access to vast ideas, people, and products.

Additionally, individuals who reported higher levels of mindfulness also re-

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ported lower financial stress and depression. These results imply that students who are able to experience a heightened sense of awareness from moment-to-moment are at less risk for financial strain and mental illness.

Practical Implications and Future Directions

Materialism may serve as a risk factor for financial stress among African American college students. Given that college students are likely to accrue large amounts of debt (Greer & Brown, 2011) and experience adverse health outcomes related to financial strain (Azibo & Dixon, 1998). Bewick, Gill, Muhlhearn, Barkham, & Hill, 2008; Westefeld et al., 2005), college campuses and universities should consider requiring all incoming students to attend financial education courses or seminars (providing this option to parents should be considered as well). Developing culturally sensitive approaches to promoting financial literacy and managing financial stress will be critical to enhancing emotional well-being among African American college students.

Results also indicate that elevated levels of depression are related to poor spending behaviors, high levels of materialism, and increased financial stress. Colleges and universities should actively promote students' use of university counseling centers. Increased financial support of university counseling centers in general to better serve African American student populations (especially at HBCU) to enhance knowledge about psychological wellbeing and reduce stigma is recommended. Additionally, mental health professionals should continue to make their presence known to the community and college campuses in an effort to educate others about mental health and offer resources geared toward these populations.

The results show mindfulness to be a promising coping mechanism in addition to its relationship with reduced materialism. It is posited that social psychological variables relevant to money management decision-making can be influenced by mindfulness training, which may increase self-awareness about financial management and result in lower rates of materialism. Therefore, additional research with African American participants may be helpful to explore ways of improving and maintaining the cultural relevance of mindfulness as an intervention strategy. Additionally, anti-materialism campaigns designed to help current college students in general to avoid succumbing to focused advertising could be helpful to reframe individuals' thinking about their finances.

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CALL FOR NOMINATIONS

APF Rosalee G. Weiss Lecture for Outstanding Leaders

The APA Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for the 2019 American Psychological Foundation's Rosalee G. Weiss Lecture, which honors an outstanding leader in psychology, or a leader in the arts or sciences whose work and activities has had an effect on psychology. The lecture is delivered at the annual APA convention; the 2019 Convention will be held in Chicago, Illinois. The APA Society for the Advancement of Psychotherapy (Division 29) and Psychologists in Independent Practice (Division 42), administer the lectureship in alternate years. The lecture was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee G. Weiss, Ph.D. The lecturer receives a $1,000 honorarium.

Eligibility Criteria:

The nominee must be an:

- Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology; or,
- Outstanding leader in any of the special areas within the sphere of psychology.

Nomination Materials:

- Letters of nomination should outline the nominee's credentials and contribution. Self-nominations are welcomed.
- Nomination letters and a brief CV ***should be submitted electronically in one PDF document*** to the Division 29 2019 Chair of the Professional Awards Committee, Dr. Michael Constantino, at mconstantino@psych.umass.edu

Deadline: January 31, 2019

ETHICS IN PSYCHOTHERAPY

Rinse and Repeat: Replication and Research Ethics

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Scandals involving psychological research have been making the headlines since World War II (see Adair, 2001, for review). These public critiques make individuals skeptical of the veracity of psychological science. Recently, participants from Phillip Zimbardo's Stanford Prison Experiment (Haney, Banks, & Zimbardo, 1973) were interviewed and revealed potential ethical violations, including feeling they were obligated to remain in the experiment (Blum, 2018). Although Zimbardo has reported the participants' accusations are unfounded, the question of research ethics and need for replicability continues to be a point of discussion.

Beyond the public discourse regarding the authenticity of psychological science, there have been concerns among psychologists as well. In recent years, researchers have noted a *crisis of confidence* in scientific research, including psychological research (Giofre, Cumming, Fresc, Boedker, & Tressoldi, 2017). Commonly cited studies sometimes go without critique or replication within the field or its subspecialties. Indeed, many introductory psychology textbooks expose students to inaccurate information or report information that is not mainstream (Ferguson, Brown, & Torres, 2018; Warne, Astle, & Hill, 2018). Therefore, there is a need within psychology to continuously monitor research ethics.

Beyond an Institutional Review Board: Research Ethics

Ethical guidelines, such as the American Psychological Association's (APA, 2017) *Ethical Principles of Psychologists and Code of Conduct,* provide foundational understanding of research ethics, but interpretation of those guidelines is still ambiguous. Given the necessity to provide accurate information to both the field and the public, an evaluation of current research ethics and limitations in current practice is warranted. Awareness and application of ethics in professional activities is a core competency of psychologist and expected component of graduate and post-graduate training in psychology (Rodríguez et al., 2014).

Although these ethical guidelines may be globally informative, some argue they provide little guidance into subspecialty areas of research, especially in social and experimental psychology (Adair, 2001; Seiber, 1994). Thus, there has been an emergence of within specialty guidelines that have been developed. For instance, individuals in psychology and law consult the *Specialty Guidelines for Forensic Psychology* (American Psychological Association, 2013). Evaluation of research ethics within subspecialties or with specific populations is needed.

Data Reporting

Reproducibility and replicability in research become increasingly important when considering the implications of research findings. Alter and Gonzalez (2018) defined reproducible as "the ability to verify published findings using the same data set" and replicable as "the ability to find similar results in a new

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study" (p. 146). Reports have revealed many published studies in psychology cannot be replicated or reproduced (Open Science Collaboration, 2015). The Open Science Collaboration replicated 100 articles from three well-regarded journals. Only 36% of those replications were statistically significant and the effect sizes were only half as strong as those reported in the original studies. Other critics have noted the presence of "p-hacking," the term used for the practice of post-hoc adjustments to data or data analyses in order to obtain a significant p-value, in psychological research. In order to avoid such conduct, data reporting measures need to be reviewed and enhanced.

Although the American Psychological Association (APA)'s publication manual establishes a baseline for what should be reported in published works, other guidelines providing more extensive details on content that should be including for the purposes of replication. For instance, the STROBE checklists are helpful for researchers and authors to provide thorough information regarding their methodology, data analyses, and study limitations (STROBE, 2007). Additionally, some journals and professional organizations have adopted their own data or submission reporting guidelines (see Giofre, Cumming, Fresc, Boedker, & Tressoldi, 2017).

Lingering Controversies

In addition to replicability, generalizability of results is another important component of psychological research, as many studies lack representative samples. However, there continues to be discussion regarding conducting research with vulnerable and marginalized populations, including, but not limited to, children and adolescents, individuals who are undocumented, minority groups (racial, ethnic, sexual), individuals who are incarcerated, individuals with physical health conditions, and students. For instance, there has been a great deal of debate on whether researchers can/should ask about abuse histories of participants, with some Institutional Review Boards (IRBs) prohibiting this practice (Becker-Blease & Freyd, 2006). Additionally, given that racial-ethnic minorities often experience a disproportionate number of psychosocial stressors, researchers should be especially mindful of the well-being of minority populations as research participants; this includes awareness of the lack of diversity among researchers, the use of culturally sensitive practices, and avoidance of exploitation (Gil & Bob, 1999). Addressing culturally considerations in ethics beyond deception is crucial in maintaining beneficence.

Emerging technology, such as the use of social media, presents additional ethical challenges. Golder, Ahmed, Norman, and Booth (2017) reviewed 17 studies to evaluate attitudes regarding social media research. Through their analysis of themes, concerns such as conducting research with vulnerable groups on social media, risks to users, privacy, and validity of research were discussed as ethical concerns. There was a lack of consensus regarding social media research ethics in general, especially in major areas such as confidentiality, informed consent, and assessing the risks and benefits of conducting social media studies. While some researchers have identified these challenges in psychological research (see Keller & Lee, 2003 for review), official guidelines have not been developed. In sum, there were challenging ethical factors to consider in social media research that need further exploration and, as emerging technologies develop, further dialogue will be warranted.

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Lastly, in working with vulnerable populations, researchers should be mindful of unintentional coercive approaches. In fact, Festinger et al. (2009) found monetary incentives improved participants recall of informed consent, which may seemingly improve the quality of the study, but may influence vulnerable populations in a different way than other participants. Currently, many researchers are using Amazon's Mechanical Turk (MTurk) to recruit participants for their studies. MTurk is a means of crowdsourcing research and can results in a more diverse sample than the traditional college student convenience sample. However, several researchers have noted ethical concerns in using these participants, including economic exploitation, comprehensive sampling, and concerns regarding effort, attention, and validity of research (Goodman, Cryder, & Cheema, 2013; McInroy, 2016). Further, other data collection sources, such as message boards and social media, have also been critiqued. Though these approaches might increase access to important subpopulations (e.g., racial, ethnic, and/or sexual minorities), researchers should critically evaluate the use of emerging technologies in data collection.

Future Directions

Several recommendations have been made to better improve research ethics in the field of psychology. Although some approaches have been in place for a while, there are innovative ideas on how improve accountability in research ethics.

Training and continuing education. As always, training and continuing education are great venues to have discussions regarding research ethics. Many continuing education workshops in ethics focus on broad clinical and professional ethical concerns, but rarely discuss research ethics. As stated above, speciality guidelines and new research considerations are frequently discussed in the literature. These venues will allow trainees and professionals the venue to dialogue about these emerging areas of research and maintain professional competence. Further, nonlicensed professionals, such as academic researchers, may not need continuing education, so this is an important training gap to address within their institutions.

Open access. Given the lack of replication of many studies, increased need for transparency of methodology and data analysis is apparent. There has been a call for more transparency in data reporting practices, as well as access to data for the purposes of replication (Alter & Gonzalez, 2018; Giofrè et al., 2017). Researchers have suggested all results are "open to challenge through reexamination, reanalysis, reproducibility, and replication" (Alter & Gonzalez, 2018, p. 146). Data repositories (i.e., organizations that maintain and distribute data) contain data files for use by other researchers, and some funding agencies require data sharing plans for research grants (DuBois, Strait, & Walsh, 2017). Materials commonly archived in these sources are interview guides, raw data, data codebooks, IRB approval documents, transformed data, research methods protocol, and references (DuBois, Strait, & Walsh, 2017). These repositories can also assist should unexpected incidents occur, such as computer or server failure, natural disasters, or the death of a primary investigator. In sum, having data readily available to provide to other researchers may help improve the data sharing process and facilitate more replication of studies.

Badges. Back to the Scouts we go! The Center for Open Science (COS) has developed three "badges" for published journal articles to designate which

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articles meet criteria for research openness. An Open Data badge is given to articles for which the collected data are stored on an open-access online site. An Open Material badge indicates the researchers have uploaded their surveys, tests, and other materials that were used in the collected of the data. A Preregistered badge indicated the researchers clearly articulated important aspect of their methodology prior to collecting data and have saved their research plan on a website. Several psychological research journals, including *Psychological Science*, *Journal of Social Psychology*, and *Journal of Research in Personality*, have supported the COS and adopted the badges (Grahe, 2014; Rouse, 2017). The *Psi Chi Journal of Psychological Research* adopted the COS badges and added an additional badge (Rouse, 2017); this Replication badge identifies replication studies.

Conclusion

Findings from research have major implications for the public and the field. Many trust that such results were obtained in an ethical manner and that the peer review process serves as gatekeeper to what is published in peer-reviewed journals. Accurate data reporting and replicability of research are crucial in the scientific process and in determining the generalizability of results. Researchers should discuss the limitations of their results and report areas of need for future study. Further, emerging approaches, such as open access repositories, can lend to better facilitating collaborating and replication efforts.

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INTERNATIONAL SCENE

International Domain Report for *Psychotherapy Bulletin*

The International Domain established two new awards in 2018: (a) Distinguished Award for International Advancement of Psychotherapy, and (b) International Research Grant for Students and Early Career Professionals. The inaugural recipients of these awards are announced elsewhere in this Bulletin with other Society award winners.

The second main activity of the domain was our continuation of participating actively in international conferences in Psychology. Following upon our participation in the World Congress of Psychotherapy in Paris (July 2017), we participated in the International Congress of Applied Psychology (ICAP) in Montreal (June 26-July 1, 2018). With

Lauren Behrman and Jeff Prince serving as program co-chairs, we partnered with the organizers of the ICAP and we offered slots for two keynote addresses and three invited symposia (see below). Members of our international affairs committee served as chairs and organizers for the invited symposia.

Congress Invited Keynote Addresses
Guillermo Bernal, Albizu University, presented "Toward a Science for Cultural Adaptation of Psychotherapy" and Frederick Leong, Michigan State University, presented on "Diversifying Psychotherapy: Challenges and Benefits."

Congress Invited Symposia
(1) *International Collaborations in Training to Advance Psychotherapy*. Participants: Lauren Behrman (Chair), The Practice Institute, New York City; Jeffrey P. Prince, University of California, Berkeley; Wensheng Yang, Shanghai Jiao Tong University, Shanghai; Beth Haverkamp, University of British Columbia, Vancouver; and Frank Hagen Hofmann, Heidelberg University, Germany.

(2) *The Design of Psychological Treatment: its Mechanisms, its Research Basis and its Efficacy/Effectiveness*. Participants: Patrick Leung (Chair) The Chinese University of Hong Kong; Suzanne Ho-wai So, The Chinese University of Hong Kong; Raymond Chan—Neuropsychology and Applied Cognitive Neuroscience Laboratory, CAS Key Laboratory of Mental Health, Institute of Psychology, Chinese Academy of Sciences; Pragya Sharma—Dr Ram Manohar Lohia Hospital, New Delhi, India.

(3) *Through the Cultural Landscape of Psychotherapy: An International Horizon That Moves Towards a More Effective Cultural Psychotherapy*. Participants: Maria del Pilar Grazioso (Chair) Universidad del Valle de Guatemala, Guatemala City, Guatemala; Guillermo Bernal, Albizu

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University, Puerto Rico; Maria Helena de Souza Jourdain, Private Practice, Guatemala; Martin La Roche, Boston Children's Hospital; Lorna Osgood, Aigle Foundation, Argentina; Pragya Sharma, Dr Ram Manohar Lohia Hospital, New Delhi, India.

The International Domain also hosted a reception at ICAP which was ably organized by Lauren Behrman and Jeff Prince and well attended by SAP members. In addition to the reception, we also organized a dinner for International Affairs Committee members at the same venue; the event was a great success.

Finally, after a successful relationship with Oriental Insight, the International Domain is working on renewing our agreement and partnership with OI.

Several members of our Society continue to provide valuable training at OI within this partnership. Changming Duan, Chair of our International Affairs Committee, continues to be the key contact person for this partnership.

EDUCATION AND TRAINING

A Reflection Upon Clinical Training

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Combined Integrated Clinical and School Psychology Doctoral Program
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When I reflect upon my journey to becoming a clinical psychologist there are three aspects that have significantly shaped my development as a therapist. The first is that, during my training, I have been exposed to a wide range of clinical settings, therapeutic approaches, and clinical populations. I have practiced at the university counseling center, a community-based clinic, and a psychiatric hospital, among other settings. This allowed me to work closely with supervisors with different clinical backgrounds and models, and to see a wide spectrum of clinical severity, ranging from clients who were in a journey of personal growth to clients who were significantly detached from the world around them. I was always expected to address all of this range of needs, understanding my clients' struggles not as combinations of symptoms but as complex and yet coherent manifestations of life experiences and dispositions. I also had the chance to work with clients with different cultural backgrounds. As a native Spanish speaker who was raised in Peru, my cultural background and language skills were an asset in creating opportunities to work with populations with unmet needs. Thus, I have worked with Spanish speaking clients and other underrepresented populations in the community, providing individual and group therapy, competency to stand trial restoration education, and conducting neuropsychological and psychoeducational assessments. Finally, although I knew since the beginning of my program that I wanted to work with adults, I was also encouraged to work with children and incorporate developmental aspects in my conceptualization and treatment of patients.

The second key aspect of my training relates to shaping my professional identity and finding my own voice, which were possible due to exposure to diverse perspectives and clinical experiences. After learning from many different models, I found in one specific therapeutic approach (Interpersonal Reconstructive Therapy; IRT) an integrative model that served as a basis from which I could develop comprehensive case formulations and plan individualized treatment. It was very important to find the clinical approach that spoke to me, as it became a tool that gave me the confidence to navigate complex scenarios and work with severe clinical cases. I have also been involved in research that uses IRT's comprehensive theory of socio-emotional functioning to look at mechanisms of change in psychotherapy. This has given me the opportunity to further deepen my clinical skills. During my practicum at an adult psychiatric hospital, I took a step forward and extended the IRT model to an inpatient group setting. I developed an IRT-based curriculum aimed at providing patients the space and tools to become more aware of their maladaptive relational patterns, their origin and impact in their life, and healthier ways of relating with others

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and with themselves. I am currently working on formalizing this curriculum for replication and testing.

The third key aspect is that I was lucky to be in a program that provides substantial supervision and mentoring. This has also significantly shaped my development as a therapist. Thanks to that support system I could be an active agent of my own education since the beginning of my training, creating opportunities for myself, taking risks, and not being afraid of "complex cases."

Every career pathway is unique. I would encourage students who are initiating their clinical training to explore with openness the range of possibilities that the field offers, find their own voice and the therapeutic model that speaks to them, and to welcome facing new challenges taking advantage of the support system that their program offers. Embrace the journey! I hope yours is as exciting and stimulating as mine has been.

IT'S KEVIN, DOCTOR--HE NEVER TAKES ANYTHING SERIOUSLY!

A Reflection Upon Teaching and Mentorship

Alice E. Coyne, MS
University of Massachusetts Amherst

I'm deeply honored and humbled to receive the Division 29 Student Excellence in Teaching/Mentorship Award. Teaching and mentoring students has been one of the most valuable experiences I've had as a graduate student. Yet, as a student, it still feels incredibly odd to be asked to write about my teaching/mentorship experiences. As graduate students, I think that we are constantly reminded of how much we don't know, which can make it difficult for us to feel qualified to teach and mentor others. With this dilemma in mind, I decided to focus in this article on some of the ways in which engaging in teaching/mentorship activities while still a student can bring unique benefits in the hope that it might encourage other students to pursue additional teaching/mentorship activities, even if they don't feel like an expert on anything yet.

In this vein, if I had to distill my experiences thus far into something like advice, it would be to figure out what makes you passionate about teaching and mentorship and to pursue opportunities that fit with your interests, even (and perhaps especially) if it means that you have to "learn on the job" so to speak. For me, one of the most exciting and rewarding aspects of teaching and mentorship is in helping students develop a scientific mindset. Consistent with this, I have pursued opportunities to work with graduate and undergraduate students in the areas of research design and statistical analysis. Some of my favorite experiences in this realm have included mentoring honors students as they complete a project in which they test their own questions about psychotherapy, running graduate and undergraduate lab sections on research methods and statistics, and working as a statistical and methodology consultant to help students and faculty develop and test empirical research questions.

All of these experiences required me to continuously push myself to learn new things, sometimes right alongside my students. Although this can certainly be scary, I've found that it has benefits too. For example, I tend to understand concepts on a deeper level when I teach them to others. This experience also seems to be valued by students, which fits with my own experiences as a mentee and student; that is, I have always found it more useful to have a mentor/teacher who models the process of continual learning than one who assumes the role of the established expert. As students, I think that we are especially well-situated to engage in this kind of modeling, and teaching students what to do when they *don't* know something may actually be one of the most valuable things that we can teach our students and mentees. Thus, my final advice to other students about teaching and mentoring would be to try to embrace the overlap between your student and teacher roles. Perhaps the best form of this is akin to the effective integration of research and practice in psychotherapy; the two can be considered truly integrated when they are almost completely confounded. ■

REMEMBRANCE

Jeremy D. Safran, PhD • April 23, 1952 – May 7, 2018

Lisa Wallner Samstag, PhD
Long Island University–Brooklyn Campus

Professor Jeremy D. Safran, a teacher, clinical psychologist, psychoanalyst, and psychotherapy researcher, was fatally attacked by an intruder in his Brooklyn home on the evening of May 7, 2018. He had just turned 66. The news of his brutal murder sent shock waves throughout the many local and international academic communities of which he was a central part.

At the time of his death, Dr. Safran held concurrent academic appointments at the New School for Social Research (Full Professor), and Mount Sinai Beth Israel Medical Center (Senior Research Scientist), and was a member of the teaching faculty of the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis (where he completed his psychoanalytic training), and the Stephen A. Mitchell Center for Relational Studies, all in Manhattan. Never one to shy away from a challenge, he joined the New School faculty in 1993 when the clinical psychology program was on academic probation, and in his role as Director of Clinical Psychology, effectively led the department to full accreditation status.

With his characteristic enthusiasm and zeal, Dr. Safran took on a number of leadership positions: he was Director of the Cognitive Therapy Unit at the Clarke Institute of Psychiatry, University of Toronto (1986-1990); served two terms as Director of Clinical Psychology (1993-1996, 2005-2008) and also as Director of Graduate Studies, at the New School for Social Research (2003-2005); and was President of the International Association for Relational Psychoanalysis and Psychotherapy (2009-2011). Dr. Safran was co-Founder and co-Chair (with Lewis Aron, PhD, and Adrienne Harris, PhD) of the Sandor Ferenczi Center at the New School, was instrumental in the expansion of the Brief Psychotherapy Research Program at Beth Israel Medical Center, under the leadership of Christopher Muran, PhD, and Arnold Winston, MD, and was co-Founder (with Christopher Muran, PhD, and Catherine Eubanks, PhD) of the Center for Alliance-Focused Training.

Over his 36-year career, Dr. Safran distinguished himself as an inspiring teacher, clinician, and researcher, and each were parts of him that contributed to his passionate commitment to the ongoing investigation of complex clinical change processes. I think one of his greatest gifts was his ability to put what took place in psychotherapy into words. Dr. Safran authored and co-authored eight books and published over 175 articles and book chapters on an impressive range of theoretical and empirical topics reflective of the wide breadth of his intellectual interests. While in graduate school at the University of British Columbia, he met Leslie Greenberg, PhD, with whom he collaborated on the expansion of cognitive behavioral treatment models that were becoming popular in the 1980s (Greenberg &

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Safran, 1980, 1981, 1984a, b, 1987a, b; Safran, 1998; Safran & Greenberg, 1982a, b, 1986, 1987, 1988) and the early theoretical development of emotion focused therapy (Greenberg & Safran, 1989; 1990; Safran & Greenberg, 1989, 1991), and who exposed him to the task analytic approach to clinical research (Safran, Greenberg, & Rice, 1988; Rice & Greenberg, 1984), a paradigm that would shape his empirical endeavors through the rest of his life. Dr. Safran also collaborated with Zindel Segal, PhD, integrating interpersonal theory into cognitive behavioral therapy (Safran & Segal, 1987, 1990). In 2013, Dr. Safran won the prestigious Gradiva Award for Outstanding Contributions to the Field of Psychoanalysis for what would be his last book, *Psychoanalysis and Psychoanalytic Therapies* (2012).

Dr. Safran is arguably best known for his in-depth work on the role of the therapeutic relationship in effecting characterological change in psychotherapy, which he began as Director of the Cognitive Therapy Unit at the Clarke Institute of Psychiatry in Toronto (1986-1990), and migrated to Beth Israel Medical Center's Brief Psychotherapy Program in New York when he left Canada for an Associate Professor position at Adelphi University's Derner Institute of Advanced Psychological Studies. With long-time collaborator Christopher Muran, PhD, he and other colleagues began tracking the moment-to-moment experiences of patient-therapist dyads in the course of psychotherapy, developing an empirically informed relational treatment model that highlighted mindfulness and therapeutic metacommunication as mutative interventions for personality disordered patients (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996; Safran, Muran, & Samstag, 1994). "Ruptures," defined narrowly as deterioration in the quality of the collaborative working alliance, and more broadly as a dimension of the larger communication situation (a conceptualization attributed to H. S. Sullivan), became a way of framing relational enactments going on between a patient and therapist—often exquisitely subtly—that could be identified and processed together, leading to shifts in characterological patterns of relating. *Negotiating the Therapeutic Alliance: A Relational Treatment Guide* (Safran & Muran, 2000), a description of the integrative treatment principles, theoretical foundation, and research support for the model, remains a transtheoretical scholarly tome for clinical training. In recognition for his outstanding contributions to psychotherapy process-outcome research, Dr. Safran was granted Fellow status by the American Psychological Association Division 29 (2015), and was honored with the International Society for Psychotherapy Research Distinguished Research Career Award (2016), as well as the American Psychological Association Division 39 Distinguished Contributions to Psychoanalytic Research Award (2017).

Dr. Safran's interest in Buddhism, which he began studying formally while an undergraduate at Simon Fraser University in British Columbia, Canada, is clearly evident in the therapist stance that he and Dr. Muran called "mindfulness in action." Mindfulness in action is a type of metacommunication, "an attempt to step outside of the relational cycle that is currently being enacted by treating it as the focus of collaborative exploration: that is communicating *about* the communication that is taking place" and bringing "ongoing awareness to bear on the interactive process as it unfolds" (Safran & Muran, 2000, p. 108). In

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order to facilitate such an ongoing, moment-to-moment awareness of the interactive process, the therapist must be genuinely curious about the patient's reactions and open to examining these contributions to the relational communication patterns as they unfold, understanding that in the attempts to step back and unpack the experience with the patient, the therapist remains, paradoxically, always embedded within the interpersonal field to some degree. Such emotional sensitivity and vulnerability on the part of the therapist is essential to the change process for some patients, and is what distinguishes this treatment model from other psychoanalytically oriented approaches that emphasize insight, rather than emotional experience, as a mechanism of change. Developing this type of therapeutic skill requires dedicated training, and a great deal of Dr. Safran's recent work turned to further refining and teaching the experiential approach (e.g., Eubanks, Muran, & Safran, 2015; Eubanks-Carter, Muran, Safran, & Hayes, 2011; Muran, Safran, & Eubanks-Carter, 2010; Muran, Safran, Eubanks, & Gorman, 2018; Ryan, Safran, Doran, & Muran, 2012; Safran et al., 2014).

In a recent interview for the *Psychotherapy Expert Talks* series ("Jeremy Safran: On Thinking Relationally, Alliance Ruptures, and Emotional Openness with Clients," May 11, 2016), Dr. Safran mused that his thinking about the role of ruptures had shifted as the result of ongoing research comparing different treatment model processes. He noted that he had always been most interested in the moments in treatment when things were not working, when he and the patient "were not on the same page." However, in reviewing old session tapes from the 1990s, he reflected that some therapists were "relentless" in their focus on the here-and-now of the therapy process, and in certain cases "creating more problems than they solved." While some patients show improvements without presenting *any* problems in the alliance, he acknowledged, attending to the subtle shifts in communication was a therapeutic stance he continued to espouse because personally meaningful change for him had always come about in subtle rather than dramatic ways.

Born on April 23, 1952, in Calgary, Alberta, Dr. Safran was predeceased by his parents (Nathan and Eeta) and older sister (Sharon). He and his wife, Jennifer Hunter, PhD, also a clinical psychologist and teacher, raised two daughters, Ayla and Eliana. Dr. Safran leaves behind his extended family, close friends, and leagues of students, colleagues, and patients who did not have the opportunity to say goodbye.

By way of an ending, I return to his interest in Buddhist psychology and the support he described receiving from his Buddhist teachers through the difficult times in his life: "Buddhism places the confrontation with death, loss, and suffering at the heart of things. And ultimately it offers refuge, not in the promise of a better afterlife or protection by a divine figure, but in the form of a pathway toward greater acceptance of life as it is, with all its pain and suffering" (Safran, 2003, p. 29).

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WASHINGTON SCENE

"I Left My Heart in San Francisco"

Pat DeLeon, PhD
Former APA President

The more than 12,300 colleagues who attended the 126th annual APA convention in San Francisco were especially fortunate to be gently reminded, especially during the remarkable Opening Session, why we had chosen psychology many years ago. The Keynote address by Attorney Bryan Stevenson provided an emotionally moving glimpse into the lives of those caught up within the criminal justice system—especially children—who have historically been "powerless." Advancing social justice clearly remains a high priority for many of those in attendance. Throughout the convention, the personal stories of President Jessica Henderson Daniel's Citizen Psychologists provided an awesome appreciation for how individuals can make a real difference in the lives of our nation's citizens at the grassroots level. The unique and pressing needs of rural America, Veterans and military family members, and Rod Baker's "Meaningful Retirement" symposium presentation highlighted areas in which psychology possesses truly unique expertise. On a personal level, I especially appreciated hearing the stories of the profession's leaders—past, present, and future—during which APA President-Elect Rosie Phillips Davis spontaneously joined Recording Secretary Jennifer Kelly and Uniformed Services University (USU) graduate student Fernanda De Oliveira for "Getting Involved in the Policy Process—Challenges, Successes, and Strategies."

Dr. Kelly's presentation, "Strategies for Effective Advocacy in the Passage of Mental Health Legislation," focused on the importance of effective advocacy in raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. She noted that advocacy on the Federal level is important as the federal government impacts psychology in numerous ways, including the funding of basic, applied, and clinical research; creating and administering social programs critical to the livelihood and health of the people psychologists serve; providing reimbursement for service delivery; and expanding opportunities in psychology education and training. She discussed ways to effectively advocate, such as making phone calls, writing letters and emails, and, most importantly, in-person visits with the lawmakers and their staffs. Dr. Phillips Davis presented her forthcoming Presidential initiative on "Deep Poverty." She is forming a work group to explore the communication patterns that have led to poverty being considered an individual shame rather than a national problem. Her work group will explore how psychologists can use psychological science to partner with cities as mayors explore ways to improve the economic outlook for their citizens. They will also explore advocacy options with policy makers, service providers, individuals living in Deep Poverty, and psychologists who want to impact the number of people living in poverty.

As discussant, Fernanda De Oliveira reflected on the recommendations pro-

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vided by Jennifer and Rosie as they apply to students eager to advocate for their ideas at the institutional level, and commonly expressed barriers to seeing oneself in the role of an advocate within our field. More specifically, she noted how the same self-reflective nature that draws many of us to psychology can also keep us from believing in our capacity to advocate for our ideas and to promote change on behalf of those we serve. She concluded her comments by urging audience members to mentor their juniors on how to develop their identity as advocates of their ideas, knowledge, and profession.

The unprecedented advances occurring within the communications and technology fields, as well as the ever-shifting landscape of our nation's healthcare environment, continue to have a major impact upon society and therefore the profession of psychology. Accordingly, the implications of these developments were present throughout the convention. Presentations on telehealth, including its complex ethical considerations, were especially timely. Fred Millan, Past President of the Association of State and Provincial Psychology Boards (ASPPB); Dr. Linda Campbell, and Jana Martin, CEO of The Trust, have been providing presentations on telehealth since the APA guidelines were adopted (they were co-chairs of the Task Force creating the guidelines) in 2013. They have an impressive case-oriented style which generates active audience participation. This year they shared scenarios on Confidentiality and Informed Consent. APA's Deborah Baker also participated by discussing legal issues and state telehealth coverage mandates. Not surprisingly, the federal government has long been on the cutting-edge of effectively utilizing telehealth and fostering integrated care, as reflected in symposiums chaired by Chris Kasper, formally at USU and now Dean of the School of Nursing at the University of New Mexico, and Lisa Kearny, Chair of the Board of Professional Affairs (BPA). Both of these evolving initiatives, with their inherent implications for licensure mobility, present intriguing challenges and opportunities for *all* of the health professions.

Transformative Challenges

Psychology and each of the mental health/behavioral health professions *must* come to appreciate *the transformational nature* of telehealth. A recent communication from a longtime Hawaii colleague, who once again is serving as Director of our Department of Health:

> Telehealth could be a valuable tool in evaluating individuals with behavioral issues who are brought to emergency rooms by police officers (i.e., 'MH-1s'). Basically, MH-1s are brought to emergency rooms because they were disruptive and pose a threat to themselves or others. I believe one of the significant barriers to hospitals accepting these individuals is the lack of psychiatrists, psychologists, and other health professionals to evaluate MH-1s quickly and accurately when they are brought in, particularly in rural areas. As a result, only the large hospitals that have psychiatrists and other mental health professionals on staff 24/7 are comfortable taking most of them (i.e., Queen's and Castle). Fortunately, some Neighbor Islands hospitals (e.g., Hilo, Kona, Maui Memorial, KVMH and Kauai Veterans) have found ways, but MH-1s are still considered a strain on limited resources. I believe telehealth would be a great way to assure a timely evaluation, so that the police officer doesn't spend hours attending the person he or she brings into the ER waiting for an evaluation and, of course, it is good for the patient to

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> be evaluated quickly, too. It seems to me that telemedicine, and particularly telepsychiatry, is a potentially terrific tool to expand the availability of mental health services in Hawaii. (Bruce Anderson)

A related, although slightly different perspective, regarding the long term implications of telehealth from a former BPA staff director:

> As it continues to unfold, it will challenge the very basis of independent practice as we have known it since the late 1940's. Licenses will cease to limit access to markets and the rationale for state regulation of practice will be called into question. APA's policy infrastructure is not up to this, nor is its politics. As a strong, vocal, and visible advocate for these changes, I would encourage you to remember what happened to your CHAMPUS peer review project. The independent practice folks killed it and ushered in managed care. One would hypothesize the same will happen here. Systems of care will adapt. Private practice will soon see the threat of nationalized companies offering 24/7, 365 days service on demand. Batten down the hatches as we move forward because it's unlikely to be as pretty as your columns suggest. (Dick Kilburg)

The Global Context

One of the most satisfying aspects of working within an academic environment, such as USU, is the daily exposure to intellectual colleagues who appreciate the "bigger picture" and who constantly remind one of the importance of being aware of the values and experiences of those from different professional and cultural backgrounds—that is, looking beyond perhaps comfortable, but intellectually isolating, "silos." Dale Smith, USU Professor of Military Medicine and History, recently provided "A History of PhD Education" for the newly enrolled PhD students ("2018 Warrior Scholars") at the Daniel K. Inouye Graduate School of Nursing. Emphasizing the revolutionary impact of education upon practice, and vice versa, he quoted Daniel Coit Gilman: "The best teachers are usually those who are free, competent and willing to make original researches in the library and the laboratory."

In 1900, 14 educational institutions joined together to create the Association of American Universities with the laudable goal of ensuring the overall quality of higher education. Psychology's visionary Boulder Conference was held in 1949. In the mid-1960s, the Professional School PsyD concept arrived, shepherd by visionaries Drs. Nick Cummings at CSPP, Ron Fox at Wright State University, and Don Peterson at Rutgers University. In the 1950s, nursing moved from its historical, often hospital-based, diploma degree to the BSN standard. By 1970, there were 20 nursing educational institutions granting advanced practice master's degrees; this number increased to 78 institutions by the year 2000. In 2001, the University of Kentucky had established the Doctor of Nursing Practice (DNP) degree. Today, there are 278 DNP programs and approximately 132 nursing programs granting the PhD.

As Dale described how nursing's educational standards had evolved over time—especially within the larger societal context—those with a psychology or clinical pharmacy background could quickly appreciate the similarities with their own profession's maturation. From this perspective, the landmark 2010 Institute of Medicine report *The Future of Nursing,* which calls for allowing nurs-

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ing graduates to practice to the full extent of their education and training and to be full partners with physicians and other health care professionals, in fact, reflects both the changing dynamics of education and how educational advances have significantly modified what each health profession's clinical practice is *and* will be expected to become. Society's very definition of "quality care" has been constantly undergoing significant change. "We all live in a yellow submarine" (The Beatles, 1966).

The Advanced Practice Registered Nurse (APRN) Legislative Experience

When one appreciates that each of the health professions functions within a changing American healthcare environment, the importance of building interprofessional relationships and collaborative legislative coalitions becomes increasingly evident. Carole Myers and Jill Alliman recently published in an American Association of Nurse Practitioners (AANP) journal *Updates on the Quest for Full Practice Authority in Tennessee*, which is considered one of the most restrictive states in the nation. In 2016, the Tennessee General Assembly established a Scope of Practice Task Force to "make recommendations on the implementation of a plan to allow health care providers to work to the full extent of their education, experience, and training and identify… unnecessary regulations." The authors noted that the resistance to progressive change that they are experiencing in Tennessee is similar to experiences in other restrictive states, many of which are located in the Southeastern United States. Advancing full practice authority will require new strategies.

Their Task Force met four times and polarization between the physician and nurse members was apparent from the first meeting. The physicians attempted to draw attention away from the assigned objectives by utilizing distractions and distortions. They assaulted the adequacy of APRN education; dismissed evidence of cost, quality, effectiveness, and acceptability of APRN-provided care; denied health care access problems existed; and blamed APRN prescribers for the state's prescription drug abuse epidemic. Attempts by the nursing members to respond to these tactics with evidence and logic proved ineffective at dispelling misconceptions and false statements. If evidence-based medicine was to be the acceptable standard of care, then actual care should be evaluated using clinical and patient-satisfaction outcomes, not the number of years of education. Perhaps physicians are, in fact, over-prepared to deliver the majority of direct primary care services and are better suited to roles related to population health management and caring for populations with complex needs. Simply stated, the physicians refused to recognize the evidence presented by nursing during the Task Force proceedings.

The key lessons learned: *It is imperative to engage nurses and stakeholders from non-nursing sectors, including business and industry. *Evidence is a beginning and a means, but not an end. It is important that evidence be translated into an easy-to-understand, effective message that resonates with stakeholders and motivates them to act. *Unity is powerful. In the past, there have been numerous efforts by a variety of organizations to divide nurses. And, *Full practice authority is primarily about access to high-quality, cost-effective care that honors patients' choice of providers. The motivation and discussion on full practice authority must remain patient-centered. Those dedicated to psychology's prescriptive authority (RxP) agenda should not be surprised to learn that Bethe Lonning reports that at their Administrative Rules Review Com-

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mittee meeting for the Iowa legislature, the lobbyist for the Iowa Psychiatric Society spoke in the public comment section to indicate that her members had concerns about the education and training of potential RxP psychologists, as written in the proposed rules.

Aloha.

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY MEMORIES FROM THE 2018 AWARDS CEREMONY SAN FRANCISCO, AUGUST 10TH – APA CONVENTION

Dr. Jacques Barber (r) accepts his award for Distinguished Psychologist of the year from SAP Awards Chair Dr. Jeff Zimmerman

Dr. Rod Goodyear accepts the inaugural Distinguished Award for the International Advancement of Psychotherapy from Dr. Jeff Zimmerman

Dr. Tony Rousmaniere, one of two awardees, accepts the APF/SAP Early Career Award from Dr. Jeff Zimmerman. The other awardee, Dr. Catherine Eubanks, could not attend.

Dr. John Norcross accepts the Most Valuable Paper Award, given for the best paper published in Psychotherapy during the previous year, from Dr. Jeff Zimmerman and Psychotherapy editor Dr. Mark Hilsenroth

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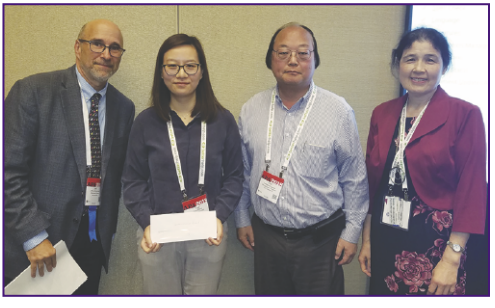
Memories from the 2018 Awards Ceremony

Alice Coyne accepts the Student Excellence in Teaching/Mentorship Award from Dr. Jeff Zimmerman and SAP Student Representative Nick Morrison

Yuye Zhang accepts the International Research Grant for Students and ECPs from Drs. Jeff Zimmerman, Fred Leong, and Changming Duan



Dr. Rob Bedi accepts the 2018 Charles J. Gelso, Ph.D. Psychotherapy Research Grant from Dr. Jeff Zimmerman and the grant's namesake, Dr. Charles Gelso

Dr. Andres Consoli and Dr. James Boswell are welcomes as Society Fellows and accept their Fellows Certificates from Dr. Jeff Zimmerman

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Memories from the 2018 Awards Ceremony

Drs. Barbara Vivino and Tony Rousmaniere are thanked for their work as outgoing committee chairs.

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY (DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION)

Call for Nominations

Distinguished Psychologist Award

The APA Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for its 2019 *Distinguished Psychologist Award,* which recognizes lifetime contributions to psychotherapy, psychology, and the Society. The awardee will receive a cash honorarium of $500 and up to $500 reimbursement for qualified expenses to attend the Society's Awards Ceremony to be held at the APA Convention in Chicago, Illinois, August 2019.

Deadline is January 31, 2019. All items must be sent electronically in one PDF document. Letters of nomination outlining the nominee's credentials and contributions (along with the nominee's CV) should be emailed to the Chair of the Professional Awards Committee, Dr. Michael Constantino, at mconstantino@psych.umass.edu

Society for the Advancement of Psychotherapy
(Division 29 of the American Psychological Association)

Call for Nominations

Award for Distinguished Contributions to Teaching and Mentoring

The Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for its 2019 *Award for Distinguished Contributions to Teaching and Mentoring,* which honors a member of the Society who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists.

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

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

The awardee will receive a cash honorarium of $500 and up to $500 reimbursement for qualified expenses to attend the Society's Awards Ceremony held at the APA Convention in Chicago, Illinois, August 2019

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Deadline is January 31, 2019. All items must be sent electronically in one PDF document. The letter of nomination must be emailed to the Chair of the Professional Awards Committee, Dr. Michael Constantino, at mconstantino@psych.umass.edu

Society for the Advancement of Psychotherapy
(Division 29 of the American Psychological Association)

Call for Nominations

Mid-Career Awards for Distinguished Contributions to the Advancement of Psychotherapy

The APA Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for its 2019 *Mid-Career Awards for Distinguished Contributions to the Advancement of Psychotherapy*, which recognize contributions made through one's mid-career to the advancement of psychotherapy research, practice, training, and theory, as well as to the Society. Nominees should be no less than 10 years and no more than 20 years post-doctoral degree.

There are two award categories: (1) distinguished scholarship contributions, and (2) distinguished practice contributions. The awardee for each category will receive a cash honorarium of $500 and up to $500 reimbursement for qualified expenses to attend the Society's Awards Ceremony to be held at the APA Convention in Chicago, Illinois, August 2019.

Nomination Requirements:

- A nomination letter written by a colleague (self-nominations not acceptable) that (a) indicates the award category to which the nomination applies, and (b) outlines the nominee's relevant contributions through mid-career. It should be clear how the nominees' contributions built on their early achievements to make a significant impact during the mid-career period of 10-20 years post-doctorate.
- A curriculum vitae (CV) of the nominee.

Nomination materials **must be sent electronically in one PDF document by the January 31, 2019 deadline.** The document should be emailed to the Chair of the Professional Awards Committee, Dr. Michael Constantino, at mconstantino@psych.umass.edu.

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.

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MEMBERSHIP REQUIREMENTS: Doctorate in psychology • Payment of dues • Interest in advancing psychotherapy

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Please return the completed application along with payment of $40 by credit card or check to:

The Society for the Advancement of Psychotherapy's Central Office,
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You can also join the Division online at: www.societyforpsychotherapy.org

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PSYCHOTHERAPY BULLETIN

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

Psychotherapy Bulletin welcomes articles, interviews, commentaries, letters to the editor, book reviews, and SAP-related announcements. Please ensure that articles conform to APA style; graphics, tables, or photos submitted with articles must be of print quality and in high resolution. Complete Submission Guidelines and the online submission portal can be found at http://society forpsychotherapy.org/bulletin-about/ (for questions or additional information, please email Lynett.HendersonMetzger@du.edu with the subject header line *Psychotherapy Bulletin*). Deadlines for submission are as follows: February 1 (#1); May 1 (#2); August 1 (#3); November 1 (#4). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.societyforpsycho-therapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or the Society should be directed to Tracey Martin at the the Society's Central Office (assnmgmt1@cox.net or 602-363-9211).

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