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BULLETIN

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2010 VOLUME 45 NO. 3

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EDITORS' COLUMN

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The *Psychotherapy Bulletin* is going green! Yes, after months of thoughtful discussion, we are ready to offer readers the option of receiving their *Bulletin* online only, rather than in hard copy form. This will not only save trees, but will provide much needed resources for the Division to use on other important projects such as our website. Individuals who choose to receive the online edition of the Bulletin will be able to read it directly on their screens, or download it as a PDF to view on their mobile devices. Eventually, we hope that the *Bulletin* will be available on media such as kindle and nook, and that our articles will be searchable via Google. In the future, we hope to produce an enhanced version of the Bulletin, optimized for the online environment. Meanwhile, we are starting with the relatively small step of allowing members to choose the green option by clicking on www.divisionofpsychotherapy.org/members/gogreen/ and filling out a brief form. Thereafter, those members will receive an email with a link to the online *Bulletin* as soon as it is available. Of course, they may still download and print out the *Bulletin* (or any specific articles) if they want to read anything in hard copy.

This issue of the *Bulletin* is filled, as usual, with excellent articles we know you will enjoy and find useful. You might want to begin by reading the President's column, filled with excellent information related to psychotherapy (and be sure to check out the surfer photo—talk about multitalented!). The Ethics paper in this issue is a particularly compelling story with an important message. The Education and Training submission is related to "deliberate practice theory," and should be of great interest to you. A helpful update on the Multicultural Toolkit Taskforce has been written by the Professional Practice representatives. A paper on facilitating emotion regulation (from Perspectives on Psychotherapy) should be useful to all practitioners, and the report on Social Justice and natural disasters will interest you as well. The Diversity submission this issue importantly focuses on treating trauma in African-Americans. We have included a book review related to earning a living outside of managed care, and the Washington Scene, as usual, includes up to date information related to psychology and politics. Finally, there are some excellent features, including papers on the relationship and common factors in "new" therapies, reasons why therapists fail, and our personal favorite (since it was written by our interns!), an article with suggestions for finishing doctoral papers on time for graduation.

We encourage all readers to go green! And, as usual, please continue sending us your ideas, questions, comments, suggestions, and submissions.

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PRESIDENT'S COLUMN

Jeffrey J. Magnavita, Ph.D.
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"My mother died when I was 2, I never knew my father and still no one will tell me who he is even though I think they know. I got up every morning at 3:00 to milk the cows before I could go to school. I left my neglectful grandparents when I was 15 and have been on my own ever since. I don't trust people. My marriage is in trouble and I don't know where to turn. Can you help?" This is just one of the many stories of suffering and resilience that psychotherapists hear daily that would shock most people, and yet, we psychologist-psychotherapists are entrusted with these narratives and our assistance is sought. We want to alleviate suffering and do no harm. We must absorb and sit with emotional suffering daily, while offering hope in what may seem to be hopeless situations. How does one go about trying to crystallize these narratives and offer a treatment that is effective? This is no simple feat and one that requires fairly sophisticated pattern recognition tools, assessment skills, and methods and techniques of psychotherapy, as well as a deep appreciation for individual differences, cultural diversity, developmental psychology, and principles and processes of psychotherapy. It is very fascinating and perplexing to me that we do not really have an empirical basis to demonstrate that psychologist-psychotherapists have better outcomes than other disciplines that practice psychotherapy, often with far less education and training. We only have some preliminary evidence to shine light on the fact that some psychotherapists attain really good outcomes and others may make people worse. How highly effective psychotherapists operate is not clear. It was these issues that sparked my interest in finding out what we know and do not know about the effectiveness of psychologists who practice psychotherapy. Under the able leadership of Dr. Jeff Barnett a group of leading scholars and researchers joined the Presidential *Task Force on Psychologist-Psychotherapists (TOPPs)* and compiled a review of the literature that led to a discussion of a list of questions we believe are important to the field. The summary of the task force's work and recommendations will be presented at the Division 29 Fall Board Meeting and then shared with our members. Although there are more questions than we have answers for at this time, I hope that the work of this task force will lead to greater knowledge about psychotherapist effectiveness. I am grateful to Dr. Barnett and the members of the task force for their participation and wisdom.

Our Division of Psychotherapy is committed to addressing the most challenging issues that are shaping our future viability as psychotherapists. These include helping us all learn how to deal with an increasingly diverse world. I was very excited to see one of our Past-President Nadine Kaslow's initiatives

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come to fruition when I received the recent special edition of *Psychotherapy* on the diversity characteristics of the psychotherapist and how these inform the psychotherapeutic process. This issue elucidates many of the challenges faced by those on the forefront of these challenges from a professional and personal perspective. It is quite gratifying to see how rapidly this issue came to fruition under Nadine's oversight.

Following a long tradition of collaboration, our Division encouraged my attendance at the *Society for Psychotherapy Researchers (SPR)* conference in Asilomar, California in June. SPR is an organization devoted to advancing psychotherapy research whose members have contributed significantly to the literature with high quality research on psychotherapy process and outcome. There has been a strong alliance between our two organizations that has been cultivated over many years by many of our Past Presidents and Board members. Our Division leadership has been committed to strengthening and advancing our relationship with SPR whose mission we view as critical to the advancement of the field of psychotherapy. I have been a member of SPR for over two decades and many of our Division 29 members are leading psychotherapy researchers who are committed to providing all of us with a solid evidence-base to guide us in effectively treating those who seek us out for our expertise. SPR draws an international group of researchers and clinicians and the conference was a hot house of new ideas and fascinating research. Collaboration among our members and SPR is prolific. I was thrilled to see the close relationships that have developed over the years between the two groups. I participated in a number of discussions and panels such as one lead by one by one of this year's Division 29 award winners Louis Castonguay entitled, *What do clinicians think about research?* Also on the panel was Rosemary Adam-Terem from our Board who is full of sage wisdom and a holistic perspective. I really hope someday that these presentations will be videotaped and broadcast for all those interested who cannot attend to see. The dialogue and interaction among the array of those who are primarily researchers, those who do some clinical work, and those who are primarily clinicians and may be involved in researcher was very engaging and at times schema busting! Another panel that I presented on led by our Past President Abe Wolf was entitled, *Working alliances: The collaborations of APA and SPR*. This included our outgoing Editor-in-Chief of our Journal *Psychotherapy*, Charlie Gelso and was to include our recently elected President-Elect-Designee starting in January 2011, Marvin Goldfried who unfortunately had to leave early. Charlie's research on a tripartite model of the therapeutic relationship is very illuminating and represents how devoted our leaders are to research and scholarship. We did get a video of Abe presenting Marv's findings from a recent clinician-researcher collaborative project, which I have been involved and has been quite illuminating. We will share more of this with you all in the near future. Also, in attendance was our current President-Elect, Elizabeth Nutt Williams who has also established herself as a leading psychotherapy researcher. Another one of our recent award winners, Michelle Newman, presented her research findings on generalized anxiety disorder and clinical implications of her work. Her team is really beginning to unpack this perplexing clinical syndrome, with which so many of our patients live. The devotion and dedication of the research community who work tirelessly tackling complex problems is commendable. I was so honored to have

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been invited to so many panels and collaborate on various projects with so many fine psychologists! At the beach party the last evening there were a number of our leading members dancing on tables but due to confidentiality I cannot share my pictures. What happens in California stays there.

We are making advances on the technology front as well. Under the direction of the Technology Task Force Chair Steve Sobelman, who is also our revered Treasurer, we are making advances in the way in which we embrace technology. Chris Overtree has worked tirelessly to advance our internet presence with new features and quality content. The website continues to expand with new features and relevant content. I am so appreciative of everyone who works to make all the parts of this division operate and evolve as we meet new challenges.

As part of my mission this year I wanted to present to some of our sister groups such as the *Society for Psychotherapy Exploration and Integration (SEPI)*, which held it's meeting in Florence, Italy in May. Again, I can say that exciting work is going on and psychologists are part of an international family who share many basic values and passions. Again, Division 29 was well represented in the roster including the keynote presentation, which was given by our incoming council representative and Past President John Norcross. John's work on the principles of psychotherapy are being embraced, demonstrating the strong commitment of our division leaders, who like John serve as emissaries of evidence-based psychotherapy around the world. I saw many familiar faces and international collaborators. SEPI was a great success and continues to have a strong and enduring relationship with us. A number of our members of Division 29 attended both SPR and SEPI's conferences and were amazed at how we get around.

This brings us up to our next major meeting place San Diego for our yearly APA convention, which I think is going to be a great success. If you have not been to San Diego it will be a real treat. You may even want to take some surfing lessons, Southern California being the place of the surf movement and the Beach Boys. We have a really exciting program shepherded by the able hand of Jack Anchin and supported by our Board and Division administrator Tracey Martin. I want to thank everyone for his or her devotion to this important divisional activity. We have our own suite this year that I hope that all of you who are attending will drop by and say hello. I will be interviewing some of the leaders in our field and will feature these on our website. I will be available when I am not presenting to talk with you about your passions for the field and concerns. We have a wonderful lunch with the Masters for students and young career psychologists scheduled for Saturday. If you teach or train students please let them know to attend for lunch, book raffle, and informal discussions with many of our leading figures. Don't miss our social hour on Friday evening. We will be honoring our award winners and sharing some good food and time together. I hope to see you all there!

Everyday when I see new patients and those who I continue to work with in my office I am strengthened by my participation in the Division of Psychotherapy and sustained by the rich network of individuals that I cherish from around the country. The work that you all do is essential and although I know it is sometimes a very lonely mission, whether you are a researcher or clinician or you have your hands in both worlds, please

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remember that members of our division are some of the most amazing and resourceful people you can ever meet. I sometimes just love picking the phone up and connecting with many of my friends or better yet seeing you on SKYPE or ooVoo, which is a real thrill when I feel lonely and isolated facing the suffering of others and trying to hold the hope. Be connected! Pack up your Woody Wagon and see you in San Diego.

Correction

Psychotherapy Bulletin 2010, Volume 45, No 2, contained an error in the order of authorship on page 14. The correct authorship order for the Perspectives on Psychotherapy Integration article ("You might think that it is cold, but it has been hot since the beginning and is only getting hotter: The therapeutic relationship in CBT") should be: McAleavey, Andrew A. & Castonguay, Louis G. The editors regret this mistake.

Practicing Deliberately: Could we all be expert therapists?

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Running a four minute mile and understanding calculus all have something in common. They were once considered impossible feats that could not be achieved with any regularity. A four minute mile was once considered a physiological impossibility. However, not only has this barrier been broken multiple times, it has been surpassed even by High School runners. Renaissance scholars believed an understanding of calculus was too difficult for most people to achieve in a lifetime. Now, calculus is considered a prerequisite for most college-bound students.

Practice structures to teach expert mastery of skills in these and other fields appear to have similar characteristics. A theory describing these characteristics, called deliberate practice (Ericsson, 2006; 1996), suggests these practice structures are largely responsible for large gains in the average level of performance over time within a given field. For example studies of practice procedures in work domains where deliberate training structures exist (including those mentioned above plus aviation, the military, and professional chess) show that dramatically higher levels of performance for the average professional over time can be achieved using specific deliberate practice activities (Ericsson, 2006). In this article we argue that deliberate practice methods may also be helpful for taking the average level of performance of psychotherapy practitioners to levels currently associated with today's master clinicians. We also sketch ways in which these methods can enhance lifelong learning and skill development in therapy practice.

How are psychotherapists trained and why are some better than others?

Common beliefs about psychotherapy training are that expert level skill is a product of training, experience and beneficial personal traits. However, evidence for any of these factors having a large effect on clinician competency or patient outcomes has not been consistently found despite training innovations such as intensive and in-vivo supervision, videotape review, and therapy manuals (Fauth, Gates, Vinca, Boles, & Hayes, 2007; Lambert & Ogles, 2004). Research instead suggests that some therapists consistently have much better outcomes than others (Brown, Lambert, Jones, & Minami, 2005). For example, Okiishi, Lambert, Nielsen, and Ogles (2003) reporting on a sample of 91 therapists from a university counseling center found large differences in outcome across therapists. On average, the self-reported symptoms of clients of the top three therapists, called "supershrinks" improved more overall, and had fewer sessions than clients seen by the bottom three therapists in the outcome distribution, whose patients tended to worsen and use more treatment resources. If personal traits, training, or experience is not clearly related to improved outcomes, then an important question is how the "supershrinks" or "exceptional therapists" consistently achieve superior

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results. Presumably, the therapists who consistently achieve better patient outcomes do so because of some type of expertise that translates into in-session behavior.

Ericsson's deliberate practice theory (2006; 1996) is similar to experience-based models of expert skill acquisition in the sense that highly skilled performance is seen in part as being the product of extensive practice. However, under the deliberate practice model, the nature of the practice is crucial. According to Ericsson, practice often fails to produce expert performance levels because most learners reach a premature plateau of skill development in which the skill set becomes "automated." Further practice does not bring commensurate increases in skill because automation leads the learner to lose "the ability to control the execution of those skills, making intentional modifications and adjustments difficult" (Ericsson, 2006, p. 684). In other words, learning requires conscious control, and when any task becomes automatic, learning will slow considerably in that area so that attention may be given to other domains. Automaticity is a feature of successful learning, but if it occurs prematurely then additional experience yields only diminishing returns. The typical skill acquisition curve (see Figure One) across many different domains supports this idea. Performance increases reliably with experience for a limited period of time but then a plateau is reached at the point of acceptable levels of skill, typically far below what might be considered the level of an expert (Ericsson, 2006).The rapid reductions in skill improvements once a satisfactory level of performance has been reached reflect an "arrested development" (p. 685). The key to continued development, for Ericsson is to engage in an ongoing, conscious, and deliberate effort to increase whatever skill set or competency is selected for further growth.

Ericsson suggests that those seeking to reach expert levels of performance can avoid prematurely plateauing by using methods of training that extend skill development and therefore delay automation. This is done through carefully designed practice opportunities that:

- Target specific, limited aspects of a skill or performance
- Target skills that are just beyond the current level of performance
- Under guidance of a coach or teacher
- Place limited cognitive demands on the learner
- Require problem solving and exploration of alternatives
- Frequent feedback and opportunities for reflection
- Repetition and frequent practice, usually daily (Ericsson, 2006).

To illustrate, imagine a professional golfer hitting a thousand practice balls every morning. In addition to extensive daily practice in a low pressure situation, our golfer, if he or she wanted to incorporate the elements of deliberate practice into this activity might add the following: 1) targeting a single adjustment to his or her swing that brings about a consistent increase in the average distance the ball travels; 2) learn and practice under the direct observation of a coach who provided frequent corrective feedback (e.g., use of video to illustrate current performance relative to the ideal). The specific adjustment to better control distance the ball travels would be mastered before going on to further changes.

This type of practice is designed to produce continued learning by 1) breaking up complex tasks into multiple simpler

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routines that are amenable to learning, 2) in a context where precise feedback about performance is available (in this case via a coach), 3) in an environment that initially places limited cognitive demands on the learner and to which complexity can be added as expert skill levels are acquired. Practice is structured and progressive so that there are many opportunities for reflection, exploration of alternatives, problem solving, repetition, and feedback as part of the process of mastery. In many respects, this method is congruent with recent emphasis on core competencies involving reflective practice (Fouad et al., 2009). Using this approach, practice occurs several times daily for short periods focusing on one skill at a time until it is fully learned. Skills are chosen such that they are just outside of current performance levels targeted.

How could a busy clinician use deliberate practice methods now?

A practicing clinician with a core set of existing skills already in place could also use deliberate practice concepts to improve his or her skills. The view of skill acquisition through deliberate practice represents a significant departure from current continuing education methods such as attending a multi-day workshop, perhaps getting practice through a handful of role-plays, supervision, or brief tape review by clinicians confident in that approach. A deliberate practice approach is more akin to, for example, increasing skills at reflective listening by examining a variety of different word combinations and inflections that could be used to reply to a *single* client statement from a recent session in order to find more succinct, or empathic, or motivating variations, and then rehearsing key aspects of that optimal response to allow better 'performance' in future sessions and new situations. The analogue that might come to mind would be a professional golfer hitting a thousand practice balls every morning before actually playing his rounds. Obviously, clinicians are only paid for performance, not practice. Therefore, the clinician who undertakes deliberate practice activities will be adding to some greater or lesser degree to his or her already busy schedule. Additional suggestions listed below are of the variety we believe can be incorporated into everyday practice schedules while writing or reviewing session notes, during unscheduled times produced by cancellations, and so on.

An eagerness to reach for that which is just out of reach

Deliberate practice involves taking an attitude of continually reaching for the level of performance that is just beyond that which is performed comfortably now. This means, in part, focusing consciously on weaknesses and gaps. This is an uncomfortable process. As we might teach a client to do when approaching an emotionally daunting task, applying mindfulness skills such as leaving value judgments aside and just observing one's own performance thoughtfully can be helpful for reducing our own reactivity and to stay task-focused on learning and improving.

Identify what needs to be improved

Training methods based upon deliberate practice principles have shown that performance improves most when focused on clearly defined targets. These targets should be observable and measurable. Competency checklists, therapy manuals, and supervisors can be used to generate concrete ideas about specific areas for improvement. Careful review of the principles that underlie a clinician's approach to treatment may also yield specific, concrete skills to be developed (e.g., timing of transference interpretations; ways to present complex concepts

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in easily understandable ways; ways to tailor intervention-specific 'scripts' to specific client circumstance). Watching videos of expert models may also be helpful. Once an area has been targeted, the skills needed to achieve expert performance should be broken down into small steps.

Redefining "practice:" Not more, but more focused

The difference in practice routines between musicians in the top two tiers at a classical music conservatory was studied, with differences found not in the number of hours practiced but in the *nature* of what was practiced. The top tier focused on limited sequences, basic drills, and weak spots. The second tier focused more on playing entire pieces (Lehmann & Gruber, 2006). This suggests our own clinical performance might improve by focusing on practicing very targeted aspects. For example, the clinician could identify the situations in which he or she is uncomfortable, confused, or at a loss for words during a therapy session, or questions they have difficulty scoring on a subtest in an assessment. These situations could then be targeted for specific practice.

One thing at a time… over and over and over again

Deliberate practice and cognitive theories of attention have shown that learning is increased when skills are practiced one at a time in successively more difficult or complex contexts. Each skill step should be practiced until it can be performed optimally. Then the next step, that which is just beyond current abilities, should be targeted. When practicing in the actual performance situations of an assessment or session, in order to avoid becoming cognitively overwhelmed, it is important to limit the amount of attention other aspects of the environment might demand. For example, improvement is more likely to occur when a single skill is practiced until mastered, starting first with simple settings/examples and then proceeding to increasingly complex and "in the moment" situations as the basics are mastered. Internalization of new skills through use of repetition and use of a gradient of difficulty allows for the primary focus of attention to remain on serving client needs as skills are increasingly implemented in actual sessions.

Recording and reviewing

Problem solving, exploring alternatives, and reflective practice are important themes in evidence-based practice, and the competencies surrounding it (Critchfield & Knox, 2010; Fouad, et al., 2006; Levant & Hasan, 2008). Research (Sweller, 1999), and common sense, suggest it is exceedingly difficult to reflect at the level of detail recommended here while practicing. Deliberate practice is optimal when detailed observation of what has occurred is available. Writing detailed notes of who said what for a portion of a session or videotaping for personal performance review is helpful and highly recommended for enhancing reflective practice around focused skill areas.

Learn one new thing in every encounter and relate it to your conceptual model

Experts are able to problem solve more quickly than nonexperts in part because they know more and can remember it (Bransford, Brown, & Cocking, 2000). This allows them to more rapidly assess the situation and recall more possible solutions. Importantly, the superior memory of experts is domain specific, not a general difference in memory capability. Knowing a lot about psychopathology, assessment, and therapy is an important step, as is the ability to recall the information quickly and apply it in response

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to clinical material. Having a conceptual model which organizes this information makes recall much easier. In order to facilitate the ability to shuttle back and forth between concepts and clinical detail, psychotherapists might perform a critical, mental review of newly learned information after a session and ask how it supports, challenges or expands the clinician's conceptual model/s. A further step would be to use the revised model to predict a client's response at the next session. These actions, if done on a daily basis, would create a feedback system that can be used to assess how the clinician is performing and accelerate the learning process—deliberately bringing automated conceptual schema about practice concepts into conscious awareness and squaring them with clinical reality.

It may be appropriate to solicit feedback from the patient in appropriate contexts, like at the end of session or after some specific technique was collaboratively implemented to reach a certain goal. Reviewing session videotapes or detailed notes also allows a clinician to measure his or her perceived versus actual or desired performance. As mentioned before, deliberate practice suggests that the largest gains in learning will occur if this review is focused on a targeted skill rather than multiple skills in concert or a global assessment of performance.

Conclusion

The methods for improving practice suggested here are ultimately not new. Many master clinicians already practice in this way. We believe that formally incorporating training methods based on the theory of deliberate practice is likely to elevate the performance of the average clinician. One of us (M.D.) is currently undertaking a study of these effects using interactive multimedia methods focused on the skill of being able to accurately parse and reflect elements of interpersonal narratives occurring in therapy sessions. The long-term goal for such tests of the learning principles surrounding specific therapeutic skills, of course, is to make the psychotherapeutic equivalents of running a four minute mile or understanding calculus more commonplace.

Note: Comments are invited on this article in the Education and Training area of the Division of Psychotherapy website (www.divisionofpsychotherapy.org). Pull down the menu titled 'Domains' and select "education/training" to find the relevant area of the site.

ETHICS IN PSYCHOTHERAPY

When A Clinician's Reality Enters into the Treatment Room

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Initially, I thought I would write a paper pertaining to the ethical issues of dealing with pregnancy in a private practice. As with many things in life, my plan did not turn out as I had envisioned, and so this paper discusses what happens when a clinician's plans go awry. I had learned that I was pregnant unexpectedly, during my work day. Once I progressed in the pregnancy past my 12-week ultrasound, I started to solicit advice and wisdom from colleagues. When I was approximately 14 weeks along, I started to tell my clients about my pregnancy. I had determined that I would take 2 months off from work and that I would give my clients several choices: they could go without treatment until I returned, and then continue treatment with me again if needed; I would give them referrals to providers that they could contact in my absence where they could begin a new treatment with them or a temporary one; or they could cease treatment altogether upon my departure. I felt good about my options and that I had started this conversation with many months of treatment left to continue it.

Along came my anticipated 20-week ultrasound. My clients were interested in what I would be having, as was I. My only expectations for this routine test were to settle a bet between my husband and me: would we have the boy that I predicted, or a girl as he was wagering. We were completely unprepared for the results. Not only were we having a boy (so I won the bet), but our son-to-be had excessive ventricular damage in his developing brain. We immediately sought a second opinion, and the ultrasound results were the same. I was referred to a specialist hospital, where I would be seen the following week.

All I could think about was the negative prognosis: my child would not develop a brain. The day of the initial ultrasound, I had clients in the afternoon. I immediately called my billing person so that she could call to cancel my appointments. I also called my business partner, to ensure that in case my clients did not receive my message, she could convey the news that due to a medical issue, I would not be in the office that day. Certainly, this was an imperfect notification system, but it was the best I could do under such duress.

That weekend, I e-mailed my clients for the upcoming week to tell them that I wouldn't be in the office. My timing was mixed, as all of this was occurring the week leading up to Thanksgiving, so there was a natural break coming up. Upon meeting with various specialists, their determination was that my unborn child would, at best, achieve the developmental capability of a 2-month-old. Not quite the prognosis that I was expecting when I learned I was pregnant, but it was what we were dealt. After long conversations with my husband and our families, we determined that this was not a life we could bring into the world. And so the day after Thanksgiving, I was induced and delivered a 21-week son. My baby did not survive beyond a few hours. And so my formal

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grieving began. My ethical dilemma of what to do in a solo-practionership around this unexpected issue also began, which weighed heavily on me, as I am an early career psychologist who has the residual effects of graduate training. Embedded within my knowledge of ethics is the black and white way that they were presented. While I can acknowledge the host of grey that exists within any ethical quandary, I felt the need to be safe within the certainty of a black and white scenario.

I was fortunate that many of my close friends happen to be psychologists. Even luckier, a few of these colleagues had been through my ordeal. But they had been in different phases of their practices, so their advice was limited. One of my close friends came over to my house in the days after the induction, and helped me compose an e-mail to my client list. To protect confidentiality, I sent it to myself, and blind CC'ed it to my client list.

The initial e-mail stated that I had some medical issues to contend with and would be out of the office until further notice. I provided a list of colleagues, both in and out-of –network so that all of my clients had options. I also included some of the referred clinicians on this email so that they would have an idea of what was going on. At this moment, in the midst of my own personal crisis, I was still acutely aware of two ethical issues that I was contending with. The first was that I could not work with clients if my competence was impaired, whether it be from emotional or physical issues. Certainly, dealing with the loss of a child would have a significant impact on my competence due to being emotionally devastated. I had to question the ethical appropriateness of continuing with my practice at that time. Second, I had an ethical responsibility not to abandon my clients. Since my decision was made with such limited time, I was concerned that my clients could construe my sudden departure as abandonment. Our ethics code allows for our humanity to emerge, as we are obligated to make a good faith effort to meet the needs of our clients. To do so, I made appropriate referrals. My own guilt about this dilemma stems from the quickness of my decisions and the fact that I was unable to prepare either my clients or the clinicians that I referred my clients to.

I tried to ensure that I sent out e-mails notifying clients that I would take the month of December off. I would return to the office in January. However, as the calendar went, I had a day in November when I normally saw clients. Most of my clients extrapolated that I would not be available UNTIL January. As my clients knew that I was pregnant, and now I was taking time off, most were able to figure out that there might be some complication with the pregnancy. I received several e-mails of support, and acknowledged that I should take the time that I needed. (For some of my clients, this was a big step; they were able to go outside of themselves and connect with another. For other clients, this meant that they had internalized some of the messages that were received in our work together).

On a clinical level, I found it was interesting that first week, when I received a few e-mails from clients who were upset about my "notification process." Even though I thought I had e-mailed my clients, apparently, cyber space had let me down. Some of my clients did not receive my e-mails which stated that I would be out of the office. My partner was able to deliver the message in person, but that did not stop the expressions of anger. Of course, it was easy to see these issues as clinical. One client in

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particular was one with whom I had only just begun a working relationship. My clinical judgment told me that something about this client was off. It wasn't until he didn't receive my e-mail, and showed up for his appointment, that he sent me a very angry email.

While I know that e-mail is anything but a perfect medium, it seemed the easiest one to use to convey that I would be absent. As I had been reaching out to friends as a way to "practice telling my story" I found that I was incapable of doing so without crying. I did not feel that this type of communication would be therapeutic for either me, or my clients. While I recognize the value in having my clients see my humanity, I was in too vulnerable of a state to do so. At this time, I could not allow myself to be a vehicle for change in another. I would be relying too much on caretaking from others, and needing my clients to fill this role. In a perfect world, I would have the opportunity to meet with my clients individually, and inform them of the options that they have, and process their choices with them. However, I was not in the emotional shape to convey that message face-to-face or over the telephone. In my emotionally devastated state it took much of my strength, with the additional ego strength of a colleague, to get this message conveyed.

The other side of this was looking at what my needs were. I work extensively with my clients to assert themselves and ensure that they are able to get their needs met. This is a task that is constantly being re-worked for each of us. Here was a time where I could practice what I preached. By isolating myself from my work, I was able to begin to nurture my own wounds. I could give validity to the importance of sustaining the self. In my thinking, if I am not whole, I am unable to provide care or support for others, both personally and professionally. My job in that 5-week period was to start to recreate the whole.

January quickly came, and I started to set up my appointments for that first week. I had some drop-off in my client load; some clients decided that they were through with psychotherapy for the time being, some decided to work with another psychotherapist, and others decided to return. Diligently, I was able to put some of my own feelings aside so that during our first session back, I could process my absence with each client. This week, for me, was both painful and gratifying. I was showing myself that I could continue with the work that I loved, despite a huge personal tragedy. I found myself engrossed in our sessions and refocused.

I am continuing to learn from this experience. One thing I know is that I certainly don't have all the answers. Upon continued reflection, I feel good about the way that I handled my situation professionally, but I am aware that there might have been other ways of doing so. Following the ethics standards when time is of the essence and when one is emotionally distraught is a daunting task. I found that sharing my story, reaching out to friends and colleagues, and making space for my emerging needs and myself were important elements in my own healing process. I was very cognizant that this was a time when I needed to "walk my talk." I found that I now have a greater degree of empathy with my clients. That being said, I am aware of the very thin line that I tow between empathy and self-disclosure. In my work, we can connect on a very human level, but I have made the choice to be vague when my clients inquire as to how I'm doing. A simple response of "taking each day as it comes"

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seems to suffice and satisfies their curiosity while enabling me to retain some honesty in my part of the relationship.

Our ethical code serves as a guideline and is not exhaustive in terms of possible situations that might actually happen in real life. As we know all too well, life is messy. Things don't go according to plan and sometimes, we just have to do the best we can with the knowledge we have at the time. We need to balance our own needs with the needs of our clients. That might mean anticipating those needs, taking time that we need, consulting with colleagues, taking a step back from our work, or revealing our own humanity to our clients. Hopefully, we use the code as one tool in making these difficult decisions.

I realize that my style of coping is not a model for everyone. I am extremely lucky that I had friends (who are also colleagues) who have experienced my situation and provided invaluable advice and support. I also made sure that I had backup before opening my practice. Having someone who manages my billing came in handy, as she had the numbers of my clients and was able to disseminate information on my behalf. Some of these decisions are more aligned with who I am and that I have need for social contact rather than isolation. I cannot say that I thought through these decisions with the forethought of emergent situations.

This situation has also humbled me. I feel so privileged to be in a field of immense understanding and support. Initially, I wanted to see our ethical standards as definitive, but as I continue with my grief, I realize that they are very allowing for life to occur while being a clinician. Wiser psychologists than I factored in unexpected events when constructing the standards so that we did not have to think of ourselves as impenetrable and invulnerable to life. Rather, we are just as human as the clients with whom we work.

As I approach my due date, I am facing more waves of grief, particularly grief for the future that will not be right now. I made the conscious decision to not work on that day. For most of my clients, just telling them I didn't have availability was sufficient. For rare ones, explaining why I would not be working was therapeutic for them. It allowed them to see outside of their pain and share this experience of just knowing. Those few who I have told have all responded positively and have encouraged me to stick with this plan. I am using this day to baby myself—as I won't have the opportunity to shed this devotion on a new child for the time being.

I'm hoping that there will not be a next time in this situation, but there was some practice for when I become pregnant again. The optimist that I am, I am also able to view this experience as a "practice round" for my subsequent pregnancy. I was able to already think about when and how to tell my clients that I was expecting, think about and plan what my maternity leave would look like, consult with other colleagues to cover my client load if therapy was desired/necessary during my time away from the office, and start to come to terms with the increased amount of juggling that adding to my family would entail. Such forethought is a necessary skill for all psychologists, as expected within our ethical code. For me, I'm fairly certain that I'll also need to ramp up my self-care during this time so that I contain my own anxiety and continue to be effective with my clients.

Facilitating Emotion Regulation: General Principles for Psychotherapy

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Difficulty in the regulation of emotion is a core issue for sufferers of many mental health disorders. Examples include: the emotional lability of bipolar disorder; the emotional avoidance associated with post traumatic stress disorder; the prolonged maladaptive sadness associated with major depression; and the pervasive emotional dysregulation characterizing borderline personality disorder.

Typically, the reason for seeking therapy is to address emotional disturbances, and there is currently greater attention being paid in the psychotherapy literature to the importance of focusing on emotion in facilitating client change (Fosha, 2001; Gilbert, 2010; Greenberg, 2002; Linehan, 1993; Power, 2010). Findings from neuroscience research highlight the crucial role of emotion in decision-making and adaptive functioning (Damasio, 1994, 1999; LeDoux, 1998). Research in the field of developmental psychology highlights the importance of early relationships in the development of emotional regulation capacities (Gottman, Katz, & Hooven, 1996; Schore, 2003a, 2003b; Trevarthen, 2001). General findings from psychotherapy research indicate that positive outcomes are associated with depth of emotional experiencing, activation of specific emotions, and making sense of one's emotional experience (for reviews, see Pascual-Leone & Greenberg, 2006;Whelton 2004.).

The majority of psychotherapies explicitly or implicitly enhance a client's capacity to regulate emotions (Burum & Goldfried, 2007; Mennin, 2006). While there are shared foci such as enhancing emotional awareness, approaches differ substantially in terms of which emotional processes are targeted and at what stage in therapy. Some of these differences arise from divergent theoretical backgrounds, some from the context of addressing the unique needs of specific client populations. These differences aside, most clinicians and theorists agree that variations in emotion regulation capacities are a result of temperamental/biological differences as well as learning/developmental histories, and that some strategies for regulating emotions may be more effective than others with specific individuals.

The goal of this article is to outline a framework for conceptualizing emotion regulation in psychotherapy in a broad integrative manner. To begin, we identify convergences in the conceptualization of emotion processes. We then present an organizing framework for understanding different domains of emotion regulation difficulties, and for tailoring interventions to address these

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difficulties in clients with diverse capacities for emotion regulation.

Emotion and Emotion Regulation

Emotion theorists and researchers converge on a few key ideas about emotion. First, emotion is a complex multi-component process (Frijda, 1986; 2007; Greenberg, 2002; Linehan, 1993; Scherer, 2000). Emotions arise in response to an internal or external situation or event, and motivate us to act to address our needs in those situations (Frijda, 1986, 2007). Second, emotional responses are complex, involving a multi-system response that dynamically integrates multiple levels of functioning (perception, sensation, both automatic and controlled cognition, memory, affect, physiological changes, and subjective experience) and they are influenced over time by culture, learning, and experience (Pos & Greenberg, in press). Third, a typology of emotion has emerged, concerning three distinct processes: primary adaptive emotion, primary maladaptive emotions and secondary emotions (Fosha, 2000; Greenberg & Safran, 1987; Linehan, 1993). Only the first, primary emotions, are considered truly adaptive. These are immediate emotional responses to a situation that can help an individual take appropriate action in the service of needs. Primary maladaptive emotions are also immediate, but involve over-learned responses that were useful in a past situation but are no longer adaptive. Secondary emotions are responses to primary emotional experiences.

No universally agreed upon definition of emotion regulation exits. Gross (1998) defines emotion regulation as peoples' attempts to influence what emotions they have, when they have them, and how they are experienced and expressed. According to Gross, people regulate emotions by intensifying or decreasing them; though most people report working to down-regulate negative emotions (Gross, Richards, & John, 2006). Other researchers and clinicians stress that emotion regulation can occur both *within* a person *and* between people (Fosha, 2001; Linehan, Bohus, & Lynch, 2007; Pos, Greenberg, & EIliott, 2007), and can occur both via controlled application of skillful behavior as well as automatically, outside of awareness. Conceptualizing emotion as a multi-component process consisting of different typologies (e.g. primary versus secondary), provides a framework for understanding maladaptive emotion regulation. That also can organize our understanding of how to intervene to enhance more effective emotional regulation capacities. Next, we will delineate common therapeutic principles to facilitate effective emotion regulation.

General Principles for Enhancing Emotion Regulation

1. Engage in an ongoing assessment of client's capacity to modulate emotions

Psychotherapy interventions need to be tailored to the individual. Consequently, a good ongoing assessment of the characteristics of the individual is a necessary foundation for effective emotion-focused interventions. Many factors influencing individuals' emotion regulation capacities need to be assessed: personality, diagnoses, and interpersonal patterns. Psychotherapists also need to monitor the degree of arousal, and emotional valence. They must as well monitor individuals' ability to modulate emotion in order to gauge how much emotional pain the client can tolerate at a particular moment in therapy. Tracking clients' nonverbal and verbal expression moment by moment, can also provide insight into the client's emotional and experiential processing style (Pos, et al., 2007). Psychotherapists can inquire about clients' level of subjective distress, and seek details about how

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in-control clients' are of their emotions and behaviors during and after the session. Essential when working with emotions in psychotherapy, therapists' must also consider how clients' different cultural backgrounds inform display rules about specific emotions, as well what may be considered adaptive or maladaptive emotion within different cultures (Kitayama & Markus, 1997). In collectivist cultures, suppressing one's emotion in the service of maintaining interpersonal harmony is often considered healthier than expressing one's emotion directly and freely. An emphasis on social hierarchy may also inhibit clients from certain cultures from expressing and experiencing negative emotions in front of the therapist who represents an authority figure.

2. Develop a safe, compassionate, accepting and genuine therapeutic relationship

Relationships with others significantly influence individual's development of emotion regulation. Research on infants indicates that early interactions with others are critical to the development of regulation of affect (Schore & Schore, 2008; Trevarthen, 2001; Tronick, 1989). Primary maladaptive emotion schemes and secondary emotion schemes are thought to form through regulation failures in this developmental process (Pos, Greenberg, & Elliott, 2007).

The therapy relationship can itself regulate emotion as well as facilitate the development of emotion regulation capacities. Interpersonal contact regulates anxiety by reducing the sense of isolation. Avoidant secondary emotions can be reduced by the therapist modeling emotional acceptance. The therapist's empathic understanding increases the client's capacity to attend to experience, symbolize emotions in words, and reflect on and make sense of them. Over time, the therapist's empathy and validation become internalized and strengthen the client's ability to regulate affective experience (Paivio & Laurent, 2001; Watson, 2002). Through this process, the client learns to tolerate emotional experience, effectively express it, and self-soothe. Another factor is therapist genuineness, which increases interpersonal trust, and can provide corrective emotional experience or new interpersonal learning that can modify maladaptive emotions over time. The strength of the alliance also supports the client's willingness and capacity to tolerate their therapist confronting maladaptive expression of emotion (Linehan, 1993).

3. Educate clients about emotions and their function

Many common misconceptions about emotions exist. It is therefore important for clients to understand their own emotions and how they play a vital role in healthy and unhealthy functioning. The therapist should convey that emotions have value; they provide us with information about a situation, mobilize us towards adaptive action, and are a means of interpersonal communication (Linehan, 1993; McCullough, Kuhn, Andrews, Kaplan, Wolf, & Hurley, 2003). Distinguishing between primary and secondary emotions can help one recognize when emotions are mobilizing adaptive action. By appreciating that emotions are complex responses, comprised of various components, clients can learn to differentiate their own emotional responses and the situational cues that evoke them. Clients should understand that emotions address a primary need of orienting people and that addressing this need regulates emotions. Orientation is especially important when a client is emotionally aroused and vulnerable. There is evidence that when a therapist evokes and intensifies

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emotional expression in the absence of a clear rationale for such activities, the client reacts with confusion, and this can contribute to ruptures in the alliance (Paivio & Pascual-Leone, 2010).

4. Promote awareness and acceptance

People are more likely to use emotional information if they place value on being aware of emotions. Initially, clients' emotional acceptance is supported by the therapists' acceptance of the client's feelings. Later on, acceptance of emotion emerges through increased emotional regulation that follows from the acceptance of all emotion (e.g. positive and negative). All components of an emotional response—the behavioral and physiological reactions, the situations that trigger responses, the needs, the thoughts and memories—can occur outside of an individual's awareness. This can occur because an emotion is feared, or not valued, and therefore is blocked from experience. Emotions can also be automatically regulated by another emotion, and/or be simply not attended to. By attending to and describing the various components of an emotional response, individuals are able to make meaning of their experience, increasing their likelihood of responding adaptively. The psychotherapist should help the client learn to pay attention to experiences of emotion as they arise both in an out of session. This can be achieved by attending to expressive signals of primary emotions including posture, tone, behavioral and facial expressions (Greenberg, 2002). As well, by directing clients to monitor their emotional responses outside of session clients can become more aware of the triggers to their reactions. Furthermore, not only does increased awareness regulate emotion through more adaptive orientation, it also provides the client with opportunities to gain mastery in capturing such experiences in words, which itself regulates experience (Gendlin, 1962; Greenberg, 2002).

5. Help clients reduce problematic avoidance and inhibition of emotions

People can't completely avoid feelings. Nonetheless, the inhibition of some emotions is necessary for adaptive emotion regulation. Through social learning we may be taught that some emotions are not acceptable with certain people, and in specific situations. People can develop pervasive problems of emotion inhibition as a result. For example, a person who learns that it is not acceptable to express a negative emotion such as anger is more likely to inhibit this potentially adaptive emotion with a secondary emotion such as sadness. The more people bottle up adaptive emotion, the more this becomes problematic because chronic emotional interruption and non-expression renders individuals out of touch with their needs and feelings as well as disconnected from others who seek connection through emotional attunement (Goldman & Greenberg, 2008; Stern, 1993). In general, helping clients loosen blocked emotional expression will improve emotion-regulation. Unblocking emotions can also help to overcome the fear of emotions associated with avoidance. This strategy needs to implemented carefully; therapists should monitor the client's ability to tolerate and contain strong emotions. By attending to in-session signs of emotion inhibition or avoidance the client can be helped to develop better awareness of how, and what emotions are being blocked. This strategy needs to implemented carefully, however; as clients should not be left overly aroused and unable to contain strong emotions. Psychotherapists must monitor the client's present ability to tolerate and contain

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strong emotions. When overwhelmed emotionally, increasing clients' emotional inhibition may be necessary. Helping clients develop abilities to both attend to and control emotions are both increased by non-avoidance and inhibition of emotion.

6. Increase the capacity to adaptively express emotion

Whether or not it is effective to express an emotion depends on the context, on how the emotion is expressed, and on to whom it is expressed (Whelton, 2004). Deficits in the ability to express emotions as well as regulate harmful behaviors associated with specific emotions can both have serious negative implications. Unmodulated emotions and behaviors can compromise interpersonal relationships and result in self-destructive behaviors. Alternatively, ineffective expression of emotions leads to unresolved needs persisting in the form of chronic perseverance of emotion. Consequently, the capacity to both express emotions effectively and inhibit maladaptive emotional response tendencies are a core emotion regulation skill (Campos, Frankel, & Camras, 2004).

The use of language to contain, regulate, make meaning of and express experience is one important means for regulating emotions. By translating one's bodily-felt emotions into words, metaphors, and narrative, people experience a gut 'knowing of what is' (Damasio, 1999). Overwhelming internal experiences are thus both contained and made meaningful through language. This can change an overwhelming experience into an informative signal (Gendlin, 1962; Horowitz, 2005). By increasing awareness of adaptive needs signalled by emotion, the individual can attend to and mobilize action to attain these needs (Goldstein, 1939). With clients prone to maladaptive expression of emotions and behaviors, therapists may need to help clients modulate their emotional arousal in order to increase their control over what, and when they express themselves. There are many possible strategies: deploying attention to alternate cues; utilizing distraction to reduce emotional salience; reappraising the situation or the urgency of a need; self-soothing; engaging action tendencies opposite to those of a presently activated emotion in order to modify it, or activating behaviors inconsistent with any emotional arousal, such as deep breathing and relaxation. Activating and expressing adaptive emotion, brings it more easily into awareness, and helps to support the genuine expression of experience, meaning, and needs.

7. Increase positive emotional experiences

A common symptom for people experiencing chronic emotional distress is the shortage of positive emotional experiences such as satisfying interpersonal relationships, joy, play, pleasure and experiences of success and mastery. For those with impoverished quality of life experiences, pleasure may be rare, and misery and pain can be prevailing moods. Clients may choose to obtain some pleasure or gratification through dysfunctional behaviors such as substance use, or sexual impulsivity. The immediate positive feelings gained through these behaviors are however typically short-lived, exacerbating negative and painful emotions over the long-term.

Healthy functioning requires the experience of positive emotions. The therapist should assess the extent to which a client's life is impoverished and lacking in positive experiences. Becoming aware of positive feelings is important because these emotions can regulate the experi-

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ence of negative emotions as well as help to build resilience to negative emotion states (Stalikas & Fitzpatrick, 2008; Tugade & Fredrickson, 2007). Emotion regulation can be enhanced by helping clients build opportunities for engaging in healthy pleasurable experiences. Strategies can include encouraging them to do something pleasurable for themselves, to engage in meaningful productive activity, or to reduce social isolation and develop meaningful interpersonal relationships. As well, the therapist can promote positive emotional experiences in session by acknowledging the client's sense of mastery and accomplishment and by responding with praise, joy, and or relief. The mutual sharing of accomplishment as well as pain helps to validate the client's change, new affects, and experience (Fosha, 2000). The regulation of emotion should involve not only creating opportunities for positive emotional experiences, but where possible avoiding negative ones (Gross & Thompson, 2007).

8. Facilitate changes in emotional processes by providing opportunities for new learning/experience

The maladaptive nature of emotional processes can lie in their uninhibited expression, faulty appraisal processes, and the habitual manner in which they lock individuals into unproductive, rigid response patterns. While the regulation of problematic emotional arousal is often stressed in discussions on emotion regulation, maladaptive emotional responses can also be transformed through new experience/learning into more adaptive emotional responses over time. For example, a therapist's consistent validation and empathy can transform a client's maladaptive shame into a sense of pride. Transformation of emotion can occur via several possible interventions: exposure; working with automatic appraisals, rules, and assumptions; accessing alternate emotional resources by accessing primary emotion with its attendant motivational potential; making meaning of maladaptive emotional processes by connecting these to original contexts; 're-storying' one's life, to name but a few. While the theorized mechanisms of change underlying these interventions remain mostly unclear, all interventions arguably share a common end state—evoking a new learning/experience. Clients experience new learning or 'corrective' experience that feeds back into the emotion structure. New information or experience is accommodated and changes the emotion structure so that emotional processes automatically function in a more modulated manner. Therapists should be knowledgeable of methods that stimulate new learning/experience and help to transform emotional processes. Some of these methods—identified in previous sections—include: decreasing emotional avoidance; increasing awareness; tolerating distress; and constructing new meaning. Considerable interpersonal support and validation of short-term pain is often essential as the client is supported in undergoing new learning/experience.

Summary

Problems regulating emotions are a core dysfunction for most people seeking therapy. A shared goal that cuts across therapeutic modalities is to facilitate clients' effective emotion regulation. While a wide range of therapeutic strategies for working with emotions have been detailed in the clinical literature, we propose that there are general principles for facilitating emotion regulation that are common to diverse approaches. In this article, we outline a selective set of integrative principles that emerge from the clinical, theoretical and empirical literature. While our discussion focuses on the work of psychotherapy, the proposed principles have relevance to the prevention and general enhancement of psychological well-being.

CALL FOR FELLOWSHIP APPLICATIONS DIVISION 29—PSYCHOTHERAPY

Clara E. Hill, Chair, Fellows Committee

The Division of Psychotherapy is now accepting applications from those who would like to nominate themselves or recommend a deserving colleague for Fellow status with the Division of Psychotherapy. Fellow status in APA is awarded to psychologists in recognition of outstanding contributions to psychology. Division 29 is eager to honor those members of our division who have distinguished themselves by exceptional contributions to psychotherapy in a variety of ways such as through research, practice, and teaching.

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- Prior membership as an APA Member for at least one year and a Member of the division through which the nomination is made;
- Active engagement at the time of nomination in the advancement of psychology in any of its aspects;
- Five years of acceptable professional experience subsequent to the granting of the doctoral degree;
- Evidence of unusual and outstanding contribution or performance in the field of psychology; and
- Nomination by one of the divisions which member status is held.

There are two paths to fellowship. For those who are not currently Fellows of APA, you must apply for Initial Fellowship through the Division, which then sends applications for approval to the APA Membership Committee and the APA Council of Representatives. The following are the requirements for initial fellow applicants:

- Completion of the Uniform Fellow Blank;
- A detailed curriculum vita (please submit 3 copies);
- A self-nominating letter (self-nominating letter should also be sent to endorsers);
- Three (or more) letters of endorsement of your work by APA Fellows, at least two of whom must be Division 29 Fellows who can attest to the fact that your "recognition" has been beyond the local level of psychology; and
- A cover letter, together with your c.v. and self-nominating letter, to each endorser.

Those members who have already attained Fellow status through another division may pursue a direct application for Division 29 Fellow by sending a curriculum vita and a letter to the Division 29 Fellows Committee, indicating in your letter how you meet the Division 29 criteria.

Initial Fellow Applications can be attained from the central office or online at APA:
Tracey Martin
Division of Psychotherapy
6557 E. Riverdale St.
Mesa, AZ 85215
Phone: 602-363-9211
Fax: 480 854-8966
Email: assnmgmt@aol.com

Completed Applications should be forwarded to:
Clara E. Hill
Chair, Division 29
Fellows Committee
Department of Psychology
University of Maryland
College Park, MD 20742
Email: hill@psyc.umd.edu
Phone: 301-405-5791

Please feel free to contact me or other Fellows of Division 29 if you think you might qualify and you are interested in discussing your qualifications or the Fellow process. Also, Fellows of our Division who want to recommend a deserving colleague should contact me with their name.

DEADLINE FOR SUBMISSION. The deadline for submission to be considered for 2011 is **December 15, 2010**. The initial nominee must enclose a *Uniform Fellow Application*, self-nominating letter, three or more letters of endorsement, updated CV, along with a cover letter, and three copies of all the original materials. Incomplete submission packets after the deadline will not be considered for this year. Those who are current Fellows of APA who want to become a Fellow of Division 29 need to send a letter attesting to your qualifications and a current CV.

Modifying Psychologists Views on Treating Trauma in African Americans

Rachelle Y. Edwards, Ph.D.
Georgia Regional Hospital at Atlanta, Georgia

Throughout the years, psychological interventions, as well as the meaning of trauma have remained narrowly focused. Trauma had long been considered an anxiety-provoking, distressing experience related to a natural disaster, accident, physical/sexual abuse, or war-related event. This initial way of thinking seemed almost unfamiliar to the general population and would only appear to occur to individuals in a particular region of the country (e.g., tornado in the Midwestern United States) or specific group (i.e., military personnel).The Diagnostic and Statistical Manual-Third Edition (DSM-III; APA, 1980) also indicated that the "stressor producing this syndrome would evoke significant symptoms of distress in most people and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses or marital conflict" (APA, 1980, p. 236). At that time, trauma had become synonymous with Posttraumatic Stress Disorder (PTSD) and was not considered to psychologically affect individuals in other ways (e.g., depression or conduct).

Obviously, little thought was considered for situations that were not considered traumatic but a societal condition. Indeed, societal challenges have mostly affected ethnic minority groups, particularly African Americans, and have been thought of as social phenomena rather than a traumatic experience. Even more, these conditions (e.g., poverty, witnessing violence, lack of education) have not oftentimes been identified as causing significant mental health challenges for individuals. These social conditions are experienced by many African Americans, directly or indirectly, and can be considered invisible traumas (i.e., racism, discrimination) or visible traumas (i.e., sexual abuse, car accidents, grief). Visible traumas are those incidents that are tangible that an individual can see and know are occurring while an invisible trauma is an incident that an individual may not be able to touch or see but the impact to an individual's mental health can be drastic (Okazaki, 2009). The invisible traumas can affect an individual just as much as those that are visible. This thought process is in contrast to earlier views. In the past, these events were not considered traumatic as defined by the criteria of PTSD. However, what has been discovered is that how one perceives the stressor is what is key and vital to their well-being. The overwhelming toll that these experiences can have on someone can be endless and the symptoms can mimic PTSD, Depression, a Personality Disorder, or even Schizophrenia.

Since the introduction of PTSD in the DSM-III (APA, 1980), epidemiological studies in the general population have emerged slowly due to researchers believing that PTSD was only applicable to those involved in events that were "outside the range of usual human experience" (Kessler et al., 1999, p. 25). These studies have emerged, as data showed that exposure to traumatic events is also high in the general population. Lifetime

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exposure to a traumatic event ranges from 36% (Resnick et al., 1993) to over 69% (Breslau et al., 1998) in the general population. Further, specific ethnic differences in endorsement of PTSD symptomatology and exposure to traumatic events have emerged. First, African American adults and children who have experienced a traumatic event report more PTSD symptomatology than European Americans (Shannon et al., 1994) and English-preferring Hispanics (Perilla et al., 2002).

Socioeconomic status is another contextual factor significant in the mental health of African Americans. While there are a large number of African Americans moving into the ranks of the middle class, as a whole, the African American ethnic group is poor. In particular, the rate of poverty in this ethnic group was 22 percent, whereas the rate of poverty in the entire country was 10 percent (Department of Health and Human Services (DHHS); 2001). African Americans, compared to European Americans, are more likely to stay in poverty longer. Not only does this challenge affect African American adults, but it also affects the children and adolescents (DHHS, 2001). Due to the economic situation of African Americans, other forms of adversity emerge, including poor neighborhood conditions. The neighborhood conditions in impoverished areas consist of poor housing and schools. A major component of these areas is a high rate of crime. These high rates of crime expose an individual to various acts of violence, as a victim or witness. For instance, in a sample of 221 African American, urban youth of low income, 43.4% reported eye witnessing a murder and 75% indicated that they had witnessed a shooting (Fitzpatrick & Boldizar, 1993). Further, African Americans of any age are more likely to be a victim of violence than European Americans (DHHS, 2001).

Significant numbers of African-Americans live in poor, inner-city communities and are at a greater risk of witnessing crime, illegal drug activity, experiencing poor school systems, having inadequate living conditions, and a host of other negative environmental conditions (Dinges, Atlis, Vincent, 1997). Furthermore, African-Americans living in these circumstances are more likely to drop out of school, leaving few options for employment. It is thought that these factors are related to increased incarceration rates (Dinges et al., 1997). Crimes committed by African Americans are usually more serious than those by other ethnic groups, leading to imprisonment. According to the US Census Bureau (2001), approximately 12% of the American population identify themselves as African-American. On the other hand, nearly half of all State and Federal prisoners are of this ethnic group (DHHS, 2001).

Further, due to a lack of research there has been scarce information on the effects these stressors have on the African American population. While African Americans are considered a resilient group and oftentimes do not identify many challenges as traumatic but as a daily part of life, individuals may not seek therapy to cope with these life stressors. Additionally, African Americans may be more likely seek services from a primary care provider due to convenience but also the stigma associated with receiving mental health services. Thus, these challenges mostly go undetected and untreated. While we know the amount of stress and trauma one can endure is based on the particular individual it should not be insurmountable and numerous. These insurmountable stressors will likely lead to eventual psychological challenges. Individuals exposed to trauma do not automatically develop PTSD and may exhibit other symptomatology. It is believed that individual differences exert a

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large role in the progression of a disorder, especially in how one perceives a trauma. It will be necessary for psychologists' thought processes to be modified. Incorporating additional traumatic events (i.e., witnessing violence, lack of education, racism) into their assessment of trauma history will allow for a group of individuals to be better understood and therapy can target the challenges accurately based on the changing society and economic conditions. This will broaden psychologists' scope of the effects of trauma and how it is expressed in other ethnic groups rather than automatically referring them for PTSD treatment.

As the landscape of politics, corporations, and neighborhoods change, so should the views of many psychological concepts and how the effects on different ethnic groups may be different than what has normally been observed in the past. As has been mentioned, the traumatic experiences African Americans face are complex and multi-faceted. Usually, there are many levels to a trauma experience and rarely due to a single event. Additionally, in the African American population there will likely be a shift in the types of challenges that lead individuals to seek therapeutic services. It has been noted that African Americans encounter experiences like racism, poverty, and high incarceration rates at a higher degree than other ethnic groups (DHHS, 2001). Thus, these groups are at greater risk of developing trauma-related disorders, as well as engaging in antisocial features as a survival mechanism. Although, the onset of psychological diagnoses has been found to be low because of resiliency factors in these ethnic groups the overall effect of the stressor can still be taxing. Therefore, therapists must be prepared and aware of the other types of trauma that the African American population experiences in order to assess more adequately during therapeutic interventions.

The worldview of the individual should be considered, as the reaction to the event can be easily explained. We should frequently be reminded that every individual experiences a situation differently. Thus, how an individual experiences or perceives an event will determine how one will respond. Each client should be assessed for trauma and as clinicians, it will be of importance to allow an individual to explain thoroughly what they have experienced and not categorize the event but pay attention to what is said in the session and how the individual is affected emotionally. Also being knowledgeable of how trauma can be experienced and that it may not develop into PTSD but a mood, personality, and/or psychotic disorder. Better understanding of what is actually occurring with the individual will allow the psychologist to appropriately treat the client and not dismiss the symptoms or desire an individual to make changes that are unrealistic (i.e., move out of a poverty stricken community). Further, the current coping mechanisms of the client will be paramount which can give more information on how the client is being affected psychologically and what coping skills are currently being utilized. For instance, as we know, suicide is steadily increasing in the young (15-24 years), African American, male population. Psychologists will benefit in learning more about the reasons for this despondency which will allow for better treatments. Usually when we think of trauma, specific, structured, manualized assessments and treatments come to mind. However, when trauma is looked at as a broad concept the type of therapy will be reconsidered and a "cookie cutter" approach will not be taken.

When invisible and unconventional visible traumas are taken into consideration as affecting an individual's psy-

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chological well-being then the assessment and treatment of an individual, particularly the African American population, will be advanced. That is, the therapeutic interventions, diagnostic considerations, and assessment tools will no longer be restricted. This will aid the client and possibly allow for treatment to progress.

PROFESSIONAL PRACTICE DOMAIN

Multicultural Toolkit Taskforce Update

Miguel E. Gallardo, Psy.D., Pepperdine University, Malibu, California, and Bonita Cade, Ph.D., Rogers Williams University, Bristol, Rhode Island

As representatives from Division 29 and in our roles as the Professional Practice Domain representative and past chair of the Professional Practice Committee for our division, we would like to share some news of an ongoing project with the membership and solicit your input. As practitioners, researchers and trainers we are constantly challenged to meet the needs of diverse ethnocultural communities.

Our society is in a constant state of change and is becoming increasingly open, and challenged, to the uniqueness demonstrated by the various cultures, ethnic groups, countries of origin and lifestyle orientations. Try as we do, it is becoming more difficult to keep up with the professional literature and practices that allow us to effectively serve and provide treatment for those who have important defining experiences, backgrounds and identities for which we as practitioners have received very little, if any training. Thus we would like to provide a multicultural resource that will be an aid in enhancing our multicultural competency.

Division 29 (Psychotherapy) and Division 42 (Independent Practice) have developed a joint work group to develop a "Multicultural Toolkit" based on the interest and commitment of Division 42 President, Dr. Lisa Grossman. The members of this work group are Bonita Cade (29) Miguel Gallardo (29, Professional Practice Domain Rep) co-chair. Doug Haldeman (42) co-chair, Kirstyn Chun (42), Konjit Page (42), Rochelle Balter (42), Rosemary Adam-Terem (29, Public Policy and Social Justice Domain Rep), and Caryn Rodgers (29, Diversity Domain Rep). We have had a number of conference calls and will be meeting in San Diego for a face-to-face meeting in the Division 29 Suite. Please feel free to contact either of the co- chairs or myself with your ideas. With this foundation mind, "we" thought that it might be helpful to have a centralized location on our divisions websites that could provide up-to-date resources to facilitate training and education links as well as information regarding various activities and approaches other practitioners' have found useful in their practice when working with those who are "diverse" to the practitioner and her/his experiences. We are currently reviewing the wide variety of approaches that other APA entities such as the SPTA's and Divisions have used to address multicultural competency and want to be careful to avoid duplication in our efforts. We believe that an interactive website might be one of the taskforce's outcomes. In addition, links to resources and information, and possibly some self-assessment options in the area of multicultural competency. The pertinent question is, "What would be most useful to you as a psychologist at this time?" We recognize that in order to develop a worthwhile product it must be both "user friendly" and "user relevant." Thus, your input is crucial and is an integral part of the MTP (Multicultural Toolkit Project). We look forward to hearing your ideas (or reading them at bcade@rwu.edu) and seeing in San Diego!

SOCIAL JUSTICE AND PUBLIC POLICY DOMAIN

Natural Disasters: Another Hill to Climb

Rosemary Adam-Terem, Ph.D.
Independent Practice, Honolulu, Hawaii

01.12.2010	Earthquake 7.0 Haiti 250,000 dead
01.27.2010	Earthquake 8.8/tsunami Chile 700+ dead
04.04.2010	Earthquake 7.2 Mexico very few dead
04.13.2010	Earthquake 6.9 China 670+ dead

As Melissa Lafsky (2010) noted in a post to the Infrastructurist, the earthquake that struck Chile in February measured 8.8 on the Richter Scale, hundreds of times more powerful than the 7.0 quake that struck Haiti in January. However, the estimated 700 or more deaths in Chile amount to only 0.3% of the estimated 250,000 who died in the Caribbean nation's capital. Comparisons with other recent disastrous earthquakes in other parts of the world show similar disparities. The death and destruction associated with natural disasters are directly related to the magnitude and quality of the event, but its effects are amplified by factors like population density, geographical remoteness, and poverty.

In Tracy Kidder's (2004) book, Paul Farmer, the founder of Partners in Health (pih.org), quoted a Haitian proverb "Deye mon gen mon," translated as "Beyond mountains, there are mountains" in describing the nature of working to provide health care against such massive forces. If you are fortunate enough to solve one problem, there will be another one right behind: always another hill to climb. Of himself, Kidder writes:

> *"The world is full of miserable places. One way of living comfortably is not to think about them or, when you do, to send money." (Kidder, 2004, p. 8)*

Psychologists understand the complexity of disasters in human terms, and want to find meaningful ways to assist in relief efforts. APA maintains a Disaster Response Network that helps to coordinate first responders from the psychological community. APA's website has a very useful page on the topic of disasters that includes numerous resources for the public as well as professionals.

A key concept to have emerged in disaster mental health is that of the phases of disaster response (Tassey et al., 1997). There is a fuller explanation in the Center for Mental Health Services (1994) Handbook. The disastrous event is generally met with a "heroic" response, where people go beyond the call and often beyond their own reasonable limits in trying to help. In the case of a community disaster, there will likely be a "honeymoon phase" where the community pulls together and shows cohesive spirit and action. However, commonly in the aftermath as days become weeks

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and weeks months, "disillusionment" sets in; people feel despondent, helpless and hopeless, and often angry at perceived failures to provide adequate resources. This was clearly seen after the cataclysmic Hurricane Katrina in the southeastern states. To reach the post-disaster "reconstruction phase," or as Bill Clinton put it in the case of Haiti "to build back better," there is a long road of coming to terms somehow with what has happened. There are many psychological tasks in these months and years, such as working through grief and loss, survivor guilt, and crises of faith, and there will be trigger events for PTSD as well as anniversary reactions that complicate the emotional healing.

Innovative service-delivery methods are often necessary to provide effective psychological assistance in the wake of widespread disaster. Psychologists may need to be out in the community perhaps offering "meetings" on coping rather than expecting to do classical psychotherapy. If the psychologists are of the affected community, they too will have sustained losses and may not have an office or a home to go to. Incoming responders need to be attentive to the needs and nature of the community, and must attend to their own self-care lest they become casualties of the situation too. The CDC Guidelines for Relief Workers (2010) note that among aid workers returning from distant disaster sites, about a third report depression and more than half report negative emotions on their return home. The Guidelines also contain very useful references to resources.

Meanwhile, for those who cannot travel to Haiti, Chile, China or Mexico, we can always raise awareness of the disproportional impact of disasters on poor and marginalized people, and work for universal health care coverage. We can climb one hill at a time. And we can send money.

The Psychotherapy Bulletin is Going Green:

Click on
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FEATURE

Factors Influencing Doctoral Paper Completion in a Captive Consortium

Greene, H.D., Howard, R., Wade, K., Bartels, J.D., Farrington, T.G., Geva, A., Glazer, J.C., Heermann, M.A., Jacklin, E., Langley, J.E., Sackett, J.J., Smith-Acuña, S., Stein, M.C., & Ward, B.S.

University of Denver Graduate School of Professional Psychology

The completion of a dissertation or doctoral paper is one of the final requirements and a monumental stepping-stone towards graduation and professional life as a psychologist. Despite the benefits of completing the doctoral paper, many doctorate of psychology (Psy.D.) students struggle to do this in a timely fashion in order to graduate on schedule. This paper seeks to better understand the factors that influence the likelihood of a doctoral student's completion of the doctoral paper. We propose that there are supportive factors present in exclusively affiliated consortium programs, where internship positions are held solely by students in that doctoral program, that may be missing for students in other internship programs. We will review the current literature on factors that affect graduation rates in doctoral programs, consider specific protective factors at the exclusively affiliated consortium program through the Graduate School of Professional Psychology at the University of Denver, and make recommendations on how these factors can be implemented at other training sites.

Literature Review

There is scant literature related to factors influencing graduation rates from Psy.D. programs. However, according to Cash and Sanchez-Hucles (1992), 24% of students in psychology professional programs do not graduate until two years after their expected completion date. As one of the final requirements, the dissertation or doctoral paper can be time consuming and challenging. Completion of a major research project is influenced by a student's skills and personal characteristics as well as by elements of the academic and internship program, which can either promote or inhibit successful completion of the paper. Several factors

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concerning the research environment of the academic program have been identified that promote scholarly productivity, including faculty modeling, positive reinforcement of a student's initial efforts, making science a partly social experience, and emphasizing varied approaches to conducting research (Kahn & Gelso, 1997). Factors within internship training environments that positively influence scholarly production include teaching students how research is conducted within practice settings, offering regularly scheduled research meetings, providing research seminars, and offering mentoring specific to scholarly activities (Gelso, 1993; Szymanski, Philips, Jovanovic Ozegovic, & Briggs-Phillips, 2007). Personal factors that inhibit research or dissertation completion include tendencies towards procrastination, perfectionism, and dependence (Yulish, Muszynski & Akamatsu, 1991; Green, 1997).

There are unique factors for students who participate in exclusively affiliated consortium programs that have a positive influence on completion of the required doctoral paper. One requirement is that students remain in the community where they attended school. Krieshok, Lopez, Somber and Cantrell (2000) recommended that academic programs encourage ongoing ties to the program throughout internship as well as offer regular structured support for completing dissertations. This contact may provide an increased source of support and more accountability for doctoral paper progress, which has been shown to be an important step in creating a helpful structure for students completing their papers (Green, 1997). In an exclusively affiliated consortium, students have the ability to maintain closer personal contact with their dissertation committee, a crucial aspect of an environment that encourages completion (Green, 1997). Students can also receive mentoring from their cohort and faculty, capitalizing on their personal and professional knowledge of, and experience with, committee members in order to most effectively advocate for themselves throughout the doctoral paper process.

Case Example

The University of Denver (DU) Graduate School of Professional Psychology (GSPP) has one of four APA-accredited affiliated internship consortium programs in the United States. As an exclusively affiliated internship program with seven sites in the Denver area, the consortium accepts applications for internship solely from DU GSPP students. The GSPP internship consortium participates in the Association of Psychology Postdoctoral and Internships Centers (APPIC) national match, so that GSPP students can apply to both GSPP consortium and national internship sites. During the internship year interns in the consortium spend four days a week at their training sites and one day a week attending seminars focused on professional issues, research, multiculturalism, and psychological assessment as well as taking part in a cohort lunch.

Since the exclusively affiliated internship consortium was created in 2000, on-time graduation rates at the GSPP have been 96% for consortium interns and 78% for other GSPP students at national sites. According to the literature reviewed above, several factors may have contributed to higher doctoral paper completion rates in the GSPP consortium compared to GSPP students who completed internship at national sites. Unlike students who have moved to a new city for internship, GSPP consortium interns are able to maintain their social and professional connections dur-

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ing the internship year. As one intern in the GSPP consortium stated, "Being situated locally, I didn't have to relocate my family. In terms of the [internship] peer group, everyone was supportive of me and I got a lot of understanding which helped decrease my anxiety and stress levels."

Additionally, the high completion rate of the GSPP consortium interns may also be attributed to the sense of community fostered in the weekly seminars and throughout the internship year. The interns and faculty in the consortium share personal and professional history. This shared history and connection to a common academic environment reduces competition between interns thereby facilitating a cooperative and supportive research environment. The research seminar requires each intern to present their doctoral paper to the cohort at the start of the year, and regularly update the group on their progress throughout the year. This increases the sense of accountability for doctoral paper completion among the interns. One member of the faculty expressed the benefits of this shared history,

> The consortium setting builds on shared research experience and knowledge of how to best work with specific faculty members and offers greater continuity in research training as well as easier accessibility to faculty resources. Being with one's established peer group and talking about the project on a regular basis provides peer pressure in a most positive way. Students develop healthy competition and inspire each other. Witnessing other students' processes makes the project seem doable.

Recommendations and Conclusion

The doctoral paper marks one of the last hurdles towards graduation and the next step in becoming a psychologist. While the completion of the doctoral paper is ultimately the student's responsibility, the structure of an internship can play a critical role in whether their interns are able to complete their doctoral papers and graduate. There are features that may be unique to an exclusively affiliated consortium that increase the chances of on-time doctoral paper completion; however, the recommendations outlined below contain elements that can be implemented across many different internship programs. The exclusively affiliated consortium fosters an environment in which accountability, support, and shared knowledge contribute to helping students finish their doctoral papers on time. These elements are often overlooked, but can be implemented to any internship program with minimal changes to format and structure.

Internship sites should create a context, such as a designated weekly check-in, in which each student reports on his or her paper progress. All students will benefit from hearing how peers are progressing, and which unforeseen, yet commonly encountered, roadblocks are faced and overcome. They can compare their progress with their peers, which can serve as a motivation for completion, and seek help from others engaged in the doctoral paper process. Finally, while establishing the context for discussing progress is a valuable tool for keeping writers on track to completion, it is also beneficial to have students commit to specific, time-limited benchmarks, to which they will be held accountable by the group.

An intern's ability to approach committee members can be a significant factor in doctoral paper completion whether the barriers to approach are real or perceived. Students who have a positive relationship with their committee members have an advantage over interns

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who have less access to committee members due to geographical distance or lack of personal connection. While geographic distance cannot be overcome, internship sites can provide opportunities for informal mentoring and networking with professionals in their new community, which may foster comfort and confidence in communicating with committee members. Site training directors, supervisors and peers can also encourage and suggest ways for interns to maintain regular, informal contact throughout the internship year, as well as provide guidance on how they might approach or respond to the challenges of the doctoral paper process.

Lastly, we find that the GSPP consortium provides a format that helps mitigate unforeseen life events that could normally result in a delay in doctoral paper completion. Particularly because internship is a stressful period and completing a doctoral paper is a significant added stressor, it would beneficial for interns to have a space to receive support for various life circumstances. Thus, we recommend that time be set aside to address unpredictable life events, and that it is clearly communicated that flexibility exists for personal issues. In a best-case scenario, hands-on assistance in contingency planning on the part of peers and supervisors at internship sites would be encouraged when unforeseen events occur.

Much of our understanding of the doctoral paper process is anecdotal; research has not specifically examined how the expectations of the Psy.D. doctoral paper affect paper completion and graduation rates. Future empirical research should focus on Psy.D. programs, students, and the doctoral paper in particular. In addition, further understanding of the challenges that face students completing their doctoral paper while on internship as opposed to before or after the internship year would be beneficial. Finally, it would also be helpful to explore how an exclusively affiliated consortium might differ from an open consortium in influencing completion rates.

NOTICE TO READERS

Please find the references for the articles in this *Bulletin* posted on our website: divisionofpsychotherapy.org

Relationship and Common Factors in 'New' Therapies

Richard A. Lewis, Ph.D., UCLA Department of Psychology, and Kristopher I. Mathis, Ph.D., U.S. Department of Veterans Affairs

Recent years have brought an intensification of focus on "new" therapies, for reasons both good and ill. While any procedure that can briefly, reliably, and effectively alleviate the suffering of those with whom we come in contact should be applied, it is worth noting that market forces often underlie the creation and dissemination of lists of approved brief treatments. These lists are for the most part compiled without reference to the limitations of the validating processes. In general, the research is done with picked patients without co-morbid conditions (who meet criteria, don't drop out, and are able to be compliant), is not well generalized across ethnic groups, and insufficiently considers the impact of common factors.

It is also worth noting that the primary promoters of these "new" treatments include third party payers, who stand to save money by decreasing the length of treatment, and university based researchers whose career advancement may hinge on the production and marketing of "successful" research. We as a profession have a long history of wanting to be viewed as a science, from the earliest days of psychophysics and the measurement of Just Noticeable Differences to today's efforts to find specific remedies for specific maladies. I have no quarrel with the results of these efforts, where they apply, and a great deal of difficulty in forcing problem definitions to fit the solutions we think we have.

The new therapies themselves are, for the most part, newly studied re-packagings of elements that are themselves generally quite old. What's new is the degree to which the elements have been formalized, structured, manualized, tested, and sold.

Inasmuch as even seemingly targeted and "well-researched" treatments such as antidepressant medications can, arguably, be shown to rely on "common (e.g., psychological) factors," (cf *Psychotherapy: Theory, Research, Practice, Training, Vol.45, No. 3, 329-339*, "Treatment of Depression with Antidepressants Is Primarily a Psychological Treatment"), the same arguments can be applied equally to many of the "new" therapies.

All interventions are performed in the context of a relationship, and it is the relationship as much or more than the intervention to which the results can be attributed. (See entire issue of *Psychotherapy: Theory, Research, Practice, Training, Vol.38, No. 4*)

The largest ever study of actual psychotherapy (*Consumer Reports*, Martin Seligman, Ph.D.), while not methodologically ideal, also clearly supports the value of longer term non-specific treatment.

I hope that with the pressure we feel to save money, be effective, promote our careers, and keep current with the unrelenting episodic fads that sweep our

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profession, we keep in some part of our awareness the fact that we serve those in need with our art and our selves as much or more than we ever could with our scientific knowledge. While we all must cope with the problem of allocating limited resources, we need not embrace as ideal that which circumstance mandates. And we should be especially careful in our teaching and supervision to pass on the best of our profession and not merely that dictated by fad, convenience, or scarcity.

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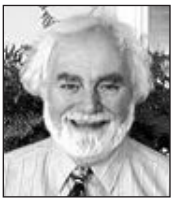
How Therapists Fail: Why Too Many Clients Drop Out of Therapy Prematurely

Bernard Schwartz Ph.D. and John. V. Flowers Ph.D.
Chapman University, Orange, California
Adapted from the book: "How To Fail As A Therapist"
Impact Publishers 2010



Depending on which study you read, between 20 and 57% percent of therapy clients do not return after their initial session. Another thirty-seven to 45% only attend therapy a total of two times. Although many factors contribute to premature client termination, the number one cited reason by clients is dissatisfaction with the therapist. (Acosta, 1980; Cross and Warren, 1984; Hynan, 1990). The problem of the "disappearing client" is what Arnold Lazarus calls "… the slippery underbelly to the successful practice of psychotherapy that is almost never discussed in graduate programs or medical schools."

As clinical supervisors of interns at a university community clinic, we are painfully aware of the high rate of client dropout, and thus the idea for our book; "How to Fail as a Therapist" was born. What we found in doing the research for the book is that high dropout rates are not just common amongst interns, but are equally prevalent among experienced therapists regardless of training and clinical orientation

When clients dropout early, everyone loses. We clinicians lose a chance to help someone in need and our wallets and reputation suffer as well. The consequences for clients are even more dire. Those clients who dropout early display poor treatment outcomes, over-utilize mental health services, and demoralize clinicians.

Now the good news (after all, therapists should be optimistic): there are a number of well researched strategies which have been proven to reduce dropout rates and increase positive treatment outcomes. For example, in one study a simple phone call to confirm a client's first appointment resulted in a two-thirds reduction in dropouts. Unfortunately, it is often labor intensive to seek out and review much of the relevant research because it is scattered throughout the literature—a journal article here, a chapter in a book there. And, unfortunately, most mental health clinicians, with and without a Ph.D., rate reading research as a very low clinical priority.

Thus, a major task in writing the book "How to Fail as a Therapist" was to assemble, organize and condense the vast body of research addressing therapeutic effectiveness. Of the fifty therapeutic errors described in the book, here we present three of the most common ones made by clinicians—both beginners and "master" therapists.

The "Infallibility Error"
"Bad Therapists Don't Know What They Don't Know." (A. Lazarus, 1977)

One of the most distinguishing charac-

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teristics of therapists who have low dropout rates is that they actively seek feedback—both positive and negative - regarding the effectiveness of their clinical work. On the other hand are those therapists who believe that after years and years of study, comprehensive exams, post-graduate supervision. and licensing exams—they do or should have all of the answers to clinical matters. Thus when their clients voice concerns about their progress, or worse yet when they drop out or deteriorate under their care, there is a tendency to avoid accepting responsibility for committing a possible therapeutic error. It is easier to point the finger elsewhere—"maybe the problems were too severe;" "the patient was not ready or willing to change;" there was too much transference operating."—the possibility for rationalization and denial is endless. These explanations, even when partially valid, may soothe the ego, but they protect clinicians from engaging in an honest and comprehensive exploration of what might have gone wrong in a particular case.

A group of interns was asked to describe a case in which a client of theirs terminated early in therapy. One intern described the case of a 10 year old male client, who had been referred by his teacher because he seemed disconsolate over his parents' divorce. During the first session the intern probed about the effect of the parents' separation and the client became emotional and wanted to change the subject. The intern persisted however, and the client stood up, tears falling, and refused thereafter to return to therapy. The supervisor responded to the case presentation by emphasizing the need for therapists to be very cautious during early sessions, particularly when eliciting difficult material from clients. Before the supervisor could get very far, the intern interrupted by stating: "I am already discussing this case with my other supervisor, so I probably shouldn't get input from both of you."

Clearly, this intern was desperate to avoid facing the possibility that he did not handle the case as delicately as perhaps he should have. None of us really relishes the idea that we may have blundered, but if we deny this possibility, we deny ourselves the chance to grow as clinicians.

One way to avoid the "infallibility" error is to seek feedback from clients who have dropped out prematurely. Arnold Lazarus describes in his book on Multimodal Therapy how he has gained great insights by writing "early terminators" and suggesting that they come in for a "feedback session" for which he doesn't charge. In one such case, a client reported that she felt the therapist had not been sympathetic when she was recounting the loss of a beloved pet. The therapist apologized for the insensitivity and the client decided to continue in therapy.

One crucial statistic to keep is mind is that the majority of clients who drop out, do so after the first or second session. Thus, we must elicit client feedback, positive and negative, early on to head off any misunderstandings or negative feelings about the therapis or, the therapeutic process. Clients can be asked directly at the end of the first session if they feel therapy is on track and if they feel liked, understood and respected. Asking for direct feedback may feel a little awkward? However, a little awkwardness is better than losing a client before he or she can be helped.

The "Pathology Orientation" Error

"The less we think, during the therapeutic process, of diagnostic categories and labels, the better." (I. Yalom, 2003)

In the field of psychotherapy, the term "The Bible" has become synonymous with the publication known as Diagnos-

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tic and Statistical Manual. This definitive compendium of emotional disorders was first published in 1952. Since that time the Manual has gone through a number of revisions (four major and several minor ones) and has continued to add new diagnostic categories. In addition, it has really bulked up over the decades, growing from a mere 138 pages at the outset to over 800 pages in its most recent incarnation.

Currently every student entering the fields of psychiatry, psychology, social work and counseling is required to virtually memorize the DSM-IV-TR, and thus professionals in our field have greatly increased their knowledge base of diagnostic criteria, demographics and prognoses of emotional disorders. Alas these advances have a down side as well. It has created an overemphasis on pathology to the near exclusion of what is healthy, resilient, and capable in the clients that we treat.

At the same time that the fields of diagnosis and assessment were becoming more sophisticated, an alternative view of human potential was also advancing. Theorists such as Carl Rogers, Abraham Maslow and Victor Frankl were among the earliest progenitors of those who tended to take a broader view of the client, looking beyond pathology toward human capability. Milton Erickson's work, which emphasized client resources, was in the vanguard of this new perspective.

Following Erickson's lead a number of other clinicians and researchers have explored the idea of utilizing client strengths as a resource in the treatment of emotional problems. Narrative Therapy avoids the exclusive focus on problems and pathology by instead exploring clients' alternative stories—occasions in which healthy, productive behaviors were enacted instead of the usual counter-productive responses.

Ryan was described as "incorrigible" by his teachers. He spent as much time in the principal's office as he did in the classroom. His main transgressions revolved around aggressive and bullying behavior. Ryan's counselor applied a narrative approach by first asking Ryan about his "problem story"—the things that get him in trouble. They then gave a name to his problem story—"Mr. Trouble." In addition to gathering the nasty details of his misbehavior, the counselor also inquired about occasions when a different Ryan, a kinder Ryan surfaced. The question itself seemed to shock the ten year old. However, after reflection he confessed that on occasion he had shown care to his younger brother when he was ill, or was lonely and needed a playmate. The counselor then asked follow up questions to explore the way "Kind Ryan" felt after demonstrating care to his brother.

"What did you think of yourself for being helpful to your brother?"

"How did your brother respond to your help?"

"What did your parents think of you?"

"What does it say about you that you show care to your brother?"

Unfortunately, in spite of the advent of "positive psychological" approaches to therapy, we have been programmed to look more at what clients are lacking and less at client strengths. Most "initial interview" forms have a space in which the client's clinical diagnosis is supposed to be entered. To avoid the "pathology orientation" we need to expand the initial interview to include a thorough assessment of a client's skills, talents and resources. We need to know what challenges they have surmounted, what kinds of accomplishments they have attained, what special abilities they have developed.

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When therapists and clients shift their focus from the "pathologized victim" to the "heroic victor" therapy becomes a much more creative and productive process.

Emphasizing Therapeutic Techniques Over Relationship Building

"It is imperative that clinicians remember that decades of research consistently demonstrate that relationship factors correlate more highly with client outcome than do specialized treatment techniques." (Castengu, et al., 1996).

One of the best things about attending continuing education seminars is learning about the latest therapeutic interventions. And every year or so, such new "breakthroughs" arrive—EMDR, DBT, ACT—you name it. We rush home from the seminars, and can hardly wait for the first patient that we can try out our new found knowledge on.

Many of these innovations do have credibility, but there is one glitch in all of the focus on techniques. As the above quote states emphatically, the most powerful predictor of positive therapeutic outcome depends less on what type of therapeutic interventions you employ, and more on what kind of therapist-client bond you develop.

An intern related to her ever patient supervisor that she had been learning about the use of "paradoxical intentions" in her advanced counseling class. She was hoping to try out this new dramatic technique with one of her clients, and did so with a patient during their very first session. The patient had returned to school after a recent divorce, and complained of being totally overwhelmed. She couldn't get herself to do any homework and was no longer the organized housewife she used to be—failing to do even the simplest of chores like laundry or dishes. The intervention the intern tried was to" join the symptom" and prescribe the homework assignment to do "absolutely no work at all this week" and report back at the next session how this went.

Unfortunately, there was no next session—the client was never heard from again. The lesson here is one that is all too commonly missed—the therapeutic relationship trumps technique. To be more precise, no other single factor affects therapy outcomes more than the quality of the client-therapist relationship. Although exact percentages of therapeutic effect are difficult to ascertain—one study did attempt to do just that. After reviewing over 100 outcome studies, Lambert and Barley (2001) derived an estimate of the relative contribution of the myriad factors which have been studied in outcome research. Surprisingly, the specific techniques employed by therapists (cognitive, psychodynamic, etc.), accounted for only 30% of therapeutic outcome. However, the quality of the client-therapist relationship predicted results 40% of the time.

In the case discussed above, the parodoxical intervention might have proven effective in the long run, if the therapist had developed enough rapport and a trusting relationship before implementing the approach. The tendency to rush into the therapist tool kit and resolve the problem quickly is of course exacerbated by the current emphasis on brief or time-limited therapy. Suffice it to say, the "bottom line orientation ("time is money") is not always in the patient's best interests.

Relationship building begins with the first hello—and handshake. In fact, in one study of medical doctors, the "handshake" was cited by patients on an exit questionnaire as the most positive factor in the office visit.

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One of the best (and least utilized) methods to ensure that the therapist and client are on the same page is to employ as "relationship assessment tool" such as the Working Alliance Inventory developed by Horvath and Greenberg and readily available on the internet. This user friendly tool predicts with a high degree of accuracy whether or not a client is at risk of dropping out of therapy. It also points to the areas of "disconnect' which can be addressed sympathetically with the client.

It is our hope in writing about the factors that cause client dissatisfaction and eventual termination, that we can the move the discussion of therapist error from "the underbelly of the profession" to the broad light of day. And in so doing can provide clinicians with added tools to enhance their professionalism, effectiveness and success.

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BOOK REVIEW

Earning a Living Outside of Managed Mental Health Care: 50 Ways to Expand Your Practice (2010)

Publisher: American Psychological Association

Editor: Steven Walfish

Reviewed by: Jeffrey J. Magnavita

When I began private practice in the mid-1980s, I had just left a full-time "secure" (the hospital has closed) position at a private psychiatric hospital and had made the transition from part-time to full-time practice. This had been a dream for many years and taking the leap was exhilarating and scary. I rented a small office suite and started a group practice with a part-time social worker. The group practice expanded and contracted over the years to its current form where I am a solo practitioner and rent space to psychiatrists and other psychologists. I remember early in my career when my group practice was expanding and thriving how exciting it was growing my dream practice. One day while getting coffee with one of the associates she commented that her old supervisor upon hearing that she was an associate in my group commented, "Oh he is that entrepreneur." Psychologists were led to believe that business interests were beneath us. I can still remember the shame that I felt when she repeated the statement. Since that time I have completely left the ranks of managed care and work fee for service, although I will submit insurance forms for those with out of network benefits. I love what I do and feel that I am well compensated for my education, training, and skills.

With this as a backdrop, I was eager to read Steven Walfish's edited volume entitled *Earning a Living Outside of Managed Mental Health Care: 50 Ways to Expand Your Practice* published by the American Psychological Association. Dr. Walfish has previously co-authored another volume with Jeffrey Barnett on the topic of achieving financial success in mental health practice but this latest volume is an edited compilation of chapters from 50 contributors who have achieved success outside of managed care. Walfish knows his topic and the territory well.

Contributors begin their chapters by introducing themselves and describing a variety of niche areas in which they have established themselves outside of the constraints of managed care. Wonderful suggestions abound in these interesting and concise summaries. The volume covers a wide spectrum of areas in which the contributors have found a need, developed a specialty, and appropriately marketed their services with quality in the forefront. I found the first chapter by David Verhaagen immensely concise and informative. He summarizes seven keys to building a dream practice outside of the constraints of managed care. I found his points, which I won't repeat here because I really hope that you will read this book, to be resonant with what I have found has worked in my own practice. I suspect your curiosity is peaked so I will reveal just one of the seven keys, which is to "think of yourself as a brand." I agree that this suggestion is essential to establishing yourself as someone distinctive.

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Branding was a major theme of APA's past President James Bray's Task Force on the Future of Practice. Another piece of wisdom that has been true in my experience is that when you are fee for service you have to be comfortable not accepting up to 40% of your referrals but to think abundance and not scarcity.

The remaining chapters are also concise and cover a range of services, which psychologists are well suited to provide and for which markets exist outside of managed care. Walfish conducted some preliminary surveys with psychologists about activities that they conducted outside the purview of managed care. This was used to guide his selection of topics. A sample of the spectrum of activities covered in this volume include premarital counseling, teaching marriage skills, collaborative divorce, pet therapy, various types of specialty evaluations, executive leadership coaching, consulting to family owned businesses, supervision of psychotherapy providers and many others. There are wonderful suggestions gleaned from experiences of seasoned practitioners with many years of honing their business models.

One of the points that is made in this volume is applicable whether you are just starting your practice or have been in it for a while: managed care can be secure in that you will likely have a stream of referrals, but you will not thrive. I suspect that this is one of the factors that leads us to burnout and is part of the industrialization of our field.

Reading this volume is certainly a treat in that it is well organized and chapters are articulate and personal conveying the contributors' passion for their work and business insight. I must say that since I started in practice decades ago it is nice to see that the entrepreneurial spirit is not longer an anathema to psychologists. I highly recommend this book to everyone in private practice who is considering making the transition from managed care and those who are just starting out in practice.

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Bridge Over Troubled Water

Pat DeLeon, Ph.D.
Former APA President

With the various provisions of President Obama's landmark health care reform legislation now being steadily, if not systematically, implemented, there is a considerable sense of uncertainty within the practice community (and the nation at large) regarding exactly how his far reaching vision will ultimately affect their daily lives. Many Republicans in Congress, a significant number of Governors, and vocal interests such as the Tea Party advocates are calling for an outright repeal – a prospect which is highly unlikely regardless of how the November elections turn out. From a historical frame of reference, we understand that a similar sense of concern existed following the enactment of the original Medicare legislation during President Lyndon Johnson's Great Society Era. Yet, almost everyone would agree that today Medicare is cherished by the vast majority of our nation's senior citizens, a number of whom routinely call for "keeping the federal government out" of their beloved program. During these uncertain times, we thought it would be useful for the readership to reflect upon the recent past and explore elements of the probable future.

Psychology's Institutional Vision: At the 2009 annual State Leadership Conference, Katherine Nordal, Executive Director of the APA Practice Directorate, noted: "We spend $2.3 trillion annually on health care, almost twice as much per person as any other industrialized nation. But studies show that we are not getting what we are paying for. Fully a third of our spending is wasted on treatments, drugs, and tests that do not improve outcomes…. I want to turn our attention now to a broader role for psychologists in the health care system, one which must focus increasingly on integrated care. Why integrated care? Over time, health, mental health, and substance use treatment systems have evolved in silos and independently from each other. As if the mind and body were two separate and unrelated systems…. We know that at least half of the care provided for common psychological disorders, such as depression, is provided in the primary care environment, not in specialty behavioral health settings…. The consequences of unmet mental health treatment needs, which can contribute to or worsen a variety of physical health problems, are too costly to ignore. Unfortunately, the first line of primary care treatment for psychological disorders is usually medication without the appropriate referral for psychotherapy…. It is foolhardy for us to focus narrowly on mental health issues when the real opportunities to make a significant difference in the quality of life for most of our citizens are in the broader domain of general health care and in delivery systems that will have stringent demands for accountability with a focus on quality and outcomes. It is time for us to view our discipline more broadly as a health care profession, with mental health as a subset of our expertise, and to communicate the breadth of our expertise to the public and policy makers." At the 2010 State

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Leadership Conference, correctly anticipating the timely enactment President Obama's health care reform legislation, Katherine highlighted several critical policy themes: "We need an integrated health care delivery system, and psychologists must be part of the health care teams in that system. We cannot afford to watch from a distance as a new health care delivery system is crafted… one that is unlikely to value what psychologists can bring to the table if we sit on the sidelines. When we fail to become involved in advocacy, we give others the power over our future as health care providers…. We also need to help more of our members become comfortable with and accustomed to using the electronic media that increasingly shape our interactions with others…."

A Visionary Psychologist's View: Ron Rozensky: "Over the years a number of psychology's national leaders have stressed the need for our colleagues to do more to educate our nation's health care leaders regarding our extensive clinical expertise and to appreciate that the forthcoming major gains in the effort (for psychology) to be fully recognized as a mainstream health profession will now require new partnerships. These new partnerships will definitely need to include advance practice nurses, clinical pharmacists, primary care and other non-psychiatric physicians, and particularly politically active consumer groups and business leaders. Political advocacy agendas will now have to be done collaboratively.

"Thanks to the efforts of Cynthia Belar and Nina Levitt of the Education Directorate, it has been exciting to be involved in that process via my appointment by the Secretary of Health and Human Services (HHS) to the Health Resources and Services Administration's (HRSA) Advisory Committee on Interdisciplinary, Community Based Linkages (ACICBL) within the Bureau of Health Professions. By its very definition, and charter from Congress, this is exactly the collaborative environment that will facilitate partnerships leading to a more efficient and effective health care system.

"I currently serve as chair of the ACICBL and our 2010 annual report to the Secretary of HHS and to the Congress will focus on 'Preparing the HealthCare Workforce to Address and Manage Health Behaviors.' Clearly, this topic is near and dear to my professional identity, having published five books and numerous articles on this subject, having spent years in clinical practice as a board certified clinical health psychologist, and spending most of my week now as a professor educating and training the next generation of psychologists who will 'address and manage' health behaviors. This current focus of ACICBL on health behaviors came about by the interdisciplinary discussions of the nurses, physicians, pharmacists, podiatrists, physician assistants, and other healthcare professionals on the committee. There was a cooperative agreement that this topic and addressing how to assure the future education, training, and practice of the entire healthcare workforce to address health behaviors will have a positive impact on individual and population health and the overall cost of our nation's health care.

"Last year our committee's report was Agenda for Change: Interprofessional Education and Practice – Implications for Primary Care in Health Care Reform. This clearly illustrates the importance of the involvement of the full range of healthcare professions, including psychology, in primary care services. Recommendations included assuring that all disciplines are educated together to understand each other's roles and how to work together in team structures like

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'The Patient Centered Health Care Home' and that reimbursement be assured for all members of the team. The ACICBL also worked with the three other advisory committees in the Bureau of Health Professions—Graduate Medical Education, Nursing Education, and Dentistry & Primary Care—to write a letter to the Secretary of HHS and Congress with recommendations for the then, upcoming healthcare reform legislation. The chairs and vice chairs of each committee signed the letter and noted that we were acting as a true team of health care providers, were not advocating for any one discipline's agenda over another's, but were advocating for quality patient care. It was gratifying to know that Members of Congress drafting the soon to be passed healthcare reform legislation not only attended to the content of our recommendations but took to heart, and mind, the importance of interprofessional education, training, and practice and helped assure that all professions were recognized as able to practice to the full extent of their scope of practice.

"There are many ways to be involved in advocacy for the future of psychology. Using the strength of our evidence-based science and our best clinical practice models as the data needed to build policy recommendations is extremely powerful. This works even better when done in the context of a strong working relationship with our colleagues across all healthcare disciplines—interprofessional professionalism is our future. As others before me have said—'Political advocacy agendas will now have to be done collaboratively.'"

An Interesting Perspective From The AMA: In their December 1, 2009 letter to the Senate Majority Leader, the AMA shared its views on the pending healthcare reform legislation. "The American Medical Association (AMA) remains committed to achieving enactment of comprehensive health system reform legislation that improves access to affordable, high-quality care and reduces unnecessary costs. We do not believe that maintaining the status quo is an acceptable option for physicians or the patients we serve." The AMA recommendations addressed a number of their concerns, especially those related to reimbursement levels and the specifics of the proposed Independent Medicare Advisory Board.

Most relevant to the issues raised by Katherine and Ron, as well as the importance of collaborative efforts across the various health professions, was the AMA position on workforce training and a related demonstration program. "The AMA supports provisions in the bill that would authorize increased funding for the National Health Service Corps and funding for Title VII health professions and diversity programs in order to address the need for more physicians and other health care professionals. The AMA also generally supports programs that increase basic nursing education opportunities, provide workforce incentives, as well as other initiatives in order to increase the supply of registered nurses. **In lieu of the proposed nurse-managed health clinics, the AMA supports fully integrated multidisciplinary health care teams that are comprised of nurses and other health care professionals, which are led by physicians to ensure that patients get the best possible care** [highlighted in letter]…. The AMA generally supports testing independence at home medical models, as provided for in the bill, but we have some structural concerns, including that the demonstration program should be led by physicians. We would suggest that psychology

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should not be surprised by the historical AMA position that "physicians should always be captain of the ship." We would seriously question, however, whether this fundamental policy position can be supported by any objective data and we would further suggest that it is important for our colleagues in psychology to become increasingly involved on behalf of their profession as Kathleen and Ron have urged. Of interest, the nurse-managed clinic provision did become public law, notwithstanding the AMA's expressed concerns.

Change Is Definitely Coming: This Summer, HRSA released a report from its Division of Nursing Dual and Joint Degree with Nursing Roundtable Working Group. HRSA had convened a working group in May, 2010 of 24 leaders from nursing and other disciplines who are program directors of dual and joint degree programs; representatives from accrediting agencies and associations that are involved with the national dialogue on dual and joint degree programs; and Division of Nursing staff. Five of the individuals participated by telephone conference call. The overall purpose of the Roundtable was to explore innovative cross cutting dual or joint degree nursing programs that seek to prepare nurses to expand the traditional scope of nursing practice; and to provide an opportunity to share experiences to gain insight about the implementation of Dual or Joint degrees with Nursing programs. Participants had an opportunity to explain the reason for starting their program, challenges, solutions, graduate employment and scope of practice, recommendations and the value of these programs in strengthening health care teams and achieving interprofessional competencies. Several of the objectives addressed were identifying critical elements necessary for integrated or parallel curricula; sharing evaluation indicators that measured program outcomes; and sharing experiences to date on how graduates are integrating both disciplines into their practice and leadership positions within the health system.

The American Association of Colleges of Nursing (AACN) 2009 survey of schools of nursing documents that there are over 100 nursing schools that offer dual degree programs: 74 MSA/MBA programs; 34 MSA/MPH programs; 10 MSN/MHA programs; 5 MSN/MPA programs; 4 MSN/MDIV programs; and, 3 MSN/JD programs. The Executive Vice President and CEO of the Association of Colleges of Pharmacy provided a report on their field's experiences and noted that one Physician Assistant and Doctor of Pharmacy (PharmD) joint program is currently accredited.

Accrediting agencies and professional association representatives provided valuable contributions. No barriers that would inhibit full accreditation of dual or joint degree programs were identified. Additional anecdotes were provided about the value of dual and joint degree programs and reasons that the schools have implemented them. Interest in participating in future meetings was received from the Association of Schools of Public Health (ASPH). The professional association representatives expressed support for innovative programs and interprofessional learning experiences.

The participants identified the value added by the opportunity for Dual and Joint degree programs, including their attention to achievement of interprofessional competencies and the extent to which practice experiences can incorporate the knowledge and skills and competency development needed for both disciplines. It was felt that additional

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evaluation needs to be carried out on the extent to which the graduates of some of these programs improve access to primary health care. Additional investigation also is needed to determine how the programs are integrating attention to addressing disparities, diversity of the workforce, and increased quality of service for underserved populations. A benefit emphasized by all was that faculty prepared in both disciplines were able to bring in-depth expertise to their teaching and research, and to continue these connections across disciplines through their academic careers and practice. The participants made recommendations for how to foster more opportunities for joint degree programs. One key area of attention is to increase connections among these programs in order to share innovations. HRSA is considering the recommendations and next steps. We fully expect that in the near future, a dual degree program between nursing and pharmacy will be established at the University of Hawaii at Hilo, with a special emphasis upon gerontology and long term care. Their current plan is to integrate course materials wherever possible, thus significantly reducing the overall length of study. The level of student interest in participating is exciting. In our judgment, this particular initiative possesses the potential for truly revolutionizing society's definition of "quality care" for a steadily growing segment of our society; i.e., our nation's elderly. All your dreams are on their way. See how they shine…. Like a bridge over troubled water. I will ease your mind. Aloha,

Pat DeLeon, former APA President –
Division 29 – August, 2010

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Figure 1. Differences in skill acquisition curves for everyday skills versus experts level performance showing plateau occuring when skills become automated. Experts performance continues to increase by employing deliberate practice strategies that delay automation. Reprinted from "The scientific study of expert levels of performance: General implications for optimal learning and creativity," by K. A. Ericsson, 1998, *High Ability Studies*, *9*, *90*, p90. Copyright 1998 by European Council for High Ability. Reprinted with permission.

Modifying Psychologists Views on Treating Trauma in African Americans

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