

Psychotherapy

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Research in Clinical Supervision*



Society for the Advancement
of Psychotherapy

2018 VOLUME 53, NUMBER 4

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Society for the Advancement of Psychotherapy ■ 2018 Governance Structure

ELECTED BOARD MEMBERS

President

Michael J. Constantino, PhD
Department of Psychological and Brain Sciences
612 Tobin Hall - 135 Hicks Way
University of Massachusetts
Amherst, MA 01003-9271
Ofc: 413-545-1388
E-mail: mconstantino@psych.umass.edu

President-elect

Nancy Murdock, PhD
University of Missouri-Kansas City
215 Education Building
5100 Rockhill Road
Kansas City, MO 64110
murdockn@umkc.edu
Ofc: 816-235-2495 fax: 816-235-6925
E-mail: murdockN@umkc.edu

Secretary

Rebecca M. Ametrano, Ph.D., 2018-2020
Office of Patient Centered Care
VA Boston Healthcare System
1400 VFW Parkway
West Roxbury, MA 02132
Ofc: 857-203-5394
E-mail: rametrano@gmail.com

Treasurer

Jesse J. Owen, PhD, 2016-2018
University of Denver
Morgridge College of Education
Counseling Psychology Department
1999 E Evans Ave
Denver CO 80208
Ofc: 303-871-2482
E-mail: jesse.owen@du.edu

Past President

Jeffrey Zimmerman, PhD
29 Todd Rd.
Katonah, NY 10536
Phone: 203-271-1990
E-mail: drz@jzphd.com

Domain Representatives

Public Interest and Social Justice
Lavita Nadkarni, PhD, 2018-2020
Director of Forensic Studies
University of Denver-GSP
2450 South Vine Street
Denver, CO 80208
Ofc: 303-871-3877
E-mail: lavita.nadkarni@du.edu

Psychotherapy Practice
Barbara Thompson, PhD, 2016-2018
3355 St. Johns Lane, Suite F.
Ellicott City, MD 21042
Ofc: 443-629-3761
E-mail: drbarb@comcast.net

Education and Training
Jennifer Callahan, PhD, 2016-2018
UNT Department of Psychology
Terrill Hall, Room 376
1155 Union Circle #311280
Denton, TX 76203-5017
Ofc: 940-369-8229
E-mail: Jennifer.Callahan@unt.edu

Membership

Jean Birbilis, PhD, 2016-2018
University of St. Thomas
1000 LaSalle Ave., MOH 217
Minneapolis, Minnesota 55403
Ofc: 651-962-4654 fax: 651-962-4651
E-mail: jmbirbilis@stthomas.edu

Early Career

Leigh Ann Carter, PsyD, 2017-2019
Towson University
8000 York Road
Ward & West - Counseling Center
Baltimore, MD 21252
Ofc: 443-470-5434
E-mail: leighacarterpsyd@gmail.com

Science and Scholarship

Susan S. Woodhouse, PhD, 2017-2019
Department of Education and Human Services
Lehigh University
111 Research Drive
Bethlehem, PA 18015
Ofc: 610-758-3269 Fax: 610-758-3227
E-mail: woodhouse@lehigh.edu

Diversity

Rosemary Phelps, PhD, 2017-2019
University of Georgia
402 Aderhold Hall
Athens, GA
Ofc: (706) 542-1812
E-mail: rehelps@UGA.EDU

Diversity

Gary Howell, PsyD, 2018
Center for Psychological Growth
2109 E. Palm Avenue, Suite 201
Tampa, FL 33605
Ofc: 813-419-7793 Fax: 866-627-1040
E-mail: garyhowellpsyd@gmail.com

International Affairs

Frederick Leong, Ph.D. 2018-2020
Michigan State University
Department of Psychology
East Lansing, MI 48824
Ofc: 517-353-9925; Fax: 517-353-1652
E-mail: fleong@msu.edu

APA Council Representatives

Lillian Comas-Diaz, PhD, 2017-2019
908 New Hampshire Ave NW Ste 700
Washington, DC
Business: (202) 775-1938
E-mail: lilliancomasdiaz@GMAIL.COM

Elizabeth Nutt Williams, Ph.D, 2017-2019
St. Mary's College of Maryland
18952 E. Fisher Rd.
St. Mary's City, MD 20686
Ofc: 240- 895-4467 Fax: 240-895-2234
E-mail: sl.williams1@comcast.net.

Student Representative

Nicholas R. Morrison, MS, 2017-2019
University of Massachusetts
Department of Psychological & Brain Sciences
602 Tobin Hall | 135 Hicks Way
Amherst, MA 01003
Phone: 413-345-2924
E-mail: nmorriso@psych.umass.edu

STANDING COMMITTEES

Continuing Education

Tony Rousmaniere, PsyD
Student Health and Counseling Center
University of Alaska, Fairbanks
612 N. Chandalar Drive, PO Box 755580
Fairbanks, AK 99775-5580
Phone: (907) 474-7043
E-mail: troumaniere@gmail.com

Diversity

Chair: Astrea Greig, PsyD
Boston Healthcare for the Homeless Program
780 Albany St, Rm 3107
Boston MA 02118
Ofc: 857-654-1324
E-mail: agreig@bhchp.org

Early Career Psychologists

Chair: Kimberly A. Arditte Hall, PhD
National Center for PTSD
VA Boston Healthcare System
150 South Huntington Ave (116B-3)
Boston, MA 02130
Phone: 857-364-6232
E-mail: kimberly.ardittehall@va.gov

Education & Training

Chair: Rayna D. Markin, PhD
Department of Education and Counseling
302 Saint Augustine Center
800 Lancaster Ave
Villanova, PA 19075
Ofc: 610-519-3078
E-mail: rayna.markin@villanova.edu

Fellows

Chair: Robert L. Hatcher, PhD
Wellness Center / Graduate Center
City University of New York
365 Fifth Avenue
New York, NY 10016
Ofc: 212-817-7029
E-mail: rhatcher@qc.cuny.edu

Finance

Chair: Jeff Reese, PhD
University of Kentucky College of Ed
Dept of Educational, School, Couns Psych
245 Dickey Hall
Lexington, KY 40506-0017
Ofc: 859-257-4909
E-mail: jeff.reese@uky.edu

International Affairs

Changming Duan, PhD
Dept. of Psychology & Research in Education
University of Kansas
Lawrence, KS 66054
Ofc: 785 864-2426 Fax: 785 864-3820
E-mail: duanc@ku.edu

Membership

Rosemary Adam-Terem, PhD
1833 Kalakaua Avenue, Suite 800
Honolulu, HI 96815
Ofc: 808-955-7372 Fax: 808-981-9282
E-mail: drozi@yahoo.com

Nominations and Elections

Chair: Nancy Murdock, PhD
E-mail: murdockN@umkc.edu

Professional Awards

Chair: Jeffrey Zimmerman, PhD
E-mail: drz@jzphd.com

Program

Chair: Gary Howell, PsyD
E-mail: garyhowellpsyd@gmail.com

Associate Chair : James Boswell, PhD

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**SOCIETY FOR
THE ADVANCEMENT
OF PSYCHOTHERAPY**

American Psychological Association

6557 E. Riverdale
Mesa, AZ 85215
602-363-9211

e-mail: assnmgmt1@cox.net

EDITOR

Lynett Henderson Metzger, Psy.D.
Lynett.HendersonMetzger@du.edu

ASSOCIATE EDITOR

Cara Jacobson, Psy.D.
chjacobson@loyola.edu

CONTRIBUTING EDITORS

Diversity

Gary Howell, Ph.D., and
Rosemary Phelps, Ph.D.

Education and Training

Jennifer Callahan, Ph.D., and
Rayna D. Markin, Ph.D.

Ethics in Psychotherapy

Apryl Alexander, Psy.D.

Psychotherapy Practice

Barbara Thompson, Ph.D., and
Barbara Vivino, Ph.D.

**Psychotherapy Research,
Science and Scholarship**

Susan Woodhouse, Ph.D., and
Joshua Swift, Ph.D.

Public Interest and Social Justice

Lavita Nadkarni, Ph.D., and
Linda Campbell, Ph.D.

Washington Scene

Patrick DeLeon, Ph.D.

Early Career

Leigh Ann Carter, Psy.D., and
Kimberly Arditte Hall, Ph.D.

Student Features

Nicholas Morrison

Editorial Assistants

Salwa Chowdhury
Salwa.Chowdhury@du.edu
Cory Marchi
Cory.Marchi@du.edu

STAFF

Central Office Administrator
Tracey Martin

Website

www.societyforpsychotherapy.org

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Entering the 2018 Stretch

Michael J. Constantino, PhD
University of Massachusetts Amherst



To follow through on the horse racing analogy that I introduced in my second President's column, we are now entering the stretch run of a productive and celebratory year for our Society. So, for one last time in "print"—happy 50th birthday, Division 29! And here's to the start of our next 50 years, which, when sticking to our *Bulletin's* theme for this year, could be considered a major *turning point*.

As this column will be my last as President, I would like to thank our members for entrusting me to lead our organization. I accepted the gavel for 2018 with gratitude, humility, and excitement, and, in a few short months, I will turn it over to our next President, Dr. Nancy Murdock, with the same. As a Board of Directors, I am grateful for and humbled by our wealth of accomplishments this year, including several movements toward my presidential theme—*Establishing and refining personalized mental health care: Promoting disruptive, evidence-informed innovations to psychotherapy training molds and methods*. I am also excited to witness our continued growth and cutting-edge contributions to the psychotherapy field during Nancy's term and beyond. In this final column for 2018, I will summarize and spotlight several of the agenda items and initiatives that our Board took up at our most recent in-person meeting, which took place at APA Headquarters from September 14-16.

Your Board at Hard Work

The following initiatives remain at the front and center of our Division's business, some of which have been com-

pleted as of this writing. Although the list is not exhaustive, it is representative of the types of important items that our Board addresses and raises for the good and betterment of our Society. As I noted in my first column, I simply use the term "we" to indicate Society actions. As there is such a wonderful collaborative spirit among our Board members, it would be too challenging to list all of the associated names behind each creative endeavor. However, if you want names, or if you would like to be involved in any of our efforts, you should never hesitate to contact our Board!

If you are reading this column, it likely means that you have accessed the entire *Bulletin* online. Thus, you can see for yourself what amazing content that our team publishes. The information is timely, diverse, and mission-relevant, and it is disseminated by authors who span different, yet interrelating cross sections of our field (students, licensed professionals, faculty members, practitioners, researchers, trainers, administrators, and others). It is always a treat to receive the *Bulletin* release notice in our inbox, and we owe a huge, and ongoing, debt of gratitude to the Editorial team.

As you click through our website, you will also notice significant upgrades, timely news, important announcements, and exciting web-only features. Simply put, the website is flush with content. There is so much good psychotherapy "stuff" to find here, and through our social media, that I urge you to browse regularly and read often. And, thank you, to our immensely talented web team.

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While I'm at it, our Publications and Communications (Pub) Board as a whole is doing a fantastic job. In addition to the *Bulletin* and website, our flagship journal, *Psychotherapy*, keeps churning out remarkable scholarship, including with the recent release of the special issue on *Evidence-Based Psychotherapy Relationships III*. The Pub Board also doubled as the Search Committee charged with interviewing candidates and selecting the next Editor-in-Chief of *Psychotherapy* who will succeed Dr. Mark Hilsenroth when his second term, and immensely successful entire tenure, ends after 2020. As I have happily announced through multiple Division 29 channels, including this *Bulletin* issue, the next Editor will be Dr. Jesse Owen. Simply put, the Journal will remain in *extremely* capable hands, and I look forward to witnessing Jesse realize his long-term vision for it. I also note that as Drs. Lillian Comas-Diaz and Heather Lyons rotate off of the Pub Board after the calendar year, we will welcome Drs. Sarah Knox and Paul Kwan as new members; further, we are thrilled to have Brien Goodwin serve a second term as student member of this Board.

Consistent with our long-standing and ongoing commitment to, and appreciation of, diversity, the Board has approved a revised diversity mission statement, which can be viewed on our website. We will also send a representative to the next National Multicultural Conference and Summit (NMCS). We also continue to contribute to the endowment for the NMCS.

Consistent with Dr. Jeff Zimmerman's 2017 Presidential theme, several Board members are involved in organizing a conference on bringing psychotherapy to the underserved.

As a consequence of efforts to further our Society's collaboration with the Society for the Exploration of Psychother-

apy Integration (SEPI), our Board has approved three concrete actions. First, the organizations have established an agreement for in kind advertising at each other's annual professional conference, as well as Division 29's no cost sponsorship of the continuing education program at SEPI meetings. Second, the organizations will invite the current President (or other designated representative) to each other's meetings, with registration waived or reimbursed. This will facilitate ongoing connection and pursuit of collaborative initiatives. Finally, the organizations have established annual, bi-directional poster awards to be given at the other organization's meeting (with both named in memory of Dr. Jeremy Safran). That is, Division 29 will sponsor and administer a poster award (with a cash prize) to be given to a SEPI poster presenter at SEPI's annual meeting. SEPI will then do the same for a Division 29 poster presenter at APA's annual convention.

The Board has approved several revisions to our bylaws on which all Division members can now vote. If you are a Member or Fellow of Division 29, or an Associate Member who is also a voting Associate Member of the American Psychological Association (APA), you are entitled to vote on the presently proposed amendments. These changes will allow undergraduate students to be student affiliate members of our Society. Moreover, we have proposed changes to the composition of the Committee on Professional Awards; namely, given the growing number of award programs that we now administer, we are proposing for there to be a Chair that serves in this role for two consecutive years. We have also clarified various membership rights and privileges. Please visit our website to see a fuller review of these three substantive changes, and

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cast your vote before the poll closes on December 9, 2018.

Speaking of awards, we have developed and will launch for the 2019 cycle two new mid-career awards; one for distinguished scholarship contributions, and the other for distinguished practice contributions. See our website for nomination details and submission guidelines (as well as for our longer-standing professional awards and grant programs).

Nancy Murdock has been hard at work finalizing her Standing Committee Chair appointments for her 2019 term (and check out her Column in this issue), and our President-Elect designate, Dr. Jennifer Callahan, has appointed (with Board approval) her Committee on Nomination and Elections.

Our Board has approved a renewed partnership with Oriental Insight (which will be signed at the start of 2019), and we remain devoted to the internationalization of our Society.

A workgroup is actively pursuing creative options for updating and upgrading our Division's logo.

The Board agreed to endorse our Division's Past-president, Dr. Armand Cerbone, for President-Elect of the APA.

We have convened a Presidential work group to develop guidelines for administering a seed grant program for a training initiative. This will be one of my Past-president initiatives in 2019.

As discussed elsewhere in this issue, we have completed our companion video series to the chapters in the forthcoming

book, *Psychotherapy Relationships That Work* (3rd ed.). In these videos, Dr. Rayna Markin interviews contributing authors who discuss the training implications of their original meta-analyses on factors that contribute to psychotherapy improvement. The videos will soon be cross-listed on our website and the Oxford University Press website, so be on the lookout!

Our Program Chair, Dr. James Boswell, is already hard at work soliciting proposals for our Divisional programming at the 2019 APA Convention in Chicago. If you have yet to do so, please submit your best work, especially as if it relates to our incoming President's 2019 theme—*Psychotherapy for the future: Promoting growth through interventions designed for diverse clients and settings*. This is such an important focus, and I am already looking forward to Division 29's sessions.

Again, these are just some of the currently salient agenda items and initiatives that I have extracted from the constant motion of our *Education and Training, Practice, Science and Scholarship, International Affairs, Social Justice and Public Interest, Membership, Early Career, Diversity (Rosemary Phelps), and Student* domains. A big "thank you," to our past, present, and future Board members for keeping these wheels in motion. And, of course, such motions are invariably supported by our tireless and gifted administrator, Tracey Martin. Thank you, Tracey, for helping me navigate this year!

It has been an honor and an absolute pleasure to serve our Division, and I look forward to my next role as Past-president, and to (hopefully) other future roles.



PRESIDENT-ELECT'S COLUMN

Greetings From the President-Elect: APA Convention Theme and Presidential Initiative

Nancy L. Murdock, Ph.D.
University of Missouri-Kansas City



Hello Society Members:

As I contemplate the transition to President next month (which, to be honest, is a little overwhelming), I would like to briefly remind you about our convention theme and my primary presidential initiative for my upcoming (2019) presidential year.

I am pleased to announce the Society for the Advancement of Psychotherapy theme for the 2019 APA convention: *Psychotherapy for the future: Promoting growth through interventions designed for diverse clients and settings*. I am guessing that you have already submitted your proposals by the time you read this note, but if not, please do! This convention theme is representative of my presidential initiative, which is to explore and promote our membership's wide range of expertise in psychotherapy, with a special focus on non-traditional intervention.

Please join me in realizing this effort to spotlight what the Society's membership is doing that falls under my tag line *Out of the Office and Into the Streets*. **If you or someone you know engages in growth-producing intervention outside of the typical office setting, please let me know.** I'd like to feature these efforts periodically on the Society's website, and I am working on a presidential symposium in the same vein for the Chicago APA convention.

It's always a little difficult for me to write about myself, but I will try to overcome that enough to offer a brief bio. I am currently Professor of Counseling Psychology at the University of Missouri-Kansas City and have been at UMKC since receiving my Ph.D. in Counseling Psychology from Virginia Commonwealth University. I have occupied numerous roles at the university, including department chair, director of training of our APA-accredited doctoral program in Counseling Psychology and currently am coordinator of our MPCAC-accredited master's program in Counseling.

Over the years, I have served in various roles in professional organizations, including program chair for the Society for the Advancement of Psychotherapy, president of the Council of Counseling Psychology Training Programs, Vice President for Education and Training and program chair for the Society of Counseling Psychology. My scholarship is in the area of psychotherapy process and family systems theory, but I consider my most significant contribution to be my textbook: *Theories of and Counseling and Psychotherapy: A Case Approach*, which is in its 4th edition.

I am truly honored to serve the Society for the Advancement of Psychotherapy as President in the coming year.



EDITORS' COLUMN

Lynett Henderson Metzger, JD, PsyD
University of Denver-Graduate School of Professional Psychology

Cara Jacobson, PsyD
Loyola University Maryland



As the year draws to a close, we are pleased to bring you the final *Psychotherapy Bulletin* for 2018. This issue has a little something for everyone, from Education and Training pieces looking at the professional development of trainees in supervision and the climate of clinical training, to considering the implications of diagnosis and assessment from an Ethics perspective, to considerations for working with clients with specific diagnoses, such as Borderline Personality Disorder or Autism Spectrum Disorder, to a review of the state of multicultural counseling competencies research for our Diversity Domain.

We are especially delighted to bring you several Special Features, including a look at *Psychotherapy: The Next 50 years* by Drs. John and Rita Sommers-Flanagan; a discussion of professional competence and ethical practice when “going it alone” by Dr. Jeff Barnett and Kendall Corcoran; and three “Turning Points,” including a piece on retirement myths by Dr. Tom Barrett.

We truly appreciate all of the contributions from our authors this year, and join SAP President Mike Constantino in thanking our Domain Representatives, Contributing Editors, members of Governance, and all of the others who have helped make this year such a memorable one for the Society (please see the

President’s Column in this issue). We also look forward to things to come—for a sneak peek, see the President-Elect’s Column, in this issue, as well.

We would also like to express our gratitude to Dr. Constantino and the members of the Publications Board for their ongoing support, and to our Editorial Assistants, Salwa Chowdhury and Cory Marchi, and SAP’s fantastic Web Team, Dr. Amy Ellis, Kourtney Schroeder, and Elizabeth Kilmer, for their amazing work. I (Lynett) would also personally like to thank Associate Editor Dr. Cara Jacobson for her invaluable assistance with every issue.

And our final “thank you” for the year goes to you, our readers! On that note, please consider writing for the *Bulletin* in 2019! Our submission guidelines can be found online (<http://societyforpsychotherapy.org/publications/bulletin/about/>), **and our deadlines are: February 1, May 1, August 1, and November 1.**

Wishing everyone a safe and joyous end of 2018, and a wonderful beginning to the year to come.

Lynett Henderson Metzger, JD, PsyD
Psychotherapy Bulletin Editor
email: Lynett.HendersonMetzger@du.edu
office: (303) 871-4684

Cara Jacobson, PsyD
Psychotherapy Bulletin Associate Editor
email: chjacobson@loyola.edu
phone: (443) 520-2036

PSYCHOTHERAPY: THE NEXT 50 YEARS

Recursive and Emerging Themes in Psychotherapy: Past, Present, and Future

John Sommers-Flanagan, PhD

Rita Sommers-Flanagan, PhD

University of Montana



Simeon woke from the nightmare, sweaty and frightened. He groped for his *Calm Now* (CN) program, plugging it into his ear-port. He didn't just hear soothing music, he felt it; his breathing slowed, his forehead relaxed. The gentle instructions, in the voice he'd chosen, brought calmness and tranquility. Thanks to an activated parasympathetic nervous system, within minutes, he was emotionally regulated.

Simeon faced a choice. He could continue with his usual daily social, vocational, and recreational routines, or he could take time for personal exploration. This was the fourth morning in the past two weeks that he'd awakened from a similar nightmare. Maybe the CN program wasn't enough. Thanks to his grandmother's influence, for nearly all of his 25 years, Simeon had been interested in understanding life at a deeper level. He made remote contact (RM) with his grandmother, conferred a bit, and decided to invest time in symptom relief and growth-producing insight. He logged into his *Living Calendar* (LC), reset his November 15, 2068, work schedule, and moved his evening date an hour later. He punched in codes that his company's employee support program provided and input his symptoms and goals. Instantly, the company sent Simeon a virtual therapist, a hologram named *Indigo*.

For the next hour, Simeon interacted with *Indigo*. He shared his dream, engaged in guided emotional processing, and began recognizing how his dream was related to a near-death experience he had during an air quality emergency that happened six months ago in his dome complex. "Duh," he thought to himself. "I should have put that together." He contemplated connections between his trauma, his daily distress, and his disconnected interpersonal relationships. Exhilarated, Simeon requested three more sessions that week. By Friday, Simeon's *Spoken Daily Log* (SDL) read, "Monday was a turning point. Even though I was nearly asphyxiated 6 months ago, I'm letting go of the pain, integrating the experience into my life, and functioning from a place of authentic self again. The week was packed with meaning. I'm communicating more effectively and choosing interpersonal connections rather than my usual distancing. My grandmother always talked about the thrill of being a psychotherapist; now I understand why. I'm so glad she nudged me to get the help I needed. Thanks grandma! Thanks *Indigo*!"

Although he always thought of her as his quirky *Grandma Nola*, Simeon's grandmother was a real (non-virtual) 75-year-old retired psychotherapist. Grandma Nola had provided in-person counseling and psychotherapy, and had contributed to the ongoing process of updating the data bases used around the globe for virtual psychotherapy.

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Having been preoccupied with his own life and issues, Simeon didn't know much about Grandma Nola's past. He didn't realize that, 50 years ago, as a graduate student in clinical psychology (2017-2021), she had been studying and writing about the existential, cognitive, behavioral, psychodynamic, and feminist-multicultural themes she would use in her work as a psychotherapist and researcher. Much later, when he enrolled in a *History of Psychotherapy* course, he would recognize his grandmother's influence on how *Indigo* had worked with him.

Past as Prologue

Simeon's nightmare was linked to a 2008 global air quality crisis that had severely damaged systems across the globe, resulting in thousands of fatalities. But Simeon's traumatic experience could have occurred any time in human history. His distress could have been due to an automobile crash, intergenerational trauma, cultural oppression, a mudslide or tsunami, child sexual abuse, or emotional neglect. Humans have been, are, and will be physically, psychologically, and emotionally vulnerable.

In 2018, Grandma Nola was in the University of Montana library. She had a class assignment to go back 50 years and identify recurring themes in the development and application of psychotherapy. As a 25-year-old graduate student, Nola had an immense drive to learn everything she could about psychology and psychotherapy.

Social Context, Gender, and Relational Solutions

Nola used a popular counseling and psychotherapy theories textbook to begin exploring themes and issues in the history of psychotherapy (Sommers-Flanagan & Sommers-Flanagan, 2018). She was captivated by a short summary of Naomi Weisstein's (1968) critique of psychology's and psychiatry's construc-

tions of gender. Nola searched and found an original Weisstein article online and the words resonated with her experience. Immediately, she found herself in a timeless space of learning and discovery. From Weisstein, she leapt back to Alfred Adler's (1931) ideas on feminism and social interest (aka: *Gemeinschaftsgefühl*). Then, she circled forward to Bowlby's (1969) and Ainsworth's (1969) work on attachment. She took the pulse of psychoanalysis, finding that it wasn't dead, but transformed. She loved the quotation, "Libido is object-seeking, not pleasure-seeking" (Fairbairn, 1952, p. 82). Looking at the past aided Nola in her understanding of contemporary feminist theory and therapy. The underlying principles of relational cultural therapy (Jordan, 2010) became clear. She recognized that social context and relational connection, long downplayed in psychology, was a theme that connected the past, present, and future of psychotherapy.

Recursive Themes: Bringing There and Then to Here and Now

Nola's assignment took her to the late 1960s. Once there, she discovered books and articles written by Jean Baker Miller, Albert Bandura, Aaron Beck, Albert Ellis, Rollo May, Donald Meichenbaum, Fritz and Lore Perls, Carl Rogers, and B. F. Skinner. But her focus didn't hold. She flitted back and forth in time, reading the Rogers-Skinner debates, finding a copy of Mary Cover Jones's (1924a, 1924b) articles on deconditioning, then taking a side-track to C. G. Jung (1953), and returning, as her professor insisted, to neuroscience, psychotherapy outcome research, and interactive roles of biology, environment, culture, and volition in psychopathology, recovery, and wellbeing. In addition to social context, gender, and relational insights, she found additional themes and principles.

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Exposure and Counterconditioning

From Jungian theory to existentialism to behavior therapy to acceptance and commitment therapy and eye-movement desensitization, Nola discovered the core principle: *Thou shalt avoid avoidance*. Nearly every perspective, for distinct and indistinct theoretical reasons, advocated approaching and embracing anxiety and feared stimuli. As she connected this idea with contemporary movements toward psychology's interest in obtaining prescription privileges, she became increasingly skeptical of quick fixes that might dull emotional and cognitive awareness.

In her future work, she questioned the overuse of primitive psychotropic drugs for mood control and testified before the United Nations to help establish global credentials for virtual and human psychotherapists. Grandma Nola was instrumental in insisting that virtual psychotherapists, like *Indigo*, integrate behavioral classical conditioning and existential embracing of emotion and interpersonal connection into their programming.

Therapeutic Relationships: Real and Virtual

As Nola continued reading for her project, she focused in on what Wampold and Imel (2015) called *the great psychotherapy debate*. Intrigued, she quickly concluded that both common factors and technical procedures were critical to efficacious psychotherapy. In particular, she became interested in relationally-based common factors (Norcross & Lambert, 2018; Sommers-Flanagan, 2015). Even more specifically, she began exploring in-vivo and virtual therapeutic relationships.

In 1969, Carl Rogers was applying client-centered therapy principles to the field of education. Rogers's core conditions for psychotherapy were deeply

meaningful to Nola. Although she imagined Rogers as averse to a future where his core conditions were implemented virtually, she started viewing congruence, unconditional positive regard, and empathic understanding as transferrable to virtual counseling and psychotherapy.

Nola thought that perhaps Jerome Frank could have helped Carl Rogers make the leap from real to virtual. In 1961, Frank had written about common healing factors that transcended culture and specific method. Frank posited that specific healing myths, rituals, and settings could be (and would be) vastly different, depending on social context. Although Frank didn't write about virtual psychotherapists, his vision opened up the possibility, "My position is not that technique is irrelevant to outcome. Rather, I maintain that . . . the success of all techniques depends on the patient's sense of alliance with an actual or symbolic healer" (1961, p. xv).

As it turned out, given the right social and cultural context, *Indigo* could become Frank's symbolic healer. Nola discovered, in 2018, that clients who choose online or virtual counseling reported having a positive therapeutic alliance—even if the alliance was with a non-living entity (Sommers-Flanagan & Sommers-Flanagan, 2017).

Humans easily anthropomorphize devices. Simeon quickly felt a sense of alliance and attachment to *Indigo*. Whether we explain it through attachment theory or classical conditioning, alliance and attachment are natural byproducts of repeated positive interactions. In 2068, relational components of psychotherapy will remain central, but these "relationships" are likely to include many variations: virtual encounters with other humans; relational

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interactions between humans in distress and artificial intelligences functioning as helping entities (such as *Indigo*); anonymous, internet-based group work; and amalgamations of all of the above.

The Brain, the Body, and Behavior

Advances in neuroscience are exciting, palpable, and no doubt will influence psychotherapy's future. However, as Nola discovered in 2018, it can be difficult to distinguish between research-based implications for psychotherapy and popular hype of the so-called "new brain science" (Satel & Lilienfeld, 2013). The challenge for Nola and other psychotherapy researchers in the future is to separate the neuroscience wheat from the neuroscience shaft.

Mind-body dualism is a consistent theme in psychology and medicine. Over time, Grandma Nola's position held brain and body as one. Distinct from, but similar to, van der Kolk's (2014) emphasis on the body, Nola fought to integrate brain and body into a fully functioning partnership. But like Rogers's battle with psychiatry in the 1960s, this was not an easy fight (see Sommers-Flanagan & Sommers-Flanagan, 2018). The biomedical push for biogenetic and pharmacological interventions, including psychosurgery, was a continual force with which Nola contended. She held that developing emotional awareness, encouraging interpersonal connection, and empowering human choice was preferred over biomedical interventions. But sometimes her grip on that position was threatened.

Relational Technology

Combining themes from the past and looking to the future brings up unlikely partnerships. Theoretical propositions from attachment, feminist, Adlerian, person-centered, and existential perspectives heavily favor the therapeutic relationship as foundational for change. In contrast,

the learning theories that are foundational to cognitive-behavioral therapy—the most empirically supported treatment of our generation, circa 2018—are far more technical and procedural, often bracketing or downplaying the transformative role of therapeutic relationships.

Most likely, therapists who believe in the centrality of the therapeutic relationship for healing and change wouldn't easily endorse the partnership of relationship with technology. However, Simeon's *Indigo* program wove relationship and technology together in ways that could and did create meaning, new learning, and insight for Simeon. We are reasonably certain that by 2068 there will be sophisticated devices able to offer comfort, promote insight, and capitalize on teachable moments in the lives of a broad swath of a technologically savvy generation.

Hopefully, though, the goal(s) of psychotherapy will be both basically unchanged *and* appropriately articulated for the times. Regardless of how technical Simeon's intervention might be, we believe the 2068 Simeon will long for healthy relationships, intimate connections with real people, meaningful work, and a sense of fulfillment. *Indigo* will weave this understanding into its treatment of Simeon, and likely Simeon will benefit. But we also predict that many humans will not accept a virtual therapist, and will prefer a human psychotherapist. And, as Grandma Nola would attest, *Indigo* will not program itself. Human therapists, thinkers, and scientists will continue to explore how to best help others heal, grow, learn, and develop.

The morning after the nightmare, when Simeon plugged his chosen program into his ear-port, he immediately benefited from counter-conditioning. Simeon didn't know the research-based origins of counter-conditioning or the subse-

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quent neuroscientific support of exposure therapies. All he did was take time to face his psychological issues, reporting his reactions into his *SDL*; these reactions were automatically uploaded into his *Psychological Needs Profile (PNP)*. In turn, Simeon was given assignments designed to increase his self-efficacy (Bandura, 1977), expose him to his anxieties (Jones, 1924a), and offer him opportunities for deepening interpersonal connections (Jordan, 2010; Yalom, 1980). The feedback and feedforward processes integrated into his PNP helped *Indigo* support Simeon as he engaged in daily decision-making that moved him toward psychological health.

Challenges

Given Simeon's positive response to psychotherapy with *Indigo*, it might feel easy to conclude that the future of psychotherapy is rosy. However, psychotherapy research and practice has always been fraught with conflict; there's no reason to expect smooth sailing ahead.

Science and Art

Divisions between the science of psychotherapy research and the art of clinical practice persist. This will not change. Fifty years from now, humans may have an even wider range of choices available to them when it comes to pursuing relief from distress or pursuing psychological growth. Some researchers and practitioners will insist that psychotherapy be an interpersonal experience; others will fight to integrate empirically-based principles into virtual scenarios; still others will hold a stronger allegiance to profit than science or principle. Consequently, the future will be shaped, in part, from battles for principles and funding. As different groups influence state, national, and global policies and beliefs, distribution of funds will undoubtedly shape the future of psychotherapy.

Credentialing

As access to medical and psychological assistance becomes increasingly virtual, traditional boundaries such as state and national credentials will give way to international credentialing. "Mid-level" providers will play a significant role, as will virtual providers such as Indigo. Corporations and other communal entities such as governments and insurance companies will invest in the layered provision of physical and mental health care.

Concluding Comments

Fifty years from now, assuming we've solved our urgent political and climate challenges, humans will continue to seek meaningful work, fulfilling relationships, and recreational opportunities. Humans will still experience trauma, pursue intellectual stimulation, and long for connection and meaning. There will be human-caused and natural disasters. Psychotherapists, both living and virtual, will offer integrated interventions, tailored closely to the person, place, needs, and resources. Greater awareness of the role of cultures, genders, and other intersecting identities, along with environments and biological factors, will inform these interventions and relationships. Surgical or medical interventions, although available, will not address longings for insight and self-improvement. These interventions will not answer the existential questions we associate with being fully human. These tasks, we hope, will continue to be in the domain of human psychotherapists at the helm of a vast array of virtual assistants.

One such psychotherapist will likely be Simeon, who after his work with *Indigo*, asked Grandma Nola for a referral for a human psychotherapist. He then followed in her footsteps, eventually being accepted into a prestigious graduate pro-

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gram in the field we currently refer to as Clinical Psychology. Then, at some point in the future, we suspect he will publish an article in *Psychotherapy Bulletin*.

References

- Adler, A. (1931). *What life should mean to you*. Oxford, England: Little, Brown.
- Ainsworth, M. D. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development*, 40(4), 969-1025.
<http://dx.doi.org/10.2307/1127008>
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191-215.
<http://dx.doi.org/10.1037/0033-295X.84.2.191>
- Bowlby, J. (1969). *Attachment*. New York, NY: Basic Books.
- Fairbairn, W. R. (1952). *Psychoanalytic studies of the personality*. Oxford, England: Routledge & Kegan Paul.
- Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. Oxford, England: Johns Hopkins University Press.
- Jones, M. C. (1924a). The elimination of children's fear. *Journal of Experimental Psychology*, 7(5), 382-390.
<http://dx.doi.org/10.1037/h0072283>
- Jones, M. C. (1924b). A laboratory study of fear: The case of Peter. *Pedagogical Seminary*, 31, 308-315.
<https://doi.org/10.1080/08856559.1924.9944851>
- Jordan, J. V. (2010). *Relational-cultural therapy*. Washington, DC: American Psychological Association.
- Jung, C. G. (1953). *Two essays on analytical psychology* (R. F. C. Hull, Trans.). New York, NY: Pantheon Books.
- Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, 55(4), 303-315. doi: 10.1037/pst0000193
- Rogers, C. R. (1969). *Freedom to learn: A view of what education might become*. Columbus, OH: Charles E. Merrill Publishing.
- Satel, S., & Lilienfeld, S. O. (2013). *Brainwashed: The seductive appeal of mindless neuroscience*. New York, NY: Basic Books.
- Sommers-Flanagan, J. (2015). Evidence-based relationship practice: Enhancing counselor competence. *Journal of Mental Health Counseling*, 37(2), 95-108. <https://doi.org/10.17744/mehc.37.2.g13472044600588r>
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2017). *Clinical interviewing* (6th ed.). Hoboken, NJ: Wiley.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2018). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (3rd ed.). Hoboken, NJ: Wiley.
- van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Viking Books.
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge/Taylor & Francis Group.
- Weisstein, N. (1968). *Kinder, kuche, kirche as scientific law: Psychology constructs the female*. Boston, MA: New England Free Press.
- Yalom, I. D. (1980). *Existential psychotherapy*. New York, NY: Basic Books.



Teaching and Learning Evidence-Based Relationships: A Division 29 Initiative to Apply Relationship Research to Clinical Training

Rayna D. Markin, PhD
Villanova University



Like many of you, at the heart of my professional identity lies a psychotherapy relationship researcher. While my specific interests have changed and evolved over time,

this aspect of my professional identity has always remained constant. This part of me has delivered professional talks about the relationship, has studied it under the lens of an empirical eye, and written about it from multiple theoretical vantage points. Yet, quite honestly, no part of me feels fully competent when it comes to *teaching students* how exactly to facilitate a “good” therapeutic relationship with patients.

While I can cite the latest research on alliance and outcome, it is a much more difficult task to actually teach beginning trainees how to facilitate a good alliance, particularly when they simply do not know how to begin. I was a collaborator on the forthcoming meta-analysis on the real relationship and therapy outcome (Gelso, Kivlighan, & Markin, 2018), but I can’t really tell you how to teach students to be “real” with a client, not exactly. As a group leader, I have experienced group cohesion or lack thereof first-hand. Yet, when it comes down to it, how exactly do we teach students to help others feel as if they belong? And, then, there is empathy. This construct haunts me as an educator because I feel at the very least I should be able to teach my students how to be em-

pathic. I view empathy as so fundamental to the therapy process that I feel as if I really should have a systematic, well-researched, and generalizable method for teaching trainees how to experience and communicate empathy to clients. Yet, while I can help students develop their conceptualization skills, and I can ask questions to inspire their curiosity into the client’s mental world, I’m not so sure that those are the same as actually teaching someone how to *do* empathy and how to *be* empathic.

While I am embellishing here somewhat to make a point, I believe many of us encounter a similar dilemma as educators and psychotherapy trainers. We understand very well the research on the relationship and treatment outcome and are adept at facilitating good relationships with our own patients; it follows that we want to train our students in the same vain. Yet, teaching the relationship is hard to do—so often we just don’t, in least not as much and as systematically as we might like.

Challenges in Teaching Relationship

Systemically integrating evidence-based relationship principles into our teaching and training of graduate students is often hard to do for several reasons. To start, we may be in academic environments that value evidence-based treatments at the exclusion of evidence-based relationship principles. As a result, faculty, especially those going up for tenure, may feel a tremendous amount of pressure to

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focus more on the treatment than the individual patient and/or therapist. Related to this, at least in part, may be the current cultural emphasis on the biological basis of behavior, concrete solutions, and quick answers, leading beginning trainees more often than not to want you as the instructor to tell them how to “fix” something, not how to relate to someone. Teaching the relationship in this context can feel like an exhausting uphill battle.

However, even without real or perceived pressure from colleagues and/or students to focus on the treatment over individual or relationship factors, there still remains a significant challenge to teaching our students how to be competent in facilitating effective elements of the therapeutic relationship. In my experience, that challenge has to do with the largely abstract, complex, experiential, and non-verbal nature of the relationship. How do you teach something explicitly when that “something” is largely implicit and intuitive? How do you explain a relational experience that is largely affective and lies outside verbal language? How do you test a student’s knowledge of a construct that oftentimes has no right or wrong answer? How do you teach someone the steps in facilitating a therapeutic relationship when the steps are somewhat different every time? Perhaps most challenging, how do we teach students to facilitate a good therapy relationship when there is something about their personality or interpersonal style that is impeding the relationship? How do we teach trainees, in a didactic classroom context, relational principles that are usually learned ... well, in a good relationship? In contrast, teaching students about concrete skills and well defined treatment packages starts to look pretty “good,” or at least more doable. In essence, teaching the relationship is a vulnerable place for students and instructors alike. It is an am-

biguous place in which to reside, a personal place, and, sometimes, a raw one, making the teaching and learning of relationship factors that much more complex and challenging.

I believe the Inter-Divisional Task Force on evidence-based relationships similarly grasped the need for more training recommendations and guidelines on the relationship when they concluded that: (a) Training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship; (b) training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success; and (c) accreditation and certification bodies for mental health training programs should develop criteria for assessing the adequacy of training in evidence-based therapy relationships.

Resources for Teaching Relationship More Effectively

Consistent with the training recommendations set forth by the Task Force and with my personal desire to more systematically integrate relationship factors into classroom instruction, I embarked on a project to translate evidence-based relationship principles to teaching and learning, along with my collaborator Dr. Michael J. Constantino, on behalf of Division 29. This project consists of a series of videos titled, *Teaching and Learning Evidence-Based Relationships: Interviews with the Experts*, and is a companion project to the third edition of *Psychotherapy Relationships that Work*, Edited by John Norcross and Michael Lambert. The videos can soon be found on the division’s web site (<http://societyforpsy->

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chotherapy.org/teaching-learning-evidence-based-relationships/), and will be posted in installments.

The overall goal of the project is to translate relationship research to teaching and learning, from the classroom context to clinical supervision. The videos consist of interviews with experts on different aspects of the therapeutic relationship and how to apply relationship research to clinical training. They are appropriate for supervisors, instructors, and students. In these interviews, I had the pleasure of speaking with various authors in the upcoming book, *Psychotherapy Relationships that Work*, edited by J. Norcross and M. Lambert. These authors briefly reviewed their meta-analytic findings, gave practical suggestions on how to apply their research findings on the relationship to the classroom context and clinical training, discussed resources for relationship teaching, and suggested readings, videos, and other teaching tools. Perhaps most helpful for me personally, these authors/interviewees talked about their own struggles in teaching the relationship to trainees and how they have dealt with these challenges. They also offer future suggestions and steps for us to take as relationship researchers, practitioners, and educators.

Some common recommendations for teaching evidence-based relationship principles that have emerged from the interviews thus far include:

- Use varied didactic and experiential teaching methods including readings, videos, and role play assignments.
- Encourage students to make mistakes and explore their fears of inadequacy, failure, and loss of control.
- Instructors should consider giving personal examples of successful and unsuccessful relationships with clients.
- Encourage peer and instructor feedback on role plays and taped sessions of student work.
- Have students complete instruments that measure various relationship factors based on “good” and “bad” sessions.
- Explore through readings and case examples how the different relationship factors are inter-related in the clinical context.

We hope that these videos will help educators, supervisors, and students continue to have this conversation, as together, we wrestle with how to best teach competencies in evidence-based relationships to the next generation of psychotherapists.

References

Gelso, C. J., Kivlighan, D. M., Jr., & Markin, R. D. (2018). The real relationship and its role in psychotherapy outcome: A meta-analysis. *Psychotherapy, 55*(4), 434-444. <http://dx.doi.org/10.1037/pst0000183>



Competence, Ethical Practice, and Going It Alone

Jeffrey E. Barnett, PsyD, ABPP

Kendall Corcoran, BS

Loyola University, Maryland



The practice of psychotherapy is typically, by its very nature, a solitary activity for the psychotherapist. Even for those psychotherapists who work in group practices, hospitals, clinics, and other similar settings, the individual nature of the practice of psychotherapy can be isolating.

The one-on-one nature of most psychotherapy and the demands placed on the psychotherapist due to confidentiality requirements add to the isolation one may experience. For psychotherapists in private practice, this can be even more pronounced. Yet, even when there are colleagues in one's practice setting, it is easy to become focused on direct client care, seeing clients hour after hour, and not taking the time to interact with colleagues. Brief breaks between treatment sessions and lunch breaks (if one takes them) may be used to keep up with documentation requirements, checking and responding to e-mails, listening to voicemail messages, and returning phone calls. Confidentiality requirements make it difficult to share clinical challenges, leading psychotherapists to keep all that transpires in their interactions with clients and the personal impact of these experiences to themselves.

Financial pressures, such as from decreasing reimbursement rates from managed care, can push psychotherapists to see more clients each day. Even

for those in fee for service practices, financial and other pressures may exist that can make taking time for oneself more challenging. It has become increasingly difficult for interactions with colleagues to occur on an ongoing basis, perhaps adding to psychotherapists' feelings of isolation. Professional isolation can be detrimental to one's professional competence and can contribute to the development of distress, burnout (Baker, 2003), and problems with professional competence (Elman & Forrest, 2007). As will be described in this article, professional isolation can contribute to difficulties with ethical decision-making and can lead to increased risks of unethical conduct occurring. Recommendations for preventing and addressing these challenges are provided.

Understanding Competence

Competence is defined by Haas and Malouf (2005) as possessing the necessary knowledge, skills, attitudes, and values to effectively provide needed professional services, and having the ability to implement them effectively. Competence is required of psychotherapists by their profession's ethics code and it is essential for the provision of effective treatment services to clients. Yet, competence is not static and is easily impacted by the presence of distress in the psychotherapist (Dunning, Johnson, Ehrlinger, & Kruger, 2003). It also is vulnerable to degradation over time due to changes in one's field and from lack of practice of certain skills; thus, ongoing efforts must be made to stay current with recent de-

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velopments in the field, to keep one's skills sharp, and to prevent professional and personal stressors from negatively impacting one's competence (Neimeyer, Taylor, Rozensky, & Cox, 2014). Because of the direct impact on the quality of care clients receive, these authors emphasize the ethical imperative of ensuring that one's ongoing competence is maintained. Yet, realizing when one's competence is at risk and knowing what corrective actions are needed can be a challenging task for even the most thoughtful psychotherapist.

Ethics codes require psychotherapists to self-monitor their competence and the effects of any ongoing threats to it. For example, Standard 2.06, Personal Problems and Conflicts, of the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2017) requires psychologists to monitor their personal functioning and to take corrective action "when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner" (p. 5). Yet, self-monitoring and self-awareness, while important, are generally insufficient for ensuring ongoing professional competence. Numerous studies demonstrate that health professionals are poor at accurately assessing their own competence (Davis et al., 2006). In fact, research shows that the more impaired one's functioning is, the more impaired one's ability to accurately assess it is, as well (Kruger & Dunning, 1999).

Professional Isolation

Professional isolation can contribute to difficulties with ethical decision-making and place the psychotherapist at greater risk of engaging in unethical behaviors (Cooper, 2009). Psychotherapists may be isolated by choice, such as when sur-

rounded by colleagues but choosing not to engage in any ongoing relationships with them. Alternatively, some psychotherapists practice in rural and other isolated areas where there may be few colleagues available. In these settings psychotherapists may need to pursue collegial relationships with members of other health professions in the local area, and they may need to establish long distance collegial and mentoring relationships with colleagues via the telephone or internet.

Colleagues can provide emotional support, serve as a sounding board, offer practical advice and suggestions, provide consultation when clinically challenging situations arise, and help manage the stresses of psychotherapy practice. The act of getting out of the office and interacting with colleagues can be important for promoting one's competence and wellbeing. Knapp and Vandecreek (2012) found that psychologists who are members of their state psychological associations have a reduced risk overall of disciplinary action by regulatory boards. Of course, just paying dues to maintain membership in one's professional association is not sufficient. Rather, active engagement with others, participating on listservs, attending continuing education and social events (getting out of the office and interacting with colleagues), and the like are important for reducing professional isolation and promoting ongoing competence. Active participation in one's professional association can lead to forming a network of colleagues with whom one can consult when faced with ethical dilemmas and clinically challenging situations, and who can serve as resources when making referrals for clients whose needs fall outside one's areas of competence (Allot & Lloyd, 2009).

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Self-Care, the Promotion of Wellness, and Competence

In addition to generally being isolating (a stressor in its own right) the practice of psychotherapy can be an emotionally taxing and demanding endeavor. We may work with clients suffering from chronic conditions who do not improve—and for those who do, some may experience relapses. Clients may be aggressive or violent and some may engage in self-harm, life-threatening behaviors, and even suicide, which Baerger (2001) describes as “emotionally devastating” for clinicians (p. 359). When treating clients who are victims of trauma, psychotherapists may experience vicarious or secondary trauma (Figley, 1995). Clients may be uncooperative with efforts to assist them, they may discontinue treatment prematurely, they may refuse to pay for services provided, and may file ethics and licensing board complaints or law suits. In addition, there are stresses and challenges associated with the business aspects of practice with which psychotherapists must contend. Finally, each psychotherapist has unique personal life challenges and stressors, such as those involving relationships, health (and mental health), and financial issues.

While the practice of psychotherapy can be tremendously rewarding and gratifying, each of the factors mentioned above, along with many others, can make it a challenging and stressful endeavor (O'Connor, 2001). In combination with other life events, this can lead to the experience of distress, the subjective emotional response to challenges that each psychotherapist will experience at various times. While distress does not imply decreased competence, as Baker (2003) describes, distress left unchecked can develop into burnout and, over time, result in reduced professional competence.

Eventually, failure to adequately manage and respond to these various stresses can result in psychotherapists experiencing emotional depletion, disrupted personal relationships, loneliness, anxiety, and depression (Johnson & Barnett, 2011). Continued practice under these circumstances can result in a decrease in competence and is not consistent with the ethical responsibility for mental health providers to take corrective action when “personal problems will prevent them from performing their work-related activities in a competent manner” (APA, 2017, p. 5).

Thus, it is vital that each psychotherapist engage in ongoing self-care and the promotion of wellness. While the specific self-care practices used are up to the individual psychotherapist, they can be especially effective when they include a social or relational component. Many of each individual's needs are relational, and the use of colleagues can be especially helpful in our efforts to promote ongoing wellness and effective functioning.

Communitarianism and Professional Competence

As Johnson et al. (2014) observe, “ethics standards and regulatory policies in psychology frame competence as an individual responsibility” (p. 212). Yet, as these authors propose, it is only through effective interaction with others that psychotherapists are able to practice ethically and competently. Additionally, while self-monitoring and self-awareness are regularly emphasized in ethics codes and professional practice standards to promote ethical practice, due to psychotherapists' flawed self-assessment overall (Dunning, Heath, & Suls, 2004), being solely responsible for one's self-assessment and for developing one's own response plan when difficul-

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ties arise is highly problematic and not likely to be effective.

Johnson, Barnett, Elman, Forrest, and Kaslow (2012) recommend replacing the current individualistic approach to professional practice with a communitarian, collectivistic, or interdependent one. As they state: "When communities of psychologists accept responsibility for supporting the functioning and professional competence of colleagues, problems of professional competence will be less frequent and less likely to harm consumers, the profession, and psychologists themselves" (pp. 557-558). In essence, psychotherapists must look out for each other and must actively utilize each other in their efforts to manage the various challenges and stresses in their lives, taking a proactive and preventive approach to defending against ongoing threats to their competence.

In addition to the above, the process of aging can bring with it decreases in functioning and effectiveness that can be difficult for individual psychotherapists to accurately assess. While some professions have a mandatory retirement age (Tarkan, 2011), licensed psychotherapists are authorized to practice their entire lives unless a complaint is filed. They have sole responsibility for monitoring and evaluating their own functioning, and for deciding when they "should" retire from practice (Guy, Stark, Poelstra, & Souder, 1987).

It is hoped that it is evident that this individualized approach to self-monitoring and independent decision-making is not optimal. Johnson, Barnett, Elman, Forrest, and Kaslow (2013) recommend creating competence constellations: networks of colleagues and others who interact and rely on each other on an ongoing basis. It is by being there for each other and by taking responsibility

for ourselves and for our colleagues in these caring networks that we have the best chance of addressing these needs through emotional and operational mentoring, feedback, and support.

It is recommended that all psychotherapists pursue the development of, and actively participate in, their own competence constellation. By actively engaging with colleagues in an open, honest, and transparent manner, psychotherapists may receive the support and assistance needed to more effectively manage the many challenges, stresses, and difficulties they face in their professional and personal lives. By being there for colleagues as an active part of their competence constellations, psychotherapists have the opportunity to assist and support these colleagues while benefitting from participation in meaningful reciprocal relationships.

An example of one aspect of a competence constellation is the peer support/consultation group. This involves a group of colleagues who meet regularly to discuss various issues and challenges in a supportive and accepting environment. Over time, each participant will have the opportunity to serve in both sharing and caring roles with these colleagues. While clinical consultations may occur, the group is not limited to this. Members may share about successes and sources of pride in their lives along with challenges, dilemmas, stresses, and frustrations. Participation in such a group will hopefully reflect a more communitarian and interdependent approach to being a mental health clinician, resulting in more effective responses to threats to one's competence.

Ethical Practice as an Interpersonal Activity

As has been highlighted, psychotherapists regularly face ethical dilemmas
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and challenging clinical situations. Knowing the best course of action to take is not always a simple proposition and is not always readily evident. Additionally, as has been pointed out, when one's competence is degraded, the ability to accurately assess one's competence, including one's ethical decision-making and judgment, may be degraded as well. Risk management experts recommend several key strategies to promote ethical practice and to help minimize risk. These include informed consent, documentation, and consultation (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013).

Consultation is described as an essential component of ethical practice. No psychotherapist can have all the answers at all times. Seeking input from colleagues can provide different perspectives on a challenging situation or dilemma, opening one's mind to options and alternative courses of action that had previously not been evident. From a risk management perspective, consultation with colleagues demonstrates an acknowledgement of the complexities of a client's treatment and a recognition of the need for input by others to best address the client's treatment needs. The use of consultation also demonstrates an understanding that one's competence is finite and that the assistance of experienced colleagues can augment one's limited competence. It also demonstrates appropriate humility in that we don't know what we don't know, as well as one's commitment to provide clients with the highest possible quality of care.

Consultation is also found as one of the essential steps in a wide range of ethical decision-making models (Barnett & Johnson, 2008, 2011; Cottone & Claus, 2000) that are suggested for use when psychotherapists are confronted by ethical dilemmas and challenging clinical

situations. The inclusion of consultation with experienced colleagues in such a wide range of decision-making models acknowledges the need to not attempt to work through such challenges on one's own and that effective ethical decision-making is not a solitary activity. Additionally, as has been highlighted, a communitarian approach to addressing the many stresses and challenges in one's professional and personal lives further reinforces the point that to practice ethically and competently, one needs active engagement with colleagues on an ongoing basis.

Moving Forward

Psychotherapists (and psychotherapists-in-training) must see themselves as part of a larger network and recognize that active participation in this network is essential for maintaining their fragile competence throughout their careers. Rather than focus on independent functioning and responsibility, there is a need to train psychotherapists to seek input and care from colleagues and to see their own roles in providing this to their colleagues. This focus on interdependence should help promote professional competence among psychotherapists at each stage of their lives and careers.

The mental health professions need to infuse a communitarian approach to ethical practice and competence into each student's training and integrate a focus on competence constellations as an essential obligation of all mental health professionals.

Educators and supervisors will need to engage in these practices themselves, modeling them for their students and trainees, helping to normalize this culture of reciprocal caring as an essential aspect of each psychotherapist's professional identity. The importance and role

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of competence constellations should be integrated into all aspects of graduate training, both in relevant academic coursework and in clinical supervision.

The APA Ethics Code (APA, 2017) and the ethics codes of the other mental health professions need to be modified to move away from their historic individualistic approaches. A focus on communitarianism and caring for each other should be infused throughout their standards. Examples include the following italicized additions to these standards, as suggested by Johnson and colleagues (2012):

Standard 2.03, Maintaining Competence: Psychologists undertake ongoing efforts to develop and maintain their competence. *Psychologists maintain regular engagement with colleagues, consultation groups, and professional organizations and routinely solicit feedback from these sources regarding their competence for work in specific roles and with specific populations.*

Standard 2.06, Personal Problems and Conflicts: (c) *When psychologists become aware that a psychologist colleague is experiencing problems that may lead to interference with professional competence, they offer care and support, and collaborate with that colleague in assessing competence and determining the need to limit, suspend, or terminate their work-related duties.*

It is hoped that such sentiments will be integrated into each psychotherapist's professional identity. Doing so should go a long way toward promoting ongoing competence despite the many challenges one may face throughout one's career. But, there is no need to wait for the APA and other professional organizations to revise their ethical standards. Each psychotherapist should take positive actions now to engage with colleagues in sup-

portive and caring communities to promote personal and collective wellness, competence, and ethical practice. It is essential that psychotherapists combat and overcome the urge to isolate themselves and attempt to manage the challenges of being a psychotherapist on their own. After all, the only way we can truly practice ethically and competently over time is with the input, support, and guidance of each other.

References

- Allot, K., & Lloyd, S. (2009). The provision of neuropsychological services in rural/regional settings: Professional and ethical issues. *Applied Neuropsychology*, 16(3), 193-206. doi: 10.1080/09084280903098760.
- American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- Baerger, D. R. (2001). Risk management with the suicidal patient: Lessons from case law. *Professional Psychology: Research and Practice*, 32(4), 359-366. <http://dx.doi.org/10.1037/0735-7028.32.4.359>
- Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/10482-000>
- Barnett, J. E., & Johnson, W. B. (2008). *Ethics desk reference for psychologists*. Washington, DC: American Psychological Association.
- Barnett, J. E., & Johnson, W. B. (2011). Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior*, 21(2), 147-164. <http://dx.doi.org>

continued on page 22

- [/10.1080/10508422.2011.551471](https://doi.org/10.1080/10508422.2011.551471)
- Cooper, R. J. (2009). Solo doctors and ethical isolation. *Journal of Medical Ethics, 35*(11), 692-695. doi: 10.1136/jme.2009.031765
- Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling & Development, 78*(3), 275-283. <http://dx.doi.org/10.1002/j.1556-6676.2000.tb01908.x>
- Davis, D. A., Mazmanian, P. E., Fordis, M., Van Harrison, R., Thorpe, K. E., & Perrier, L. (2006). Accuracy of physician self-assessment compared with observed measures of competence: A systematic review. *Journal of the American Medical Association, 296*(9), 1094-1102. doi: 10.1001/jama.296.9.1094
- Dunning, D., Heath, C., & Suls, J. M. (2004). Flawed self-assessment: Implications for health, education, and the workplace. *Psychological Science in the Public Interest, 5*(3), 69-106. doi: 10.1111/j.1529-1006.2004.00018.x
- Dunning, D., Johnson, K., Ehrlinger, J., & Kruger, J. (2003). Why people fail to recognize their own incompetence. *Current Directions in Psychological Science, 12*(3), 83-87. <http://dx.doi.org/10.1111/1467-8721.01235>
- Elman, N. S., & Forrest, L. (2007). From trainee impairment to professional competence problems: Seeking new terminology that facilitates effective action. *Professional Psychology: Research and Practice 38*(5), 501-509. <http://dx.doi.org/10.1037/0735-7028.38.5.501>
- Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner/Mazel.
- Guy, J. D., Stark, M. J., Poelstra, P., & Souder, J. K. (1987). Psychotherapist retirement and age-related impairment: Results of a national survey. *Psychotherapy: Theory, Research, Practice, Training, 24*(4), 816-820. doi: 10.1037/h0085784
- Haas, L. J., & Malouf, J. L. (2005). *Keeping up the good work: A practitioner's guide to mental health ethics* (4th ed.). Sarasota, FL: Professional Resource Press.
- Johnson, W. B., & Barnett, J. E. (2011). Preventing problems of professional competence in the face of life-threatening illness. *Professional Psychology: Research and Practice, 42*(4), 285-293. doi: 10.1037/a0024433
- Johnson, W. B., Barnett, J. E., Elman, N. S., Forrest, L., & Kaslow, N. J. (2012). The competent community: Toward a vital reformulation of professional ethics. *American Psychologist, 67*(7), 557-569. doi: 10.1037/a0027206
- Johnson, W. B., Barnett, J. E., Elman, N. S., Forrest, L., & Kaslow, N. J. (2013). The competence constellation model: A communitarian approach to support professional competence. *Professional Psychology: Research and Practice, 44*(5), 343-354. doi: 10.1037/a0033131
- Johnson, W. B., Barnett, J. E., Elman, N. S., Forrest, L., Schwartz-Mette, R., & Kaslow, N. J. (2014). Preparing trainees for lifelong competence: Creating a communitarian training culture. *Training and Education in Professional Psychology, 8*(4), 211-220. <http://dx.doi.org/10.1037/tep0000048>
- Knapp, S., & VandeCreek, L. (2012). Disciplinary actions by a state board of psychology: Do gender and association membership matter? An update. In G. J. Neimeyer & J. M. Taylor (Eds.), *Continuing professional development and lifelong learning: Issues, impacts and outcomes* (pp. 155-158). New York, NY: Nova Science Publishers.
- Knapp, S. J., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. N.

continued on page 23

- (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). Rockville, MD: The Trust.
- Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology*, 77(6), 1121-1134. doi:10.1037/0022-3514.77.6.1121
- Neimeyer, G. J., Taylor, J. M., Rozensky, R. H., & Cox, D. R. (2014). The diminishing durability of knowledge in professional psychology: A second look at specializations. *Professional Psychology: Research and Practice*, 45(2), 92-98. <http://dx.doi.org/10.1037/a0036176>
- O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice*, 32(4), 345-350. <http://dx.doi.org/10.1037/0735-7028.32.4.345>
- Tarkan, L. (2011, January 24). As doctors age, worries about their ability grow. *The New York Times*. Retrieved from <http://www.nytimes.com/2011/01/25/health/25doctors.html?page-wanted=all>



Therapist Dishonesty and Its Association With Levels of Clinical Experience

*Devlin Jackson, MA
Catherine Crumb, MA
Barry Farber, PhD*

Teachers College, Columbia University



Introduction

Despite many distinguishing characteristics of the therapeutic relationship, aspects of the dialogue between a therapist and a client can sometimes resemble everyday conversations. Namely, individuals in therapy may occasionally engage in the normative human behavior of lying. Blanchard and Farber (2016) found that 93% of clients report lying or otherwise being dishonest to their therapist in psychotherapy. Client

lying behavior largely stems from feelings of shame or embarrassment, making disguising or hiding the truth easier than confronting the truth straightaway. While this is a well-studied phenomenon in psychotherapeutic research, a comparatively under-researched topic is the occurrence of dishonesty on the part of the therapist.

Therapists must use their professional judgment in deciding what is relevant, appropriate, and helpful to disclose or not to disclose to a client in psychotherapy. Traditionally, therapists practicing classic psychoanalysis were instructed to remain objective and anonymous within the therapeutic relationship, pre-

cluding the therapist from self-disclosing (McWilliams, 2011). As the practice of psychotherapy has evolved, however, therapist self-disclosure became viewed as a possible tool with which the clinician might normalize a client's humanness (Audet, 2011; Farber, 2006). Acknowledging fallibility and modeling open expression may strengthen the therapeutic relationship and even encourage client disclosure when used in moderation (Hanson, 2005; Henretty, Currier, Berman, & Levitt, 2014; Ziv-Beiman, 2013). However, not all therapist self-disclosure is equally beneficial. Clients tend to respond more positively to disclosures that reveal information about in-session events rather than disclosures that are overly personal in nature (Audet, 2011).

In an effort to maintain professional boundaries and situate the focus on the client, therapists occasionally choose non-disclosure over self-disclosure. But while non-disclosure is typically clinically appropriate and benign, therapists may also at times engage in concealment, exaggeration, or explicit misrepresentation. Curtis and Hart (2015) were among the first to study patterns of therapist concealment and deception. They found that 96% of therapists reported intentionally keeping information from clients "in order to protect the client," while 81% reported directly lying to their clients. The topic of therapist lying

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similarly interests the research team at Columbia University, Teachers College, especially in regard to the frequency and content of therapist lies. The purpose of our current study is to characterize the nature of clinician dishonesty and the demographics of dissembling therapists.

Method

We recruited 271 (N=271) practicing therapists from 38 states and 12 countries to participate in research that investigated the extent to which therapists are occasionally dishonest in psychotherapy. Among this sample, 19.2% were male, 79.7% female, and 1.1% other; 61.7% had been practicing less than 10 years, 21.4% between 10 and 20 years, and 16.9% more than 20 years. When asked about primary therapeutic modality, 11.3% of respondents indicated Dynamic, 21.4% indicated Cognitive Behavioral Therapy/Dialectical Behavior Therapy (CBT/DBT), 1.5% indicated Humanistic, 57.9% indicated Integrative/Eclectic, and 7.9% indicated Other.

The Psychotherapists' Assessment of Truth, Candor, and Honesty (PATCH) Survey explores the frequency of "therapist lying" across 23 topics:

1. Being less than alert
2. Forgetting something a client said
3. Competence or expertise
4. Confidence in being able to help
5. Clinical progress
6. Clinical availability
7. Reasons for canceling/rescheduling
8. Reasons for being late/absent
9. Conversations with others
10. Discussing diagnosis
11. Explaining fees
12. Discussing training or credentials
13. Having outside knowledge
14. Own physical/mental health
15. Own physical or emotional state

16. Aspects of one's own personal life
17. Personal beliefs or values
18. Knowledge of someone or something
19. Liking/disliking clients
20. Feelings of frustration/disappointment
21. Romantic/sexual feelings for a client
22. Reasons for not taking on a client
23. Reason for termination

The frequency of lying for each topic is measured on a 7-point Likert scale with 1 = Never, 4 = Sometimes, and 7 = Frequently. Therapists' responses to the scaled lying items were averaged to determine the most common topics of lies.

In addition to our lab's overarching hypothesis that therapists occasionally are less than completely honest more frequently about certain topics, we also hypothesized that more experienced therapists dissemble with greater frequency. Since therapists theoretically become more comfortable navigating conversations in psychotherapy as they gain more experience, we predicted that a longer period of time practicing therapy would correlate to an increased ability to use tools of redirection and tactful concealment. To study this hypothesis, we performed a Latent Class Analysis (LCA) to identify class membership by lying topics. The distinct classes were then compared to the demographic variables "practice years," "student vs. non-student," and "age" to determine if experience effects the lying behavior of therapists.

Results

Overall, therapists are most frequently dishonest about their feelings of frustration or disappointment with a client, whether or not they like or dislike a client, their physical or emotional state, their personal beliefs and values, and

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whether they forgot something a client has said (See Table 1). Conversely, therapists are least frequently dishonest about their training or credentials, their fee structure, reasons for terminating a client, reasons for being late or absent, and a client's diagnosis (See Table 2).

Table 1: Most Frequent Lies Told by Therapists

Most Frequent Lies (Overall)	
1	Frustration/Disappointment Mean = 3.27 SD = 1.36
2	Liking/Disliking Mean = 3.15 SD = 1.67
3	Physical/Emotional State Mean = 3.13 SD = 1.56
4	Personal Beliefs/Values Mean = 2.8 SD = 1.61
5	Forgetting Mean = 2.8 SD = 1.38

Table 2: Least Frequent Lies Told by Therapists

Least Frequent Lies (Overall)	
1	Training/Credentials Mean = 1.3 SD = 0.81
2	Fee Structure Mean = 1.49 SD = 1.04
3	Terminating Mean = 1.71 SD = 1.05
4	Being Late/Absent Mean = 1.74 SD = 1.16
5	Diagnosis Mean = 1.89 SD = 1.20

Even among the topics that are most frequently lied about, different types of therapists dissemble with varying levels of frequency. The LCA distinguished two classes within our data: Class 1 being the therapists who dissemble less frequently and Class 2 being the therapists who dissemble with greater frequency comparatively (2 classes, $p = .0008$).

Independent t-tests, ANOVAS, and chi-square analyses were run against the demographic variables, revealing significant differences among the demographic characteristics of the classes. Class 1, the less frequently dishonest clinicians, consists of therapists who are currently in a graduate program, are younger than 30 years old, and have less than 5 years in practice. Class 2, the more frequently dishonest clinicians, are the therapists who are already licensed, are older than 30 years old, and have greater than 5 years in practice (see Table 3 top of next page).

The results of our analyses support the hypothesis that therapists with more experience engage in forms of dishonesty or dissembling with greater frequency than less experienced therapists. Although experience correlates with frequency of dissembling, instances of therapist dishonesty occur relatively infrequently overall. The means of each topic of lie are lower than 4 on our 7-point Likert scale.

Discussion

Compared to graduate students, experienced therapists generally have more freedom and autonomy to construct therapeutic conversations as they see fit. Having completed graduate-level clinical training, experienced therapists have fewer regulatory bodies monitoring their actions. Graduate students, conversely, practice under supervision, which likely regulates the level of student dishonesty. It is far more likely that students would get "caught" in a lie, if not by the client, than by a supervisor. Consequently, it follows that experienced therapists may engage in dishonesty more frequently because they are better able to bend the rules in service of the therapeutic relationship. Still, it bears keeping in mind that the occurrence

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Table 3: Breakdown of the Class Characteristics

Class 1: Less Frequently Dishonest	Class 2: More Frequently Dishonest
Student	Licensed
Younger than 30	Older than 30
< 5 years in practice	> 5 years in practice

($p < .05$ for all analyses)

rence of any of these deceptions is not especially common.

Although our results indicate that greater experience is correlated with greater rates of dishonesty, it is important to consider the context in which therapeutic untruths are told. The therapeutic relationship requires that the therapist fulfill the role of the primary listener and the client fulfill the role of the primary discloser. Even as the field shifts towards increased levels of therapist self-disclosure, the professional boundaries within the alliance must be maintained. To disclose every thought and feeling a therapist has would reverse the intended roles of therapy, thereby exploiting the position of the client (Audet, 2011). Experienced therapists may be expressly aware of this fact and deliberately choosing to use tactful dishonesty to preserve the roles of the alliance.

The American Psychological Association (APA; 2002) recognizes the necessity and utility of occasional dishonesty, in stating:

In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their

responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques. (p. 3)

Evidently, dishonesty is permissible when used to benefit the client if the consequences of taking such an action are carefully considered. Therapists must acknowledge the potential for resulting mistrust if dishonesty is recognized and left unresolved. Experience may afford therapists the ability to better judge when the benefits of being less than completely honest outweigh the consequences.

As noted above, although instances of dishonesty in psychotherapy are present, our results indicate that they are relatively infrequent and primarily involve the therapist's feelings towards the client. Both experienced and beginning therapists may recognize that revealing one's feelings of frustration towards a client or feelings of liking or disliking a client could do more harm than good. Therapists make clinical decisions in consideration of what would benefit the client. Engaging in occasional dishonesty is likely considered in this context as well. In line with this, Curtis and Hart (2015) found that therapists admit to in-

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tentionally deceiving clients; however, “mainly with the intent of protecting clients” (p. 290). Therefore, therapist dishonesty may in fact be a necessary tool for the sake of therapeutic tact and protection of the client.

Future Directions

Our findings offer initial insight into the virtually unexplored topic of therapist dishonesty. Therapist lying is clearly an existing and likely consequential phenomenon in psychotherapy that varies by therapists’ demographics. With this knowledge, clinical training in psychotherapy has the potential to expand to include techniques to work with therapeutic lying, including considerations of when lying is clinically justifiable, discussions of how therapists can manage their feelings when they have lied or concealed information, and how therapists might anticipate and deal with the potential clinical consequences of this behavior. To expand on our preliminary findings, our lab plans to conduct follow-up surveys to investigate motivations, justifications, and perceived consequences of therapist dishonesty.

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References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating

boundaries or removing barriers? *Counseling Psychology Quarterly, 24*(2), 85-100. <http://dx.doi.org/10.1080/09515070.2011.589602>

Blanchard, M., & Farber, B. A. (2016). Lying in psychotherapy: Why and what clients don’t tell their therapist about therapy and their relationship. *Counseling Psychology Quarterly, 29*(1), 90-112. <http://dx.doi.org/10.1080/09515070.2015.1085365>

Curtis, D. A., & Hart, C. L. (2015). Pinocchio’s nose in therapy: Therapists’ beliefs and attitudes toward client deception. *International Journal for the Advancement of Counseling, 37*(3), 279-292.

Farber, B. A. (2006). *Self-Disclosure in Psychotherapy*. New York, NY: Guilford Press.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counseling and Psychotherapy Research, 5*(2), 96-104. <https://doi.org/10.1080/17441690500226658>

Henretty, J. R., Currier, J. M., Berman, J. S., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology, 61*(2), 191-207. <http://dx.doi.org/10.1037/a0036189>

McWilliams, N. (2011). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process*. New York, NY: Guilford Press.

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration, 23*(1), 59-74. <http://dx.doi.org/10.1037/a0031783>



PSYCHOTHERAPY PRACTICE

Retirement Myths

Thomas Barrett, PhD
Clinical Professor Emeritus
Graduate School of Professional Psychology
University of Denver



By last count I had retired three times—once from the state of Colorado as the mental health director, once from the World Health Organization in Geneva, Switzerland, and finally from the Graduate School of Professional Psychology at the University of Denver. You might conclude that it was difficult for me to retire! Retirement is a significant life event. According to the Holmes-Rahe Stress Inventory, retirement is the 10th most stressful event you can experience. I am far from an expert on retirement. However, my experiences might provide some insight into some of the myths and misconceptions about retirement.

According to the U.S. Census Bureau; “the average retirement age in the United States comes to about age 63. ...The U.S. Census Bureau data shows that people experience an average retirement length of approximately 18 years” (Anspach, 2018). However, the change in social security benefits may be encouraging later retirements (Brandon, 2018). Also, there is some evidence that University professors retire at a much later age (Hicken, 2013).

The media is flooded with advice about the financial aspects of retirement but there are other considerations about when and how to retire. These considerations are particularly relevant for pro-

professionals who have been very busy in their pre-retirement years. This article will focus on the professional and personal aspects of retirement.

So, you took the trip of a lifetime you didn’t have the time for before retirement, now what?!

Retirement Myths

Myth number one: It is easy to retire from an active professional life to a less active lifestyle. It is not easy. Like any transition, it requires some forethought and hard work. My financial advisor says that it is better to retire to something rather than away from something. So, it is important to have some activities that you want to do more in retirement. For me, it was to spend more time with my family and to be able to pick and choose what I wanted to do professionally. Like many people, I was doing many things that I liked in my professional life, but I was also doing some administrative things that I did not like. Retirement can offer you the opportunity to say “yes, I want to continue to teach, but I do not want to do the administrative work.” However, this transition was not easy. It took more work than I had imagined to make this transition. For example, I had less control with organizations after I retired. Before retirement, I could usually teach the courses that I wanted to teach. After retirement, it was much more complicated. Understandably, active professors have priority over retired professors.

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Myth number two: Retired people do not want to work. I was not planning to go from a pretty active professional life to no professional activity. Some of my retired colleagues are happy with no professional activity but most want some professional life after retirement. For most of us, working has become an essential part of our persona. The work ethic is pretty difficult to abandon and there are many ways to continue that work ethic in retirement. For me, it was important to feel that I could still have an impact on making the world a better place. So, I have pursued some consulting positions where I could continue to make a difference but in a less time consuming way. I had the fantasy that I would be called upon as a wise elder statesman. In some situations, this has actually happened. In others, I had to work pretty hard to convince colleagues that my work still had relevance.

Myth number three: Retired people do not want to be paid. I believe in volunteer work and I increased my volunteer time in retirement. I am now chair of the Mental Health Colorado Board of Directors and that is a considerable volunteer commitment. However, I was not willing to volunteer all of my services after retirement. Retiring was a big change for me but I could not abandon everything I had been doing for 50 years. So, I wanted to continue to do consulting and teaching. Some suggested that I should volunteer my consulting and teaching services since retired people do not need to be paid! This is a pretty common misconception. I am not rich, but I did plan for retirement. However, that does not mean that I do not need money. Also, it was important that my work still had a financial value.

Myth number four: Retired people have unlimited free time. My wife tells me that I am just as busy in retirement as I was before I retired. Other retirees have told me

that they have experienced the same thing. They do not believe how they could have had time to work before they retired because they are so busy in retirement. However, this does not happen automatically. It takes some work to balance your personal life, hobbies, and the professional work that you want to continue. There were times in my retirement transition where I was working more than I had planned and more than I desired.

If you think about your time in the two broad categories of professional time and personal time, you can set a goal for your ideal mix of time. Personal time should include all those things that you wanted to do but never had the time to do. For example, reconnect with high school and college friends, take the trip of a lifetime, pursue the hobby that you never had time for, or volunteering for organizations outside your profession. It should also include things like spending more time with family and friends. Your professional time should include teaching, consulting, volunteering in professional groups, and private practice. Before retirement, I spent about 50% of my time in professional activities. My goal in retirement was to spend about 20% of my time in professional activities. My actual postretirement time is about 35% (partly because I did not want to turn down opportunities). So, I may need to adjust my ideal plan or my actual plan! (See Figure 1 top of next page)

Pre-retirement: Professional time 50%, Leisure time 50% (I am excluding maintenance time—sleeping, household tasks, hygiene, etc.).

Planned post-retirement time: Leisure time 80%, Professional time 20%.

Actual post-retirement time: Leisure time 65%, Professional time 35%.

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Suggestions for a Successful Retirement

1. Retiring is a significant life event and it requires not only financial planning but also professional and personal planning. Set a goal for your ideal mix of personal and professional time.
2. Don't let stereotypes of retirement determine your retirement plans. If you really want no professional activity, go for it. However, if you want some professional activities, you need to work on making that happen in retirement.
3. By all means, do those things that you always wanted to do but did not have time for. However, make sure that you have a long range plan also. As mentioned above, the U.S. Census Bureau reports that the average retirement

length is 18 years. Your plan should be at least that long!

References

Anspach, D. (2018, July 24). How to use Monte Carlo simulations to stress test your retirement plan. *The Balance*. Retrieved from <https://www.thebalance.com/stress-test-retirement-income-plan-2388487>

Brandon, E. (2018, July 12). 8 benefits of claiming social security later. *US News*. Retrieved from <https://money.usnews.com/money/retirement/social-security/articles/2017-06-12/8-benefits-of-claiming-social-security-later>

Hicken, M. (2013, June 17). Professors teach into their golden years. *CNN Money*. Retrieved from <https://money.cnn.com/2013/06/17/retirement/professors-retire/index.html>



PUBLIC INTEREST AND SOCIAL JUSTICE

Thrills, Chills, and Social Justice in Forensic Psychology

Neil Gowensmith, PhD

University of Denver, Graduate School of Professional Psychology
Forensic Institute for Research, Service, and Training



As I've reflected on the question of what made me choose forensic psychology as a profession, I realize that the answer may be a surprising one: heavy metal music and horror movies. The 1980s were a great time to be in high school and college. For an adolescent male with grief and loss (and subsequent latent anger) issues, heavy metal and horror movies provided a perfect outlet. This was the era of the slasher movie—*Halloween*, *Friday the 13th*, *Nightmare on Elm Street*. I watched every horror movie I could get my hands on, and I found myself increasingly curious about the character development of the killer. Why did he turn out that way? How did his mind work? Why *wouldn't* poor Jason Voorhees be angry at the camp counselors who let him drown? Michael Myers spent 15 years in a dank, horrifying insane asylum as a child, for goodness' sake. *The Silence of the Lambs*, released in 1991, was the best of the bunch in terms of exploring the "mind of the maniac."

Horror is to film as heavy metal is to music. Heavy metal is fueled by themes of mental illness and violent crime. These songs were formative in my earliest understanding of the criminal mind. Metallica's "Welcome Home (Sanitarium)" and Anthrax's "Madhouse" describe being unjustly placed in an asylum (a common theme shared across many metal songs). Slayer's "Criminally

Insane," "Dead Skin Mask," and "Killing Fields" all describe the mind and behavior of the psychopathic killer in gruesome detail, with many other metal artists creating entire catalogs out of these types of themes. And I was all in. Channeling the words of Quiet Riot's singer Kevin DuBose, pictured wide-eyed in a straitjacket on the album cover, I just *knew* that "metal health will drive you mad."

So here I was, my understanding of psychology informed and titillated by the stories I watched and heard in movies and music. It didn't take long for me to find forensic psychology in graduate school, focusing on a career in which I could see these movies and songs come to life. I created an external rotation at my internship in which I shadowed a forensic psychologist in private practice, which piqued my interest in forensic assessment and evaluation. Walking into jail the first time, ready to evaluate a defendant who was charged with a violent assault, was the culmination of years of training, study, schooling – and yes, movies and metal. My postdoctoral fellowship at St. Elizabeth's Hospital cemented my focus on forensic evaluation.

My first job as a psychologist was at New Jersey State Prison (NJSP), the state's featured maximum security institution. At that time, it held more than 2000 men, all sentenced to at least 30 years, with most serving life sentences.

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Nicknamed “The Wall” because of its imposing exterior multi-story walls, NJSP housed New Jersey’s death row, management control unit, several mental health units, and (to my excitement) many of the state’s most infamous inmates. My job as a staff psychologist was to provide acute mental health emergency care, conduct risk assessments for internal and external transfers, check the mental health status of inmates in Administrative Segregation, and oversee mental health care for certain units.

For the first six months, I was like a kid in a candy store. I pored over case files that read like Hollywood B-movie scripts—heinous criminal offenses, offenders with brutal histories. I interviewed the same offenders at their cell doors, trying to understand how and why they committed the crimes they had been accused of. Many of these offenders were diagnosed with various mental illnesses—the songs and movies of my adolescence were truly living and breathing before me. Between St. Elizabeth’s and NJSP, I was working in the world of the “criminally insane,” and like any good voyeur, I was fascinated by the stories around me. In fact, several movies and songs had been written about the very offenders I was working with.

But an interested thing happened about six months into my job. Within one particular week, I had a spate of jarring experiences that challenged my voyeuristic fascination. I was asked to complete a suicide assessment on a depressed offender serving a multi-year stint in Administrative Segregation who pointedly and genuinely asked about the point of spending the rest of his natural life in his cold, dark cell. Another inmate, diagnosed with paranoid schizophrenia, told me his story—he had killed his father while in the midst of a delusional psy-

chosis (essentially to stop his father from “taking over the world,” since he believed his father had been plotting to eradicate the world’s population one nation at a time); despite having no previous criminal record, he was sentenced to life in prison by a jury skeptical of the insanity defense. Another inmate was given an institutional charge of “destroying state property” for smearing feces inside his cell while psychotic.

The most significant event, however, occurred on a Friday afternoon. Things were winding down for the work week. Most professional staff didn’t work weekends, so most of the mental health and medical operations were moving toward “maintenance mode” until we returned the following Monday. However, we received a call from an officer in a general population unit. He asked us to come to the unit immediately. Upon our arrival, the officer told us about a potentially lethal situation. The unit was composed of more than 40 cells, each with two inmates per cell. One of the cells housed an unlikely pair: a prototypical, tattooed, muscle-bound man with a history of high-level biker gang membership, and a lithe, emaciated man with schizophrenia. Both were serving life sentences. We arrived at the unit during rec time. While the first inmate was pumping iron outside in the yard, his schizophrenic cellmate experienced an acute psychotic episode. He began defacing his cellmate’s television in a bizarre cleansing ritual, carving symbols into the tv and covering it with milk. The correctional officer stated gravely, “Yard ends in 10 minutes. When that guy comes back and sees his tv destroyed, he’s gonna want to kill that guy.” We managed to move the man with schizophrenia to the mental health unit just before the close of the day—potentially saving his life.

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These events were not uncommon in the prison, nor were they endemic to NJSP. Similar events and experiences occurred throughout my two years at the prison—and no doubt were occurring at other correctional facilities around the country. Like many institutions before and after, NJSP was in the midst of a class-action lawsuit in which inmates had successfully sued on the grounds of inadequate mental health care. In fact, that was the primary reason I had the job in the first place. The lawsuit created a slew of mental health positions at the prison. I had eagerly taken the position, unaware of the context that had led to the creation of the job in the first place. But I soon learned that the job, like those of my hard-working counterparts, was only a salve for a gaping wound. I was totally unprepared for the overwhelming need for mental health care at the prison—the sheer scale of chronic mental illness as well as acute mental health emergencies was unlike anything I had been trained for.

That was, in a phrase, my turning point. I unwittingly transformed from a thrill-seeking forensic psychologist into a justice-seeking one. I could no longer work in the metaphorical dark, simply reading case files or talking with inmates for my own selfish excitement. I became aware of the troubling yet pervasive reality in which people with mental illness had filled the prison largely by default. Of course, most inmates had committed terrible crimes and were justifiably being held accountable for their actions. This should never change. However, I began to understand that much of the misery I witnessed as a correctional psychologist was significantly exacerbated by the failings of our country's misguided approach to mental illness. My entire career since that week has therefore been rooted in the pursuit of social justice for people with mental illness—

through applied research, teaching, consultation, legislative action, policy advocacy, and clinical work.

I should say that this was not a problem exclusive to NJSP. The state's entire correctional system was captured under the lawsuit and its subsequent ramifications. Nor was the state of New Jersey alone in this challenge. Nearly every state has faced these barriers. In my opinion, it's become the number one mental health issue in our country and can be summed up succinctly: We have abdicated care for people with mental illness from people with licenses to people with badges.

Now for a few statistics that help tell the real story about mental health care in America. Persons with mental illness are more than three times as likely to be arrested than people without mental illness for the same behavior (Qureshi, Liefman, Coffey, & Carney, 2015; Teplin, 1984). Nearly 60% of all persons with a serious and persistent mental illness will come into unwanted contact with law enforcement at least once in their lifetimes, and 40% have spent at least one day in jail (Steinwachs, Kasper, & Skinner, 1992). Especially tragic is the reality that people with serious and persistent mental illnesses are 4-10 times more likely to be victims of violence and crime than perpetrators—a harsh reality for group of people with a life expectancy in the sixties (Gundaya, Crisanti, Steffen, & Gowensmith, 2009; Treatment Advocacy Center, 2016; Walker, McGee, &, Druss, 2015).

However, the sad story only worsens after arrest. Jails and prisons have become our nation's largest inpatient mental health facilities. County jails far outpace state hospitals in terms of numbers of persons with mental illness

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served and housed. Los Angeles County Jail treats approximately 3000 men with mental illness each day, with other large urban jails rivaling that total. Most of these men—now labeled as criminal defendants—are facing misdemeanor charges after being arrested for low-level, quality of life transgressions that come as a byproduct of living on the streets with a major mental illness. Criminal courts order them to state hospitals for mental health treatment, but wait times are enormous. Persons with mental illness wait in jails for weeks to months for transfer, because state hospitals operate at a meager eight percent of previous capacities (Beachum, 2016). Persons ordered by the criminal court in Colorado, for example, now wait more than 100 days on average for admission, as compared to 25 days in 2017 (Sherry, 2018). As state hospitals become increasingly filled with court-ordered forensic patients, space for voluntary and civil admissions evaporate. Individuals with serious and persistent mental illness thus have fewer and fewer options when experiencing acute symptoms. Behavior then becomes increasingly erratic and disruptive, the police are called—and the cycle continues.

Statistics tell part of the story. Human stories tell the rest. In January 2017, a defendant waiting 12 days for his transfer to competency restoration services died in the San Luis Obispo County Jail from complications due to his mental illness (McGuinness, 2017). A few years earlier, a northern California man previously adjudicated as IST (Incompetent to Stand Trial) hanged himself in jail awaiting transfer to Napa State Hospital (Shafer, 2015). In Washington state, one woman with deteriorating mental health was eventually deemed “gravely disabled” after waiting in jail for more than five months for competency-related services to materialize; she was trans-

ferred to a civil hospital as an emergency measure (*Trueblood v. State of Washington Department of Human and Social Services (DSHS)*, 2015). Across the country in the Philadelphia county jail, a homeless man awaiting inpatient competency restoration services for more than seven months was beaten to death in his cell by another inmate – while in a separate nearby facility, a different homeless man accused of stealing candy from a Dollar Store remained in jail awaiting competency-related services for nearly one year (Moraff, 2015). Finally, Mr. Jaymichael Mitchell died in his cell, covered with feces and urine, after spending more than three months in a Virginia county jail while psychotic. Mr. Mitchell was facing misdemeanor charges after allegedly stealing a bottle of Mountain Dew, a Snickers bar, and a Zebra Cake from a convenience store (Swaine, 2018).

These stories are incomprehensibly tragic, and they should hold us accountable. In the most powerful and wealthiest nation in history, we have relinquished the care of our most vulnerable citizens to retributive correctional systems built on deterrence and punishment. We would never allow these sorts of realities to beset people with heart disease or diabetes, yet as a society we turn a blind eye while it’s happening to people with treatable mental illness.

The stories above are the same stories that got me into the field of forensic psychology. It’s the stuff that horror movies and heavy metal are made of. It fueled my early fascination with this field. But after witnessing these events, one after another after another after another, I experienced a turning point that switched me from voyeur to advocate. People with serious and persistent mental illness are often marginalized and misunderstood, and they deserve better than

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jail cells from the professionals and systems working to serve them.

I hope this has been informative. Please feel free to contact me at neil.gowensmith@du.edu.

References

Beachum, L. (2016, July 1). Nation's psychiatric bed count falls to record low. *The Washington Post*. Retrieved from https://www.washingtonpost.com/news/to-your-health/wp/2016/07/01/nations-psychiatric-bed-count-falls-to-record-low/?noredirect=on&utm_term=.c626eae899e5 on October 28, 2018.

Gundaya, D. M., Crisanti, A., Steffen, J., & Gowensmith, W. N. (2009, October). *Forensic involvement and victimization among Adult Mental Health Division consumers*. Poster presentation at the Hawaii Psychological Association conference, Honolulu, HI.

McGuinness, C. (2017, May 31). No place to go: Inmates declared mentally unfit to stand trial languish in jails. *New Times SLO*. Retrieved from <https://www.newtimeslo.com/san-luis-obispo/no-place-to-go-inmates-declared-mentally-unfit-to-stand-trial-languish-in-jails/Content?oid=2978784>

Moraff, C. (2015, November 2). Pennsylvania's mentally ill spend years in jail without trial or treatment. *Daily Beast*. Retrieved from <https://www.thedailybeast.com/pennsylvanias-mentally-ill-spend-years-in-jail-without-trial-or-treatment>

Qureshi, S., Leifman, S., Coffey, T., & Carney, R. M. (2015, June). *Outcomes of the Miami-Dade County Forensic Alternative Center: A diversion program for mentally ill offenders*. Poster presentation at the University of Miami's Miller School of Medicine Annual Research Day, Miami, FL.

Shafer, S. (2015). Long, dangerous wait

for hospital beds for those incompetent to stand trial. *KQED News*. Retrieved from: <https://ww2.kqed.org/stateofhealth/2015/10/20/long-dangerous-wait-for-hospital-beds-for-those-incompetent-to-stand-trial/>

Sherry, A. (2018, July 23). *Colorado faces growing legal jeopardy over dealing with mentally ill inmates*. Colorado Public Radio. Retrieved from <http://www.cpr.org/news/story/colorado-faces-growing-legal-jeopa> on July 24, 2018.

Steinwachs, D., Kasper, J., & Skinner, E. (1992). Patterns of use and costs among severely mentally ill people. *Health Affairs*, 11(3), 178-185. doi: [org/10.1377/hlthaff.11.3.178](https://doi.org/10.1377/hlthaff.11.3.178)

Swaine, J. (2015, August 25). Young black man jailed since April for alleged \$5 theft found dead in cell. *The Guardian*. Retrieved from https://www.theguardian.com/us-news/2015/aug/28/jamychealmitchell-virginia-jail-found-dead?CMP=share_btn_tw

Teplin, L. A. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist*, 39(7), 794-803. <http://dx.doi.org/10.1037/0003-066X.39.7.794>

Treatment Advocacy Center. (2016). *Victimization and serious mental illness*. Publication retrieved at <http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3630-victimization-and-serious-mental-illness> on October 28, 2018.

Trueblood v. State of Washington Department of Human and Social Services, 101 F. Supp. 3d 1010 (W.D. Wash. 2015).

Walker, E. R., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *JAMA Psychiatry*, 72(4), 334-41. doi: [10.1001/jamapsychiatry.2014.2502](https://doi.org/10.1001/jamapsychiatry.2014.2502)



SPECIAL FEATURE

Personality Disorder, Interpersonal Challenges, and a Missed Clinical Turning Point: A Case Example

Lauren M. Lipner, MA
Adelphi University

Benjamin N. Johnson, MS
The Pennsylvania State University



The interpersonal difficulties experienced by patients diagnosed with a personality disorder (PD) tend to pose great difficulty in negotiating a strong therapeutic alliance between patient and therapist (Muran, Segal, Samstag, & Crawford, 1994; Stern, 1938; Vaillant, 1992; Waldinger & Gunderson, 1984). Patients with PDs often generate intense and uncomfortable reactions in their therapists, sometimes producing iatrogenic therapist behaviors, sometimes referred to as countertransference (Bateman, 1998; Bateman & Fonagy, 2006; Levy, 2013). Forming a strong therapeutic alliance with clients with a PD diagnosis is challenging. For instance, therapists of patients diagnosed with Cluster B (i.e., “dramatic, emotional, erratic”) PDs often rate the alliance negatively, while patients with diagnoses of Cluster A (“odd-eccentric”) PDs may have difficulty establishing a working alliance at all (Lingiardi, Filipucci, & Baiocco, 2005). Furthermore, patients with Cluster B PD traits (e.g., impulsivity, dysregulation, and affective lability) have been found to experience more ruptures in the therapeutic alliance than non-PD patients, even after the relationship has been established (Tufek-

cioglu, Muran, Safran, & Winston, 2013), while patients diagnosed with Cluster C (“anxious-fearful”) PDs may not display *more* ruptures than other patients, but may take significantly longer to experience a repair of these ruptures, specifically in less interpersonally based treatments (e.g., CBT versus brief relational therapy; Lipner, Muran, Zilchamano, Eubanks, & Safran, 2017). Given the interpersonal complexities associated with each cluster of PDs, some have suggested unique modifications to maintain an alliance with different presenting concerns. For instance, when working with patients with Cluster B traits, therapists may do well to be mindful of crossing interpersonal boundaries to avoid colluding with the poor boundary setting common among these patients (Bender, 2005; Levy in Magnavita, Levy, Critchfield, & Lebow, 2010). Directly addressing ruptures in the alliance when they occur has also been shown to improve outcome in psychotherapy for patients with PD diagnoses in Clusters B and C (Muran, Safran, Samstag, & Winston, 2005).

Given that working with patients with PDs presents a unique relational challenge, and that therapists may experience confusion, discomfort, or negative countertransference when treating these patients, we aim to provide an empiri-

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cally contextualized clinical case example from a group psychotherapy with a PD patient (conducted by the first author). We focus specifically on areas of difficulty in fostering an alliance, the ability to repair alliance ruptures, the importance of developing empathy, and a willingness to tolerate difficult emotions in therapy. We point out specific therapeutic maneuvers, deriving from an alliance-focused treatment approach, that may help clinicians when working with patients with personality difficulties.

Patient Narrative: Vincent

Note: Client information has been de-identified to protect patient confidentiality.

Vincent is a 63-year-old, White, heterosexual male who was a member of an interpersonal process group co-lead by the first author. He had been a member of this group for three years when I joined the group, alongside a female co-leader. The group consisted of Vincent and three other female group members. He was initially referred to the group by his individual psychotherapist, with the goal of building upon his limited interpersonal skills and his ability to develop relationships, particularly with women.

Vincent's presentation is complex and regularly evokes feelings in me of being overwhelmed and confused. Vincent was initially described to me as being "terrified of women." This came to life early on, as I learned that, due to past experiences, Vincent develops strong, eroticized, reactions (or "transference") to female group leaders and therapists, particularly when they are young and blonde—two criteria I met. In addition, Vincent presents at times as feeling hopeless and suicidal (e.g., "What's the point to all of this?"). Alongside his depressed presentation, he exhibited significant Cluster B personality pathology in terms of suicidality, fear of abandon-

ment, provocative statements to therapists, dissociative experiences, and so forth, as well as some dependent and avoidant features.

One likely contributor to the diametrically opposed feelings Vincent experiences towards women, fear and desire, is likely the extreme traumas he reported from his childhood. During the course of group, Vincent revealed that he had been sexually abused as a child by several women. Though these experiences may not be the sole explanation of Vincent's psychopathology, it is understandable given his early traumatic experiences, which influenced the complexity of his feelings towards women. He has learned to fear them tremendously, and that he must be submissive to them, particularly towards women in roles of power (e.g., his therapists). At the same time, he longs to be able to "touch a cheek," "be held," or receive any physical contact he can from women. He has expressed in group a wish to "be submissive" to my co-leader and me, to "get on [his] knees, kiss [our] feet, and just worship [us]." This eventually led to his explicitly describing how attracted he was to me, while reassuring me that he would never do anything to threaten our professional relationship. Even more complex is his anger towards women for "doing what *they* did to me," which manifests in secret violent fantasies that he did not share in the group, only in individual therapy. His admissions of attraction and desire to be submissive to me made me feel uneasy, and unsure of what to do or say. At the same time, I found myself able to empathize with his current difficulties given an awareness of his difficult childhood, which was an important factor in my ability to work effectively with Vincent in the face of feeling at times overwhelmed by his way of relating.

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The impact of empathy—a moment of understanding. Vincent's complex transference towards me did not develop immediately. In fact, during the first months of my joining the group as a co-leader, he would make statements frequently such as, "I look at [other co-leader] as completely, 100% dominant," and then turn to me and say, "and I don't know you yet, Lauren, but I'm sure you'll get there." During a group session approximately four months into my joining, Vincent was having difficulty explaining the paradoxical reaction he had to a phone call he had made to me, stating that he would not be able to come to group that week. My response over the phone was simply, "All right, no problem—see you next week." To my surprise, he expressed in the following group feeling extremely disappointed by my reaction, stating that, in his experience, care for him was expressed through anger. The other group members were puzzled by the explanation of his reaction to my relatively mundane response, particularly why he wanted me to be angry with him, even though that would simultaneously upset him. I took this opportunity to jump in, and rephrase what I understood Vincent's feelings to be to the group: "I think what Vincent is saying is that by not reacting in an angry or frustrated way that he would not be able to attend group, it seemed as if I did not care whether he came to group or not. But, if I had gotten angry and berated him for not coming, he would know that his presence in group mattered to me, even though he would feel badly that he had angered me." Although Vincent initially did not respond to my comment, at the next group he stated: "There are very few people that I believe really, truly understand me. My therapist is one of them, but from what you said last week, I see that you also have her ability to peel my layers like an onion. I am so appreciative of that, but it's petrifying." It was at this point that Vincent had begun to see me as another

dominant figure in the room, laden with feelings of fear and attraction.

My ability to find aspects of Vincent's experiences with which I could empathize, in spite of my own challenging reactions to him, was crucial in allowing an admittedly complex alliance to begin to form between the two of us. While my initial comment on the phone (i.e., "no problem"), meant to assure him that missing group was okay, was experienced as upsetting and invalidating for Vincent, in my rephrasing of his conflictual feelings, I demonstrated that I understood him and his experience from his point of view. This led to his both recognizing me as a dominant force in the room, but also seeing me as a trusted protector. Though his transference appeared to be activated by this comment, becoming both fearful and enamored of me, this moment served to open up the space for work with his transference, which had not previously been a possibility. The use of interventions that capture the totality of a patient's experience, rather than simply trying to assuage or reassure the patient, are an essential ingredient in both maintaining therapeutic alliance and opening the door to further exploration of the patient's challenging and distressing experiences (e.g., Clarkin, Yeomans, & Kernberg, 2006).

Addressing the therapist's difficult reactions. Although I am able to empathize with him, there is no doubt that Vincent's expressions of his feelings towards me make me uncomfortable. How is one to respond to statements such as, "I would love to just kiss your feet"; "I'd give anything to touch your cheek"; "I would love to serve you, to get on my hands and knees and worship you"? Interestingly, Vincent experienced intense remorse after making such statements, and expressed fear of having destroyed the relationship as a result of behaving

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inappropriately. Vincent was right that these statements *did* make it challenging for me to work with him and potentially threatened our working alliance. This dynamic is characteristic of that experienced by many therapists of patients diagnosed with PDs, which may lead to negative reactions or behaviors on the part of the therapist, such as not rescheduling patients who miss appointments (Bateman, 1998; Levy, 2013). Clearly an awareness of these dynamics is vital in order to address them, and requires therapists to be attuned to their own emotional responses to their patients. In these moments, I had to make a decision: Do I forbid Vincent from sharing these thoughts, feelings, and fantasies with me and pretend as if they do not exist in order to decrease my own uneasiness? Or do I withstand my own discomfort and allow for him to bring up these complex emotions so that we can explore them in the therapy? I consistently aimed for the latter, which, while it was incredibly difficult—as it left me vulnerable in front of the group—in fact allowed for some of Vincent’s feelings to lessen in intensity as he was able to put words to the conflict he experienced regarding both desiring and fearing closeness with me.

One group session, I arrived dressed in a black sweater dress, black tights, and tall black boots. The group began as usual, each member providing us with a quick update. As Vincent took his turn to speak, his storytelling grew increasingly convoluted and difficult to follow. When another member asked him for clarification, Vincent suddenly stopped, looked at me, and said “I have a real problem with tall, black boots.” I was suddenly hit by the realization that my outfit resembled to him that of a dominatrix, and perhaps those he had interacted with in clubs many times in the past. Immediately, I clapped my hand

to my mouth, feeling exposed and ashamed. I felt guilty for having been so thoughtless as to wear something so clearly triggering for Vincent. Before thinking further, I blurted out, “I’m so sorry, Vincent. I will keep this in mind going forward, and would never intentionally do or wear something to make you uncomfortable,” a feeble attempt to erase the moments that had just occurred. I spent the rest of the hour tucking my feet under my chair as far back as they would go.

In retrospect, this moment provided a missed opportunity to explore Vincent’s dynamics. In my impulse to allay my own shame and discomfort, I quickly apologized and promised not to repeat the mistake. However, had I been prepared to withstand the uncomfortable feelings evoked in me, I could have asked him what my boots meant to him, or to take an even larger risk, I could have noted that I would likely wear them again and ask what his reaction to this might be, or even gently inquiring of him his sense of how his comments might make me feel. Rather than further increasing my sense of shame and guilt as my apologizing had done, any of these scenarios could have prompted Vincent to acknowledge my own subjective experience, to come to a clearer understanding of his own experience, and increase his awareness of his role as a member of a therapeutic dyad. Though this would have been difficult for Vincent, I imagine it would also have been consoling to learn that our relationship would not fall apart, nor would he be punished, for expressing genuine thoughts about me, even if they were uncomfortable for the two of us.

Five Specific Recommendations

In summarizing the case above, we reit-

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erate several treatment principles that have also been proposed in the literature for working with patients with PD diagnoses, specifically regarding building and maintaining an alliance, generating empathy, and addressing the therapist's own difficult feelings in this work:

- Early diagnostic assessment for PDs can aid the therapist in being prepared for difficult interpersonal dynamics in therapy.
- It is important to understand the developmental history of PD patients in order to empathize with challenging behaviors, anger, attraction, etc., that they may display in therapy.
- The most empathic comments for a patient are often those that capture the conflicts or dilemmas that they experience, rather than simply aiming to reassure an explicit (often surface-level) concern that they share.
- Therapists working with challenging patients must pay attention to their own emotional responses to their patients, as these can negatively influence the work of therapy and can also be important tools for exploring the patient's own inner world and effect on others.
- Dynamics between therapist and patient that risk destroying the therapeutic alliance or effective psychotherapy must be addressed appropriately and gently, rather than ignored or reflexively acted upon.

References

- Bateman, A. W. (1998). Thick- and thin-skinned organisations and enactment in borderline and narcissistic disorders. *The International Journal of Psychoanalysis*, 79(1), 13-25.
- Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment for borderline personality disorder: A practical guide*. England: Oxford University Press.
- Bender, D. S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice*, 11(2), 73-87.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: Focusing on object relations* (1st ed.). Arlington, VA: American Psychiatric Publishing.
- Levy, K. N. (2013). Treating borderline personality disorder. In G. P. Koocher, J. C. Norcross, & B. A. Greene (Eds.), *Psychologists' desk reference* (pp. 193-196). New York, NY: Oxford University Press.
- Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy. *Psychotherapy Research*, 15(1-2), 45-53. <https://doi.org/10.1080/10503300512331327047>
- Lipner, L. M., Muran, J. C., Zilcha-Mano, S., Eubanks, C., & Safran, J. D. (2017, June). *The unique contributions of personality pathology to the therapeutic alliance: Therapist and patient perspectives*. Paper presented at the 2017 meeting of the Society for Psychotherapy Research, Toronto, Canada.
- Magnavita, J. J., Levy, K. N., Critchfield, K. L., & Lebow, J. L. (2010). Ethical considerations in treatment of personality dysfunction: Using evidence, principles, and clinical judgment. *Professional Psychology: Research and Practice*, 41(1), 64-74. <https://doi.org/10.1037/a0017733>
- Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, 42(4), 532-545. <http://dx.doi.org/10.1037/0033-3204.42.4.532>
- Muran, J.C., Segal, Z.V., Samstag, L.W., & Crawford, C.E. (1994). Patient pre-

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- treatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology*, 62(1), 185-190. <http://dx.doi.org/10.1037/0022-006X.62.1.185>
- Stern, A. (1938). Borderline group of neuroses. *The Psychoanalytic Quarterly*, 7, 467-489.
- Tufekcioglu, S., Muran, J. C., Safran, J. D., & Winston, A. (2013). Personality disorder and early therapeutic alliance in two time-limited therapies. *Psychotherapy Research*, 23(6), 646-657. <https://doi.org/10.1080/10503307.2013.843803>
- Vaillant, G. E. (1992). The beginning of wisdom is never calling a patient a borderline; or, the clinical management of immature defenses in the treatment of individuals with personality disorders. *The Journal of Psychotherapy Practice and Research*, 1(2), 117-134.
- Waldinger, R. J., & Gunderson, J. G. (1984). Completed psychotherapies with borderline patients. *American Journal of Psychotherapy*, 38(2), 190-202.



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Rupture-Resolution Processes in Early Treatment for Borderline Personality Disorder

Tali Boritz, PhD

Centre for Addiction and Mental Health

University of Toronto



The quality of the therapeutic alliance is a robust predictor of psychotherapy outcomes (Horvath, Del Re, Flückinger, & Symonds, 2011). Recent studies have shown that some therapists are consistently better at developing and maintaining alliances with their patients than others (Baldwin, Wampold, & Imel, 2007; Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010), suggesting that alliance quality may be systematically related to certain therapist characteristics or behaviours. In this vein, recent research on the alliance has sought to more precisely clarify key therapist factors that contribute to alliance development, including how therapists identify and resolve alliance ruptures, i.e., tensions, strains, or breakdowns in the patient-therapist collaborative relationship (Safran & Muran, 2006). Unresolved alliance ruptures have been shown to relate to poorer outcomes and increased dropout rates, whereas the resolution of ruptures relates to better outcomes (Safran, Muran, & Eubanks-Carter, 2011).

Research on alliance rupture and resolution has important implications for the study of the alliance in psychotherapy for borderline personality disorder (BPD). BPD is a complex mental health disorder characterized by pervasive pat-

terns of emotional instability, disturbed interpersonal relationships, identity disruption, and behavioral dyscontrol. The interpersonal difficulties associated BPD often manifest with treatment providers, leading to an increased likelihood of alliance ruptures (McMain, Boritz, & Leybman, 2015 Shearin & Linehan, 1992; Waldinger & Gunderson, 1984). Dialectical Behavior Therapy (DBT), one of the evidence-based treatments for BPD, was developed, in part, to address the challenges of engaging and retaining BPD patients in treatment. Nevertheless, dropout from DBT and other specialized BPD treatments remain high, ranging from 25% to 30% (Barnicot et al., 2012).

Consistent with the broader alliance literature, these studies have linked patient and therapist-rated alliance with treatment retention and outcome (Hirsh, Quilty, Bagby, & McMain, 2012; Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007; Turner, 2000). In DBT specifically, the therapeutic alliance in sessions one through four has been shown to predict treatment outcomes, including dropout (McMain, Burckell, Links, & Guimond, 2009). However, there is limited research on more fine-grained observational assessments of therapist characteristics and in-session behaviors that contribute to the formation of a good alliance in BPD, including strategies for identifying and resolving alliance ruptures that may

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correlate positively or negatively with treatment outcomes for BPD patients.

In a recent study by Boritz, Barnhart, Eubanks, & McMMain (2018), we conducted an exploratory analysis of alliance rupture and resolution processes in the early sessions of a small sample of clients (N=6) who underwent one year of standard DBT for BPD. Alliance rupture and resolution processes were coded using the observer-based Rupture Resolution Rating Scale (3RS; Eubanks, Muran, & Safran, 2015), which differentiates whether a client responds to tension, misunderstanding, or conflict in the therapy relationship by withdrawing from or confronting the therapist. Findings showed that unrecovered clients evidenced a higher frequency of withdrawal ruptures than recovered clients. Additionally, withdrawal ruptures tended to persist for unrecovered clients despite the degree of resolution in the prior session, unlike for recovered clients, for whom the probability of withdrawal ruptures decreased as the degree of resolution increased. This study suggests that alliance rupture and resolution processes in early treatment differ between recovered and unrecovered clients in DBT for BPD.

The present study was an effort to replicate and elaborate the findings from our exploratory study, with the following aims: (1) to determine whether alliance rupture and resolution processes predicted clinical outcomes in BPD, and (2) to assess the moderating effect of specific therapist baseline characteristics on alliance rupture and resolution processes and clinical outcomes.

Method

Sample. The sample was drawn from an ongoing RCT titled, "Faster Application of Suicidal Treatment—Evaluating Response to Dialectical Behavior Therapy"

(FASTER-DBT; McMMain et al., 2018). The FASTER-DBT trial assessed the clinical and cost-effectiveness of randomly assigned six months versus one year of treatment for chronically suicidal individuals diagnosed with BPD. In this study, 12 participants (six from the six-month arm, six from the one-year arm) were drawn as a simple random sample from the available participant pool of the FASTER-DBT study after the conclusion of its first year. Ethics for the FASTER-DBT Study were obtained from the Centre for Addiction and Mental Health (CAMH).

All participants met DSM-IV diagnostic criteria for BPD, as assessed using the International Personality Disorder Exam (IPDE; Loranger, 1995). Inclusion criteria were the presence of at least two suicide attempts or non-suicidal self-injurious behaviours in the five years prior to study enrolment, with at least one of these episodes occurring in the previous three months. Exclusion criteria included DSM-IV diagnoses of psychotic disorder, bipolar I disorder, dementia, or IQ less than 70, chronic or serious physical health problems requiring hospitalization within the treatment year, or plans to move out of the treatment region during the study duration. The sample was comprised of seven women and five men, who had a mean age of 28 (range = 19 to 43).

Treatment. All participants received comprehensive Dialectical Behaviour Therapy (DBT), an evidence-based treatment for BPD developed by Marsha Linehan (1993). The four standard components of DBT treatment were delivered: individual therapy (one hour per week), group skills training (two hours per week), phone coaching (available 24 hours a day), and a therapist consultation team meeting (two hours per week). There

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were no restrictions on ancillary pharmacotherapy. Therapy sessions were videotaped. DBT adherence ratings were applied to randomly selected video recordings and the results indicated that therapists adhered to the treatment protocols (see McMain et al., 2018).

Measures.

Process measures. This study examined four process measures: (1) *Rupture Resolution Rating Scale (3RS; Eubanks et al., 2015)*; (2) *Alliance Rupture-Resolution Section from the Post-session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1992)*; (3) *Working Alliance Inventory Short Form (WAIS; Horvath & Greenberg, 1989)*; and (4) *Kentucky inventory of mindfulness skills (KIMS; Baer, Smith, & Allen, 2004)*. The 3RS was applied to the first four treatment sessions. The PSQ was completed by patients and therapists following the first four treatment sessions. The WAIS completed by patients and therapists following the first four sessions, then at three and six months of treatment. The KIMS completed by therapists at baseline (pretreatment), then monthly through to the end of the follow-up phase (i.e., 24 months).

Outcome measures. This study examined three patient outcome measures: (1) the *Symptom Checklist-90-Revised (SCL-90R; Derogatis, 1983)*; (2) *Suicide Attempt and Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006)*; and (3) *Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD; Zanarini et al., 2003)*. Clinical assessments occurred at baseline (pretreatment) and at three, six, and 12 months of treatment.

Anticipated Outcomes

Given the broader empirical and theoretical literatures that implicate the clinical importance of alliance quality and treatment outcome in BPD, we hypothe-

size that higher frequencies of unresolved alliance ruptures in early treatment (session one to four) will predict poorer outcomes at mid- and post-treatment. We further hypothesize that the association between the frequency of unresolved alliance ruptures in early treatment and outcome at mid- and post-treatment will be moderated by mindfulness. Specifically, unresolved alliance ruptures will have their most harmful impact when involving a less mindful therapist.

Analytic Plan

All research questions will be evaluated using multilevel modeling. Explicit testing of our hypotheses will be examined by testing the regression coefficients for the frequency of alliance ruptures and rupture-resolution episodes by time interaction, while controlling for baseline characteristics, across all outcome variables. Individual and joint Wald χ^2 tests will be used. We will test for moderation effects by expanding the regression model to include the interactions of all baseline characteristics of interest by time, and then evaluating both the individual and joint effects of these variables. These tests will include individual and joint Wald χ^2 tests and likelihood ratio tests of model parameters, as well as the evaluation of the reduction of unexplained variance in the variance components. Evaluation of model fit will be provided by statistical indices including Akaike's Information Criteria (AIC) and Bayesian Information Criteria (BIC) and likelihood ratio tests.

Summary

Results from this study will highlight therapist characteristics and therapeutic strategies that are critical to enhancing therapeutic alliances with BPD patients. Such work can be used to improve DBT and other evidence-based therapies for

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BPD by enhancing training practices in light of research evidence for adaptive in-session behaviours and preexisting therapist characteristics.

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References

- Baer, R. A., Smith, G. T., & Allen, K. B. (2004). Assessment of mindfulness by self-report: The Kentucky Inventory of Mindfulness Skills. *Assessment, 11*, 191-206.
- Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852.
- Barnicot, K., Katsakou, C., Bhatti, N., Savill, M., Fearn, N., & Priebe, S. (2012). Factors predicting the outcome of psychotherapy for borderline personality disorder: A systematic review. *Clinical Psychology Review, 32*(5), 400-412.
- Boritz, T., Barnhart, R., Eubanks, C., & McMMain, S. (2018). Alliance rupture and resolution in dialectical behavior therapy for borderline personality disorder. *Journal of Personality Disorders, 32*(Supp), 115-128.
- Derogatis, L. R. (1983). *SCL-90-R Revised manual*. Baltimore, MD: John Hopkins School of Medicine.
- Dinger, U., Strack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology, 64*, 344-354.
- Eubanks, C., Muran, J. C., & Safran, J. D. (2015). *Rupture resolution rating system (3RS): Manual*. New York, NY: Beth Israel Medical Centre.
- Hirsh, J. B., Quilty, L. C., Bagby, R. M., & McMMain, S. F. (2012). The relationship between agreeableness and the development of the working alliance in patients with borderline personality disorder. *Journal of Personality Disorders, 26*, 616-627.
- Horvath, A. O., Del Re, A. C., Flückinger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16.
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223-233.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
- Linehan, M., Comtois, K., Brown, M., Heard, H., & Wagner, A. (2006). Suicide Attempt Self-Injury Interview (SASII): Development, reliability, and validity of a scale to assess suicide attempts and intentional self-injury. *Psychological Assessment, 18*(3), 303-312.
- Loranger, A.W. (1995). *International Personality Disorder Examination (IPDE) manual*. White Plains, NY: Cornell Medical Center.
- McMMain, S., Boritz, T., & Leybman, M. (2015). Common strategies for cultivating a positive therapy relationship in the treatment of borderline personality disorder. *Journal of Psychotherapy Integration, 25*(1), 20-29.
- McMMain, S., Burckell, L., Links, P., & Guimond, T. (2009, June). *The role of the therapeutic alliance in two treatments for borderline personality disorder*. The Society for Psychotherapy Research Annual Meeting, Santiago, Chile.
- McMMain, S. F., Chapman, A. L., Kuo, J. R., Guimond, T., Streiner, D. L., Dixon-Gordon, K.L., ... Hoch, J. S. (2018). The effectiveness of 6 versus 12-months of dialectical behaviour therapy for border-

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- line personality disorder: The feasibility of a shorter treatment and evaluating responses (FASTER) trial protocol. *BMC Psychiatry*, 18(1), 230, 1-16.
- Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (1992). Patient and Therapist Postsession Questionnaires, Version 1992. New York, NY: Beth Israel Medical Center.
- Safran, J. D. & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, 43, 286-291.
- Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy*, 48, 80-87.
- Shearin, E. N., & Linehan, M. M. (1992). Patient-therapist ratings and relationship to progress in dialectical behavior therapy for borderline personality disorder. *Behavior Therapy*, 23, 730-741.
- Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 75, 104-115.
- Turner, R. M. (2000). Naturalistic evaluation of dialectical behavior therapy-oriented treatment for borderline personality disorder. *Cognitive and Behavioral Practice*, 7, 413-419.
- Waldinger, R. J. & Gunderson, J. G. (1984). Completed psychotherapies with borderline patients. *American Journal of Psychotherapy*, 38, 190-202.
- Zanarini, M. C., Vujanovic, A., Parachini, E. A., Boulanger, J. L., Frankenburg, F. R., & Hennen, J. (2003). A screening measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder. *Journal of Personality Disorders*, 17, 568-573.
- Zuroff, D., Kelly, A., Leybman, M., Blatt, S., Wampold, B. (2010). Between therapist and within-therapist differences in the quality of the therapeutic relationship: Effects on maladjustment and self-critical perfectionism. *Journal of Clinical Psychology*, 66, 681-697.







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The State of Multicultural Counseling Competencies Research

Minnah W. Farook, MA, EdS
University of Kentucky



Due to changes in demographics in the United States, counselors and therapists are likely to serve clients who have a culturally diverse background. Data from the 2010 United States (U.S.) Census indicated that foreign-born individuals represented 13.3% of the U.S. population, some 42.3 million people (Colby & Ortman, 2014). In 2014, the U.S. population by race was represented by 62.2% of non-Latina/o Whites, while multiracial individuals and racial and ethnic minorities represented 37.8% (Colby & Ortman, 2014). By 2044, this percentage is expected to grow to more than 50% for racial and ethnic minorities, and by 2060, 20% of U.S. population is expected to be foreign born (Colby & Ortman, 2014).

These changes demand that counselors and therapists prepare to effectively serve the needs of these diverse populations. Although there has been growth in research and services on the health and mental health needs of racial and ethnic minorities, racial and ethnic minority populations in the U.S. suffer disproportionately from mental health disparities (Dillon et al., 2016; Holden et al., 2014; Smedley, Stith, & Nelson, 2003). The health disparities literature indicates that compared to White Americans, racial and ethnic minorities are less likely to have access to mental health services, less likely to utilize mental health services, more likely to receive lower quality mental health care, and

less likely to retain treatment (Dillon et al., 2016; Holden et al., 2014). Racial and ethnic minorities are also more likely to leave treatment prematurely and less likely to seek mental health care (Holden & Xanthos, 2009). When they do seek mental health care, they are more likely to be underdiagnosed and undertreated for affective disorders, overdiagnosed and overtreated for psychotic disorders, and less likely to receive newer and more comprehensive care (Agency for Healthcare Research and Quality [AHRQ], 2013; Greenberg & Rosenheck, 2003). Research has indicated that a lack of culturally competent care contributes to these disparities (Holden & Xanthos, 2009; Shim et al., 2013; van Ryn & Fu, 2003). The overall disparities in mental healthcare have been associated with a lack of cultural competency (Holden et al., 2014; Holden & Xanthos, 2009; Shim et al., 2013). Researchers and leaders in mental health care, including the American Psychological Association (APA), have recommended and mandated mental health professionals provide culturally competent care to reduce mental health disparities (APA, 2010, 2017; Arredondo et al., 1996; Sue et al., 1982).

APA ethical principles (2010) and the American Counseling Association (ACA)

Code of Ethics (2014) advise psychologists and counselors on the boundaries of competence and instructs them to only provide services to populations included in their education, training, supervised experience, consultation,

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study, or professional experiences. The APA (2003) has provided guidelines for multicultural education, training, research, practice, and organizational change for psychologists. Ratts, Singh, Nassar-McMillan, Butler, and McCullough (2016) also developed multicultural and social justice counseling competencies that offer guidance for counselors in practice and research. These guidelines, ethical principles, and codes suggest that it is unethical for counselors and psychologists to provide services to culturally diverse populations if they have not had any education and training in multicultural competencies.

Although the need for multicultural competencies has been widely accepted and multicultural competency guidelines have been widely implemented in professional psychological organizations and training programs (Worthington, Soth-McNett, & Moreno, 2007), there is still surprisingly little empirical research (Worthington et al., 2007) that directly examines the effectiveness of multicultural competencies (MCC), and the validity of the widely used tripartite model of MCC (Sue et al., 1982). Multicultural competence, as defined by D. W. Sue (2001), is obtaining the awareness, knowledge, and skills to work with people of diverse backgrounds in an effective manner. Sue and colleagues (1982) developed the tripartite model of MCCs that include attitudes and beliefs, knowledge, and skills. They proposed that 1) culturally competent mental health providers are aware of their own beliefs, attitudes, values, and worldviews that might impact their work with their clients; 2) they have the knowledge of beliefs, attitudes, values, and worldviews that are common to the specific populations they work with; and 3) they have the skills necessary to work with diverse populations (Sue et al., 1982).

As the acceptance of MCC has grown over the last three decades, there have been many conceptual and indirect empirical research on MCC (Ridley & Shaw-Ridley, 2011; Worthington et al., 2007). However, much of the empirical MCC literature includes studies with flaws in their methodologies (Ridley & Shaw-Ridley, 2011), measures with poor validity (Kitaoka, 2005), and an overreliance on analogue studies, college student populations, and indirect measures (Worthington & Dillon, 2011; Worthington et al., 2007). The existing literature has a lack of empirical studies examining MCCs using strong measures and research design, real clients, and participants who are representative of the population at large. Below I provide a review of the existing MCC literature that demonstrates the need for additional research examining the efficacy of MCC in psychotherapy.

Multicultural Competency

Scholars and researchers have defined MCC in various ways (Cornish, Schreier, Nadkarni, Henderson Metzger, & Rodolfa, 2010). D. W. Sue, Arredondo, and McDavis (1992) defined MCC as counselors having the awareness of their own worldviews, biases, and beliefs related to racial and ethnic minorities, understanding the worldviews of individual clients, and acquiring and using culturally responsive interventions and strategies in their work with clients. According to S. Sue (1998), MCC is the ability to appreciate diverse cultures and populations, and the ability to effectively work with culturally diverse individuals. He stressed that MCC is possessing culture-specific skills needed to work effectively with clients from specific populations. Cornish and colleagues (2010) defined MCC as, "the extent to which a psychotherapist is actively engaged in the process of self-

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awareness, obtaining knowledge, and implementing skills in working with diverse individuals" (p. 7). Likewise, Owen, Tao, Leach, and Rodolfa (2011), focused on the behavior of the counselor, and defined MCC as "a way of doing" that evaluates the counselor's ability to apply their multicultural awareness and knowledge in counseling (p. 274). The definitions and dimensions of MCC continue to be defined and re-defined, along with models counselors can use to develop their MCCs.

Multicultural Competency Model. Similar to the definition of MCC, there are many conceptualizations of MCC. One of the most widely used and most researched models (Worthington et al., 2007) of MCCs in the literature is the tripartite model (Sue et al., 1982; Sue et al., 1992). As noted, Sue and colleagues' (1992) conceptualization of MCCs include three dimensions: 1) beliefs and attitudes, 2) knowledge, and 3) skills (Sue et al., 1982, Sue et al., 1992). Sue and colleagues (1992) described the three dimensions of culturally competent counselors as: 1) being aware of their own values, beliefs, and worldviews, and limitations that might impact their work with a culturally different client; paying special attention to the impact ethnocentrism might have on their work with racially, ethnically, and otherwise culturally different clients; 2) making a genuine effort to understand the client's values, beliefs, and worldviews, and how those impact the client's life; the counselor approaches this in a nonjudgmental manner and accepts the client's worldviews as a valid way of life; 3) and possessing the skills and interventions necessary for working with the culturally different client, as well as practicing them in their work with the particular client (Sue et al. 1982; Sue et al., 1992; S. Sue et al., 1998). For the purposes of this study, the tripartite model of MCC will be used to conceptualize MCC.

Empirical literature. Research supports that therapist training in multicultural issues and therapist MCC may predict psychotherapy processes and outcomes. In a study that investigated clients' perceptions of therapists and client attrition, Wade and Bernstein (1991) found that therapists who attended a culture sensitivity training received higher ratings from clients on expertness, trustworthiness, attractiveness, unconditional regard, and empathy compared to counselors who did not receive a culture sensitivity training. Clients of therapists who attended a culture sensitivity training attended more follow-up sessions and reported higher satisfaction with the therapeutic process compared to clients of therapists who did not attend a culture sensitivity training. The results of this study found that training accounted for increased client satisfaction and client attrition for both Black and White counselors, and that ethnic matching did not account for client perception of therapist MCC and psychotherapy outcomes.

In another study, Constantine (2001) found that counselors who reported higher levels of formal multicultural training rated higher on a self-report measure of empathy, and that counselors who had an integrative theoretical orientation were more likely to be rated higher on their multicultural case conceptualization ability. The use of multicultural case conceptualization ability provided assessment of demonstrated skills rather than self-reported empathy or self-reported awareness, knowledge, or skills alone (Constantine, 2001). These findings support that culture sensitivity training plays an important role in enhancing MCC and improving psychotherapy processes and outcomes (Wade & Bernstein, 1991).

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In analogue studies with African American (Poston, Craine, & Atkinson, 1991; Thompson, Worthington, & Atkinson, 1994), Mexican American (Atkinson, Casas, & Abreu, 1992), Japanese American (Atkinson & Matsushita, 1991), and other Asian American clients (Gim, Atkinson, & Kim, 1991; Kim, Li, & Liang, 2002), MCC scholars have found that culturally congruent and culturally responsive verbalizations in therapy had a more positive impact on client outcomes compared to verbalizations that focus on the universality of human experiences. Kim, Li, and Liang's (2002) study ($N = 78$) on Asian American clients' (recruited from undergraduate psychology and Asian American studies courses) experiences in psychotherapy showed that clients reported higher working alliance and higher therapist empathic understanding when their therapists used interventions that sought immediate resolution of problems rather than focusing on gaining insight through exploration. Clients with higher adherence to Asian values reported higher therapist MCC when therapist encouraged emotional expression rather than expression of cognitions. These results are congruent with the Asian value of favoring immediate problem resolution early in therapy and anticipating emotional needs of others for interpersonal harmony (Sue & Sue, 2012).

A relationship between therapist MCC and psychotherapy processes and psychotherapy outcomes with actual clients has also been found. In a meta-analysis of 20 independent samples, Tao, Owen, Pace, and Imel (2015) found strong and positive effects of client perceptions of therapist MCC on important psychotherapy processes ($r = .58$ to $.72$), such as therapeutic alliance, and a moderate relationship between MCCs and psychotherapy outcomes ($r = .29$). This association between clients' ratings of

therapist MCC and psychotherapy outcomes is supported by similar findings in the empirical literature, such as the association between therapist MCC and psychotherapy processes that include working alliance, empathy, genuineness, goal consensus and collaboration, and alliance-rupture repair (e.g., Elliott, Bohart, Watson, & Greenberg, 2011; Norcross & Lambert, 2011). The strong correlations between therapist MCC and psychotherapy process suggest that the two processes might occur simultaneously. When the client perceives the therapist as multiculturally competent, the client is more likely to have a strong therapeutic alliance with the therapist (Tao et al., 2015).

In addition to influencing perceptions of greater understanding and stronger therapeutic alliance, therapist MCC may also predict client satisfaction. Constantine's (2002) study of clients of color ($N = 112$) at a college counseling center found that clients' perceptions of their counselors' (trainees) MCC and general counseling competencies predicted their satisfaction with treatment. Moreover, clients' perception of their counselors' MCC predicted satisfaction beyond the variance previously accounted for by general counseling competencies (Constantine, 2002). Constantine also found that clients' perceptions of their counselors' MCCs mediated the relationship between their general counseling competence and treatment satisfaction (Constantine, 2002). In a later study, Constantine (2007) examined the experience of African American clients ($n = 40$) with White therapists ($n = 19$) and found that clients' perceptions of microaggressions in therapy, therapist MCC, and therapists' general counseling competence were not significantly associated with client satisfaction. However, the results of this study did indi-

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cate that higher perceptions of microaggressions were predictive of weaker therapeutic alliance and lower ratings of MCC and general counseling competence. These findings suggest that therapist MCC is an important relational factor in therapy.

Therapeutic Alliance

One of the most important components of psychotherapy is therapeutic alliance. Therapeutic alliance refers to the quality of relationship between the therapist and client, the therapist's ability to engage the client and aid in effecting change in the client (Owen, Tao, Imel, Wampold, & Rodolfa, 2014). The negative impact of therapist biases and discriminatory attitudes on the therapeutic relationship and treatment outcomes are documented in several studies (e.g., Constantine, 2007; Owen et al., 2014; Owen, Tao, & Rodolfa, 2010). Owen et al. (2014) examined the therapeutic experiences of racial and ethnic minority clients ($N = 120$) at a university counseling center to explore whether experiences of microaggressions are being addressed in therapy. They found that 53% of clients reported experiencing racial and ethnic microaggressions from their therapists, and 76% of those clients reported that the microaggressions were not addressed as part of therapy. The results indicated that clients' perceptions of microaggression had a negative relationship with therapeutic alliance, even after controlling for clients' psychological well-being, number of sessions, and therapist racial and ethnic identity. Furthermore, therapeutic alliance ratings were even lower for clients who experienced microaggressions, but did not discuss it with their therapists, compared to clients who experienced microaggressions and discussed it with their therapist and clients who did not experience any microaggressions.

In another study with 121 female clients and 37 therapists, Owen et al. (2010) found that female clients' reports of gender-based microaggressions had a negative association with therapeutic alliance and therapy outcomes. The results also demonstrated that clients' perception of a strong therapeutic alliance could have a mediating effect on the relationship between perception of microaggressions and psychotherapy outcomes. These findings suggest that therapist biases can cause ruptures in the therapeutic relationship and may impact treatment outcomes and client attrition, particularly when the ruptures are not repaired (Owen, Tao, et al., 2014; Owen et al., 2010).

The literature on alliance and psychotherapy outcomes indicate that stronger therapeutic alliance is associated with improved outcomes (Owen, 2012; Owen, Tao, et al., 2011; Owen, Reese, Quirk, & Rodolfa, 2013; Zilcha-Mano & Errázuriz, 2015; Zilcha-Mano et al., 2015). In a study with 232 clients and 29 therapists, Owen, Imel, et al. (2011) found that clients' ratings of microaggressions had a negative relationship with treatment outcomes. However, clients' ratings of therapeutic alliance mediated the relationship between clients' perceptions of microaggressions in therapy and treatment outcomes.

Meta-analyses of psychotherapy studies indicate that therapeutic alliance (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Norcross, 2010) and empathy are good predictors of successful treatment outcome (Greenberg, Watson, Elliot, & Bohart, 2001). Still, therapists exhibit difficulties with accurately assessing both therapeutic alliance and empathy in clinical practice (Greenberg et al., 2001). Greenberg et al.

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(2001) found discrepancies in the ability to assess empathy in treatment among clients, observers, and therapists. Client's ratings of empathy ($r = .25$) were the most predictive of treatment outcomes compared to observer ratings ($r = .23$) and therapist ratings ($r = .18$). Thus, therapist ratings were the least predictive of treatment outcomes (Greenberg et al., 2001). Given the average premature termination rate, deterioration rate, no reliable change rate, and discrepancy between therapists' perceptions and client perceptions, it appears that therapists' perceptions of their effectiveness with some clients are inaccurate. This finding supports evidence from other empirical studies that found therapists are often inaccurate in their assessment of therapeutic alliance and treatment outcomes, suggesting the need for improvement in research, education, and training to enhance therapists' ability to accurately assess therapeutic alliance and treatment progress.

Limitations in Existing MCC Research

As the MCC literature has grown over the last three decades, scholars have raised concerns about the limitations of the empirical studies in the current literature. Limitations of MCC research include the effectiveness of existing measures, use of indirect variables to measure MCCs and psychotherapy outcome, use of self-report measures, scant inclusion of real clients, and lack of diversity in participants. These limitations suggest that findings of the MCC literature are debatable, as discussed below.

The validity of many of the existing MCC assessment instruments has been questioned (Kitaoka, 2005; Ridley & Shaw-Ridley, 2011). Research indicates that the theoretical bases of the current MCC assessment tools are questionable due to discrepancies in the factor structures (Constantine, Gloria, & Ladany,

2002; Kitaoka, 2005). Some "direct" measures use specific MCC models to assess therapist MCC by focusing on the therapists' skills and interventions, while "indirect" measures focus on concepts related to MCC, such as engaging in microaggressions or measuring cultural humility (Tao et al., 2015). Additionally, outcome variables in MCC studies that investigate effectiveness of MCCs also use indirect measures. For example, some studies focus on treatment attrition as indicator of therapeutic change or treatment effectiveness, as well as client perception of counselor as an indicator of effective counseling (Ridley & Shaw-Ridley, 2011). Another critique of MCC measures is that some self-report measures of MCC might be assessing counselors' self-efficacy in multicultural counseling instead of MCC (Constantine & Ladany, 2000; Otavi, Pope-Davis, & Dings, 1994).

Several MCC assessment tools are self-report measures, which are vulnerable to social desirability. Some limitations of using self-report measures include the possible influence of social desirability, political correctness, and attitudinal and attributional biases (Worthington et al., 2007). Constantine and Ladany (2000) found that social desirability attitudes are linked with the subscales of three of the four MCC measures they investigated. The three MCC measures are the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991; Kim, Cartwright, Asay, & D'Andrea, 2003), and the modified self-report version of the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991). Their study also indicates that after controlling for social desirability, there was no

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association between the reported MCC and multicultural case conceptualization ability (Constantine & Ladany, 2000). Due to these results, Constantine and Ladany (2000) recommend the use of social desirability measures in MCC studies that use existing self-report measures.

Another limitation of the existing literature concerns the use of analogue research. Worthington and colleagues (2007) noted that 24.7% of the studies in their meta-analysis of MCC research used analogue research (i.e., research in a laboratory setting meant to approximate reality), and 82.4% of studies that included client ratings of counselor MCCs included pseudo clients. Study participants also lack diversity as there is an overreliance of White, female, young college students and underrepresentation of real clients from racially diverse and low socioeconomic backgrounds (Worthington et al., 2007). Given that clients from diverse racial and low socioeconomic backgrounds are the biggest consumers of mental health services in the U.S. and that the preponderance of evidence indicates worse outcomes for racial minority clients compared to White clients (Holden et al., 2014), there is surprisingly little research that examines the experiences of these clients in the MCC literature. Inconsistent findings in existing studies that have examined therapist MCC and treatment outcomes are also concerning. Some studies indicate that there is a positive relationship between multicultural competencies and therapy outcomes (Atkinson & Lowe, 1995; Ponterotto, Fuertes, & Chen, 2000), while others indicate a lack of association or weak relationship between therapists' multicultural competencies and treatment outcome (Owen, Leach, et al., 2011; Tao et al., 2015).

Although MCC have been widely endorsed and implemented in professional organizations and training programs (Constantine & Ladany, 2000; Worthington et al., 2007), there is a dearth of empirical research evaluating the influence of multicultural competencies on psychotherapy processes and outcomes with real clients (Ridley & Shaw-Ridley, 2011; Worthington et al., 2007; Worthington & Dillon, 2011). Existing multicultural competencies studies with actual clients have focused on the client's perspective, and there is a paucity of research that includes both client and therapist perspectives on multicultural competencies, therapeutic alliance, and treatment outcomes. Due to the abovementioned limitations of current studies and difficulties of capturing components of MCC, additional empirical research on psychotherapy processes and outcomes is necessary (Ridley & Shaw-Ridley, 2011; Worthington & Dillon, 2011; Worthington et al., 2007).

References

- Agency for Healthcare Research and Quality. (2013, May). *National health disparities report*. Retrieved from <https://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr12/index.html>
- American Counseling Association. (2014). *2014 ACA code of ethics*. Retrieved from <https://www.counseling.org/knowledge-center/ethics>
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for Psychologists. *American Psychologist, 58*(5), 377-402. <http://dx.doi.org/10.1037/0003-066X.58.5.377>
- American Psychological Association. (2010). 2010 amendments to the 2002 "Ethical Principles of Psychologists and Code of Conduct." *American Psychologist, 65*, 493.

continued on page 55

- American Psychological Association. (2017). *Multicultural Guidelines: An ecological Approach to context, identity, and intersectionality*. Retrieved from <http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42-78. <https://doi-org.ezproxy.uky.edu/10.1002/j.2161-1912.1996.tb00288.x>
- Atkinson, D. R., Casas, A., & Abreu, J. (1992). Mexican-American acculturation, counselor ethnicity and cultural sensitivity, and perceived counselor competence. *Journal of Counseling Psychology, 39*(4), 515-520. <http://dx.doi.org/10.1037/0022-0167.39.4.515>
- Atkinson, D. R., & Lowe, S. M. (1995). The role of ethnicity, cultural knowledge, and conventional techniques in counseling and psychotherapy. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 387-414). Thousand Oaks, CA: Sage.
- Atkinson, D. R., & Matsushita, Y. J. (1991). Japanese-American acculturation, counseling style, counselor ethnicity, and perceived counselor credibility. *Journal of Counseling Psychology, 38*(4), 473-478. <http://dx.doi.org/10.1037/0022-0167.38.4.473>
- Blais, M. A., Lenderking, L. B., deLorell, A., Peets, K., Leahy, L., & Burns, C. (1999). Development and initial validation of a brief mental health outcome measure. *Journal of Personality Assessment, 73*, 359-373.
- Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin, 56*, 81-105.
- Colby, S. L., & Ortman, J. M. (2014, March). *Projections of the size and composition of the U.S. population 2014 to 2060*. Retrieved from <https://www.census.gov/library/publications/2015/demo/p25-1143.html>
- Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*(4), 588-598. doi:10.1037/0022-006X.65.4.588
- Constantine, M. G. (2001). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling, 23*(4), 357-372.
- Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*(2), 255-263. <http://dx.doi.org/10.1037/0022-0167.49.2.255>
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1-16. <http://dx.doi.org/10.1037/0022-0167.54.1.1>
- Constantine, M. G., Gloria, A. M., & Ladany, N. (2002). The factor structure underlying three self-report multicultural counseling competence scales. *Cultural Diversity and Ethnic Minority Psychology, 8*(4), 334-345. doi:10.1037/1099-9809.8.4.335
- Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47*(2), 155-164. doi:10.1037/0022-0167.47.2.155

continued on page 56

- Cornish, J. A. E., Schreier, B. A., Nadkarni, L. I., Henderson Metzger, L., & Rodolfa, E. R. (2010). *Handbook of multicultural counseling competencies*. Hoboken, NJ: John Wiley & Sons.
- D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development, 70*, 143-150. <http://dx.doi.org/10.1002/j.1556-6676.1991.tb01576.x>
- Dillon, F. R., Odera, L., Fons-Scheyd, A., Sheu, H.-B., Ebersole, R. C., & Spanierman, L. B. (2016). A dyadic study of multicultural counseling competence. *Journal of Counseling Psychology, 63*(1), 57-66. doi:10.1037/cou0000118
- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*, 43-49. doi:10.1037/a0022187
- Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *Journal of Counseling Psychology, 38*, 57-62. <http://dx.doi.org/10.1037/0022-0167.38.1.57>
- Greenberg, G. A., & Rosenheck, R. A. (2003). Change in mental health service delivery among Blacks, Whites, and Hispanics in the Department of Veterans Affairs. *Administration and Policy in Mental Health and Mental Health Services Research, 31*, 31-43. doi:10.1023/A:1026096123010
- Greenberg, L. S., Watson, J. C., Elliott, R., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 380-384. doi:10.1037/0033-3204.38.4.380
- Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., & ... Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services, 11*(4), 357-368. doi:10.1037/a0038122
- Holden, K. B., & Xanthos, C. (2009). Disadvantages in mental health care among African Americans. *Journal of Health Care for the Poor and Underserved, 20*(2), 17-23. doi:10.1353/hpu.0.0155
- Kim, B. S. K., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003). A revision of the Multicultural Awareness, Knowledge, and Skills Survey—Counselor Edition. *Measurement and Evaluation in Counseling and Development, 36*(3), 161-180. <https://doi.org/10.1080/07481756.2003.11909740>
- Kim, B. S. K., Li, L. C., & Liang, T. H. (2002). Effects of Asian American client adherence to Asian cultural values, session goal, and counselor emphasis of client expression on career counseling process. *Journal of Counseling Psychology, 49*(3), 342-354. <http://dx.doi.org/10.1037/0022-0167.49.3.342>
- Kitaoka, S. K. (2005). Multicultural counseling competencies: Lessons from assessment. *Journal of Multicultural Counseling and Development, 33*, 37-47. <https://doi.org/10.1002/j.2161-1912.2005.tb00003.x>
- LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory-Revised. *Professional Psychology: Research and Practice, 22*(5), 380-388. <http://dx.doi.org/10.1037/0735-7028.22.5.380>
- Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113-141). Washington, DC: American Psychological Association.
- Norcross, J. C., & Lambert, M. J. (2011).

continued on page 57

-
- Psychotherapy relationships that work II. *Psychotherapy*, 48, 4-8. doi:10.1037/a0022180
- Ottavi, T. M., Pope-Davis, D. B., & Dings, J. G. (1994). Relationship between White racial identity attitudes and self-reported multicultural counseling competencies. *Journal of Counseling Psychology*, 41, 149-154.
- Owen, J. (2012). Systemic alliance in individual therapy: Factor analysis of the ITAS-SF and the relationship with therapy outcomes and termination status. *Journal of Marital and Family Therapy*, 38(s1), 320-331. doi: [10.1111/j.1752-0606.2011.00268.x](https://doi.org/10.1111/j.1752-0606.2011.00268.x)
- Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology*, 58, 1-9. doi:10.1037/a0021496
- Owen, J., Reese, R. J., Quirk, K., & Rodolfa, E. (2013). Alliance in action: A new measure of clients' perceptions of therapists' alliance activity. *Psychotherapy Research*, 23, 67-77. doi:10.1080/10503307.2012.731088
- Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, 45(4), 283-290. doi:10.1037/a0037420
- Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, 48(3), 274-282. doi:10.1037/a0022065
- Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions and women in short-term psychotherapy: Initial evidence. *The Counseling Psychologist*, 38(7), 923-946. doi:10.1177/0011000010376093
- Ponterotto, J. G., Fuertes, J. N., & Chen, E. C. (2000). Models of multicultural counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 639-669). Hoboken, NJ: John Wiley & Sons.
- Ponterotto, J. G., Rieger, B. T., Barrett, A., Harris, G., Sparks, R., Sanchez, C. M., & Magids, D. (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247-282). Lincoln, NE: Buros Institute of Mental Measurements.
- Ratts, M. J., Singh, A. A., Nassar McMullan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, 44(1), 28-48. <http://dx.doi.org/10.1002/jmcd.12035>
- Ridley, C. R., & Shaw-Ridley, M. (2011). Multicultural counseling competencies: An analysis of research on clients' perceptions: Comment on Owen, Leach, Wampold, and Rodolfa (2011). *Journal of Counseling Psychology*, 58, 16-21. <http://dx.doi.org/10.1037/a0022221>
- Shim, R. S., Baltrus, P., Bradford, L. D., Holden, K. B., Fresh, E., & Fuller, L. E. (2013). Characterizing depression and comorbid medical conditions in African American women in a primary care setting. *Journal of the National Medical Association*, 105(2), 183-191.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press.
- Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory. A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, 41(2), 137-148.
- Sue, D. W. (2001). Multidimensional

continued on page 58

- facets of cultural competence. *The Counseling Psychologist*, 29, 790-821. <https://doi-org.ezproxy.uky.edu/10.1177/001100001296002>
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, 20(2), 64-88. <http://dx.doi.org/10.1002/j.2161-1912.1992.tb00563.x>
- Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, 10(2), 45-52. doi:10.1177/0011000082102008
- Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., & ... Vasquez-Nuttall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: John Wiley & Sons.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53, 440-48.
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology*, 62(3), 337-350. doi: 10.1037/cou0000086
- Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology*, 41(2), 155-161. doi: [10.1037/0022-0167.41.2.155](https://doi.org/10.1037/0022-0167.41.2.155)
- van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health*, 93(2), 248-255. doi:10.2105/AJPH.93.2.248
- Wade, P., & Bernstein, B. L. (1991). Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology*, 38, 9-15. doi:10.1037/0022-0167.38.1.9
- Worthington, R. L., & Dillon, F. R. (2011). Deconstructing multicultural counseling competencies research: Comment on Owen, Leach, Wampold, and Rodolfa (2011). *Journal of Counseling Psychology*, 58, 10-15. doi:10.1037/a0022177
- Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, 54(4), 351-361. <http://dx.doi.org/10.1037/0022-0167.54.4.351>
- Zilcha-Mano, S., & Errázuriz, P. (2015). One size does not fit all: Examining heterogeneity and identifying moderators of the alliance-outcome association. *Journal of Counseling Psychology*, 62(4), 579-591. doi:10.1037/cou0000103
- Zilcha-Mano, S., Solomonov, N., Chui, H., McCarthy, K. S., Barrett, M. S., & Barber, J. P. (2015). Therapist-reported alliance: Is it really a predictor of outcome? *Journal of Counseling Psychology*, 62(4), 568-578. doi:10.1037/cou0000106



EARLY CAREER

Counseling for Teens and Young Adults With an Autism Spectrum Diagnosis: Using Evidence to Inform Treatment

Beth A. Trammell, PhD, HSPP

Anita M. Kraft, BGS

Indiana University East



For the early-career clinician, getting started in the world of therapy in either private practice or an outpatient clinic can be both overwhelming and exciting. After graduation, many of us are in this state of transition out of student mode and into professional mode. Developing confidence as a young professional, while also building a caseload, can be challenging as we face clients who present with more complicated issues than we have encountered during training. Individuals with an autism diagnosis represent one specific subpopulation for whom more than half of mental health providers have not received specific training (Williams & Haranin, 2016). In particular, adolescents (ages 14-22) with autism spectrum disorders (ASD) present a unique set of challenges by which even the seasoned clinician may feel intimidated.

Introduction

Recent figures suggest that one out of 59 children in the U.S. have been identified as having an ASD by the age of eight, an increase from one in 68 in 2012 (Baio et al., 2018). This represents a large number of children who will be growing into teens and young adults within the next 10 years. Over the last two decades, the awareness and visibility of ASD diagnoses have increased, but the research informing professionals in helping those

children transition into young adulthood is still lacking (Hendricks & Wehman, 2009). ASD is considered a lifelong diagnosis, though prevalence rates among teens and young adults are still forthcoming. Although precise prevalence data are not readily available, mental health problems often persist from childhood into adolescence (Simonoff et al., 2013), and some suggest problems may be exacerbated during the teen years due to difficulties with social norms, anxiety, and depression. Furthermore, the risk of suicide during the adolescent years has been found to be notably higher for those with an ASD diagnosis than neurotypical peers (Casidy et al., 2014), despite this being an understudied phenomenon (Richa, Fahed, Khoury, & Mishara, 2014). In addition, an estimated 50,000 teens with ASD age out of services provided by their schools on a yearly basis (Baio et al., 2018). This suggests these individuals will need community-based support, like outpatient therapy, to fill the gap in services. Mental health professionals thus need to be astute to the specific needs of this population.

With half of mental health professionals having little, or no training in autism, and fewer than 16% of therapists having supervisors with expertise in working with clients with autism (Williams & Haranin, 2016), the lack of confidence and support in working with these individuals proves to be a continuing issue in our field. Beyond that, upwards of

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70% of individuals with ASD having co-occurring mental health issues (Joshi et al., 2010), which suggests a huge need for effective therapeutic resources in the community. While there has been a major push for evidence-based practice, particularly in the realm of working with individuals with ASD, much of the research has been on younger populations (Wright, Brooks, D'Astous, & Grandin, 2013). With the lack of consistent evidence-based practices for adolescents and young adults with ASD in the therapy room, combined with the wide variability in skills and abilities within the ASD population, we argue here for an "evidence-informed" therapeutic approach. This type of clinical decision-making approach derives from the medical literature and may be more appropriate as the clinician considers the contextual variables associated with individuals with ASD. In following an evidence-informed approach, the clinician takes that most supported evidence about the client's presented issues and uses that information to inform the treatment planning based on the individualized variables of that client.

The Process of Therapy With Adolescents With ASD

The process of therapy for clinicians who work with individuals whose symptoms fall on the spectrum requires a unique subset of therapeutic skill that is not always taught in graduate training. While it is important to utilize all of the common microskills (e.g., showing empathy, active listening, open-ended questioning) with the ASD population, it is also important to recognize these teens and young adults may have an additional set of needs for the therapy room. For instance, they may not have the cognitive capacity to follow metaphors and/or analogies that are often used in therapy. Furthermore, due to challenges with social nuances, a client with ASD may not

have the skill to speak up when they don't understand a question or to correct a misinterpretation that a therapist makes. Using concrete and relatable examples will minimize the chances of misunderstandings. It should be noted that the client's inability to react appropriately to a clinician's questions might have less to do with autism, and more to do with the clinician's inability to ask the question correctly. One should continue to check in with both the client and, as appropriate, the family, to gauge how the client is interpreting personal progress in therapy.

Despite the DSM-5 (American Psychiatric Association, 2013) collapsing all forms of autism into one diagnosis (ICD-10, F84.0), there will still be clients who identify with high-functioning autism, Asperger syndrome, and other pervasive-developmental disorder diagnoses. Since autism falls along a continuum, it is often more important for the clinician to focus on the client's abilities, strengths, and areas of need, rather than the specific diagnosis. This will also make utilizing the evidence-base to inform treatment a more achievable goal for the clinician—as we can search for therapies related to anxiety, depression, or social deficits.

Setting goals. In working with teens and young adults, developing appropriate goals that are consistent with their abilities and objectives should be a collaborative process. Many clients with ASD will still require significant support from parents and teachers, so including them in goal-setting will be critical for success. Some specific goals that may be common for teens and young adults include goals related to personal hygiene, social connections, and independent living skills. Keeping in mind that males are four times as likely to be diagnosed with ASD (Baio et al., 2018), the clinician

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should become particularly invested in researching common issues for males presenting with these symptoms.

Engaging the family. When the client experiences more mental health problems, parents' and caregivers' levels of stress also increase; beyond that of the diagnosis of ASD alone (Kerns et al., 2015). In addition, helping caregivers determine the right balance of freedom and independence for their adolescent's developmental level can be challenging. Moreover, parents and guardians of individuals with an ASD diagnosis may have become accustomed to fully supporting their child for much of their lives; this makes that transition even harder, because they may become anxious with this release of control. Common challenges include determining when to give freedom with technology and social media; when it is appropriate to date, drive, work; and navigating differences between what each parent thinks is most appropriate—along with many others.

Although it is important to support the individual with ASD, the clinician should also recognize the need to honor the challenges of siblings. Frequently, the siblings of individuals with ASD can feel forgotten or less important because there is so much emphasis placed on supporting the client with ASD. Connecting with a local applied behavior analysis (ABA) clinic or autism treatment facility for additional treatment options, such as support groups for parents or siblings, could also be recommended.

Using the evidence to inform treatment. For some clients, insight-oriented therapies may not be a good fit for their level of cognitive and emotional functioning. Literature reviews may be a good starting point for clinicians working with adolescents interested in cognitive-behavior therapy (Kerns, Roux, Connell, & Shat-

tuck, 2016; Weston, Hodgekins, & Langdon, 2016; Wood, Fujii, & Renno, 2011) and possible psychosocial interventions (Bishop-Fitzpatrick, Minshew, & Eack, 2014). Behavioral skills training is a performance-based and competency-based training protocol to teach specific complex skills that has had promising results (Parsons, Rollyson, & Reid, 2013). This type of approach could be used with either caretakers or clients who wish to improve specific skills. The process entails clearly describing the target behavior goal (e.g., Andrew will load and unload the dishwasher every other day), modeling the target behavior, providing immediate feedback to the client during practice of that behavior, and continuing a level of support until feedback is no longer needed. The use of video modeling, through YouTube or other services, is also a helpful strategy, as it clearly shows the client exactly what the task should look like (Franzone & Collet-Klingenberg, 2008). Researchers have developed a practice-based approach to analyzing the function of behavior that may also be appropriate—including operationally defining the behavior and gathering data (Powers, Palmieri, D'ErAMO, & Powers, 2011).

Recent research into relevant mental health issues has demonstrated a correlation between social identity or autism acceptance and mental well-being in adolescents with ASD (Cage, 2017; Cooper, 2017). Moving from a "disorder" and medical model of diagnosis, to a well-being approach for ASD can significantly change the negative impact of the diagnosis as the social identity of an adolescent with ASD varies from a negative association to a positive association. The perception of general societal acceptance, and perceived acceptance by family and friends, directly impacts the level of depression and stress reported

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(Cage, 2017). Furthermore, individuals with positive self-esteem, who reported being proud of the autism identity, showed significantly lower levels of depression and stress (Cooper, 2017).

Social identity theory has broad implications for clinicians, as social identity can be an avenue for positive change. Increasing access to autism groups run by people on the spectrum can improve positive identification. Social groups advocating for neurodiversity are increasing online, in social media, and for students and teens with ASD. These groups can be a source of not only improved self-esteem but pride in their social identities. Moreover, online interactions might be preferred, because there are no physical, social norm obstacles. They can become a shared basis for self-definition from a positive, instead of a negative, identity (Cooper, 2017). Working with ASD on self-disclosure and self-advocacy can affirm positive social identity. Reviewing idiosyncrasies to highlight both challenges and strengths can help to build a positive social identity. When possible, including family members in this approach can help the client perceive higher levels of external acceptance. Psychoeducational groups, like PEGASUS, have been shown to have preliminary effectiveness in positive self- and ASD-awareness (Gordon et al., 2015).

Self-stimulatory behaviors (i.e., stimming) represent one of several behaviors unique to the ASD population that also lacks informative research at the teen- and young-adult level. Many parents, teachers, and education professionals work to reduce stimming, without replacing the behavior and failing to understand its importance. Stimming is often a coping skill and can be used positively, with a calming, grounding effect. However, stimming is also a sign for the clinician that the client may be under

stress that could escalate to more unhealthy behaviors (e.g., aggression, hair pulling, or other self-injurious behaviors). Working with ASD, it is important not to try to eliminate stimming altogether, but rather find positive stimming outlets. Hand squeezing, leg shaking, rocking, arm flapping are all safe and effective stimming behaviors.

Knowing the Resources in Your Community

Assisting with the transition process. It is now both possible and advisable for individuals with ASD to engage in a post-secondary plan, regardless of the level of ability, whether it be directed toward college or the workforce (Hart, Grigal, & Weir, 2010). Transitioning from high school should include plans for increased independence, gainful employment, post-secondary education, and increasing social connections—and those plans should begin as early as possible. Many school districts have transitioning plans in place by the eighth grade, but sometimes transition plans are not even considered until well into high school. The clinician should collaborate with parents and school personnel as soon as possible to give input into the best individualized plan for the client. This transition plan should include the student's specific goals (e.g., four-year college, two-year college, employment), current level of functioning, and practical steps toward achieving those goals throughout high school (Szidon, Ruppert, & Smith, 2015). These might include obtaining a driver's license, attending college fairs, explicit teaching of social skills, and evaluation of assistive technology needs, among other pre-adult life skills. Beyond that, this transition plan should include the supportive individuals responsible for assisting the individual in meeting these goals and holding the client accountable.

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Researchers have developed preliminary guidelines for the transition process that could also be helpful. For instance, recommendations about high school curriculum, job skill development and social skills training should be included (Hart et al., 2010; Wehman et al., 2014). In addition, the National Longitudinal Transition Study-2 provides information for the clinician about specific variables that are of importance during the transition to adulthood (Wagner, Newman, Cameto, Garza, & Levine, 2005).

Increasing independent living skills. When students have more functional independence skills, they are more likely to have more success after high school, regardless of their long-term goals (Shattuck et al., 2012). For instance, skills like telling time, counting money, understanding signage in public, and using public transportation are critical for interacting independently as an adult. Therefore, the clinician may choose to include these very specific sub-goals in their treatment plans. While these may seem less relevant for outpatient therapy, these increased skills in independence are likely to directly relate to the client's overall mental health in a positive way. Utilizing a quick checklist of adaptive skills to assess the client's current functioning would be a good place to start, though formal assessments of adaptive functioning could also be appropriate.

Strategies for the college path. For clients who are interested in a two- or four-year degree, clinicians can assist caregivers and clients in making informed decisions collaboratively. Clients who are still in high school may want to take college courses as a dual-enrollment option, which allows the client to experience the college environment while still having the close support of

teachers and parents (Adreon & Durocher, 2007). Depending on the client's interests and abilities, trade or vocational colleges may also be a good option. These options minimize the need for general education courses, and have increased job-specific training opportunities that may seem more relevant for the client's chosen path. While in high school, many students rely on the support of teachers and parents to provide guidance for difficult situations. Upon leaving high school, clients with ASD will have to adjust to many changes, and the level of support at college is significantly reduced from the support received through special education or 504 plans. In the therapy room, clinicians could prepare the client for college life through creating a checklist of skills required to be successful at each type of institution. For instance, at a four-year college, the client will need to manage schedules, roommate struggles, food options, and appointments with faculty, among many other tasks. At the two-year college, the student may need to arrange transportation to and from classes, make appointments for academic advising, join student clubs, and so forth. The fit between the client and the institution is critical for success (Adreon & Durocher, 2007), so a collaborative evaluation of these factors should be considered.

Ideas for the workforce path. When working with clients who are not interested in a two- or four-year degree, the clinician should connect with local resources for job support. Specifically, employment services such as vocational rehabilitation have been helpful in connecting individuals with ASD and other disabilities to jobs (Burgess & Cimera, 2014). Vocational rehabilitation also provides services such as on-the-job training, interviewing practice, and career

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guidance. Other options within the community might include sheltered workshops whereby individuals with ASD could receive additional training and mentoring prior to entering the job market. Connecting with other career-counseling resources within the community may also be advisable.

Future Directions

Future research is needed to continue to expand the current knowledge about working with teens and young adults with ASD. In the meantime, utilizing the current evidence, combined with the specific needs and strengths of the individual client, is our best course of action with these clients. In addition, providing continuing professional development to clinicians and, in particular, their supervisors, would also help increase the number of professionals competent in providing these services.

References

Adreon, D., & Durocher, J. S. (2007). Evaluating the college transition needs of individuals with high-functioning autism spectrum disorders. *Intervention in School and Clinic, 42*(5), 271-279.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Baio, J., Wiggins, L., Christensen, D. L., Maenner, M. J., Daniels, J., Warren, Z., ... & Durkin, M. S. (2018). Prevalence of autism spectrum disorder among children aged 8 years—Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2014. *MMWR Surveillance Summaries, 67*(6), 1-23.

Bishop-Fitzpatrick, L., Minshew, N. J., & Eack, S. M. (2014). A systematic review of psychosocial interventions for adults with autism spectrum disorders. In *Adolescents and adults with*

autism spectrum disorders (pp. 315-327). New York, NY: Springer.

Burgess, S., & Cimera, R. E. (2014). Employment outcomes of transition-aged adults with autism spectrum disorders: A state of the states report. *American Journal on Intellectual and Developmental Disabilities, 119*(1), 64-83.

Cage, E., Di Monaco, J., & Newell, V. (2018). Experiences of autism acceptance and mental health in autistic adults. *Journal of Autism & Developmental Disorders, 48*(2), 473-484. <https://doi.org/10.1007/s10803-017-3342-7>

Cassidy, S., Bradley, P., Robinson, J., Allison, C., McHugh, M., & Baron-Cohen, S. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: A clinical cohort study. *Lancet Psychiatry, 1*, 142-147.

Cooper, K., Smith, L. G. E., & Russell, A. (2017). Social identity, self-esteem, and mental health in autism. *European Journal of Social Psychology, 47*(7), 844-854. <https://doi.org/10.1002/ejsp.2297>

Franzone, E., & Collet-Klingenberg, L. (2008). *Overview of video modeling*. Madison, WI: The National Professional Development Center on Autism Spectrum Disorders, Waisman Center, University of Wisconsin.

Gordon, K., Murin, M., Baykaner, O., Roughan, L., Livermore Hardy, V., Skuse, D., & Mandy, W. (2015). A randomised controlled trial of PEGASUS, a psychoeducational programme for young people with high-functioning autism spectrum disorder. *Journal of Child Psychology and Psychiatry, 56*(4), 468-476.

Hart, D., Grigal, M., & Weir, C. (2010). Expanding the paradigm: Postsecondary education options for individuals with autism spectrum disorder and intellectual disabilities. *Focus on*

continued on page 65

-
- Autism and Other Developmental Disabilities*, 25, 134–150.
- Hendricks, D. R., & Wehman, P. (2009). Transition from school to adulthood for youth with autism spectrum disorders: Review and recommendations. *Focus on Autism and Other Developmental Disabilities*, 24(2), 77–88. <https://doi.org/10.1177/1088357608329827>
- Joshi, G., Petty, C., Wozniak, J., Henin, A., Fried, R., Galdo, M., ... & Biederman, J. (2010). The heavy burden of psychiatric comorbidity in youth with autism spectrum disorders: A large comparative study of a psychiatrically referred population. *Journal of Autism and Developmental Disorders*, 40(11), 1361–1370.
- Kerns, C. M., Kendall, P. C., Zickgraf, H., Franklin, M. E., Miller, J., & Herrington, J. (2015). Not to be overshadowed or overlooked: Functional impairments associated with comorbid anxiety disorders in youth with ASD. *Behavior Therapy*, 46, 29–39. doi:10.1016/j.beth.2014.03.005
- Kerns, C. M., Roux, A. M., Connell, J. E., & Shattuck, P. T. (2016). Adapting cognitive behavioral techniques to address anxiety and depression in cognitively able emerging adults on the autism spectrum. *Cognitive and Behavioral Practice*, 23(3), 329–340.
- Parsons, M. B., Rollyson, J. H., & Reid, D. H. (2013). Teaching practitioners to conduct behavioral skills training: A pyramidal approach for training multiple human service staff. *Behavior Analysis in Practice*, 6(2), 4–16.
- Powers, M. D., Palmieri, M. J., D'Eramo, K. S., & Powers, K. M. (2011). Evidence-based treatment of behavioral excesses and deficits for individuals with autism spectrum disorders. In *Evidence-based practices and treatments for children with autism* (pp. 55–92). Boston, MA: Springer.
- Richa, S., Fahed, M., Khoury, E., & Mishara, B. (2014). Suicide in autism spectrum disorders. *Archives of Suicide Research*, 18(4), 327–339.
- Shattuck, P. T., Narendorf, S. C., Cooper, B., Sterzing, P. R., Wagner, M., & Taylor, J. L. (2012). Postsecondary education and employment among youth with an autism spectrum disorder. *Pediatrics*, 129, 1042–1049
- Simonoff, E., Jones, C. R., Baird, G., Pickles, A., Happé, F., & Charman, T. (2013). The persistence and stability of psychiatric problems in adolescents with autism spectrum disorders. *Journal of Child Psychology and Psychiatry*, 54(2), 186–194.
- Szidon, K., Ruppap, A., & Smith, L. (2015). Five steps for developing effective transition plans for high school students with autism spectrum disorder. *Teaching Exceptional Children*, 47(3), 147–152.
- Wagner, M., Newman, L., Cameto, R., Garza, N., & Levine, P. (2005). After high school: A first look at the postschool experiences of youth with disabilities. A report from the National Longitudinal Transition Study-2 (NLTS2). Retrieved from <https://files.eric.ed.gov/fulltext/ED494935.pdf>
- Wehman, P., Schall, C., Carr, S., Targett, P., West, M., & Cifu, G. (2014). Transition from school to adulthood for youth with autism spectrum disorder: What we know and what we need to know. *Journal of Disability Policy Studies*, 25(1), 30–40.
- Weston, L., Hodgekins, J., & Langdon, P. E. (2016). Effectiveness of cognitive behavioural therapy with people who have autistic spectrum disorders: A systematic review and meta-analysis. *Clinical Psychology Review*, 49, 41–54.
- Williams, M.E., & Haranin, E.C. (2016). Preparation of mental health clinicians to work with children with co-occurring autism spectrum disorders and mental health
- continued on page 66*
-

- needs, *Journal of Mental Health Research in Intellectual Disabilities*, 9(1-2), 83-100. doi: 10.1080/19315864.2016.1166302
- Wood, J. J., Fujii, C., & Renno, P. (2011). Cognitive behavioral therapy in high-functioning autism: Review and recommendations for treatment development. In *Evidence-based practices and treatments for children with autism* (pp. 197-230). Boston, MA: Springer.
- Wright, S. D., Brooks, D. E., D'Astous, V., & Grandin, T. (2013). The challenge and promise of autism spectrum disorders in adulthood and aging: A systematic review of the literature (1990–2013). *Autism Insights*, 2013(5), 21-73.



NEXT EDITOR OF PSYCHOTHERAPY APPOINTED

Dear Members of Division 29 (Society for the Advancement of Psychotherapy),

I am pleased to announce that upon recommendation of the Society for the Advancement of Psychotherapy Publications and Communications Board, with the concurrence of the President and Executive Committee, the Society's Board of Directors has ratified the appointment of **Dr. Jesse J. Owen** to Editor of our flagship journal, *Psychotherapy*. Dr. Owen's five-year term will begin January 1, 2020. Among other attributes that qualify him to serve as the Journal's Editor-in-Chief, Dr. Owen has a very strong psychotherapy research program, an expansive and impressive publication record, deep editorial experience both for *Psychotherapy* and other journals, leadership experience in the Society, and strong recommendations/endorsements from several leaders in the psychotherapy field.



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

Please join me in congratulating Dr. Owen on his well-deserved appointment. We look forward to benefitting from his vision for, and leadership of, our high-impact journal for years to come.

Michael J. Constantino
President, Society for the Advancement of Psychotherapy

Paging Dr. House: Improving Assessment and Diagnosis

Apryl Alexander, PsyD
University of Denver



Primary care physicians and pediatricians are often the first ones to provide a mental health diagnoses and prescribe psychotropic medications. In fact, one study found the proportion of primary care visits at which antidepressants were prescribed, but no psychiatric diagnosis was noted in the record, increased from 59.5% to 72.7% from 1996 to 2007 (Mojtabai & Olfson, 2011). Psychologists have a great deal of value to add to the practice of assessment and diagnosis of psychological disorders. Training in clinical interviewing, personality, cognitive and behavioral assessment, and report-writing allows practitioners to address referral questions regarding diagnostic clarification. Moreover, clients often are seeking an explanation regarding symptomatology and perceived difficulties. Appropriate and accurate diagnosis is critical in providing answers to client questions, as well as providing clients with the appropriate treatment and/or referrals they need.

Given the high stakes nature of psychological assessment and the implications surrounding proper diagnosis, abiding by ethical codes is paramount. The present article will discuss the importance of ethical practice in assessment and diagnosis, areas of difficulty practitioners commonly encounter with diagnosis, and a discussion of the impact of misdiagnosis.

Ethics in Assessment and Diagnosis

Assessment of one of the core foundational competencies of doctoral training

in psychology (Belar, 2009). Diagnosis is an inherently imperfect process and requires careful assessment of client symptoms over time (Dougherty, 2005). Complex symptoms can be difficult to assess and diagnose, particularly when a client presents with co-morbid symptoms, has a history of substance use, or there are underlying medical complaints (e.g., traumatic brain injury, organic disorders). Thus, it is unrealistic to expect psychologists to provide an accurate diagnosis in every case. Rather, clinicians should strive to implement the best methodology possible in their assessment process and discuss the potential limitations of their opinion in their written work.

Pope and Vetter (1992) found issues regarding assessment practices to be the most common ethical dilemmas reported by psychologists, citing availability of tests, basing conclusions on inadequate data, or ignoring data as the core themes of ethical complaints. The APA Ethical Principles of Psychologists and Code of Conduct notes, "Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings" (American Psychological Association, 2017). It has been recommended that clinicians should take reasonable care to avoid including data that are beyond the scope of the evaluation and/or referral question(s), even if the information would benefit the client (Michaels, 2006).

A graduate student once remarked her

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practicum supervisor made her write a diagnosis for everyone. When the student did not find evidence of a disorder, she was encouraged to document an adjustment disorder. This is unethical practice. The most commonly cited reason for misdiagnosis is to facilitate access to services by a third-party payor (Cartwright, Lasser, & Gottlieb, 2017; Kielbasa et al., 2004; Lowe, Pomerantz, & Pettibone, 2007). Research indicates method by which clients pay for psychological services influences the diagnostic decisions made by psychologists. For instance, Kielbasa, Pomerantz, Krohn, and Sullivan (2004) found clients who paid by managed care were more likely to be diagnosed with a *DSM-IV-TR* (American Psychiatric Association, 1994) disorder and were more likely to receive an adjustment disorder diagnosis. Overdiagnosing for insurance reimbursement violates the APA Code of Ethics. Misdiagnosing clients for insurance reimbursement can also result in civil and criminal prosecution for fraudulent practice. Mead, Hohenshil, and Singh (1997) surveyed 334 mental health counselors about their opinions on, and use of, the *DSM* diagnostic system. Over 70% of participants reported believing their clients were deliberately underdiagnosed, at least occasionally, and over 60% believed their clients were overdiagnosed. Although psychologists may be well-intentioned by trying to address a social problem (i.e., difficulties in adequate access to care and services), current managed care systems encourage psychologists to provide a diagnosis early in the course of treatment (Dougherty, 2005). An inaccurate or unnecessary diagnosis can cause more harm than good, particularly for children, and should be prevented (Cartwright, Lasser, & Gottlieb, 2017). Also, the impact of inadequate training on a supervisee is worrisome. Graduate students are encouraged to look to their clinical supervi-

sors for guidance on professional practice. In coursework and training programs, students and trainees should be provided space and appropriate mechanisms for seeking consultation on how to address these professional practice concerns with supervision in a professional and ethical manner.

Appropriate, comprehensive psychological assessment can help inform diagnostic decision-making. Psychologists are tasked with selecting and administering measures that are appropriate for their clients, and discussing the strengths *and* limitations of test results in their interpretations. While there are many assessment tools available to address numerous clinical problems, these tests are not without flaws. It is important for psychologists to examine the psychometric properties of these measures, as well as evaluate the population the test was normed on. The Code of Conduct reads, "Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norm, validity, reliability, and applications of the procedures and any special qualifications applicable to their use" (American Psychological Association, 2017). It is important to recognize the limitations of psychological assessment measures, particularly when clients do not fit within the normative sample. Additionally, this is an important call for researchers and test developers to examine the reliability and ecological or cross-cultural validity of measures through replication studies.

Finally, there have been discussions on whether to share diagnoses with clients. Many psychologists have discussed the importance of covering the implications of diagnosis with clients (Kress, Hoffman, Adamson, & Eriksen, 2013; Phillips, 2013). Kress and colleagues

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(2013) note clients “should have the opportunity to freely determine whether they will agree to receive a diagnosis” (p. 18). While knowing a diagnosis provides some clarity and insight for many clients, there may be some unintended consequences. Diagnosis can affect several aspects of a client’s life, including future insurance coverage, child custody disputes, and employment opportunities (Phillips, 2013). Ultimately, it is important for psychologists to take reasonable steps to discuss the potential implications of assessment and diagnosis on clients.

Areas of Need and Impact

In general, children and adolescents are difficult to diagnosis. Given variability in symptom presentation and short duration and history to assess their symptoms, it can be difficult to determine what symptoms are simply a function of normative adolescent development (Cartwright, Lasser, & Gottlieb, 2017). Psychologists should use extreme caution to avoid misdiagnosing adolescents, as the label can have negative consequences (Michaels, 2006). Labeling has major implications for individuals and diagnoses and treatment recommendations can contribute to the iatrogenic consequences. Diagnoses can be stigmatizing. For instance, if a child is evaluated for a threat or risk assessment in school, administered the Hare Psychopathy Checklist: Youth Version (PCL:YV), and has a score in the clinical range, how do we report those results? What are the implications of those results? I have witnessed reports in which evaluators label this pre-teen explicitly as a psychopath.

Neuropsychological testing and testing for neurocognitive complaints and traumatic brain injuries is often underutilized. However, availability of trained neuropsychologists in certain areas may

be limited. Psychologists must take the appropriate course of action to discuss the limitations of available assessment approaches in providing a diagnosis. Also, psychologists want to be mindful of their own competence to assess for these diagnoses if they do not have the appropriate training and experience. Medical causes for symptoms may also be an area of consideration for appropriate diagnosis. For instance, medical evaluations (including updated physical examinations) may be warranted to rule out medical causes of psychological symptoms or those caused by side effects of certain medications.

Use of skilled interpretators is important for assessment of clients for whom English is not the primary language. Selecting culturally appropriate assessment measures, as well as conducting clinical and diagnostic interviews with the assistance of an interpreter is recommended. The Code of Conduct notes, “Psychologists use assessment methods that are appropriate to an individual’s language preference and competence, unless the use of an alternative language is relevant to the assessment issues” (American Psychological Association, 2017). Some states require interpreters to have advanced training to work in mental health settings; therefore, it is important for psychologists to be aware of legal requirements in the states in which they practice (Boness, 2016). For example, given language problems present among many in the Deaf community, a qualified and culturally competent interpreter is necessary in providing ethical treatment (Boness, 2016). This interpreter would need to be aware of the unique mental health concerns among members of the Deaf community. Lack of knowledge in Deaf culture, understanding of systemic oppression, and appropriate training in cultural and

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linguistic issues relevant to Deaf and hearing impaired individuals has resulted in mistrust of mental health professionals. Continued training in cultural competence in assessment is also recommended in order for professionals to maintain and enhance their skill sets in these important areas of practice.

Lastly, access to resources could become a barrier in providing comprehensive assessment to inform diagnostic considerations. What if you don't have an access to an Arabic translator? What if the nearest pediatric psychologist works two hours away? What if there is limited access to training in assessment for individuals with autism spectrum disorders? Practicing within the boundaries of competence is particularly important in these high stakes contexts, including educational assessments and civil and criminal forensic evaluations (Sackett, Borneman, & Connelly, 2008; Sackett, Schmitt, Ellingson, & Kabin, 2001). Further, as a field we must continue to address these important barriers to access for clients.

Conclusion

Psychological assessment has much to offer in the way of developing diagnostic formulations for clients. Appropriate and accurate diagnosis is needed to prevent labeling and provide proper treatment to clients in need of services. Unethical practice in assessment and diagnosis has major, long-term negative consequences. Therefore, psychologists must be mindful of the strengths and limitations of assessment and diagnostic opinions in their practice and written work.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders—text revision*. (4th ed.). Arlington, VA: Author.

American Psychological Association.

(2017). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/>

Belar, C. D. (2009). Advancing the culture of competence. *Training and Education in Professional Psychology*, 3(4), S63-S65. doi: 10.1037/a0017541

Boness, C. L. (2016). Treatment of Deaf clients: Ethical considerations for professionals in psychology. *Ethics & Behavior*, 26(7), 562-585. doi: 10.1080/10508422.2015.1084929

Cartwright, J., Lasser, J., & Gottlieb, M. C. (2017). To code or not to code: Some ethical conflicts in diagnosing children. *Practice Innovations*, 2(4), 195-206. doi: 10.1037/pri0000053

Dougherty, J. L. (2005). Ethics in case conceptualization and diagnosis: Incorporating a medical model into the developmental counseling tradition. *Counseling and Values*, 49, 132-140.

Kielbasa, A. M., Pomerantz, A. M., Krohn, E. J., & Sullivan, B. F. (2004). How does clients' method of payment influence psychologists' diagnostic decisions? *Ethics & Behavior*, 14(2), 187-195.

Kress, V. E., Hoffman, R. M., Adamson, N., & Eriksen, K. (2013). Informed consent, confidentiality, and diagnosing: Ethical guidelines for counselor practice. *Journal of Mental Health Counseling*, 35(1), 15-28.

Lowe, J., Pomerantz, A. M., & Pettibone, J. C. (2007). The influence of payment method on psychologists' diagnostic decisions: Expanding the range of presenting problems. *Ethics & Behavior*, 17(1), 83-93.

Mead, M. A., Hohenshil, T. H., & Singh, K. (1997). How the DSM system is used by clinical counselors: A national study. *Journal of Mental Health Counseling*, 19(4), 383-401.

Michaels, M. H. (2006). Ethical considerations in writing psychological assessment reports. *Journal of Clinical*

continued on page 71

- Psychology*, 62(1), 47-58. doi: 10.1002/jclp.20199
- Mojtabai, R., & Olfson, M. (2011). Proportion of antidepressants prescribed without a psychiatric diagnosis is growing. *Health Affairs*, 30(8), 1434-1442. doi: 10.1377/hlthaff.2010.1024
- Phillips, D. G. (2013). Clinical social workers as diagnosticians: Legal and ethical issues. *Clinical Social Work Journal*, 41, 205-211. doi: 10.1007/s10615-013-0444-3
- Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association. *American Psychologist*, 47(3), 397-411.
- Sackett, P. R., Borneman, M. J., & Connelly, B. S. (2008). High stakes testing in higher education and employment: Appraising the evidence for validity and fairness. *American Psychologist*, 63(4), 215-227. doi: 10.1037/0003066X.63.4.215
- Sackett, P. R., Schmitt, N., Ellingson, J. E., & Kabin, M. B. (2001). High-stakes testing in employment, credentialing, and higher education: Prospects in a post-affirmative-action world. *American Psychologist*, 56(4), 302-318. doi: 10.1037/0003-066X.56.4.302



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EDUCATION AND TRAINING

Growing Pains: The Professional Development of Psychology Trainees in Supervision

Joseph S Nijmeh, MS

Justin A. Davich, MS

Hannah R. Saltzman, BA

Palo Alto University



Introduction

Supervision is a crucial aspect of training and psychology trainees gain many benefits from it (Hook, Watkins, Davis, Owen, Van Tongeren, & Ramos, 2016). The supervisors' actions guide the psychology trainees to help them increase their treatment knowledge and improve their abilities to apply that knowledge (Wrape, Callahan, Ruggero, & Watkins, 2015). Supervision is defined as a professional working relationship between a more experienced member and a less experienced member of the same profession (Wheeler & Richards, 2007).



The supervisory relationship is the foundation that helps psychology trainees develop professionally. What occurs during supervision helps the psychology trainee be better prepared and more effective when conducting psychotherapy in the psychotherapy session (Watkins, 2011). Although the majority of the research is in agreement that supervision benefits trainees, there is no clear consensus about which aspects are the most beneficial (Watkins, 2017).

Every supervisor is unique. Different supervisors identify with different

theoretical orientations, utilize different training approaches, and develop distinct relationships with each of their trainees. What are the specific actions or aspects of the supervisory relationship that lead to psychology trainees' growth as professionals? This question is geared at helping both the supervisor and the trainees learn from the supervisory process. Although each individual supervisory relationship is unique, many benefits that trainees gain from supervision can be generalized. In this article, three PhD psychology trainees describe their respective supervisor's actions and the impact these had on their professional development.

Case Example 1: Challenging the Trainee to Grow With the Use of Video Recordings

In the first case example, the psychology trainee worked in a community mental health clinic. Of the many clients this trainee treated, one client in particular stood out (she has been de-identified to protect confidentiality). She was an African American female in her 20s with a serious mental illness, housing insecurity, poor interpersonal relationships, and moderate substance use issues. The client was often hypomanic and displayed pressured speech with tangential thought patterns. As the client struggled with multiple clinical concerns, she often brought up different worries in every session. This one client over-

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whelmed the trainee more than his other three clients combined. During the sessions, the trainee felt like a deer in headlights and the supervisor was essential in guiding him over this hurdle.

The supervisor was able to simultaneously support and challenge the supervisee to help him improve his self-awareness, treatment knowledge, and therapeutic abilities. During supervision, the supervisor and trainee reviewed video recordings of his therapy sessions. After the third week, it was clear to the supervisor that the trainee was stuck. After reviewing the video session, the supervisor and supervisee discussed the student's specific actions, thought process, and perceived challenges. She recognized his use of empathy, reflective listening, and his supportive demeanor, but she knew he was capable of doing more. She challenged the trainee by being direct and telling him to do more in the session. At first this advice was difficult for the trainee to hear, but he recognized that he needed to hear it. The supervisor then challenged the trainee to conceptualize all of the client's clinical concerns and appropriate therapeutic techniques, and to formulate a treatment plan. The trainee learned far more by being the lead in the treatment planning, instead of the alternative of having the supervisor dictate every aspect of the treatment.

In the following supervision sessions, the supervisor and trainee would review his video recorded therapy sessions. The two would then collaboratively evaluate the therapeutic techniques he had attempted and how these related to the treatment goals. Then they would discuss the trainee's thought process during the session, his concerns, which aspects of the therapy were executed well, and which areas needed improvement. While watching the tape, the supervisor would also make some

behavioral observations of which the trainee was unaware, but that had impacted the effectiveness of his sessions. The trainee used too many hand gestures and was verbose. Just as the supervisor was direct with asking the trainee to do more in the session, she was direct in sharing her observations as well. The therapist would then challenge the therapist to role play with her and practice being more concise in his speech and hand gestures. These minor changes appeared to have a major impact in his therapy sessions. Although the supervisor challenged the therapist to grow as a clinician, she was consistently warm and supportive throughout the process.

With the utilization of video recording of the psychology trainee's psychotherapy sessions, the supervisor had a positive impact on the trainee's professional development. The trainee was able to increase his own self-awareness and improve his therapeutic abilities. Through the supervisory relationship, the trainee was also able to improve his professional relationships with his clients and his clients demonstrated improvements in their treatment outcomes. The psychology trainee never enjoyed watching his video recorded sessions, even when he was being praised by the supervisor. Although the trainee always felt apprehensive while watching his videos, he cannot deny the benefits he received from doing so.

Since the early 1960s, supervisors have used video recordings of their supervisees as a training tool for supervision (Huhra, Yamokoski-Maynhart, & Prieto, 2008). Some benefits of using video recording include helping improve the supervisee's self-awareness in the therapy

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room and helping the supervisor better assess the supervisee's abilities in the therapy sessions (Huhra et. al., 2008). With videos, the supervisor and trainee can analyze specific moments in the therapy, which helps the trainee recognize both the strengths and weaknesses in the session (Huhra et. al., 2008). After strengths and weaknesses are identified, the supervisor can help reinforce those strengths and improve on the weaknesses.

Case Example 2: Actively Learning With the Use of Role-Play

The following case example involves a supervisor at an integrated VA health-care setting who was influenced by cognitive behavioral theory, positive psychology theory, and a coping framework. At this practicum site, the trainee learned how to use technology (i.e., mobile applications such as Virtual Hope Box, Adobe Spark Video, Breathe2Relax, ACT Coach, and PTSD Coach) to augment therapy with older clients who experienced complex problems relating to medical issues, severe mental illness, and cognitive impairment (e.g., dementia). Much of the supervision process consisted of opportunities for professional development (i.e., inter-professional collaboration), case presentations, and role plays. The supervisor was effective at finding the trainee's areas of interest and using these to assist him in learning more about the population that they served, as well as demonstrating to the trainee how to use a specific technology to assist in the therapy session.

During supervision, there were role plays in which he was the therapist; in others, he would be the client. The trainee was grateful to have been in both roles, so that he could learn from practice, as well as learn how the client may feel on the receiving end of therapy.

Seeing specific and tangible explanations given by the supervisor as the mock therapist in the role play provided the trainee a foundation from which to build in his own work with clients. There were many moments during role plays in which the supervisor demonstrated how to use the mobile applications creatively in his work with clients.

One example involved the psychology trainee's inability to utilize the Adobe Spark Video application to assist a particular client with adversarial growth. When he discussed this barrier with the supervisor, the supervisor assumed the role of the therapist in a role play and directed the trainee to be the client. He began asking the trainee questions about the client's interests, work history, and hobbies. The supervisor went on to use what the trainee had said to develop a creative analogy that connected not only the client's interests/hobbies and place of employment, but also the client's adverse experience. After the role play, the supervisor explained how to use the information to create a slideshow in the Adobe Spark Video application. The supervisor then advised the trainee to collaboratively improve the slideshow with his client. This supervision process assisted the trainee in successfully using the technology to benefit his clients. This knowledge will stay with the trainee as he continues in his professional endeavors as a clinician.

Role playing has many benefits in the supervision process. Research supports that it provides an opportunity for direct observation and is an important element in developing competency in the provision of therapy (Weck, Kaufmann, & Witthöft, 2017). Role plays offer a supervisor the opportunity to directly observe the trainee's therapeutic

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competencies and provide constructive feedback. Furthermore, research shows that effective supervisors use role plays as a form of interactive and experiential practice for the development of therapeutic skills (Falender & Shafranske, 2014). This particular supervisor was the only one of the trainee's supervisors who incorporated the use of role plays into the individual supervision process. The supervisor was effective in using this form of interactive and experiential practice and provided the trainee with sufficient tools to be successful in his work with his clients. His actions will have an enduring impact on the trainee's professional development. Not only did supervision help the trainee improve his clinical skills, it also helped him experience the positive impact of having a competent supervisor. This demonstrated for the trainee a valuable and effective training tool, role plays, that he may implement in his future role as a supervisor.

Case Example 3: Navigating Your Way to a Theoretical Orientation

This last case example illustrates both the daunting and appealing task a trainee will be faced with when choosing a theoretical orientation. Theoretical orientations are the frameworks clinicians employ to navigate their analytical minds. Case formulations, cultural formulations, and treatment plans will be influenced and shaped by one's theoretical orientation (Herbert, 2000). Yet, there is little guidance or research for clinicians in training regarding how to navigate the process of choosing a theoretical orientation (Heffler & Sandell, 2009; Spruill & Benshoff, 2000). This choice can shape a clinical career and trainees feel the weight of this decision. Most clinicians in trainings will adopt their supervisor's orientation while working under that supervisor's license. However, a select

few will have the opportunity to explore orientations of their choice, perhaps with additional supervision.

One trainee was given the opportunity to explore a theoretical orientation of her choice early on in her training. The trainee's supervisor provided her the space to explore a different orientation with one caveat. The trainee needed to articulate a clear and clinically sound reason why her theoretical orientation of choice was more beneficial to the client. Knowing she might be faced with such a decision, the trainee started to think about what theoretical orientation she had found most impactful during her training so far.

As the trainee started working with a new client, it was evident that her supervisor's theoretical orientation would not be most beneficial to employ. The trainee asked her supervisor what theoretical orientation she should adopt with this new client. The supervisor stated it was up to them to figure it out. It was in this moment that the trainee felt the weight of power and responsibility. To pick the most appropriate, clinically sound approach, the trainee had to both decide what she believed in as well as keep in mind how the client understood the world. The trainee felt she had to make a thoughtful decision in order to satisfy her supervisor's request, but also to ensure the client was receiving the most beneficial care. Such a choice should be made cautiously, as some have argued that clinicians who choose an orientation based on a specific client's needs may fall into the trap of randomly selecting before finding evidence that supports the efficacy the intervention (Corey, 2004).

The opportunity the trainee was presented with provided her with the chance to avoid haphazardly choosing
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an orientation. The supervisor's criteria for exploration allowed the trainee to delve into an orientation before committing to years of specialized training. Many factors have been noted to influence a trainee's choice of theoretical orientation, including personality, exposure to certain training styles, practicum sites, and supervisors (Petko, Kendrick & Young, 2016). In this case, the trainee chose to pursue a theoretical orientation to which she had been exposed during a conference. It piqued her interest because it reflected many of the ways she navigated her personal life. The trainee was able to dedicate time to exploring her values and beliefs by researching this theoretical orientation. Ultimately, the trainee discovered the theoretical orientation was helpful for the client, but was not an approach she wanted to specialize in. It must be noted that the trainee was grateful because she was able to actively engage with the theoretical orientation, as opposed to simply learning about it.

The complex process a trainee undergoes when choosing a theoretical orientation is reflected in the literature (Arthur, 2001; Buckman & Barker, 2010; Heffler & Sandell, 2009). This choice can shape a clinical career and trainees are aware of the importance of this decision. Some trainees will be pressured to find a theoretical orientation that reflects their worldview, beliefs, and values without given the time or resources to do so (Spruill & Benshoff, 2000). For this reason, clinicians in training are urged to take advantage of all opportunities that will allow them to be exposed to a variety of different theoretical orientation before making their choice. Trainees should also keep in mind that their decisions are not lifelong commitments and can be deviated from if need be. If a supervisor provides you the support to try something new, even if it does not

match your current path, take up the offer—you never know what you might learn about yourself.

Conclusion

The supervision process is an essential aspect of the psychology trainee's professional development. It is an opportunity for the trainee to learn from the experience and knowledge of their supervisor. The actions that the supervisor takes during supervision have the potential to have long lasting positive impacts on the professional development of the trainee, as demonstrated by the three trainee experiences described above. Each of the trainees continues to learn from the experience they had with their supervisor, and it is hoped that others may benefit from their testimonials, as well. It is important for supervisors to be cognizant about the rationale for their actions and to think through the potential impacts on their trainees. It is also essential for the psychology trainees to be aware of their supervisors' actions and how these impact their own development. After all, today's trainee may well be another trainee's supervisor in the future.

References

- Arthur, A. R. (2001). Personality, epistemology and psychotherapists' choice of theoretical model: A review and analysis. *European Journal of Psychotherapy and Counselling*, 4(1), 45-64. doi:10.1080/13642530110040082
- Buckman, J. R., & Barker, C. (2010). Therapeutic orientation preferences in trainee clinical psychologists: Personality or training? *Psychotherapy Research*, 20(3), 247-258. doi:10.1080/10503300903352693
- Corey, G. C. (2004). *Designing an integrative approach to counseling practice*. Retrieved from <https://www.>

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-
- counseling.org/resources/library/VI STAS/vistas04/29.pdf
- Falender, C. A., & Shafranske, E. P. (2014). Clinical supervision: The state of the art. *Journal of Clinical Psychology, 70*(11), 1030-1041. doi:10.1002/jclp.22124
- Heffler, B., & Sandell, R. (2009). The role of learning style in choosing one's therapeutic orientation. *Psychotherapy Research, 19*(3), 283-292. doi:10.1080/10503300902806673
- Herbert, M. (2000). Clinical formulation. In T. Ollendick (Ed.), *Comprehensive Clinical Psychology* (Vol. 5, pp. 38-52). Oxford, UK: Elsevier Science.
- Hook, J. N., Watkins, C. E., Jr., Davis, D. E., Owen, J., Van Tongeren, D. R., & Ramos, M. J. (2016). Cultural humility in psychotherapy supervision. *American Journal of Psychotherapy, 70*(2), 149-166.
- Huhra, R. L., Yamokoski-Maynhart, C. A., & Prieto, L. R. (2008). Reviewing videotape in supervision: A developmental approach. *Journal of Counseling & Development, 86*(4), 412-418. <http://dx.doi.org/10.1002/j.1556-6678.2008.tb00529.x>
- Petko, J. T., Kendrick, E., & Young, M. E. (2016). Selecting a theory of counseling: What influences a counseling student to choose? *Universal Journal of Psychology, 4*(6), 285-291. doi:10.13189/ujp.2016.040606
- Spruill, D. A., & Benschhoff, J. M. (2000). Helping beginning counselors develop a personal theory of counseling. *Counselor Education and Supervision, 40*(1), 70-80. <http://dx.doi.org/10.1002/j.1556-6978.2000.tb01800.x>
- Watkins, C. E., Jr. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor, 30*(2), 235-256. <http://doi.org/10.1080/07325223.2011.619417>
- Watkins, C. E., Jr. (2017). How does psychotherapy supervision work? Contributions of connection, conception, allegiance, alignment, and action. *Journal of Psychotherapy Integration, 27*(2), 201-217. <http://dx.doi.org/10.1037/int0000058>
- Weck, F., Kaufmann, Y. M., & Witthöft, M. (2017). Topics and techniques in clinical supervision in psychotherapy training. *The Cognitive Behaviour Therapist, 10*(e3), 1-17. doi:10.1017/S1754470X17000046
- Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7*(1), 54-65. <http://doi.org/10.1080/14733140601185274>
- Wrape, E. R., Callahan, J. L., Ruggero, C. J., & Watkins, C. E., Jr. (2015). An exploration of faculty supervisor variables and their impact on client outcomes. *Training and Education in Professional Psychology, 9*(1), 35-43. <http://dx.doi.org/10.1037/tep0000014>
-

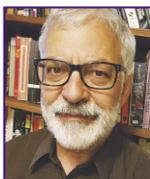


The Cultural Climate of Clinical Training: Showing Up or Hiding Out

Judith Fox, PhD

Michael Karson, PhD, ABPP (Clinical)

University of Denver



Freud (1913) invented the application of self-reflection to psychotherapy by making himself the subject and the object of the first therapy. He used one of his own dreams as the specimen dream in his breakthrough book, *The Interpretation of Dreams*, because it was in thinking about this dream that his early ideas came into focus. Ironically, and tellingly, the dream itself was about the loss of status that comes from identifying with patients rather than with doctors (Karson, 2008). Thus, for precisely as long as there has been a clinical profession in the contemporary sense of the phrase, there have been quandaries about the courage needed to apply one's psychology to oneself and about the status issues involved in wearing the doctor cloak instead of personhood.

Such quandaries also complicate the supervisor-trainee relationship. While there is an expectation that both supervisor and trainee "show up" authentically for supervision and openly engage in self-reflection, they may experience a bind about doing so. We provide examples of ways in which trainees may manifest this bind in supervision, explore how the supervisor and broader training culture co-create this bind, and end with recommendations for enhancing the possibilities of showing-up in supervision.

Therapist Self-Reflection and Personhood

Supervisors highly prize openness and self-reflection in supervisees. Indeed, one of the common measures of a therapist's clinical competence as well as suitability for advancing in clinical training as a student in training is self-reflective practice (Falander & Shafranske, 2004; Fouad et al., 2009; Ladany & Inman, 2012). Further, life-long learning in advancing clinical skills is thought to hinge on the therapist's ability to self-reflect (Falander et al., 2004; Orchowski, Evangelista, & Probst, 2010).

The Relational-Competency model of supervision emphasizes that learning and demonstrating self-reflection requires supervisory relationships where trainees authentically engage, presenting their work and themselves openly for consideration, and allowing for useful feedback to be heard and integrated (Mangione & Nadkarni, 2009; Watkins, Budge, & Callahan, 2015). Feedback not only comments on therapeutic technique, it involves discussing and commenting on ways in which trainees co-create relationships with clients (and supervisors) in both facilitative and complicating ways. Showing up for supervision requires that trainees not only show themselves and their work, but that they engage in supervisory relationships where they tolerate considering feedback about both.

The therapist's personhood is a critical

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component of positive outcomes in treatment (Blow, Sprengle, & Davis, 2007; Kissil & Claudio, 2015) and needs examination in supervision (Aponte et al., 2009; Kissil & Claudio, 2015). Desirable therapist characteristics include such traits as positive interpersonal skills, empathy, warmth, and personal fit with theoretical orientation (Ackerman & Hilsenroth, 2003; Castonguay & Beutler, 2006; Lambert & Barley, 2002; Norcross, 2002). Beyond commenting upon the performance of these traits in supervision, supervisors must identify personal vulnerabilities (or “signature themes”) that are life-long (Aponte, 2014; Stone, 2008 in Aponte).

While some supervisors might view personal struggles or vulnerabilities as necessarily requiring resolution in order to practice competently, the inclusion of the therapist’s “self” as a powerful tool in therapy is embraced by others in order to maximize their conscious and productive use (Aponte, 2014). In this inclusive approach, the full person of therapists, and their personal vulnerabilities in particular, are the central tools through which therapists do their work in the context of the client–therapist relationship (Aponte et al., 2009). The courage to authentically show one’s personhood in supervision must be present for training of this nature to occur, and this courage will no doubt be influenced by multiple, interacting contexts that support or hinder it, including the quality of the supervisor-supervisee relationship (Bernard & Goodyear, 2014; Bordin, 1983).

The Cultural Norms of Clinical Training and the Co-created Dynamics of Stigma

While a culture of self-reflective practice may promote openness or “showing up” in supervision, the dynamics of stigmatization may promote impression manage-

ment or “hiding out.” Stigma is a socially-constructed mark of disgrace or discredit that invalidates the individual’s efforts to play a role (Goffman, 1963). This is a mark that distinguishes someone as different from others, as unsuitable to the role, eliciting negative judgment and bias against those with that “spoiled” identity element. Stigma may be public or self-imposed (Corrigan, 2004), a public endorsement of prejudice against a stigmatized group, versus the individual’s internalization of the public’s devaluing and discriminatory social construction. In a training environment where the press is to be open, but the concern about evaluation is present (perhaps for both student and supervisor), the fear of being discredited may lead to the hiding of personal identities, at least until the cultural norms are learned about what discredits the role of therapist.

Supportive, empathic relational bonds are essential to both therapeutic outcomes and supervisory ones (Angus & Kagan, 2007; Bernard & Goodyear, 2014; Bordin, 1983; Orchowski et al., 2010;). Showing up as a client in therapy involves the challenges of revealing oneself within a co-created therapeutic relationship influenced by intrapersonal, interpersonal, and systemic factors that may facilitate or detract from authenticity (Fox, 2012). With clients, the challenges of showing-up are the very meat of psychotherapy.

Unlike psychotherapy, supervision involves close monitoring and evaluation of trainees, complicating the cultural expectation in supervision that you talk about yourself (Barnett & Molzon, 2014). As an evaluator, the supervisor has significant power over the fate of the trainee to proceed in their training. The expectation to show one’s personhood may inherently promote a sense of needing to

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show the “right” personhood, a personhood that will be deemed acceptable and even, exceptional by the supervisor. The more that the cultural training environment elucidates specific factors related to acceptable trainee traits, the options for showing aspects of one’s personhood may decrease. Instead of the trainee showing up authentically for supervision, the cultural press may be to perform only culturally-sanctioned traits while hiding others. One example of a fear to reveal personhood might be related to the trainee’s concern about personality styles or qualities revealed in supervision as being deemed unacceptable by the cultural values of the training program. For example, while warmth and empathy are highly esteemed attributes of the therapist (Ackerman & Hilsenroth, 2003; Castonguay & Beutler, 2006), being “real” in supervision may look very different when the student is not in the therapist role. Traits involving anxiety, introversion, self-consciousness or even self-preoccupation in the supervisory relationship may evoke concerns that these traits appear with clients.

Indeed, supervisees may not disclose or may selectively discuss their work to make a positive impression on the supervisor (Ward, Freidlander, Schoen, & Klein, 1985). Further, even in relationally-focused, feminist supervision the overt discussion of the dynamics of power in supervision was found to be a rarity (Mangione et al., 2009), suggesting that power dynamics, and the consequent tendency to engage in impression management, may be present in supervisor-supervisee relationships even though collaboration and authenticity may be stressed by the supervisory approach.

In the following section we offer a few examples that illustrate ways in which the dynamics of co-created stigma may

operate to promote supervisee inauthenticity, and some ways in which supervisors might facilitate authentic supervisory relationships.

Co-constructing Stigmatization in the Supervisor-Trainee Relationship

1. Trying to stay off the radar.

Supervisory Vignette:

Students in a clinical psychology training program talk with their faculty member supervisor in one of their seminars. Momentarily forgetting her status as one of “them” (the faculty) and not “us” (the students), they lament the approaching evaluation period. “It’s just important to stay off the radar. Once you’re on the faculty’s radar, it’s all over,” the group collectively agreed. Taking the discussion further, the faculty member asks them about what they fear the radar would detect. The sentiment is revealed that once any problems (personal or performance) are identified, the assumption of incompetence follows. Further, “problems” may often be experienced as individual differences where the concern is that differences (behavioral or internal) may not fit into the expected norm of the faculty member who would thereby deem them incompetent (not like her). It is safest to avoid making any impression that might be commented upon.

This pattern is self-perpetuating for both faculty and students. In clinical training programs, as elsewhere, people are cautious about revealing their backstage thoughts, histories, or personal or relational differences for fear of becoming stigmatized (Karson, 2008). Those who can keep up a facade that simulates the norm do so, while others may be found out (or fear being found out) as deviat-

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ing in some way. The price of deviation is high when the fear is related to stigmatization. For students facing evaluation by their supervisors, they fear that negative evaluation may leave them in the "out" group, defenseless and at risk for not obtaining their degree.

The approach to commenting on trainees' personal psychology as it affects performance may contribute to the tendency for trainees to be motivated to stay off the radar and engage in impression management. These supervisory methods of giving feedback may likewise reinforce the status differential in a way that creates concern or, even, fear of evaluation. For example, although supervisors have thoughts along the way about the personal psychology and work of their trainees, they may save such feedback for an evaluation meeting in the future, rather than making comments along the way. Indeed, supervisors have been found to have difficulty discussing negative as opposed to positive impressions of supervisees' work in supervision (Hoffman, Hill, Holmes, & Freitas, 2005). Having useful, evaluative thoughts about the performance and personal psychology of the trainee, but not revealing them, adds to the experience of the supervisor as maintaining a below-board, hidden style of relating where her authentic self is kept out of the relationship. Supervisor authenticity, of course, includes the supervisor's personal psychology, and this is revealed in the moment-to-moment connection with the trainee. Keeping one's reactions out of the supervisory interaction decreases connection and maintains one's status as an evaluator with secrets and power, and supervisors sharing reactions and reflections have been found to promote supervisee engagement, disclosure and self-reflection (Orchowski et al., 2010). A culture in which evaluative comments are kept under wraps until a formal

evaluation is one in which the trainee wonders what the content will be, potentially strengthening the tendency to hide out.

2. *Having negative reactions to clinical sessions and/or the supervisory relationship.*

Supervisory Vignette:

Feeling overwhelmed and angry about the hours of work in his training program, Matt sat down with his supervisor who was fidgeting with his pen, something that Matt found to be very annoying. In a frustrated tone of voice, Matt told him how much coming to supervision weekly made his schedule intolerable and wondered if they could meet bi-monthly instead. "I'm not really enjoying seeing the clients you supervise. I think you'd agree it's not very interesting; nothing happens so we don't have much to talk about." Although the supervisor may have felt like decreasing meetings with Matt, he didn't. Concerned about Matt's irritability and general instability, he brought the situation up to colleagues in the faculty meeting for consultation, and then met with Matt to discuss his behavior in their last meeting. Feeling called on the carpet, Matt said angrily, "I was just being real, but obviously faculty can't handle that."

The concern about the identification of a personal vulnerability, and consequent stigmatization, may come up in discussing personal reactions to clients or supervision sessions even though this is a clearly stated goal of supervision. The press to be "real" in supervision is complicated and, at times, confusing for all concerned. Further complicating the picture is a goal of supervision, to examine the co-constructed relationship between therapist and patient partly by looking

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at the supervisees' experience of the client and themselves in their relationship. This stands true for the co-constructed supervisory relationships as well but may be complicated for trainees who are evaluated as well as for supervisors operating in an evaluative collegial context. Not only have supervisors needed to have experience risking professional stigmatization in their collegial context (by showing their personal self), they need to participate in a supervisory relationship in ways that permit students to explore personal reactions and behaviors that fall within and without professional "norms," for that is the nonjudgmental intimacy that they attempt to co-construct with their clients. The academic climate may encourage and promote faculty "showing-up," or, alternatively, advance a clear cultural norm for "acceptable" behavior. A student's anxiety is heightened when she is taught to discuss personal reactions in supervision while sensing the supervisor's/faculty's ambivalence about taking off the doctor's cloak.

In the vignette above, the supervisor might take off his cloak and add, "I've thought about my contribution to the atmosphere between us, including my confusion about how stuck the therapy with your client seems to be. Perhaps my pen-clicking is a sign or illustration that there is also something difficult between us. Let's look at the case and our interaction and see what we can make out of it." But such a statement, like the mutual examination of co-constructed problems in therapy, requires a supervisor willing to acknowledge having a psychology and willing to relinquish the posture of superiority.

3. Experiencing stigmatization while presenting authentically.

Supervisory Vignette:

"I just wanted to wring his neck,"

said the student about a father engaging in emotionally abusive behavior with his 7-year-old son. "It reminded me of the rage I felt at my own father whose temper was scary and dangerous." The student began to cry, feeling so sad and scared for the boy she was treating, and for herself. Taken aback by the personal, family content to do with her wanting to "wring the neck" of this parent, the supervisor was concerned about this student's mental health status. The supervisor wasn't sure how to respond. Sensing her supervisor's anxiety, the student quickly wiped her eyes and became more composed, thinking she had just been totally inappropriate.

In the confusion about wearing or not wearing a cloak, both supervisor and student are left to interpret the interaction. The student felt ashamed and potentially stigmatized by her sudden revelation of her personal history and its place in her treatment of this family, and the supervisor questioned whether the revelation suggested emotional problems on the part of the student, or insightful strengths.

Rather than seeing the training opportunities available when students sense familiarity and pain associated with a client's behavior or background, supervisors may experience anxiety not knowing enough to be able to deem the pain as pathological or resilient or merely informative. Clearly, students sense this balance beam of stigmatization and pathology versus acceptance and/or perceived resilience when supervisor anxiety is expressed, and they worry about on which evaluative side they will land. Rather than walk the beam, impression management may be far more appealing.

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In this example, the supervisor might have turned the moment into a lesson on how to tell the difference between what might be called a neurotic pattern, in which the individual uses an outdated map that interferes with her functioning, and what might be called a characterological pattern, in which the individual uses the only map she knows. A key element of the discrimination might be the student's awareness or lack of it that her client's father might or might not be like her own father in important ways, with the supervisor in the position to help the student with the natural tendency to react to new people (clients) with old expectations.

4. *Experiencing life-stresses and emotions as a barrier to competence.*

Supervisory Vignette:

Amy slinked into supervision having just signed divorce papers. Feeling a failure in her marital relationship, she had no clue how she could present the couple's work she was doing in supervision, let alone do it. On top of that, she needed to look for part-time work to help support herself through graduate school and was worried that she would be viewed by faculty as having a lack of focus and commitment to her school work. She would need to change her supervision time to accommodate a new job. Describing these circumstances, she became even more disillusioned about herself when her faculty supervisor said, "This must be a lot to handle. Perhaps you should consider taking a break from school right now to get things on track? Do you think this might be negatively affecting your ability to focus in sessions?"

Stressful life events and/or personal vulnerabilities in the throes of clinical training may be difficult to reveal, par-

ticularly if emotional energy for training is drained. Students in training may perceive themselves as failing if they "succumb" to the stresses of life events, and if these events are so emotionally challenging that their work is affected. The idea that one's personal psychological health, or lack thereof, may be subject to examination and stigmatization may inhibit discussing these factors in supervision. While some life stresses may be ones that can be compartmentalized so that work with others continues unaffected, others may not be. This is a lesson particularly important to learn in graduate training, since the avoidance of compromised practice depends upon making solid judgments about one's psychological capacity to work with others (Schoener, 2013).

Faculty, however, may succumb to the same stigmatizing notions as the general public and stigmatize trainees who experience negative life events and, even, some mental health symptoms (Corrigan, 2004), fueling a tendency for trainees to fail to mention these in supervision. Highly stigmatizing life events and consequent emotional symptoms such as depression may lead to self-stigma and a sense of shame and blame. Events like these are especially stigmatizing in clinical training. Goffman (1963) says that a stigma is information that discredits an individual's performance of a role, usually the role of a normal or fully authorized group member. Clinicians are supposed by some to be experts on relationships and families, and an event such as a divorce can discredit that expertise. Further, life circumstances assumed to be stressful, such as going to graduate school at the same time as raising a family, tend to raise questions about the student's ability to manage therapeutic relationships

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competently. The thought here is, perhaps, that when life is taxing there's not enough left to invest in therapeutic relationships or psychotherapy training.

The tendency for faculty to become braced when hearing of life events, rather than embracing these life circumstances as a normal part of development and grist for the training mill, may co-create the conditions that the best course is to hide that one has a personal life at all. These issues may also be present for faculty, who may feel they need to disguise problems in their personal lives from colleagues for fear of being discredited. Amy's supervisor might have discussed with her strategies for managing her sense of failure and her distractibility before raising questions about whether these were manageable at all and, even, disclosed times when she herself had experienced life-stresses being difficult and getting in the way.

5. *Having an expectation of premature competence.*

Supervisory Vignette:

Audrey called her supervisor after a confusing session to say that she wanted to see the client again before meeting for supervision. She indicated feeling confused about a presentation of highly discrepant information from the client including such facts as place of birth and marital status. Audrey said that she wanted to get the "real story" on the client before presenting her in supervision and that more time with the client would be helpful.

Another common presentation of hiding out in supervision involves the real or perceived idea that clinical competence is expected by oneself and/or others (faculty) from the get-go. Most graduate students have experienced significant academic success prior to their graduate

training, showing a high degree of competence to perform academically. The competition in graduate admissions may also lead to an overabundance of graduate student applicants who have high self-expectations that involve immediate performance excellence in graduate school. While many of the same skills may be applied to their academic coursework and confirm these performance expectations, the skills required for clinical work are unlike listening to lectures, writing academic papers, or taking tests. Many trainees have been praised all their lives for even modest attempts in various fields, leading to participation medals and graduation ceremonies from kindergarten. Many trainees have not been exposed to the rewards and frustrations of delayed reinforcement where learning new skills is involved. Having self-expectations of excellence may stigmatize taking a long time to learn a difficult skill, which may in turn lead to a variety of ways of hiding out in supervision. This may take the form of the trainee acting overconfidently, counterdependently, and avoidantly with respect to supervisory relationships. In this way, internal distress related to not knowing is masked by a presentation of already knowing and not needing supervision. Ironically, this can lead trainees to avoid supervisors they think might make them feel ignorant. Similarly, supervisors who may feel uncomfortable revealing their own mistakes or lack of knowledge may fuel the co-creation of supervision avoidance.

Additionally, many graduate training programs institute a competency examination wherein trainees display their "competence." While the timing of this is specific to the training program, it may be given as early as the end of the second year. The very name of this examination suggests something that is truly unattainable so early in one's train-

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ing but implies the attainment of competency to practice psychotherapy, something that most seasoned therapists would indicate takes many years (Barnett, 2009).

6. *When there may be something to hide.*

Supervisory Vignette:

Anna presents two seemingly conflicting scenarios when explaining her failure to call her child client's parent back to answer a question. A few weeks earlier, she had reported a confusing explanation of the lack of completed paperwork in her client's file. This time, the student explains to the supervisor her thoughts about the clinical benefits to the parent of keeping the boundaries of their contacts to their already scheduled parent meeting. When the supervisor inquires about her thinking on this, the student senses the supervisor's disapproval. She becomes concerned about the quality of her explanation and expresses concern that this parent is disengaging from treatment and will only talk with her on the phone. Because of her performance anxiety and sense of mistrust, the student struggles to come up with the "right" answer that will satisfy the supervisor who, she hopes, will ultimately retreat from exploring what was probably a mistake. Whether this hiding-out is related to trainee psychopathology or a cultural environment that stokes a sense of dangerousness to show-up is difficult to tease out.

When hidden clinical practices and/or professional behaviors reflect a level of deviance from the training program's cultural norms, they may reflect unethical or pathological behavior on the part of the student. They also may reflect personal vulnerabilities (such as a history of

trauma and/or difficulties in psychological functioning) that, for concerns of stigmatization, have been left unexplored in supervision as to their relevance to the trainee's work with a particular client (Kern, 2014). Untangling the dynamics of personal psychopathology and/or personal vulnerabilities from the cultural dynamics of the training environment is a formidable task. Specifically, are trainee difficulties in clinical performance hidden for personal pathological reasons, or are they hidden because of a fear of shame, humiliation, and/or punishment fueled by real and perceived environmental circumstances?

Anna's supervisor might use the moment as a lesson in the difficulties in obtaining useful information across a power differential. The supervisor can make explicit what can be learned about clients' caution in revealing themselves to therapists by examining Anna's concern about what will become of any information she reveals. If good therapists wonder with their clients what they might do to make showing-up in therapy more likely, good supervisors do the same with supervisees.

Promoting Authentic Engagement in Clinical Training

1. *Articulating the mutual goal of showing-up.*

Showing-up in supervision is largely dependent on the sense of safety and security in the trainee-supervisor relationship, although there is often much confusion about what the supervisee is supposed to be safe *from* (many trainees think it's criticism!). Expecting a trainee to immediately show her personhood would be unrealistic given the complicated cultural factors involved in the trainee-supervisor relationship. Indeed, Goffman (1963) teaches us that new roles are more easily discredited than

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those with which the performer and audience have a history. Just as is true in psychotherapy relationships, a trainee-supervisor bond takes time to develop. This bond requires an initial articulation of the goals of supervision, with one goal being an examination of the trainee's personhood as this interacts with her work with clients. Without this expressed and agreed-upon goal being commented upon, showing up and revealing one's clinical work may be experienced as a sign of failure and embarrassment rather than one constant and important intention of supervision. Beginning supervision by asking the trainee what would need to happen in supervision for it to be a place where looking forward to sharing their work, especially their mistakes, would be a welcomed experience positions this supervision goal as an essential and primary task.

2. Explicitly acknowledging the bind.

While articulating showing-up as a mutual goal seems rather straightforward, it is not. Similar to developing initial treatment goals with clients, the stated goals may come with unspoken and unknown psychological barriers that make tackling them together challenging. In the case of trainee-supervisor relationships, recognizing the barriers to showing-up, and agreeing to notice when these barriers are present, helps make authenticity in supervision a goal rather than an initial starting point. It also parallels how some goals in psychotherapy are obtained, i.e., through noticing the personal and/or therapist-client variables that make them challenging to simply do. In that way, the agreed upon task in supervision is to assist the trainee to learn self-reflection, where showing one's personhood in supervision is one identified process of developing self-reflective practice. Acknowledging this as a goal to work on in the process of the

trainee-supervisor relationship rather than as a foregone conclusion, allows for an empathic and expectable look at times when this is difficult, rather than fueling impression management strategies to simply perform self-reflection.

Another advantage to acknowledging the bind involves the lessons to be learned about communicating across a power differential. Therapists have a particular power over clients—the power to define what's going on (Karson, 2008)—that parallels the supervisor's power to evaluate the trainee. Examination of the bind in supervision can teach trainees how to examine the power differential in therapy.

3. Modeling authenticity

Supervisors can help by ensuring that hiding their own all-too-human psychologies does not become part of the role of clinical expert. Commenting upon one's personal psychology, or inviting others to, may seem status-reducing to supervisors functioning in a culture of training that also monitors their performance as supervisors. Similar to the impact of monitoring and evaluating trainee competence, trainee ratings of supervisor competence impact decisions of job security, promotion, and/or tenure. If showing one's personhood is seen as separate from competent supervision, this leaves open the prospect of stigmatization and the supervisor's trust that authenticity is valued is hampered.

In a system that sometimes divides between the roles of commentator and commented-upon, it becomes a status move to comment on others and a reduction of status to be commented upon (Johnstone, 1981). This feature of interpersonal comments is probably rooted

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in childhood, where parents and other adults comment on children, but it really takes hold in clinical training, where the professionals do the commenting and the clients get commented upon. Trainees do both, commenting on their clients and on other people's clients, and getting commented upon by faculty. The whole enterprise makes it stigmatizing to get commented upon, and what gets commented upon is typically any deviation from the assigned role, and any sign of having a psychology.

To counter this tendency, faculty can good-naturedly accept the fact that their own psychologies are continually on display, and only the tact of their colleagues and students keeps others from pointing out the displays. Faculty can even take this a step further and treat unwanted behaviors by students as commentaries on the psychology of the faculty. The very public nature of group supervision, for example, where the supervisor's all too human psychology is displayed may be received well by some trainees, but not by others. Reception of the supervisor's personhood, and the modeling of this as part of supervision and psychotherapy, is likely increased the more that the supervisor comments on her personhood, rather than leaving this up to trainees to do so. Taking ownership of one's psychology maintains the role of expert and being the first to comment on oneself models the very behavior supervisors are trying to teach.

4. Acknowledging the role of stigma in the cultural climate.

Departments and agencies vary considerably with regard to the valuing of personhood in clinical work, clinical training, and in collegial work relationships, and this sets the tone for supervisors to include or exclude these as variables in their work with trainees. While a primary disciplinary goal is in-

clusiveness, faculty are subject to the same stigmatizing dynamics as are present in the larger sociocultural environment. Power and privilege may be maintained through the creation of "in" and "out" groups that place value on particular types of clinical expertise, such as theoretical orientation or whether or not one subscribes to "evidence-based" or evidence-informed notions. The more circumscribed and narrow the view of acceptable theoretical orientations in practice, the greater the likelihood that personhood variables are excluded as important in training and practice with an emphasis on the procedures of the psychotherapeutic approach as the emphasis of training. We recommend that faculties periodically revisit the question of what they want the role of supervisor to entail. These value statements, which are always humanist in our experience, can quell concerns about stigma associated with being all-too-human.

5. Acknowledging factors related to anxiety about corrective feedback in supervision.

Although the advice of "comment on the behavior as bad but not the child as bad" may be aptly adopted by parents as a means of preserving their child's self-esteem, in supervision the very discussion of personhood and its influence on the trainee's therapeutic skills and behaviors makes these factors inseparable at times (O'Donovan & Dyck, 2005). Such personhood factors as emotional vulnerabilities and functioning, personality, and interpersonal skills may influence trainee effectiveness with a need to focus on these in supervision.

That supervisors may be overly concerned about providing critical feedback, consequently avoiding it altogether, may be key to limiting trainee learning (Green, 2011). Another

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complicating factor includes the frequency with which trainees' self-evaluations do not match the evaluations of others who are more advanced. Trainees with less skill, for example, were found to have a higher degree of confidence in their therapeutic abilities than those with more skill (Overholser, 2010). Further, there may be a general tendency for trainees to overestimate their counseling skills (Urbani et al., 2002). Not only could supervisor feedback assist in providing information about specific clinical skills development, it may also assist trainees in more accurate self-reflection about the level of their abilities.

Supervision is one of the few relationships where "already knowing" is stigmatized and communicating "not knowing" gains prestige in the eyes of the supervisor. An open discussion and supervisory agreement that the performance of self-reflection in supervision includes engaging with corrective supervisory feedback about oneself and one's performance is required for effective supervision. Viewing "not knowing" as a valued trainee role in supervision may decrease anxiety about revealing vulnerability or lack of skill and make way for increased learning. Open discussion of this role may increase trainee openness to learning and allay the anxiety that both trainee and supervisor may experience about grappling with corrective feedback. Corrective feedback no longer is defined as problematic, aggressive, and/or hurtful in the relationship but as expected and valuable. Of course, this view of corrective feedback can help trainees provide their clients with observations about what they see without feeling as if they are thereby humiliating or harming their clients.

6. *Allaying trainee anxiety about the need to know.*

The supervision relationship is a unique

teaching relationship where the roles of "knowing" or "not knowing" are determined not only by the relative levels of professional experience and development of the participants, but by the need to develop skill at approaching co-created therapeutic relationships with clients. While learning and supervised practice in the field of psychology enter into increasing levels of competence to perform the therapist role, the skills needed to develop therapeutic relationships require comfort with ambiguity and "not knowing." Such a stance allows therapists to remain open to coming to unique understandings of clients and therapeutic relationships.

"Knowing" is often a more familiar trainee stance than "not knowing." This stance may have been shaped by such experiences as participation in education systems and/or family dynamics where producing the "right" answer may be the task. In such environments, competence is associated with getting the right answer and receiving positive reinforcement for this. The cultural climate of evaluation in psychotherapy training may similarly complicate the task of presenting in supervision in a questioning, self-examining way when trainees connect competency with "knowing."

Helping trainees see "not knowing" and curiosity as a prestigious stance in supervision is required in order to both profit from supervision from someone more expert and learn how to understand and form therapeutic relationships with clients. Further, when acknowledgement of one's developmental level of training is clear in supervision, the position of learning and "not knowing" becomes more comfortable. Explicating this developmental process in supervision may further the

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trainee's capacity to show up in a curious fashion that promotes self-esteem rather than detracts from it. We like to introduce ourselves to trainees as a "42nd-year student" or a "40th-year student," signifying our ongoing effort to get a little better at clinical work this year than we were last year.

7. *Understanding oneself with compassion.*

The supervision relationship offers an opportunity to untangle the stigmatizing dynamics that lead to hiding out by emphasizing a need to practice self-care and self-compassion (Kern, 2014). The acknowledgement in supervision that self-reflection and awareness of the need to grapple with personal vulnerabilities are a part of professional identity that can empathically inform work with clients may reduce stigma, specifically the stigma that may be exacerbated by a sense that mental health professionals should be unaffected by personal vulnerabilities. Instead, an acknowledgement of these all too human personal factors as they enter into therapeutic work and supervision frees up trainees to show themselves in supervision and practice self-reflection.

Many of the difficulties that bring people to psychotherapy have to do not with what the person sees when they look at themselves but with the *way* they look at themselves. Much of the work of psychotherapy involves providing clients with a new, more welcoming way of looking at themselves. The training program's culture and the supervisor's stance can further the goal of looking at people with compassion and curiosity.

Conclusion

Although the valuing of professional traits of openness, self-reflection, and authenticity in supervision is clearly a part of training in psychology, articulating and addressing the cultural factors that may

contribute to trainee reluctance to "show up" in supervision are necessary to address practicing these values in a training environment. The bind created by the complexities of the supervisor-trainee relationship, if not addressed overtly, may lead to trainees hiding-out in such a way that one of the major goals of training, i.e., self-reflective practice, is left unmet. Addressing these relational binds earnestly and mutually in the supervisory relationship is key to promoting authentic engagement in clinical training.

References

- Ackerman, S., & Hilsenroth, M. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.
- Angus, L., & Kagan, F. (2007). Empathic relational bonds and personal agency in psychotherapy: Implication for psychotherapy and supervision, practice, and research. *Psychotherapy: Theory, Research, Practice, Training, 44*, 371-377.
- Aponte, H. J. & Kissel, K. (2014). If I can grapple with this I can truly be of use in the therapy room: Using the therapist's own emotional struggles to facilitate effective therapy (2014). *Journal of Marital and Family Therapy, 40*(2),
- Aponte, H. J., Powell, F. D., Brooks, S., Watson, M. F., Litzke, C., Lawless, J., & Johnson, E. (2009). Training the person of the therapist in an academic setting. *Journal of Marital and Family Therapy, 35*, 381-394, 1-13.
- Barnett, J. (2009). The complete practitioner: Still a work in progress. *America Psychologist, 64*(8), 793-801.
- Barnett, J., & Molzon, C. (2014). Clinical supervision of psychotherapy: Essential ethics issues for supervisors and supervisees. *Journal of Clinical Psychology: In Session, 70*(11), 1051-1061.
- Bernard, J. M., & Goodyear, R. K. (2014).

continued on page 90

-
- Fundamentals of clinical supervision* (5th ed.). Upper Saddle River, NJ: Merrill.
- Blow, A. J., Sprenkle, D. H. & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, 33(3), 298-317.
- Bordin, E. H. (1983). A working alliance based model of supervision. *The Counseling Psychologist*, 11, 35-42.
- Castonguay, L. G., & Beutler, L. E. (2006). Principles of therapeutic change: A task force on participants, relationships, and techniques factors. *Journal of Clinical Psychology*, 62, 631-638.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614-625.
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.
- Fouad, N., Hatcher, R. L., Hutchings, P. S., Collins, F., Grus C., Kaslow, . . . & Crossman, R. (2009). Competency benchmarks: A model for understanding and measuring competency in professional psychology across training levels. *Training and Education in Professional Psychology*, 3(4), S5-S26.
- Fox, J. E. (2012). Co-constructing stigma and the therapist-parent alliance. *Psychotherapy: Theory, Research, Practice, Training*, 49(1), 38-45.
- Freud, S. (1913). *The interpretation of dreams*. London, England: Macmillan Press.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon and Schuster.
- Green, H. (2011). Skills training and self-esteem: Educational and clinical perspectives on giving feedback to clinical trainees. *Behaviour Change*, 28(2), 87-96.
- Hoffman, M., Hill, C., Holmes, S., & Freitas, G. (2005). Supervisor perspective on the process an outcome of giving easy, difficult or no feedback to supervisees. *Journal of Counseling Psychology*, 52(1), 3-13.
- Johnstone, K. (1981). *Impro: Improvisation and the Theatre*. New York, NY: Routledge.
- Karson, M. (2008). *Deadly therapy: Lessons in liveliness from theater and performance theory*. Lanham, MD: Jason Aronson.
- Kern, E. (2014) The pathologized counselor: Effectively integrating vulnerability and professional identity. *Journal of Creativity in Mental Health*, 9, 304-316.
- Ladany, N., & Inman, A. G. (2012). Training and Supervision. In E. Altmaier & J. C. Hansen (Eds.), *Oxford handbook of counseling psychology* (pp. 179-207). New York, NY: Oxford University Press.
- Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 17-32). New York, NY: Oxford University Press.
- Mangione, L., & Nadkarni, L. (2009). Relationship competency: Broadening and deepening. In M. B. Kenkel and R. L. Peterson (Eds.), *Competency-Based Education for Professional Psychology*. Washington, DC: American Psychological Association Press.
- Norcross, J. C. (2002). Empirically supported therapy relationship. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness of patients* (pp. 3-16). New York, NY: Oxford University Press.
- O'Donovan, A., & Dyck, M. J. (2005) Does a clinical psychology education moderate relationships between personality or emotional adjustment and

continued on page 91

- performance as a clinical psychology? *Psychotherapy: Theory, Research, Practice, Training*, 42, 285-296.
- Orchowski, L., Evangelista, N., & Probst, D. (2010). Enhancing supervisee reflectivity in clinical supervision: A case study illustration. *Psychotherapy: Theory, Research, Practice Training*, 47, 51-67.
- Overholser, J. (2010). Clinical expertise: A preliminary attempt to clarify its core elements. *Journal of Contemporary Psychotherapy*, 40, 131-139.
- Schoener, G. R. (2013). Recognizing, assisting, and reporting the impaired psychologist. In G. P. Koocher, J. C. Norcross, & B. A. Green (Eds.), *Psychologists' desk reference* (3rd ed., pp. 572-576). New York, NY: Oxford University press.
- Stone, D. (2008). Healing: Exploring the circle of compassion in the helping relationship. *The Humanistic Psychologist*, 36, 45-51.
- Urbani, S., Smith, M. R., Maddux, D. C., Smaby, H., Torres-Rivera, E., & Crews, J. (2002). Skills-based training and counseling self-efficacy. *Counselor Education and Supervision*, 42, 92-106.
- Ward, C. C., Friedlander, M., Schoen, L., & Klein, J. (1985). Strategic self-presentation in supervision. *Journal of Counseling Psychology*, 32, 111-118.
- Watkins, C. E., Budge, S., & Callahan, J. L. (2015) Common and specific factors converging in psychotherapy supervision: A supervisory extrapolation of the Wampold /Budget Psychotherapy Relationship Model. *Journal of Psychotherapy Integration*, 25(3), 214-235.



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STUDENT FEATURE

Trainee Perspectives on the Importance of Self-Care and Research in Clinical Supervision

Jennie David, MS
Drexel University

Stephanie Callan, MS
University of Colorado, Denver



The breakneck speed of working on an inpatient behavioral medicine team of an urban tertiary hospital is quite often both exhilarating and exhausting for clinical psychology doctoral students. There is an idiosyncratic rhythm to the workload, as new consults roll in or patients the service follows are

readmitted to the hospital. The expectation for trainees often seems to follow the so-called rule of comedic improvisation: saying “Yes and ...” to everything, such that you are accepting more tasks and then contributing to them in novel ways. The pace of inpatient hospital work maintains the impression that practicum days are non-stop work, and that any basic self-care—like excusing yourself to eat a granola bar—would be time better spent doing something “productive.” While many faculty and supervisors will talk about self-care, it is rarely demonstrated, modeled, or given time and space to happen. Self-care is frequently encouraged within the clinical supervision literature, in efforts to mitigate burnout and optimize a clinician’s long-term ability to provide quality care (Barnett & Cooper, 2009; Elman & Forrest, 2007). Underscoring the relationship between psychologist self-care and the ethical protection of patients, the American Psychological Association’s

(APA) Advisory Committee on Colleague Assistance (ACCA) directly lists poor self-care as a reason why psychologists are vulnerable to occupational stress occurs (ACCA, 2006). To prevent occupational stress, the ACCA lists several suggestions that incorporate the principles of self-care, such as maintaining work-life balance and attending to spiritual and physical well-being. The ACCA also asserts that making and maintaining professional relationships in which modelling and having an open dialogue regarding the stresses of clinical work can occur are effective methods to protect oneself from occupational stress (ACCA, 2006).

Additionally, self-care has been emphasized as an ethical imperative for psychologists and trainees as written in the APA ethics code (APA, 2002; Barnett & Cooper, 2009). To this end, self-care is considered one of the competency benchmarks for trainees (Fouad et al., 2009). Language encouraging the utilization of supervision is embedded in the APA’s revised self-care competency benchmark and behavioral anchors (APA, 2011). For example, trainees are considered ready for internship when they “monitor issues related to self-care with [their] supervisor” (APA, 2011). Given the field’s general positive view of self-care, it is perhaps surprising that trainees feel unprepared about how to integrate self-care into their education and clinical work (Munsey, 2006). In one

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study, 85% of trainees reported not receiving educational materials about self-care in their programs, 63% reported that their programs did not sponsor self-care activities, and 59% reported that their programs did not promote self-care activities (Munsey, 2006). In turn, there is an apparent disconnect between the understood value of self-care and the clinical supervision and support of trainees to build this developmental skill. Though researchers have advocated for the incorporation of self-care into graduate training (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Rodolfa et al., 2005), particularly through supervision (APA, 2011; Barnett & Cooper, 2009; Elman & Forrest, 2007), there are still barriers to self-care to address that may help bridge the gap between knowing the benefits to self-care and teaching those benefits. Education must be done regarding self-care, as psychology graduate students may not be aware of the risks professional psychologists face (Fuselier, 2004), such as burnout and work-life imbalance. Also, students may fear that faculty and peers would question their professional dedication should they engage in self-care behavior (ACCA, 2009; Norcross & Guy, 2007). To break down these barriers, Elman and Forrest (2007) argued that supervisors should express to their supervisees that self-care is just as respectable a practice as hard work. Elman and Forrest (2007), like Barnett and Cooper (2009), suggested that creating a culture of self-care is necessary beginning at the graduate school level, through modelling, teaching, and skill-building.

For this particular behavioral medicine service, noon is synonymous with self-care in the form of group lunch in the cafeteria. At 12:01 PM, the supervisor will stand at the front of the narrow row of desks where trainees chart. "What are

we still doing here?" She will exclaim with a smile. "It's time for lunch!" We all turn to her, nod in her direction with our eyes still glued to the computer screens, and state variations of, "Just one minute, I'm almost done this note!" The supervisor deepens her smile, and gently says, "The notes can wait until after lunch, it's time to eat." We all dutifully pend our notes, sign off the computers, and walk as a group with our supervisors to the cafeteria, where conversation turns from evidence-based strategies to what the lunch special is that day. The cafeteria is a strategic move by our supervisors, a common space where we can all gather, but also a public space to temper the urge to discuss confidential cases and continue to work. We instead focus our attention to discussing weekend plans and take turns showing pictures of pets on our phones to the group.

Our designated self-care time is not only encouraged, but always modeled and reinforced by supervisors. It replaces the nebulous concept of "engaging in self-care" into a tangible action and establishes both the precedent and habit of basic self-care activities. Self-care also seems to mitigate the exhaustion that often accompanies practicum days, as we return well-fed and hydrated to our computers to check the consult list. It is refreshing to have the externship culture support daily self-care, without sacrificing a demanding and high-quality training experience in an inpatient setting. Of note, this experience aligns with the extant literature on self-care, such that self-care enables high quality practice (Barnett & Cooper, 2009). Perhaps, if anything, the standardized self-care activities propel us further into the challenges of our clinical population and provide training experiences that support the development of competent clinicians.

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An externship in a pediatric outpatient interdisciplinary specialty clinic shares many qualities with an inpatient medical setting, and is also a demanding training experience. In one such clinic that focuses on young children with failure to thrive (FTT), a condition with a multifactorial etiology that often includes medical and behavior variables, clinical recommendations were varied for the families with which we worked. Thus, no guidelines existed in the literature for assessing longitudinal adherence to such recommendations and outcomes related to FTT.

Given the clinic's emphasis on evidence-based interventions, alongside the other healthcare providers on the interdisciplinary team, the clinic supervisors encouraged and supported the trainees in developing a quality improvement research project to assess adherence in the clinic's population. While there is limited data on the supervision of trainees engaging in research, the generation and evaluation of research is also considered to be a core competency benchmark for trainees, including behavioral anchors of engaging in research activities during training (Falender et al., 2004; Fouad et al., 2009). This blends into another competency benchmark focused on the assessment and application of evidence-based strategies into clinical care (Fouad et al., 2009). Further, it emphasizes the importance of the trainee's developing competency of integrating knowledge and skills in providing evidence-based clinical care (Falender et al., 2004). The FTT adherence research project was integrated into the clinic's care, as it addressed the fundamental question of how to improve outcomes for a singular clinical population with diverse needs. And so, the adherence measure became interwoven into our clinical experiences, and in essence became a formal structure to ask about and assess adherence to

recommendations for our families in order to provide personalized care.

Clinical supervisors often extended supervision to discuss research methodology as it was relevant to the project and provided consistent mentorship in the design and implementation of the research. This supervision worked to support the research competency benchmarks described above and is consistent with the supervisory role as proposed in supervision research (Falender et al., 2004; Fouad et al., 2009). The research study facilitated conversations during group supervision to probe our increasingly nuanced understanding of adherence in a complex pediatric population, and the clinical strategies we could use to assess these hypotheses. Were families and providers leaving a clinical encounter with the same expectations and understanding? Did families and providers place the same cultural value in ameliorating a behavioral or medical need? Did families have the social and financial resources to implement what the team had recommended? Do we think of adherence in pediatrics to involve only caregivers, or to describe the dynamic relationship between caregivers, their children, and their providers?

This opportunity highlighted the importance of understanding the theoretical and applied mechanisms of a given intervention to determine its evidence base and clinical utility. Engaging in the research project gave us as trainees the ability to develop our research skills related to our competencies as training clinicians. Further, it facilitated insight into the complementary relationship between clinical work and research, aligned with the professional development of externs who are pursuing clinical research careers.

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In sum, the supervisory experiences detailed above fostered enriching learning opportunities for trainees building competencies across diverse domains. As trainees, we feel strongly that these supervisory experiences have led to our academic and professional development. Future research should assess the utility of supervisors modeling and instituting self-care procedures in the self-care competency development of trainees, as well as investigating how research engagement may foster research literacy/evidence-based assessment competency development in trainees. The opportunities described in this paper underscore how supervisors who continually support self-care and research acumen are vital to the development of competent, compassionate, and critically-minded future clinical psychologists.

References

- Advisory Committee on Colleague Assistance. (2006, February 10). *Advancing colleague assistance in professional psychology*. Retrieved from <http://www.apa.org/practice/resources/assistance/monograph.pdf>
- Advisory Committee on Colleague Assistance. (2009). *Who cares? Barriers, benefits and resources in colleague assistance and self-care*. PowerPoint presentation presented at the 117th Annual Convention of the American Psychological Association, Toronto, Canada.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- American Psychological Association. (2011, June). *Revised competency benchmarks for professional psychology*. Retrieved from <http://www.apa.org/ed/graduate/competency.aspx>
- Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice*, 16, 16-20. <https://doi.org/10.1111/j.1468-2850.2009.01138.x>
- El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, 6(2), 122-134. <http://dx.doi.org/10.1037/a0028768>
- Elman, N. S., & Forrest, L. (2007). From trainee impairment to professional competence problems: Seeking new terminology that facilitates effective action. *Professional Psychology: Research and Practice*, 38(5), 501-509. doi:10.1037/0735-7028.38.5.501
- Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., ... & Grus, C. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology*, 60(7), 771-785. doi: 10.1002/jclp.20013
- Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., ... & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3(4S), S5-S26. <http://dx.doi.org/10.1037/a0015832>
- Fuselier, D. (2004). *Self-care among psychology graduate students and psychologists: Implications for physical, mental, and spiritual well-being* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses. (AAT 3130527)
- Munsey, C. (2006, November). Questions of balance: An APA survey finds a lack of attention to self-care among training programs. *gradPSYCH*, 4(4). Retrieved from <http://www.apa.org/gradpsych/2006/11/coverbalance.aspx>
- Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: A guide to*

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psychotherapist self-care. New York, NY: The Guilford Press.

Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Ritchie, P. (2005). A cube model for competency develop-

ment: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice*, 36(4), 347-354. doi:10.1037/0735-7028.36.4.347.



Dear Division 29 Members,

Please see below for important information about:

1. [Several proposed bylaws changes that require a full membership vote](#). The Division 29 Board of Directors (BOD) unanimously recommends three distinct amendments to the bylaws of the Society for the Advancement of Psychotherapy (The Society), as outlined on the ballot below. The Society's bylaws were last revised in April 2016. Members of the Division who are APA Regular, Associate or Fellow members are eligible to vote for bylaws changes.

To do so, please review the corresponding rationale for each amendment, and cast one vote in favor of (YES) or opposed to (NO) each change. As per our bylaws, "an affirmative vote of two-thirds (2/3) of the voting members who have returned their ballots shall be required to ratify the proposed amendment which shall go into effect immediately." Voting will remain open for 30 days: November 9, 2018 to December 8, 2018.

For more information, please visit: <http://societyforpsychotherapy.org/proposed-bylaws-changes-2018/>

2. [Upcoming Apportionment Ballot](#). The Apportionment Ballot will be arriving soon from APA. This is your chance to make Division 29's voice heard in the APA Council of Representatives—APA's governing body.

The Council makes decisions about policy, about APA's stance on issues, and about the Association's finances. It is essential to keep strong representation in Council to ensure that psychotherapy is protected, enhanced, and supported throughout the field, in science, in practice, and in education and training. Our Council Representatives bring our voice, and we need to make sure that voice is strong.

When you receive your apportionment ballot, DON'T THROW IT AWAY! Send it back to APA with your voice coming through loud and clear.

Give all 10 votes to the Society for the Advancement of Psychotherapy—Division 29. That gives us the strongest voice possible in APA governance activities and decisions. If you can't give all 10 to SAP, please give as many as you can. Doing so helps ensure that psychotherapy is protected and advanced on the floor of APA Council and in all of APA.

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The Rising Tides—Waves of Change

Pat DeLeon, PhD
Former APA President



One of the advantages of serving on the U.S. Senate staff or the APA Board of Directors (especially as President) is that one is systematically exposed to evolving trends within our nation's healthcare environment and the field of psychology. The position essentially forces one to think creatively beyond personal agendas and previous "comfort" levels. One's perspective becomes broader and more integrative—similarities across engaged stakeholders become more evident. A review of this year's Appropriations conference reports, which have been signed into public law, for the Department of Health and Human Services (HHS) and the Department of Veterans Affairs (VA) clearly illustrates an increasing Congressional interest in encouraging the development of a wide-range of mental health services, to be provided by various disciplines, and via evolving technological platforms. More specifically:

- The HHS Behavioral Health Workforce Education and Training account includes support for Master's level social workers, psychologists, counselors, marriage and family therapists, psychiatric mental health nurse practitioners, occupational therapists, psychology doctoral interns, and behavioral health paraprofessionals. HRSA should continue to encourage all eligible health professions to apply.
- \$150,000,000 is provided for the Certified Community Behavioral

Health Clinics program under SAMHSA.

- The VA is directed to work with the Office of Personnel Management (OPM) to create an Occupational Series for Licensed Professional Mental Health Counselors and Marriage and Family Therapists and to create a staffing plan to fill such open positions and assess shortages.
- The Secretary of the VA is urged to work with facilities that have not yet implemented VA's final rule granting full practice authority to advanced practice registered nurses to ensure quick implementation. VA is directed to accelerate the rollout of competitive pay for physician assistants and develop a plan on how to better utilize the Health Professional Scholarship Program and Education Debt Reduction Program.
- Telehealth – HHS: \$1,000,000 is included through the Telehealth Network grant program to fund awards that use evidence-based practices that promote school safety and individual health, mental health, and well-being. The grants should provide assessment and referrals for health, mental health, or substance use disorders services to students who may be struggling with behavioral or mental health issues. In addition, grants should provide training and support to teachers, school counselors, administrative staff, school resource officers, and other relevant staffs to identify,

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refer, and intervene to help students experiencing mental health needs or who are considering harming themselves or others.

- VA: \$30,000,000 is provided *above* the budget request for telehealth capabilities. This additional funding should be used to further expand telehealth capacity and services in rural and remote areas. The VA is directed to provide a report to the Committees on Appropriations of both Houses of Congress specifying measures the Department is taking to expand telehealth and telemental health capacities in rural areas, particularly regions with limited broadband access. The report should also include information on any ongoing collaboration between VA and other Federal agencies to target remote and rural areas to maximize coverage.

“I am very pleased with the extent to which APA has been increasingly active in terms of legislative activities and developing policies that affect, not only psychologists but all citizens of this country. At our March 2018 meeting, the Council of Representatives voted to support pursuing accreditation of Master’s level programs in psychology in areas where APA already accredits. In addition, Council voted to adopt as APA policy the Guidelines on Core Learning Goals for Master’s Degree Graduates in Psychology. A Task Force was formed and has been charged to outline a plan by which APA could pursue development of an accreditation system for Master’s programs in health service areas (clinical, counseling, school, etc.) of psychology.

“On a national level, the APA and the APA Practice Organization government relations staff worked throughout the year with Members of Congress to help shape legislation to address the opioid

epidemic. The bill (the ‘SUPPORT for Patients and Communities Act’) passed both the House (by a vote of 393 to 8) and Senate (with a vote of 98 to 1). The SUPPORT Act makes helpful policy changes spanning several federal agencies, including the Centers for Medicare and Medicaid Services and the Department of Health and Human Services.

“Finally, APA has acknowledged that the most effective way to have the maximum impact legislatively is to have ‘One APA,’ a unified advocacy model. In 2017, APA began exploring options for modernizing its structure to create a ‘One APA’ model in which two distinct components (a 501(c3) organization and a 501(c6) organization) seamlessly address the full range of member expectations and the needs of the discipline and profession related to advocacy and member benefits. To guide this transformation, APA committed to maintain, at a minimum, the current budget levels for all advocacy and government relations programs across practice, science, education and public interest. The Work Group recognized the importance of both long-term goals and the need for agility in carrying out the advocacy priorities in a fast-paced political environment. Also critical to the Work Group was that the process emphasizes psychology as a whole, while ensuring that the various sub-fields have a voice and representation in the prioritization process. I am genuinely excited about the future and have decided that the time has arrived, both personally and professionally, for me to run for APA President” [Jennifer Kelly, APA Recording Secretary].

The Global Perspective

In 2002, the World Health Organization (WHO) released its report *Prevention and Promotion in Mental Health* in which it re-

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iterated that health is: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Thus, in order to attain health, improvement of the mental health of individuals is essential” (p. 5). The report noted that mental disorders are growing and are responsible for a high degree of *burden*. “It is essential that effective preventive and promotional measures be taken in mental health to reduce the impact of mental disorders on the individual and society.” WHO estimated that about 450 million people suffer from mental disorders; one person in every four individuals will be affected at some stage of their life. By 2020, it was estimated that depression will become the second leading cause for disease burden. This burden extends into the community and society as a whole, having far-reaching economic and social consequences.

“Natural or human-made disasters and conflicts generate a huge number of psychosocial and mental health problems that cause enormous strains on society. These conflicts tend to be in the poorest regions of the world and the associated burden of mental health problems leads to severe financial strains on the already impoverished monetary situation in these countries,” There were *vast differences* between countries in available mental health resources. The concept of what constitutes mental illness varies amongst cultures based on local beliefs and practices. WHO called on professional associations and prevention research groups to become mobilized to undertake research in the development of evidence-based effective strategies, which might well differ across countries and cultures.

More than a decade and a half later, former APA President Alan Kazdin: “There is now a well-documented crisis in mental health in the United States and

world-wide. Stated generally, the vast majority of individuals in need of mental health services receive absolutely nothing. Just considering the U.S., we know that approximately 70% of individuals in need of mental health services receive nothing; i.e., no formal treatment of any kind by a health practitioner. In clinical psychology, there is a massive outpouring of evidence-based treatment, quibbles about treatment as usual (often just as effective as evidence-based treatments), what meta-analyses of therapy really show or do not show, why therapy works, can we bridge the research practice gap, and so on. All are arguably important and classic questions. All are arguably missing the point. Most people receive **no** treatment.

“Among the many problems is the dominant model of treatment delivery. As a profession in clinical practice and graduate training, we are committed primarily, almost exclusively, to one-to-one individual therapy with a trained mental health professional. The professions not only advocate that, they are very interested in protecting that. We have considerable evidence now that lay individuals (heresy to mention but they are not licensed) can administer treatment effectively to treat individuals with mental disorders. And we now have many models of delivery that can reach people in need but are not at all part of training among the mental health professions and do not seem to be of much interest.

“Individual psychotherapies of all kinds, task force reports about the problem, various ‘resolutions’ and consensus statements continue to ignore the problem. What is psychology doing to reduce the burdens of mental illness and to reach people in need of services? I am not implying that we are not doing won-

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derful things. But treatments, evidence-based or not, just are not getting to people in need. The situation is even worse among subpopulations (individuals of an ethnic minority, children and adolescents, single parents, elderly individuals, victims of domestic violence, and the list goes on). What are we doing to reach people in need and to reduce the burdens of mental illness? The professions could do more. Our effectiveness in addressing each of these can be measured and measurement is our (psychology's) specialty. Clinical psychology does not seem to show interest in moving away from treatment models that do not reach people. Could we turn some or more of our mental health profession to problems I have outlined here? Our psychotherapy research and debates aside, this is so much it seems like 'an emperor's new clothes' situation. Imagine if we turned our research and clinical turrets to people in need on a scale that not only made a difference to individuals but to the burdens experienced by their families and society at large. Perhaps I am expecting too much from our discipline. Public Health is probably more relevant."

We recently discussed this seeming "disconnect" between the potential contributions of psychology (and psychiatric mental health nursing) and the documented worldwide need for mental health services, with Dale Smith, Professor of Military Medicine & History at the Uniformed Services University (USU). Dale pointed out that for WHO to issue such a report, international scholars and public health officials had undoubtedly been seriously discussing this situation for at least a decade, if not longer. He asked: Was our collective failure to act a reflection of our lack of political will? That is, do we really know what we should do, but we have consciously decided not to expend the financial, pro-

fessional, and political capital necessary to successfully engage? Or, in the alternative, is this the type of complex situation where we genuinely do not know how to address such a compelling need? He suggested that if it were the latter, perhaps the next step should be the development of a comprehensive research strategy exploring what efforts have been attempted in the past and why have they not been successful. Significant change *always* takes time; often more than one would anticipate.

Unique Interprofessional Training Experience

At USU, psychology and nursing graduate students can join with fourth-year medical students in participating in an intensive five-day field training exercise in the mystical country of Pandakar (located in the woods of rural Pennsylvania). "Bushmaster gave us a unique opportunity to hone our skills in a deployed setting in three primary roles. In the Combat Stress Control (CSC) team role, we immersed ourselves in the Pandakar setting and visited each platoon to conduct a Unit Needs Assessment (UNA). This required us to engage with each platoon's security team, obtain buy-in from their leadership, and build rapport with their unit members to learn how we could best help them. In the Combat and Operational Stress Control (COSC) clinic role, we established an independent clinic in Pandakar and prepared to accept all types of combat stress casualties for treatment or medevac. Finally, in our 'real world' Bushmaster role, we engaged countless participants (to include moulage artists, actors, faculty, and military leadership) to build morale with assistance from our mascot, Panda Pauli. As future leaders and providers in mental health, Bushmaster gave us a glimpse into our deployed role

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that would be impossible in any other educational setting. Not only did it help prepare us for future clinical care, but it also gave us an opportunity to educate other students on the importance of supporting our troops' mental health and morale needs downrange" [Michelle Binder, Capt., USAF; Psychiatric Mental Health Practitioner graduate student].

Aloha

References

World Health Organization. (2002). *Prevention and promotion in mental health*. Retrieved from http://www.who.int/mental_health/media/en/545.pdf



Society for the Advancement of Psychotherapy

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

**SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
BOARD OF DIRECTORS MEETING
SEPTEMBER 15-16, 2018 – WASHINGTON, D.C.**



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Why Join?

Rosemary Adam-Terem, PhD
Honolulu, HI



When I was in graduate school, the Scientist-Practitioner Model was every clinical psychologist's ideal. We were trained to appreciate, understand, and actually do research following the lines of the Boulder Model (1949 Conference). In 1973, a new clinical psychology training model was proposed at the Vail Conference on Professional Training in Psychology. The Practitioner-Scholar model placed more emphasis on clinical practice. Over the next 45 years, these two models of training produced psychologists with either PhD or PsyD degrees. While both models value both science/scholarship and practice, the emphasis of the models has tended to direct psychologists towards one or the other. Market forces reinforced these silos.

In my early life as a professional psychologist, at a counseling center housed in a major women's and children's hospital, we saw patients, trained students and residents, and had time to do our own research. Within a decade, however, the pressure to produce greater "billables" increased to the point where research was squeezed out and finally the training program's funding was cut. Like so many of my colleagues, I then moved into independent practice and no longer engaged in anything but clinical work, with an occasional cameo appearance as a teacher.

This was a sad loss to those of us who had created a program that seemed to embody the Boulder Model and valued

the Vail Model. Independent practice can be isolative and unless you try very hard, there is a tendency to settle into doing what you have been doing and no longer seek new information (**Editors' Note:** For more on the ethical implications of this, see Barnett & Corcoran's piece on "Competence, Ethical Practice, and Going It Alone," in this issue).

Our story is not at all unusual. In their 2015 article, LeJeune and Luoma noted that

most clinical psychologists work in private fee-for-service settings with little, if any, opportunity to engage in psychological research. The bulk of psychological research is produced by a small minority of psychologists working primarily in academic settings removed from clinical practice. (Norcross & Karpiak, 2012). (p. 421)

LeJeune and Luola (2015) propose one interesting solution, outlined in their article, but for those of us who are settled into solid clinical practices, there is another option: The Society for the Advancement of Psychotherapy (SAP)!

In our Division 29, the SAP, we have all the elements of the profession: the clinical practitioners, the researchers, the academics, the teachers, the mentors. We are a home for clinical work in all its dimensions, and particularly welcome students and early-career psychologists.

So why join?

First, and this is a boon for everyone, it's a really good deal. Membership dues are

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low, thanks in large part to the success of our journal *Psychotherapy* (see below) and it is not necessary to be a member of APA to be a member of the SAP.

Second, why not be a member? Isn't it your civic duty? But seriously...

If you are a student, you can interact with the people whose books you have been reading in school, and with others at various career stages. We have live opportunities to do this at Convention every year with our "Lunch with the Masters" events where students not only get a free meal, but also the chance to talk with a range of senior psychologists. There are also grants and awards for student members. We like to encourage students to be on all our committees, and we have a dedicated student position on the SAP Board. We're friendly!

For early-career psychologists (ECPs), the SAP has grants and awards, mentorship programming, and, again, the opportunity to be side-by-side with esteemed senior colleagues. We have a dedicated Board position for ECPs as well, and actively seek their input on all our committees. For more on ECP issues, join the ECP listserv, check Leigh Ann Carter's (2017) take on benefiting from membership, or see Rayna Markin's (2017) article on mentoring. We really *are* friendly.

Mid-career psychologists who might otherwise be isolated in their professional silos can come together and share their work. Clinicians talk with researchers, researchers talk with teachers, and we thus recreate the integrated model of scientist/scholar and practitioner.

Our senior psychologists also benefit from membership in the Society, often by giving mentorship and role modeling to their colleagues. No matter how sen-

ior you are, you also learn from the upcoming generation of psychologists and it is great to see the pipeline in action (**Editors' Note:** And, should you be considering closing a private practice or retirement, see O'Leary, 2018, or Tom Barrett's article on "Retirement Myths" in this issue).

In his presidential column for the *Bulletin* (2018), Michael Constantino congratulated the winners of all the Society's awards and honors. The list is truly impressive and hopefully inspiring.

All members of the Society have the advantage of receiving our quarterly journal *Psychotherapy*. It is a great resource and an esteemed place to publish. The *Psychotherapy Bulletin* is the other official publication of the Division of Psychotherapy. It serves as the primary communication with members and publishes short articles and official notices from the Society.

Finally, the Society has two delegates to the APA Council of Representatives, the governing body of the association, and as such represents the voice of psychotherapy in all its forms at the national level.

So please join or renew your membership and encourage others to join too.

References

- Carter, L. A. (2017). Looking ahead in the new year: How you can benefit from your Society membership in 2017. *Psychotherapy Bulletin*, 52(1), 32-34.
- Constantino, M. (2018). President's column: Thank you, Division 29 friends and colleagues. *Psychotherapy Bulletin*, 53(3), 2-4.
- LeJeune, J. T., & Luoma, J. B., (2015). The integrated scientist-practitioner: A new model for combining research

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and clinical practice in fee-for-service settings. *Professional Psychology: Research and Practice*, 46(6), 421–428.

Markin, R. (2017). New mentoring hour program for early career psychologists:

Getting mentorship one hour at a time. *Psychotherapy Bulletin*, 50(2), 54–55.

O’Leary, M. (2018). Closing a private practice. *Psychotherapy Bulletin*, 53(3), 12–16.



ALICE F. CHANG CANCER WELLNESS GRANT

\$10,000 TO SUPPORT RESEARCH AND RESEARCH-BASED PROJECTS TO IMPROVE THE LIVES OF CANCER PATIENTS AND/OR CANCER SURVIVORS THROUGH PSYCHOLOGY

The **Alice F. Chang Cancer Wellness Grant** was made possible by the generosity of the Academy for Cancer Wellness, Inc., a non-profit organization established in 1995 by Alice F. Chang, along with John J. Welker and his wife, the late Gertrude Welker. Its purpose is to provide support for cancer patients, as well as for their family and friends.

The **Alice F. Chang Cancer Wellness Grant** will be awarded to a graduate student in 2019.

Applicants from Arizona and New Mexico are encouraged to apply.

Applicants must:

- Be a graduate student in psychology
- Be affiliated with a nonprofit charitable, educational, or scientific institution, or governmental entity operating exclusively for charitable and educational purposes.

See our website for more information

<http://www.apa.org/apf/funding/chang.aspx>

Click here to apply for this grant:

<https://www.grantinterface.com/Home/Logon?urlkey=apa&>

The deadline for applications **February 1, 2019**.
Please feel free to distribute this call as you see fit.

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

Psychotherapy

Call for Papers: Ethics in Psychotherapy

Ethics seems ubiquitous for psychotherapists. It is infused into our training, we are tested on it to become licensed, and we each strive to be ethical in our professional roles, whether motivated by doing the best possible for those we serve or by a desire to avoid complaints against us. But, ethics is about so much more than just reading and attempting to follow the ethics code of one's profession and not falling below minimal expectations for our behavior. In each of our professional roles, to include those of psychotherapist, educator, clinical supervisor, consultant, and researcher, myriad ethics issues, challenges, and dilemmas arise. How to prepare for and best to respond to these ethical gray areas is every psychotherapist's ongoing challenge. Providing the latest thinking and research on ethics, ethical decision-making, and ethical practice, to guide psychotherapists, psychotherapy researchers, and those in training for these roles will be a valuable contribution for psychotherapy professionals and those they serve in their varied professional roles.

Psychotherapy invites manuscripts for a special issue on **Ethics in Psychotherapy**. The goal of this special issue is to share the latest thinking and research findings on ethics in psychotherapy, broadly defined. Rather than being proscriptive, the goal for the articles in this special issue is to expand our thinking on ethics and ethical practice in a thought-provoking manner. All ethics issues relevant to psychotherapy practice, education, training, and research are relevant for this special issue. Articles may address more general ethics issues and challenges to include new ways of thinking about ethics in psychotherapy, new and innovative ways of conducting ethics education and training, advances in ethical decision-making, and ways of preventing ethical transgressions while promoting the highest possible quality of services for those we work with in our professional roles.

Articles may address ethics in all areas of psychotherapy practice, education, training, and research running the gamut from informed consent, confidentiality and privacy issues, competence in general and with specific populations to include individuals from diverse backgrounds, boundaries and multiple relationships, telepsychology and the use of social media, personal challenges for psychotherapists and the role of self-care, to termination and abandonment and so many others. Ethics challenges and dilemmas specific to the academic, training, and research settings are welcomed such as, but not limited to, innovative teaching methods to promote ethical practice and faculty-student relationship challenges, new ways of integrating ethics training into clinical supervision and gatekeeper challenges faced by supervisors, and guidance on psychotherapy research ethics issues and challenges. The use of clinical examples or vignettes to illustrate points being made are strongly encouraged. If clinical case material is reported, authors are required to state in writing (in both submission letter and text of the manuscript) which criteria they have used to comply with the APA Ethics Code (i.e. specific informed consent, de-identification or disguise), and if de-identification or disguise is used how and where it has been applied. Alternatively, authors may note that the case examples were created by the author and do not represent any individual clients known to the author (i.e. amalgam). Relevant sections of the APA Ethics Code, practice guidelines, and other sources of ethics guidance should be referenced and recommendations for changes to them, when appropriate, should be made.

Prospective authors with questions about the suitability of a particular topic and to discuss their ideas for articles prior to beginning work on their manuscript should feel free to contact this special issue's guest editor, Jeffrey E. Barnett, PsyD, ABPP at jbarnett@loyola.edu. Manuscripts should follow APA style in keeping with the APA Publication Manual (Sixth edition). Manuscripts can be submitted through the journal's electronic portal, under the Instructions to Authors at: <http://www.apa.org/pubs/journals/pst/>. Please note in your cover letter that you are submitting for this special issue. The deadline for submitting manuscripts for this special issue is **May 1, 2019**.

Visit the Division of Psychotherapy on the web at www.societyforpsychotherapy.org Click on this link to unsubscribe from this list [UNSUBSCRIBE](#)

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2019 NORINE JOHNSON PSYCHOTHERAPY RESEARCH GRANT FOR EARLY CAREER PSYCHOLOGISTS

Brief Statement about the Grant:

The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually by the Society for the Advancement of Psychotherapy to Early Career Psychologists (within 10 years post earning the doctoral degree), provides \$10,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Eligibility

Early Career Psychologists (doctoral-level researchers who are within 10 years post earning the doctoral degree) with a successful record of publication are eligible for the grant.

Submission Deadline: April 1, 2019

Request for Proposals

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT for Early Career Psychologists

Description

This program awards grants to early career psychologists (ECPs) for research on psychotherapist factors that may impact treatment effectiveness and outcomes, including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Program Goals

- Advance understanding of psychotherapist factors that may impact treatment effectiveness and outcomes through support of empirical research
- Encourage researchers with a successful record of publication to undertake research in these areas

Funding Specifics

One annual grant of \$10,000 to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see *Additional Information* section below).

Eligibility Requirements

- Early Career Psychologists (Doctoral-level researchers who are within 10 years post earning the doctoral degree). Note: applications by investigators who are not ECPs will not be considered.
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
- The selection committee may choose not to award the grant in years when no suitable nominations are received
- Researcher must be a member of the Society for the Advancement of Psychotherapy. Join the society at <http://societyforpsychotherapy.org/>

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

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2019 Norine Johnson Psychotherapy Research Grant for Early Career Psychologists, continued

Proposal Requirements for All Proposals (please submit as a single pdf)

- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information

- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion
- After the project is completed, recipients will submit a practitioner-friendly summary of the research for publication in *Psychotherapy Bulletin* and/or the website of the Society for the Advancement of Psychotherapy. This summary is meant to not conflict with or duplicate publication in a research journal, but rather is meant to inform Society membership and the public about the research in a way that translates the research in a practice-friendly way.
- Grant funds that are not spent on the project within two years of receipt must be returned
- When the resulting research is published, the grant must be acknowledged by a footnote or author's note in the publication
- All individuals directly receiving funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st)

Submission Process and Deadline

- All materials must be submitted electronically in a single pdf document at the same time
- All applicants must complete the grant application form, in MSWord or other text format. This document can be found on the Society for the Advancement of Psychotherapy website: www.societyforpsychotherapy.org The application must be submitted at the same time as the supporting materials, but in a separate MSWord (or other text format) document.
- The proposal should include a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net

You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.

Deadline: April 1, 2019

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at woodhouse@lehigh.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.

2019 CHARLES J. GELSO PSYCHOTHERAPY RESEARCH GRANTS

Brief Statement about the Grant Program

The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually by the Society for the Advancement of Psychotherapy to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three \$5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

Eligibility

All graduate students, predoctoral interns, postdoctoral fellows, and doctoral-level researchers with a promising or successful record of publication are eligible for the grant. The research committee reserves the right not to award a grant if there are insufficient submissions or submissions do not meet the criteria stated.

Submission Deadline: April 1, 2019

Request for Proposals Charles J. Gelso, Ph.D. Grant

Description

This program awards grants for research projects in the area of psychotherapy process and/or outcome.

Program Goals

- Advance understanding of psychotherapy process and/or psychotherapy outcome through support of empirical research
- Encourage talented graduate students towards careers in psychotherapy research
- Support psychologists engaged in quality psychotherapy research

Funding Specifics

Three (3) annual grants of \$5,000 each to be paid in one lump sum to each of the researchers who receives the award, to the researcher's university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities.

A researcher can win only one of these grants (see *Additional Information* section below).

Eligibility Requirements

- Demonstrated or burgeoning competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The same project/lab may not receive funding two years in a row
- Applicant must be a member of the Society for the Advancement of Psychotherapy (Division 29 of APA). Join the Society at <http://societyforpsychotherapy.org/>

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals (please submit as a single pdf)

- Description of the proposed project to include, title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within two years)

continued on page 111

2019 Charles J. Gelso Psychotherapy Research Grants, continued

- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows

Graduate students, predoctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.

Additional Proposal Requirements for Graduate Students, Predoctoral Interns, and Postdoctoral Fellows:

- Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work
- Graduate students, pre-doctoral interns, and postdoctoral fellows must also submit one letter of recommendation from the mentor who will be providing guidance during the completion of the project and this letter must indicate the nature of the mentoring relationship

Additional Information

- A full accounting of the project's income and expenses must be submitted within six months of completion
- After the project is completed, recipients will submit a practitioner-friendly summary of the research for publication in *Psychotherapy Bulletin* and /or the website of the Society for the Advancement of Psychotherapy. This summary is meant to not conflict with or duplicate publication in a research journal, but rather is meant to inform Society membership and the public about the research in a way that translates the research in a practice-friendly way.
- Grant funds that are not spent on the project within two years must be returned
- When the resulting research is published, the grant must be acknowledged by a footnote or author note in the publication
- All individuals who directly receive funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st)

Submission Process and Deadline

- All materials must be submitted electronically in a single pdf document at the same time.
- All applicants must complete the grant application form, in MSWord or other text format. This document can be found on the Society for the Advancement of Psychotherapy website: www.societyforpsychotherapy.org. The application must be submitted at the same time as the supporting materials, but in a separate MSWord (or other text format) document.
- The proposal should include a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net

You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.

Deadline: April 1, 2019

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at woodhouse@lehigh.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.

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

Description

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

Eligibility

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

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

How to Apply

Application materials should include:

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

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

\$1,600 APF/Division 29 Early Career Award

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

Nominees should be a member of Division 29, be within 10 years post-doctorate, and will be rated on:

- Accomplishment and achievement related to psychotherapy theory, practice, research or training

Nomination Requirements:

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

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

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

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

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY



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The Society meets the unique needs of psychologists interested in psychotherapy. By joining the Society for the Advancement of Psychotherapy, you become part of a family of practitioners, scholars, and students who exchange ideas in order to advance psychotherapy. The Society is comprised of psychologists and students who are interested in psychotherapy.

Although the Society is a division of the American Psychological Association (APA),

APA membership is not required for membership in the Society.

JOIN THE SOCIETY AND GET THESE BENEFITS!

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This quarterly journal features up-to-date articles on psychotherapy. Contributors include researchers, practitioners, and educators with diverse approaches.

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Quarterly newsletter contains the latest news about Society activities, helpful articles on training, research, and practice. Available to members only.

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

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Member Type: Regular Fellow Associate

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If APA member, please
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Psychotherapy Practice

Chair: Barbara Vivino, PhD
921 The Alameda #109
Berkeley, CA 94707
Ofc: 510-303-6650
E-mail: bvivino@aol.com

Psychotherapy Research

Chair: Joshua Swift, PhD
Department of Psychology
University of Alaska Anchorage
3211 Providence Drive, SSB214
Anchorage, Alaska 99508
Phone: 907-786-1726
E-mail: jkswift@alaska.edu

Social Justice

Linda Campbell, PhD
Dept of Counseling & Human Development
University of Georgia
402 Aderhold Hall
Athens, GA 30602
Ofc: 706-542-8508 Fax: 770-594-9441
E-mail: lcampbel@uga.edu

PUBLICATIONS BOARD

Chair: Laurie Heatherington, PhD, 2018
Dept of Psychology / Williams College
Williamstown, MA 01267
Ofc: 413-597-2442 | Fax: 413-597-2085
E-mail: laurie.heatherington@williams.edu

Lillian Comas-Diaz, PhD, 2014-2019
908 New Hampshire Ave., NW Suite 700
Washington, D.C. 20037
Ofc: 202-775-1938
E-mail: lilliancomasdiaz@gmail.com

Steven Gold, PhD, 2013-2018
Center for Psychological Studies
Nova Southeastern University
3301 College Ave
Fort Lauderdale, FL 33314
Ofc: 954-262-5714 | Fax: 954-262-3857

Publications Board, continued

Robert Hatcher, PhD, 2015-2020
Wellness Center / Graduate Center
City University of New York
365 Fifth Avenue
New York, NY 10016
Ofc: 212-817-7029
E-mail: rhatcher@gc.cuny.edu

Heather Lyons, PhD, 2014-2019
Department of Psychology – Loyola University Maryland
4501 N. Charles St.
Baltimore, MD 21210
Ofc: 410-617-2309
E-mail: hzlyons@loyola.edu

Terrence Tracey, PhD 2018-2023
College of Integrative Science & Arts / Arizona State University
446 Payne Hall, mc-870811
Tempe, AZ 85287-0811
Office: 480-965-6159
Email: Terrence.Tracey@asu.edu

Brien Goodwin (2017-2019) – Student Representative

EDITORS

Psychotherapy Journal Editor

Mark J. Hilsenroth, PhD, 2011-2020
Derner Institute of Advanced Psych Studies
220 Weinberg Bldg.
158 Cambridge Ave.
Adelphi University
Garden City, NY 11530
Ofc: (516) 877-4748 Fax (516) 877-4805
E-mail: hilsenro@adelphi.edu

Psychotherapy Bulletin Editor, 2014-2019

Lynett Henderson Metzger, JD, PsyD
University of Denver-GSPF
2460 South Vine Street
Denver, CO 80208
Ofc: 303-871-4684
E-mail: lhenders@du.edu

Internet Editor

Amy Ellis, PhD
Albizu University
2173 NW 99 Avenue
Miami, Florida 33172-2209
Ofc: 305-593-1223 x3233
E-mail: amyellisphd@gmail.com

PSYCHOTHERAPY BULLETIN

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

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



Society for the Advancement of Psychotherapy (29)

Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215

Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net

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