Psychotherapy

OFFICIAL PUBLICATION OF THE SOCIETY
FOR THE ADVANCEMENT OF PSYCHOTHERAPY
OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.societyforpsychotherapy.org

BULLETIN

In This Issue

2019 VOLUME 54, NUMBER 1

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PSYCHOTHERAPY BULLETIN
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PSYCHOTHERAPY BULLETIN

Official Publication of the Society for the Advancement of Psychotherapy of the American Psychological Association

2019 Volume 54, Number 1

CONTENTS

PRESIDENT'S COLUMN

Nancy L. Murdock, PhD
University of Missouri-Kansas City

Greetings to all! I am honored and excited to begin my presidential year in service to the Society for Advancement of Psychotherapy (SfAP). I am really looking forward to the year's work, which began January 1, just as they all promised me it would (smile). As I write this note, I have just returned from our very productive spring Board of Directors meeting in Washington, DC, held February 8-10. More on this meeting later.

Before I get on to news, several thank yous are in order. Michael Constantino served as 2018 Society president, and we are truly fortunate that an individual of such talent and dedication devoted his time and energy to furthering the mission of SfAP. Mike now will serve as past-president, taking over for Jeff Zimmerman, who did such an admirable job in his three years in the presidential roles.

My heartfelt appreciation goes out to your board and committee members, who work all year to realize the SfAP mission. And as always, my undying gratitude to Tracey Martin, our outstanding administrator. I can say confidently that every president would attest that they couldn't do their jobs without the able Tracey's unwavering assistance.

Presidential Theme and APA Convention

As I have noted previously, my presidential theme is *Out of the Office and Into the Streets* and is intended to seek out and highlight psychotherapy interventions (I like to call them growth-producing interventions) that take our efforts to diverse, nontraditional venues which inherently have the potential to reach clients who are less than likely to show up at traditional places where psychotherapy happens. It bears repeating that if this type of activity is on your list, please let me know! As one step toward realizing the theme, I have composed a panel of outstanding individuals who will present on out of the office interventions for my presidential symposium at APA in Chicago.

Speaking of APA……one of the most exciting events of the year, of course, is our program at the APA convention in Chicago this August, which carries the sister theme to my presidential one: *Psychotherapy for the future: Promoting growth through interventions designed for diverse clients and settings.* The program for the convention has been finalized, with 23 hours of excellent programming, including a many high-quality symposia and posters, our fabulous Lunch with the Luminaries for students and early career professionals, and of course, our wonderful Business Meeting and Awards Presentation and Reception. Once we get the final blessings from APA, we will post the program on the Society website. My heartfelt thanks to James Boswell, our program chair, who put this program together. Please pay close attention to the program when we are free to let the details out, closer to convention time—but you do know that we can be fairly confident that the Business/Awards/Social Hour happens on Friday afternoon, so mark your calendar now!

Other Important SfAP News

You may recall that Mike Constantino, who now serves as our distinguished

continued on page 3

past-president, described bylaws changes that were proposed to the membership by the Board of Directors. The proposals created a membership for undergraduate student affiliates, modified the composition of the Committee for Professional Awards, and made some clarifications regarding membership rights and privileges. The vote is in! I am pleased to report that these changes were supported by the vote of our membership in the fall. To see the full text of these changes, please visit our most excellent SfAP website. https://societyforpsychotherapy.org/proposed-bylaws-changes-2018/

From the Board of Directors Meeting, February 8-10, 2019

After an orientation session on Friday (which included some animated cha cha cha on the part of your representatives), your Board of Directors and Committee Chairs went hard to work on division business Saturday morning. One of the first business items was to establish a **Presidential Task force on Communication and Membership**, which carries the charge of reviewing how we communicate as a division and suggesting improvements in communication. In addition, we are interested in hearing from membership about their perceptions of the benefits of being a part of SfAP, with an eye toward increasing member benefits where possible. This means… yes… a survey. Please do take the time to respond when you see it hit the Society's email lists.

Other Board meeting items of note included the signing of our renewed agreement with Oriental Insight, an organization devoted to promotion of psychotherapy practice, research, and education based in Wuhan, China. Our treasurer, Jesse Owen, assured us that SfAP is in good financial health. A particularly exciting part of our meeting was previewing concepts for a new logo for the Society. The Board chose one possibility for further development; it is not ready for prime time yet, but stay tuned. There are lots of interesting things going on in the Diversity and Social Justice Domains and committees, too. The board was also treated to a review of the qualitative study of independent practitioners spearheaded by the Professional Practice domain and committee. More information on that can be obtained from the Practice Domain Representative, Barbara Vivino. (Please see photos on page 74!)

Thank you again for allowing me the honor of serving as your President. I am excitedly anticipating the year's work!

EDITORS' COLUMN

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We hope your 2019 is going well so far! Inside this issue of *Psychotherapy Bulletin* you will find a variety of articles on topics ranging from this year's Special Focus—Self-care Across the Lifespan—to the future of psychotherapy research to transitioning into integrated primary care. There is even a bit of Psychotherapy Practice-related poetry, in the form of a call and response between a supervisor and supervisee. We are also excited to announce a new Ethics Q&A feature from Dr. Apryl Alexander (be sure to check out this issue's Ethics column for more details!).

As we begin our last year serving as Editor and Associate Editor, respectively, Lynett and Cara would like to thank everyone who contributed to the *Bulletin* over the past year, and those who served SAP in so many ways. We would also like to welcome new members of Governance and future contributors, including incoming Domain Chairs, Representatives, officers, and you, our readers!

You can meet just a few of the many people who work to make SAP a fantastic organization on the pages of this issue—and we hope you will consider joining them. Apply for a position, run for office, write a piece on self-care, or submit an idea for the website or Bulletin. ***For SAP members who are traveling to Cuba for CIPCUBA 2019, please consider reaching out to us about sharing your experiences!***

Our remaining deadlines are May 1, August 1, and November 1, 2019, and you can find the Bulletin submission guidelines online (http://societyforpsychotherapy.org/publications/bulletin/about/).

We look forward to hearing from you!

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EDUCATION AND TRAINING

Who Am I? Inter-professional and Self-care Education in Clinical Psychology Training

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Clinical Psychology Training in Australia

Currently in Australia there are over 35,000 registered psychologists. There are multiple pathways to registration as a psychologist within Australia, including a combination of undergraduate Bachelor degree, supervised practice, and/or postgraduate studies. Many students choose to undertake a postgraduate training program within a university setting. Postgraduate training programs include a combination of University-based teaching and clinical placements, which can occur internally or within external agencies or health settings. As defined by Australian Psychology Accreditation Council (APAC, 2018), the key purposes of clinical placements are to: integrate theory into practice, familiarise students with the practice environment, and build the core competencies required for professional practice. At least 1,000 hours of clinical placement experience is required and about an hour of clinical supervision should be provided for every seven hours of placement; hence, clinical supervision is a core component of psychology training.

Psychology training programs in Australia are regulated through APAC, with the newest regulations coming into effect from 1 January 2019 (these can be accessed at www.psychologycouncil.org.au). They list standards for both the accredited programs as well as the expectations of graduates from the programs. A number of these standards have direct relevance to the practice of group supervision within training programs, particularly as they relate to the focus of this paper. For example, graduates are expected to demonstrate interpersonal skills and teamwork, demonstrate an understanding of appropriate values and ethics in psychology, and demonstrate self-directed pursuit of scholarly inquiry in psychology. Likewise, the accreditation standards for psychology programs include standards such as inter-professional learning and practice, and self-care skill development (APAC, 2018).

There is increasing demand on postgraduate clinical psychology courses due to the growing popularity of psychology as a career pathway. Job Outlook data suggests very strong growth predicted in the next 5 years (Job Outlook, n.d.). Furthermore, there are a limited number of postgraduate courses and places available, meaning that positions in these courses are competitive (Littlefield, 2016). Other constraints include: funding and regulatory challenges, enrolment loads, over-demand for places (creating a "bottleneck" from undergraduate to postgraduate programs), difficulty in sourcing external placements, a gap between costs of running the course and the government funding supplied to universities (hence undergraduate enrolments subsidize the postgraduate professional pro-

continued on page 6

grams, or programs run at a loss) (Littlefield, 2016).

Moreover, those who complete a clinical psychology training program are likely to experience significant stress during and after graduation. Recent statistics suggest that there are high levels of exits from the psychology workforce in Australia (Littlefield, 2016). An Australian study found that early-career psychologists were stressed by the transition from student to professional and reported they would benefit from ongoing mentoring and access to support from more experienced psychologists (Rice, Murray, Kazan, & Felman, 2016). Similarly, Knoetze and McCulloch (2017) reviewed the experiences of new psychology graduates in South Africa. Although they identified a positive view of the profession and a sense of a learning community, they also reported concerns about work overloading and a commitment to high standards, which created some distress. These findings are consistent with research identifying that psychologists are vulnerable to mental health difficulties, due to personal vulnerabilities, distress associated with clinical practice, and a (ill) perceived sense of invulnerability to stress (Barnett & Cooper, 2009).

Bettney (2017) reviewed self-care practices taught during clinical psychology training in the United Kingdom, and found that a number of factors contribute to burnout in trainees, including competing demands (of coursework, research, and clinical practice), performance anxiety, and peer competition. These findings occur in spite of a recent U.S.-based review that reported that most training programs incorporate self-care into the curriculum (Vally, 2018). Taken together, it appears that clinical psychology trainees and graduates are vulnerable to stress regardless of geographical location.

The Role of Group Supervision in Clinical Psychology Training

Group supervision provides an opportunity for clinical psychology trainees to reflect on their clinical development in a forum that to some extent mimics the complexity of "real life" clinical decision-making (Fisher, Chew, & Leow, 2015). Group supervision is most effective when core processes of reflection, information exchange, scaffolding, modeling, and a strong supervisory alliance exist (Goodyear, 2014; Johnston & Milne, 2012). An important outcome is for trainees to develop an "internal supervisor" and engage in a process of lifelong learning (Fisher et al., 2015; Woodward, Keville, & Conlan, 2015).

Within group supervision, the supervisory alliance is necessary but it is insufficient for learning; rather it mediates the processes of information exchange, scaffolding, modeling, and reflective practice. At different "developmental stages" of training, these processes may be less pronounced; for example, reflective practice is likely to be more evident as trainees are more experienced, whereas in early stages information exchange may be more paramount (Goodyear, 2014; Johnston & Milne, 2012). Goodyear (2014) identified that the ability to engage in reflective practice is impacted by the provision of knowledge about the content and process of reflection, suggesting that explicit instruction in reflective practice can be helpful, especially early in the practice of group supervision.

Who Are You? Inter-professional Education (IPE) in Clinical Psychology Training

Recent data shows that a majority of medical patients are presenting with mental health issues (The Royal Australia College of General Practitioners,

continued on page 7

2018). Therefore, it is timely to consider the possibility of a more integrated approach to mental health care, and more specifically, the involvement of clinical psychology trainees within an integrated model (Cubic, Mance & Turgensen, 2012; Linton, 2017; Smith et al., 2015). Inter-professional education (IPE) provides opportunities for learning about practices of other professions; for example, their discipline-specific expertise, scope of practice, and what they can contribute to patient care. It involves learning effective communication strategies, including common language, problem solving, conflict resolution, and teamwork (Cubic et al., 2012).

IPE can involve a wide range of learning methods (small group, role play, simulations, video/audio) and has the potential to develop a wide skill set through the use of an integrated curriculum (Bradley & Postlethwaite, 2003; Pauzé & Reeves, 2010). Hence, it has many advantages that are particularly relevant to post-graduate clinical psychology training and group supervision in particular. This includes self-directed learning and integration of theory into practice (Bradley & Postlethwaite, 2003). However, while a number of studies have advocated for, and examined the use of IPE in psychology training, there is a lack of specific evaluation of the impact of IPE on collaborative practice and client outcomes (Linton, 2017).

Pauzé and Reeves (2010) wrote a systematic review of the effectiveness of IPE in mental health settings nearly 10 years ago. They identified 14 papers that met criteria to be included in their review. A key conclusion was that the research is limited by flawed methodology. For example, they suggested that including client outcomes in future research and evaluations was important. However, themes from the papers reviewed suggest that some learning outcomes may be specific to (or enhanced by) IPE, including: improved collaboration, team functioning, and decision making.

An examination of papers that evaluated the practice of IPE in clinical psychology training was undertaken to further expand on the Pauzé and Reeves review. Papers were included in the current paper if they included the following criteria: published within the past 15 years; in the English language; the study examined clinical psychology trainees; the study included a group teaching program; the study included an evaluation of the impact of the training program. Five papers were identified that met these criteria. Table 1 (page 8) summarizes these findings. Four of the five papers reviewed reported positive findings from their IPE program.

In contrast, Priest et al. (2011) reported that their IPE program, which involved nursing and psychology students, was received negatively and did not achieve the desired outcomes in improved collaborative practice. This may be because they met only seven times over a two-year period, and there was poor attendance across the timespan of the program, which impacted negatively on attitudes over time.

Peterson and Brommelsiek (2017) reported increased self-efficacy and persistence in providing client care as a result of engaging in IPE among a diverse cohort of health professional trainees. Specific to IPE, they reported both an improved understanding of other professionals' roles as well as their own discipline specific role. Based on their findings, they recommended that IPE is a good forum through with to

continued on page 8

Table 1. IPE in clinical psychology education

Authors	Year	Location	Research design	Key findings	Recommendations
Priest et al	2011	UK	21 students (10 clinical psychology, 11 nursing). IPE sessions – creative group work. 7 sessions over 2-year period. Qualitative and quantitative evaluations of inter-professional learning	Quantitative data suggested poor attitude to IPE and low effectiveness Qualitative analyses – themes were around professional identity, teamwork, roles and responsibilities	• Very few studies of IPE in mental health settings • Potential for IPE to build positive relationships in mental health systems across disciplines • Poor attendance at IPE impacted findings
Howell et al	2012	USA	6 students (OT, psychology) were supervised in developing a program for working with children with ASD. Qualitative evaluation of learning outcomes.	4 themes: professional identity, teamwork and communication, improved client outcomes	• IPE is essential in preparing students to represent their profession within a diverse inter-professional health care team. • Need to emphasize importance of collaborative care as students value the clinical experience over the IPE learning
Jones et al	2015	Canada	247 students (medicine, nursing, clinical psychology, occupational therapy, physiotherapy) blended teaching (PBL, lectures, online) about intellectual disability in healthcare. Evaluation pre-post knowledge development across different disciplines.	All discipline groups showed significant improvement in knowledge and skills. Some indication of improved understanding of IPE although only 1 evaluation question was related to this.	• IPE can be helpful in training future health care professionals particularly for work with vulnerable cohorts who require an integrated approach to care
Peterson & Brommelsiek	2017	USA	8 week course prior to students commencing clinical practicum at a primary care clinic. Focus on IPE – communication, teamwork, values/ethics, roles. Nursing, pharmacy, clinical psychology, social work students – numbers were not provided in the study. Qualitative evaluation using surveys and reflective journals.	4 themes: increased self-confidence, reduced anxiety, improved commitment to client care, and increased inter-professional collaboration	• The IPE course built resilience in health professional students and prepared them for managing the demands of working within a health care team. • Educating all health care students in coping with workplace stress is important and this might be achieved through IPE.
Straub et al.	2017	Germany	IPE course for students from medicine, psychology, social work, educational science, and clinical education (N = 85). Course focused on family services and child protection. Students are taught requirements for interprofessional cooperation and then solve cases in teams. Course evaluations were assessed quantitatively and qualitatively.	Course ratings across all disciplines were high. No significant difference across disciplines. Qualitative evaluation indicated that inter-professional education and collaboration was highly valued. Students requested more opportunity for IPE in future.	• Very positive evaluations for the course, but evaluation instruments changed over time, which complicated interpretation of findings. • Continuous personal communication and promotion of the course was necessary to ensure it ran ongoingly due to logistical demands working across faculties and disciplines.

continued on page 9

work on self-care skills and development (Peterson & Brommelsiek, 2017). Straub, Krüger, and Bode (2017) developed a course for a diverse range of disciplines, with a focus on child protection and family services. They reported positive findings, with high course ratings from all students involved and no significant differences across disciplines. Qualitative evaluation showed that students rated the interprofessional aspects of the course highly. However, they reported that the logistics of running a course across diverse faculties was time-consuming and challenging, particularly with regard to staffing and timetabling.

Jones, McQueen, Lowe, Minnes, and Rischke (2015) evaluated an inter-professional education model in working with clients with intellectual disability. They included online learning, lectures, problem-based learning, and client interviews with health professionals from different faculties. They reviewed the impact of IPE on learning outcomes and found that communication, client-centered care, role clarification, and team functioning were all improved post-curriculum (compared to pre-curriculum). Thus, the IPE improved understanding of the course content (on client-centered care), as well as skills in working with other professionals. Similarly, Howell, Wittman, and Bundy (2012) involved occupational therapy and psychology students in developing social skills programs for children with Autism Spectrum Disorder. They found four themes regarding the impact on educational outcomes for the trainees involved: professional identity, professional differences, communication, and client outcomes. Moreover, trainees reported benefits in making theory-practice connections. However, client outcomes were not reported in either study.

In summary, most of the studies exploring the use of IPE in clinical psychology training have reported positive findings in relation to the impact on professional identity development and teamwork. However, most studies have not used comparison groups, and outcome measures have been inconsistent. Therefore, it is difficult to make robust findings as to the effectiveness of IPE. To this end, Schwindt and colleagues (2017) have developed an instrument to measure IPE and its impact on collaborative practice, which might be used in future studies. Their instrument identified a two-factor model: perceived ability to provide interdisciplinary care, and perceived ability to work as part of an inter-professional team. Of the five studies identified that met inclusion criteria, none investigated client outcomes in addition to the student learning outcomes. Furthermore, studies have tended to focus on a specific client cohort to investigate IPE, rather than practicing IPE broadly across the mental health or primary health care system.

What About Me? Self-care in Clinical Psychology Training

Given the stress associated with clinical psychology training, as well as the ongoing risk of burnout linked to psychological practice, engagement in self-care is integral for practicing psychologists. Furthermore, the integration of learning therapy for personal *and* clinical application is likely to maximize practice of the competencies as well as lead to improved client and personal outcomes (Pakenham, 2015). Group supervision is an ideal forum through which to develop self-care skills, particularly through the use of reflective practice.

Norcross published a seminal guide to therapist self-care over 10 years ago, and this has recently been updated, based on the latest research (Norcross & VandenBos, 2018). The authors identify 12 key

continued on page 10

areas of self-care, including: valuing personal development; focusing on the rewards of therapeutic work; understanding warning signs and triggers; looking after relationships, the body, and the mind; boundary setting; personal therapy; mindfulness practice; and fostering personal growth and development.

An examination of the literature relating to self-care specifically in clinical psychology training programs found little empirical research in this area. Some studies have explored specific self-care training programs, while others have focused on the role of self-care in mediating stress after graduation. Four papers that met the criteria (as outlined above) are summarized in Table 2 (on page 11).

Two studies explored the role of perceived emphasis on self-care within the training program, and found that having an emphasis on self-care tended to mediate use of these skills after graduation (Goncher, Sherman, Barnett, & Haskins, 2013; Zahnisher, Rupert, & Dorociak 2017). Engagement with self-care strategies also related to higher wellbeing and life satisfaction after graduation (Goncher et al., 2013). Zahnisher et al. (2017) also found that self-care was identified as a buffer against the stress associated with training. Two key self-care methods were identified in their study: professional support and self-awareness, both highly relevant to the practice of group supervision.

An Australian study has investigated the specific use of a therapy-based framework in fostering self-care in clinical psychology trainees, based on Acceptance and Commitment Therapy (ACT) principles. Pakenham (2015, 2017) incorporated training and workshops on ACT, which included didactic instruction, experiential exercises, demonstration, roleplays, and self-reflection. Pakenham (2015) found that greater acceptance and connection with values, as well as lower thought suppression, was associated with better adjustment to the stress of training. Furthermore, feedback from trainees indicated that self-care workshops were helpful in nurturing self-care, and about three-quarters of trainees reported at least one behavioural self care change as a result of their participation (Pakenham, 2017). Importantly, trainees indicated that they valued the training in self-care practices as highly as they did their clinical skills training.

All of these studies recommended that explicit training in self-care be provided to trainees, as well as the active promotion of a culture that values self-care. This would likely improve distress management in trainees, with the likely outcome of reducing professional burnout in future (Goncher et al., 2013; Zahnisher et al., 2017). Importantly, although all trainees are exposed to self care during training (either explicitly or implicitly), not all utilize this during training and after graduation; hence, further exploration regarding the barriers to engaging in self-care is recommended (Goncher et al., 2013).

In summary, the research into self-care training is positive and suggests that it improves future wellbeing as well as assisting clinical psychology trainees with the management of the stress of their training. This has important implications for burnout and lifelong self-care practices. However, studies are limited by the lack of research into the impact of self-care practice on client outcomes. Furthermore, longitudinal data is required to further assess the impact on future professional burnout and wellbeing.

Conclusions

Psychology as a discipline is a growth industry and there is increasing pressure

continued on page 11

Table 2. Self care in clinical psychology education

Authors	Year	Location	Research design	Key findings	Recommendations
Goncher et al	2013	USA	N = 262. Measures: Quality of life, personal use of self-care strategies, perceived emphasis on self care during training. Quantitative analysis of correlations between these measures.	Perceived emphasis on self-care during training was correlated with quality of life (after graduation) – this correlation was partly mediated by practice of self-care strategies.	• More emphasis on self-care competencies during training • Promotion of a 'culture of self care' during training • Assessment of competent use of self-care strategies may be helpful in future studies
Zahniser et al	2017	USA	N = 358 Quantitative evaluation of correlations between self care, personal wellbeing, progress in training. Qualitative evaluation of open-ended question	Correlations between program self-care culture and measures of academic progress, stress, affect and wellbeing. Professional support and cognitive awareness were especially important. Self-care was a buffer for students with high stress. Themes from qualitative analysis – a need for systematic instruction in self care, active encouragement of self-care, modeling of self-care.	• Graduate training programs should explicitly teach and encourage self-care in trainees • Faculty staff should model self-care and build a culture that values and promotes self-care.
Pakenham	2015	Australia	N = 116 ACT processes (values, defusion, mindfulness, acceptable) were measured. Outcome measures (adjustment) were stress, distress, life satisfaction, and clinical training satisfaction. Quantitative analysis.	Greater levels of acceptance and values, and lower thought suppression were related to better adjustment. Mindfulness was unrelated to adjustment. Thought suppression related to all 4 outcome measures, values related to life satisfaction and distress only, and acceptance related to distress, stress, and life satisfaction.	• Including ACT training in courses may help in promoting self care practice In future • Further longitudinal research is required to further evaluate this
Pakenham	2017	Australia	N = 57 Trainees were taught self care skills (ACT based) Evaluation of training course (N = 57). Subsample of N = 22 completed measures of self-care efficacy	100% of the students reported the course was helpful in nurturing self care. 74% of students reported behavioural self-care change since completing the course In the sub sample, self-care efficacy significantly increased from beginning to end of course.	• Findings supported the interweaving of training in therapy competencies and self-care skills within training programs. • Students rate self-care training as highly as they do clinical skills training

continued on page 12

on universities to provide an extensive curriculum and training in many diverse aspects of psychological practice. Psychologists face significant stress in their work settings, and the importance of training in and the practice of self-care and interprofessional education should not continue to be understated. These two areas of clinical practice should be explicitly emphasized and can develop through group supervision, which is an ideal modality through which to support development of these skills.

Recommendations

- Training courses should focus on self-care as a key area of curriculum and would benefit from a multi-faceted approach, including explicit instruction, practice, reflection, and modeling during group supervision. This might include using measures of supervision to ensure ongoing feedback and reflective practice (e.g., using the Leeds Alliance in Supervision scale; Wainwright, 2010).
- Training courses would benefit from regular inter-professional education embedded within the curriculum, through explicit instruction as well as inter-professional group supervision experiences, in order to provide practice and modeling of, and reflection upon, these skills. Potentially self-care skills could be practiced within IPE group supervision.
- Training programs should formalize assessment of skill development in self-care and inter-professional communication. This might include rubrics that are developed for group supervision participation.
- Researchers should increasingly explore the impact of training in self-care and IPE on future wellbeing and burnout of clinical psychology graduates, particularly using consistent definitions and measures
- Researchers should additionally incorporate measures that capture the impact of training in self care and IPE on client outcomes, rather than only focusing on the trainee outcomes
- Finally, given that studies have tended to rely on qualitative data, researchers are encouraged to incorporate empirical research utilizing quantitative outcomes in the future, so that the costs and benefits of group supervision focusing on self-care or IPE (or both) can be better understood.

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PUBLIC INTEREST AND SOCIAL JUSTICE

The Advocate: Building a Bridge Between Self-care and Advocacy

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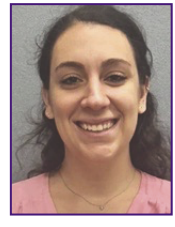

Advocacy and clinical psychology are inseparable. All good psychologists advocate for their clients' overall well-being, effective treatment, and access to needed resources. Given that larger societal issues impact the mental health of the individual, it is important that this advocacy role generalizes beyond our therapy offices. Clients enter therapy shouldering an enormous load of struggles related to systemic issues. Many therapists consider "unpacking" these experiences to be reparative for our clients. Why isolate our ability to help lighten these loads to the confines of the therapy room? It is our opinion that we fail to address the systems of oppression that our clients face across all of their identities by exclusively interacting with them directly. This is a disservice to our clients and our professional community. As students at the University of Denver's (DU) Graduate School of Professional Psychology (GSPP), we are also well aware of the barriers that students face when trying to connect with those who are involved in social justice and advocacy work around our campus and the greater community. We humbly aim to challenge some of these barriers.

Step 1: Recognizing the Barriers
Clinical psychology graduate students at DU are disconnected from the campus-at-large. If you were to select a student walking around the campus at random and ask, "Where is the Graduate School of Professional Psychology?," you might meet a confused expression. In the unlikely event that you were directed to the correct building, you would encounter a street brimming with cars parked bumper-to-bumper. A flustered-looking trainee may rush into the double doors after illegally parking in a neighboring apartment parking lot, and crossing their fingers. Similarly, if you were to ask any of the graduate students milling around GSPP about how to navigate the remainder of the DU campus, you would find they rarely consider that other buildings exist beyond their four walls.

As students, our weeks tend to be consumed by driving to and from the same three places: home, school, and practicum. The way we remain connected to extracurricular advocacy work

continued on page 16

is through sporadic emails. We spend the first few weeks of our graduate program reading every email we receive, attentively. Quickly, we learn to decipher which sender's emails are urgent and whose require a quick "mark-as-read" in order to make room for more. It can be difficult to take our advocacy work beyond the realms of individual treatment and into the world at large when those opportunities are collecting dust at the bottom of our inboxes. We seem to regard advocacy in the same way that many voters treat political issues. We are aware that we should be more informed and involved, but we are busy, and doing so feels daunting and tedious.

Step 2: Bridging the Gap

We recognized that motivating busy students to participate in events of which they are unaware, on a campus in which they feel geographically isolated, was going to be a significant challenge. Thus, we appealed to the Dean and Directors of our program to support our creation of a concise and easily accessible platform to share resources and opportunities for community engagement. Our first approach was to streamline the information channels by creating a single platform with a selection of events happening on campus and in the community. We named this platform *The Advocate*. Our mission was to promote collaborative engagement in the community through activism, advocacy, and volunteer work. We have distributed an issue on the first of each month, to ensure that distribution was predictable but not excessively frequent. A monthly "Advocate Award" was included in order to celebrate students who moved social justice to the top of their to-do lists. This peer nomination process recognizes students for their work in the community and highlights that being a student advocate is both possible and worth applauding. Because delving into advocacy can be a scary leap for a student, we wanted to take some of the guesswork and anxious hesitation out of the equation. Students may wonder where to start and who will be joining. In addition to the monthly email distribution, our aim is to facilitate other student connections through social media. By creating groups for students, mentors, and faculty to mark their plans to attend certain events, we hope to help to answer the where and who for students.

Step 3: Maintenance and Growth

Advocacy is an ongoing process that evolves along with the evolution of our roles in the field of psychology. As the four of us inch closer to graduation, our sincerest wish is that this platform and the momentum it has created live on after us. We are all passionate about issues of multiculturalism and marginalization based on the various identities we and our loved ones carry. We each grew tired of sitting in class lamenting the terrible realities that our clients face in the world and feeling that our hands were tied. This project was born out of a desire to channel that frustration and hopelessness into positive action. In this vein, we consider addressing social injustices to be good self-care. The support of our professors and program made *The Advocate* a reality. However, the four of us do not consider ourselves particularly special. Any like-minded graduate students can mirror what we built at *The Advocate*, and we hope they do.

STUDENT FEATURE

Safety in Clinical Supervision: A Mechanism to Promote Professional Development Among Trainees

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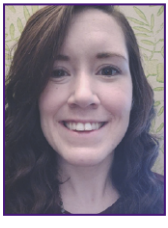

Introduction

Perceived safety in the supervisor-supervisee relationship can influence the level of supervisee self-disclosure (e.g., of mistakes, countertransference, or personal factors such as self-care; Gunn & Pistole, 2012), as well as supervisee outcomes (e.g., self-awareness and self-confidence in session with clients; Johnston & Milne, 2012; Wheeler & Richards, 2007). The development of safety in this relationship is facilitated by qualities such as consistency, empathy, and warmth among supervisors (e.g., Wilson, Davies, & Weatherhead, 2016). Additionally, supervisor self-disclosure, when used appropriately (e.g., with the clear intent of responding to supervisees' training needs) is related to greater working alliance between supervisors and supervisees (Knox, Edwards, Hill, & Hess, 2011). In the authors' experience, when supervisors engaged in judicious self-disclosure, perceived safety in the supervisory relationship increased. This in turn augmented our own level of self-disclosure in supervision and improved our outcomes, as evidenced by greater self-perceived competence in clinical work. To illustrate, we present interactions with supervisors in which self-disclosure promoted our development as trainees across three themes. From our perspective, when supervisors used self-disclosure as a tool to engage in the actions presented, the quality of the supervisory relationship was strengthened through greater perceived safety, furthering our development as clinicians.

Supervisory Example by Author 1: Promoting Self-care in Supervision

Maintaining self-care is an ethical responsibility for both supervisor and supervisee (Falender & Shafranske, 2017b). These authors emphasized supervisors' duty to maintain a "multiple complex relationship with self-care" (p. 44) in how they encourage supervisees to take care of themselves. Maintaining one's health through self-care is especially important when providing services to clients in a process that is challenging, "full time, intimate, confidential, and nonreciprocal" (Falender & Shafranske, 2017b, p. 44). Supervisors also want their supervisees to be as productive as possible with clients, and to simultane-

continued on page 18

ously balance clinical training with other training expectations (e.g., thesis or dissertation, teaching assistantships). As Falender and Shafranske (2017b) discussed, supervisors may not present self-care as accessible, but rather as another task to be added to an already full agenda. In Barnett and Molzon's (2014) discussion of supervisors' legal and ethical responsibilities, self-care emerged as essential in therapeutic work.

Setting the stage. As a practicum student who sets high expectations for herself, it has been easy for me to invest many hours into clinical work at the expense of self-care. However, some of my supervisors noticed this tendency, and encouraged my self-reflection on the implications of these choices through different means. One supervisor pointed out my tendency to avoid self-care in a formal competency evaluation, while another used examples from her own experience to highlight the importance of self-care. The following exchange highlights how supervisors' discussion of self-care benefitted my professional development.

Modeling. While reviewing a competency evaluation with a supervisor, she pointed out my substantial investment in both clinical work (i.e., readings, preparation, writing, reviewing) and in several academic projects outside of this work. This supervisor discussed the importance of having a work-life balance in the psychology profession and encouraged me to pursue an interest or a hobby that would promote my health. Through the discussions, this supervisor helped me set limits with clients by being firmer with my availabilities and work to be done with them. This in turn helped me to ensure sufficient time to pursue my other interests. My supervisor was also helpful in reinforcing the importance of self-care: She described her challenges in maintaining her own self-care and helped to normalize my difficulty in balancing work and high expectations. She validated my concerns about this balance and empathetically clarified that it can be difficult to lower one's expectations and take time to do things to maintain my own health.

Supporting supervisee's self-reflection. These exchanges helped increase my awareness of the importance of self-care, not only to live a fulfilling life but also to maintain my energy and empathy as a clinician. I felt safe discussing my difficulty prioritizing self-care because the supervisory environment was open, confidential, and above all without judgment. Supervisors also disclosed about their own journeys as students in clinical psychology, allowing me to reflect on mine and share it with them. I felt that I could be vulnerable and could discuss my thoughts and emotions with these supervisors. These supervisors' ability to support me while maintaining our professional relationship allowed me to feel that they cared about my well-being as much as about my work with clients. This encouraged the development of my professional identity and helped me to increasingly appreciate the work done for and with my clients.

Supervisory Example by Author 2: Supporting Disclosure of Countertransference

Therapists are not neutral beings, and each has a set of experiences and beliefs that influences how they feel, think, and act in relation to other people. These reactions, when they occur in the therapeutic context, are called countertransference (CT; Ponton & Sauerheber, 2014). CT can lead therapists to engage in unhelpful behaviors towards clients. In their meta-analysis of CT studies, Hayes, Gelso, and Hummel (2011) found that CT was inversely related to therapy outcomes. However, when therapists effectively managed

continued on page 19

CT, it was related to improved therapy outcomes and greater therapist self-awareness (Hayes et al., 2011).

Managing CT is an important skill for therapists. To develop this skill, clinicians must reflect about how their personal experiences (e.g., memories and beliefs) interact with client characteristics. For trainee therapists, this self-reflective process can be facilitated by the guidance of competent, empathic supervisors. However, supervisees are reluctant to disclose CT in supervision (Hess et al., 2008). Reasons for this include personal characteristics (e.g., the degree to which they value self-reflection) and the perceived quality of their relationship with their supervisors (Spence, Fox, Golding, & Daiches, 2014). Thus, while supervisees' decision to disclose CT is voluntary, supervisors can contribute to their students' growth by providing a safe environment in which to do so. Described below are a few actions by supervisors that promoted my disclosure of CT in supervision.

Setting the stage. Supervisees' initial interactions with their supervisors can set the tone for the remainder of the relationship. At the onset of the supervisory relationship, a recommended task between supervisor and supervisee is the establishment of a supervision contract (Thomas, 2007). In this contract, goals and expectations for supervision are discussed. This is an excellent opportunity for supervisors to build the foundation for a secure supervisory relationship by adopting a collaborative approach and asking about supervisees' needs, strengths, and areas for growth (Barnett & Molzon, 2014). In my experience, I have felt most comfortable with supervisors who allowed me to take up space in supervision and responded to my early self-disclosures (e.g., areas for growth) in an empathic and nonjudgmental way. This set the stage for further self-disclosure throughout the supervisory relationship.

Modeling. Supervisees can feel self-conscious about their personal reactions to clients. In my case, this has sometimes prevented me from disclosing CT in supervision. However, supervisors who judiciously disclosed their own reactions to clients, as is promoted in the literature (Wilson et al., 2016), have helped to normalize my own CT and build safety in the supervision environment. I have learned the most from supervisors who discussed their emotional responses to clients, the self-reflective process that followed, and how they learned to manage these reactions. For example, one supervisor discussed how she had taken on a "rescuing" role with a particularly distressed client (e.g., adding additional sessions for this client throughout the week and feeling a disproportionate sense of responsibility for the client's safety outside of sessions). She explained that after self-reflection, she realized this reaction was related to similarities between her client and a family member, and she learned to manage her CT by addressing it with her own therapist. This and other supervisors' modeling of their management of CT helped to normalize my own reactions to clients and set me on the path toward developing a self-reflective practice.

Supporting supervisee's self-reflection. In my experience, choosing to disclose CT in supervision meant accepting being vulnerable with my supervisors. As Coburn (1997) suggested, supervisors who are empathic and nonjudgmental can increase supervisees' sense of safety and encourage the process of self-reflection. Supervisors who are aware of supervisees' CT can also offer guidance by proposing alternative reasons for their emotions, based on their own experiences or those common to trainees. I had

continued on page 20

the most positive experiences with supervisors who presented such explanations as possibilities, rather than facts, and respected my own self-reflective process. These experiences contributed to my professional growth by allowing me to develop greater self-awareness and to learn to distinguish between my clients' emotions and my own.

Supervisory Example by Author 3: Acknowledging Developmental Level

Throughout clinical training, supervisees' skill development may progress in patches: Some domains strengthen more quickly than others, and it is advantageous to supervisees' development to evaluate their training needs across domains (Barnett & Molzon, 2014). At different points in a supervisee's training, support that is more intensive may be required to promote growth in areas of weakness; this can be achieved by considering the supervisee's experience, knowledge, and skill (Falender & Shafranske, 2017a). Supervision can thus develop supervisees' self-awareness (Johnston & Milne, 2012) and clinical confidence (Wheeler & Richards, 2007) by highlighting areas of strength and domains in need of support throughout training. A powerful learning opportunity may also arise when supervisees report perceived failure, as supervision can support self-reflection on areas of difficulty (De Stefano et al., 2007). The following example highlights the potential for growth when a supervisor demonstrated awareness of my developmental level across skill areas and modeled self-reflection on his own supervisory style.

Setting the stage. This exchange occurred during an assessment in which a child's functioning was impacted by a medical condition. At the beginning of the practicum placement, the supervisor assessed my clinical experience, as well as areas of relative strength and weakness. As I became more confident in communicating results, the supervisor gradually transferred leadership of feedback sessions to me, contributing as needed. In areas where I lacked expertise, the supervisor collaboratively presented results, allowing me to present aspects with which I felt comfortable while also benefitting from the supervisor's explanations.

Through this approach, I increasingly gained independence in communicating results. One feedback session, however, did not proceed as planned and I stumbled to present the case conceptualization. Directly after the appointment, I disclosed to my supervisor that I regretted my performance. My supervisor and I discussed what I thought contributed to my difficulty and how to strengthen my skills in delivering feedback in the future.

Modeling. The following week the supervisor returned to the feedback. He disclosed that, upon reflection, he believed that he could have better supported me after the feedback by focusing on the aspects of the appointment that had gone well, rather than on what had gone poorly. The supervisor reported that though it was clear that I wanted to learn from my errors, it was also important to highlight my areas of strength.

Supporting supervisee's self-reflection. The supervisor then disclosed that he perceived me as advanced for my developmental stage, making it easy to forget that there were areas in which my skills were relatively less developed—in this case, in understanding the interplay between relevant medical conditions and functioning. This was helpful for me to develop my skills in self-reflection, both in witnessing my supervisor's modeling of reflecting on his actions, and in recognizing my areas of weakness. This ex-

continued on page 21

change supportively emphasized my skills that needed further development in a manner that encouraged self-reflection. It also underscored the value of using moments of perceived failure as learning opportunities. Finally, this experience reasserted that clinical skills do not develop at an equal pace across domains, and that when supervisees engage in open discussions with supervisors about both weaknesses and strengths, our clinical development benefits.

Lessons Learned

Safety in supervision is essential, given its relation to positive outcomes for supervisees, such as improved confidence, motivation and therapeutic perceptiveness (Nelson & Friedlander, 2001) as well as perceived trainee growth. In the cases presented above, safety in supervision was promoted by supervisors' own self-disclosures, and led supervisees to feel comfortable self-disclosing and reflecting on their development as clinicians. Gunn and Pistole (2012) recommended that supervisors focus on the relationship aspects of supervision, and not only on skill development, to build a foundation for safety in supervision. As trainees, we believe that it is important to highlight supervisors' actions that contribute to this safety in supervision and promote positive outcomes for trainees. In our experiences, we have valued and benefitted from the following circumstances:

- When supervisors adopted a warm and nonjudgmental attitude toward supervisees from the beginning of the supervisory relationship.
- When supervisors and supervisees collaboratively developed a supervision contract. This provided an opportunity for supervisors to empathically assess our developmental levels and discuss our needs in supervision.
- When supervisors empathically and collaboratively addressed supervisees' areas for growth according to their developmental levels, including discussion of the interaction between personal and professional development (e.g., the importance of self-care).
- When supervisors encouraged professional development by using judicious self-disclosure. This included addressing mistakes or missteps made by the supervisor in supervision, disclosing examples of managing countertransference with clients, and disclosing personal experiences of self-care.

Examples such as these can contribute to trainees' professional and personal development. More specifically, by promoting a healthy work-life balance, encouraging the practice of self-reflection in therapy, respecting supervisee's developmental level and identifying and addressing areas for continued growth, the trainee's development may progress beyond concrete skill acquisition and encourage self-reflective practice. Supervision guidelines developed by the Canadian Psychological Association (CPA, 2009, p. 3) recommend that supervisors take the lead on resolving challenges in the supervisor-supervisee relationship, and we agree that it is essential that the supervisor create an open and accepting environment. We also recognize that supervisees play a role in supporting the development of this environment: By approaching supervision with an openness and nondefensiveness to feedback on both strengths and weakness, and an awareness of how their actions may influence the supervisory relationships, trainees can also promote the development of a safe supervisory relationship.

continued on page 22

Suggestions for Future Research

Safety in supervision is related to improved outcomes for trainees in terms of their professional development (Gunn & Pistole, 2012), and future research could explore which factors contribute to the development of this quality in supervisory relationships. For example, elucidating supervisor-specific factors (e.g., training in supervision practices, personal experiences of supervision, values) that may contribute to a supervisory practice that promotes safety would be helpful in developing recommendations for best practices in supervision. Further, examination of trainee-specific variables (e.g., personal experiences of supervision, openness to feedback, comfort with vulnerability, perception of supervisory relationship) could clarify trainees' contributions to the supervisory relationship. This could support the development of concrete recommendations for trainees' approaches to supervision and how they can positively influence supervisory relationships to support their development throughout clinical training.

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We'd love to hear from you!

SPECIAL FEATURE

If You Give a Supervisor a Trainee: Examples of Influential Clinical Supervisors

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Editors' Note: *This article is part of a special student series on supervision and training that will be featured in* Psychotherapy Bulletin *issues throughout 2019.*

Supervision will be introduced to students in many graduate cohorts as an aspect of their training they will both enjoy and endure. Framing it this way inherently leads students to start to question what they want in a supervisor. Some will think of the worst and ponder what it would be like to have a negative experience during the supervision process. Others might review their previous supervision experiences and make note of their own shortcomings. Whatever the reaction may be, with supervision on the horizon, it is the start of a new chapter in each student's life. Even though the clinical supervision process is defined as two professionals working together, one with considerably more experience than the other, students can sometimes experience the relationship as more of an authoritarian dictatorship. This term is employed because clinicians in training will often hear "in the end of the day, it is your supervisor's license on the line—so do whatever they say."

Supervisors extend an opportunity for clinicians in training to practice their skills without a license. This should not be taken lightly, given the great deal of effort, time, and money it takes for a clinician to become licensed. With this in mind, it is important for clinicians in training to understand the responsibility that accompanies the role of being a supervisor. A supervisor must balance being a teacher while also being a gatekeeper. Trainees should therefore strive to develop a relationship founded upon respect and trust so their supervisors can confidently provide opportunities for their trainees to grow into independent and autonomous professionals.

The Humanity of Self-Care

The trainee had just started working at a new practicum site and was still getting acclimated to the environment, the policies, and her supervisor. She had 10 days of orientation before beginning to see clients. Once her training was over, the trainee's schedule was full; she was seeing multiple clients every day, going to class, attending supervision, working part-time, and also trying to spend time with her family. She found the transition difficult during the first few weeks. The trainee realized she had not come to

continued on page 25

terms with the fact that perhaps she had taken on more than she could handle. Toward the end of her third week, she realized she had paperwork that needed to be submitted, but the trainee did not have the time to do it. The trainee was prepared to work through the night, as this is the graduate student's diet, however her practicum site was closing. The trainee's supervisor noticed her scrambling to get things done and simply told her to finish her work on Monday. The trainee was stubborn in nature, and waiting to complete work on Monday was not something she could easily accept. The trainee found solace after deciding she would come back to her practicum site bright and early Saturday morning to finish her paperwork.

The trainee spent most of Saturday working and then went home to enjoy the weekend. She felt a sense of resolve and empowerment that she was able to complete her work before Monday. She thought her supervisor would be impressed and bask with her in the accomplishment. The trainee received an unexpected call from her supervisor shortly after returning home. Her supervisor was neither delighted nor angry, but confused. The supervisor asked the trainee why she had decided to come into work on a Saturday. The supervisor also noted that taking time for oneself is extremely important. The supervisor's confusion was met with the trainee's own confusion. The trainee was so certain that getting work done would only serve her. She did not think that time for herself was more important than having her work completed on a weekend, rather than the next business day. She thought coming to work on Saturday would only prove her dedication. The trainee did not realize that her actions reflected the lack of importance she gave self-care. Her supervisor still wanted an answer. The trainee told her supervisor she had managed her time improperly and added that she appreciated her supervisor's concern. A few days later the supervisor provided the trainee with resources that focused on self-care. The most valuable piece of information that the trainee took from the resources was the following statement: You are a human before being a psychologist.

The call the supervisor made was not to scrutinize the trainee's work or the display of inadequate time management. The call was made to advocate for the trainee as a human, and support the fact that the trainee can and needs to prioritize self-care. The next few weeks at the site, the trainee dedicated time to learning how to balance her professional and personal life. She was empowered to work her hardest at the practicum site while fully enjoying herself during her time off. She felt it was the first time she was able to relish in her time away from work. The trainee was able to decompress and relax and just be a human. The trainee will be forever grateful to her supervisor and this experience. The trainee learned that to be a psychologist one must first learn to be human.

The literature fully supports the supervisor's actions and clearly outlines the benefits of advocating for self-care (Barnett & Cooper, 2009; Shallcross, 2011; Thompson, Frick & Trice-Black, 2012). There is an abundance of research regarding the importance of self-care as well as evidence that supports it as an efficacious way to avoid burnout (Barnett, 2017). Supervisors who are able to advocate for self-care, and provide resources for their trainees will help them both in the short and long term. If trainees find themselves frequently overwhelmed and unable to keep up with their workloads, self-care might

continued on page 26

come in the form of reassessing priorities, determining the quality of their training, ensuring they have access to the support they need to meet the demands of the setting, and integrating task management strategies.

Overcoming the Challenge of Countertransference

A supervisor who had a strong impact on this second clinical trainee was a motivating and charismatic psychologist. The supervisor's personality type encouraged the trainee to look forward to his supervision time and open up concerning his clinical work. The supervisor was open and compassionate, but most importantly, was able to offer constructive feedback. The clinical supervisor was skilled at offering criticisms in a disarming manner that assisted in the trainee's development. This approach allowed the trainee to markedly improve his case presentation abilities as well as his clinical skills. An example that reflects this is when the supervisor asked the trainee to present a difficult client from his caseload during individual supervision.

Throughout the case presentation, the supervisor asked questions that helped the trainee learn how to become a more skilled student therapist by exploring specific areas that he had not thought about during the session. The supervisor also asked the trainee about possible transference and countertransference that occurred during therapy sessions. The trainee responded that the client's physical characteristics reminded him of his grandfather. A particular challenge that the trainee experienced with this client was that he would deflect most questions, and seek other topics to distract from the purpose of the session. The supervisor helped the trainee by providing strategies that would help navigate the client back to the topic of discussion. The supervisor also provided the trainee a platform to explore the impact the client's resemblance to his grandfather had on his objectivity.

Transference and countertransference can be difficult to handle, especially as an entry-level clinician. In one therapy session, this second trainee's client had accurately guessed his religious affiliation. The client also appeared to have noticed the trainee's physical response. The trainee decided in the moment to self-disclose because he thought that the honesty would assist in building rapport and trust with the client. However, the information caused more distraction from the purpose of the session. The supervisor helped the trainee to further explore how this countertransference impacted the remainder of the session. The supervisor also prepared the trainee for upcoming sessions, and taught him how to respond in a manner that was objective and maintained rapport.

According to Barnett, Erickson Cornish, Goodyear, and Lichtenberg (2007), an effective supervisor is committed to the trainee's professional development, emotionally invested, and collaborative; in addition, an effective supervisor provides constructive feedback in a nonthreatening and supportive manner, creates a safe environment in which trainees feel comfortable to share their work and address insecurities or concerns, and provides the freedom to try new strategies in therapy. An effective supervisor also demonstrates empathy and respect for their trainees (Barnett et al., 2007). The supervisor's actions, demonstrated in this case example, portray compassion, empathy, support, and constructive feedback in a nonthreatening and supportive environment fostered by the supervisor.

continued on page 27

The supervisor's focus on countertransference is also supported by research indicating that its exploration is an important clinical responsibility and informer of treatment, as it may help direct or limit therapy (Falender & Shafranske, 2014). The supervisor's actions will have a lasting impact on the trainee's professional development. This experience enabled the trainee to better realize the potential impacts of transference and countertransference, as well as the value mentorship and diligent supervision can have on one's professional development.

Guiding Trainees Toward a Balanced Life

As psychology trainees advance in their training, they transition to advanced practicum sites. Working in a psychiatric inpatient unit can be a challenge for practicing psychologists; for some psychology trainees, it can be a nightmare. Patients often have more severe symptomatology, are usually lower functioning, and may be at risk of harming themselves or others, which can make providing therapy more difficult. In this setting, the supervisor is a critical source of support to help guide psychology trainees. Providing treatment for an acute population requires modified treatment approaches, therapeutic techniques, and treatment expectations. For young psychology trainees, it is not uncommon to be idealistic and overemphasize the positive impact of their treatments.

The third psychology trainee worked in such an inpatient hospital setting. The focus of the training was conducting group psychotherapy, but there were opportunities available to conduct various assessments and individual psychotherapy sessions. The trainee was eager to prove himself and accepted every opportunity available. If a patient needed an assessment, he was the first to volunteer. If patients requested an individual session with him, he would not hesitate to offer his time. Yet, as much as he enjoyed taking advantage of the various opportunities, he still had other graduate school obligations, which included coursework and research. It was clear to everyone (but the trainee) that his overachieving attitude would lead to a "burnout effect."

During an individual supervision, the supervisor was direct in voicing this concern. The supervisor praised the trainee's dedication and work ethic, but warned him about his own mental health and other responsibilities. The supervisor emphasized the importance of being present during each session, and the problems with being stretched so thin that one's quality of work could decline. The supervisor then shared with the trainee a book, *Five Good Minutes: 100 Morning Practices to Help You Stay Calm and Focused All Day Long* (Brantley & Millstine, 2005). The supervisor was able to relate to the trainee's ambitious state of mind, but shared the importance of being mindful to avoid burnout. The supervisor told the trainee that the book was on the supervisor's desk, and that the trainee could read it at any time.

It was during this same supervision session that the trainee shared his frustration regarding a difficult group psychotherapy session. The group consisted of 10 patients, with the majority experiencing severe symptoms of depression. Two of the clients were experiencing active hallucinations, and one client was expressing paranoid thoughts and disrupting the group cohesion. The trainee described his unrealistic expectations for an acute inpatient group. He took responsibility

continued on page 28

for the disruption of the patients, and his inability to redirect the patients experiencing active hallucinations. He also took responsibility for two patients with severe depression who left the group.

Before the trainee could continue being self-critical, the supervisor interrupted him. The supervisor asked him what appeared to be a random question. The supervisor asked if the trainee watched baseball and, when he said yes, the supervisor went on to describe the statistics of home runs in Major League Baseball. The supervisor then emphasized that those relatively few home runs were what the best athletes could do—and invited the trainee to now imagine what the expectations were for minor league or college baseball players. The supervisor brought the focus back to the psychology trainee in a reassuring way. The supervisor said to the trainee, "you are still in training; why would you expect to accomplish what licensed psychologists don't expect of themselves?" The supervisor went on to discuss statistical averages and told the trainee "as you progress in your training, your average group session will improve, yet there will still be some groups like this past one that fall below the average and some groups that fall above the average." The two of them then discussed the variables outside the control of any healthcare provider and some positive ways to respond.

The trainee greatly benefited from his supervisor's actions. The supervisor treated the trainee as a human first and the advice given demonstrated his genuine concern. The supervisor helped give the trainee some perspective on his current situation, which included the discrepancy between his expectation for himself and the expectation of the training site. The supervisor emphasized that the trainee's role was to learn and improve his abilities, which helped the trainee adjust his expectations to be more realistic. With more realistic expectations, the trainee adjusted his treatment approaches, therapeutic techniques, and treatment outcomes to better fit the population he was serving. The trainee found that with more appropriate treatment expectations, he has become a more effective treatment provider.

In this case example, the supervisory relationship was the foundation of the supervision work. The supervisor's concern for the trainee's wellness was critical for his professional development. Self-care is a crucial training component for preventing burnout and stress (Barnett & Cooper, 2009). Supervisors are professional role models, and their actions significantly influence their trainees (Barnett & Molzon, 2014). By sharing their own self-care techniques, supervisors demonstrate the importance of prioritizing one's own wellness. It is how the supervisors conduct themselves in supervision that impacts how the trainee is able to overcome clinical challenges (Barnett & Molzon, 2014). The supervisor was supportive when challenging the trainee's unrealistic expectations, which helped the trainee be more receptive to feedback. Now, the trainee provides a similar supportive approach when challenging his patients' unrealistic expectations.

Concluding Thoughts

The interactions you have during supervision will vary as each supervisor approaches the process in a unique way. Depending on their personal training and theoretical beliefs, one supervisor may hold an hour of individual supervision and an hour of group supervision, whereas another supervisor may provide didactic training in addition to, or as a dominating characteristic of,

continued on page 29

group supervision. The individual and group supervision may also be implemented differently in distinct training settings. Due to the stark differences in theoretical orientations among clinical supervisors, many trainees will receive a broad experience of supervision.

The supervision process of each trainee will be whatever they make it out to be. If they adopt a passive approach to this part of their training, they will most likely see little to no return on their investment. However, if trainees play an active role in the supervision process, they can establish a rich, professional relationship that will only serve to benefit their clinical training. Supervisors are often incredibly busy, so it will be important for trainees to take a proactive role in building this strong relationship. It is up to the trainee to put in the effort so their supervisor can clearly understand when they are ready to take on more responsibilities.

Your supervisor might not be walking the path you want to follow, but they have taken the steps to achieve your current goal of becoming a licensed clinician. Take the opportunity to learn from their choices and mistakes. They provide you a platform to explore a field about which you are *both* passionate, so do not miss out on basking in the challenges together. Your supervisor will support you as well prevent you from taking on that which you cannot handle. This invaluable learning opportunity should not be gone unnoticed.

Authors' Note: *The information in the case examples provided has been de-identified in order to protect the confidentiality of the clients and the supervisors. Some information about the clients has also been altered in order to further protect their identities.*

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Becoming Trainees, Becoming Therapists: A Poetic Call and Response Between Supervisor and Supervisee

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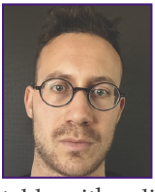
Not as Urgent as a Toothache (JM)
The Analyst stares into the steam of his green tea. A morning Rorschach for no one to interpret.



The first of his five patients for the day is out in the waiting room, flicking through one of the old lit mags fanned out on the scuffed coffee table with splintered legs. After all, the Analyst wanted to make and maintain the right impression. Urbane, intellectual, and playful were three adjectives he hoped crossed some folks' minds some of the time.

The Analyst should have been revisiting his process notes. Instead he is brooding. Since his mid-career burst of publications on posthumanism and psychoanalysis, he had been wondering whether he was a better therapist than person. The idea skittles his innards. Think of the sensation of ingesting a large pill on an empty stomach.

The notion was a parting gift from his second wife, a landscape architect with kind eyes. The day she uttered those words they separated. For several months he had been urging her into psychodynamic treatment.

'Address the relational disturbance inherited from your deprecating parents.'

His formulation, not hers.

In the Analyst's mind every one of her attempts to connect became instances of neurotic transference, unjustly projected. Really they were meant for her absent father.

For weeks he'd wake up in the early morning with molten tension in his legs, arms and abdomen. He'd shake her from her sleep.

'Quit with the unending projective identification.'

These feelings were hers. Not his, he thought.

> 'Own them, metabolize them. Take the rocks of your childhood back, stop handing them to me'.

It only got worse when she began psychoanalysis with someone trained at an institute in the right part of town.

She started using all of the in-house terms.

His language, he thought.

For the next few months every few nights, he'd wake up with a jolt and ask her to stop being so ocnophilic.

continued on page 31

He said that.

'Find your own identity'.

'Quit with the relentless introjective identification'.

'Stop raiding my stash, build up your own.'

'We're not one person, you know.'

She'd respond with red squalls of confusion in her widening eyes.

'What do you want from me?'

His response was always the same.

'You'll work it out, you'll figure it out, free your mind of the past'.

But she never did figure it out. Neither did he.

She left him on a bright spring morning.

'You gave up your goodness running after unconscious conflicts and magic-bullet insights'.

The words struck him. A volley of glossy charcoal pebbles.

As the door closed behind her, he shuffled into the kitchen and found her copy of Buber's *I and Thou* on the counter top.

He opened it at random, settling on the word *vergegnung*: mismeeting, mis-counter. Think of two wolves baring their teeth, circling one another before trotting off in opposite directions.

He wept heavily. No tears fell.

A windy pain bore into his middle.

He snapped the book shut and put it outside on the stoop for a stranger to pick up. He found himself in a cold house that used to be their home. He went upstairs to finish writing a paper. "Healing beyond words: on the co-creation of silent mutuality."

The Analyst broke from his reverie and the ceiling in his office spun. The ovoid light above leered at him. He sighed, lips billowing. Think of the tattered sails of a boat blown off course.

The Patient was new to analysis.

'You know, none of my stuff is that bad. It's not as urgent as a toothache'.

He mumbled this the first time they met.

The Analyst, embodying a well-worn pose of clipped kindness, beckoned him into the room.

In their previous session The Analyst, a psychiatrist from elsewhere, wrote the Patient a prescription. The Patient hadn't slept safely in weeks, waking up each night with gargoyles in his stomach and spiders in his bronchi.

'Have you taken a benzo before?'

'No.'

'That's rare in this day and age. How have you avoided them?'

'Well, I don't usually get into relationships with people. That's the trick'.

Their sessions usually began in thick silence. Today was different. As soon as he uncrossed his arms, laying them by his sides, he spoke.

'You have an accent. Where are you from?'

The Analyst froze in time. A blaze swept his hippocampus and amygdala, scorching through neglected neural circuits. Think of the cracked concrete floor of an abandoned courtyard. Green life reaching for the sun from below.

The Analyst is four years old, nestled under the staircase.

He is absorbed in play, building castles in the air.

continued on page 32

His cheap plastic figurines are knights on a quest to rescue a princess held captive by an evil sorcerer. Think of *Grendel*, think of *Sauron*. They run into many obstacles on the way. Most perish. As the last two reach the sorcerer's fortress, readying themselves for the final standoff, a voice dials in from another universe.

'Come meet your sister'.

The analyst puts down his toys and exits the alcove. Think of the feeling of waking up from a technicolor dream before it ends. An aborted promise.

The Analyst slowly climbs the staircase to the bedroom above.

He squeezes through the crack in the sliding door, entering the adjacent bathroom. He hovers on the outskirts. Think of an evening sky before a thunderstorm.

At the center of the rectangular bathroom, lined floor to ceiling with cold charcoal tiles, is a large oblong tub. Water on the brink, almost overflowing.

The Mother washes life into the Newborn. Two entangled souls.

The water darkens with blood. Think of beet soup, maybe borscht, with two dollops of sour cream, one subtending the other.

The Analyst stares at this scene, something inside him coils. He doesn't know what.

The Mother speaks.

'This is your little sister. Come meet her.'

The analyst speaks.

'oh'.

He turns away, banging his left shoulder on the frame of the sliding door.

It stings.

He walks past the bare bed and down the stairs, back to his universe in the alcove.

The Analyst tries to resume his quest but can't. He batters the heads of his knights against the iron balustrade of the staircase. Once the demolition is over, he lies down.

The Analyst looks up into the dusty crevices zig-zagging the cream surface of the ceiling above. There is usually a story to find up there. Think of clouds that congeal in the shape of a fox or the face of someone you know in profile.

But the Analyst sees nothing. A palette of unnamable feelings.

A dream, recurring for the Analyst in his forties.

He is driving a matte black, helmet shaped car down a looping highway into the pith of the city.

To his left a mountain clambers into the sky, draped in a cotton-wool pall of stringy clouds. To the right, a bay spangled with the burst of early morning sunshine extends into infinity. Inert cargo ships draw his gaze to the horizon. Beyond lies an Island circled by sea gulls with the smoke of past atrocity in the beat of their wings.

The highway is empty, not another vehicle insight. The Analyst is not alone. Two figures sit in the back of the car, bodies with heads but no faces. Think of what it is like to strain for sight in a dark room. That is what it is like trying to picture who they are.

There are no cars, only pedestrians in single file. They walk in the emergency lane, in the opposite direction, with broken umbrellas in hand.

The Analyst is feverish, his breathing shallow. He feels his heart thudding in

continued on page 33

his fingers wrapped around the steering wheel.

The car is perilously close to the slow-walking caravan. Think of the rush of stale air as a subway car hurtles past.

The Analyst takes the nearest off ramp and stops at a bronze traffic light. The sky is a ruddy brown, a convexity of dried blood. He turns his gaze to the left, catching his faceless companions in his peripheral vision. An old fort, wound tight in barricade tape, abuts the road.

He exits the car and squints into the glinting sun. He joins the silent chain of travelers lilting onwards. No words are exchanged.

The two faceless figures on the back seat sit still as statues. Then each extends a gloved hand into the chasm of the other's blank face.

The Analyst, momentarily immobilized, returns to his office. To his Patient, lying there. Looking upwards. Wanting answers, craving respite.

A stranger, promising to revitalize the Analyst's tiring curiosity.

The Analyst veers back to the irruptive question.

Think of the feeling stirred in your body by the atonal bark of a PA system in a government office of one kind or another.

'Well, I would like to give you an answer. I wonder though, if we could explore where

that question is coming from first?'

Response: Better Get That Tooth Checked (DG)

Reading the beginning of Joshua Maserow's piece, "Not as Urgent As A Toothache," reminded me of a 90s newspaper cartoon one of my graduate school professors posted on her door. It depicted a monstrous, twisted depiction of a therapist. The text surrounding this image read:

By day a Rogerian counselor, at night she turned into…

PSYCHO-therapist

No matter how hard she tried, she couldn't stop the frothy fount of senseless psychobabble from spilling out and dominating the conversation. Just when you thought you were safe… *she came to your party*

The PSYCHO-therapist was depicted spouting tropey lines such as "You're putting up barriers! Get in Touch! Let Go! You're Projecting! Unfinished Business!" Each charge more accusatory than the last. An empathic, caring, intuitive therapist in the consulting room, no less than the warm, brilliant mind that comes across in books and articles. They look like a duck and quack like a duck, but do not be fooled—they may both turn out to be an asshole.

Nobody Likes to Go to the Dentist

A wave of anxiety washes over me—Is this Joshua's future? Is it *mine*? Is it *ours*? Are those of us who work in the science of human relationships at risk of rupturing, breaking, losing them?

The therapist in Joshua's story was successful, scholarly, clearly very intelligent and versed in the art and science of our field, and yet "he had been wondering whether he was a better therapist than person." Is this the price exacted by our field? To sacrifice our relationships, our happiness, our inner life? To hide behind the veneer of "the therapist" while our world crumbles about? To help patients create and find a life worth living while failing—even refusing—to live our own? To ignore the molar that has been stinging for

continued on page 34

months? Years? Decades?

A lifetime.

In a moment of total disconnect, having "miscountered" his wife and lost her, the therapist goes on to connect with the analytical ideas and themes that haunt him so. Later his patient makes what we might call an interpretation, not only of himself but of the therapist—None of *his* stuff is that bad, "not as urgent as a toothache." Ignoring the pain. Putting it on the other. Causing and experiencing suffering. Many patients, but especially those with histories of trauma, are highly adept at picking up on our "professional hypocrisy," to use Ferenczi's phrase. The belief that *our* stuff is not that bad, not in dire need of being addressed, worked through, challenged, brought to light, and freed up so we may live a fuller, freer life with joy and integrity instead of bitterness and grit.

Open Up and Say . . .

An accent takes us down the winding roads of memory to a staircase. The therapist slays dragons and rescues princesses—as Oedipal boys are wont to do. Except this princess is in another castle and not in need of rescue. "Come meet your sister," she bellows. The therapist responds by returning to the staircase to finish a fantasy, but he can't. Fear of connection and the failure to connect, or fear of love and the loss of love as another of my professors once put it, haunts him. Possibly—probably—haunts us all. The therapist comes to, returning his attention to his patient, "a stranger, promising to revitalize the Analyst's tiring curiosity." We connect with our patients, driven by curiosity, empathy, and care. But what happens when *that* is our primary mode of connection in life? What happens when we push others away more and more? Do we risk depending more and more on this work for nourishment, meaning, excitement?

I turn to my students. I remind them to mind self-care. Go out. Pick a hobby. Date. Write a song. Watch the game. Play a game. Sing karaoke. Go dancing. Go to a concert. Take to the streets. For all that is good and true *go* and *do* something outside this field. Save yourself, run away! Practice what we preach as therapists and *live*. Then I realize these are the first four years of graduate school talking.

Haunting.

How often do we preach self-care while depriving trainees of the means to practice it?

How little do we care for them to? I think, and this is just a hunch:
We all have cavities.

How to Become a Beginner (DG)

The teacher is of course an artist, but being an artist does not mean that he or she can make the profile, can shape the students. What the educator does in teaching is to make it possible for the students to become themselves.
—Paulo Freire

I am not her father

Firm, authoritative but not authoritarian

Guiding, questioning, supporting

holding back hands impelled to reach out and soothe-say

"It's going to be ok"

Restraining warmth that blossoms tears when I see her grow

And learn

And in learning, *I* learn

continued on page 35

And grow with her

I am not his therapist

But I'd be lying to you if I said pedagogy can be spelled

Without empathy

Caring, mindful, sustaining

Extending a part of yourself that remembers

what it was like to

fum-ble

your

words

"So it sounds like I'm hearing what you're saying is…"

His and her intervention

My memory

Look,

not exactly my best moment

Not exactly

the best example of technique

It was, what, first year?

I had read through the instructions for the camera in the consulting room

I read them again

Ok, I think I got it working

Wait.

Did it delete the video?

It deleted the video.

… … … Fuck.

Then again, I won't have to embarrass myself in supervision

The memory was fresh, crisp

As she bashfully reported she didn't have a video this week

Oh,

like I didn't know that subtle smile

creeping

behind blush apologies

I smiled that smile too, you know

I blushed that blush

But that's exactly why I take a beat, step back

Let the memory wash over me

And in remembrance,learn

She and I talk about how exposing training can be

How vulnerable it is to share your imperfections and your

Fears

"What's good for the gander *is* good for the goose"

I explain

They laugh nervously

How can we ask others to show us their worlds

Revea their wounds

Put it in words

If we don't learn about our own?

More importantly, how can I get them to understand that?

That question was my first mistake

The "fundamental rule" is fundamental, but also

Meant to be broken

Isn't that what we do?

Work with what is broken and not demand to be "fixed"?

A doctor who tells their patient "How

continued on page 36

dare you have allergies!" is going to have a hard time treating allergies

A therapist who tells their client "How dare you resist!" is in dire need of their own therapy

A teacher who tells their student "How dare you be afraid!" needs to go back to school

I am neither his father nor her therapist

But I know joy when I see them learn

I know pain when I feel their struggle

And once the year is over I'll know sadness

That's when I realize

love is a sign that learning is happening

I just had to become a student again to remember

Ha,

"good for the gander" indeed.

Response: On the Importance of Staying a Beginner (JM)

"I cannot see any basic difference between a handshake and a poem."
—Paul Celan

Reading Dr G's poem, "How to Become a Beginner," conjured a number of recollections and associations for me. The first is a memory of our first supervision together. Dr G, three of my peers, a co-supervisor and I gathered around an oval table with a large, dark, blank but blinking screen mounted on the wall looking over us ominously. The supervision began with a grounding exercise, settling our attention and bringing us into the present moment. Once we opened our eyes, slowly returning to the task at hand, I recall Dr G asking us, "What is going on for you?" Instantaneously, I felt the pull of two dueling forces. On the one hand, I wished to speak as candidly as possible, as I might in the sanctum of my therapist's office. On the other hand, I thought: "Here I am, in a sterile, cloistered room, with five people I don't know all that well. Would sharing my safely guarded thoughts and feelings be appropriate? What is supervision anyway? Is it a class? Is it therapy? Is it some undecidable chimera purling in the spaces between those two? What should and should not be disclosed here?"

In response to the question, which became louder and louder in my mind with each passing moment, I responded: "I don't really like the sound of my voice." As you might guess, Dr G followed up with: "What is it that you don't like about it?" I paused for a few seconds and ventured a few words that skirted the edges of the truth. The discussion moved on. Eventually, I acknowledged that my response was evasive, but I stopped there, waiting for a time when I thought I might have a firmer grip on the puzzling ontology of supervision. Several months have passed since then and I must admit that moment is yet to come.

It's a cliché to say this but I will say it anyway: The power of poetry lies in its irreducible suppleness. It is able to do justice to paradox, aporia and ambiguity in ways that few other forms of representation can. Dr G's poem enacts the polysemy of supervision—that I found, and still find, so stupefying—from a different vantage point: that of the supervisor. In the ebb and flow of his lines, we hear a voice sparring with what it means to be a clinical supervisor. Is he a father? No, not entirely but sort of. Is he a therapist? No, not that either really but there's a little of that in the mix. Is he a seer? No, that would be over-reaching. So, what is a supervisor? A supervisor is 'Firm, authoritative but not authoritarian'. I found myself

continued on page 37

repeating this line over and over to myself, appealing to reason to fathom out its meaning. After a while, I relaxed my will to meaning and settled down with the notion that it conveyed a felt sense rather than a symbolizable idea.

As I read on, it became clear to me that the speaker in the poem—who may or may not be one with Dr G—is not trying to define "supervision," "supervisor" or "supervisee." Instead, it is staging the mercurial, ever-shifting identities, relations and boundaries which emerge when "supervision" occurs. This verve to trace the shimmer of the ineffable brought to mind the lionized words of John Keats, who in a letter written in 1817 wrote:

> Several things dovetailed in my mind, and at once it struck me, what quality went to form a Man of achievement especially in Literature & which Shakespeare possessed so enormously—I mean negative capability, that is when man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact & reason.

In this poem, the voice who may be Dr G points out the tremendous importance of maintaining a beginner's mind, of "becoming a student again," for the "supervisor" in order to ensure that the mystery of supervision is nourishing and mutative. It demands that we, supervisor and trainee alike, build the capacity to tolerate ambiguity and uncertainty "without any irritable reaching after fact & reason." Bringing Keats's notion of negative capability into the psychoanalytic fold, W.R. Bion notes, "the capacity of the mind depends on the capacity of the unconscious—negative capability. Inability to tolerate empty space limits the amount of space available" (1992, p. 304). It is in the process of becoming a student again, of welcoming the empty space between being authoritative without being an authoritarian, between being neither a parent nor its opposite, between being a therapist and not a therapist, between being an expert and a beginner that the supervisor exists. It is in this role between roles where love may arise and be a "sign that learning is happening."

I was also reminded of Ogden's (1999) message in his paper "'The Music of What Happens' in Poetry and Psychoanalysis." For Ogden, the acoustics of poetry and psychoanalysis are alike: both require an aural attentiveness that demands a relaxation of the proclivity to get behind the text of a poem, and the surface of the person, to their underlying truths. Both psychoanalysis and poetry have this in common: they are more likely to yield answers—to unveil their vaulted secrets—when curiosity shifts its emphasis from content to form, in the case of poetry, and from pure interpretation to process, in the case of psychoanalysis. Ogden articulates this by stating that the question analysts should be asking of the ever-shifting field in which patient and analyst exist is *what's going on here?* rather than *what does that mean?* After reading Dr G's poem, I will hear the question *what's going on for you?* in a new register—one that celebrates the vulnerability, vitality and therapeutic importance of being, and always remaining, a beginner.

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The Future of Psychotherapy Research: Where Are We Going and How Can We Get There?

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While an impressive amount of knowledge has been gathered so far from psychotherapy process and outcome research (see Lambert, 2013), there are still many unanswered questions and areas of needed additional attention. Some of these remaining questions focus on clarifying currently unanswered debates in the field; others represent ways to improve current outcomes; and some focus on the use of new technologies to enhance the understanding of how and why psychotherapy works.

Some of the Current Questions in the Field

One of the most important areas of study for psychotherapy researchers is identifying what causes change in psychotherapy. Theoretical orientations have long provided suggestions on the causes and mechanisms of change, but the existing psychotherapy research has yet to identify a universal explanation. This is despite the fact that many of the long-standing debates in the field focus on this issue. For example, whether specific factors or common factors are more important for change in psychotherapy and whether or not psychotherapy orientations and even specific interventions are equally effective in their outcomes (Wampold & Imel, 2015). In addition, thousands of studies have been conducted seeking to identify effective therapy ingredients (Norcross & Lambert, 2018), but much of this research has only provided suggestions on variables that correlate with psychotherapy outcomes (such as the therapeutic alliance) and no clear evidence about which variables are necessary and sufficient to bring change about.

Another important area for future psychotherapy research is to continue the trend toward conducting research in practice settings. As noted by Campbell & Stanley (1963), while previous emphasis on randomized control trials (RCTs) has focused on the internal validity of psychotherapy research (the degree that the outcomes could be attributed to the intervention), focus is now being turned to examine the external validity of psychotherapy research (the degree that the results generalize to conditions outside of psychotherapy research labs). There is the overall question if information from RCTs generalize to real world practice, as there are a number of differences between RCTs and practice (such as the types of clients seen and the degree that a specific treatment protocol is followed). Because of the limitations with RCTs, some have indicated that "the dissemination of transportability of efficacious treatments may

continued on page 39

be one of the most fertile areas of study for the next decade" (Lambert, 2013, p. 193), and, given the rising costs of healthcare, ways to improve the cost-effectiveness of psychotherapy are also likely to be explored (Wampold, Hollon, & Hill, 2011).

Another research area that needs more attention is the study of why some clients get worse in therapy. Some research has suggested that approximately one-third to one-half of all adult psychotherapy clients either do not improve or get reliably worse while in psychotherapy (Hansen, Lambert, & Forman, 2002). And some studies suggest that the deterioration rates in children and adolescents in psychotherapy might be even higher (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010). There are various reasons patients might not respond to treatment, including factors specific to the client (low motivation, lack of social support), therapist (poorly delivers treatment), and treatment (inadequate conceptualization, wrong treatment for specific problem). Various research studies have examined how to adapt treatment for non-responders (Cooper & Fairburn, 2011; McCauley, Schloredt, Gudmundsen, Martell, & Dimidjian, 2011); however, much more information is needed regarding why specific people do not respond to treatment and how to improve treatment for them (Lambert, 2013).

In recent years, there has been increased attention given to the complexities of the dyad in psychotherapy. Not only are researchers now more fully studying therapist effects and predictors of therapist effectiveness (Baldwin & Imel, 2013), they are more closely examining the reciprocal and dynamic nature of the client and therapist relationship. These include studies about tailoring approaches to individual clients (Norcross & Lambert, 2018) as well as investigations of the immediate influence of the client on the therapist and the therapist on the client (Zilcha-Mano, 2017).

Recent Advancements in Psychotherapy Research

There are a variety of recent advancements in the field of psychotherapy research that will allow for a more in-depth study of the research questions discussed above. A few of these advances include the use of meta-analytic techniques, the proliferation of practice-research networks, micro-process research, the use of natural language processing, and the use of online data collection.

While meta-analysis, or "the analysis of analyses" (Glass, 1976, p. 3), has been utilized in psychotherapy research since the late 1970s (Smith & Glass, 1977), its use has skyrocketed over the past decade. For example, over 100 articles in six psychotherapy journals from 2011 to 2013 were identified as having a reference to meta-analysis in the title or abstract (Baldwin & Del Re, 2016). The rise in popularity of this technique is likely linked to its robust power. Inthout, Ioannidis, and Borm (2012) have found that even a meta-analysis with only a few studies that lack full statistical power still had lower error rates than one well-powered clinical trial. Given this, Baldwin and Del Re (2016) have emphasized that meta-analysis is "arguably one of the most important methodological innovations in the history of psychotherapy research" (p. 249). Meta-analyses will likely continue to be used to help statistically summarize psychotherapy research on a variety of topics in the future.

Another more recent development in psychotherapy research involves the use of practice-research networks, which

continued on page 40

were introduced into the field in the mid-1990s (McMillen, Lenze, Hawley, & Osborne, 2009). These networks were originally developed in an attempt to address several problems with previous psychotherapy research, including the fact that psychotherapists are not always influenced by research when doing clinical work and researchers sometimes pay little attention to the questions that clinicians who do full time clinical work have (Beutler, Williams, Wakefield, & Entwistle, 1995; Cohen, Sargent, & Sechrest, 1986). These problems can create a divide between science and practice in psychology, and negatively impact the scientist-practitioner model. Thus, there is a growing movement to include practitioners in the research process by having practice-research networks in which clinicians are involved in determining research questions and developing designs that work in their real-world clinical settings (Castonguay, Barkham, Lutz, & McAleavey, 2013). This line of research has four main goals: (1) to have practitioners be active participants in the scientific studies, (2) to have practitioners use the data collected in the studies to inform their clinical work, (3) to have practitioners and researchers examine questions that are relevant to practice, and (4) to have practitioners contribute to the development of scientific knowledge. While this approach has some challenges (such as limited funding and the extra time needed to collaborate to design the study and to collect the data) this model can lead to research that answers a number of questions about psychotherapy in real-world contexts (Castonguay et al., 2013; McMillen et al., 2009).

A third more recent development in psychotherapy research is to focus in more detail on the micro-processes of psychotherapy. Much of the existing process research that has thus far been done focuses only on examining process variables at a session or a treatment episode level. However, it is possible that many process variables change within the course of a single session. Micro-process research aims at gaining a deeper understanding of how and why change happens in psychotherapy by focusing on the moment-to-moment experiences in session. Although this line of research has existed in the past, researchers are now beginning to expand into this micro-process domain in much more detail (Altenstein, Krieger, & Holtforth, 2013; Flückiger, Zinbarg, Znoj, & Ackert, 2014; Pace et al., 2016). For example, in a recent study, Altenstein and colleagues (2013) had trained coders watch a middle session of psychotherapy for depression in order to code both the clients' and therapists' dominant and affiliative behaviors each moment using a joystick rater. In another study, Flückiger and colleagues (2014) focused on minute-by-minute rating of the fifth session of 20 different psychotherapy clients' sessions in order to examine which in-session factors were linked with treatment outcomes. The raters coded for factors such as experience of negative emotions, personal and interpersonal strengths, goals, and positive reinterpretation of problems. As this research area grows, the field will likely learn much more detail about the changes that can occur during the course of a single psychotherapy session and how to train psychotherapists to be as effective as possible in promoting client growth.

New technologies are also now available that can help researchers focus more on the linguistic processes that occur in treatment. Natural language processing is a subfield of computer science that is beginning to be used in psychotherapy research. The goal of Natural Language Processing is to "learn, understand, and

continued on page 41

produce human language content" (Hirschberg & Manning, 2015, p. 261). This field can be useful to study the conversations that occur in the course of psychotherapy using computer science. It was previously difficult to study the language that was used in psychotherapy because of the manual labor of human coding of transcripts. With the recent growth in this technology, researchers have been able to do complex analyses such as identifying depression in people based on information in their Twitter feeds (Mowery, Way, Bryan, & Conway, 2015). By using this technology to help analyze conversations during the course of psychotherapy, much more detailed information can be gleaned about the psychotherapy process. Pace et al. (2016) outline a number of ways that natural language processing can be used in psychotherapy research, such as testing relational processes, examining fidelity to treatment protocols, and providing automated feedback to providers based on their session audio tapes.

In addition to these advances in data coding and analysis, another important development in psychotherapy research is the development of additional ways to collect data from clients in the first place. With the advances in technology that resulted in the development of the internet, researchers quickly started to examine the potential of the internet for collecting survey data (McGlade, Milot & Scales, 1996; Mehta & Sivadas, 1995; Stanton, 1998). Using the internet, psychotherapy research data can now be collected via a variety of methods, such as through social media or online survey distributors (King, O'Rourke, & DeLongis, 2014; Kosinski, Matz, Gosling, Popov, & Stillwell, 2015). Horton, Rand, and Zeckhauser (2011) suggest that "online experiments can be an appropriate tool for exploring human behavior, and merit a place in the experimentalist's toolkit alongside traditional offline methods" (p. 406). Given the proliferation of social scientists collecting data online, this development has the strong potential to contribute to our understanding of psychotherapy. However, research is needed to first test whether online recruitment methods, such as Amazon's Mechanical Turk, are indeed reliable and valid methods for conducting psychotherapy research. Further, ethical issues such as fair pay and ensuring confidentiality should be considered.

Conclusions

Psychotherapy researchers have the monumental task of working to improve the effectiveness of the interventions that we offer to clients who seek out treatment. Several important questions about treatment efficacy, causes of change, external application of research, and the dynamic nature of psychotherapy remain. Fortunately, psychotherapy researchers now have a number of important technological, methodological, and statistical advances that can help them in answering these unresolved questions. We have come a long way through our scientific studies as a field and it will be exciting to see where the next age of psychotherapy research will bring us.

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continued on page 42

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continued on page 43

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SAP Diversity Domain 2019

Manijeh Badiee, PhD
Diversity Domain Representative

Sheeva Mostoufi, PhD
Diversity Committee Chair

Meet Your SAP Diversity Domain Representative and Chair

Manijeh Badiee, PhD, is a licensed counseling psychologist in California (License# PSY 30484). She has over 10 years of experience counseling clients of various backgrounds and specializes in women of color, LGBTQ individuals, and/or adolescents. Currently, she provides therapy services in a private practice setting. She is also an Assistant Professor of Psychology at California State University, San Bernardino. In this role, she teaches undergraduate psychology students as well as graduate students in a clinical counseling Master program. The courses she regularly teaches are relevant to psychotherapy (e.g., Advanced Clinical Seminar and Counseling Theories) as well as to diversity (e.g., Psychology of Women and Cross-Cultural Counseling). Additionally, growing up as a first generation Iranian American immigrant woman in Texas shaped her personal and professional identity. Her immigrant background has made her passionate about social justice and the delivery of multiculturally competent services to all. Her research is on women's empowerment, with a focus on Iranian and Latina women. She routinely provides presentations on diversity-related topics to community members, students, and faculty. She looks forward to collaborating and serving the Society of Psychotherapy as the Diversity Domain Representative. To learn more about Dr. Badiee, click here: https://search.csusb.edu/profile/MBadiee.

Sheeva Mostoufi, PhD, is the Diversity committee chair for Society for the Advancement of Psychotherapy and is a Licensed Psychologist in Maryland. She earned her doctorate in clinical psychology from the San Diego State University/University of California, San Diego Joint Doctoral Program. She completed her predoctoral internship and postdoctoral fellowship training at the Veteran Affairs Puget Sound Healthcare System—Seattle division specializing in primary care mental health integration as a fellow. Her clinical training and research has focused primarily on the co-occurrence of various emotional and behavioral concerns with chronic health conditions. She currently works in a private practice setting specializing in the treatment of obsessive compulsive disorder (OCD), trichotillomania, post-traumatic stress disorder, Tourette Syndrome, a range of anxiety disorders, depression, and other emotional difficulties, as well as coping with co-occurring health-related concerns such as fibromyalgia, insomnia, and chronic pain. She additionally has specialized training and experience in providing exposure therapy, Acceptance and Commitment Therapy (ACT), and mindful-

continued on page 45

ness-based interventions. Her immigrant background has fueled a strong passion in the promotion of multiculturally competent services that are easily accessible to all. She is very excited to serve and collaborate with the Society of Psychotherapy as the Diversity committee chair.

Goals for the Diversity Domain in the Coming Year

As your Representative and Chair, we are focused on developing the Advocacy and Mentoring Program for Diversity (AMPD) and creating an online multicultural toolkit resource.

Become Involved!

Your Diversity Domain Representative and Chair welcome you to submit ideas for what you would like to see in an online multicultural toolkit (e.g., therapy demonstration videos). Thank you!

If you are interested in writing for the website or *Psychotherapy Bulletin*, please contact us. We especially welcome ideas on this year's Special Focus for the Bulletin, with a special emphasis on self-care and diversity.

You can contact Dr. Badiee at: Mbadiee@csusb.edu

Moving Target: Addressing Modern Ethical Dilemmas

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In late 2018, Chinese scientist He Jiankui revealed that twin girls had been born from embryos he had created using genome editing (referred to as the "CRISPR babies" after the molecular tool used that may render them immune to HIV). Internationally, legal and ethical debates quickly began. There is a fear that other scientists will engage prospective parents into gene altering without fully discussing risk to the child and potential risk to future generations. In the United States, Congress has prohibited the Food and Drug Administration (FDA) from conducting embryo editing clinical trials and the National Institutes of Health (NIH) cannot fund such research. With emerging science, medicine, and technological advances, new ethical challenges are presenting rapidly.

Psychology is susceptible to similar changing dialogues about ethics. Although our ethical principles and guidelines have remained the same, ethical dilemmas encountered in practice, teaching, supervision, and research are constantly evolving. For instance, use of technology within psychology has been a frequent topic at various conferences. Recordkeeping, tele-mental health security, social media access, use of virtual and augmented reality, and many other topics have been discussed, but the opinions on proper ethical decision-making are varied. As another example, when I was in graduate school, we used sand trays, games, and puppets in our play therapy course and clinical practice with children. Now, registered play therapists are having discussions on the ethical use of technology, such as online games, Youtube, and a sand tray app (!), in their work (Altvater, Singer, & Gil, 2018). Even as an early career professional, I did not think of how I must recalibrate my thoughts on the implementation of such technology so quickly. In a study by Harris and Kurpius (2014), more than 80% of psychologists who conducted an online search of their client indicated they never obtained consent, did not document the search in their client's file, did not consider it to be a possible breach of confidentiality, and never discussed the benefits or consequences of the search with their client. Are all these behaviors unethical? Unprofessional? What are the next steps in addressing online client searches? Clinicians and researchers have discussed the *dark side of professional ethics*, which speaks to psychologists believing they are behaving ethically by disproportionally emphasizing their own beliefs and values over professional ethics (Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). Continued dialogue needs to be had in these ambiguous (or not-so-ambiguous) scenarios to help improve ethical decision-making in these emerging areas.

Further, the role of psychologists in non-traditional contexts is also evolving. Consultation and assessment in public, private, and non-profit sectors, work with legislators, and work in international contexts are all blooming areas where psychologists need to navigate

continued on page 47

their ethical decision-making abilities in ways that may be different than traditional clinical and research settings. Again, required continuing education in ethics can be helpful, but many of those trainings continue to cover broad topics—avoiding topics that may be relevant to sub-specialties within psychology or emerging areas of concern. As an example, psychologists are becoming involved in tasks related to public policy and legislation that where few guidelines have been developed. With many states discussing "red flag" legislation (i.e., gun violence prevention legislation aimed at allowing family members or law enforcement to petition for removal of one's gun ownership if they pose a risk to others or are in a mental health crisis), psychologists may be increasingly called upon to assess individuals for their ability to own a firearm. Can you identify the core areas of assessment that need addressed? Are you familiar with the legislation? Are you adequately and competently trained to answer the psycholegal question? Although researchers and clinicians are addressing the emerging topic (Kangas & Calvert, 2014), peer-reviewed articles may be inaccessible to some professionals.

In recognizing my status as an academic and conducting work within the subfields of clinical and forensic psychology, the subject matter I discuss in this column may be narrow in scope. For instance, if a practitioner were to ask me about ethical considerations involving emotional support animals, it is a subject I have given little consideration. Therefore, I want to begin to invite readers to submit ethical dilemmas quarterly and I will address them given the current literature (or consult with an expert!). This will allow for the opportunity to address problems in "real time" and create a dialogue on the challenges that readers are facing in their work. I look forward to your questions, topics, and de-identified scenarios!

Editors' Note: *Please send your psychotherapy research-, practice-, and training-related Ethics questions to* Apryl.Alexander@du.edu. *Please note that questions may be selected by Dr. Alexander for inclusion in* Psychotherapy Bulletin *or on the SAP website/social media platforms at her discretion, and not all questions may be answered. In addition, information provided to Dr. Alexander and SAP in this context is for the purpose of furthering public knowledge and discourse around ethical issues, and will not be kept confidential.*

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What's Next for Me? Transitioning From Specialty Mental Health to Integrated Primary Care

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I sat in an integrated primary care elective course during the third year of my doctoral program in counseling psychology, mesmerized by the opportunity of working in primary care as a behavioral health consultant. After my completing this primary care elective and conducting brief psychotherapy for five years, I was convinced I would be prepared to jump into primary care. It is fair to say I severely underestimated the difficulty of this transition and found myself face to face with the steep learning curved promised by my supervisor. I felt underprepared and shell shocked by the multiple roles I played within the medical team. After a year-long practicum rotation in primary care, I began to understand the intricate details of impacting patient care through a population health approach. This transition took more than just skill acquisition—it required a complete cognitive shift of professional identity. I am a behavioral health consultant, not a therapist, and I am here to assist the primary care team with improving patients' overall health. Below, I have provided a few, evidence-informed ideas to help the Early Career Professional begin to make the shift into primary care.

Introduction

Primary care providers (PCPs) have adapted their practices to integrate behavioral health consultants into their work flows in response to recognizing the limited access patients have to mental health services provided by specialty mental health. This comprehensive primary care approach has grown exponentially across the United States (Kelly & Coons, 2012). Integrated primary care consists of integrating behavioral health consultants (BHC) into primary care settings, working collaboratively with PCPs (Hunter et al., 2017). This need was rooted in the realization that PCPs provide most of this nation's mental healthcare (Terry, 2016). Incorporating behavioral health into primary care addresses the question, "How do we make mental health services more accessible to the community?" In responding to this need, we have to ponder new questions: Who do we hire to provide these services, and how do we support the successful transition of specialty mental health providers into the culture of primary care?

Working in Integrated Primary Care

Programs that provide direct systemic training in integrated primary care are scarce, and spaces in pre-doctoral and post-doctoral psychology training programs in integrated primary care settings are limited. Due to the imbalance of available training opportunities and growing need for BHCs in primary care, a large majority of behavioral health provider positions are filled by licensed professionals who received their training in traditional psychotherapy models (Dobmeyer et al., 2016). However, competencies required to be efficient in integrated primary care are different from traditional psychotherapy approaches

continued on page 49

(O'Donohue, Cummings, & Ferguson, 2003). Mental health professionals (clinical social workers, psychologists, family therapists, and professional counselors) are asked to adapt their training and skills to provide same-day services in integrated primary care without the guidance of an accrediting body or specific training experiences outlining competency (Peek, 2009; Tew, Klaus, & Oslin, 2010; Serrano, Cordes, Cubic, & Daub, 2018).

Those providing traditional psychotherapy and behavioral consultation differ in their in roles, responsibilities, and systemic foundations. The role of the BHC is not only to provide intervention for the patient, as seen in traditional psychotherapy models, but also to serve as a consultant to the PCP, which can improve the health of the primary care clinic population. This requires the BHC to conduct brief, focused assessments and interventions (15 to 30 minutes) and communicate intervention plans clearly and concisely to PCPs (Pomerantz, Corson, & Detzer, 2009; Robinson & Strosahl, 2009). Medical knowledge is essential for BHCs in order to consult with PCPs and medical staff on how to effectively counsel their patients on disease self-management, health behavior change, and medication adherence (Blaney et. al., 2018). Therefore, mental health professionals trained in traditional psychotherapy approaches encounter the need to acquire new skills to function in an integrated primary care setting, which requires them to adopt a new professional identity. This identity is located within the medical team, and the transition requires acculturating to the medical team's language, pace, and culture (Blount, 2003; Christian & Curtis, 2012; Hooper, 2014; Hunter et al., 2017 Patterson et al., 2002; Tew, Klaus, & Oslin, 2010). Finally, mental health professionals must expand their scope of practice beyond traditional mental health concerns (e.g., depression, anxiety, substance use) to include the behavioral management of chronic health issues (e.g., diabetes, chronic pain, hypertension) and health behavior change interventions (e.g., tobacco cessation, medication adherence; Glueck, 2015).

Robinson and Reiter (2016) provided a clear and concise description of roles and responsibilities a BHC has in an integrated primary care team. The GATHER acronym outlines the key essentials of primary care behavioral health. G is for Generalist. To be useful to the PCP it is important that the BHC is a generalist in training due the nature of Primary Care. The PCP serves people from birth to death and with a wide variety of medical and behavioral health needs. This does not mean you will know everything about everything but that you will know a little about a lot and know where to find and applying knowledge to aid in the treatment any condition. BHC can also participate in curb-side consults to PCP to assist in dx clarification, skill building, medication recommendation, and providing resources. The BHC may also serve as a mediator for communication difficulties between the PCP and the patient during patient visits.

A is for Accessible. The BHC must be available for same day consults (also known as "warm hand offs"). This allows the PCP to have feedback in real time to inform their decision about treatment. Additionally, this ensures that the BHC embraces population-based health in serving the many as opposed to serving the few. T is for Team-Based. The BHC is available in a variety of ways as a regular member of the team. BHC can assist with the flow of the PCP visit by participating in pre-PCP visits ("PCP

continued on page 50

prep") to gather information and provide an intervention in order to shorten the PCP visit. The BHC can engage in consultation after the PCP visit or address another condition the PCP did not have time to discuss. Moreover, the BHC can come in after the PCP to make a concrete plan on recommendations and discuss possible barriers to plan implementation. BHC can provided group medical visits, classes, and assist with resource connection. The BHC can assist in brainstorming ways to reduce high utilization of emergency rooms and frequent re-hospitalizations. BHC can conduct co-visits with the PCP to help facilitate behavior change and improve communication between the PCP and patient. H is for High Productivity. The BHC sees 8-14 patients daily. BHC is readily available to assist with patients on PCP's panel. If the PCP is expected to see 25 patients in one day, the BHC should also be highly productive while providing high quality patient care. The BHC should work at a comparable pace as the PCP. E is for Educator. The BHC teaches other members of the team behavioral interventions, behavioral manifestations of physical health conditions, and other aspects of patient behavior that impact primary care. The PCP will always see more patients when compared to the BHC. By teaching the PCP behavioral interventions, the BHC's impact on patient care grows. Additionally, the BHC can introduce different skills such as redirection and Motivational Interviewing to aid in the effectiveness and efficiency of PCP visits. Other members outside of the team can be trained in behavioral interventions such as medical assistants, case managers, community health workers and nurses to help assist in the patient flow if the BHC is not available. R is for Routine Pathways. The BHC can design clinical pathways or protocols that are routine for certain populations. This allows the PCP to have a clearly defined decision tree in the ways that the team can be helpful for the patient. Additionally, the BHC can train PCPs to introduce BHC services as a part of routine primary care to help de-stigmatize behavioral, habit, and emotional interventions and focus on improving health outcomes. This results in an increase in patient willingness to accept BHC services. Mental health professionals interested in primary care should review these roles and expectations to gather a sense if they are well-suited and attracted to a position as a BHC. Additionally, the GATHER acronym serves as an easy way BHC and their supervisors can examine current fidelity to the primary care behavioral health model (Robinson & Reiter, 2007).

Considering the challenge of identity transformation necessary for a BHC in integrated primary care, it is important to note the discovery that mental health provider attitudes may influence their adoption of a new way of practicing and training (Aarons, 2004). A change in mindset and differences in pacing for integrated primary care settings has been outlined as a necessity in anecdotal reports from mental health professionals in integrated primary care pilot projects (Pomerantz et al., 2009; Robinson & Strosahl, 2009). James and O'Donohue (2009) outlined key attitudes and behaviors conducive to working in primary care, regardless of one's training background. These include: 1) readiness to learn and accept change, 2) high energy, 3) finding enjoyment in fast-paced practice, 4) competency in medial and behavioral health interventions, 5) case management skills, 6) clear and concisely communication in verbal and written form, 7) good emotional regulation, 8) knowledge of the population served by the clinic, 9) awareness of community resources, 10) ability to rise to a chal-

continued on page 51

lenge, and 11) not steadfast to the specialty care assessment and treatment models. Blaney and colleagues (2018) highlighted that a clinician's readiness to transition into a BHC role in primary care is a vital. Nash, McKay, Vogel, and Masters (2012) also stressed the importance of the clinician's readiness because BHCs perform multiple roles within the medical system, including: direct patient care, champions or advocates in the process of successful integration, and training future trainees. The aforementioned characteristics are important for both employers and mental health professionals to consider when a traditionally trained provider is thinking of pursuing a career in primary care.

Post-Graduate Training in Integrated Primary Care

The availability of trainings focused on integrated primary care for BHCs is a significant barrier to effective integration (Blount & Miller, 2009; Bluestein & Cubic, 2009; Nash et al., 2012, Robinson & Strosahl, 2009). Since most BHCs lack prior training or experience in primary care, formalized training is necessary to function effectively in their new roles (Dobmeyer et al., 2016). There are a variety of options for those seeking training. For independent study, O'Donohue (2009) designated the following resources as key readings for clinicians interested in working in integrated primary care (see the **Resources List** at the end of this article).

Dobmeyer and colleagues (2016) added on to the concept of self-study by providing an outline for initial self-guided activities. Their discussion about BHCs' training included a subsection called "pre-training requirement" to prepare potential BHCs for formal education on practicing in primary care. The BHCs were required to review readings, primary care service specific policies and clinical practice manuals, materials on clinical assessment formats, an initial appointment outline, and the Tri-Service BHC Core Competency Tool (CCT). The CCT evaluates the six different domains essential for practice as a BHC: clinical practice skills, practice management skills, consultation skills, documentation skills, team performance skills, and administrative skills (Air Force Medical Operations Agency, 2011; Robinson & Reiter, 2016) and expands upon detailed behavioral descriptions of desired behaviors and attributes. The CCT can inform employers and BHCs if they have met their training goals and are prepared to practice in primary care. Additionally, trainees were asked to memorize an informed consent introductory script specific for integrated primary care and designed to orient patients to the services in the initial patient encounters. Finally, trainees attended staff meetings and team huddles; shadowed PCPs in clinic; and learned about local mental resources for the community. Although these requirements were specific to Dobmeyer and colleagues' training program, a similar structure can be adopted by other organizations or individuals interested in working in primary care setting.

Specialty mental health professionals interested in formal education on integrated primary care could investigate certificate programs. Interested individual can go to https://sites.google.com/view/integratedprimarycare2/training for further information on these programs. An example of a certificate program is through the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. The program's cost is approximately $1,600 per student and the program requires both onsite and distance learning activities. The certifi-

continued on page 52

cate takes six months to complete and covers topic such as: culture and language of primary medical care, behavioral health needs in primary care, consulting with PCPs, substance abuse in primary care, and evidence-based therapies. Interested individuals can seek this opportunity independently or request their current employer to consider integrated primary care certificates as part of employee training. Day-long continuing education workshops or integrated primary care certificates have been deemed as useful for training behavioral health providers. However, these trainings do not provide the in-depth, on-site, and recurring training needed to be successful in integrated primary care (Belar, 2011; Kelly & Coons, 2012; Linton & Coons, 2011).

At the systemic level, organizations should consider hiring a technical assistance consultant to train their BHCs as well as the primary care team. This strategy is most cost effective when seeking to train multiple clinicians and beginning to create a culture of change towards comprehensive primary care. Examples of consulting programs offering this assistance are Primary Care Behavioral Health Strategies, LLC (https://stacyogbeide.com/pcbh-consultation) and Mountainview Consulting (http://www.mtnviewconsulting.com).

Conclusion

Specific training for BHCs is necessary to effectively work in an integrated primary care setting. Despite the growing need for this training, limited options are available for the post-graduate mental health provider population looking to transition into a primary care setting. Options such as reading material, self-study activities, organizational consultation, higher education, and workshops or certificates are available. Regardless of type of training a new BHC acquires, Dobmeyer and colleagues (2016) stress the importance of an organization never underestimating the difficulty BHCs encounter when transitioning from specialty mental health. When personally facing this challenge, I found working in an environment that encouraged the team members to learn from one another, consistent review and conceptualization on BHC practice using the GATHER acronym for a BHCs roles (Robinson & Reiter, 2016), regular supervision and feedback from the medical team, and faith in the research supporting the effectiveness of integrated primary care as most helpful. Hall et al. (2015) found a pattern of underestimation of resources and time needed to prepare a new BHC for newly integrated primary care practice. The reality may be that some new BHCs will be unable to develop and demonstrate skills necessary for success, despite participation in a structured training program. Finally, a crucial component of continued success is the ongoing training and evaluation to enhance, expanded, and protect against the "regression to the mean" phenomenon (falling back in to old patterns of providing traditional mental health) of the BHCs' competency and skills.

Resources List (adapted from O'Donohue, 2009)

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continued on page 53

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continued on page 54

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continued on page 55

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INTERNATIONAL SCENE

A Work-in-Progress: A Supervisee's Reflections

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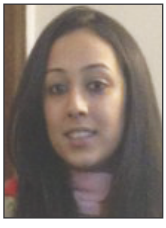

Introduction

To be in supervision for beginner therapists is a nerve-racking experience, which has the capacity to change the life of the trainee. Hyde (2015) describes beginner therapists as intelligent, gifted, and successful individuals who in supervision face scrutiny, which threatens their self-esteem and stirs up anxieties and defenses. She says, "In supervision, we feel all our core selves are exposed, leaving us not so much concerned about our patient's or client's capacity to flourish or flounder, but our own" (p. 14).

In this paper I describe three experiences in supervision that trace my personal journey as a trainee psychotherapist. To undertake this experiential process, a framework of the context of my training seems imperative. When I joined the National Institute of Mental Health and Neurosciences (NIMHANS) Bangalore in Southern India, I had a master's degree in psychology and the experience of working with adults and children, both in internships mandated by my graduate program as well as in a job as a psychologist at an inclusive school. I felt myself adept in theoretical concepts and counseling skills. I assumed that this new undertaking would allow for me to gain mastery in dealing with cases with complex psychopathologies, and I was prepared to read and understand all I could to be a better therapist. I had taken on, as I thought then, an intellectual challenge. I understand now that the challenge was an emotional one. The training entailed large caseloads, time-intensive attempts at therapy, and diverse supervisors with different therapeutic frames. It meant managing time to complete coursework, psychodiagnostic assessments, and to attend outpatient clinics and departmental programs, in addition to seeing clients in therapy. The training program has been discussed elsewhere at length (Grover, 2015; Rao, 2001). In attending to my anxieties about performing well and dealing with a depowered position in the institution, the struggle was often about getting the job done and not about my personal growth as a therapist. Supervision was a way for me to attain direction in proceeding with case management and, perhaps, reinforcement for my work.

Underlying the three experiences discussed below is my changing notion of supervision. In the first experience, I thought of supervision as a vehicle of intellectual learning and positive reinforcement, aimed at bolstering the confidence of the trainee. In the second experience I realized that it was an emotional medium to enhance trainees' reflective skills. In the third experience, which happened much later after the completion of my clinical psychology course and during my doctoral work, I accepted supervision to be for my own professional and personal growth. My perception of what entailed my growth as a therapist, too, may have changed over time as proposed by Kumaria, Bhola, and Orlinsky (2017).

continued on page 57

Beginning Steps and Narcissistic Anxieties

The first of the three experiences was in supervision for a female client who had been raped and suffered from posttraumatic stress disorder. I went into supervision with a detailed history and a psychological formulation of the case. The supervisor reinforced my efforts and my understanding of the case, and asked me to initiate supportive psychotherapy. She was confident in my abilities and allowed for me to take autonomous decisions. I felt reassured and ready to take on what was a complex case of psychological trauma.

Early on in therapy itself, I remember feeling that the client related to me on a superficial level and did not emotionally engage with me, but I dismissed this feeling as arising out of the client's emotional numbing. I did not talk about these feelings in supervision and instead would update my supervisor on tasks completed in therapy. We discussed how best to make the client functional and engage in meaningful activities that could keep negative emotions at bay. The supervisor displayed trust in my work and, in an attempt to remain a "good student," I did not discuss my worries. As the therapy progressed, I continued to feel that I was not truly understanding the client's gruesome experiences and not allowing for the trauma to be emotionally processed.

When I think about the case now, I can see that my relationship with the client and with the supervisor had many similarities. Both relationships were positive and cordial but superficial. In neither relationship were real emotions being discussed. Also, the client was not telling me that I was not discussing her feelings in depth, and I was not telling my supervisor that we were not engaging in deep emotional conversations about therapy. I had begun to judge the supervisor as being incompetent in handling complex cases; perhaps the client had similar feelings about me. The parallel process that had emerged here went unnoticed and unaddressed. The parallel process is a phenomenon in supervision that was first discussed in psychodynamic literature. Here the supervisee brings into supervision therapy material to which the supervisor responds as a therapist and the supervisee takes the role of the client. In skillful supervision, parallel processes are discussed and supervisors attempt to respond differently so as to model for the therapist ways to break patterns in the therapist-client relationship (Tracey, Bludworth, & Glidden-Tracey, 2012).

This example highlights three challenges in supervision. The first is the question of autonomy. While allowing self–direction and autonomy in supervision has been recognized as a positive supervisor quality (Ladany, Mori, & Mehr, 2013), it may be important to consider how much autonomy is adequate, especially for beginner therapists. I felt that the trust and autonomy I received, over-estimated my capabilities and compelled me to handle too much on my own. There is merit in over-schooling beginner therapists as discussed in an Indian study wherein supervisees mentioned the importance of metaphorical hand-holding and providing direction in supervision (Bhola, Raguram, Dugyala, & Ravishankar, 2017). Ladany and colleagues (2013) advise against offering unbridled optimism about supervisees and instead create a positive supervisory space wherein supervisee may take on challenges. A balance between providing direction and autonomy needs to be struck, with the emphasis shifted to the former for beginner therapists.

continued on page 58

The second issue is that of nondisclosure in supervision. Despite needing greater direction and feeling incompetent to handle the case, I did not discuss this with the supervisor as I felt that it would rob me of the positive regard I was receiving and bring to the fore my deficiencies. Feelings of shame have been related to nondisclosure in supervision in literature wherein feelings of inadequacy and an over-evaluation of the self may lead to disturbances in communication in supervision (Yourman, 2003). Hyde (2015) describes this as follows,

> When suffused with shame, trainees bring little to supervision, or, in an attempt to avoid this most uncomfortable feeling, repeatedly tell tales of how well they are doing, focusing on and amplifying their successes; it's all about them, not the patient. At these times, for the supervisor, supervision feels empty and boring as the trainee skates across the surface of issues, not revealing what is truly happening, not describing sessions or the patient sufficiently for the supervisor to get a sense of the process, all with a brittleness and brightness that betrays their underlying vulnerability. They use the supervisor to mirror their great successes. (p.16)

I also felt at the time that disclosing my difficulties with supervision would mean that I was questioning the supervisor's methods. I was afraid that this would be perceived as being disrespectful and arrogant of me, and flouting the implicit hierarchy. Bhola and her colleagues discuss that in India, the supervisory relationship tends to be more formal than in the West, due to the cultural notions of deference towards authority figures in collectivistic societies. The authors found that Indian psychotherapy trainees may tend to refrain from questioning their supervisors and advised that supervisors need to address the power hierarchy explicitly early on in the relationship so that supervisees can express their opinions and feelings freely (Bhola et al., 2017).

The third issue was that of the perceived competence of the supervisor. Supervisors' ability to demonstrate their clinical skills and disclose clinical information to aid the discussions has been considered an important aspect of effective supervision (Ladany et al., 2013). Good supervision has been understood as bridging the gap between scholastic knowledge and clinical practice (Jacobsen & Tanggaard, 2009). I felt that my supervisor provided minimal clinical or theoretical input and rather relied on my understanding of the case. The supervisor, who is assumed to be more competent that the supervisee, bears the responsibility to ensure that skilled and competent psychotherapy is provided. It is the supervisor's job to ascertain when the trainee is ready to be trusted with this responsibility (Falender & Shafranske, 2007), and this my supervisor was certainly not able to do.

Scaffoldings and Self-reflections

Another important experience in supervision was in my second year of training. I sought supervision for therapy with a client who seemed quite burnt out in the context of her son's autism, her marital discord, and her poor social support. I felt that a supportive stance in therapy would be useful in helping her vent about her caregiving burden and the difficulties with her marriage. My supervisor, however, believed that I was underestimating the client's emotions and her ability to accept more intense forms of therapy. My supervisor's style was a bit uncomfortable, and without her saying anything too incriminating, I would become defensive about therapy.

continued on page 59

I learned over time that instead of defending myself, I needed to reflect on what made me uncomfortable and unsure about the work I was doing. Supervision became an experiential space for me. The supervisor encouraged me to first allow myself to feel with the client and focus on what the client evoked in me, rather than hide behind cognitive techniques. For this patient, processing decades of anger was understood as being much more pertinent than learning to cope with her day-to-day crises and negative thoughts. The supervisor posed what has been called in literature as a *constructive challenge*. This has been understood as an important characteristic of effective supervisors and can help scaffold the trainee to a higher level of skill (Ladany et al., 2013). Some supervisees work better if they are knocked off their pedestal and pushed to attain new insights (Jacobsen & Tanggaard, 2009). Feedback and provision of alternative methods of management from supervisors has been considered to enable learning of the supervisee and has been shown to be valued by them. Effective supervisors tend to discuss explanations of therapists' feelings in therapy, provide meta-perspectives and allow reflection (Wilson, Davies, & Weatherhead, 2016). My supervisor not only challenged my theoretical orientation but also my emotional one. In supervision, we would speak about various levels of processes in therapy such as immediate skills, the purpose of therapy in the life of the client, and the purpose of this client in my life. The supervisor also provided instances in her own journey as a therapist where she had only touched the surface of what had turned out to be an ocean of emotional strife. Self-disclosure in supervision has been advised in literature to be used judiciously and in the service of the supervisee (Ladany et al., 2013). There is evidence that supervisors' self–disclosure is perceived positively by trainee therapists, as it helps normalize supervisees' experiences and encourages them to share their own feelings (Wilson et al., 2016). In my experience, the self-disclosure served as an opening to discuss my own feelings about the therapy.

The supervisor's clinical skill resulted in the lowering of my own defenses and an emotional awakening. Resolution of my discomfort in supervision helped resolve several instances of my discomfort in therapy. Supervision is meant to provide a safe space to process feelings and allow for the development of an internal supervisor (Wilson et al., 2016). I was truly connecting to clients' emotional difficulties perhaps for the first time since I had joined the training. I felt less inclined to excel academically and more enthused to have emotionally meaningful experiences. Looking back I realize that, unlike a majority of my supervisors, this one did not evaluate me purely on my theoretical knowledge and verbal fluency, but on my reflective capacities and therapeutic skill. I have since become more comfortable with discussing my frailties and mistakes in therapy, and have become a more authentic therapist.

The Real Relationship

The third experience was the supervision of my doctoral work. My study population was comprised of women who had substance use issues, emotional difficulties, histories of trauma, and difficult relationships. The process of recruitment, assessment, therapy, and follow up seemed unending and exhausting. My doctoral guide supervised the cases that I recruited and even though by this time I felt much more competent in handling complex cases, I needed my supervisor to contain the enormous anxieties that arose in the process of the doctoral study, which I am certain is the case for most doctoral students.

continued on page 60

I realize now how I had evolved as a person through my training. When I started out, I was self-assured, almost conceited about my capabilities. Through the years I learned about my many shortcomings, and by the time I started my doctoral work, I believed that I was not actually as skilled and efficient as people assumed. This phenomena has been explained as disillusionment with the self of a trainee therapist (Hyde, 2015). It would emerge often in my doctoral reports, wherein I would portray the work I had done as much lesser than it had really been. My supervisor had the ability to tell me that I was selling myself too short in an encouraging and insightful manner, making me reflect upon why I was doing this and how my sense of self had changed.

For a majority of my colleagues the doctoral supervisor, with whom they spent the largest amount of time in their training, was also the person toward whom strong ambivalent feelings and avoidance developed. The supervisor's role was not only to supervise therapy but also to oversee the research at large, and so this dual relationship would often become strained. In my supervisory experience, any potential strain or avoidance on my part would be discussed by my supervisor, often with humor and always centered on my personal growth. In one such experience, the clinical team had planned an outing and a few of us decided to have tea at my residence. We decided to not disclose the location to my supervisor and keep it a surprise. When the location became known, my supervisor refused to accompany us, stating that it would be a violation of professional boundaries. I had prepared the meal and was extremely disappointed—even angry—that my supervisor could not let go of professional ideals. My supervisor perceived that this impersonal move could potentially alter the positive working relationship we enjoyed and discussed the issue with me at length. She explained about the "slippery slope" that seemingly innocuous boundary crossings could create. I understood the notion of "supervisors serving as fiduciaries" and that they are ethically and legally bound to model appropriate professional conduct in the best interest of supervisees (Barnett, Cornish, Goodyear, & Lichtenberg, 2007; Gottlieb, Robinson, & Younggren, 2007). This instance helped me understand my own feelings of attachment towards my supervisor and served as an excellent example of resolving ethical dilemmas in supervisory relationships.

In an institutional context where my experiences with other supervisors were short lasting, often limited to single cases, my experience with my doctoral guide was the longest supervisory relationship I had had. I view this relationship as consisting of all the ingredients of a real relationship. There existed mutual genuine regard for the person behind the professional role and I feel that my authenticity and nondistortion arose from the implicit and the unshaking support that my supervisor provided. The real relationship has been understood in psychotherapy and supervision to encompass realism and genuineness, and has been understood to enhance professional connectedness, social relatedness, and attachment. It contributes to building the identity of the therapist (Watkins, 2011; Watkins, Jr., 2017). In my relationship with my supervisor, I learned better to thrive in my organizational system and manage my professional anxieties better.

My Developmental Journey in Summation

In this developmental journey from a therapist-in-training to a trained thera-

continued on page 61

pist and a doctoral student, my needs changed. In the first experience, I had needed structure and skill-based inputs from my supervisor. I also needed to learn how to talk about difficulties in therapy and supervision, and how to access supervision better. Having eventually developed these capacities, by the second experience I needed to loosen up in my process of therapy, allowing myself to stay with emotions and not try to "fix" problems automatically. In the third experience, I enjoyed much greater autonomy in psychotherapy, and needed supervision to help manage multiple roles and anxieties. My experiences trace Loganbill, Hardy, and Delworth's (1982) stages of counselor development: stagnation (naïve unawareness), confusion, and integration. The authors added that in becoming master counselors, eight critical issues need to be resolved: competence, emotional awareness, autonomy, theoretical identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. In tracing my journey, several of these issues have been touched upon and highlight that experiences of supervision in India do not differ qualitatively from those described in Western literature. These experiences highlight the pivotal role of the supervisor in transitioning through the stages of development, and call upon the need for competent supervision in therapist training.

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continued on page 62

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STUDENT FEATURE

Strong Through Every Mile: My Experience Empowering Survivors of Domestic Abuse and Addiction Through Running

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Running has been a fervent hobby of mine for over a decade. It is a pastime which I paradoxically find relaxing, as well as a sport through which I test and challenge myself. Running has provided me many benefits over the years, including improved physical health, social connections, and self-confidence. I am a strong believer that running and exercise is, and can be, therapeutic for many. For these reasons, I support (quite enthusiastically) others who pursue running-related goals, whether it be to run one mile or 26.

Therefore, when I learned of a local running program created specifically for women who were victims of domestic violence or in recovery for alcohol and/or drug addiction, I jumped at the opportunity to become a volunteer "coach." The program, called Strong Through Every Mile (STEM), appeared to be a curiously perfect blend of two of my biggest passions—psychology and running. Needless to say, I was excited when I was approved to be a volunteer and eager to get started. The introductory information provided about STEM was straightforward: The program followed a 10-week couch-to-5k format and gathered three times per week at a confidential location (for the safety of the women). The program would conclude with all runners and volunteers participating in a local 5k road race, with all registration fees covered by the program. I was told that, although the women were of varying skill levels, most had little running experience or had never run before, let alone run three consecutive miles. The ages of the women varied, and volunteers were allowed to disclose as much about themselves as they felt comfortable with. In fact, they mentioned that several volunteers kept in touch and continued to run with women who previously participated in the program. Finally, I was told that all runners had signed up willingly to participate in the STEM program rather than it being a requirement of any sort. Thus, I already admired the courage of these women for choosing to participate in a program they would likely find challenging, yet optimistic that they would also find it beneficial and rewarding for the same reasons I have, and more.

On the first day of training I found myself both justly excited and unexpectedly nervous. The nerves arose out of uncertainty of the overall experience, but especially over how I should interact with the runners. *What should I talk about with them while running? There is quite a lot of time for chatting. Are they going to talk about their domestic violence and addiction histories? Should I utilize the therapeutic skills and techniques I have been taught to use in the therapy room? How much personal information do I disclose? I am sure they will ask about me. How do I even be a "coach"? I have never done anything like*

continued on page 64

that before. I hope I am not bad at it. The questions and concerns seemed endless.

After meeting the runners and other volunteers, however, I quickly realized that these worries were completely unwarranted. The first several training sessions were fun and lighthearted, and consisted of introductions and casual conversation. In many ways, it felt like any other group of runners. However, there were certainly noticeable differences. The first workout involved alternating one minute running and one minute walking intervals, which a number of women were unable to complete. Additionally, because many of the women had never run before or had not done so in years, most attended the first few weeks of training in jeans, and nearly all of them did not have a pair of proper running shoes.

Yet, the runners maintained their motivation and continued to show up even under awful weather conditions, including bitter cold, strong winds, and heavy rain (or, on too many occasions, a combination of all three). To me, this spoke greatly of their resilience. Fortunately, a few weeks into training the STEM organizers brought all the women to a local running store and provided them with new pairs of shoes and activewear, which undoubtedly boosted their confidence. Over time, their resilience was made even more apparent as some of the women gradually opened up and willingly shared their stories with me. One woman informed me that running may be difficult considering one of her hips was mostly metal, and later revealed to me that this was due to her hip shattering in a car accident she was in as a teenager, which killed two of her best friends and was the impetus for her use of painkillers.

A few weeks into training I was asked by a program organizer to pair myself with one particular woman, who I will call Anne, because we had similar running paces. I had spoken to Anne a few times during the first training sessions, and I remember vividly the pair of 1-inch wedge heel sneakers that she initially ran in, which simultaneously impressed and terrified me for her safety. At the end of each training session, I always commended her for her efforts and for finishing the run, and asked how it felt for her mentally and physically. The progression of her responses was notable: At first, her answers were typically along the lines of, "Wow, that felt *really* hard" and eventually changed to, "That wasn't too bad this time" or, "It was difficult because I pushed myself, but I feel great." Over the weeks, she shared with me other goals she set for herself in hopes of improving her lifestyle, health, and running. Anne would tell me that she wanted to cut down or even quit smoking, and that she had been trying to eat foods that she read would improve running abilities. While it was amazing to see her endurance and pace improve over time, this was secondary to watching her motivation and confidence grow. One particular conversation toward the end of the program fully embodied this evolution. After running three miles consecutively, I exclaimed "Anne! You just ran an 8:00 minute [per mile] pace, and that last mile you did in 7:30! You did incredible! How did it feel?" Her facial expression could not hide her excitement and shock. She replied, "Really? I can't believe that! When I started my goal was just to run it under 30 minutes." I said that it was probably time to set a new goal.

Anne was one who never talked specifically about her substance abuse history and recovery with me in detail, nor did she need to do so. Over the weeks, she told me in other, more subtle ways how STEM was beneficial to her and her so-

continued on page 65

briety. She would tell me that each day she looked forward to coming to the program, how great she felt afterwards, how it kept her busy, and the sense of accomplishment she gained. The only time she made any reference to her struggles with addiction was when she told me that running gave her a sense of achievement as well as something to work toward, "just like [her] recovery. It keeps [her] motivated to stay sober."

The 5k road race at the end of the program came quickly. On the drive over, many of the women mentioned how excited they were, yet also nervous. The other volunteers and I explained that this was normal, but reminded them that the most important thing was to have fun and appreciate all the hard work they put in to get here. Most of the women had never attended or participated in such a race, so I was not only excited for them to fulfill their running goals, but was just as excited for them to experience one of my favorite aspects of these races—the atmosphere.

The running community is welcoming, friendly, and encouraging, which generates an incredibly supportive race environment. At these races, it is not unusual to hear "great job," or "keep going, you can do it" from other runners who pass by, or for strangers on the side line to cheer you on. I knew the women would enjoy this considering they continually expressed their appreciation toward the STEM volunteers for our support throughout the program. One woman in particular frequently thanked me for taking the time to attend the training runs despite having a busy schedule. Another expressed gratitude on social media for helping her through a particularly difficult training session. These women, as with any psychotherapy client, benefit from having positive supports in their lives, and there was no lack of gratitude from the STEM women for this.

Needless to say, all of the women successfully completed the 5k race. Anne even won her age group division. Though it was exciting to watch everyone finish, it was sad that the "season" had ended. The potential benefits of such a program are vast and apparent, and parallel several elements of therapy that I, and we as a field, aim to encourage and foster with clients, such as goal-setting, increasing positive supports, and a sense of accomplishment, strength, and capability. For some, running is able to provide many of these elements and is a hobby at which they will continue to work. In fact, a number of the women have signed up for STEM's first half-marathon training program, including Anne. As for myself, I look forward to continuing my participation in STEM's training programs as a volunteer coach, and am optimistic that the women will take what they have gained from this program and apply it to their lives and recovery moving forward.

For more information about the program and becoming involved, please visit the STEM website at http://www.stemrunning.com/, watch a brief video about the program at https://www.youtube.com/watch?v=uhk4GvdbMDo, or email Brittany King at bking3@albany.edu.

MEMBERSHIP

Why We Joined Division 29, the Society for the Advancement of Psychotherapy (SAP)

Jean M. Birbilis, PhD
Membership Domain Representative

Rosemary Adam-Terem, PhD
Membership Committee Chair

Barbara Thompson, PhD
Committee Member

In the coming months, SAP will be surveying members of the Division to find out more about why individuals have chosen to join, what keeps them involved, and what member benefits would increase their commitment to and satisfaction with the Division. In anticipation of this, the Membership Domain Representative, Committee Chair, and Committee Member reflected on those questions and offer their perspectives below.

Jean M. Birbilis, PhD, Membership Domain Representative

I found my way to APA's Division 29 (known then as the Division of Psychotherapy and now the Society for the Advancement of Psychotherapy) relatively late in my professional career. I had been working in higher education for about 20 years, and I was on a listserv through NCSPP (National Council of Schools and Programs in Professional Psychology). The listserv periodically carried announcements of various opportunities. One day an email arrived indicating that Division 29 was looking for a Committee Chair for its Education and Training Committee (ETC). Given that I was (and still am) a full time professor in a PsyD program educating psychotherapists and was/am a licensed psychologist in a part time private practice, I was intrigued by both the Division and the ETC. I volunteered to chair the committee and joined Division 29.

I had been involved in some of the evolution of competency-based education through NCSPP prior to joining Division 29, and the NCSPP model of education and training was used in the creation of the PsyD program that I teach in. In the course of chairing the ETC and sharing information about competency-based PsyD programs, I discovered that psychotherapists trained in practitioner-oriented PsyD programs were underrepresented in Division 29. I eventually became involved in the Membership Committee and have a particular desire to increase the number of Division 29 members trained in PsyD programs as we reach out to all psychotherapists to join us.

Division 29 is a wonderful professional home for practitioners of psychotherapy because practice is equally valued with science and teaching of psychotherapy.

continued on page 67

This inclusiveness and equanimity is not always present among mental health professionals. I personally attribute this equity to the relationally-oriented nature of the members themselves. I have felt not only welcomed, but embraced by them from my first interactions. The motto of Division 29, "Be connected!" Is a truly lived motto among its members.

Rosemary Adam-Terem, PhD, Committee Chair

I joined APA as a late-stage graduate student and joined divisions that seemed relevant to my interests: Women, Peace, and Psychotherapy. I was not sure how APA worked or what the Divisions actually did, but I enjoyed reading the journals. I considered the Division of Clinical Psychology but stayed with Psychotherapy since I went on to become a full-time practitioner.

I ran for APA's Council of Representatives as the Representative of my State Psychological Association, and I didn't know how Council worked until I attended my first meeting. Fortunately, APA had thought to provide an orientation for the cohort of new Representatives, allowing us to meet people and get to know them a little before plunging into the parliamentary (and argumentative) world of over 160 psychologists. There was also a mentoring system, and I was assigned to Cindy Sturm who helped me enormously and remains a good friend and fellow chocolate-lover. My seat neighbor on the other side was Jennifer Kelly, another strong leader who gave me guidance and helped me understand what was going on. Without these relationships, it would have been overwhelming.

I attended the various caucuses (what were they?!) and met other psychologists working together to pursue their interests and agendas within the massive structure of APA. Many of the people I was drawn to in these meetings were psychologists whose work I had been following in the Psychotherapy journal and were members of Division 29—Psychotherapy. I felt connected. A fond memory of the Psychotherapy Caucus was of Linda Campbell honoring Jeff Barnett for one or more of his outstanding achievements with a life-size cutout figure of Jeff. Linda was so sharp, dry and witty; I know she could have had a career in stand-up comedy if she had not chosen Psychotherapy.

And so later when I read in the Bulletin that Division 29 was looking for people to run for positions as Domain Representatives on the Board, I put my name in for the Public Policy and Social Justice area. Showing up for my first meeting, I was happy to see familiar faces I had come to know through Council or other Committee work—Armand Cerbone, Nadine Kaslow, Norine Johnson, Jeffrey Magnavita, Jeffery Younggren (so many Jeffs…), among others. I met new people too—Sheena Demery, Barbara Thompson, Caryn Rodgers, Jeff Zimmerman (another Jeff) and many more each year. It was a friendly, warm group spurred along by the indomitable Tracey Martin, our Administrator.

I have remained connected to this group and feel that I have true friends here. Working in smaller group formats on projects like our current membership initiative with Jean Birbilis and Barbara Thompson has deepened those relationships and made for enjoyable interactions in between Board meetings.

Barbara Thompson, PhD, Committee Member

I became a member many years ago because when I read the mission of the Division of Psychotherapy, as it was called

continued on page 68

then, it fit how I most identified with the APA and psychologists. Although the majority of my work life has been focused on providing clinical care, I have also maintained participation in psychotherapy research projects, regularly attended the Society for Psychotherapy Research and been an adjunct, supervising students through my alumni university as well as teaching at several other universities training counselors and psychologists. There is no other Division in the APA that ticks all of these boxes so well.

I was a somewhat silent member of the Division and just enjoying the quarterly *Bulletin* reports and issues of *Psychotherapy*. Then, about nine years ago I was approached by a fellow alumni of my Counseling Program, Libby Nutt-Williams, who was president elect of the Division, to be a Chair of one of the committees of the Division (Professional Practice). The following year I was elected to a board position as Domain Representative which I held until the end of 2018.

My commitment to and interest in the Division has only increased since actively being part of the Board. I am reassured and inspired by the other individuals serving on the Board, the various projects the Board takes on, the Board's sensitivity to issues of diversity and inclusion, and the desire to promote psychotherapy on the three fronts of practice, scholarship, and education/ training. In my involvement, I have actively worked to involve other like-minded therapists in the Division. This includes seasoned therapists like myself, early career, mid career, and students. My wish for the Division is that it had more presence in the therapy world. I am not sure how helpful others know the website can be in terms of providing much clinical information. I have always been impressed by the knowledge and expertise of the members of our Division and would like to figure out a way to share more of that knowledge and expertise.

The three of us hope that you will share your story of joining SAP with us. Perhaps you'll submit it to the *Bulletin* . . . ?

WASHINGTON SCENE

"Come Gather 'Round People Where Ever You Roam"

Pat DeLeon, PhD
Former APA President

Colleagues with Exceptional Vision

One of the advantages of being personally involved within the governance of APA, at either the national or state level, is that, over time, one becomes exposed to the wide range of professional issues which each of the nation's health care professions must eventually address. The recent announcement by Walmart, for example, that they were establishing a mental health clinic within one of their Texas facilities is reminiscent of the intensive discussions within optometry and ophthalmology when it was becoming increasingly evident that consumers would soon be able to obtain their eye examinations and purchase glasses at major shopping mauls, rather than having to rely upon visits to "mom and pop" eye specialists. Those concerned about the change frequently presented a "public health hazard" allegation; that is, that the quality of care would be compromised, as if the *locus of care* was a significant issue. Others, including the Federal Trade Commission (FTC), raised the underlying issue of potential "restraint of trade." Today, consumers have considerable choice in deciding where and by whom they wish to receive their eye care.

Russell Petrella, a long-time colleague and APA member, is President and CEO of Beacon Health Options, a Boston-based behavioral health services company which is running the Walmart clinic. Consumers will be able to walk in, call, or make an appointment online to see a licensed mental health professional about daily problems in living; such as anxiety, depression, grief, social and family relationships, and stress. On-site clinicians will provide assessments and develop mutually agreed upon treatment plans. Russ: "Our goal is to increase access, reduce stigma and mainstream behavioral health services." We would rhetorically ask: If psychology is serious about addressing the adverse consequences of the historical stigma surrounding receiving mental health care — What better way than to normalize behavioral health services, as is the case today with eye and dental care?

This fall I had the opportunity to attend the 127th annual meeting of AMSUS (The Society of Federal Health Professionals); titled *The Future of Healthcare is Now*. One of the most intriguing presentations addressed the enthusiastic embracement of telehealth by the Department of Veterans Affairs (VA). Their 2018 data noted approximately 2.29+ million episodes of care via telehealth, which were received by more than 782,000 Veterans at 900 sites of care. There was a reported satisfaction rate of 88-90% with slightly less than one percent receiving care in their home or at a non-VA location. This latter finding is expected to significantly increase in the coming year, pursuant to recently enacted expansive legislation.

Earlier this year, *The Psychology Times* focused upon the efforts of Tiffany Jennings who is the Louisiana Psychological Association (LPA) Rural Health

continued on page 70

Coordinator for APA and the Chair of the LPA Rural and TeleHealth Services Committee. One of her goals is to: "Develop an ongoing community where those in rural areas, or who serve rural populations, can collaborate with each other…. Telemedicine has been gaining more ground in treatment, particularly for those in rural areas where treatment services may be limited, or non-existent. University Health in Shreveport was highlighted in the local media highlighting the advantages of telemedicine – such as cost, reduced transportation burden – and that telemedicine can be as effective as traditional in-person treatment."

Within both the VA and the Department of Defense (DOD), mental health specialists have been particularly supportive of utilizing this ever-improving technology. Ray Folen, former Chief of the Department of Psychology at Tripler Army Medical Center (TAMC) in Honolulu and now Executive Director of the Hawaii Psychological Association (HPA), has been providing telehealth services since the mid-1990's. "As a U.S. Army tertiary care facility in the middle of the Pacific, we were responsible for providing health care in a catchment area that covered 50 percent of the earth's surface, most of it water. Telehealth was not just an option for us, it was an absolute necessity. In many situations it was the only way we could get behavioral health services to our servicemen and their families located in remote Pacific areas. In the beginning, the only viable 'teleconferencing' tools available were videophones, which had less than one percent of the '4G' bandwidth we have now. The technology was challenging but it worked and, over time, the bandwidth, infrastructure and equipment improved as did our skills and understanding of distance therapy. By 2015, we had ten full-time and many part-time tele-psychologists providing needed services to thousands of service members and their families located throughout the Pacific, Asia and the continental U.S.

"The technology and infrastructure are now readily available, treatment outcomes are reported to be equivalent to face-to-face therapy (our data found, in some instances, that telehealth was superior to face-to-face), insurance companies are now reimbursing for telehealth services, many state and federal telehealth regulations have been written, state interjurisdictional agreements are being established, and safety and liability issues are being addressed. Patient satisfaction with telehealth is high and it provides access to care that patients located in remote areas, or who are home bound, would not otherwise receive. Why, then, are more of our colleagues not embracing this technology and receiving the appropriate and necessary training?"

Marlene Maheu has long been on the cutting-edge of psychology's gradual evolution towards effectively utilizing telehealth technology. "Despite the promise of technology for increasing access, reducing overhead costs and delivering higher quality assessment/care, many psychologists are unaware of the legal and ethical issues needed for telepsychology. To shed light on this inconsistency, we have now published two studies of psychologists' attitudes and beliefs related to telepsychology. In our 2000 study, only approximately one third of the respondents surveyed reported awareness of laws of relevance to behavioral telehealth or online counseling, as it was called at the time. In our 2017 study, the number of clinicians who believed that current laws are relevant to telehealth increased to two thirds. In other words, approximately one third of

continued on page 71

psychologists still believe that current laws did *not* apply to telehealth.

"The problem is that they are incorrect. All current state law and ethical codes apply to telepsychology, whether or not the state has interpreted existing regulations for the use of technology it then falls on the clinician to know how issues such as privacy and confidentiality apply to video conferencing, suggesting apps, posting on Facebook, practicing over state lines, billing through PayPal, and/or using artificial intelligence in practice management.

"Our research also showed that willingness to use technology in the clinical arena varied with age of the respondent. Not too surprisingly, psychologists who were 65+ years old (digital immigrants) were the least likely to use technology in their practices. However, psychologists in the youngest subgroup of survey respondents were the next least likely group to use technology. The reluctance of younger psychologists (digital natives) to adopt technology for clinical services seems counterintuitive; except when one considers the origins of telehealth. As a grassroots effort that started with clinicians creatively seeking solutions for clients/patients who couldn't access needed care, the cauldron for forging telehealth practice was not the laboratory or university. Rather, it was in the heart of the clinician trying to assist a Hawaiian islander who couldn't find help for her ADHD child, it was with psychologists serving the rural farmer who realized that his son suicided. Telehealth was borne of the creative powers of the clinicians who sat with prisoners convicted to life sentences in the midst of undiagnosed and untreated bipolar disorder. Given the grassroots origins of telehealth, one factor contributing to the slow adoption rate found in our survey was hypothesized as being as being related to slow faculty acceptance of telehealth. Although few studies have reported on faculty adoption related to telepsychology, a poster paper presentation we saw back in 2013 showed very slow internship adoption rates for telehealth. Another factor explaining the low adoption rate of telehealth technologies by the younger psychologists may be the tendency for these psychologists to start their careers by working for established groups rather than in private practice, where fewer authorities need to approve service delivery mechanisms.

"As faculty members and internship directors become more acquainted with the evidence-base in support of telepsychology, graduates may learn more about the strong evidence base and be inspired to seek placements and employment in more telehealth-supportive environments. The immediate need for graduate school training as well as professional certification is evident. Of particular concern when looking at the need for professional telepsychology training is the growing number of licensed professionals who choose to work for online employers, many of whom fail to offer technological processes for complying with basic legal and ethical mandates." For those interested in pursuing these issues and especially their ramifications for training and practice, we would suggest attending various presentations Marlene will be making at our annual APA conventions.

Over the years, we have come to especially appreciate the contributions of those involved with the Association of State and Provincial Psychology Boards (ASPPB). ASPPB recently reported that by the end of 2018: "Seven states (Arizona, Utah, Nevada, Nebraska, Colorado, Missouri, and Illinois) had

continued on page 72

adopted the Psychology Interjurisdictional Compact (PSYPACT). PSYPACT will allow those psychologists who possess an E.Passport as part of PSYPACT to provide electronic services across state lines into another compact state without having to be licensed in that state. For the 2019 legislative session, North Dakota has introduced legislation (NDHB 1343) and New Hampshire and New Mexico have prefiled PSYPACT legislation. We are anticipating that Georgia, Pennsylvania, and the District of Columbia will follow and introduce a PSYPACT bill. In Texas, PSYPACT is part of the Texas sunset legislation which will hopefully be introduced in the near future. In addition, ASPPB has heard from several other states which have expressed an interest in pursuing PSYPACT legislation (Alex Siegel, asiegel@asppb.org)."

The Maturing Psychopharmacology (RxP) Agenda

Steve and Anthony Ragusea: "For the last five years, the Florida Psychological Association (FPA) has been quietly pursuing RxP legislation. Our RxP committee has diligently done its groundwork, consulting with membership, lobbyists, gathering letters of support, and meeting with our legislators. It has been exciting to watch our legislative efforts make gradual but definitely steady progress over time. As with all such legislation, the path to success is often slow and uneven as things move forward step by step. But, we have been relentless in keeping our eyes on the prize of securing RxP for Florida psychologists and the patients we serve.

"We now have two primary sponsors; Representative Cary Pigman has been our House sponsor for over a year. Rep. Pigman is a board-certified emergency room physician with military experience who, in the past, has successfully increased scope of practice for other health professions. He understands the need for psychologists who can safely prescribe psychoactive medications and he has already been of enormous assistance. He has not yet submitted his bills for the current legislative session, but he will soon do so and he has assured us our legislation will be included in his submission. In addition, we now have a Senate sponsor in Senator Jeff Brandes! We're very excited to have him representing our bill, which has already been introduced in the Senate as SB304. Senator Brandes has just publically announced that, 'Florida is facing a mental-health epidemic. Five States and the U.S. Military allow certain psychologists to prescribe once they receive specialized training. Expanding scope of practice must be an option as we seek to address this crisis.' We are grateful to both Senator Brandes and Representative Pigman for their enthusiastic support. We even were featured on National Public Radio (NPR). Soon, we expect the usual stale, ancient arguments to emerge from organized medicine that have been tried for over half a century. Despite the fact that they *always* eventually fail, organized medicine always insists on a fight. Things are about to get very interesting in Florida!" "For the times they are a'changin'!"

Aloha, (Bob Dylan).

REMEMBERING ABE WOLF

It has been said that a good psychotherapist is empathic, wise, supportive, collaborative, and knowledgeable. Abraham W. Wolf, Ph.D., was all of that as a therapist because that's who he was as a person. Abe cared deeply, and it showed. He cared about his patients. He cared about his family. He cared about his friends and colleagues. He cared about advancing the field. And he put his caring into action in what he did for others and the profession.

Abe, an exceptional clinician, respected researcher, and gifted leader of APA's Psychotherapy Division, died at the age of 68 on February 28, 2019 after a courageous battle with cancer. We join thousands of his colleagues and clients in mourning his passing and in celebrating his life.

Although it seems almost ineffable to describe all the ways that Abe impacted our lives, his patients and colleagues have movingly expressed how they felt about him. Upon learning of his death, a former patient of his said: "He was a Mensch and a damn good therapist. My life has been richer for having been his patient." Some of his colleagues remember him as "a respected scholar and therapist," "a major force for good in many people's lives," "a world-class scholar that was surpassed only by his generosity of spirit," and as a person who "exuded kindness and positivity."

Abe was a vibrant presence and enduring contributor to the APA Division of Psychotherapy (now the Society for the Advancement of Psychotherapy). He chaired the organization's Student Development Committee, served on the Publication Board, worked as the internet editor, and was elected to both the Board of Directors and as Treasurer. In 2006, he was President of the Society. Abe served with distinction in one capacity or another for more than 20 years. While he also served on other local and national bodies, the Society remained his passion and priority.

Quite apart from his positions, Abe proved a treasured colleague who naturally encouraged and mentored fellow therapists. He was conscientious and demanding about the quality of service while simultaneously making others feel good about the results and themselves. Abe sagely reminded us on numerous occasions, when we felt frustrated by the slow progress of professional organizations, that "We can only expect so much work from volunteers at Temple or Church. Let's celebrate what they do give us for free." Through his service, Abe propelled the Society for the Advancement of Psychotherapy into the future while collaborating with others to get us there.

Abe's 40-year affiliation with Case Western Reserve enabled him to contribute to the field as an educator, clinician, and administrator. His multiple workshops on item response theory in psychotherapy outcome, his co-edited book on *Transforming negative reactions to clients: From frustration to compassion*, his guest editing one of the earliest journal issues on technology in psychotherapy, and his influential collaborative research on the effects of lead and iron on child development begin to convey the range and impact of his scholarship. He retired as Professor Emeritus of Psychology in Psychiatry at Case Western.

Abe repeatedly stepped up to serve while others hesitated. The "Wolf Man," as he was affectionately known in APA circles, established and directed the first APA Psychotherapy Online Academy. He served as program chair for the Society for the Exploration of Psychotherapy Integration (SEPI). The theme of the 2019 SEPI conference, which will focus on "Building Alliances," will pay a tribute to Abe for having done so in so many aspects of his life.

Abe is survived by his wife of 27 years, Idelle K. Wolf; son, Adam P. Wolf; siblings, Ruth Wolf (Vincenzo Votto) of Philadelphia and Bruce Wolf of Philadelphia; and nephew, Louis Wolf.

Those who would like to honor Abe's memory may contribute to the Abraham W. Wolf, PhD, Endowed Fund for Graduate Fellowship in Clinical Psychology, c/o Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106, or the Mandel Jewish Day School, Head Masters School Discretionary Endowment Fund, 26500 Shaker Blvd., Beachwood, OH 44122.

Marvin R. Goldfried, PhD
John C. Norcross, PhD

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
BOARD OF DIRECTORS MEETING
FEBRUARY 2019

Highlights from the Board of Directors Meeting, February 2019. Please see this issue's President's Column (pages 2 & 3) for details on the Board meeting, plus much more!

MEET NEW MEMBERS OF SAP GOVERNANCE!

Marilyn Cornish, PhD
Education and Training Domain Representative

It is an honor to begin my 3-year term as Domain Representative for Education and Training for the Society for the Advancement of Psychotherapy. I am writing this introductory message on my way to my first Board meeting for the Society, feeling energized by the knowledge that I will be working with a great group of professionals to support our Society. Over the coming weeks I will be working with the Education and Training Committee, Continuing Education Committee, and Student Development Committee to develop our Education and Training initiatives for the coming year, which we plan to align with Dr. Nancy Murdock's presidential theme "Out of the Office and into the Streets!" Members hoping to get involved are encouraged to reach out. I can be reached at mac0084@auburn.edu.

To provide some context on my background: I am an assistant professor and Director of Training for the APA-accredited counseling psychology PhD program at Auburn University in Auburn, AL. In that role, I teach courses such as Counseling Supervision, Advanced Practicum, and Group Counseling. I similarly provide individual and group supervision and supervision of supervision to doctoral students, and I coordinate the practicum placement process for our students. My research lab has a central focus on psychotherapy process and outcome, with interests branching out to other types of positive relationships and effective interventions—including teaching and supervision. I thoroughly enjoy my training roles in my current position, and I look forward to having a broader reach as our Society's Domain Representative for Education and Training over the next three years.

Ken Critchfield, PhD
Continuing Education Committee Chair

Dr. Critchfield is a licensed clinical psychologist, a psychotherapist, who joined the faculty of James Madison University's Combined-Integrated Doctoral Program in Clinical and School Psychology in 2014. He has been involved with SfAP for some years, including as chair of the Education and Training Committee. He teaches psychotherapy skills and focuses on human change processes through direct supervision of doctoral students as they work with a wide range of patients/clients. Ken is director of the JMU program, as well as Chair-Elect of the Consortium of Combined-Integrated Doctoral Programs in Psychology (CCIDPIP). Prior to JMU, he worked at the University of Utah for over a decade as co-director of the Interpersonal Reconstructive Therapy (IRT) clinic, which had the three-fold mission of service, research, and training for treatment of adult patients with comorbid psychiatric disorders, chronic suicidality, and personality disorder. His ongoing clinical research focuses on testing putative mechanisms of change in IRT.

continued on page 76

Meet New Members of SAP Governance!, con't from page 75

Sara Danitz, PhD
Early Career Committee Chair

Dr. Danitz is excited to be the Early Career Psychologist Committee Chair of Division 29. Dr. Danitz is a clinical psychologist at VA Boston Healthcare System in the Women's Health Sciences Division of the National Center for PTSD. She works as the Project Manager for Dr. Katherine Iverson's study on implementing and disseminating an intervention for women veterans who have experienced intimate partner violence. In addition to her clinical research role, she sees patients in the Women's Trauma Recovery Team at VA Boston and provides clinical supervision. Dr. Danitz is passionate about supervision and training, and she serves on the internship selection committee at VA Boston and supervises trainees. Dr. Danitz also works part time as a consultant on research studies for treatment-resistant PTSD.

Dr. Danitz's research interests are in mindfulness and acceptance-based behavioral interventions, outcomes of psychotherapy that include increasing quality of life and valued action, and dissemination and implementation more broadly. Dr. Danitz's clinical interests are in evidence-based treatments for trauma, mood, anxiety, and obsessive-compulsive related disorders in both veteran and civilian populations.

Outside of work, Dr. Danitz enjoys yoga and dancing, and she is excited to engage in a 200 hour yoga teacher training certification this winter. She is thrilled to be a part of division 29 and is looking forward to working with the board and the division 29 community more broadly to better meet the needs of early career psychologists and to advance psychotherapy.

Carly Schwartzman, MA
Student Development Committee Chair

Carly M. Schwartzman is a third-year clinical psychology doctoral student at the University at Albany, SUNY, under the mentorship of Dr. James Boswell in the Psychotherapy and Behavior Change Research Lab. She joined APA's Division 29: Society for the Advancement of Psychotherapy to further her knowledge of the field of psychotherapy process research and enhance her networking in the research community. Her research interests involve the study of the therapeutic process and mechanisms of change. In particular, she has become acutely interested in the methodology used in studying processes within psychotherapy (e.g., alliance, warmth, empathy) that contribute to patient outcome, as well as how these processes translate in the context of e-therapy (i.e., therapy delivered online via videoconferencing, instant message, and/or email message). Carly is also passionate about the enhancement of the graduate student experience within the University setting and in the broader professional community. She hopes to work to enhance

continued on page 77

Meet New Members of SAP Governance!, con't from page 76

Carly Schwartzman, continued

student support and involvement within Division 29 to foster collaboration and networking. Additionally, she would like to encourage conversation and advocacy among students regarding the state of psychology as a profession and help students navigate the new technological era of psychotherapy.

MEET NEW MEMBERS OF THE SAP PUBLICATIONS AND COMMUNICATIONS BOARD

Sarah Knox, PhD
Publications Board Member

After teaching high school English for 11 years, Sarah Knox completed her doctoral training in counseling psychology at the University of Maryland. She is a Professor in the Department of Counselor Education and Counseling Psychology at Marquette University. Her research focuses on processes and relationships in psychotherapy, supervision, and training, phenomena she examines qualitatively. She is also Co-Editor-in-Chief of *Counselling Psychology Quarterly*.

Paul Kwon, PhD
Publications Board Member

Paul Kwon received his BA in Psychology and Economics from Williams College in 1990, and his PhD in Psychology from the Pennsylvania State University in 1996. He completed his clinical internship at SUNY Upstate Medical University and joined the faculty at Washington State University in 1996. He served as Director of the Psychology Clinic at Washington State University from 1997 to 2003, and also served as Director of Clinical Training from 2004 to 2008. He is currently an Associate Editor for *Psychology of Sexual Orientation and Gender Diversity* and serves as the Diversity Advisor for Graduate Recruitment and Retention for the Department of Psychology at Washington State University.

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY • APA DIVISION 29
2019 Convention Program Summary

THURSDAY, AUGUST 8TH

Symposium (A): Contextual Trauma Therapy for Clients With Complex Trauma—Skill-Building Using a Video Recording
8:00 AM - 9:50 AM • McCormick Place Room W175c
Cochair
Amy Ellis, PhD
Steven N. Gold, PhD
Participant/1stAuthor
Nathan R. Daly, MS
Discussant
Laura S. Brown, PhD

Symposium (A): Effective Psychotherapy Using Principles From Attachment Theory and Developmental Psychopathology
10:00 AM – 11:50 AM • McCormick Place Room W179a
Chair
Lorna Smith Benjamin, PhD
Participant/1stAuthor
Lorna Smith Benjamin, PhD
Kenneth L. Critchfield, PhD
Elizabeth Skowron, PhD
Michael J. Constantino, PhD

Symposium (A): Bringing Psychotherapy to Underserved Populations—Challenges and Strategies
1:00 PM – 2:50 PM • McCormick Place Room S104b
Chair
Linda F. Campbell, PhD
Participant/1stAuthor
Jeffrey Barnett, PhD
Jeffrey Zimmerman, PhD
Pei-Chun Tsai, PhD
Hamid Mirsalimi, PhD
Douglas C. Haldeman, PhD
Libby N. Williams, PhD

Symposium (A): Testimonio Therapy—-Healing, Artivism, and Social Justice
3:00 PM – 3:50 PM • McCormick Place Room W176a
Chair
Lillian Comas-Diaz, PhD
Participant/1stAuthor
Carmen I. Vazquez, PhD
Daniel Gaztambide, PsyD
Carrie Castaneda-Sound, PhD
Discussant
Patricia M. Arredondo, EdD

Thursday, August 8th, continued on page 79

FRIDAY, AUGUST 9TH

Symposium (A): Message-based Teletherapy—How Well Does It Work and For Whom?
3:00 PM – 3:50 PM • McCormick Place Room W178b
Chair
Shannon Wiltsey-Stirman, PhD
Participant/1stAuthor
Shannon Wiltsey-Stirman, PhD
Thomas D. Hull, MS
Matteo Malgaroli, PhD
Discussant
Carlos Gallo, PhD

Symposium (A): Supervision—Supervisees Show/Discuss Their Supervision Session Videos With Master Supervisors
8:00 AM – 9:50 AM • McCormick Place Room S103bc
Cochair
Hanna Levenson, PhD
Arpana G. Inman, PhD
Participant/1stAuthor
Nahal Kaivan, PhD
Tiffany G. O'Shaughnessy, PhD
Michael W. Glavin, MA

Symposium (A): Out of the Office and Into the Streets—Interventions for Diverse Clients and Settings
9:00 AM – 10:50 AM
Chair
Nancy L. Murdock, PhD
Participant/1stAuthor
Gary Howell, PsyD
Daniel Gaztambide, PsyD
Jeffrey Zimmerman, PhD
LaVerne A. Berkel, PhD
Discussant
Michael J. Constantino, PhD

Symposium (A): From Humility to Telepsychology—Contemporary Practices in Therapy Through a Multicultural Lens
10:00 AM – 10:50 AM • McCormick Place Room W178a
Chair
Robert J. Reese, PhD
Participant/1stAuthor
Alyssa Clements-Hickman, MS
Emily Murphy, BS
Kelsey A. Redmayne, MS
Jade M. Hollan, MS
Discussant
Jesse Owen, PhD

Conference Program Summary, continued on page 80

Poster Session (F): Psychotherapy for the Future—Promoting Growth Through Interventions Designed for Diverse Clients and Settings
11:00 AM – 11:50 AM • McCormick Place Hall F
Participant/1stAuthor
Mengfei Xu, MEd
Justin W. Hillman, BA
Norian Caporale-Berkowitz, BA
Zongqi Li, MA
Elizabeth A. Penix, BA
Caitlin A. Martin-Wagar, MA
Yixiao Dong, MA
Andrew M. Pomerantz, PhD
Yunling Chang, MS, MEd
Alyssa Clements-Hickman, MS
Kelsey A. Redmayne, MS
Jessica A. McDonald, MS, MSW
Arcadia Ewell, BA
Jazmin M. Gonzalez, MEd
Yesim Keskin, PhD
Robert J. Reese, PhD
Norah Chapman, PhD
Vladimir Nacev, ABPP, PhD
Yu-Chin Lin, BS
Anna K. Edelman, MS
Ashlie A. Obrecht, MS
Andrea R. Jumper, MA
Kimberly A. Alexander, MS
Dong Xie, PhD
Jeremy J. Coleman, MA
Wilson T. Trusty, BS
Amanda R. Oliva, BA
Megan K. Benton, MAT, MA
Keeyeon Bang, PhD
Rachel L. Dyer, BS
Eileen E. Joy, MA
Jade M. Hollan, MS
Tristan P. Patterson, MS
Emily A. Leeper, BS
Yun Xu, PsyD
Susan Torres-Harding, PhD
Kehan Shen, MEd
Amanda Strano, MS
Michelle Norman-Bryant, PsyD
Joshua M. Dredze, PsyD

Symposium (A): Psychotherapy Research in American Indian Community Settings
12:00 PM – 12:50 PM • McCormick Place Room W179a
Chair
Joseph P. Gone, PhD
Participant/1stAuthor
Kamilla L. Venner, PhD
Mark Beitel, PhD
Joseph P. Gone, PhD
Discussant
Michael J. Constantino, PhD

Business Meeting (B): Journal Editorial Lunch – INVITATION ONLY
Fri 12:00 PM – 12:50 PM • McCormick Place Room W184d

Business Meeting (B): and Awards Ceremony
4:00 PM – 4:50 PM • Marriott Marquis Chicago Hotel Grand Horizon Ballroom G

Social Hour (B): Awards Reception
5:00 PM – 5:50 PM • Marriott Marquis Chicago Hotel Grand Horizon Ballroom G

Conference Program Summary, continued on page 81

SATURDAY, AUGUST 10TH

Conversation Hour (A): Experience Learned and Lessons Learned in International Work—-Divisional and Individual Efforts
8:00 AM – 9:50 AM • McCormick Place Room W192a
Cochair
Amanda B. Clinton, PhD
Changming Duan, PhD
Participant/1stAuthor
Prerna G. Arora, PhD
Jill B. Bloom, PhD
Ayse Ciftci, PhD
Frederick Leong, PhD
Gargi Roysircar, EdD
Ashland Thompson, MA, MS

Symposium (A): Therapy and Center Effects and Distress Among International Students
11:00 AM – 11:50 AM • McCormick Place Room W179a
Cochair
Theodore Bartholomew, PhD
Brian TaeHyuk Keum, MA
Participant/1stAuthor
Na-Yeun Choi, PhD
Brian TH Kim, MA
Krista Robbins, BA
Discussant
Yu-Wei Wang, PhD

Social Hour (S): Lunch With the Luminaries
12:00 PM – 1:50 PM • Marriott Marquis Chicago Hotel George Pullman Room

Symposium (A): The Role of Therapist Cultural Comfort in the Process and Outcome of Psychotherapy
4:00 PM – 4:50 PM • McCormick Place Room W175c
Chair
Andres E. Perez-Rojas, PhD
Participant/1stAuthor
Allison Lockard, PhD
Theodore Bartholomew, PhD
Andres E. Perez-Rojas, PhD
Discussant
Jesse Owen, PhD

Symposium (A): Microaggressions in Psychotherapy—An Examination of Different Identities and Modalities
5:00 PM – 5:50 PM • McCormick Place Room W186c
Chair
Joanna M. Drinane, PhD
Participant/1stAuthor
D. Martin Kivlighan III, PhD
Stephanie W. Black, PhD
Joanna M. Drinane, PhD
Discussant
Karen W. Tao, PhD

Conference Program Summary, continued on page 82

SUNDAY, AUGUST 11TH

Conversation Hour (A): Uncovering Assumptions—Can Telesupervision Propel Our Practice and Training Forward?
8:00 AM – 8:50 AM • McCormick Place Room W187b
Cochair
Carly E. McCord, PhD
Jessica E. Groberio, PhD
Participant/1stAuthor
Ellen Reinhard, MA

Symposium (A): Silence Is Not an Option—Navigating Sociopolitical Divisions in Practice, Activism, and Prevention
10:00 AM – 10:50 AM • McCormick Place Room W186a
Chair
Saba R. Ali, PhD
Participant/1stAuthor
Yunkyoung L. Garrison, MA
Alyssa Choate, BA
Meredith A. Martyr, PhD

Skill-Building Session (A): Psychotherapy's Holy Grail—Searching for an Approach That Creates Training and Experience Effects
10:00 AM – 11:50 AM • McCormick Place Room W176a
Chair
Stephen C. Bacon, PhD

2019 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY AWARD WINNERS

Please join us as we honor the 2019 Society for the Advancement of Psychotherapy Award Winners! Our 2019 Awards Ceremony is scheduled for Friday, August 9th, 4:00 pm. Marriott Marquis Chicago Hotel Grand Horizon Ballroom G, during the APA Convention in Chicago, Illinois

ARMAND CERBONE, PHD – 2019 Award Distinguished Psychologist Award

Dr. Armand Cerbone has a long history of leadership in APA governance. In addition to more than ten years on the Council of Representatives, he is a former member of the Board of Directors of the American Psychological Association (APA), a past Chair of the APA Board for the Advancement of Psychology in the Public Interest, the APA Ethics Committee, the Policy and Planning Board, a past president of Division 29 (Psychotherapy) and Division 44 (SOGI), as well as the Illinois Psychological Association. He holds a diplomate in Clinical Psychology and is a Fellow of seven divisions of the APA. He is co-author of the APA Guidelines on psychotherapy with LGB Clients and chaired the working group that developed the APA's Resolution on sexual orientation and marriage and Resolution on sexual orientation, parents and children. He has received many awards for his work. Among them are the APA's Committee on LGBT Concern's Outstanding Achievement Award and The Society for the Psychological Study of LGB Issues' (Div 44 in APA) awards for Distinguished Professional Contribution, and Distinguished Contributions to Education. In 2003 he was inaugurated into the City of Chicago Lesbian and Gay Hall of Fame. In 2016 he received the Ray Fowler Award, APA highest award for Outstanding Member Contributions.

NAN PRESSER, PHD – 2019 Award for Distinguished Contributions to Teaching and Mentoring

Dr. Nan Presser is a Clinical Professor at the University of Missouri where she teaches clinical graduate students on Advanced Ethical and Legal Issues and provides supervision and training for clinical psychology doctoral students. She was the Director of the University of Missouri's Psychological Services Clinic for 10 years and currently serves as the Clinic's Director of Administration and Training. She has also maintained an active psychotherapy practice throughout her career.

Dr. Presser was awarded her doctorate in psychology from the University of Texas at Austin, and her undergraduate degree from the Ohio State University. She worked previously at Illinois State University as the Coordinator of the Clinical Psychology program and as a Staff Psychologist at the Illinois State Student Counseling Center.

Dr. Presser has been recognized with the University of Missouri's "Gold Chalk"

continued on page 84

Nan Presser, PhD, continued from page 83

Award for Excellence in Teaching and Mentoring doctoral trainees. She also received the 2018 APA Ethics Educator Award for Outstanding Contributions to Ethics Education and Psychology. Dr. Presser served on the APA Ethics Committee from 2015-2018. Her students have won over a dozen APA awards for outstanding papers on ethical issues.

ROBERT W. RESNICK, PHD – 2019 Distinguished Award for the International Advancement of Psychotherapy

Robert W. Resnick, Ph.D., Clinical Psychologist, has been a Gestalt and Couples Therapist for over 55 years and an international Gestalt Therapy and Couples Therapy trainer for 50 years. Trained (1965-1970) and personally certified by examination (1969) by Drs. Fritz Perls and James Simkin, he is still the youngest of the "old timers". Proudly, Dr. Resnick was chosen by Fritz Perls to introduce Gestalt Therapy to Europe in the summer of 1969 - Rotterdam, Holland. He has been presenting Gestalt and Couples training workshops primarily in Western and Eastern Europe 16-18 weeks annually since that time—as well as many trainings in Australia, and intermittently South America and Asia. He has been a member of APA since 1968 - and although a New Yorker—has lived and maintained a private practice in Los Angles since 1967 with local training programs both in Los Angeles and Seattle.

His interview "Gestalt Therapy: Principles Prisms and Perspectives" defining his views of Gestalt Therapy at that time, appears in the British Gestalt Journal (1995). "The Recursive Loop of Shame" in the Gestalt Review (1997). "Chicken Soup Is Poison" (Perls Festschrift) circa 1967 (Voices, 1970). He has entries in the Sage Encyclopedia of Counseling and Psychotherapy (2015) on both Gestalt Therapy and Fritz Perls. He is currently offering a series of contemporary Gestalt Therapy demonstration and training films (including a theory synopsis film) with subtitles in over a dozen languages to be soon followed by Couples Therapy films with Rita Resnick, Ph.D. (vimeo.com/ondemand/gestaltfilms). These films have been screened at universities (NYU, UCLA, Seattle University, University of Oslo, University of Palermo, Catholic University of Rio, University College Cork) as well as many postgraduate psychotherapy training centers, conferences and national psychological associations.

CCNY, Columbia University, University of Florida and UCLA Neuropsychiatric, his first "clinical practicum" (after his family)—while moonlighting as a Columbia master's student—was driving a New York taxi. Bob's style is warm and engaging and he speaks with clarity and humor. The Resnicks are frequently happily married. Email: BobResnick360@gmail.com

continued on page 85

JOHN PACHANKIS, PHD – 2019 Mid-career Award for Distinguished Contributions to the Advancement of Psychotherapy (scholarship category)

Dr. John Pachankis is an Associate Professor of Public Health with tenure at Yale and the Director of the Esteem Research Group in New York City. His research seeks to bring evidence-based mental health interventions to LGBTQ people in the US and around the world. With NIH funding, including three current R01s, he examines the efficacy of LGBTQ-affirmative interventions delivered via novel technologies (e.g., smartphones), in diverse settings (e.g., Eastern Europe, Appalachia), and with diverse segments of the LGBTQ community (e.g., rural youth, queer women). He has published over 100 scientific papers on LGBTQ mental health and stigma. This work appears in journals such as Psychological Bulletin, American Psychologist, Developmental Psychology, Journal of Consulting and Clinical Psychology, AIDS, and Health Psychology. He has also recently co-edited the Handbook of Evidence-Based Mental Health Practice with Sexual and Gender Minorities published by Oxford University Press. His research has had national and international scholarly, legal, and popular impact, having been referenced in national professional guidelines for LGBTQ mental health practice, cited in numerous amici curiae briefs before U.S. state and federal courts, including the U.S. Supreme Court, and featured in national and international media outlets. He received his Ph.D. in clinical psychology in 2008 from the State University of New York at Stony Brook and completed his clinical psychology internship at Harvard Medical School / McLean Hospital.

BRADLEY BRENNER, PHD – 2019 Mid-career Award for Distinguished Contributions to the Advancement of Psychotherapy (practice category)

Brad Brenner, Ph.D. has built a multi-city private practice with offices in Washington, DC and New York City to provide psychotherapy that emphasizes the ideals of Counseling Psychology. This emphasis includes reinforcing the mutuality of science and practice, an overarching orientation towards growth and strength, LGBTQA+ and multicultural competence, and ensuring that the next generation of practicing psychologists is well equipped with the skills and technology needed to broaden therapy's reach. Recognizing that high-quality and accessible psychotherapy is best supported through intensive, thoughtful training Dr. Brenner established two training programs. One is a postdoctoral fellowship and the second is the Capital Therapy Project, a community-based psychotherapy training institute providing lower fee individual therapy and career counseling staffed by predoctoral externs.

In recognition of his contributions to the field, Dr. Brenner was named the recipient of the 2013 John D. Black Award for Outstanding Achievement in the Practice of Counseling Psychology by the Society for Counseling Psychology. He was given a presidential citation in 2016 from the Society for the Advancement of Psychotherapy for his efforts as the Society's Internet Editor.

continued on page 86

Bradley Brenner, PhD, continued from page 85

Dr. Brenner completed his undergraduate degree in psychology at the University of Colorado at Boulder. At the University of Cambridge, he completed an M.Phil. in Social and Developmental Psychology. He completed his doctorate in Counseling Psychology at the University of Maryland at College Park. His biography would not be complete without an acknowledgment of the instrumental role of family, teachers, professors, colleagues, and dear friends who lent their support, fueled his dreams, and challenged him along the way to his version of academic and professional success and fulfillment.

SIGAL ZILCHA-MANO, PHD – 2019 American Psychological Foundation/Society for the Advancement of Psychotherapy Early Career Award

Sigal Zilcha-Mano, Ph.D., is an Associate Professor of Clinical Psychology in the Department of Psychology, University of Haifa, and a Visiting Associate Professor at Columbia University, the Psychiatric Institute. She is a licensed clinical psychologist. She heads the Psychotherapy Research Lab in the Department of Psychology, University of Haifa. She is Associate Editor of the Journal of Counseling Psychology, and on the editorial board of the Journal of Consulting and Clinical Psychology, Psychotherapy, and Psychotherapy Research.

Dr. Zilcha-Mano is the recipient of several awards and grants, including the International Society for Psychotherapy Research Outstanding Early Career Achievement Award, and the Dusty and Ettie Miller Fellowship for Outstanding Young Scholars. Among grants she received to support her work are the Fulbright Fellowship, the Israel Science Foundation research grant and equipment grant, the U.S.-Israel Binational Science Foundation (BSF) grant, JOY-Innovating Neuro Wellness grant, the Norine Johnson Psychotherapy Research Grant, and the Gelso Research Grant.

Dr. Sigal Zilcha-Mano explores processes of change in psychotherapy, especially in individuals suffering from depression. She is especially interested in personalized treatment approaches aimed at tailoring the treatment to the needs and characteristics of each patient, according to the mechanisms of change most effective for each individual. Her work focuses on distinguishing stable individual differences between patients (the trait-like components) from the factors that have the potential to act as active curative ingredients in treatment (the state-like components).

Sigal is honored and grateful to receive this award from Division 29 that consists of so many people she loves and admires.

continued on page 87

JEFFREY J. MAGNAVITA, PHD - 2019 Rosalee Weiss Lecturer
Jeffrey J. Magnavita, Ph.D., ABPP is a leading psychologist, psychotherapist, and theorist. Dr. Magnavita, while engaged in full-time private practice for over 30 years, has been a scholar, influential leader, and tireless contributor to advancing psychotherapy and clinical science. His scholarly activity and contributions have spanned such diverse areas as psychotherapeutics, personality theory, unified psychotherapy, technology-based approaches, and clinical decision making. In each of these areas he has made significant contributions and has been an innovator through the publication of highly regarded books, numerous high impact journal articles, APA psychotherapy videos, and his many influential presentations. He has significantly impacted the direction of our field, influenced a generation of researchers and practitioners, and that he has been a visionary for our profession.

He previously served as President of the *Society for the Advancement of Psychotherapy* in 2010 and was a member of the APA *Clinical Treatment Guidelines Advisory Committee*. He is the Chair of the Practice Advocacy Committee for the *Society for the Exploration of Psychotherapy*. He is founder and CEO of Strategic Psychotherapeutics ®, LLC whose mission is to provide the resources to make psychotherapists better and improve their outcomes. His latest edited volume with APA, *Using Technology in Mental Health Practice* was published in 2018 and presents an overview of various technological advances and their application to clinical practice. Jeffrey serves on a number of editorial boards and presents his work internationally on a variety of topics including treatment of personality disorders, unified psychotherapy, and technology. He is in private practice in Glastonbury, CT.

2019 Most Valuable Paper Award to
"The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis"
by Christoph Flückiger, A. C. Del Re, Bruce E. Wampold,
Adam O. Horvath.

Tony Rousmaniere, Psy.D.

I am honored and humbled by the nomination to serve the Society for the Advancement of Psychotherapy (SAP) in the role of president. The Division has long been my APA home. I was pleased to be able to serve as Chair of its Continuing Education Committee from 2014 through 2018 and was privileged to be a co-recipient of the Division's Early Career Award. If elected, I would like to focus my Presidency on two areas where I believe the Division can further serve its members: (a) raising awareness about new methods for psychotherapy training, including Deliberate Practice, and (b) expanding our outreach to psychotherapists who work with under-served and disadvantaged populations.

One of the Division's unique strengths has been the extent to which it represents both practitioners and researchers and that its leadership has always had a mixture of both. This has special resonance to me as I identify with both groups. I am Clinical Faculty at the University of Washington in Seattle, where I also have a private practice. As a supporter of the "open-data" movement, I post the clinical outcome data from my private practice on my website www.drtonyr.com for free access by potential clients and researchers. Additionally, I run the clinical training website www.dpfortherapists.com, which provides free webinars, lectures, and interactive Deliberate Practice exercise videos for training programs around the world. I have authored/co-edited four books on clinical training and professional development and published over 30 peer-reviewed empirical research articles and chapters. In my writing I encourage therapists to embrace their strengths and challenges with honesty and vulnerability (for example, see my article "What your therapist doesn't know" in *The Atlantic*.) My newest writing project is serving as co-editor (with Rodney Goodyear) of the American Psychological Association's forthcoming series of Deliberate Practice clinical training books, *The Essentials of Deliberate Practice*, in collaboration with an international team of leading researchers. Previously I was Associate Director of Counseling & Director of Training at the University of Alaska Fairbanks Student Health and Counseling Center, where I founded and ran a practicum for psychologist trainees.

If elected, my first goal is to raise awareness about the opportunity to use Deliberate Practice to improve the effectiveness of psychotherapy across the career-span, from beginning trainees achieving competence to seasoned clinicians acquiring advanced skills or new specializations. My presidential initiative will focus particularly on using Deliberate Practice to help trainees and psychotherapists provide more effective multicultural services and better assist populations that are under-served and disadvantaged.

In the past few years the Division has made considerable progress expanding its outreach, such as adding an international Domain and establishing itself as an international association. If elected, my second area of focus will be supporting and expanding these efforts. Particularly, I would like to expand our outreach and services to psychotherapists who work with under-served and disadvantaged populations.

Thank you very much for considering my candidacy to serve the Society. ■

Gary R. VandenBos, Ph.D.

Psychotherapy is a robust clinical intervention. When skillfully performed, adjusted to the individual and the circumstance, it can help improve many psychological problems and challenges. Psychotherapy should be able to all who wish to undertake it.

Our division efforts over the past three years have done much to advance the value and utilization of psychotherapy. Doctors Zimmerman, Constantino and now Murdock have lead efforts to bring psychotherapy to the underserved, refine personalized mental health care, and design psychotherapeutic services for diverse clients and settings. I wish to continue to lead the Division is these efforts to shape the focus and effectiveness of psychotherapy to serve all Americans and aid them in living happier and healthier lives within the context of their lived experience.

Division 29 must be among the leaders in advancing public information and professional information about psychotherapy. Our advocacy must be directed towards the public, professionals in other health care disciplines, and insurance and government officials. The message of how psychotherapy can relieve psychological pain and suffering, support recovery and growth, and strengthen future functioning is needed. The Division should use its resources to continue to support such goals and expand on them.

Division 29 is not alone in such efforts, as we can work collaboratively with other Divisions and with the Central APA in such efforts. I urge us to systematically examine how we are collectively communicating "our story" to the world—looking for any gaps in coverage and any aspects that need to be communicated clearer or better. Division 29 can be leader in coordinating such an examination and developing specific proposals for improvement.

I am grateful to have received both the Division 29 Early Career award and the Division 29 Lifetime Achievement award. Division 29 is the first APA Division I joined, and I have always considered it my "home Division." I would be honored to serve Division 29 as President. Thank you. ■

CANDIDATE STATEMENTS

Council Representative

Lillian Comas-Díaz, Ph.D.

It is an honor to be nominated to run for a position of Council Representative for a second term. As a current Council Represntative for our division, I believe that a second term enhances my efficiency in serving our Division in this role. I am a psychotherapist in full time private practice. I also serve as a Clinical Professor at the George Washington University Department of Psychiatry and Behavioral Sciences. As a practi-

continued on page 90

tioner-scholar-activist, most of my publications are about psychotherapeutic issues. My main professional areas of interest are multicultural and feminist psychotherapies, social justice, international psychology, and psycho-spirituality. I believe in giving psychology away and do so through media presentations in the Spanish language.

I trust that I can continue to well represent the Society for the Advancement of Psychotherapy at the Council of Representatives. I have extensive experience in APA governance, both as a past director of the APA Office of Ethnic Minority Affairs and as a past member of numerous governance groups. Previously I have served as Council Representative for Divisions 12 (Clinical Psychology) and 35 (Women's Issues). Additionally, I have been president of Division 42 (Independent Practice), chair of the APA Committee of International Relations, a Consulting Editor for *Psychotherapy: Theory, Research, and Practice* (and past member of the Editor Search Committee), and a Fellow of our Society.

I will be honored if you vote for me. If you vote for me, you will be voting for passion, experience, and commitment to psychotherapy. ■

Stewart Cooper, Ph.D. ABPP

As the practice, education, and training of psychotherapy as well as practice-based research and conceptual scholarship have been the central cornerstones of my career, it is an honor and privilege to stand for election to serve as a Council Representative for the Society for the Advancement of Psychotherapy. The Society and the American Psychological Association and the world at large are amid significant transformations. Within SAP, the numerous initiatives and member facing services require tremendous coordination and creativity. Within APA, a new financial structure, an ethics code undergoing revision, a new consensually- developed strategic plan are just a few of the transformative processes. Developments in technology and AI will provide yet undreamed-of possibilities. Externally, changes in the context and funding for both the practice of and research on psychotherapy remain in state of high fluidity. The priorities of the Society need strong advocacy to remain and expand as a central focus for psychology and psychologists. Our students and ECPS are the future meriting special focus and inclusion.

I believe that my experiences on the Executive Boards of Division 29 as well as Divisions 17 (Counseling) and 13 (Consulting) along with my being past Chair of the APA Board of Professional Affairs, past Chair of the APA Membership Board, and a member of the APA Board of Directors these past three years have given me the knowledge and skills, as well as the connections with key groups and individuals, to enable me to be effective in advancing and advocating for the priorities of the Society. Internally, I pledge to support the further development of the many awesome programs and resources the Society is currently offering and has plans to expand upon. Leveraging new technologie—those that exist and those to come in the near future—offers significant promise. ■

Gerald P. Koocher, Ph.D., ABPP

As a long time Fellow and former President of the Division, I would welcome the opportunity to serve as one of the Division's Council Representatives. I served as APA President (2006) and APA Treasurer (1995-2004). At present I serve as Provost and Senior Vice President for Academic Affairs at Quincy College (Massachusetts). I have also been appointed to serve as Parliamentarian of the Council by APA Presidents Daniel and Davis. I previously served in senior leadership roles at DePaul University (Chicago) and Boston Children's Hospital / Harvard Medical School. I have consistently maintained an independent practice over forty years.

My scholarly activity includes more than 350 publications and 17 books including: *Ethics in Psychology and the Mental Health Professions*, the *Psychologists' Desk Reference*, and *the Parent's Guide to Psychological First Aid*.

The Division needs attentive and energetic representation to address many evolving issues related to psychotherapy research and practice including practice guidelines, changing standards of practice, masters level practice, APA strategic plan, and attention to practice issues in the aftermath of the integration of the professional mission formerly managed by CAPP and the APAPO with the APA. If elected I would work tirelessly in support of Division interests on these and all matters coming before the council. ■

Libby Nutt Williams, Ph.D.

It has been an honor to serve as one of your Council Representatives for the Society for the Advancement of Psychotherapy (Division 29) over the last two years. I have served alongside Lillian Comas-Diaz as a united voice for psychotherapy practice, research, and advocacy. I have spoken on the floor of Council several times on issues related to clinical practice guidelines, APA structure, and advocating for diversity. As a Council Representative, I am invested in collaborative, solution-oriented process. I would be very happy to continue to serve in this role and to serve our Division 29 community. Thus I am delighted to run for a second term.

Outside of my role on Council, I have been a professor at St. Mary's College of Maryland, the national public honors college, for over 20 years. I received my bachelor's degree in psychology from Stanford University and my doctorate in Counseling Psychology from the University of Maryland. My scholarly interests focus primarily on psychotherapy process, feminist multicultural approaches to counseling, and mixed methods research. I am a Fellow of the APA (Divisions 17, 29, and 35), and I have served on several editorial boards (most recently for *Psychotherapy* and *The Counseling Psychologist*).

I have worked with Division 29 governance over the last 14 years, first as the Early Career representative to the Board of Directors in 2005, then as the Membership Domain Representative (2008-2010), and as President of the Division in 2011. I have consistently focused on a few key issues: 1) clarifying our divi-

continued on page 92

sional identity, 2) strengthening the link between psychotherapy science and practice, and 3) promoting tangible evidence of our commitment to diversity and multiculturalism. I care deeply about the Division, and I would be honored to continue to serve as a Council Rep for 29. Thank you for your consideration. ■

CANDIDATE STATEMENTS
Science and Scholarship Domain Representative

Gregg Henriques, Ph.D.

My scholarship has been primarily concerned with the field of psychotherapy and its connection to the science of psychology. Early in my career, I became concerned with the conceptual fragmentation in psychotherapy, and came to see that it was deeply related to the conceptual confusion associated with the science of human psychology. I came to see the "problem of psychology," which refers to the fact that the field resists definition and remains a collection of different paradigms as being central to achieving more coherence in psychotherapy. In 2011, I outlined my solution to the problem of psychology in *A New Unified Theory of Psychology*. Over the past several years I have been concerned with applying the unified theory to the psychotherapy integration movement, with the vision for the emergence of a "unified psychotherapy movement," which recently became recognized as a fifth approach to psychotherapy integration. I have developed a number of conceptual models that allow for this vision to be realized, including Character Adaptation Systems Theory (Henriques, 2017; Henriques and Mays, 2018) as a way to unify the major psychotherapy paradigms with modern holistic approaches to personality. In addition to being an active scholar, I am also heavily involved teaching psychotherapy and doing clinical work, providing both direct services and supervising doctoral students. I have also outlined an approach to evidence based clinical decision making called TEST RePP (Henriques, 2016), and am working on a book detailing the identity of a unified Health Service Psychologist. In short, I believe I am well suited for this position, as I have a broad and deep knowledge base regarding both the science of psychology and psychotherapy, as well knowledge of the varieties of practice and how the field might evolve going forward. ■

Patricia T. Spangler, Ph.D.

I'm honored and inspired to be a candidate for Division 29 Science and Scholarship Domain Representative. I've been a member since graduate school and value the Society for the Advancement of Psychotherapy's (SAP) role in my development as a researcher and clinician and its contributions to our field. I've served as a Private Practice Domain committee member since 2014, writing and soliciting articles for the *Bulletin*, generating ideas for website contributions, and initiating a study of the needs of psychotherapists in private practice. Our committee presented preliminary findings at APA (2018) and SPR (2018) and plans further dissemination via the SAP website and a journal article.

My work as a SAP committee member combined with my experience with varied psychotherapy research methods and success as a grant writer give me a solid background that will help me serve as Science and Scholarship Domain Representative. As doctoral student (University of Maryland, 2010) and post-doctoral researcher, our research team used mixed methods to investigate relational factors in long-term psychotherapy. Currently, as a research assistant professor at Uniformed Services University, I am co-PI on a DoD-funded ($954K) feasibility study of a treatment for PTSD nightmares on which we are integrating genomic and physiologic markers with psychometric measures of in-session distress and treatment outcome.

As a recipient of awards and grants as a student and early career researcher, I understand the impact that funding has on career development. If elected, I will happily undertake administration of the Charles J. Gelso, Ph.D., Psychotherapy Research Grant and the Norine Johnson, Ph.D., Psychotherapy Research Grant, two important mechanisms for nurturing early career researchers and thus for the future of psychotherapy process and outcome science. In addition, I'll work with Board and Domain committee members to identify and develop initiatives to serve our members' research endeavors. ■

Georita M. Frierson, Ph.D.

Dr. Georita M. Frierson received her BA with honors (Psychology) at Hampton University a historical black college/university (HBCU), her MA (Clinical Psychology) and PhD (Clinical Psychology) at The Ohio State University, and received training in an APA accredited Internship/Residency (Clinical Psychology) and Postdoctoral Program (Clinical Health Psychology) at The Warren Alpert Medical School at Brown University. The two foci of her work with medically under-served populations are in 1) cancer education and control and 2) physical activity interventions or longitudinal designs. She has expanded her cancer survivor research to examine the psychological, behavioral, and quality of life outcomes of medically under-served triple negative female breast cancer patients (TNBC; who typically are African American, BRCA 1 mutation, and/or advanced stage disease).

She is a licensed clinical psychologist trained in health psychology, and currently a tenured Full professor and the Department Head of the Department of Psychology at Rowan University. Since 2015, she has held the Director of Clinical Training position of the newly formed Ph.D. Program in Clinical Psychology at Rowan University. She presently serves on the American Psychological Association Commission on Accreditation as Commissioner (2016-2021). In 2019, she has started her second 3rd-year term as a commissioner. She is also the Chair of the Training Committee for site visitor andaccreditation application training for Commission on Accreditation. More recently, Dr. Frierson was appointed as IT Director for CUDCP and to the Associate Editorial Board for APA's prestigious *Training and Education in Professional Psychology* Journal. Dr. Frierson was also appointed Dean's Fellow of Graduate Education for Rowan University's College of Science and Mathematics/School of Health Professions (CSM/SHP) for the 2017-2018 academic year. She has recently served on the Association of State and Provincial Psychology Boards (ASPPB)/Job Task Analysis Task Force (2016); and has served as an American Psychological Association Accreditation Site Visitor (2015). ■

Rosemary Phelps, Ph.D.

Dr. Rosemary E. Phelps is a professor of Counseling Psychology, director of the UGA Preparing Future Faculty (PFF) in Psychology Program, and coordinator of the Human Services minor in the Department of Counseling and Human Development Services at the University of Georgia. She served as Department Head from 2006-2012. Dr. Phelps received her bachelor's degree in Psychology and master's degree in Guidance and Counseling from The Ohio State University, and her Ph.D. in Counseling Psychology from the University of Tennessee, Knoxville. She is the recipient of the 2010 American Psychological Association's (APA) Distinguished Contributions to Education and Training in Psychology Award and is an APA Fellow

continued on page 95

(Division 17: Society of Counseling Psychology). Dr. Phelps also received the 2016 Ohio State University College of Education Career Achievement Alumni Award. She has built her 30+ year career around teaching, research, and practice related to diversity issues, ethnic and racial identity development, professional issues for students and faculty of color, and mentoring students. Currently, Dr. Phelps's research focuses on the unique and varied experiences of African Americans in both personal and professional domains that affect psychological well-being. Her professional activities have included national and regional membership and leadership positions including member of the APA Education and Training Awards Committee, chairing the Ethnic and Cultural Diversity Committee and serving as Program Chair of APA Division 17, chairing the Minority Interest Group of the Southeastern Psychological Association (SEPA), and chairing the SEPA Committee on Equality and Professional Opportunity (CEPO)/PSI CHI Undergraduate Research Program. She served as the 2018 President of SEPA. "I have spent my career engaged in training counseling psychologists to be committed to culturally responsive practice and to the advancement of psychotherapy—it would be a privilege to serve the Society for the Advancement of Psychotherapy in the capacity of Diversity Domain Representative." ■

Susan S. Woodhouse, Ph.D.

My name is Susan Woodhouse and I am an Associate Professor at Lehigh University. I am running to serve as a Diversity Domain Representative for the Society for the Advancement of Psychotherapy (SfAP). During the time I have served on the Board, first as the Early Career Domain Representative and most recently as the Science and Scholarship Domain Representative, advancing attention to diversity and inclusion within the Board and in SfAP initiatives has been in the front of my mind with each project I have undertaken. I believe it is important that attention to issues related to diversity and inclusion not be considered the sole responsibility of people of color or other marginalized groups. As a white woman and ally, I would be excited to serve in this domain and to offer my support and collaboration to both ongoing and emerging initiatives that focus on enhancing diversity and inclusion within the field.

My research program focuses on psychotherapy and prevention work with racially and ethnically diverse, low-income, underserved families with young children. In particular, my work focuses on supporting under-recognized strengths in parents of young children, and on culturally appropriate psychotherapy and community support for parents. In my community-engaged research, I have worked hard to build trust with community stakeholders, collaborate with the community in the research, and bring the results of the research back to the community. I am currently organizing a SfAP-sponsored mini-conference focused on how to make psychotherapy more accessible and available to underserved communities. I am also collaborating with the Social Justice Domain of SfAP on a project to better understand the relational and therapeutic competencies of clinicians who work in underserved communities.

I am deeply committed fostering diversity and inclusion within our field through mentoring, grants, and other initiatives, and would be honored to serve. ■

CANDIDATE STATEMENTS
Early Career Psychologist Domain Representative

Beatriz Palma, Ph.D.

My name is Beatriz Palma, and I'm a Resident in Psychology and Staff Psychotherapist at the Counseling and Psychological Services (CAPS) at the University of Virginia-Charlottesville. I earned a PhD in Counseling Psychology from the University of Maryland – College Park, and my advisor was Dr. Charles Gelso. I'm originally from Chile, were I am a clinical psychologist (Licenciatura y Título Professional de Psicólogo, from Pontificia Universidad Católica de Chile). In my home country, I worked as a clinical psychologist for several years before coming to the US.

During my PhD program at Maryland, I was very involved both in clinical practice and psychotherapy research. A highlight of my experience was using brief treatment models with university students, while at the same time seeing longer-term community clients at a psychodynamically-oriented department clinic for four years. My shorter- and longer-term experiences informed each other, helping me attain depth in terms of my client conceptualization and the interventions that I utilized. Additionally, both my Master's thesis and my Dissertation were psychotherapy research work. Besides these studies, I was involved in several psychotherapy research projects, both with my advisor and Dr. Clara E. Hill, and under their guidance, I presented several times at the Society for Psychotherapy Research (SPR) conferences. I was also the recipient of the 2015 Fretz award, which was given to a student in the program who embodied the scientist-practitioner model.

My internship, post-doc, and current job have all been at University Counseling Centers, where I have not only worked with a wide range of diverse clients but also have been an advocate for addressing mental health. I look forward to being involved with APA's Division 29 as an Early Career Psychologist, as it will provide me valuable opportunities to continue contributing to the advancement of the field. ■

Josh Turchan, PhD.

I am beyond excited to accept the nomination for Early Career Domain Representative for Division 29 and for your consideration in choosing me for this role. As an ECP myself, I know that there are both unique opportunities and challenges posed to us in our early careers, whether they be more clinical or academic in nature. My hope is to not only help Division 29 to continue its already strong support of Early Career Psychologists, but to also promote the Division's emphasis on developing practical, experiential and scholarly advances that are applicable to us in our Early Career.

By day, I am the Assistant Director of Training and Research at Michigan State University's Counseling and Psychiatric Services (CAPS), an interdisciplinary collegiate mental health center and an APA-accredited Health Service Psychology internship. As training director, I en-

continued on page 97

sure our program focuses on training the next generation of burgeoning ECPs in a foundation of multiculturalism and evidence-based practices in psychology focusing not just on evidence-based techniques, but also evidence-based psychotherapy relationships and the cultural adaptation of both. By night, I am also a psychologist in private practice. Like many ECP's, I have multiple roles in my early career, which I believe provides me a well-rounded perspective into the needs of many Early Career Psychologists across career paths.

I feel strongly about promoting the practical applications of psychotherapy, supervision & training, and research that are relevant to us in our early career and fostering the curiosity and passion that are an inherent part of being an early career psychologist. If elected as the Early Career Domain Representative, my goal would be to work with the ECP committee to help address the needs that are identified as part of the Division's ECP needs assessment and to help implement practical applications via outreach, mentorship, and publication. ■

Society For The Advancement Of Psychotherapy

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY

MEMBERSHIP APPLICATION

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

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

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Member Type: ❑ Regular ❑ Fellow ❑ Associate
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Please return the completed application along with payment of $40 by credit card or check to:

The Society for the Advancement of Psychotherapy's Central Office,
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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.

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