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PRESIDENT’S COLUMN

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On behalf of the Division 29 leadership, I would like to thank everyone who attended the American Psychological Association’s 2014 convention in Washington, D.C. We appreciate the assistance of all of the volunteers, those who presented or participated in Division-related programming, and everyone who stopped by the Division 29 booth to say hello.

We look forward to great things for the Division in the coming year, and I am particularly excited to welcome our new officers and representatives. Heartfelt congratulations to President-elect Armand Cerbone and Secretary Barry Farber, as well as to our new Domain Representative for Diversity and Social Justice, Rosemary Adam-Terem, and our new Council Representative, Jeffrey J. Magnavita.

Division 29 thrives on the involvement of each of us. If you are reading this and are not a member, join today! If you are a member but not active in the Division, explore what opportunities are available. Volunteer. Submit a paper for publication. Consider running for office. Mentor an early career psychotherapist. Encourage a colleague to check us out on http://divisionofpsychotherapy.org/, or talk to any of our officers to find out more.

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org
Welcome to the third issue of this year’s *Psychotherapy Bulletin*. We hope that everyone had an enjoyable summer and that many of you were able to attend the APA Convention—don’t forget to check out the Division 29 Awards Ceremony photographs starting on page 50! While you are looking through this issue of the *Bulletin*, please take a moment to complete your 2015 Nominations Ballot and review the important award and membership information included. We also hope you will enjoy articles on foundational principles in supervision, culturally-aware internship training, and ethical considerations in national security work. We are particularly delighted to include a practice-related piece that ties in with the Special Section on Technology and Psychotherapy featured in the June 2014 issue of *Psychotherapy*, the official Journal of APA Division 29. Also, don’t miss this issue’s Student Features, including a just-for-fun “PlayBuzz” quiz on theoretical fit (which you can take for yourself online). On a much more somber note, we were saddened to learn of the death of Dr. Alvin R. Mahrer, and a Remembrance of his life and work may be found in this issue.

Please continue to reach out to us with submissions and suggestions. *Bulletin* information may be found on the Division 29 website at http://www.divisionofpsychotherapy.org. Our next deadline is November 1, 2014.

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Doing Supervision With Attitude: Three Foundational Principles for Supervisory Action¹

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With this being the first in a series of Bulletin papers on supervision, we thought that it might be interesting to consider some of the foundational principles that seem to most enliven and substantively impact supervisory process and outcome. Three such principles—eminent valuation, abiding fidelity, and relational privilege—will be identified and described; supervisees’ perspectives will then follow on why each principle has mattered in their own supervisions. In our view, these principles are supremely significant in guiding supervisor action, can collectively be viewed as reflecting a fundamental supervisor attitude of caring, prizing, and generativity with regard to the whole of supervision, and will be sufficiently in evidence wherever competent, effective practice occurs. In sharing our ideas, we are a writing group composed of a psychologist/supervisor (EW) and six doctoral students in approved American Psychological Association training programs in counseling, clinical, and clinical health psychology.

The Principle of Eminent Valuation  
This principle foremost involves living in spirit and actuality “to supremely value and respect”: It is the supervisor’s assigning the highest value to supervision as a crucial educational experience and acting accordingly in deed. Clinical supervision may well be our single most powerful learning experience in “making” practitioners (Watkins & Milne, 2014); with eminent valuation, that critical reality is fully embraced. The effective supervisor supremely values supervision’s unmatched power and promise in stimulating therapist development. Of these three principles, eminent valuation would seem the most fundamental—being the nucleus from which the other two principles naturally follow.

Eminent valuation affects supervision via consistent investment in the supervisee and supervision experience. Supervisors readily give their utmost respect to the supervisory hour—being prepared, on time, and treating supervision as

continued on page 6
sacred time; fully investing their energy, emotion, and intellect; and forever being concerned with the question “How can I best help this particular supervisee now?”. It is a ready and willing, full and complete, total and absolute giving of oneself to the supervision endeavor. Where eminent valuation is not granted primacy of place, the very opposite of the above described behaviors and features become much more likely (e.g., the supervisor’s disrespecting the supervisee or patient through inappropriate or demeaning comments), and a de-valuing of supervision, the supervisee, and patient gets communicated. Experience suggests that there may be nothing more deadening to supervisee growth and excitement than a supervision process that is conducted absent eminent valuation.

Supervisee perspectives on eminent valuation. Supervisee 1: “How can a student therapist strive for eminent valuation in the therapy room if the supervisor does not strive for eminent valuation in the supervisory room? That lack of interest in and valuing of the supervision process can be evidenced in many ways. I have had supervisors forget to tell me that they will not be able to make it to supervision, routinely come late or cut the hour short, spend considerable time talking about themselves, not read what they assigned me to read, or not watch my tape after having asked me to record myself. I have even had supervisors openly complain to me about other supervisees during my supervision hour; this has caused me to wonder what they might be saying about me when I am not around. In such cases, any respect for and prizing of supervision on the part of the supervisor has been totally and completely absent in my opinion.”

Supervisee 2: “In one of my most growth-fostering experiences, the supervisor consistently communicated her level of investment in and valuation of supervision wholeheartedly in both word and action—conducting a direct and honest discussion about supervision roles, boundaries, and expectations and collaboratively setting goals with me from the outset. This supervisor was committed and invested in a way I had not previously experienced. If something was going to interfere with our supervision hour, it was promptly discussed and rescheduled to fit both of our needs; if conflict or tension arose, it was addressed in the moment, and we arranged a time to revisit that after both having a chance to process the interaction. She regularly showed up with an agenda or areas she hoped we would have time to address and was fully engaged in that hour, as she also expected from me, and she made it a point to overtly discuss the gray areas within our supervisory relationship and what occurred outside of the room (e.g., mutual attendance of a social event).”

The Principle of Abiding Fidelity
This principle foremost involves living in spirit and actuality “to be studiously loyal and committed”: It is the supervisor’s full, complete, active commitment to supervision and personal continuing development as a supervision professional. The supervisor is passionately faithful about making supervision a best practices endeavor and recognizes two correlated realities: (a) “The training of psychotherapists can never be better than the competence of its supervisors” (Gordon, 1997, p. 135); and (b) supervision thereby merits periodic study to remain currently informed. Such continuing education/self-challenge potentially maximizes supervisory impact and serves as vital antidote to role stagnation. As another aspect of abiding fidelity, supervisors also show direct faithfulness and commitment to their supervisees—com-

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municating a sense of protection and preservation, a message of “I have your back” and “we will work tirelessly together for your maximal benefit.” Such an attitude would optimally involve a “staying with” and “working through” to help supervisees overcome problematic deficiencies.

Where faithfulness and commitment to supervision are not granted primacy, again, the opposite of the above described behaviors become increasingly likely (e.g., the supervisor’s lack of commitment to a best practices supervision process, failure to engage in any continuing education efforts). What ultimately gets communicated is that the supervision process and supervisor’s own growth are not priorities. It provides a model of professional unfaithfulness and lack of commitment that we as supervisors would do well to avoid.

Supervisee perspectives on abiding fidelity. Supervisee 1: “As I reflect on supervisors who most demonstrated abiding fidelity, I am reminded of a supervisor who embodied this through not only his supervision but his own personal clinical work. When we met each week, he spoke about learning with a contagious passion. I quickly learned that if I wanted to develop a professional identity as a clinician who is not only empathic but well-informed and knowledgeable about current research and clinical interventions, I would need to embrace my inner desire to learn much as my supervisor had demonstrated. He did this through regularly referencing books or articles during supervision and quickly applying their content to the client of focus as well as acknowledging when he did not know answers to my questions or have solutions to my concerns. I could depend on him to point me in the right direction while knowing he would be there if I got stuck.”

Supervisee 2: “I was fortunate to work with several supervisors who valued continuing education and demonstrated commitment to staying current with literature in the field of psychotherapy. These supervisors subscribed to listservs on supervision and training, which exposed them to the recent publications and informed them of relevant webinars and trainings. Both of these supervisors frequently assigned current readings and proctored lively round-tables in order to update supervisee knowledge and provoke critical thinking about practice. Supervisees were typically asked to consider the readings in reference to their current caseload and explain how their updated knowledge would modify their practice of psychotherapy on a client-by-client basis. The supervisors’ enthusiasm for current psychotherapy literature illustrated the curiosity and wonderment with which they approached the field. Furthermore, their model of incorporating new knowledge informed the supervisees that they were expected to implement new knowledge, not just read about it.”

The Principle of Relational Privilege
This principle foremost involves living in spirit and actuality “to supremely privilege and esteem”: It is the supervisor’s highest privileging of the supervisor-supervisee relationship and assigning it preeminent value as a crucial mechanism in making the totality of supervision work. The relationship between supervisor and supervisee is a sacred trust and, we believe, should always be regarded as such. Supervisors well recognize that a good supervisor-supervisee relationship (a) serves as the quintessential medium for any and all supervisory action and (b) is their most powerful means of modeling a message of professional goodness, charity, curiosity, challenge, and integrity. Conviction about that power of relationship is not without empirical foun-

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dation, with the supervisor-supervisee alliance having received considerable research support (Watkins, 2014). Whenever a favorably-perceived alliance is in place, it does indeed appear that many other much desired supervision variables will often also be in place (e.g., higher degree of supervisee perceived stress). Furthermore, when relationship ruptures do occur, they are more apt to be missed, go uncorrected, and potentially fester. What ultimately gets communicated is that the supervision relationship is at best a low priority and not deserving of the utmost supervisor time and attention. This provides a model that loudly and clearly sends the wrong message and is antipathetic to responsible supervision practice.

Supervisee perspectives on relational privilege. Supervisee 1: “For me, there is a clear distinction between the supervisors who honored and respected the supervisor-supervisee relationship and those who did not. For example, one supervisor always made an effort to eliminate all distractions during our supervision hour. This behavior conveyed the highest level of importance placed on the supervision hour and it also translated into me feeling comfortable, respected, and valued as a supervisee. In her office, I felt safe and free to curiously explore my thoughts and feelings regarding my therapeutic work. In addition to her example, I have also found that supervisors who privilege the supervisory relationship are consistently available and approachable, encouraging, fully engaged, and eminently trustworthy. They tend to directly or indirectly ask the questions, ‘Are we doing all right here? Are we moving in the right direction? Are we doing what is most needed?’ And to most meaningfully advance supervision, they truly care about and want to know the answers to those critical questions.”

Supervisee 2: “I recall one experience in particular where I felt that my supervisor placed high privilege on our supervision relationship. During the early part of my training, I found myself much overwhelmed and extremely anxious about working with my first client-related legal issues. My supervisor was most sensitive to my needs as well as the boundaries of supervision. As our supervision hour neared its end, I still did not feel like I had the clarity or confidence necessary to move forward with my client. I specifically recall my supervisor recognizing my uneasiness, validating my concern, and identifying the need for an additional supervision meeting that week. In that moment I knew that my client and I both mattered to my supervisor. From this, I developed a great sense of safety working with this supervisor.”

Conclusion
In setting the stage for this series of Bulletin supervision papers, a good starting point seemingly would be considering what must first be in place for an optimal supervision experience to occur. In that spirit, eminent valuation, abiding fidelity, and relational privilege have been presented as both fundamental and foundational for that purpose.

References for this article can be found in the online version of the Bulletin published on the Division 29 website.

Authors two through seven contributed equally; their authorship assignments were randomly determined. Expanded version of paper, with more detailed principle/example descriptions, available from watkinsc@unt.edu.
Program-Led, Guided Self-Help Interventions: Developing the Role of the “Coach”

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Introduction
In the June issue of Psychotherapy, Newman, Przeworski, Consoli, and Taylor present a study on the use of a palmtop computer-assisted therapy for Generalized Anxiety Disorder (GAD) (Newman et al., 2014). This novel evaluation of the efficiency of coupling a computer program with face-to-face Cognitive-Behavioral Therapy (CBT) was the culmination of questions that began percolating in the early 1990s: How can we deliver therapy in a more cost-effective and accessible way?

In 1995, a typical course of individual therapy for GAD was about $2,181.00 per client and required 23.2 billable hours of therapist contact (Turner et al., 1995). Such a price tag created a significant barrier to receiving treatment. One proposed solution was computer-delivered treatments, which were estimated to save up to a thousand dollars per client in costs (Newman et al., 1999; Newman et al., 1996). By programming portions of therapy onto a device, many barriers to receiving treatment might be lowered (e.g., scheduling conflicts during 9-5 business days, over-booked clinicians, and physical distance).

Although the benefits of therapist-free or therapist-reduced therapy are manifold, there is a significant caveat: As therapist contact decreases, so too may patient engagement and positive outcomes. Although the content programmed into self-guided programs is evidence-based, it appears that efficacious therapy may involve more than valuable content presentation. Below we review our work on computer-assisted therapy and the evolution of Guided Self-Help (GSH) interventions. We also highlight some considerations for developing the role of a program “coach.”

Our Work on Computer-Assisted Psychotherapy
Motivated by previous research demonstrating utility in the use of computers for psychological treatment based on tasks ranging from assessment and self-monitoring to progressive relaxation, Newman et al. (1996) developed a computer program to complement CBT for panic disorder. Recognizing that CBT involved a structured therapy protocol that could be programmed into computers interactively (Selmi et al., 1990) and that most therapeutic change occurs in response to “homework” outside of therapy sessions, Newman and colleagues designed a treatment protocol for panic that coupled a computer program with a condensed therapy component (4 weeks versus traditional 12 weeks), a design meant to provide all the content but in a shorter period of time. The computer program delivered

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daily anxiety assessments as well as interactive exercises for cognitive restructuring, exposure, and breathing retraining tasks.

As had been previously proposed (Taylor et al., 1991), they observed that the key advantage of computer-assisted CBT—beyond obvious cost-savings—was facilitation of homework and compliance with ongoing assessments. Furthermore, increased patient self-management and practice could improve the experience for both patient and therapist, as less in-person time was dedicated to repetitive instructions.

Following additional case studies, Newman et al. (2014) conducted an RCT to evaluate the efficacy of a similar computer-assisted treatment for GAD compared to treatment as usual. Newman and colleagues demonstrated that a 6-session computer-assisted Group CBT for GAD was more efficacious than 6-session Group alone, confirming hypotheses about the benefits of this medium of therapy (e.g., increased assessment compliance). They also demonstrated that the computer-assisted intervention was as efficacious as traditional 12-session Group CBT, suggesting that the integration of technology can reduce therapist time necessary to achieve results.

Newman and colleagues’ research over the years has effectively demonstrated that components of therapy are well delivered via a computer platform (Newman et al., 1996; Newman et al., 1997; Newman, 1999; Newman et al., 1999; Newman et al., 2011). Our early research focused on using computers as an adjunct to face-to-face treatment rather than as the sole treatment (Taylor et al., 1991). However, many studies have demonstrated the benefits of guided self-help, and a next step in our research is to evaluate guided, Smartphone-led treatments based on our previous work. In this model, the Smartphone application is the central component of therapy versus a supplement to therapy. However, the element of human touch that is lost in purely self-help programs is retained. Ideally, this model will allow for both cost-effectiveness and efficacy in a manner purely self-help has not been able to achieve.

The Motivation for Guided Self-Help Programs

There is a clear need for more cost-effective and accessible routes to therapy. It is also important that clients have a variety of ways to access treatment. This is true regardless of whether the goal is to accommodate individual preferences or to serve a population for which there are not enough resources.

One solution to resource constraints is to train more therapists. However, the level of scaling up of therapist training and on-going supervision that is required to meet individual needs is neither possible given existing resources nor sustainable. Although solutions such as “train the trainer” models and “web-centered training” alleviate some constraints, therapist-centered approaches will always struggle to meet the growing need for psychological treatment (Fairburn & Patel, 2014).

Fairburn and Patel (2014) proposed a model for increasing the availability of psychological treatments by moving from therapist-led to program-led treatments. Enacting such a model would involve shifting focus from therapists to programs. If greater emphasis is placed on developing educational and interactive programs, opportunities to reach more people may increase. In this model, the majority of the user’s time is spent using the program while the therapist serves as a “coach” who provides

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instruction on using the program effectively and encourages the user through check-ins and motivational feedback. Beyond increasing the efficiency of providing therapy through standardized treatment and reduced variable costs, program-led interventions may also reach individuals who would not seek treatment through traditional routes.

The Evolution of Coaching in Psychotherapy
The idea of alternative methods of delivering healthcare treatment has been around for a long while, motivated by a need to make the most of limited resources. Perhaps the most popular example is the community health care manual, Where There Is No Doctor, which has been translated into over 100 languages since it was written in 1970 (Werner et al., 1995). This manual provides vital yet simple information on diagnosing, treating, and preventing common medical problems, particularly relevant to areas in which trained medical professionals are scarce and paraprofessionals must lead.

More recently, alternative psychotherapy delivery models have become increasingly possible with the evolution of technology. A 1992 study found that the demand for behavioral psychotherapy exceeded its supply in the United Kingdom and that “care could be cloned by the dissemination of effective self-help technology” (Marks, 1992). In anxiety disorder treatments, for example, exposure therapy provides the greatest effect size (Marks, 1987) and is better executed via self-exposure (Marks et al., 1988). During session, both clinician and patient devise the exposure protocol, which the patient can carry out between sessions aided by a computer program. In the next session, both review logged homework, discuss any problems, and negotiate further tasks. In that way, time with a clinician is drastically reduced and treatments are far more accessible. Given recent technological developments (e.g., more powerful mobile computing, stronger network coverage, cheaper mobile devices), Marks’ vision is not only more feasible but also scalable.

The Parameters of Coaching in GSH
When designing a coached intervention, a number of components must be considered. First, traditional program content must be organized within a self-help framework, adapting content, tone, and format (e.g., paper manual, online program, or app). Second, program delivery must be determined, specifying the dose and length, modality (e.g., face-to-face or via telephone), and structure of coaching sessions. Third, and most importantly, program guidance must be outlined.

Program content: In a study developing a GSH program for PTSD treatment, researchers and pilot users outlined important program themes of tailoring, choice, and simplicity (Lewis et al., 2013). GSH programs should be adaptable per user rather than one-size-fits-all, customizable based on user preference, and simple. These authors also stipulated multimedia delivery and mandatory components of psychoeducation, relaxation techniques, exposure guidance, and maintenance and relapse prevention. Another qualitative study, which leveraged research on the patient experience in primary care to define the framework for GSH, emphasized highlighting the intervention as a method of regaining control and defining the individual as the agent of change (Khan et al., 2007).

Program delivery: The program delivery should involve six to eight 20- to 30-minute sessions over three to four months. Though most sessions can be

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conducted via telephone or even through messaging, the initial session should be more intimate (e.g., face-to-face) to establish the relationship and discuss the program plan. Each session should follow a similar format, involving reviewing patient’s progress by evaluating a representative sample of monitoring records, identifying problems and discussing potential solutions, and providing encouragement to continue engagement with the self-help program (Carter & Fairburn, 1995).

**Program guidance:** The first step in outlining guidance is defining a set of coach criteria (e.g., necessary interpersonal and therapeutic competencies and educational training). Although there is debate around the level of professionalism of the coach, most researchers are in agreement that trained paraprofessionals can facilitate GSH programs (Bennett-Levy et al., 2010).

Second, develop a coaching manual to aid treatment delivery. For online programs, design a coaching “dashboard.” This should display an overview of user(s) progress, provide tools to facilitate coaching, and—most critically—be easy to use. The dashboard should align with key coach responsibilities. The coach must set the program pace by ensuring users do not progress too quickly or slowly through the content. The coach must also motivate the user to continue the program by identifying and praising progress and troubleshooting difficulties. Finally, the coach should keep the users focused on their goals for using the program (Carter & Fairburn, 1995).

Third, create a protocol for quality assurance of coaching, ensuring appropriate training and supervision as well as coach accountability. In addition to the coaching manual, coaches should receive a limited amount of training (e.g., treating two to three pilot users while supervised by a clinical psychologist) (Carter & Fairburn, 1998).

Finally, devise a system to optimize coaching by monitoring outcomes and identifying moderators of GSH treatment effect. Beyond designing the structural components of a coaching system, a set of principles should guide coaches’ interactions with users to maximize likelihood of positive outcomes. For example, research suggests a strong predictor of patient success in anxiety programs is consistent homework completion (Mausbach, 2010). Therefore, a key role of an anxiety program coach is to monitor homework completions and intervene with motivational feedback when necessary. Similarly, a set of client predictors of positive outcomes should be identified. These could include the user’s belief in the program, motivation to use it, treatment goals and expectations, and satisfaction with program and coach. Based on these predictors, coaches can guide treatment and motivate users accordingly.

**Evaluating the Efficacy of GSH Interventions**

GSH has potential to be not only a more accessible but also an effective route of treatment. A meta-analysis of 21 RCTs with 810 participants found the effect size of the difference between GSH and face-to-face psychotherapies for depression and anxiety disorders at post-test to be $d = -0.02$, in favor of GSH (Cuijpers et al., 2010).

Although we can say with confidence that GSH can be as efficacious as face-to-face therapy, there are still a number of unknowns. The research on GSH interventions is scattered across disorder types and often does not follow similar development protocols. Resultantly, there is not enough evidence from studies in routine clinical practice to deem GSH

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effective for those accessing primary care services (Coul & Morris, 2011). Overall, more research is necessary to define the parameters of GSH and how it can be incorporated into a system that must treat a variety of patients with different needs and preferences.

To evaluate GSH, we must understand the ecosystem in which it will be delivered, specifically how it can be initiated, evaluated, and sustained. The British government provides the best example of implementing GSH within an ecosystem. In 2009, they launched the biggest expansion of mental health services in the world, the Improving Access for Psychological Therapy (IAPT) initiative. The program aimed to improve access to National Institute for Health and Care Excellence (NICE)-recommended evidence-based psychological therapies and close the resource gap by training new therapists in evidence-based therapies. For example, Psychological Well-Being Practitioners (PWPs) could be trained in one year to support GSH interventions (Department of Health, 2012).

Using universal outcome monitoring within the IAPT system, GSH can be introduced and evaluated in a stepped care model of treatment. Assessing metrics such as step-up rates and treatment compliance, GSH was designated as Step 2 in a 5-step system, meant for treating and monitoring mild mental health problems (Evans, 2013).

In addition to monitoring clinical outcomes, assessing patient satisfaction and treatment accessibility is necessary for program evaluation. Process measures such as therapeutic alliance and compliance with treatment can provide information about patient experience and inform therapy improvements (Newman et al., 2011).

Finally, attention must be given to those delivering the treatment. To use computerized self-help treatments with clients, practitioners reported wanting more research on treatment efficacy, training, and lower technology costs (Whitfield & Williams, 2004). Similarly, PWPs in the IAPT system have expressed concern over insufficient training for difficult cases and limited career progression (Evans, 2013). Monitoring these concerns are just as important as monitoring outcomes to sustain a GSH program.

**New Frontiers for Program-Led Interventions**

The opportunities for GSH interventions and, more broadly, program-led interventions and the tools that support them are boundless. Beyond solving a problem of resource constraint, program-led solutions may actually prove more effective than traditional face-to-face routes for certain treatments. A research team at the University of Southern California explored the use of virtual humans (VHs) in clinical interviews; they found that subjects who believed they were interacting with a computer were more willing to disclose information than those who believed the VH was controlled by a human operator (Lucas et al., 2014). Using this alternative approach, VHs can partner with clinicians to help overcome the significant issue of limited disclosure.

Another group of researchers in Australia evaluated an automated interactive telephone system aiming to improve the uptake and maintenance of diabetes self-care behaviors (Williams et al., 2012). In this GSH model, the “guide” was both the facilitator and the telephone program. The Telephone-Linked Care (TLC) Diabetes system, which consists of a computer equipped with speech recognition and voice processing software, tracked blood glucose

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monitoring and patient activity and provided tailored feedback and encouragement. The TLC Coordinator instructed the patient on program usage, programmed individual self-care clinical targets, and responded to atypical program use alerts as necessary. Compared to treatment as usual, the TLC program intervention demonstrated a significant reduction in average blood glucose levels and a significant improvement in mental health-related quality of life, suggesting this computer-supported GSH program could be an accessible and cost-effective intervention for individuals with diabetes.

Researchers at the Massachusetts Institute of Technology founded GeriJoy, which provides “cost-effective 24/7 dementia oversight and companionship” (GeriJoy, 2014). Virtual talking pets, which are monitored and controlled by GeriJoy’s team of remote care staff, keep older adults company and improve health through pet therapy. By leveraging a combination of human and program, GeriJoy can deliver natural and compassionate company to seniors at scale.

Once new GSH treatment modalities become standardized, researchers can focus on how to improve them. For example, researchers at Stanford have demonstrated that patients who are matched to a physician who mirrors their reported ideal affect (i.e., how they want to feel) show greater physician preference (Sims et al., 2013). Imagine assessing whether affect-matching in virtual humans (or pets) or automated phone systems improves upon non-affect matching equivalents.

**Bringing It All Together**

In order to make novel GSH interventions accessible routes of treatment, they must be integrated into existing treatment delivery systems. For example, these interventions must be a step in a stepped care model like IAPT. They must be supported by either adapting existing resources or creating new resources (e.g., PWP in IAPT). And, they must be monitored for continued improvement. When integrating a new treatment, ongoing studies must ensure that patients are faring just as well or better in comparison to treatment as usual.

By adding this variable factor of coaching, we are exponentially increasing the ways in which treatment can be delivered. However, with increased options comes a greater chance of not providing the most appropriate or evidence-based treatment. Therefore, we must integrate new interventions into systems, monitor outcomes, and determine inflection points based on meeting benchmarks of expected outcomes. In this way, we can give GSH interventions a fair opportunity to become standardized and prescribed treatments.

**References for this article can be found in the online version of the Bulletin published on the Division 29 website.**
ETHICS IN PSYCHOTHERAPY

Ethical Concerns Regarding Psychologists’ Roles in National Security

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Throughout the history of the United States, the strength of American national security has been put to the test. A product of postwar social unrest, labor struggles, and anti-capitalist agitation, the Wall Street Bombing in the 1920s, which left many dead, injured, and confused, still leads investigators and historians to question the source of the tragedy to this day (McCormick, 2005). A few decades later, the Sunday Bomber set bombs in New York’s subways, the Unabomber mailed homemade bombs through the U.S. postal service, and the Oklahoma City Bombing took the lives of nineteen children (The Federal Bureau of Investigations). Similar stories proliferated at the beginning of the millennium, with Al-Qaeda’s attacks on the World Trade Center on September 11, 2001, dominating headlines. Rogers (2013) notes “the Global Terrorism Database reports a total of 207 terrorist attacks—domestic or international—on the United States of America between 2001 and 2011,” (START Global Terrorism Database).

When national security is jeopardized, many professionals become involved in the aftermath of traumatic events, including psychologists. Typically, psychologists are thought to provide treatment and psychotherapy to survivors of trauma, in which psychological tolls may impact daily life and even persist for a lifetime if left untreated. However, psychologists also collaborate with law enforcement officials in investigations as well as design and implement interrogation techniques (Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security, 2005). Currently, there is much debate on the ethical considerations of psychologists working outside traditional health-care provider roles, particularly when they become involved in issues concerning national security.

The Presidential Task Force on Psychological Ethics and National Security (Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security, 2005) has released a report of guidance for psychologists in national security-related settings, outlining role boundaries, and upholding the Ethical Principles of Psychologists and Code of Ethics (American Psychological Association, 2010), hereinafter the Ethics Code. Organizations such as the Coalition for an Ethical Psychology continue to seek to remove loopholes within the code of ethics pertaining to torture and detainee abuse even though the Ethics Code was revised in 2010 to address these issues. The PENS Task Force addressed the Coalitions concerns regarding the ethical considerations no longer applying to psychologists working as consultants in national security activities. However, the Task Force established that psychologists are always bound by the APA Ethical Principles of Psychologists and Code of Conduct regardless of their profes-

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sional capacity. The PENS Task Force went beyond the ethical codes of the prohibition of torture originally, clarifying that “psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman or degrading treatment”; in addition, ethical reporting obligations for psychologists witnessing acts against human rights were included, reaffirming the 1982 APA Resolution against Torture and Other Cruel, Inhuman, or Degrading Treatment (APA, 2006). The new addition reads: “Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities” (APA, 2007), requiring psychologists to report any inhumane acts to appropriate authorities. The Council policy prohibits certain interrogation techniques such as mock executions and isolation in the 2008 revised version of the APA’s Code of Conduct (APA, 2008a). The Council further revised the policy two years later with the addition that the APA Ethics Code “may never be used to justify or defend violating human rights.”

Fidelity and Responsibility, Principle B of the Ethics code, states that psychologists “are aware of their professional and scientific responsibilities to society” (APA, 2004). As stated in the PENS Task Force Report on Psychological Ethics and National Security, “psychologists have a valuable and ethical role to assist in protecting our nation, other nations, and innocent civilians from harm, which will at times entail gathering information that can be used in our nation’s and other nations’ defense” (Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security, 2005). For psychologists whose professional expertise expands to national security-related responsibilities, the fundamental duty lies in protecting society from harm and assuring all individuals that procedures are safe, legal, and ethical, thus abiding by the Do Not Harm principle. Furthermore, the Beneficence and Non-maleficence principle (Principle A), Respect for People’s Rights and Dignity (Principle E), and Justice (Principle D), assert that psychologists are to ensure the safety, welfare, and rights of all persons with whom they interact professionally and respect the dignity of all by “exercis[ing] reasonable judgment and tak[ing] precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices” (Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security, 2005). Psychologists in the professional capacity of national security-related investigations are ethically bound to these principles; however, the ability to measure how one’s actions may or may not fall under such codes is ambiguous.

First, conflict exists among the standards and definitions of “torture.” The PENS Task Force exclusively utilizes the U.S. administration’s definition of the word, without providing consideration to international guidelines such as the Geneva Convention and U.N. Declaration of Human Rights (Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security, 2005). Some debate exists as to whether or not to encompass international standards in the U.S. national security, as well as whether the definition should differentiate between domestic acts of terrorism versus perceived international threats (Fenstermacher, Kuznar, & Speckhard 2010). What constitutes torture or de-

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grading behavior is not effectively defined in any segment of the report. Moreover, operational definitions of interrogation/torture-related technique is absent in the PENS Report. The conditions under which interrogation becomes torture are never defined, nor are the standards of an “ethical” interrogation outlined.

Ethical concerns over consent and coercion are also not addressed in the PENS Report. For instance, the Ethics Code prohibits coercion of individuals; however, in the Guantanamo interrogations, “detainees [were] incarcerated indefinitely without adequate legal representation,” (Olson, Soldz, & Davis, 2008). If they did not cooperate or did not have any useful information for interrogators, they were punished. If detainees supplied interrogators with intelligence matters, they were rewarded. Under such conditions, the interrogations are indeed coercion (Olson, Soldz, & Davis, 2008). Reported examples of detainee abuse such as “20-hour interrogations, sleep deprivation, isolation, and severe temperatures” are not addressed in the PENS Report (Cratty, 2012). Case vignettes are not provided to give psychologists potential scenarios, nor are U.S. detention centers mentioned. Real-world examples from past interrogations and sample vignettes would be helpful for framing best and worst case scenarios, as would outlining the appropriate ethical boundaries to be followed. However, ambiguity and lack of concise definitions and information in the broad regulations provided leave room for uncertainty and ethical misconduct.

Due to the overwhelming amount of unrest surfacing around the world and within national boundaries, it is imperative to critically evaluate the provisions set forth for psychologists. Although it is not possible to capture all the possible circumstances in which mental health providers might find themselves, elementary baselines must clearly be established in order to prevent too much autonomy in psychologists’ scope of practice. Unlike traditional psychotherapists, whose work typically involves an individual, couple, or family, psychologists active in the national security sector may be faced with decisions that impact an entire country, or beyond. The scope of psychologists’ potential professional roles has increased; the guiding principles should expand, as well.

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Cultural Training in Internship: A Relational Model Founded on Cultural Humility

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Introduction
In recent years, the importance of cultural training in the education of psychologists has been particularly emphasized (American Psychological Association, 2003). However, clear guidelines for cultural training have not been established. As a result, internship sites vary significantly in their notions of what makes cultural training effective (Brooks, Mintz, & Dobson, 2004; Constantine & Sue, 2005; Magyar-Moe et al., 2005).

Two approaches to cultural training in internship have been identified. First, didactic approaches focus on teaching facts about specific cultures. Research suggests that a didactic approach may improve self-awareness (Brown, Parham, & Yonker, 1996). However, this approach has limitations. For example, it is impossible to provide training on all cultures and, furthermore, research on many cultures is not available (Canady et al., 2011). Second, the “cultural roadmap” approach involves teaching interns a process of how to learn about specific cultural groups, rather than facts about cultural groups.

In this approach, interns first gather general information about a particular cultural group. Next, interns meet with community representatives and groups of community members and, finally, develop a project using the information learned to serve the cultural group studied (Canady et al., 2011).

In contrast to these approaches, the cultural training at The National Asian American Psychology Training Center at Richmond Area Multi-Services, Inc. (RAMS) provides an alternative approach to cultural training for its interns. This approach is consistent with the relational and intersubjective psychoanalytic orientation of the internship’s training. In these approaches, the advent for change in therapy is the relationship between patient and therapist. In exploring the interactions and subjective experiences of the patient within this

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relationship, therapeutic change occurs, and the patient is able to process their own past and present experiences of self and other in relationship. Thus, the therapist him/herself is a vital tool in the therapy, and self-awareness is critical in being able to utilize the self effectively. Given this emphasis on the relational elements of the therapeutic relationship, this model for cultural training focuses on helping interns identify their own cultural biases and identify how these biases impact their clinical work.

Literature Review
Cultural competency has been defined as “the ability to work effectively across cultures in a way that acknowledges and respects the culture of the person or the organization being served” (Hanley, 1999). Although it was developed less than two decades ago, the construct of cultural competence has quickly become an important part of graduate training in psychology (Furlong & Wight, 2011). Cultural competency training programs are intended to help individuals and institutions to increase their proficiency in understanding, accepting, and working with culturally different individuals. In fact, evidence suggests that educational interventions intended to improve cultural competency are capable of positively impacting the knowledge, attitudes, and skills of health professionals (Beach et al., 2005).

At the same time, the construct of cultural competency has received some critique. For example, Furlong and Wight (2011) have argued that instead of pursuing cultural competency as an “add on” to graduate education, critical awareness that involves the interrogation of received knowledge and lifelong reflection on one’s own ideological and cultural commitments should be emphasized. From this point of view, critical awareness involves at least two components: (a) working on the princi-
stantly changes. Instead, each clinical encounter must be followed by intentional self-reflection on one’s reactions, feelings, beliefs, assumptions, and values. The ultimate goal is self-awareness, and respect and recognition of each individual’s cultural values within the therapeutic dyad.

Humility is a dispositional character trait, and in order to grow in cultural humility, engagement in a process of exploration of one’s attitudes, biases, and values is foundational. Holmes (2012) argues that the model of cultural competency training our field espouses is biased toward surface-level training. As a result, she argues, there is a discrepancy between what the therapist knows about cultures and what the therapist does in session (Holmes, 2012). What one knows cognitively must be processed, and the transformation to becoming a culturally competent therapist must be fostered within a training model that espouses deep-level changes (Holmes, 2012; Hunt, 2001). The training model that we present in this paper attempts to fill this gap of deep-level transformation among therapists toward greater multicultural competence and awareness.

The Training Model
The development of clinical sensitivity to culture and diversity is a central feature of the APA-accredited pre-doctoral internship training program at The National Asian American Psychology Training Center at Richmond Area Multi-Services, Inc. (RAMS). This training consists of two parts. First, the three pre-doctoral interns meet for a weekly cultural process group with the program’s training director, Dr. Alla Volovich, with the intention of exploring and discussing each of the intern’s cultural experiences. During the first half of the training year, with the help of the training director and other interns, each intern identifies a particular cultural bias believed to be impacting clinical work. During the remainder of the year, each intern uses the cultural process group as well as individual supervision and independent research to explore that bias. Second, at the end of the year, interns present their research in a written paper, as well as in a lecture given to clinic staff and trainees.

The cultural process group involves exploring one’s own culture with other group members, receiving support and feedback throughout this process, and eventually choosing and presenting on a topic of interest related to personal cultural biases. In this context, culture is construed in the broadest sense as describing the ways of living developed by groups to meet their biological and psychosocial needs. In most cases, culture includes patterns of thought, behavior, language, customs, institutions, and material objects (Leighton, 1982). When thinking about culture, it is important to differentiate between its superficial, readily apparent aspects and those that exist on a deeper level.

The iceberg concept of culture offers a framework for understanding culture that is divided into three tiers: (1) high or surface culture, (2) folk culture, and (3) deep culture. Using the metaphor of an iceberg, Weaver (1986) suggests that much of culture is outside conscious awareness. While surface and folk culture are readily apparent, they are limited manifestations of deep culture. Within this framework, deep culture includes the foundational elements of a culture, including its metaphysics, epistemology, and logic. One aspect of deep culture is worldview. Worldviews consist of one’s attitudes, values, opinions, concepts, thought and decision-making processes, as well as how one behaves and defines events (Sue & Sue, 1999).

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The cultural process group provides an opportunity for interns to gain increased awareness of the deep aspects of their individual culture and to learn about the deep aspects of one another’s cultures. Drawing on the influence of intersubjective psychoanalytic thought, interns are able to increase their awareness of the deep aspects of their own cultures by recognizing its immediate impact on fellow participants and directly experiencing how cultural beliefs shape interpersonal encounters. Within a framework of cultural humility and critical awareness, ongoing self-disclosure, support, and confrontation allows interns to find a place in which they can explore the meaning of their own and each other’s cultural differences. Over time, interns develop an increased capacity for cultural self-formulation insofar as it impacts countertransference dynamics in clinical work.

Illustration
The following encounter in the cultural process group occurred about four months into the training year and illustrates the concepts that we have discussed above.

T. Wooldridge: I’m still not sure what we are doing here.

S. Prasad: Even now? After you talked about what a powerful impact growing up in the South had on you?

TW: Yeah, but I’m unclear of what that has to do with the everyday. When I look at Carissa, I don’t see her as being Indonesian. I just see Carissa as Carissa. I mean she’s human, like me and you and everyone else.

(Long, uncomfortable pause)

A. Volovich: Carissa, you have a look.

C. Dwiwardani: I’m thinking of how to say it...I know you mean to make me feel accepted in some way by saying that, but it hurts me to hear you say what you said. It makes me feel unseen, like you’ve taken something important away from me.

TW: I’m sorry. I didn’t mean to do that.

CD: I know you didn’t, but that was how it affected me.

SP: It’s like colorblindness. People think it makes everyone closer somehow, but it actually creates distance. It disallows a part of you—your culture—and it feels pretty awful.

Tom: I wouldn’t have thought that.

In writing this paper, we each reflected on this particular encounter that occurred almost two years ago. We reproduce each of our reflections on this encounter verbatim.

TW: Although cultural competency was emphasized during my graduate education, at the beginning of my pre-doctoral internship I was deeply ambivalent about whether that emphasis had been beneficial to me in my clinical work. Notably, I was nonetheless drawn to pursue my pre-doctoral internship at the National Asian-American Psychology Training Center at RAMs, Inc., a training program well-known for working with immigrant populations and its concomitant emphasis on cultural competency.

In hindsight, I attribute my ambivalence about cultural matters to early experience. I grew up in Mississippi, an area of the United States well-known for its history of racial and cultural strife. An African-American nanny was a central figure in my childhood, someone to whom I was deeply attached. Even as a child I had a nascent recognition that my nanny was, somehow, regarded as fundamentally different from me both by my family and the larger social milieu. In reaction to the painful emphasis on difference I experienced then, I now tended toward a denial of difference, both in others and in myself.

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Around the fourth month of internship, an interaction that was both difficult and enlightening occurred during the cultural competency seminar. Although our training cohort had been remarkably cohesive throughout the year, the cultural differences between us were beginning to make themselves known. More importantly, perhaps, my difficulty acknowledging the importance of these differences was becoming evident. As we discussed the interpersonal process between us, I said, “Carissa, I don’t see you as Indonesian. I see you as a human being.” This naïve comment launched a long discussion, extended over many weeks, through which I came to see that my comment left Carissa feeling unseen and misunderstood. Equally important, I began to understand how my own developmental process had led me to deny cultural difference both in others and in myself. In time, I was able to increasingly acknowledge this previously denied aspect of myself and, therefore, to acknowledge its existence in others. Unsurprisingly, this had a significant impact on my clinical work.

CD: When Tom stated that he did not see me as Indonesian—that he simply saw me as a person—I was stunned. While colorblindness is not a new concept to me, I was quite surprised at how it affected me directly when someone—not just someone, but a friend and colleague—exhibited it so bluntly toward me. As I reflected on the hurt I felt, I realized that I felt unseen, that a big part of me was being overlooked. The context of our friendship made it confusing, too. I was certain that Tom is a friend who cared for me, but why this hurtful overlooking of who I am? It did not seem to make sense.

As I began to voice my experience to Tom, I sensed openness on his part to hear how his comment affected me, and this was the beginning of a deeper understanding of myself—how colorblindness affects me, and growth in my learning of how to address it interpersonally. This experience taught me that cultural awareness of oneself and of others must happen in a relational context. If Tom were not a friend and colleague, if he had been just a stranger to me, it would have been easy to dismiss him entirely. The relational context forced me to wrestle with the complexity of the interaction, to put the complexity into words, and to experience receptiveness in Tom’s reaction, all of which were healing to our relationship.

SP: When I heard Tom say the words “I just see you as a human,” I felt my blood pressure starting to rise. I was angry not only for what Tom said, but for all of the many times that kind, well meaning people, even friends, had made me feel either unseen or ashamed of my culture. My thoughts jumped to when my closest friend told me that the music to which I danced sounded like an alarm going off but that she meant no offense, or the many times in Wisconsin that people said that race and ethnicity had no impact on how they saw others while they argued that affirmative action was reverse racism. These interactions made me feel misunderstood and angry, but I could not experience that anger without anyone to help me hold it, so I internalized it at first, and later processed it in the displacement in college by studying neo-colonialism in the context of Latin America.

In graduate school, I read everything about microaggressions and racism that I could, and began to understand its impact on me, but before I was able to process these interactions during internship, I did not realize that I took the many cues that people did not want to see my cultural self and would prefer if I were an acultural being; I did not recognize that I, like my parents, had com-

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plied with this given our social context and fear of rejection should we confront these interactions. Even now, when I find myself in homogenous setting where I am the “other,” I feel isolated, and when I find myself among Indians, I feel less Indian than I should, sometimes attributing my shame about this to others around me and sometimes recognizing negative judgment from others who rejected my parents’ relatively liberal stance and their inter-caste marriage. These realizations did not come in therapy or in other contexts of self-exploration but were possible because of the training that I received at RAMS through the interactions like the one shown above. I had a space to work out my thoughts and feelings, which were at times incredibly painful, with the support of a supervisor and colleagues. Equally important, I had the opportunity to support my colleagues in processing their own experiences without the high level of conflict that I have witnessed in other conversations about race, ethnicity, and culture. This experience fostered dialogue and patience, and the interaction between Carissa and Tom allowed me to let go of some of the anger that I had held on to. It gave me hope that people can understand what it means to be different from the norm if they have the patience and support of others. This patience and support was possible because we knew and cared about each other and because we sat down for at least an hour a week to talk about culture.

Reflection
This illustration of an encounter in the cultural process group illustrates one group member (TW) moving from cultural naïveté toward a place of increased cultural humility and curiosity about both his own cultural experience and the other’s. Although this did not involve learning facts about a particular culture, it nonetheless dramatically influenced his future clinical work and sense of identity as a cultural being.

In fact, this transition can be mapped according to a developmental model of cultural competency (Mason et al., 1996). This model consists of five stages: (1) cultural destructiveness, (2) cultural incapacity, (3) cultural blindness, (4) cultural precompetence, and (5) cultural competence. In brief, cultural destructiveness is a stage in which individuals and groups are unable to acknowledge the importance of cultural differences. In the cultural incapacity stage, cultural differences are provided with neither a positive or negative valuation and, therefore, ignored. In the cultural blindness stage, cultural differences are seen as inconsequential and of no importance. In this stage, being “color-blind” is desirable. In the cultural precompetence stage, individuals acknowledge the need for cultural competence and attempt to correct harmful practices. In the cultural competence stage, individuals learn to value cultural differences.

In the illustration we have provided, TW can be seen as moving from a stage of cultural blindness, in which cultural differences are seen as irrelevant, toward a stage of cultural precompetence. As the process group continued throughout the year, so did this development.

Finally, the encounter brought forth several aspects of deep culture present in members of the process group. For example, TW recognized that one aspect of his own culture consisted, with a few notable exceptions, of minimizing the importance of cultural difference. In this way, the complex feelings associated with being a member of the “majority” culture could be bypassed. SP recognized a parallel bias in herself to dis-

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count the value of her own cultural experience given that she internalized others’ assumption and desire for colorblindness, and CD learned to voice her reactions to colorblindness and gained a deeper and experiential understanding of the impact of colorblindness. Thus, each intern grew developmentally through this experience.

Limitations
The model that we propose does have its limitations. In order to have a successful group, there must be a facilitator who is attuned to cultural issues, cares about the topic, and has adequate training to manage in-depth discussions. In addition, there is a need for enough diversity in the training group to allow for lively discussion and counterpoints and also a need for the group to not consist of two sides of a historical trauma without any other members to mediate the intense emotional valence.

Because one’s culture cannot fully be separated from self and family, it is innately emotional, such that transference and countertransference often emerge during the group, and can be difficult to contain. This is particularly apparent in the context of an internship program that requires ego strength and a consolidated self in order to manage the rigors of training. This model of cultural competency training, however, requires interns to deconstruct themselves in cultural terms. This can result in emotionally charged interactions and distress at times if interns choose to self disclose and engage in the process fully. This requirement of self-disclosure is also a limitation in that participants may have difficulty feeling comfortable self-discoeusing to peers about their own experiences. We feel as though this is necessary given the difficulty of finding other venues to engage in this level of discussion around culture. Because most therapists themselves have not undergone extensive training around issues of culture, interns’ personal therapy often does not provide adequate support and knowledge to hold a patient in the process of working through personal culture.

In addition, although not included in the scope of this article, we believe that a two-pronged approach to cultural training is indicated. The two facets of this training involve both the in-depth reflection and relational interactions described in this article, as well as research about one’s culture of origin in the form of readings and consultation with others to gain knowledge from an external perspective.

Conclusion
In this paper, the authors have attempted to present a training model on multicultural competence that is directed toward promoting a cultural awareness that goes beyond a cognitive knowledge of others’ cultures. The cultural competence training model at the National Asian American Psychology Training Center’s predoctoral internship program at RAMS, Inc. was presented. The model is carried out over a period of the internship year, during which the interns meet weekly in a group with the internship Training Director. Along with working on individual cultural competence projects, the interns engage in a process of cultural awareness development and exploration in the weekly group meeting. An illustration of a process that took place in the group was presented, as well as interns’ reflections on the process. Limitations of this model of training were also presented. The training model presented is one that is directed toward a deep-level transformation within a relational context. This model, we believe, increases the thera-

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practitioners’ level of comfort with discussions of cultural dynamics in therapeutic contexts and sharpens therapists’ sensitivity to cultural nuances presented in various therapeutic contexts.

References for this article can be found in the online version of the Bulletin published on the Division 29 website.

NOTICE TO READERS

References for articles appearing in this issue can be found at the end of the on-line version of Psychotherapy Bulletin published on the Division 29 website.

Practitioners: Interested in writing about your practice experiences? The Div 29 Professional Practice Domain is renewing its efforts to include and disseminate the knowledge and experiences of practicing psychotherapists. We’re seeking articles that are reflections on therapists’ experiences, thoughts, or concerns related to any practice-related topic. Topics may include but are not limited to the following: clinical techniques, the psychotherapy process, countertransference, therapist self-care, working with specific client populations, and ethical/legal considerations. Psychotherapy Bulletin editors will review submitted articles to determine if they are appropriate for the Bulletin and provide feedback as needed. Articles should be submitted to the Bulletin Editor, Lynett Henderson Metzger, at jurisources@aol.com.

The official submission criteria appear on the last page of the Bulletin.
2015 NOMINATIONS BALLOT

Dear Division 29 Colleague:

The Division of Psychotherapy (29) seeks creative individuals and great leaders! We’d like both new and experienced voices to help further our increasingly important work on behalf of the advancement of psychotherapy.

**NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN THE DIVISION OF PSYCHOTHERAPY.
THE OFFICES OPEN FOR ELECTION IN 2015 ARE:**

- President-elect
- Treasurer
- Domain Representative for Psychotherapy Practice
- Domain Representative for Education & Training
- Domain Representative for Membership
- Domain Representative for Diversity

*All persons elected will begin their terms on January 2, 2016*

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

The Division’s eligibility criteria for all positions are:

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

The deadline for receipt of all nominations ballots is January 3, 2015. **As per the Division’s bylaws changes, you may now email your nominations to: assnmgt1@cox.net. Please put DIVISION 29 NOMINATIONS in the header of the email.** You may also fax your nominations to: 480-854-8966, or mail to Division 29, 6557 E. Riverdale St., Mesa, AZ 85215.

If you would like to discuss your own interest or any recommendations for identifying talent in our division, please feel free to contact the division’s Chair of Nominations and Elections, Dr. Armand Cerbone, at arcerbome@aol.com or 773.755.0833.

Sincerely,

**Raymond DiGiuseppe, Ph.D.**  **Rodney Goodyear, Ph.D.**  **Armand Cerbone, Ph.D.**

President  President-elect  Chair, Nominations & Elections

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**NOMINATION BALLOT** (INCLUDING SELF-NOMINATIONS!)

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Finding your Theoretical Fit: A Unique PlayBuzz Quiz

Nahed Barakat, PsyD
Brain Beaumund, PsyD
Rebecca DeHass, PsyD
Alana Fryer, PsyD
Lindsey Harcus, PsyD
Eli Johnson, PsyD
Emily Laux, PsyD
RuthAnn Lester, PsyD
Alexandra McDermott, PsyD
Risa Muchnick, PsyD
Shane Spears, PsyD
Nick Sotor, PsyD
Ashley Sward, PsyD

University of Denver GSPP Internship Consortium

In clinical and counseling psychology, human behavior is understood through varying lenses called theoretical orientations. Key factors that influence orientation include a practitioner’s unique personality and particular way of conceptualizing the human condition. These factors come into play in clinical and counseling psychology training programs, where students must select one of these orientations in order to practice psychotherapy in a coherent manner.

The programmatic demands of many training programs are such that a trainee must simultaneously develop a didactic mastery of the varying theoretical orientations while also expanding their understanding of themselves as related to a particular theoretical preference. Particularly for a first year student, this is a potentially daunting task.

One way of bridging this gap is to develop an informal tool which is light-hearted yet informative, and could potentially orient the student toward a clinical perspective without pigeonholing them. The authors of this study will present such a tool in the form of a “PlayBuzz” quiz, developed with the specific intent of elucidating preference for a specific theoretical orientation by assessing aspects of the individual’s personality and worldview.

Literature Review
Previous research suggests that certain factors may lead a psychotherapist in training toward a specific theoretical orientation. “At its most basic level, theoretical orientation can be conceptualized as a therapist pretreatment characteristic or a factor that is thought to relate to psychotherapy process and outcome” (Boswell, Castonguay, and Pincus, 2009, p. 291). Trainees often seek out an approach to psychotherapy that is meaningful and congruent with their personality traits (Mason, 2012).

Some studies have used specific personality measures to capture this. Ogunfowora and Drapeau (2008) used the HEXACO Personality Inventory, which continued on page 30
defines some specific traits as follows: agreeableness is a tendency toward forgiveness, compromise, cooperation, and control of one’s temper; conscientiousness is a tendency toward organization, discipline, and perfection; openness is a tendency toward inquisitiveness, imagination, and beauty in art and nature. Specifically, a psychodynamic orientation is positively predicted by openness and negatively by agreeableness, whereas a humanistic/existential orientation is positively predicted by openness and negatively by conscientiousness. Further, a family systems orientation is positively predicted by agreeableness, and a cognitive behavioral orientation is positively predicted by conscientiousness (Ogunfowora & Drapeau, 2008).

While there are other factors that contribute to a psychotherapist’s choice of theoretical orientation (including worldview and past experience), for the sake of this paper, personality factors will be the main variable explored.

Proposed PlayBuzz Quiz
So how does one go about creating a map that can allow introductory students to find their way through the many theoretical orientation options and choose those that best fit their personalities and their worldviews? The answer lies in understanding the pedagogical rationale behind the PlayBuzz questions. According to the research conducted by Ogunfowora & Drapeau (2008), the personality features that best predict a student’s predilection toward a specific theoretical orientation are agreeableness, conscientiousness, and extraversion.

The authors, all interns at the University of Denver Graduate School of Professional Psychology Internship Consortium (an exclusively affiliated program that is APA accredited), decided to develop a PlayBuzz quiz in Research Seminar as their shared scholarship project for the year. To make the quiz more efficient, we chose four different theoretical orientations on which to focus: Cognitive Behavioral Therapy, Psychodynamic, Humanistic, and Systems theories. We then took the personality features shown to be correlated to orientation preference and developed questions with answers highlighting those features. We agreed on the final questions through group brainstorming.

For example, to highlight agreeableness, the authors chose the question “Someone cuts you off in traffic. How do you understand this?” The answers to these questions that emphasize the trait of agreeableness include, “They probably didn’t see me” and “Everyone has bad days sometimes.” When an individual chooses one of these answers, they load on agreeableness which indicates a predilection to systems theory. If an individual chooses one of the other options, it loads them on the opposite of agreeableness and indicates a partiality for psychodynamic theory.

Another example includes questions that emphasize conscientiousness. CBT is positively correlated with conscientiousness while Humanistic/Existential is not (Ogunfowora & Drapeau, 2008). The answers to the question “What’s your ideal weekend?” and the prompt: “Pick a Hashtag” are positively associated with organization and discipline. Aspects of conscientiousness (“Being Productive” and “#justdoit”) will load on a CBT preference, while answers that are negatively associated with conscientiousness (“#YOLO” and “Pondering life in the park”) will load on a Humanistic preference.

In total, we designed a quiz with 9 questions. All of these questions addressed various domains and finish by offering the quiz taker with a suggestion for a continued on page 31
specific theoretical orientation that may fit their specific personality aspects. The questions for the quiz are listed in Appendix A and the quiz we developed may be accessed here: https://www.PlayBuzz.com/lindseyIi/what-is-your-psychological-theoretical-orientation

Discussion
This quiz was a light-hearted attempt to provide guidance to incoming graduate students in clinical and counseling psychology. We are hoping that rather than providing a true assessment of an individual’s theoretical orientation, it will open up meaningful discussion about areas of potential clinical interests. The authors recommend using the PlayBuzz quiz during an orientation activity or in a beginning seminar or class to elucidate how one’s personal characteristics might guide clinical practice.

It is important to understand the limitations of this PlayBuzz quiz. The quiz is not an accurate predictor of future orientation or career paths. Rather, it is strictly a tool that can help students understand how their personal characteristics align with certain theoretical orientations. It is not an empirically validated measure and would require further study to determine its validity and reliability. Additionally, the authors only looked at some aspects of personality that were highlighted in the literature as being correlated to theoretical orientation preference. Research also suggests that other aspects about an individual’s personality as well as demographics and worldview influence preference toward an orientation as well. This PlayBuzz quiz did not take these into account, but one could be created that would better encompass personal characteristics, demographics, and worldview while maintaining the playful approach.

Summary and Recommendations
The purpose of this paper is to provide an assessment measure in the form of a simple quiz to help determine whether or not individual personality factors and worldview can predict an affinity for theoretical orientation. Although there has been research to suggest that there is a relationship between personality traits and ascribed theoretical orientation, there is little research exploring the relationship between worldview and these factors. Future research that explores this hypothesis that worldview, in addition to personality, can help predict theoretical orientation is recommended. Additionally, it is recommended that future researchers conduct a statistical analysis or longitudinal study aimed at establishing whether or not the current measure can be empirically validated. This type of measure could be an extremely valuable tool in providing clinicians in training with guidance and direction in choosing an appropriate theoretical orientation that best fits their personality and worldview. In the meantime, we hope this quiz will be a fun and creative way to help psychologists in training find their best theoretical fit.

References for this article can be found in the online version of the Bulletin published on the Division 29 website.
STUDENT FEATURE

Poetry as Self Care

Mili Thomas, MA
PhD Student, Georgia State University
Clinical Psychology Intern, Pennsylvania Hospital

Like most of you, I am a secret-keeper. I am given the gift of hearing private thoughts and exploring strong emotions with strangers who become clients. I am a purveyor of hope. I often do little more than listen, but the impact on some clients is profound. I marvel at how the process of revealing oneself unfolds from person to person. Sometimes, I offer interventions that enable clients to see themselves more clearly. I witness the work people do to change their lives; to put together puzzle pieces often shattered by circumstances outside their control. Every client I sit with makes me feel something. Some days I am inspired, other days I feel hopeless or helpless.

I channel the emotions I feel in the therapy room into my poetry. I don’t write poems every day, but about once a week I pen a few lines or compose a complete poem to capture what I have felt or witnessed. This is one way in which I care for myself. Writing poetry helps me release some of the emotions I hold for my clients. Being involved in the lives of my clients, I feel their distress and writing down what I have experienced helps me better understand what has gone on in the therapy room. My poem, Survivor, encapsulates my experience running an Intimate Partner Violence Survivor group in Atlanta, GA. This poem was inspired by a dozen different women whose courage, resilience, and love have made me a better clinician and a more honest person.

Survivor
Somatic memories plague
Sensory stimuli inhibit
Motor movements distort
Involuntary flashes
Unplanned lapses
Panicked pauses
Tears are my currency
Meekness my weakness
Nightmares=Daydreams
Constant vigilance
Practiced Control
Safety is possible
Victim, I was.
Survivor, I am.
Thriver, I will be

NOTICE TO READERS

References for articles appearing in this issue can be found at the end of the on-line version of Psychotherapy Bulletin published on the Division 29 website.
An Exciting Future by Embracing Change

Pat DeLeon, Ph.D.
Former APA President

The Centers for Disease Control and Prevention (CDC)
One of the most vibrant agencies within the Department of Health and Human Services (HHS) is CDC, headquartered in Atlanta, Georgia. Since 1946, CDC has served as a public health leader in the U.S. and around the world. It has experts assigned to all 50 states and more than 50 countries. Its budget request for Fiscal Year (FY) 2015 approximates $6.6 billion. In 1996, Rodney Hammond became the first Director of the CDC Division of Violence Prevention, emphasizing a public health approach to child abuse and family violence, as well as stressing that the best way to address these critical issues is to prevent them before they occur. Rodney actively promoted the notion that the wide spread expansion of evidence-based parenting and early intervention programs throughout the public health systems would, in the long run, make a significant difference. Over time, this resulted in an institutional appreciation for the potential contributions that psychology and the behavioral sciences could make to the agency’s overall mission, with its emphasis upon data-driven decision making.

The CDC Director: “As we continue to expand and strengthen our collection and use of data, we gain greater knowledge and insight about the extent of our biggest health problems, which populations are most affected by them, and what we need to do to solve them. Information is power—and this power makes it possible for us to implement programs that fulfill our promise to keep America healthy and our nation strong.” Reflecting upon his decade-plus involvement, Rodney notes, “Psychologists currently occupy prominent roles throughout CDC signaling the critical importance of behavioral health to the prevention of disease, injury, and disabilities across the population. For example, Ileana Arias, who I recruited, is a psychologist and serves as the CDC Principal Deputy Director. It is encouraging to see these ideas now taking hold.”

Gwendolyn Keita, Executive Director of the APA Public Interest Directorate, and her colleague Steve Sauter: “It seems hard to believe, but the forthcoming 11th International Conference on Work, Stress and Health will mark the 25th anniversary of the inaugural conference in this series. It also represents the 25th anniversary of the 1990 issue of the American Psychologist containing a cluster of articles that envisioned the new field of Occupational Health Psychology (OHP). From these beginnings, OHP has spread throughout the occupational safety and health field, with graduate training programs in OHP worldwide, a new Society for Occupational Health Psychology, a new Journal of Occupational Health Psychology....” The critical catalyst was the visionary Director of CDC’s National Institute for Occupational Safety and Health (NIOSH), Dr. Don Millar.

The CDC FY 2015 budget notes that chronic diseases are among the most prevalent, costly, and deadly of all health problems—and the most pre-

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ventable. Chronic diseases are the leading causes of death and disability in the U.S. and account for 70% of all deaths annually (almost 1.7 million). They also cause major limitations in the daily living for approximately one out of every ten people. Core CDC activities in this area include: Preventing and controlling the leading causes of disease, death, and disability, including tobacco use, obesity, heart disease, and stroke, diabetes, and cancer; promoting community health, oral health, safe motherhood, infant health, and healthy behaviors such as physical activity and nutrition; and maintaining surveillance systems to track and monitor behavioral risk factors. Tobacco use is the leading preventable cause of disease, disability, and death, with one of five adults and one of four U.S. high school students currently smoking.

In the area of obesity—one out of every six children (17%) and one out of three adults (36%) are obese, and thus at increased risk for hypertension, high cholesterol, type 2 diabetes, heart disease, and certain cancers. Obese individuals have an annual per capita medical spending that is $1,429 greater than spending for non-obese people. CDC leads the national agenda on physical activity promotion. Walking is the most popular form of physical activity, with six in ten adults reporting walking, yet many people engage in NO leisure time activity. CDC initiatives include engagement in: *Pedestrian-friendly street design. *Physical education requirements in schools and child care centers. *Community agreements permitting after-hours use of school and mall facilities. And, *Infrastructure support for persons on bicycles and in wheelchairs. CDC is working closely with the Surgeon General’s Office on a “Call to Action on Walking,” in order to provide critical guidance on factors that support and facilitate physical activity and improve health across the lifespan. Those involved in training our next generation of clinicians should be actively engaged in CDC’s efforts to educate more health professionals on population health and make public health education more practical. Specifically, CDC plans on working with “academic partners to integrate population health concepts into the curricula of medical and nursing schools.” Why not psychology’s?

CDC is the nation’s leading authority on violence and injury prevention. Its objective is to keep Americans safe by researching the best ways to prevent violence and injuries, using science to create real-world solutions to keeping people safe, healthy, and productive—thereby fulfilling President Obama’s “Now is the Time” initiative. The Intentional Injury Prevention program works to prevent youth violence and bullying, child maltreatment, teen dating violence, sexual violence, intimate partner violence, suicide, and firearm-related injuries and deaths. In 2010, over 16,000 individuals died as a result of a homicide and over 38,000 individuals committed suicide. Youth violence was especially prevalent, with over 4,600 homicides and over 585,000 non-fatal physical assaults of individuals between the ages of 15 and 24 being treated in emergency departments that year. Violence affects lives throughout the lifespan. In 2010, approximately 50 children per hour were victims of child maltreatment and more than 1,500 children died as a result of child maltreatment nationally. Children who are maltreated are at higher risk for serious health problems as adults; including obesity, heart disease, and chronic obstructive pulmonary disease. In addition, they are more likely to smoke and engage in high-risk sexual behaviors later in life. Overall, violence-related injuries and deaths, including interpersonal and self-

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directed, cost approximately $107 billion a year in medical and other costs. Teen dating violence is an area of particularly growing concern in violence prevention. Teen victims of dating violence are more likely to be depressed and do poorly in school. Current science demonstrates it is more effective to begin working with teens at a younger age to stop dating violence before it starts.

At the Uniformed Services University of the Health Sciences (USUHS), the issues being addressed by CDC are of considerable interest. Nate Galbreath, Senior Executive Advisor to the DoD Sexual Assault Prevention and Response Office, noted that in FY 2013, DoD received 5,061 reports of sexual assault that included at least one service member victim or perpetrator. In FY 2012, a DoD survey found that about 26,000 active duty members indicated experiencing some form of unwanted sexual contact, ranging from rape to unwanted sexual touching. Underreporting is a significant problem, due to fear, stigma, or shame, complicating victim care and holding offenders accountable. A number of those reporting had been victimized prior to joining the military, with 30% of the women and 6% of the men reporting unwanted sexual contact incidents. Alcohol was commonly the only “weapon” involved, with non-stranger offenders often not believing their behavior was criminal. The DoD experience clearly reflects the underlying CDC concerns and that the Services are but a microcosm of society.

Given APA’s long history of advocacy in addressing our nation’s unfortunate health disparities, psychology should be particularly interested in the efforts of the CDC Office of Minority Health and Health Equity. This Office includes the Office of Women’s Health and the Diversity Management Program. It provides leadership for CDC-wide policies, strategies, planning, and evaluation to eliminate health disparities. The Office monitors and reports on the health status of vulnerable populations and the effectiveness of health protection programs; provides decision support to CDC executives in allocating resources to programs of surveillance, research, intervention, and evaluation; coordinates CDC’s response to White House Executive Orders and HHS health disparity initiatives; initiates strategic partnerships with governmental, non-governmental, national, and regional organizations; and provides guidance and oversight to the agency-wide implementation of the CDC Diversity Plan.

Visionary Reflections
“My Presidential Future of Psychology Practice Initiative identified many areas for the growth of professional psychology. Working in integrated health care systems and expanding our focus to include population-based, public health perspectives are two of these important areas for expansion. CDC is the federal agency charged with many of these initiatives and has been moving towards areas in which psychologists are experts, such as violence and trauma prevention, fetal alcohol syndrome prevention, and many others. Yet most psychologists are trained in, and therefore limited to think only about, individuals rather than intervening for the population as a whole. It is time for psychology to step up to these societal challenges and apply our research and clinical expertise to address the ‘big picture’ issues that require us moving out of the individual psychotherapy rooms and into the public health care system. If we don’t step up now, other professions will and we will continue to see our incomes and opportunities drop” (James Bray, former APA President).

“Recently, I heard Early Career Psychologist-extraordinaire Le Ondra Clark continued on page 36
Harvey talk about the importance of including policy in the graduate training of all psychologists. I couldn’t agree more. In 1998, I was fortunate to be the first APA representative to the HHS Primary Care Policy Fellowship. For a year in 1998, I worked with a stimulating group of health professional leaders (from Deans and Chairs to Medical Directors and Nurse Leaders) to learn about healthcare policy. We each developed a policy project, + I made a video with 16 different disciplines making fun of their own discipline’s stereotype. This was a lot of fun and very revealing about the stereotypes we each held about each other. We came to see how we could fit together as a team. Through all this I learned the importance of strengthening alliances with other health professional organizations; it benefits us as psychologists when we are pushing legislation, and it benefits the public when we can collectively collaborate on their behalf” (Susan McDaniel, 2007 APF-Cummings Psyche Award recipient).

Giving Back (Sandra Haber): “You have a bone marrow cancer. There are medications that can manage it but the only cure is a stem cell transplant.” This was the gut wrenching news as presented to me in 2012. For the past 20 years, I had worked with many cancer patients in my practice, but this was my diagnosis and it was a doozy. I was fortunate in that I had plenty of support from family and friends. ‘How can I help?’ became the question I was most frequently asked. Fast forward to 2014—one year post-transplant. Enter a new stage of my life. I feel great, I am back at work and now it is time to ‘give back.’ It is time to give psychology away.

“I have a vision. I want to write a booklet called ‘Giving meaning to ‘How Can I Help? What To Do When Someone You Know Has Cancer.’” I want this booklet to be published by a national organization (maybe APA, maybe not). It should be heavily advertised and given away for free. It would be the first ‘gift’ you get from your oncologist along with the cancer diagnosis.

“Let me walk you through an example. Jane Smith has breast cancer and will need chemotherapy and surgery. As the news spreads, Jane gets calls from family and friends. ‘How can I help?’ they ask. Jane feels cared for but none of these calls have really helped her worries. Now imagine that Jane had a booklet of suggestions. Her friend says ‘How can I help?’ and Jane, who has read her booklet, says—‘Well, I know you walk your dog every morning. Are you able to walk my dog at the same time? How often can you do this? For how long?’ Or, Jane says ‘Suzy and Johnny, my kids, need a 9:00 a.m. school drop off. But that is the same time as my chemotherapy. Do you think you could drop the kids at school next week?’ Or, ‘You have such a flair with fashion. I know I should go wig shopping but don’t want to go by myself. Will you come with me?’

“The booklet I envision has checklists where friends and family can assess what they are comfortable doing and how often they are available. Ideally, a best friend or spouse could coordinate all of the potential participation from the well-wishers. What happens is that specifics and structure can now shape the question ‘How can I help?’ and the patient has a valuable ‘buddy system’ to help with the details of managing life while undergoing cancer treatment and recovery. Any feedback or ideas about this are welcome [DrSandraHaber@gmail.com].”

Aloha.
REMEmBRANCE

Remembering Alvin R. Mahrer, PhD

Howard Gontovnick, PhD
SUNY Plattsburgh, NY

In April of 2014, the field of Psychotherapy lost another member of an elite group of “distinguished psychotherapists.” Known as an innovator and a passionate critic of psychotherapy, Alvin Mahrer’s contributions have been known to both challenge and enhance the field of psychotherapy for decades. In his book Current Psychotherapies (7th Edition, 2005), Raymond J. Corsini wrote: “I was amazed by the audacity of (Mahrer’s) experiential psychotherapy, which in many ways turns the world upside down.”(Corsini & Wedding 2005, p. XI)

For Corsini, Mahrer’s methodology was “as revolutionary as was Freud’s 100 years ago and Carl Rogers’s 50 years ago,” and, because of this, Corsini recommends that all psychotherapists should learn from this approach (Corsini & Wedding 2005, p. XII).

If you never had the chance to hear Alvin Mahrer in a classroom, lecture hall, or as part of a discussion, you missed the opportunity to learn from an educator the likes of which we will probably never know again. His style of engaging students, presenting examples, or defining an idea, often created an enthusiastic discussion. You see, Mahrer was not just someone that gave a lecture—but a person who encouraged one to think and think again. Whether the theme was his theories on the origins of human behavior or developing a model for self-transformation, Mahrer was passionate about understanding the dynamics of human nature. He simply wanted to know how to best help a person learn how to become what they could become.

Mahrer, who was influenced by Freud, Jung, Rogers, and George Kelly, favored a humanistic view of psychotherapy. He is perhaps best known for his unique theory of personality, outlined in his book Experiencing: A Humanistic Theory of Psychology and Psychiatry (1978). Across the 844 pages of this impressive work, Mahrer illustrates how individuals should be understood in terms of their potentials for experiencing. According to Mahrer, certain “potentials” (ways of experiencing) are closer to the surface (consciousness), whereas others are found at a deeper level, occasionally rising to the surface. A person’s unique behavioral style is based on the location of these potentials and their relationships with each other. “It is an experiencing person which organizes their behavior,” Mahrer wrote. “The aim is to describe the nature of the experience and not to explain the behavior” (p. 23).

Mahrer’s Experiential Psychotherapy
According to Mahrer’s model of psychotherapy, the task for the therapist is to assist the individual to become aware of what is deeper, to understand the dynamics between these potentials, to discover new ways of experiencing and how to become a whole new person (Mahrer, 1998). For these reasons, each session has two simple goals: (a) to become a qualitatively new person, and (b) to be free of scenes of bad feelings (Mahrer, 1996). Mahrer considered psy-

continued on page 38
chotherapy an opportunity to guide the person forward, evoking and facilitating access to their deeper experiences. Therefore, if I were to highlight the notion of success in therapy according to Mahrter, the end result would be toward becoming a whole new person—the optimal person.

In Mahrer’s model of psychotherapy, the therapist starts the session by guiding the individual through a series of the four basic steps. Beginning with Step 1, the initial task is to discover and then live in a scene of strong feeling—meaning, to invite the person to recall a memory and image themselves as if they were experiencing that moment. Once this is done, the therapist will guide the individual toward finding the exact moment when the feeling is strongest. Using what Mahrer calls the critical moment, this becomes the doorway to discover the deeper potential. Step 2 involves exploring, welcoming, and relating to the newly discovered deeper potential. This potential for experiencing is then named and described in greater detail. In Step 3, opportunities are created for the person to try out what it is like or would have been liked if this newly discovered deeper potential was actually part of what that person was like. To some extent, this point becomes a testing ground for how one could have been, while anticipating in a playful way what one could actually become. In the concluding part known as Step 4, the main task is to become more of this new person and practice as if one were living and acting this way—living as a qualitatively new person, or someone who is different from the person they were at the beginning of the session. From this point onward, the person is encouraged to apply what was experienced during the session and try out being this whole new individual. In future sessions, the same basic steps are followed to either to strengthen or discover other, deeper qualities within that person.

**Mahrer’s Later Work**

In the years that followed, building on the success of his therapeutic model, Mahrer introduced the practice of having one’s own experiential session without the therapist present (Mahrer, 2002). Radically different from any other therapeutic exercise, this technique involved the individual following the same methodology and proceeding through the same four steps without the direction of a psychotherapist. Mahrer offered guidance and specially-developed audio tapes for those interested in pursuing this path of self improvement.

In 2007, Mahrer’s unrelenting interest in self-transformation led to another inventive method of personal change. Recognizing the transformative nature of experience, Mahrer envisioned how learning and practicing a series of unique behaviors would create new opportunities to bring about change. Optimal behaviors, according to Mahrer, are transformative behaviors that can guide a person beyond the ordinary moment and reach a “higher plateau” (Mahrer, 2008, p. 17). In a sense, optimal behaviors are like creating opportunities to open doors to greater learning experiences, with the intention to bring about an extensive transformation in a way that person experiences the world.

According to Mahrer, “you can rehearse and modify what you are inclined to do... (become like)... try it out and modify it... until you are ready and eager to go ahead and do what you have rehearsed and modified” (Mahrer, 2008, p. 216) That is, those who incorporate optimal behaviours as a natural part of their “style of behaving” will express feeling good and content about their actions. Ultimately, the person moves to—

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ward a more unified objective of an integrative individual who is “becoming a different kind of person” (Mahrer, 1978, p. 471). In this way, unwanted long-time behavior has no further basis for existence and will gradually fade away. Mahrer saw this process of integration as an option for change that welcomed opportunities to set new goals, “an indication that something good and desirable is occurring” (p. 473).

Recognizing his influence on the field of psychotherapy, the man who introduced the phrase “to become the person you can become” appears to have envisioned a healthier psychology. He was not interested in bureaucratic games, but, rather, seriously dedicated to growth and realistic attainments. Although I have no statistical verification, I would venture to say that from his writings and discussions Mahrer probably “nudged” (a word he would often say) a growing interest in a psychology that was more positive in focus and minimized the older model of psychotherapy as the treatment of an illness. In 2010 he wrote, “I believe that our understanding of ourselves and our world is in its infancy and that we have barely begun to realize what we and our world can become” (Mahrer, 2010, p. 273). Once again Mahrer was challenging us to avoid complacency, and to continue forward and achieve what we should become.

On April 13, 2014, Dr. Mahrer died peacefully at home in Ottawa at the age of 86. He was a Professor Emeritus at the University of Ottawa where he started in 1978. In 1954, he graduated from Ohio State University with a doctorate in clinical psychology, and then went on to work at the VA Hospital in Denver. In 1967, he became Professor and Clinical Director at Miami University, Ohio, and later held similar positions at the University of Waterloo. Throughout his career, Dr. Mahrer received a number of awards and acknowledgments: In 1975, he was made a Fellow of the American Psychological Association. In 1992, he won the Award for Excellence in Research from the University of Ottawa to be followed in 1997 with the Distinguished Psychologist Award from the American Psychological Association, Division 29. In 2002, Dr. Mahrer won the Living Legend in Psychotherapy Award from the American Psychological Association, Division 29. In 2006, Dr. Mahrer was awarded the Rollo May Award for Pursuit of New Frontiers from the American Psychological Association, Division 32. Throughout his lifetime, Dr. Mahrer wrote over 300 journal articles and 24 books covering subjects related to psychotherapy research, his model of Experiential Psychotherapy, personality development, transformation, and philosophy of science. His last coming book is titled The Relativity of Psychological Things: Toward a Paradigm Shift in the Field of Psychotherapy, and will be published in early 2015.

References for this article can be found in the online version of the Bulletin published on the Division 29 website.
CALL FOR NOMINATIONS
DIVISION 29 EARLY CAREER AWARD

About the American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people’s lives.

APF encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the Division 29 Early Career Award
This program supports the mission of APA’s Division of Psychotherapy (Division 29) by recognizing Division members who have demonstrated outstanding promise in the field of psychotherapy early in their career.

Amount: One $2,500 award

Eligibility Requirements & Evaluation Criteria
Nominees should demonstrate and will be rated on the following dimensions:
• Division 29 membership
• Within 10 years post-doctorate
• Demonstrated accomplishment and achievement related to psychotherapy theory, practice, research or training
• Conformance with stated program goals and qualifications

Nomination Requirements
• Nomination letter written by a colleague outlining the nominee’s career contributions (self-nominations not acceptable)
• Current CV
• Nomination must be submitted as a single PDF document

Submission Process and Deadline

Please be advised that APF does not provide feedback to applicants on their proposals.

Questions about this program should be directed to Samantha Edington, Program Officer, at sedington@apa.org.
Patricia Keith-Spiegel’s new book, *Red Flags in Psychotherapy: Stories of Ethics Complaints and Resolutions*, provides an insider’s view of what happens when an ethics complaint is lodged against a psychologist. Keith-Spiegel is the ideal person to write such a book: She has been a member of the Ethics Committee of the California State Psychological Association and was also on the Ethics Committee of the American Psychological Association for over half a decade. Her vast experience has provided her with a wealth of stories, some of which left me shaking my head exclaiming, “You really can’t make this stuff up.” The stories Keith-Spiegel crafts attest to the ethical messes psychologists can make in the course of practice, and the difficult challenges we all face in our work with patients who are often vulnerable and challenging in all sorts of ways.

*Red Flags in Psychotherapy* begins with an explanation of the method Dr. Keith-Spiegel uses in her approach to teaching about ethics complaints and the work of an ethics committee. Instead of using the familiar case history method, she has chosen an expanded narrative non-fiction approach. The body of the book consists of stories about the ethics committee of the fictional League of California Psychologists over the course of a two-day period in which they will hear 13 cases that have been referred to the committee for potential ethics violations. The stories are primarily told from the point of view of the newest member of the ethics committee, who in the course of the two days comes to appreciate that most ethics complaints are not straightforward, and that multiple points of view exist among professionals as to what the threshold for ethical misbehavior might be. The stories Keith-Spiegel tells draw the reader in, both as a member of the profession, a potential offender, a potential member of the ethics committee, and as a member of the public. The method of narrative non-fiction invites the reader into a multiplicity of identifications, which is useful for deepening the reader’s reflection.

In the introduction, Dr. Keith-Spiegel opens with the acknowledgement that as humans we have an astonishing capacity to deceive ourselves or to rationalize our behavior in self-serving ways. In the course of her work on various ethics committees, Dr. Keith-Spiegel has had the opportunity to see patterns of behavior or specific contexts that set the stage for an ethics violation. Her capacity to translate the years of work she has had on the “inside” of ethics committees is an extremely useful contribution to the profession where often we are left to imagine or project into the ethics complaint process with little data beyond the few anecdotes or gossip that may come our way in the course of our professional lives. Most usefully, Dr. Keith-Spiegel is able to empathize with those psychologists who have the unhappy

*continued on page 42*
experience of having to appear before an ethics committee. Writing about the shame and stigma experienced by many psychologists who have an ethics complaint lodged against them, Keith-Spiegel effectively makes the case for a more compassionate response from colleagues.

In the introduction, Keith-Spiegel distills her years of experience and offers a taxonomy of red flags in psychotherapy that might alert practitioners that they are on a potentially slippery slope. The broad categories are: A desire on the part of the therapist for a different relationship from client/psychotherapist; rationalizing the acceptability of a contemplated boundary crossing or deviation from standard practice; concerns about personal ambition or financial gain; needs for enhancing one’s own self-esteem; expecting a client to fulfill the psychologists personal and social needs; fear of being rejected or a client terminating therapy, negative feelings toward a client; signs that the client is the more powerful individual in the relationship; personal life contaminating professional performance; and other general red flags. Under each of these categories, Dr. Keith-Spiegel gives examples of how the therapist may be engaged in these problematic dynamics.

In reading the introduction, I was reminded of the psychoanalyst James McLaughlin’s categories of understanding how enactments occur in psychoanalytic psychotherapy and believe these apply to the slippery slope of ethics violations (McLaughlin, 1991). McLaughlin notes that psychotherapists encounter “dumb spots” where they simply do not know something or are unable to recognize the trouble or respond appropriately to the patient; “hard spots” that occur when a therapist is rigidly adhering to a theory or a position and unable to take in new or shifting information from the client or context; and “blind spots” which occur when the therapist has an internal conflict that leads to sub-optimal or even unethical responses to the patient.

What I found difficult in Keith-Spiegel’s list is that many of the red flags as presented are the essential meat and potatoes of psychotherapy. I was left with the concern that negative countertransference and transference are seen simply as red flags rather than as potentially golden opportunities for the client to engage the presenting problem. I was concerned that the take home message in the cases presented is that it is the therapist’s job to keep the patient happy, and that when a patient is angry or upset it is a sign that the therapist should end the work or refer the patient elsewhere. This observation raised a red flag for me, namely that the book is an excellent ethics text but a relatively poor psychotherapy theory and technique manual, and the reader must be mindful of this distinction.

Each of the 13 case chapters follows a particular format: a description of the psychologist and the client’s presenting problem, a brief narrative about how an ethics violation was perceived by the client or member of the public or profession, the letter the psychologist receives from the ethics committee, the psychologist’s reaction to receiving the letter, the details and questions of the hearing with the ethics committee, and the deliberations and decision of the ethics committee. As in any good story, there is a brief follow up on how the psychologist and the client are reported to be doing. Most usefully at the end of each chapter there is a case summary and a well thought out discussion of the particular ethics issue embedded in the story. Finally, each chapter includes discussion questions, which are thought provoking and make this book a good graduate level text for

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the classroom. There are ample references at the end of each chapter, providing a rich source of information for students, teachers, or the interested reader. An appendix provides resources for various professional ethics codes or ethics boards. There is also an appendix summarizing the sanctions the Ethics Committee of the American Psychological Association may make, which demystifies the process for the reader.

The book successfully achieves its aims of creatively educating psychologists about the difficulties we may encounter in our work and the ethical dilemmas that challenge us to maintain an awareness of our ethical duties and responsibilities to clients, the public, and the profession. Yet, as a psychotherapist, I was also left feeling alarmed and sad about what I read. Most of the therapists described in the illustrative stories seem to have veered off course in fewer than 10 sessions with a patient. In one story, a therapist is working with an adult patient raped by her father as a child, and now has symptoms of anxiety and relationship problems. In the fifth session, this therapist feels that the patient has made significant progress and only needs three more sessions “to come to terms with the merciless actions her father forced upon her as a child” (p. 135). The ethics dilemma as presented by Keith-Spiegel in this chapter is that the therapist gets into a failed bartering agreement with the patient to pay for the remaining three sessions. Throughout the book one gets the sense that normative practice involves the profession as a whole accepting that eight sessions of psychotherapy will be fully sufficient to treat long-standing and significant problems. Of course the patients are aggrieved when the doctor buys into this sort of thinking.

Another concern I had about the portrayal of the fictitious ethics committee was an implied agreement in the committee’s deliberations that it is the job of the therapist to keep the patient calm, happy, and even-keeled, as if the emergence of the negative transference is an indication that something is wrong in the psychotherapy. Indeed, Gabbard (2003) suggests that it is the failure of the therapist to fully engage the negative transference that leads to such boundary disturbances. Therapists who are unable to work with the negative transference are likely to provide gratification in an attempt to sidestep the transference, and it is here that many of the fictional therapists seem to err. So while the book succeeds in its project as an ethics text, I am concerned that graduate students might get a superficial and simplistic view of what psychotherapy entails. Ethics entails decisions about how to pursue a course of right action. The trouble with many of the cases presented is that the therapists seemed plagued by a compulsion to act, and not act rightly—but act. Indeed, the book is action packed. Wisely the committee recommends that some of the therapists pursue their own course of psychotherapy—at a minimum of 10 sessions, again a scant number to work on some of the trouble presented. Supervision is less often spoken about in Red Flags as a way to help psychologists calibrate their ethical compass, although this may be a useful way of addressing issues of the novice therapist, the troubled therapist, or the lost therapist.

In any depth-oriented psychotherapy, irrationality in both participants may be part of the landscape. Hopefully we become curious about our reactions and develop the capacity for introspection and reflection rather than simply moving into action in our work with patients. In the ideal world, the therapist’s academic and clinical training, along with sufficient experience as a patient

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who has participated in personal psychotherapy in a deep way, will allow for sufficient awareness of these dynamics to maintain an ethical frame throughout the course of a psychotherapy career. But as we know, we often fall short of our ideals as individuals and as a profession. Keith-Spiegel is sensitive to the falling short dimension of practice and seeks to show through storytelling the various pathways to ethics trouble: lack of training, interpersonal conflict, trouble at home, or, in the rare case, frank sociopathy.

Psychotherapy immerses two participants in a world of conscious and unconscious meanings, at times strong affects are evoked in each participant, and transference and countertransference dynamics may challenge our ethical compass. Legendary psychotherapist Elvin Semrad characterized psychotherapy as “an encounter between a big mess and a bigger mess” (Shapiro & Carr, 1991, p.182). This pithy summary may not be what we want to hear about ourselves, but it serves as a warning to all therapists that we must attend to whatever messy areas we are likely to encounter within ourselves as we practice psychotherapy. Keith-Spiegel’s book Red Flags in Psychotherapy utilizes an engaging method of narrative nonfiction which, combined with the author’s real-world experience as a member of an ethics committee, makes the book compelling and useful. I recommend her book to psychologists who are curious about how ethics complaints unfold and what the process of an ethics committee looks like from the inside.

References for this article can be found in the online version of the Bulletin published on the Division 29 website.
BOOK REVIEW


Daniel Araoz, EdD, ABPP
Long Island University, NY

In her book *Solving Modern Family Dilemmas: An Assimilative Therapy Model*, Patricia Pitta gives us an encyclopedic text that is an excellent tool for the serious study of family therapy. Centered on the classic Bowenian approach, Pitta explains the contributions of many other schools “assimilating” or being integrated into the Bowenian approach to develop practical and effective modes of intervention. This is a comprehensive textbook for working with modern couples and families. Underlying much of her discourse is a subtle but important message that makes her theory and technique uniquely respectful and humane: The book’s title does not point to mental pathology. Pitta, joining other contemporary great minds like Allen Frances, focuses on normal people who are in the midst of normal human dilemmas and need assistance to resolve them.

She gives a history of the field of psychotherapy integration and describes fully how she formulated the Assimilative Family Therapy (AFT) model, the various approaches (psychodynamic, cognitive behavioral, communications, and other systems-based theories) included in the model, and how they can be used in an integrative fashion with the home theory (Bowenian Family Systems) to enable today’s clients and families to heal and thrive.

Pitta is also respectful of the client’s context and works to educate clients about the effect of their unique contexts on their perspectives and actions, promoting healing by enabling them to begin to envision their dilemmas in a different way. She shows the reader how to effectively tailor treatment to the family’s contexts. In applying a “contextual approach,” Pitta implicitly also adds herself—the therapist—as a contextual variable when regarding the present therapeutic context. This contextual approach purifies the working atmosphere, allowing the clinician to avoid many distortions and assumptions that often obfuscate work with families.

The book’s clinical case descriptions appear to view the family therapy “clients” as basically healthy, but caught by the many mysteries of relating to others—rather than as “sick” and diagnosable by default. This subtle stress makes a big difference in the treatment and its outcome. Pitta’s approach is emphatically personal, compassionate, and genuinely helpful. For each population she treats, she offers the reader an extensive literature review related to the type of family she is treating.

She applies the AFT model to working with a multitude of issues that one may face throughout the life cycle: the dilemmas of parenting children and teens; the differentiation process of a lesbian who wants to “come out” to her parents; a modern-day two paycheck couple caught in the throws of anger and disillusionment over managing the problems of working too much, spending too

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little time together as a couple, and sexual estrangement; and, finally, with a baby boomer stuck in the caretaking role to many generations and in the process losing herself.

This book is comprehensive, describing each concept with case examples and extensive research. A reader can comfortably learn how to do family therapy with the assimilative model that Pitta describes; she also supplies a multitude of references for anyone looking to further explore theories, concepts, case conceptualizations, interventions, and their applications and outcomes. This is a special book that will be of use to students and professionals alike as they learn to work more effectively with modern families by integrating numerous other approaches that help heal.

I find Dr. Pitta quite creative and humbly innovative as a family therapist. She teaches us how to guide the couple or family members to inner peace, effective communication, mutual satisfaction, and constructive living. She teaches the reader how to become an agent of change and healing.

NOTICE TO READERS

References for articles appearing in this issue can be found at the end of the on-line version of Psychotherapy Bulletin published on the Division 29 website.
CALL FOR FELLOWSHIP APPLICATIONS
DIVISION 29—PSYCHOTHERAPY

Bob Hatcher,
Chair, Fellows Committee

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

The APA Fellows Committee offers this summary of its expectations:

Fellowship is a special distinction for APA members who have received a doctoral degree in psychology or a related field from a regionally accredited institution and can show evidence of unusual and outstanding contributions in the field of psychology. Fellow status requires that a person’s work have had a national impact on the discipline beyond a local, state or regional level. A high level of competence or steady and continuing contributions are not sufficient to warrant Fellow status. National impact must be demonstrated.

Within this framework, the Division of Psychotherapy has specific criteria for election to the category of Fellow, which include:

• Attainment of the category of Member of The Division of Psychotherapy.
• Five years of qualifying experience in the field of psychotherapy.
• Demonstration of evidence of unusual and outstanding contribution or performance in the field of psychotherapy. Please see the division website for more details on Division 29’s criteria
  www.divisionofpsychotherapy.org/members/fellows

Fellowship Nominations
If you would like to nominate a colleague for Fellow status, please forward their name and e-mail address to the Division 29 Fellows Chair, Bob Hatcher, at rhatcher@gc.cuny.edu. The committee will review the nomination and contact the nominee as indicated.

Fellowship Applications
For APA members who are currently APA Fellows
We welcome self-nominations from current Fellows of APA. Simply send a letter describing your qualifications with reference to Division 29’s Fellows criteria (see www.divisionofpsychotherapy.org/members/fellows) along with a current CV to Bob Hatcher (rhatcher@gc.cuny.edu), the Fellowship committee chair. Your nomination will be reviewed by the Division 29 Fellows Committee and the Division 29 Executive Board, and you will be notified in the spring.
Deadline for submission is December 1, 2014.

Initial APA Fellowship Application
Division 29 warmly encourages its current members who are not APA Fellows to consider applying. Application is made through the APA Fellows Online Application Platform, which is accessed through APA’s excellent and informative website:  http://www.apa.org/membership/fellows/index.aspx

Clear, useful, and important instructions for the process may be obtained from this website, and directly at http://www.apa.org/membership/fellows/help-applicants.pdf

Most people find the application process to be easy and not time consuming!

Please notify the Division 29 Fellows Chair, Bob Hatcher, at rhatcher@gc.cuny.edu, prior to initiating your online application.

Deadline for submission is December 1, 2014.

For questions about the submission process, or for guidance and advice about the application and forms, please contact:

Bob Hatcher, Ph.D.
Chair, Division 29 Fellows Committee
rhatcher@gc.cuny.edu
Phone: 212-817-7029

Incomplete applications or applications submitted after the deadline cannot be considered for this year.

Fellowship Criteria
Division 29 Psychotherapy
Fellow status in APA is awarded to members in recognition of significant, outstanding, and lasting contributions to the profession of psychology. Division 29 is eager to honor those members of our division who have distinguished themselves by exceptional contributions to psychotherapy in a variety of ways to include researcher, psychotherapist, teacher/trainer, scholar, theorist, etc.

The minimum standards for Fellowship under APA Bylaws are:
1. The receipt of a doctoral degree based in part upon a psychological dissertation, or from a program primarily psychological in nature;
2. Prior membership as an APA Member for at least one year and a Member of the division through which the nomination is made;
3. Active engagement at the time of nomination in the advancement of psychology in any of its aspects;
4. Five years of acceptable professional experience subsequent to the granting of the doctoral degree;
5. Evidence of unusual and outstanding contribution or performance in the field of psychology; and
6. Nomination by one of the divisions in which member status is held.

Attaining Fellow status in Division 29 requires that the individual has achieved
national or international recognition from one’s colleagues for contributions to the field of psychotherapy.

Contributions may be through any of the following individually or in combination:

1. Excellence in Practice of Psychotherapy. Those who have demonstrated excellence in the practice of psychotherapy which is evident by national standing. This can include innovative models or programs of practice, applications of scholarship to programs of practice, publications that impact practice, training, etc.

2. Teacher/Trainer/Mentor. Those who have demonstrated excellence and a national reputation as a teacher, trainer, or mentor of psychotherapists, to include the development of innovative models with a wide ranging impact.

3. Scientific Work. Documented research in the area of psychotherapy or related areas that impact the practice of psychotherapy such as neuroscience, psychotherapy process, outcome, training, etc.

4. Theoretical and Treatment Advances. Those who have contributed to the field with the development of theory, methods, and techniques of psychotherapy.

5. Leadership, Advocacy, Scholarly Application. Those who have demonstrated leadership in the advancement of the art, science, and policy of psychotherapy or innovative programs of training, practice or administration.

Evidence of Criteria Used by Nomination Committee
The following are offered as examples of the range of activities that may be considered when being nominated for Fellow but are in no way to be considered exhaustive:

1. Published scholarly articles in professional journals that are considered important in the field.

2. Author of books and texts in the field of psychotherapy or related areas in that have important impact on the field of psychotherapy.

3. Demonstrated a high degree of involvement in the advancement of psychotherapy at the national level.

4. Developed a theory of psychotherapy that is widely considered important to the field.

5. Developed approaches to psychotherapy that are widely considered important to the field.

6. Produced innovations in the practice of psychotherapy such as models of practice that address novel problems or the needs of special populations in the delivery of mental health services.

7. Administered a novel or excellent program for training psychologists in psychotherapy or related areas.

8. Demonstrated evidence of service that is distinguished.

9. Demonstrated evidence of scholarly work that advances the field such as editor of an influential journal or special editions.

10. Made contributions that advance the status of psychotherapy as a healing art and science.

11. Exhibited excellence in serving as a mentor in the field.

12. Demonstrate a program of research that advances the field.
Lorna Benjamin, recipient of the Division of Psychotherapy Distinguished Psychologist Award, with President Ray DiGiuseppe

Mark Hilsenroth, recipient of the Division of Psychotherapy Distinguished Contributions to Teaching and Mentoring Award, with President Ray DiGiuseppe

Bruce Wampold, winner of the *Psychotherapy* Most Valuable Paper Award, with Ray DiGiuseppe, Publications Board Chair Jeff Barnett, and *Psychotherapy* editor Mark Hilsenroth

Zac Imel, recipient of the APF/Division of Psychotherapy Early Career Award, with President Ray DiGiuseppe

James Bowell, recipient of the 2014 Norine Johnson Psychotherapy Research Grant for $10,000, with President Ray DiGiuseppe

Jamie Bedics, one of the recipients of the 2014 Charles J. Gelso Psychotherapy Research Grants for $5000, with President Ray DiGiuseppe
Ashlee Warnecke, recipient of the Mathilda B. Canter Education and Training Student Paper Award, with President Ray DiGiuseppe and Student Representative Meg Tobias

Harold Chui, recipient of the Jeffrey E. Barnett Psychotherapy Research Student Paper Award, with Jeff Barnett, President Ray DiGiuseppe, and Student Representative Meg Tobias

Jackson Taylor, recipient of the Division 29 Diversity Student Paper Award, with President Ray DiGiuseppe and Student Representative Meg Tobias

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Meg Tobias, Student Development Chair, 2013-2014

Rod Goodyear, Program Chair, 2014
DIVISION 29 PSYCHOTHERAPY 
OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)

Call for Nominations

*Distinguished Psychologist Award*

The APA Division of Psychotherapy invites nominations for its 2015 *Distinguished Psychologist Award*, which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

**Deadline is January 1, 2015. All items must be sent electronically.** Letters of nomination outlining the nominee’s credentials and contributions (along with the nominee’s CV) should be emailed to the Chair of the Professional Awards Committee, Dr. Raymond DiGiuseppe, digiuser@stjohns.edu

Call for Nominations

*Division 29 Award for Distinguished Contributions to Teaching and Mentoring*

The APA Division of Psychotherapy invites nominations for its 2015 *Award for Distinguished Contributions to Teaching and Mentoring*, which honors a member of the division who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists.

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

1) a letter of nomination describing the individual’s impact, role, and activities as a mentor;
2) a vitae of the nominee; and,
3) three letters of reference for the mentor, written by students, former students, and/or colleagues who are early career psychologists. Letters of reference for the award should describe the nature of the mentoring relationship (when, where, level of training), and an explanation of the role played by the mentor in facilitating the student or colleague’s development as a psychotherapist. Letters of reference may include, but are not limited to, discussion of the following behaviors that characterize successful mentoring: providing feedback and support; providing assistance with awards, grants and other funding; helping establish a professional network; serving as a role model in the areas of teaching, research, and/or public service; giving advice for professional development (including graduate school postdoctoral study, faculty and clinical positions); and treating students/colleagues with respect.
Deadline is January 1, 2015. All items must be sent electronically. The letter of nomination must be emailed to the Chair of the Professional Awards Committee, Dr. Raymond DiGiuseppe, digiuser@stjohns.edu

**ROSALEE G. WEISS LECTURE AWARD**

The Rosalee G. Weiss Award is a joint award, bestowed by the Divisions of Psychotherapy and Independent Practice in alternate years and administered by the American Psychological Foundation (APF). It was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee. The award is administered by Division 29 and by Division 42 (Independent Practice) in alternating years.

The criteria for receipt of this award are as follows:
- Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology
- Outstanding leaders in any of the special areas within the spheres of psychology

Award recipients receive an $800 honorarium from the APF.

Deadline for nominations for this award should be submitted to Division 29 by January 1, 2015.

Questions about this award should be directed to the Chair of the Professional Awards Committee, Dr. Raymond DiGiuseppe, digiuser@stjohns.edu
REQUEST FOR NOMINATIONS
APF DIVISION 37 DIANE J. WILLIS EARLY CAREER AWARD

About the American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people’s lives.

APF encourages nominations from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the APF Division 37 Diane J. Willis Early Career Award
The APF Division 37 Diane J. Willis Early Career Award is named after Dr. Willis, to honor her life-long advocacy on behalf of children and families. Dr. Willis’s work cuts across many areas including clinical child, pediatric, developmental and family psychology. Through her publications, clinical work, and mentoring/teaching she has changed policy at the local, national and international level.

She has advocated for children’s rights at the United Nations, developed programs on prevention and early intervention for Native American children living on reservations, and established services promoting the wellbeing of children with developmental disabilities, chronic illness, and those who have suffered from maltreatment.

The APF Division 37 Diane J. Willis Early Career Award supports talented young psychologists making contributions towards informing, advocating for, and improving the mental health and well-being of children and families particularly through policy.

Program Goals
• The APF Division 37 Diane J. Willis Early Career Award
• Advances public understanding of mental health and improve the well-being of children and families through policy and service.
• Encourages promising early career psychologists to continue work in this area.

Funding Specifics: One $2,000 award

Eligibility Requirements
Applicants must be:
• psychologists with an Ed.D., Psy.D., or Ph.D. from an accredited university no more than 10 years postdoctoral

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Evaluation Criteria
Nominations will be evaluated on:
• Conformance with stated program goals and qualifications stated above
• Magnitude of professional accomplishment in advancing public understand-
ing of mental health and improves the well-being of children and families
through policy and service.

Nomination Requirements
• Nomination letter outlining the nominee’s career contributions
• Current CV
• Two letters of support
• Nomination must be submitted as a single PDF document

Submission Process and Deadline
Submit a completed application online at http://forms.apa.org/apf/grants/

Please be advised that APF does not provide feedback to grant applicants or award
nominees on their proposals or nominations.

Please contact Samantha Edington, Program Officer, at
sedington@apa.org with questions.

NOTICE TO READERS
References for articles appearing in this issue can be found
at the end of the on-line version of Psychotherapy Bulletin
published on the Division 29 website.

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PSYCHOTHERAPY BULLETIN

Psychotherapy Bulletin is the official newsletter of Division 29 (Psychotherapy) of the American Psychological Association. Published 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.

Contributors are invited to send articles (up to 2,250 words), interviews, commentaries, letters to the editor, book reviews, and announcements to Lynett Henderson Metzger, JD, PsyD, Editor, Psychotherapy Bulletin. All submissions for Psychotherapy Bulletin should be sent electronically to lhenders@du.edu with the subject header line Psychotherapy Bulletin; please ensure that articles conform to APA style. If graphics, tables or photos are submitted with articles, they must be of print quality and in high resolution. Deadlines for submission are as follows: February 1 (#1); May 1 (#2); August 1 (#3); November 1 (#4). Past issues of Psychotherapy Bulletin may be viewed at our website: www.divisionofpsychotherapy.org. Other inquiries regarding Psychotherapy Bulletin (e.g., advertising) or Division 29 should be directed to Tracey Martin at the Division 29 Central Office (assnmgmt1@cox.net or 602-363-9211).

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