Psychotherapy

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BULLETIN

In This Issue

Psychotherapy Integration
Integrating Mindfulness Into Different Approaches to Psychotherapy

Psychotherapy Research
What Does the Therapist Bring to the Relationship? The Connections Among Real Relationship, Countertransference and Attachment

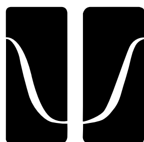
Education and Training
Starting a Pre-Doctoral Internship Consortium

Psychotherapy Practice and Education and Training
DSM-5 and the ICD-10: Clinicians Prepare Yourselves Clinical Educators Prepare Yourselves, Too!

Training and Education Perspective on DSM-5 and ICD-10

Ethics in Psychotherapy
Ethical Practice in Psychotherapy: Empirically Validating Ourselves

Diversity
Invisible Identities: Psychotherapy for Undocumented Immigrant Youth in College Counseling Settings



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CONTENTS

President's Column 2

Editors' Column 3

Psychotherapy Integration 6
Integrating Mindfulness Into Different Approaches to Psychotherapy

Psychotherapy Research 12
What Does the Therapist Bring to the Relationship? The Connections Among Real Relationship Countertransference and Attachment

Education and Training 17
Starting a Pre-Doctoral Internship Consortium

Psychotherapy Practice and Education and Training
DSM-5 and the ICD-10: Clinicians Prepare Yourselves 23

Clinical Educators Prepare Yourselves, Too! Training and Education Perspective on DSM-5 and ICD-10 27

Ethics in Psychotherapy....................30
Ethical Practice in Psychotherapy: Empirically Validating Ourselves

Division 29 Convention Program....................37

Diversity....................43
Invisible Identities: Psychotherapy for Undocumented Immigrant Youth in College Counseling Settings

Early Career....................47
Finding Good Mentoring: An Early Career Psychologist's Journey and Creation of Division 29's New Mentoring Program for ECPs

Student Feature....................57
Specialization in Infant Mental Health: Obstacles in Training Clinicians & Practice

Washington Scene....................62
Evolving Professions – Interesting Times

APA Council of Representative Reports 68

Student Section 71
La Migra

References 72

Member Application 80

PRESIDENT'S COLUMN

William B Stiles, Ph.D.
Glendale Springs, NC

I am looking forward to seeing as many of you as can make it at the 2013 APA Convention, July 31 – August 4 in Honolulu. This is Division 29's annual chance to meet face to face. Rod Goodyear, our Program Chair, has filled the 16 substantive hours allotted to us by APA with an outstanding program of symposia and posters. Note that the number of programming hours allotted to Division 29 at this convention was based on attendance by Division 29 members at last year's convention. If you come this year, we'll have more hours next year.

The full Division 29 program is listed within the pages of this issue of the *Bulletin*. Look at it carefully. You will see names you recognize as well as new names you will see again, addressing topics across the spectrum that is psychotherapy. As I said in my last column, this year Division 29 is celebrating the 50th anniversary of our journal, *Psychotherapy*. For the convention, Editor Mark Hilsenroth has organized a symposium entitled "Celebrating the 50th Anniversary of *Psychotherapy*—-Looking Ahead to the Next Decade of Research," with prognostications by some of the investigators likely to shape research in the next decade: Zac Imel, Henny Westra, Cheri Marmarosh, and Heidi Levitt. Come to room 302B in the Convention Center at 10am on Saturday morning.

Recognizing that convention attendees this year will want to take advantage of Honolulu's opportunities for recreation, APA put most substantive programming in the morning and early afternoon, so you will have free time after 2pm on most days. To accommodate this, the convention has been extended an extra day, beginning on Wednesday morning (July 31) rather than Thursday.

The big exception to no programming in the afternoon is Saturday afternoon, when Division 29 will hold a special three-hour gathering in Honolulu Suite II at the Hilton Hawaiian Village Beach Resort. We will begin at 4pm with a symposium on the "History and Future of Division 29," organized by Libby Williams, with contributions by Matty Canter, Gerry Koocher, Linda Campbell, and Ray DiGiuseppe. This will be followed at 5pm by the annual Awards Ceremony, at which we will honor some of our members' significant achievements. And no later than 6pm, we will begin our Social Hour, which will celebrate the journal's golden anniversary and give us all a chance to talk with our Division 29 colleagues. It will be a good party. Y'all come.

EDITORS' COLUMN

Lavita Nadkarni, Ph.D.
Lynett Henderson Metzger, Psy.D., J.D.
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We are very excited that this issue is so full of thought provoking and enjoyable articles that we are only able to fit in a short paragraph from the editors. This *Bulletin* issue includes two features on DSM-5 and ICD-10, nicely timed to coordinate with the release of DSM-5. We also know you will enjoy an important article on integrating mindfulness into treatment, a helpful piece on the "real" therapeutic relationship, a thoughtful submission on psychotherapy for undocumented immigrant youth, and an informative feature on one program's creation of a pre-doctoral consortium internship. In addition, as always, you will find it interesting to read the President's column, the Washington Scene, and the APA Council of Representatives Report. Take a moment to also read this issue's Early Career submission-mentorship at its best-and information on Division 29's new mentoring program for Early Career Professionals! As one of the goals of the *Bulletin* is to offer an exchange of information about psychotherapy, it is with pleasure that we offer an article on training and practice needs for a specialization in infant mental health. Information on the upcoming APA Convention is included in this issue. Looking forward to seeing you in sunny Hawaii!

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Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

CONGRATULATIONS TO THE DIVISION 29 2013 GRANT RECIPIENTS

The Norine Johnson Psychotherapy Research Grant for $10,000 was awarded to Joshua Swift, Ph.D. and Jennifer Callahan, Ph.D. for their proposal: Improving Psychotherapist Effectiveness through Mindfulness Training.

Joshua K. Swift, Ph.D. is an Assistant Professor in the Psychology Department at the University of Alaska Anchorage. He earned his Ph.D. in Clinical Psychology from Oklahoma State University and completed his pre-doctoral internship at SUNY Upstate Medical University. His research interests include the areas of premature termination, client expectations and preferences, and therapist effects. As an early career psychologist he has published over 25 peer-reviewed journal articles and has received a number of local and national awards, including the Donald K. Freedheim Student Development Award (2008) and the Distinguished Publication of Psychotherapy Research Award (2012) from the Division. Outside of work he enjoys spending time with his wife and four children (#5 is due in November) enjoying the beauties of Alaska.

Jennifer L. Callahan, Ph.D., ABPP (Clinical) is an Associate Professor in the Department of Psychology at the University of North Texas (UNT). She earned her Ph.D. in Clinical Psychology from the University of Wisconsin-Milwaukee and completed her pre-doctoral internship and post-doctoral fellowship at Yale University School of Medicine. Her research interests span the psychotherapy and assessment domains, with particular attention to advancing the empirical study and practice of doctoral training in these areas for the purpose of fostering progressively higher levels of competency among trainees as they emerge into the profession. She is currently Chair-elect of the Div 29 Educ and Training Committee and serves as the Director of Clinical Training of the Clinical program at UNT.

The Charles Gelso Psychotherapy Research Grant was awarded to Jenelle-Slavin-Mulford, PhD for her proposal: Trainee Therapist Characteristics related to therapeutic Alliance and Technique.

Jenelle Slavin-Mulford, Ph.D. is an early career psychologist. She received her bachelor's degree from Middlebury College where she graduated as salutatorian of her class in 2004. She then received her Ph.D. in clinical psychology from the Derner Institute of Advanced Psychological Studies at Adelphi University in 2011. Her clinical internship and postdoctoral fellowship were both completed at The Massachusetts General Hospital/Harvard Medical School where she specialized in psychotherapy and personality assessment with adult populations.

Dr. Slavin-Mulford is currently an Assistant Professor of Psychology at Georgia Regents University. At Georgia Regents, she devotes her energy to teaching, clinical

continued on page 5

supervision, and research. This past year, she was nominated for the campus wide *Caught in the Act of Great Teaching Award* and was honored with the *Best Graduate Faculty Award* in the department of psychology.

Dr. Slavin-Mulford's research interests include personality assessment, training/supervision, and psychotherapy process and outcome. She has several peer-reviewed journal articles in these areas and currently serves on the editorial board of the American Psychological Association journal *Psychotherapy.* Her research as also been honored with three awards from the APA's Division of Psychotherapy (29). Specifically, she won the Mathilda B. Canter Student Education and Training Award in 2008 and the Donald K. Freedheim Student Development Award in 2011. Most recently, she has been awarded the Charles J. Gelso Early Career Psychotherapy Research Grant for her project "Trainee Therapist Characteristics Related to Therapeutic Alliance and Technique." She is grateful to Division 29 and excited to continue conducting psychotherapy research.

The Inaugural Division 29 Diversity Research Grant has been awarded to Ms. J. Alexis Ortiz at the University of New Mexico for her dissertation: Bridging the Gap: A Comparison of Adapted and Standard Version of Mindfulness-based Stress Reduction with Latino Populations.

J. Alexis Ortiz is a doctoral candidate in the Clinical Psychology Ph.D. program at the University of New Mexico. She was born in San Jose, California, and has lived in Mexico, Japan, and Taiwan. She received her Bachelor's degree in Psychology from the University of Michigan and her Master's degree in Psychology from the University of New Mexico.

Alexis' primary research and clinical interests focus on stress, coping, mindfulness and effects on health and health inequities, particularly in Latino populations. Clinically, Alexis has sought out opportunities to complete much of her training with underserved populations. She feels very fortunate to be a Ford Foundation, APA/SAMHSA, and Robert Wood Johnson Foundation Fellow.

Alexis' dissertation project is entitled "Bridging the Gap: Adapting Mindfulness-based Stress Reduction for Latino Populations." Her research study seeks to improve retention, accessibility, and effectiveness of this health-promoting intervention in underserved Latino populations. She is extremely grateful for the support of APA Division 29 and being named a 2013 recipient of the Diversity Research Grant.

PSYCHOTHERAPY INTEGRATION

Integrating Mindfulness into Different Approaches to Psychotherapy

Carol R. Glass, Ph.D., Diane B. Arnkoff, Ph.D., Scott C. Woodruff, M.A., David D. Maron, M.H.S., Katherine E. McMorran, M.A., Maureen F. Monahan, B.A., and Elizabeth W. Hirschhorn, M.A.
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Mindfulness can be defined as the process of being fully aware of one's present-moment experience and paying attention purposefully without judgment (Kabat-Zinn, 1994). Over the past several decades since the introduction of Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990), this concept has received an increasing amount of attention in the field of psychology, and in recent years interest in mindfulness has grown exponentially (see Baer, 2003; Bishop et al., 2004; Wallace & Shapiro, 2006). Although mindfulness interventions have been used as an adjunct to psychotherapy (Weiss, Nordlie, & Siegel, 2005), integrating mindfulness into psychotherapy, especially cognitive behavioral approaches, has received the most attention. There has also been some interest in the integration of mindfulness into other psychotherapy orientations. Mindfulness can additionally be seen as an important common factor in psychotherapy change (Martin, 1997).

Thus, the purpose of this article is to discuss the integration of mindfulness into clinical practice across all major theoretical orientations (CBT, psychodynamic, humanistic, and family systems), and to spur interest in new directions. Issues we will focus on include: (1) How have mindfulness and acceptance-based interventions been integrated into different approaches to therapy? (2) What aspects of mindfulness share common factors with the theories and methods of different theoretical orientations? (3) How can therapists' mindfulness contribute to the process of psychotherapy as well as to their own enhanced well-being?

Cognitive Behavioral Therapy
Reviews of mindfulness-based treatment approaches (e.g., Baer, 2006) focus almost exclusively on treatments with cognitive behavioral foundations, and the integration of mindfulness and acceptance into cognitive behavioral therapy (CBT) has been heralded as the "third wave" of behavior therapy (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004). Within mindfulness and acceptance-based cognitive behavioral therapies, the focus on awareness and non-judgmental acceptance of thoughts, sensations, perceptions, and emotions offers an alternative to traditional goals of CBT such as modified behavior and explicit change in cognitions. Cognitive behavioral treatments incorporating mindfulness (see Herbert & Forman, 2011) include Dialectical Behavior Therapy (Linehan, 1993), Acceptance

continued on page 7

and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011), and Mindfulness-Based Cognitive Therapy for depression (Segal, Williams, & Teasdale, 2012).

Although CBT largely targets the *content* of thoughts and feelings, mindfulness and acceptance-based therapies focus on a person's *relationship* or reaction to his or her thoughts, emotions, and behavior (Brady & Whitman, 2012; Forman et al., 2012). By taking a third-person perspective, clients learn to objectively observe their thoughts and non-judgmentally accept them for what they are, a process called "decentering" (Greeson & Brantley, 2009). However, some argue that CBT and mindfulness approaches may be less different than they seem; for example, "decentering" has been likened to the idea of "distancing" in conventional CBT (Hofmann, Glombiewski, Asnaani, & Sawyer, 2011). Research on mediators of change in therapy supports this similarity, as Arch and Craske (2008) found that cognitive defusion, a construct analogous to decentering, mediated therapeutic gains in both ACT and CBT. Separating oneself from the cognitive process links CBT with mindfulness and acceptance-based therapies.

In addition, exposure therapy is consistent with mindfulness-based approaches (Hayes & Wilson, 2003; Meuret, Twohig, Rosenfield, Hayes, & Craske, 2012). For example, in exposure therapy for anxiety disorders, clients learn to confront negative thoughts and feelings with acceptance and defusion that results in a reduction in the intensity of these feelings over time (Arch, Wolitzky-Taylor, Eifert, & Craske, 2012; Kumar, Feldman, & Hayes, 2008). The expectation is that prolonged exposure to panic-related symptoms without catastrophic consequences will desensitize patients to these feelings, and eventually the feared stimulus will no longer be threatening (Baer, 2003). In practices such as identifying and acknowledging cognitions, observing thoughts, and purposely experiencing or exposing an individual to his or her own disturbing internal experiences, mindfulness-based approaches to therapy can be found within the CBT framework, just as CBT is apparent in certain mindfulness applications (Heimberg & Ritter, 2008).

Psychodynamic Therapy

Not surprisingly, there is a longer history of views about Buddhist ideas in psychodynamic writings. Donning the colorful pseudonym "Joe Tom Sun" (1924), analyst Joseph Cheesman Thompson penned one of the earliest known pieces comparing Buddhist and psychoanalytic thought. In it, he described several areas of overlap, including a transference-like concept within Buddhism and connections between free association and meditation (Epstein, 1990). On the whole, however, early influential psychoanalytic thinkers were skeptical of Eastern practices and meditation (Cooper, 1999). Limiting much of their attention to the concentration practices alone, numerous figures connected the changing consciousness of meditation with a return to near-birth experiences (Epstein, 1990).

Freud's (1930/1961) understanding of meditative states prompted his famed comments on the "oceanic feeling," a religious experience aimed at the "restoration of limitless narcissism" (p. 20). While Alexander (1931) acknowledged that Buddhism and psychoanalysis both seek to rise above affect, improve recognition, and spur the individual to break free of repetitive patterns, he dismissed meditation as "artificial catatonia" (Cooper, 1999). Jung (1936/1969) was more positive toward Eastern practices themselves. Yet he cautioned Westerners against using them and feared the West-

continued on page 8

ern cultural framework would spur misuse, possibly resulting in even further repression of the unconscious (Rubin, 1992).

The intervening decades have brought a change of heart. As insight practices have become better known, the potential facilitative role of mindfulness has been highlighted through the benefits of open, focused attention (Martin, 1997). Psychodynamic writers have acknowledged similar overlap between mindfulness and mentalizing, or a person's ability to recognize the role of internal thoughts and feelings with respect to overt behavior (Davis & Hayes, 2011). By generating awareness of and nonjudgment toward mental states, insight meditation may create the preconditions for mentalization, if not directly promote it (Allen, 2008). Similarly, Neo-Freudian analysts such as Horney and Fromm argued for the benefits of adjunctive practice after developing interests in Zen (Cooper, 1999). A small study testing meditation concurrent with long-term dynamic-explorative therapy found that clients reported pronounced symptom improvement during the structured meditation intervention (Kutz et al., 1985). Therapists observed the same, as well as a marked increase in client insight.

However, the potential benefits of mindfulness are not limited to clients. Parallels can be found between mindfulness practice and a therapist's "evenly hovering attention" that Freud (1912/1959, p. 324) advocated and the "wholeheartedness" that Horney (1951/1999, p. 187) discussed (Mace, 2008). Multiple writers have proposed that meditation practice can make the clinician more effective inside the therapy room by promoting greater concentration in the moment, increased accessibility to subtle processes, and the cultivation of attention that is capable of healing in itself (Coltart, 1993; Cooper, 1999; Epstein, 1996; Mace, 2007). There is some evidence supporting this idea, as trait mindfulness and participation in a mindfulness intervention have been linked to greater therapist empathy and perspective-taking (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo., 2007; Shapiro, Schwartz, & Bonner, 1998). Thus, despite initial skepticism, there is reason to believe mindfulness practice may enhance the therapeutic process in multiple ways.

Humanistic Therapy

A small number of articles suggest that mindfulness is compatible with a humanistic or person-centered approach (Anderson, 2005; Deatherage, 1975). Humanistic psychology emphasizes personal transformation through self-awareness and acceptance, which strongly parallels important principles of mindfulness-based therapeutic approaches. Two common themes emerge across humanistic approaches: increasing awareness and integrating experiences, and helping clients experience themselves as "feeling/being" rather than "thinking/doing" (Rosenbaum, 2009).

The emphasis on awareness and present-moment processing in humanistic therapy coincides with the exploration of bodily sensations and awareness of internal experience that characterize contemporary mindfulness-based therapies (Kabat-Zinn, 2003). In Gestalt and somatic therapies, techniques focus on increasing awareness of thoughts and sensations in an exploratory and nonjudgmental way (Perls, Hefferline, & Goodman, 1972). As in contemporary mindfulness approaches, Gestalt "here and now" exercises and experiments also help the client focus on present internal experiences and allow emotional content to be recognized. Developing awareness of one's awareness is another common thread in humanistic and

continued on page 9

mindfulness-based approaches (Perls et al., 1972; Rosenbaum, 2009).

Additionally, the client's acceptance of his or her own emotional experience is common ground for mindfulness and humanistic approaches. In emotion-focused therapy, Greenberg (2011) posits that psychotherapeutic change is "facilitated first by acceptance [of emotion]…rather than by direct efforts to deliberately change or achieve a specific goal" (p. 67). Similarly, ACT targets the dysfunctional process of experiential avoidance, in which people attempt to control or alter internal experience (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Frankl (1967) encouraged his patients in logotherapy to accept their symptoms rather than flee from or fight them, as a means to detach themselves from negative emotional experiences. The Gestalt approach also holds that there is no type of experience that must be rejected or avoided; awareness and integration of experience are seen as the keys to improving psychological health (Perls et al., 1972).

Researchers have also highlighted the importance of the therapist's own practice of mindfulness (Lazar, 2005). This aligns with the humanistic perspective that the therapist's accepting presence, deep awareness, and focused attention are critical to the therapeutic process (Dryden & Still, 2006). For example, in person-centered therapy (Rogers, 1951), *unconditional positive regard* involves the therapist's capacity for acceptance and the ability to note any judgmental or critical reactions. *Empathic understanding*, another core condition, is acquired through "intense, continuous and active attention to the feelings of the other, to the exclusion of any other type of attention" (Raskin, 2005, pp. 6-7). *Congruence* requires the therapist to be aware of and willing to represent his or her own present-moment feelings about the client (Baldwin, 1987). Thus, the humanistic therapist's ongoing striving to accept clients as they are parallels the client's efforts in mindfulness and acceptance-based therapies to accept their experience without trying to change it (Hayes et al., 1996).

Family Systems Therapy

Family systems therapy served as a paradigm shift away from individual psychotherapy by directing the focus of treatment to the family instead of the individual client. Therapists become an involved member of the family's interpersonal processing, playing both supportive and challenging roles to each member. This requires the therapist to shift quickly between each member emotionally while attending to distinct family interaction patterns (Goldenberg & Goldenberg, 2013). It seems clear that mindfulness, involving paying attention to the present moment non-judgmentally (Kabat-Zinn, 1994), can serve as a useful therapeutic tool for both clients and family systems therapists.

The integration of mindfulness techniques into family systems therapy has increased rapidly over the past decade (Harnett & Dawe, 2012). This burgeoning field has developed mindful models for parenting (Duncan, Coatsworth, & Greenberg, 2009a), parent training programs (Dumas, 2005; Singh et al., 2009), and mindfulness guides for families and therapists (Higgins-Klein, 2013; Napoli, 2011). Initial studies have been conducted to assess the feasibility of integrating these mindfulness modalities, with reasonable success (Altmaier & Maloney, 2007; Duncan, Coatsworth, & Greenberg, 2009b). These interventions have shown, at least initially, to be beneficial to families with children at different developmental stages, including the neonatal period (Duncan & Bardacke, 2009), infants (Reynolds, 2003), children

continued on page 10

and adolescents (Dumas, 2005), along with clinical populations (Singh et al., 2009).

Couple therapy has also begun to incorporate mindfulness approaches clinically (Gehart, 2012), and research suggests that mindfulness may predict relationship satisfaction and reactions to conflict (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007; Pruitt & McCollum, 2010). It has also been suggested that mindfulness can help clients in couple or family therapy to relate differently to loss and trauma in interpersonal relationships (Gehart & McCollum, 2007). An intervention called mindfulness-based relationship enhancement was found to improve relationship satisfaction and decrease psychological distress, with the amount of mindfulness practice related to the extent of gains (Carson, Carson, Gil, & Baucom, 2004, 2006). Effective interventions such as integrative behavioral couple therapy (Christensen et al., 2004), which focus on emotional acceptance of upsetting behaviors, are consistent with mindful acceptance and non-judgmental awareness.

Future research directions on integrating mindfulness into family systems approaches include examining mechanisms of change (Harnett & Dawe, 2012). As in other approaches to therapy, the focus on mindfulness in family systems therapies will undoubtedly continue to grow (Cohen & Semple, 2010).

Conclusions and Future Directions

In reviewing these four approaches to psychotherapy, clear mindfulness themes emerge from theory, cut across orientations, and provide insight into this "common factor" (Martin, 1997). First, there is a collective emphasis on mindfulness on the part of the *therapist* in the form of steady *attention*, continuous *awareness*, and *acceptance and non-judgment* of the client and experiences in session. Mindfulness-based interventions for therapists in training have been associated with decreases in stress, anxiety, and rumination, along with increases in trait mindfulness, positive affect, and self-compassion (Shapiro, Brown, & Biegel, 2007). The therapist's ability to embody these internal conditions in therapy can result in the creation of a space in which the client can benefit, no matter how this benefit is defined by disparate theories. This is consistent with Bruce, Manber, Shapiro, and Constantino's (2010) notion of *attunement* as a benefit of therapists' mindfulness. By being more attuned to themselves, therapists are better able to understand and connect both with themselves and their clients, resulting in clients being more attuned to themselves, feeling that they are understood in the mind of the therapist, and experiencing reduced symptoms and positive therapeutic outcomes. Mindfulness on the part of the *client* is another recurring presence in the theoretical orientations that have been reviewed here. In all of these approaches to therapy, clients are encouraged to bring *awareness* and *attention* to their internal experiences and external behavior in order to uncover the source of their dysfunction, observe their dysfunction as distinct from their core self, and/or focus on the "here and now" of their direct experience in treatment. Like their therapists, clients are simultaneously challenged to not repress, avoid, deny, or shun the negative experiences that arise within or that play out in their behavior. Instead, they are taught to be *accepting* of the process while still being hopeful that there is room for change.

Future directions include investigating whether actively incorporating mindfulness-based exercises and techniques into sessions (or prior to treatment) could

continued on page 11

add to, detract from, or have no impact on the effectiveness of therapy. This research would have significant implications for therapists in training. Finally, some have suggested that the present rush towards integration overlooks many of the unique and rich facets of meditation and its underlying philosophies (Grossman, 2008; Walsh & Shapiro, 2006). Thus clinicians and researchers need to be open to more complex or nuanced understandings of mindfulness, in order to deepen psychotherapy process and improve outcomes across different theoretical orientations.

References for articles can be found starting on page 72.

NOTICE TO READERS

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

What Does the Therapist Bring to the Relationship? The Connections Among Real Relationship, Countertransference, and Attachment

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It has been empirically demonstrated that the therapeutic relationship has "healing qualities" (Norcross & Lambert, 2011, p. 4) and is a key factor in the success or failure of psychotherapy. Although the global therapeutic relationship has been found to be important, it is equally important to study what composes this global relationship, and how these elements relate to one another. Based on Greenson (1967), Gelso and his colleagues have proposed that the therapeutic relationship consists of three constituents: the working alliance, the transference-countertransference configuration, and the real relationship. These interdependent components are thought to be present in therapies of all orientations and durations (Gelso & Hayes, 1998; Gelso & Samstag, 2008). The present study focuses on the relationship between two of these components, the real relationship and countertransference, as well as their association with a third relational variable, therapist attachment. All variables are examined from the perspective of the therapist.

The least studied of the three aforementioned constituents is the real relationship. This element may be defined as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, 2011, p. 12). According to Gelso, the real relationship has two components, realism (experiencing and perceiving the other as the other is) and genuineness (being who one is; not being fake). Studies have shown a positive relation between strength of the real relationship and outcome (e.g., Gelso et al., 2012; Lo Coco, Gullo, Prestano & Gelso, 2011; Marmarosh et al., 2009). The real relationship has also been related to working alliance and transference. However, no published study to date has related real relationship and countertransference.

Countertransference can be defined as "the therapist's internal and external reactions that are shaped by the therapist's past or present emotional conflicts or vulnerabilities" (Gelso & Hayes, 2007, p. 25). Therapist's reactions can be useful when they inform his or her work (Gelso & Hayes, 2007). However, when acted out, these reactions are likely to be a hindrance (see meta-analysis by Hayes, Gelso, & Hummel, 2011). Because countertransference that is acted out in the session can be so damaging, an inverse relation between real relationship and countertransference behaviors has been theorized (Gelso & Hayes, 2007). Research has indeed demonstrated a negative relationship between countertransference behavior in a session and the working alliance, a close theoretical cousin to the real relationship. Thus, Ligiéro and Gelso (2002) found that the working alliance between a therapist-trainee and a client (rated by

continued on page 13

therapist-trainees and their supervisors) was negatively related to negative countertransference. Also, the bond subscale of the working alliance scale rated by supervisors was negatively related to positive countertransference.

Ligiéro and Gelso (2002) included a third variable in their research: Attachment style, which can be understood as a "person's characteristic ways of relating in intimate caregiving and receiving relationships with 'attachment figures,' often one's parents, children, and romantic partners" (Levy, Ellison, Scott, & Bernecker, 2011, p. 193). In Ligiéro and Gelso's study, therapists' attachment styles did not relate to working alliance or countertransference. However, Fuertes et al. (2007) found that therapists' rating of the real relationship was negatively related to therapists' attachment avoidance.

The present work focuses on the relationships among therapist-trainees' real relationship with a client as rated by the trainees and supervisors, therapist-trainees' attachment, and countertransference behaviors as rated by supervisors. Based on clinical theory (Gelso, 2011; Gelso & Hayes, 2007) and research (Ligiéro & Gelso, 2002), we hypothesized (1) a negative correlation between therapist-trainees' rating of the real relationship and supervisors' rating of negative countertransference behavior; (2) that supervisors' rating of the real relationships established by the trainees with their clients would be negatively correlated to the supervisors' rating of both therapists' negative and positive countertransference behaviors; (3) that the greater the attachment security of the trainee, the stronger the real relationship as rated by both the therapist trainee and his or her supervisor; and (4) that security of attachment would be negatively related to countertransference as rated by supervisors.

Method

Participants. Participants were 48 students from three Eastern and Mid-Atlantic Universities, and their clinical supervisors (*n* =40). Thirty-six trainees were in counseling psychology doctoral programs, 11 in clinical psychology doctoral programs, and one was in a master's in counseling program. All had completed at least one graduate level psychotherapy practicum.

Student trainees. Thirty-seven of the 48 trainees were females (average age = 28 years) Racially, 64.6% was Caucasian, 20.8% Asian, 14.6% Black, and 4.2% marked other (could mark more than one). Eleven participants (22.9%) stated bachelor's as the most advanced degree, and 37 (77.1%) had a master's degree. Trainees reported 3.3 years of clinical experience on average (range: 1-10). Trainees rated their theoretical orientation on a scale from 5 (Strongly Representative) to 1 (Not at all), and mean ratings were: Humanistic/Experiential theory 3.48 (*SD* = 1.3), Psychodynamic/Psychoanalytic theory 4.08 (*SD* = 1.1), Cognitive/Behavioral theory 3.10 (*SD* = 1.3), Systemic theory 2.25 (*SD* = 1.1), and Other 2.4 (*SD* = 1.6).

Supervisors. Thirty-two of the 40 supervisors were females (average age = 43 years, ranging from 27 to 69). Racially, 87.5% of supervisors were Caucasian, 5% Asian, 5% Black, and 2.5% marked other. Considering last degree, one supervisor indicated M.A./ M.S. (2.5%), three M.S.W. (7.5%), and 36 Ph.D. or Psy.D. (90%). On average, the years of clinical experience were 15.10 (range: 2 to 42), and the average of years providing supervision was 10. Considering theoretical perspective, the average representativeness for Humanistic Experiential theory was 3.5 (*SD* = 1.1), for Psychodynamic/Psychoanalytic theory,

continued on page 14

3.9 (*SD* = 1.3), for Cognitive/Behavioral theory, 3.4 (*SD* = 1.0), for Systemic theory, 2.8 (*SD* = 1.2), and for Other, 2.25 (*SD* = 1.5).

Measures.

Experience in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998). It is a 36-item self-report measure, with items rated on a 7-point scale (1 = *disagree strongly*, 7 = *agree strongly*). It assesses two dimensions of adult romantic attachment: Anxiety (18 items, e.g., "I worry about being alone") and Avoidance (18 items, e.g. "I prefer not to show a partner how I feel deep down"). The ECR was used to assess trainees' attachment security within adult romantic relationships. Following previous studies (e.g., Moore & Gelso, 2011), attachment security was calculated by first adding the anxiety and avoidance scores. Then, the inverse of this additive combination was taken to calculate degree of security (higher scores reflected higher attachment security). Scores from the ECR have shown adequate validity and reliability in previous studies (e.g., Brennan et al., 1998; Fuertes et al., 2007).

Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). This 21-item measure was used by supervisors to assess trainees' countertransference behaviors. Items are rated on a 5-point Likert scale, ranging from 1 (*to little or no extent*) to 5 (*to a great extent*). The higher the score the more countertransference behaviors are displayed and thus perceived by the rater. The measure yields three scores of countertransference behavior: positive (e.g., "Talked too much in session"), negative (e.g., "Was apathetic toward the client in session"), and overall. The ICB has demonstrated adequate convergent and face validity. Friedman and Gelso (2000) reported alpha coefficients of .83 for the total subscale, and of .79 for each subscale.

The Real Relationship Inventory-Therapist Form (RRI-T; Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa & Hancock, 2005). The RRI-T measures therapist's evaluation of the real relationship established with a client. It is a 24-items self-report measure that has two subscales: Realism and Genuineness. The RRI-T has shown adequate convergent and discriminant validity. The alpha coefficient values obtained by Gelso et al. were Realism = .79, Genuineness = .83, and Total score = .89.

The Real Relationship Inventory-Supervisor Form (RRI-S). The RRI-S was developed for this study, and is based on the RRI-T. It is a 24-item measure, evaluating the real relationship between a supervisee and a client as perceived by the trainee's supervisor. RRI-T items were rephrased to reflect the items from an observer's perspective. The authors of this study [one whom is the senior author in the Real Relationship-Therapist reference, and has extensively theorized about and studied the real relationship (Gelso, 2011)] reworded the items. Then, four counseling psychology Ph.D. students completed the RRI-S, providing suggestions that were incorporated for a final version.

Trainees and supervisors also completed a demographic questionnaire. Finally, the Alpha coefficients for all the scales and subscales in this study ranged from .68 to .95.

Procedures. Therapists in training from three universities were invited to participate via personalized email. The email included a brief description of the study, and trainees were asked to discuss the study with their supervisors. They were also asked to reply if the supervisor agreed to participate, and were told that both would need to identify a client to

continued on page 15

keep in mind when completing the study's measures (i.e., the first client scheduled to meet with the trainee after the conversation about the study with the supervisor, who attended at least three sessions, and was discussed in depth in supervision). If both members of the dyad agreed to participate, they were sent separate emails, with a link to the measures. A total of 135 trainees were invited to participate. From these, 35 replied that they would not participate, and 38 never replied. Sixty-three trainees agreed to participate and asked their supervisors. From these, 48 dyads completed the measures. Finally, an average of four emails were sent to the trainees.

Results

Descriptive data (including means, standard deviation, internal consistency, and correlations) for each measure and its subscales were calculated and are available from the first author upon request. When testing for normality of the data, it was found that, as in other studies, the measure of countertransference was positively skewed. Following Tabachnick and Fidell (2007), we transformed the data. However, even after transformation, the data were still positively skewed. Therefore, correlations including the countertransference measure were calculated using Spearman's Rho, a non-parametric test that can be used when there is violation of the assumptions of parametric statistics.

As predicted, there was a negative significant correlation between real relationship as rated by the trainees and negative countertransference ($r_S(46) = -.281$, $p = .026$). The second hypothesis was partially supported. As expected, there was a negative significant correlation between real relationship as rated by the supervisors and negative countertransference ($r_S(46) = -.375$, $p = .004$). However, no relationship was found between real relationship from the supervisor's perspective and positive countertransference. Contrary to expectations, attachment security did not relate either to real relationship ratings of therapist trainees or supervisors, or to countertransference.

In order to have a nuanced look at the obtained correlations, we decided to conduct post-hoc analysis considering the measures' subscales. Even though this was an exploratory study, we decided to apply a Bonferroni correction to avoid Type I errors. Thus, significance was set at the .004 level. Results showed that the realism subscale of the therapist's ratings of the real relationship was negatively correlated to positive ($r_S(46) = -.377$, $p = .004$), negative ($r_S(46) = -.406$, $p = .002$), and overall countertransference ($r_S(46) = -.481$, $p = .000$). Supervisor's ratings of the real relationship showed that the genuineness subscale was negatively related to negative countertransference ($r_S(46) = -.464$, $p = .000$).

Discussion

Real Relationship and Countertransference. As theorized, a negative relationship emerged between both trainee-rated and supervisor-rated real relationship and supervisor-rated negative countertransference behavior. Post-hoc analysis showed that considering the trainees' ratings of real relationship, the realism subscale seemed to be driving such results. Countertransference reflects therapists' unresolved conflicts and vulnerabilities (Gelso & Hayes, 2007). Such personal reactions might make it harder to see a client in ways that befit her or him (i.e, realism), which might translate into a weaker real relationship with the client.

Contrary to our expectation, supervisors' ratings of the real relationship were not negatively related to trainees' posi-

continued on page 16

tive countertransference. One could speculate that supervisors might be more attuned to negative countertransference than positive. Supervisors, for example, might be considering behaviors like befriending a client (one of the positive countertransference items) as a sign of support and miss the countertransferential aspects in it (e.g., enmeshment) (Friedman & Gelso, 2000). On the other hand, supervisors may consider negative countertransference more punitive (Ligiéro & Gelso, 2002), and thus more readily perceive it as a reflection of countertransference. Also, analysis of the subscales showed that the genuineness subscale was the one that correlated to countertransference. In the supervisors' eyes, low therapist genuineness within the real relationship may have been a signal of countertransference.

Attachment, Real Relationship, and Countertransference. The hypotheses related to trainees' attachment were not supported. Specifically, attachment security did not relate to either real relationship (from therapists' and supervisors' perceptions) or countertransference. One could speculate that trainees' attachment in romantic situations pertains to a different domain than the therapeutic work. However, other studies have found certain relations between RRI-T and ECR subscales (e.g., Fuertes et al., 2007, between real relationship and attachment avoidance). It may be that the therapist's attachments patterns are connected to the real relationship and countertransference only at certain points in the treatment or under certain conditions. Further research is needed to resolve these disparate findings.

One could think that there are certain moments in therapy in which therapist's attachment might get triggered (e.g., client's rejection, termination). Nevertheless, such attachment activation might not affect directly the real relationship or the countertransference behaviors a therapist might have. In addition, one could speculate that in the cases in which attachment is activated and there is strong acted-out countertransference or weak relationship, clients discontinue therapy and thus were not captured in this study.

The present study was limited in that it employed a small sample, and consisted of only trainees. Thus, results might not be generalizable to more experienced therapists. Further studies could focus on how the relationship between real relationship and countertransference unfolds during treatment, seeing the pattern of interaction between these two constructs over time. This could help detect moments in therapy in which having countertransference and/or a weak real relationship might be more detrimental to the work. Future studies could also focus on potential mediators and moderators in the relation between these two variables.

References for articles can be found starting on page 72.

Starting A Pre-Doctoral Internship Consortium

Michael Kestenbaum, Jonathan Jackson, Ph.D., and Jairo Fuertes, Ph.D.
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Most, if not all, of our colleagues are well aware of the imbalance with the internship match process in professional psychology. The problem is complex, but as a consequence, depending on the year, it leaves anywhere between 20-25% of applicants unable to match with a pre-doctoral internship. One solution that has been implemented by doctoral programs throughout the country has been the creation of new internship opportunities for students, and one model that has been used is the creation of an internship consortium. The consortium essentially pools resources, builds on existing training partnerships and alliances, and creates training positions for students who would otherwise have to wait a year to apply again or take on a training experience likely to be below training program expectations. The current article highlights one program's experience in creating an internship consortium in clinical psychology.

We sat with Dr. Jonathan Jackson, the Director of Practicum Training and the Center for Psychological Services at the Derner Institute for Psychological Studies, to hear what led him to successfully implement the Derner Internship Consortium for doctoral clinical psychology students. During our discussion, Dr. Jackson spoke of the overarching problem with the internship matching process. "I've been overseeing the internship process for fourth year students for several years, and ever since I took it over, there's been an imbalance, a national imbalance. There are more students applying for accredited spots then there are accredited spots. And every year…there would be a small number, sometimes none, but more typically a small number of students, who would not match."

This occurred despite the fact that the students not matching were strong academically and had sufficient training to make them competitive for the match. It was discouraging to him and especially to the students that high-quality and intelligent individuals would not match. Understandably, for some of these students, it was a major blow to their confidence, not to mention to their overall professional and personal plans.

"…the experience of not matching dealt a very unfortunate blow to the self-esteem of those students who didn't match," Dr. Jackson reiterated. "It really affected the entire class, the morale of the whole class."

Eventually a potential solution to this problem emerged, in the form of an affiliated internship that a doctoral program could create. Although such a program either could function exclusively for students of the particular doctoral program or could consider applicants from other programs, the decision was made to operate the Internship

continued on page 18

Program for Derner students only, at least at first. Basing his ideas on how other programs operated similar internships, Dr. Jackson saw an opportunity for such an internship to assist those current students in obtaining high-quality internship experiences and to add to the distinction of the Ph.D. clinical psychology program at the Derner Institute. "There was nothing stopping anybody with the resources and the will to create an internship…" for a doctoral program. Dr. Jackson iterated, "The wheel had been invented." So two years ago, discussions began at the program level among faculty, students, and administrators about the need for creating an internship and ways to go about building it in a way that modeled other programs, while being consistent with the program goals and distinct identity of the Derner Institute. Early on, members of the Derner faculty met and spoke with individuals from different universities who had had experience in building internships within clinical psychology doctoral programs. Firstly, Dr. Jackson was primarily concerned with how to begin the construction of such an arduous project. In large part due to the consultation received from his colleagues at other universities, it became clear that partners would be needed, that is, potential sites to join the Internship Consortium. Several locations were approached, and Dr. Jackson pitched the idea about the Internship. These particular locations were sites where the doctoral program had a history of placing externs, where there were established relationships with the supervisors and training directors, and where said trainers might be receptive to the idea of participating in an internship. Where Dr. Jackson received positive responses, they followed up with these locations by discussing with them the details of the Internship at each location and what the timeframe would be for the Internship.

The locations that agreed to participate in the Internship Program are the following: the Student Counseling Center at Adelphi University; the Village Institute for Psychotherapy in New York City, NY; the William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology; and the Employee Assistance Program in the Corporate Office of North Shore Long Island Jewish Hospital. Each location has had experience with Derner students working there in some capacity. Just as important, each site, in particular the analytic institute, was interested in affiliating with Derner's Internship Consortium because of their ambitions to keep doctoral training relevant and to encourage more analytic ways of working with patients. "I did anticipate a receptiveness on the other end," Dr. Jackson noted, "and that was very much the case."

Three of the participating sites agreed to take two part-time interns, which equates to three full-time interns among the three locations. Additionally, the Employee Assistance Program decided to participate in the Internship Consortium, accepting a trainee who had previously worked and trained there as an extern. Placement at the sites is half-time. As such, interns will accrue a total of 2,000 hours by the end of their respective training years. Each site will require that interns carry responsibility for treating patients in a variety of modalities: individual, group, couple, etc. Individual supervision by a licensed clinical psychologist, group supervision, case conferences, and didactic training will also be offered at every site. In addition, all interns will attend weekly didactic/case conference meetings at Derner throughout the year. These will be taught by Derner faculty in their respective areas of expertise. For example, some areas included are trauma, short-

continued on page 19

term therapy, case formulation, group therapy, and diversity.

Each location has a specific character determined by the staff that supervises, the theoretical underpinning of the therapeutic interventions, and the patient population served. The White Institute, as one of the oldest established psychoanalytic training institutes in the US, embodies the conviction that psychopathology originates in difficulties in relationships with others and emphasizes the personal relationship between therapist and patient as the primary curative force in facilitating growth and development. The White Institute has numerous treatment programs in its adult and child clinics, and a great wealth of alumni who participate in training by providing supervision and seminars on current topics. The Village Institute has a history of treating individuals with compulsive and addictive problems. The Village Institute emphasizes interventions that leads to effects including rapid and lasting change, and that highlight the importance of insight into the origins of personal problems. The Student Counseling Center at Adelphi emphasizes responding to crises and other impending student needs through walk-in services and regularly scheduled sessions. The Student Counseling Center tends to take a more developmental approach to psychopathology, understanding problems that occur in the context of developmental leads and lags and taking into account the presence or absence of resources that may be needed to cope with social, academic, and psychological stressors.

During the process of building the Derner Internship Consortium, Dr. Jackson was able to apply for an American Psychological Association-sponsored stimulus grant that was specifically designed to assist start-up internships and to encourage existing internship programs to undertake the costly and time-consuming steps of applying for APPIC membership and for APA accreditation. The grant provides support over a two-year period for start-up costs. By successfully gaining this grant of slightly over $20,000, Dr. Jackson has been able to apply the funds to accreditation costs and student stipends. For example, students will receive a stipend of $3,000 from the grant, in addition to the $20,000 that the internship sites will provide. Moreover, the grant has heightened the confidence levels in the Internship Program from the Derner administration and the respective training affiliates. "When you're applying for a grant, you have to be clear about your goals and your ability to reach them," Dr. Jackson said. "It's in consideration of your articulated goals and your ability to assemble the needed resources that you are awarded the grant."

Once the foundation had been laid, it was time to initiate the matching process for those Derner students who had applied to this Internship Program. As with many aspects to the Internship process, Dr. Jackson had to learn how to receive applications through the Training Director online portal. Out of the 22 students of the current Derner fourth-year cohort, 11 applied for the Derner Internship Consortium, and approximately half of those who applied were granted interviews. Through the mechanism of the National Match, four students matched with the Derner Internship. As previously mentioned, these students will receive a stipend from their internship location as well as a supplemental stipend from the Internship Grant, which equates to the average full-time stipend for psychology interns in the New York area.

There were barriers and difficulties that were, respectively, hurdled and over-

continued on page 20

come in order to attain the successful beginning to the Internship Consortium at Derner. As Dr. Jackson expressed during the interview, "There [were] a lot of little bumps that I tripped over along the way. Everything that I tripped over I have learned from. A lot of unforeseen problems, but we're charting the course…." For example, he was initially unfamiliar with the matching process from the vantage point as an Internship Training Director. Specifically, he had to determine how many applicants to rank for the Match and how to distribute those that matched to different training sites according to their unique experience and competencies. Although Dr. Jackson was very much "on his own" for much of the work involved in setting up the Internship Program, he had the encouragement of his colleagues at Derner and a key resource in the form of the APPIC Mentorship Program. Through this program, he was in contact with Dr. Gayle Norbury, who currently directs the Mid-Atlantic Internship Consortium and acted as his APPIC mentor throughout the internship-building process. Dr. Jackson cited this program, and Dr. Norbury specifically, as vital to understanding what the necessary steps were in establishing the program and how to proceed with each and every progressive step.

Dr. Jackson has continued to think of and implement new strategies in order to further improve the quality of the Derner Internship. For example, he is currently preparing an application so that the Internship Consortium may obtain membership in APPIC (Association of Psychology Postdoctoral and Internship Centers). Such membership will grant the Derner Internship Consortium permanent access to the National Match. Two years from now, Dr. Jackson expects to begin application for APA accreditation for the Derner Internship once outcome data are available for those who worked as interns in the program. Future plans include reaching out to other locations to add to the current roster of Internship training sites, and to eventually add five more intern spots with said locations. Specifically, we would like to add a hospital as well as smaller clinics and centers. Dr. Jackson emphasized that he is looking for independent entities with their own staff and their own approaches to treatment and commitment to training.

It can be inferred that the willingness of these sites to participate in the Internship demonstrates their dedication to training and their fundamental drive to establish connections with those in the service of contributing to the mental health field. The model of independence, good practice, and ambition that these locations embody acts as a positive example for graduate students who may be inspired to enter the professional world and establish themselves according to such a model. "I think of the Internship as emerging, taking shape," Dr. Jackson affirmed. "That's the tenor. That's the flavor that I'd like for it to assume. The important thing this year was to get it started. And we did."

Although the Internship Program will certainly grow, it is not expected to replace the current general internship matching process. "I don't foresee the Derner Internship replacing fully the Internship training opportunities that students now seek," Dr. Jackson stated. "I see it as being complementary to it, an alternative for students who want to consider it."

In terms of advice for other doctoral programs that may be looking to lay the groundwork for their own Internships, Dr. Jackson advised that one needs to do the proper research on the affiliated internships currently in operation in the

continued on page 21

US. For example, he spoke of Widener and Denver as two well-known examples of long-standing affiliated internships. In addition to addressing the necessity of having the proper support to accomplish the job of establishing such a program, it is important to obtain knowledge about the existing internship programs. "You can look at their literature," Dr. Jackson elaborated. "See how they're organized and contact…the training directors of the internships. Go meet with them. Go see it. See how it actually functions. It takes a lot of the mystery out of it."

The Derner Internship Consortium will officially begin during Fall 2013, with Interns reporting to their individual training sites for orientation during the summer of 2013, specifically in June for the Village Institute and in August for the Student Counseling Center and the White Institute. It will certainly grow, thanks in large part to the willingness of the many parties involved, from Dr. Jonathan Jackson to the students to the Derner administrative body to the Internship Training directors, to contribute more to the program. Through such a program, perhaps it will help to demonstrate what is required in the current doctoral training climate and how other programs may help to provide a first step for their students as they prepare to enter the professional world.

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DSM-5 and the ICD-10: Clinicians Prepare Yourselves!

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Psychologists are still getting used to the new CPT procedural coding system and now they have two new diagnostic coding schemas to learn as well, the DSM-5 and the ICD-10. The long anticipated revised version of the DSM, DSM-5 (APA 2013), is available this month. It is unclear, however, when or whether psychologists will be expected to update their diagnostic coding with DSM-5 codes. However, for billing purposes, all HIPPA healthcare entities and those billing insurance companies will be required to switch to using the ICD-10 mental and behavioral disorders diagnostic codes by October, 2014.

For those of you who are unfamiliar with the International Classification of Diseases or ICD, here is a brief overview. The ICD was developed by the World Health Organization (WHO) to provide a worldwide standard of classification of all medical diseases, including mental and behavioral health, to be used to report epidemiological and health statistics ("*ICD Fact Sheet*",n.d.). All WHO treaty member countries, including the United States, are required to use the ICD for reporting death and disease statistics. And in fact, hospitals, physicians, and other healthcare providers in the United States, except mental health care providers, have been using the ICD-9 coding system for many years. The United States has been a little behind the rest of the world in adopting the most recent ICD classification system, the ICD-10, which is the version that will be implemented in 2014.

What some clinicians may not know is that ICD-9 codes have been used for all behavioral health claims processing by insurance companies in the United States for many years. Because of the similarities between the DSM IV-TR and ICD-9 diagnostic codes, insurance companies were able to easily transform DSM codes into ICD-9 codes. This will not be the case once ICD-10 is implemented. Currently, however, behavioral health divisions of insurance companies continue to specifically require DSM codes in requests for authorization and for clinical management purposes. What has not yet been published is whether insurance companies will require the DSM-5 for clinical management or just switch totally to the ICD system. It may be that we continue to use the DSM IV-TR coding until the October 2014 transition to the ICD-10.

ICD-11 is currently being tested and evaluated and is slated to be adopted by WHO in 2015. Switching from ICD-9 to ICD-10 has been a major shift for United States companies and governmental agencies, thus the delay. It is anticipated, however, that the shift to ICD-11 will be more gradual and implemented over several years with yearly updates to the coding system. (To add to the confusion even more, the official versions that are used in the United States are referred to as ICD-10-CM and ICD-11-CM.)

continued on page 24

Most psychologists are much better acquainted with the DSM coding system than the ICD system and the new DSM-5 will seem familiar to them. According to a December 2012 News Release from the American Psychiatric Association, while there are many disorders and codes that are unchanged, the organization of the new DSM-5 is very different from that of the DSM-IV-TR. For example, in the DSM-5, there is no longer a chapter entitled Disorders First Seen in Childhood. Some of these disorders will be placed with similar disorders (e.g., Separation Anxiety is now in the Anxiety and Related Disorders) and others will be in the new chapter entitled Neurodevelopmental Disorders (e.g., Autism Spectrum Disorders) or Disruptive, Impulse-Control, and Conduct Disorders. Depressive Disorders and Bipolar Disorders are now in separate chapters and Obsessive Compulsive Disorder and Related Disorders is in a separate chapter and includes an official Hoarding Disorder diagnosis. Acute and Post Traumatic Stress Disorders are separated from Anxiety Disorders and are part of a specific chapter entitled Trauma and Related Disorders (which now includes Adjustment Disorders). There are other changes of varying degrees including the elimination of the multi-axial coding system. However, there is also much that will be familiar to clinicians. (See http://www.psychiatry.org/advocacy—newsroom/news-releases December 2012 for more information.)

Although the new DSM might take a while to get used to, it would not be advisable to spend too much time memorizing codes because of the anticipated switch to ICD-10-CM codes. A series of joint conferences were held between 2003 and 2008 between American Psychiatric Association/WHO/National Institutes of Health (NIH) with the goal of creating international collaboration on the two systems so effort was made to make the two classification systems similar. Since the official version of the DSM-5 was not available as this article was being written, we will have to wait to see how different the two coding systems actually are. However, the DSM-5 does have an appendix that provides a crosswalk between the two systems similar to the one in the DSM IV-TR. It does make us wonder why the DSM was not created to correspond completely to the ICD, which would streamline coding and make the clinician's life easier.

Many clinicians we have spoken to are confused about why we must continue to use the DSM when most of the world, now including the United States, use the ICD diagnostic system. A comparison of the ICD-10 (WHO, 2010) and the DSM-IV-TR (American Psychiatric Association, 2000) demonstrates some of the benefits of maintaining a DSM-like resource. Unlike the DSM, the ICD-10 was designed to be used by all allied health and public health professionals so it is less detailed or specific to mental health professionals. The DSM clearly includes much more information on associated features, specific culture, age, and gender features, prevalence, course, familial pattern, and differential diagnosis than the ICD-10 (see the example below for the ICD-10 information for a particular diagnosis). On the other hand, the ICD-10 is available in 48 languages and was designed to be used throughout the world requiring cultural diversity be built into the system.

We encourage you to take a few minutes to look through the ICD-10 website - http://apps.who.int/classifications/icd10/browse/2010/en#/V. An example demonstrating the brevity of the ICD from the online version of ICD-10 (WHO, 2010, Chapter 5, F30-F39) diag-

continued on page 25

nostic criteria for Dysthymia is shown below:

F34.1
Dysthymia
A chronic depression of mood, lasting at least several years, which is not sufficiently severe, or in which individual episodes are not sufficiently prolonged, to justify a diagnosis of severe, moderate, or mild recurrent depressive disorder (F33.-).

Depressive:
neurosis
personality disorder
Neurotic depression
Persistent anxiety depression
Excl.:
anxiety depression (mild or not persistent) (F41.2)

The good news is that there are resources available to help clinicians negotiate the differences between ICD-10 and the new DSM-5. As was available for the DSM-IV-TR, the DSM-5 (American Psychiatric Association, 2013) includes appendices that link the two systems. The American Psychological Association (APA) will likely produce a "crosswalk" between the two (see http://www.apapracticecentral.org for current examples). Unlike the DSM-5, the ICD-10 is readily available on line to review: (see link above). There are also some helpful resources on the www.cms.gov and www.cdc.gov/nchs/icd/icd10cm websites, although these apply to all healthcare providers not just mental health providers. Additionally, there are numerous continuing education workshops available through APA and other organizations that address both the new DSM-5 and the ICD-10. Psychologists are encouraged to stay abreast of these changes. Change can be difficult but as we often discover with our clients, change that is embraced with openness and curiosity is preferable to change confronted in dread.

References for articles can be found starting on page 72.

From APA's Online Academy Programs
The Proper Focus of Evidence-Based Practice
CE Credit: 4

To identify the proper focus of evidence-based practice, preeminent psychotherapy researchers advocate for the treatment method, the psychotherapy relationship, the client as self-active healer, and the principles based on the preponderance of evidence from the process out come research.

Presented by: Steven D. Hollon, PhD; Bruce E. Wampold, PhD; Michael J. Lambert, PhD; Arthur C. Bohart, PhD; Larry E. Beutler, PhD; John C. Norcross, PhD; Leon VandeCreek, PhD; Abe Wolf, PhD.
http://www.apa.org/education/ce/aoa0007.aspx

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

Clinical Educators Prepare Yourselves, Too! Training and Education Perspective on DSM-5 & ICD-10

Jesse Owen, Ph.D., University of Louisville
Ken Critchfield, Ph.D., University of Utah

Thompson and Vivino (see article in this issue) have provided a very nice summary (not to mention great resource) of the issues facing psychologists in the coming years. Our hope is to provide a perspective on training and education issues related to this upcoming change. Clearly, there are countless ways to train future psychologists to conduct diagnostic assessment. We do not wish to revisit the entire range of such issues here. Instead, we wish to focus on the key issue of our responsibility to educate students for the realities of practice in the field, whether educators utilize the DSM, ICD, other diagnostic frameworks such as the Psychodynamic Diagnostic Manual (PDM), or even no taxonomy at all. Upcoming changes to insurance and billing "CPT" codes, as well as DSM and ICD diagnostic frameworks reflect changes in standards of communication, accountability, and administrative practice. They will also likely impact clinical standards for science and practice to the extent that funding paradigms are keyed to any given framework.

These changes offer an opportunity to think through our priorities as educators, which at its most basic involves training individuals to be independent psychologists with the competencies needed to face the challenges in the profession. To this end, the APA competency benchmarks (revised in 2011) suggest that psychologists who are ready for entry into practice should have wide range of knowledge of and skills with assessment methods. More specifically, the benchmarks denote that psychologists ready for practice should: (a) know a range of diagnostic/assessment approaches, (b) be able to critically examine the merits and limitations of such approaches, and (c) be able to utilize diagnostic/assessment information in their treatment planning while considering clients' cultural heritage and other socio-political contexts.

Our priority, typically, when approaching these topics is to convey a great deal about the evidence-base used to support the variety of clinical constructs, assessment methods, and intervention choices put forward by our field from its range of theoretical perspectives. This is already a tall order given the "moving target" of ever-evolving clinical theory, science, and practice. Upcoming changes raise questions about how much our teaching should also convey about the "real world" of health care administration, billing, and cross-disciplinary communication standards, shaped as they are not just by science and practice issues alone, but also by various political, international, cross-disciplinary, regulatory, and insurance industry concerns. If today's psychology trainees are to become tomorrow's leaders in mental health assessment and treatment, how should they best become acquainted with these broader forces shaping the field now?

continued on page 28

As the insurance coding taxonomy continues to consolidate and expand internationally, it may be tempting to simply "teach the ICD" (or DSM, or whatever reigning method exists into the future). Our view, however, keyed to the language of the APA benchmarks, is that educational practice, at a minimum, should be designed to expose trainees to multiple ways of conducting/approaching assessment (e.g., multiple diagnostic taxonomies) and promote forms of critical thinking that encourage evaluation of the multiple approaches, based on scientific support, as well as the individual needs, preferences, and context of clients. Ideally, psychologists will be trained to engage in the shaping of future taxonomic developments based on broad scholarship, knowledge of the expanding evidence-base, and appreciation of administrative demands within health care delivery systems, rather than being trained only to follow in tracks laid by others.

Upcoming changes to the DSM, ICD, and to a lesser extent the CPT code changes, provide an opportunity to examine the relevant topics. For example, educators may want to present a diagnosis from the ICD and DSM for trainees to compare and contrast in terms of theory and practice. As trainees become more advanced and experienced with these conceptual issues, broader implications of implementing a standardized taxonomy in practice settings could also be brought into the discussion: What are the advantages for within- and cross-disciplinary communication? How might diverse clients/patients respond to specific language and constructs invoked? Are some theories implicitly favored over others? Do some taxonomies facilitate treatment planning of one type better than another? What ethical issues are raised (e.g., diagnosis based on "what is covered"?) and how can they be successfully navigated? If trainees are given orientation to the cultural, historical, and political forces shaping the field, as well as science and practice issues, they will be in a much better position to effectively shape future developments in the field as data accumulate.

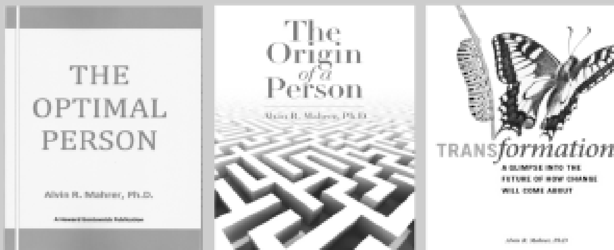
Like it or not, there is also a pragmatic reality to the transition to the ICD. As educators, our responsible to trainees is to assist them to be competent independent psychologists. At a minimum, trainees should be exposed to the ICD and how to navigate between the ICD and other taxonomies (or lack thereof). For example, an educator might want to encourage students to compare and contrast the diagnostic criteria for a particular disorder/condition from multiple taxonomies. In doing so, trainees can see whether the diagnostic criteria are sufficiently overlapping and, when they are not, how they can approach gaining more information to make an ethical and appropriate diagnosis.

Much of the clinical education in the US has in recent years been keyed to the DSM. This may or may not continue to be the case as the various systems compete. Since issues and procedures around billing and coding are typically introduced by clinical supervisors in clerkship, internship, and post-doctoral settings, it may be tempting to leave orientation about these new developments to those settings. A concern here is that our current handling of these issues tends to be site- and specialty-specific, without systematic presentation of how clinical practice is framed within health care systems. We believe that in the short term, pedagogical tools are needed to aid the process of understanding and navigating our multiple taxonomic systems. But in the longer term, we encour-

continued on page 29

age clinical educators to write about and develop instructional materials that will anticipate and scaffold all the clinical practice concerns, while also orienting new generations of trainees to the history, rationale, and uses of our competing professional languages.

Thought Provoking Books By Alvin R. Mahrer, Ph.D.



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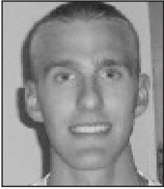
www.hgpublications.ca

Ethical Practice in Psychotherapy: Empirically Validating Ourselves

Trey Cole
Doctoral Student, University of Denver Graduate School of Professional Psychology



Human beings are complex. This statement seems simple at first glance, but the implications of variety in human life are vast and continue to leave scientists puzzled on how to explain their inner workings to anyone's satisfaction. In fact, the National Academy of Sciences (1999) documented the well-supported and robust evidence base for the modern evolutionary synthesis, which at its heart states that no genotype can remain viable in the long-term. Even neuroscience, the promising study of the brain and nervous system, cannot explain human behavior. A large chasm exists between watching areas of brain activation on a functional magnetic resonance image (fMRI) and seeing a behavior come into existence. As neuroscientist Raymond Tallis (2010) notes, "What neuroscience does not do, however, is provide a satisfactory account of the conditions that are *sufficient* for behavior and awareness" (p. 3). As it turns out, for many reasons, human beings are difficult to explain holistically. This ultimately begs the question of why practitioners of psychotherapy are able to sit with other human beings and help them make sense of the struggles that come with being human. If we know so little, what makes psychotherapy so special? What provides the ethical basis for competence in effective psychotherapy?

A Brief History

In recent decades, a paradigm shift has occurred in the field of psychology. An effort to establish empirically validated treatments (EVT) and evidence-based practice (EBP) has become the focus not only in research but in the treatment of individuals seeking psychotherapy. Indeed, the ethics code of the American Psychological Association (2010) defines competence in practice as "established scientific and professional knowledge of the difference" (Standard 2.04). This is the standard of care. Much of this shift began with gathering evidence through randomized controlled trials (RCT) in favor of Cognitive-Behavioral Therapy (CBT). As evidence began to mount for CBT, many began to infer that it was the more efficacious treatment and, therefore, the more ethical option (Butler, Chapman, Forman & Beck, 2006). However, practitioners from other therapeutic modalities argued that simple double-blind experimental designs and lab research did not begin to tap into the complexity of human behavior. Regardless, other theoretical modalities began to follow suit, doing their best to conduct their own studies to test the effectiveness of their treatment in order not to be left behind. After much debate, and in some cases, animosity, what researchers have found in meta-analytic studies is that there is no significant difference in treatment outcomes among major psychotherapeutic orientations (Wampald, 2001). In many cases, the em-

continued on page 31

phasis on empirically validating treatments has been criticized for too narrow a focus, lack of validity, and bias towards certain orientations that are more easily measured (Koocher, 2004; Lampropoulos, 2000; Levant, 2004).

Missing the Mark

In western societies, where efficiency is increasingly valued and scientific reasoning is replacing metaphysical explanation, it is easy to understand why there is such intense focus on "proving" that one therapy is better than another. Hackenberg (1988) illuminated this process in his discussion of Whorf's linguistic hypothesis on western culture. He stated, "Take, for example, the sentence, 'The lightning flashed.' According to the Hopi, the lightning *is* the flash. Western languages, however, tend to require agents for such events" (p. 193). This construction of language leads naturally to scientific inquiry. It is not shocking, then, that the focus in scientific endeavors is viewed through a lens that demands both mechanistic and reductionist explanations and results. In response, reimbursements from insurance companies for psychotherapy in health care have given preference to therapies that are shorter-term and more cost effective, despite the fact that there were no significant outcome differences in treatment modality. As the emphasis of psychotherapy has changed a bit from dynamics to symptom relief and more measurable factors (in an effort to seem more in line with mainstream, traditional science), it is illogical to posit that the effectiveness is the same when the standards of what being effective means have changed. Furthermore, there aren't as many long-term follow-ups to judge it dispassionately. Shorter-term, symptom-focused therapies certainly have their place, but if this becomes the sole focus, what will the cost be? Will the ultimate result be to remove the relationship from psychotherapy?

What is Left?

It should go without saying, then, that something has been missing from psychological inquiry. Despite the evidence accumulated from thousands of research studies, there is little that offers an explanation as to why practitioners of psychotherapy are effective in helping and understanding the complexities of humanity. The ethical mandate for competence has little bearing in which treatment modality is used. What has been shown consistently in outcome studies, however, is the importance of the therapeutic relationship as a healing factor. Fluckiger, Del Re, Wampold, Symonds and Horvath (2012) discuss findings that there is and has consistently been a robust relationship between the therapeutic alliance and outcomes measures on the effectiveness of psychotherapy. So, following this logical pattern, focus on the therapeutic relationship is the most evidence-based practice, regardless of technique or modality. But this relationship, like any, is difficult to measure experimentally. This is likely why neuroscience has such difficulty explaining human behavior. Fortunately, scientific inquiry is not the only epistemology. In order to create a more holistic understanding of an individual, an epistemological pluralism must be adopted that allows scientific inquiry to be a necessary but not sufficient explanation for the complexity of human interaction and behavior. Attention upon the relativistic nature of human behavior falls closer in line with the well supported modern evolutionary synthesis of biology than does a static norm that is enveloped on a theoretical Gaussian curve. Looking back several hundred years, Albert Camus (1991) sums this very concept perfectly in stating, "I shall forever be a stranger to myself. In psychology as in logic, there are truths but no truth" (p. 167). In-

continued on page 32

herent in this statement is a tension between human subjectivity and the focus on objectively describing it that represents an epistemological pluralism. Perhaps the field of psychology has been concentrating on only a part of human variability in recent decades, with a fervent focus on reducing individuals to the sum of their parts. Maybe the missing part in understanding human beings and being ethically responsible lies within the very nature of their complexity, and an understanding of this can only fully be understood through experience and relationship (Gadamer, 2004).

References for articles can be found starting on page 72.

NOTICE TO READERS

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

Bulletin ADVERTISING RATES

Full Page (4.5" x 7.5")	$300 per issue
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Deadlines for Submission

February 1 for First Issue
May 1 for Second Issue
August 1 for Third Issue
November 1 for Fourth Issue

All APA Divisions and Subsidiaries (Task Forces, Standing and Ad Hoc Committees, Liaison and Representative Roles) materials will be published at no charge as space allows.

DIVISION OF PSYCHOTHERAPY EARLY CAREER PSYCHOLOGISTS MENTORING PROGRAM

This one-year mentoring program provides mentoring for Early Career Psychologists (i.e., within 10 years of completion of the Ph.D. or Psy.D., regardless of the number of years in the field prior to attaining the doctoral degree). Mentoring is provided in mentoring groups comprised of two senior, experienced mentors and up to 3-4 mentees. Three mentoring programs are offered:

Mentoring: Psychotherapy Practice Issues
The practice mentors will aid their mentees in issues related to practice such as licensure, the business of establishing a private practice, or professional and ethical issues related to being a licensed psychologist. Practice mentees may elect to work on developing new areas of competence, developing skills with diverse clientele, or addressing mental health care disparities. The program does not provide clinical supervision, but does provide mentoring to support mentees in reaching their professional goals.

Mentoring: Psychotherapy Research
The research mentors will work closely with their mentees on their psychotherapy research. Psychotherapy research mentees may elect to work on any aspect of their research program (e.g., setting a research agenda to working, developing successful grant applications, engaging diverse communities in psychotherapy research, and research as a part of success in the tenure process).

Mentoring: Teaching and Training
The teaching mentors will help their mentees to improve on areas related to lecturing/teaching in psychotherapy-related classes and may, if applicable, provide support to help new professors as they embark on the track to tenure. Teaching mentees may work on topics such as addressing diversity in the classroom, engaging students in the classroom, creating effective syllabi, teaching helping skills, and growing as an instructor.

Three or four applicants will be selected for each of the three areas, and will be assigned to a mentoring group that focuses on that specific area. Each mentoring group will meet by phone conference six times per year (every 2 months) to discuss mentee projects and other mentoring concerns.

Program Goals

- Provide support and mentoring to promising early career psychologists
- Help early career psychologists to establish and further their careers
- Build positive and supportive relationships between mentees and more experienced members of the Division of Psychotherapy
- Build positive professional relationships between mentees within each group and mentoring cohort

continued on page 34

- Support diversity in psychotherapists, scholars, educators, and professional leaders interested in psychotherapy
- Support attention to diversity in psychotherapy practice, psychotherapy research, and teaching about psychotherapy
- Encourage early career psychologists to step into leadership roles in the field of psychotherapy practice, research, or training

Program Structure and Benefits

- Selected mentees will work on their individual projects with support and feedback from the mentors and the rest of the mentoring group
- Selected mentees will meet as a group via video conference for 1 hour every 2 months (6 times/year) for mentoring
- During the mentoring meetings, mentees will discuss their projects and any other mentoring concerns with the mentoring group and the mentors
- Mentors would work as a sounding board for new ideas and offer unique perspectives to help shape and refine the ideas of their mentees.
- Mentors will help connect mentees with other Division 29 members working in areas relevant to the mentee's work, as relevant.
- Mentors and mentees would have the opportunity to meet in person at the annual APA Convention at the Lunch for the Masters.
- Mentees selected to participate in the program would receive a travel award reimbursing travel costs/convention registration (up to $600) to attend the APA conference.
- Participants in the Mentoring Program would present their work at Division 29's Lunch with the Masters.

Funding Specifics
There will be no cost to mentees/mentors for participating in the 6 phone conferences.

Eligibility Requirements

Eligibility criteria that apply to <u>all three</u> mentoring programs:

- Must be a member of Division 29 (Psychotherapy)—information for joining the Division of Psychotherapy is available at the following website: http://www.divisionofpsychotherapy.org/members/membership-application/
- Must have graduated from the Ph.D. or Psy.D. programs within 10 years from the time of their application (Note that some applicants may have had many years in the mental health field prior to attaining the doctoral degree—time from graduation is calculated only from graduation with the Ph.D., Psy.D., or other doctoral-level degree).

continued on page 35

Eligibility criteria that apply only one of the three specific mentoring programs:

- Mentoring: Psychotherapy Practice Issues. Individuals must articulate their interest in psychotherapy practice, be invested in future clinical work, and articulate how a mentor should help him or her with professional development issues.
- Mentoring: Psychotherapy Research. Applicants must demonstrate that they have a clear research agenda and plan in an area of psychotherapy and demonstrate research competency consistent with their level of training and experience.
- Mentoring: Teaching and Training. Individuals must demonstrate a particular interest in building a career in teaching/academia or be involved in teaching or training future psychotherapists as a part of their professional lives. Applicants should have an interest in approaches to teaching psychotherapy, supervision, or issues related to training.

Information on Mentors

- Mentors will be experienced members of Division 29 to serve as mentors (two in psychotherapy practice, two in psychotherapy research, and two in teaching/training).
- The mentors agree to serve as mentor for a period of one year.

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Clarity with which the applicant articulates the way in which the mentoring program could help the applicant attain the goals stated in their application
- Clarity with which the applicant articulates the proposed project to be completed with the support of the mentors and mentoring group
- Applicant's ability/competence to execute the project

Application Process

All applicants (regardless of type of mentoring program sought) should submit:

- a CV
- 1 letter of reference from someone who is familiar with the applicant's work in a professional or academic context
- A statement of purpose (no more than 1 page, single-spaced, no smaller than 12-point font, 1-inch margins on all sides).

Statement of Purpose Requirements Vary by Mentoring Program Desired:

- Mentoring: Psychotherapy Practice Issues.

  Interested individuals should explain their area of clinical interest, discuss the work done thus far in clinical practice, and future plans to practice psychotherapy. Applicants should clearly delineate which areas they are requesting mentoring group support, and why. Describe the specific outcomes that are expected from the mentoring process (e.g., establishment of competence in a new area of

continued on page 36

practice or in practice with a new population, specific skill-building, specific practice development plans, etc.)

- Mentoring: Psychotherapy Research.

  Applicants must explain their program of research and future research plans. Applicants should specify a project that they would like to work on in the coming year with the support of the mentoring group and present at the Lunch with the Masters.

- Mentoring: Teaching and Training.

  Applicants must submit a statement demonstrating a serious ongoing interest in teaching courses related to psychotherapy or being involved in training of future psychotherapists. The statement of purpose should include a description of teaching strategies and philosophy, a summary of any available documentation of teaching effectiveness, and a plan for an innovate teaching/training endeavor that the mentee would work on developing with the mentoring group and eventually present at the Lunch for the Masters.

- Applicants may reapply in subsequent years; reapplications are permitted.
- Applicants may only submit one application for each year (i.e., one may not apply for the teaching and the research mentorships in the same year).
- Anyone who has been awarded the mentorship is barred from applying in the future.
- Only complete applications will be reviewed.

Funding Specifics
There will be no cost to mentees/mentors for participating in the 6 phone conferences.

Submission Process and Deadline
- All materials must be submitted electronically via e-mail
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format.

Submit all required materials for proposal to:
Susan Woodhouse, PhD, woodhouse@lehigh.edu

DEADLINE: SEPTEMBER 30, OF EACH YEAR

Questions about this program should be directed to
Susan Woodhouse, PhD

WEDNESDAY, JULY 31st

Symposium (S): *Novel Approaches to Professional Training and Dissemination—Trauma Psychology*
9:00 AM – 9:50 AM • Convention Center, Room 319B
Chair: Elana Newman, PhD
Participant/1st Author:
Ernestine Briggs-King, PhD
Joan M. Cook, PhD
Josef I. Ruzek, PhD
Discussant: Elana Newman, PhD

Symposium (S): *Single-Session Therapy—Capturing the Moment*
11:00 AM – 12:50 PM • Convention Center, Room 322A
Chair: Michael F. Hoyt, PhD
Participant/1st Author:
Moshe Talmon, PhD
Monte Bobele, PhD
Jeff Young, PhD

THURSDAY, AUGUST 1st

Symposium (S): *Treating Abuse Trauma in Family Context—Research Findings and Clinical Implications*
8:00 AM – 8:50 AM • Convention Center, Room 321A
Cochairs: Siddika Mulchan, BS and Steve N. Gold, PhD
Participant/1st Author:
Bryan T. Reuther, PsyD
Scott M. Hyman, PhD
Veronica F. Juanes-Vaquero, MS
Discussant: Steve N. Gold, PhD

Symposium (S): *Making Graduate and Continuing Ethics Training*

Engaging, Relevant, and Inspiring
9:00 AM — 10:50 AM • Convention Center, Room 305A
Chair: Elizabeth R. Welfel, PhD
Participant/1st Author:
Cindy L. Juntunen, PhD
Derek Truscott, PhD
Elizabeth R. Welfel, PhD
Beth Haverkamp, PhD
Sharon K. Anderson, PhD
Discussant: Stephen H. Behnke, JD, PhD

Thursday, August 1, continued on page 38

Poster Session (F): *Psychotherapy and Supervision Processes and Outcomes*
11:00 AM – 11:50 AM • Convention Center, Kamehameha Exhibit Hall
Participant/1st Author:
Joel Simons, MA
Christina H. Krieg, MA
Tatiana Glebova, PhD
Hwa Jin Cho, MA
James W. Lichtenberg, PhD
Martin J. Amerikaner, PhD
Scott M. Hyman, PhD
David M. Martin, PhD
James I. McCollum, MA
Evan J. Lima, MA
Halley J. Brown, BA
John A. McCullagh, MS
Erin Winterrowd, PhD
Susan S. Woodhouse, PhD
Pao-Ling Yeh, PhD
Barbara Morrell, PhD
Tyler Pedersen, PhD
Benjamin D. Newsome, MS
Elizabeth J. Schmidt, BA
Joshua A. Wilson, BA
Ha Yan An, MA
Mari Yoshikawa, EdD
Elizabeth R. Wrape, MS
Cassie M. Watkins, MS
David A. Vermeersch, PhD
Paula A. Errazuriz, PhD, MA
Evangelina E. Regner, PhD
Rayna D. Markin, PhD
Keisha Love, PhD
Kristin M. Perrone-McGovern, PhD
Eun Jung Shim, PhD
Kara Cattani, PhD
Dianne Nielsen, PhD

FRIDAY, AUGUST 2nd

Symposium (S): *Responding to Sexual Orientation Change Efforts—Affirmative Policy and Treatment*
8:00 AM – 9:50 AM • Convention Center, Room 313C
Chair: Judith M. Glassgold, PsyD
Participant/1st Author:
Clinton W. Anderson, PhD
Jo Linder-Crow, PhD
Judith M. Glassgold, PsyD
Caitlin Ryan, PhD
Discussant: Douglas C. Haldeman, PhD

Symposium (S): *Renewal of Humanism in Psychotherapy—A Roundtable Discussion*
12:00 PM – 1:50 PM • Convention Center, Room 321A
Chair: Kirk J. Schneider, PhD
Participant/1st Author:
David N. Elkins, PhD
Orah T. Krug, PhD
Robert D. Stolorow, PhD
Lillian Comas-Diaz, PhD
Discussant: Melba J.T. Vasquez, PhD

Conversation Hour (N): Lunch With the Masters
12:00 PM – 1:50 PM • Hilton Hawaiian Village Beach Resort, Iolani Suites I and II

SATURDAY, AUGUST 3rd

Committee Meeting (N): Editorial Board
8:00 AM – 8:50 AM • Hilton Hawaiian Village Beach Resort, Sea Pearl Suite IV
Chair: Mark J. Hilsenroth, PhD

Poster Session (F): *Psychotherapy Theory and Practice*
Sat: 9:00 AM – 9:50 AM • Convention Center, Kamehameha Exhibit Hall
Participant/1st Author:
Randolph B. Pipes, PhD
Joshua K. Swift, PhD
Sharon K. Anderson, PhD
Rosalie N. Brueske, MA
Mark Pedrotty, PhD
Ashley N. Nazario
Michelle M. Block, MA
Piero A. Peirano Ambut, MS
Alex Torstrick, MA
Satoko Kimpara, PhD
Sibylle Georgianna, PhD
Nicole L. Park, MA
Pamela B. Wilansky-Traynor, PhD
George Richardson, PhD
David L. Vogel, PhD
Jessica L. Gahm, MS
Nicholas R. Wiarda, MA
James W. Lichtenberg, PhD
Roxana Zarrabi, MA
Rachel S. Wahto, MS
Michal Ferencz, PhD
Vladimir Nacev, PhD
Courtney K. Pickworth
Jennice S. Vilhauer, PhD
Kelley A. Tompkins, BA
Debra Japko, BA
Jessica Henritze-Hoye, BA
Surender Kumar, PhD
Brandi R. Schmeling, BA
Adam M. Lewis, BA
Philinda S. Hutchings, PhD
Rebecca A. Klott, PhD
Emily M. Becker, MS

Symposium (S): Celebrating the 50th Anniversary of *Psychotherapy*—Looking Ahead to the Next Decade of Research
10:00 AM – 11:50 AM•Convention Center, Room 302B
Chair: Mark J. Hilsenroth, PhD
Participant/1st Author:
Zac E. Imel, PhD
Henny Westra, PhD
Cheri L. Marmarosh, PhD
Heidi M. Levitt, PhD
Discussant: William B. Stiles, PhD

Symposium (N): History and Future of Division 29
4:00 PM – 4:50 PM • Hilton Hawaiian Village Beach Resort, Honolulu Suite II
Chair: Elizabeth N. Williams, PhD
Participant/1st Author:
Mathilda B. Canter, PhD
Gerald P. Koocher, PhD
Linda F. Campbell, PhD
Raymond DiGiuseppe, PhD

Saturday, August 3, continued on page 40

Business Meeting (N): and Awards Ceremony
5:00 PM – 5:50 PM • Hilton Hawaiian Village Beach Resort, Honolulu Suite II

Social Hour
6:00 PM – 6:50 PM • Hilton Hawaiian Village Beach Resort, Honolulu Suite II

SUNDAY AUGUST 4th

Symposium (S): *Psychotherapy Revealed—A Glimpse of Eminent Psychotherapists at Work*
8:00 AM – 9:50 AM • Convention Center, Room 312
Chair: Jeffrey J. Magnavita, PhD
Participant/1st Author:
Jeffrey J. Magnavita, PhD
Hanna Levenson, PhD
Laura S. Brown, PhD
Howard A. Liddle, EdD
Discussant: Nadine J. Kaslow, PhD

Symposium (S): *Why Would You Say Such a Thing? Evaluating What a Psychotherapist Actually Says During a Session*
10:00 AM – 11:50 AM • Convention Center, Room 307B
Chair: Stevan L. Nielsen, PhD
Discussants:
Raymond DiGiuseppe, PhD
Michael J. Lambert, PhD
Elizabeth N. Williams, PhD

Be Sure to Visit Division 29 in the APA Convention Exhibit Hall – Booth 914

Congratulations to the Division 29 Student Paper Award Winners!

DONALD K. FREEDHEIM
STUDENT DEVELOPMENT AWARD
Alexey Tolchinsky, George Washington University
For his paper: *Acute Trauma In Adulthood in The Context of Childhood Traumatic Experiences*

THE MATHILDA B. CANTER
EDUCATION AND TRAINING AWARD
Mallaree Blake-Lodestro, Adler School of Professional Psychology
For her paper**:** *The Impact of Bug Chasing on the Spread of HIV*

THE JEFFREY E. BARNETT
PSYCHOTHERAPY RESEARCH PAPER AWARD
Lily A. Brown, M.A., University of California, Los Angeles
For her paper **:** *CBT Competence in Novice Therapists Improves Anxiety Outcomes*

THE DIVERSITY AWARD
Joan DeGeorge, University of Massachusetts – Amherst
(Additional Authors: Michael J. Constantino,
Samuel S. Nordberg, David Kraus)
for her paper: *Individual Differences in Psychotherapy Change Among Ethnic Minority Patient*

Please join us as we honor our student paper award winners at the Division 29 Awards Ceremony, Saturday, August 3rd
Hilton Hawaiian Village Beach Resort, Honolulu Suite II

ATTENTION GRADUATE STUDENTS AND EARLY CAREER PROFESSIONALS

YOU ARE INVITED TO

"Lunch with the Masters – For Graduate Students and Early Career Psychologists"

Friday, August 2
12:00 PM – 1:50 PM

• • •

Hilton Hawaiian Village Beach Resort
Iolani Suites I and II

Hosted by Division 29 (Psychotherapy) at the 2013 APA Convention

Come join:

Laura Brown
Jean Lau Chin
Bill Stiles
Ray DiGiuseppe
Rosemary Adam-Terem
Jeffrey Barnett
Dennis Kivlighan
John Norcross
Linda Campbell

for a lunch and conversation.

We will also host a book raffle, discuss the needs of our students and early career constituents, and provide information about the newly developed Division 29 (Psychotherapy) Early Career Mentoring Program.

No RSVP needed, but please feel free to contact Dr. Rayna Markin at rayna.markin@villanova.edu for additional information.

Come find out more about Division 29 and invite others to join!

You do not need to be a member of Division 29 to attend, but we will have membership information available on site for those who are interested in joining.

Invisible Identities: Psychotherapy for Undocumented Immigrant Youth in College Counseling Settings

Maria L. Larrimore, B.A.
Lehigh University

Immigration in the U.S. has been a much-debated topic in recent years. Currently, approximately 65,000 undocumented students graduate from U.S. high schools each year (Bruno, 2012) and 4.4 million unauthorized immigrants under the age of 30 reside in the United States (Passel & Lopez, 2012). Undocumented youths have been overlooked in the mental health literature and are often invisible within the greater immigrant context (Sullivan & Rehm, 2005). With the enactment of the Deferred Action for Childhood Arrivals Program in 2012 and the subsequent presentation of an immigration reform bill submitted to the Senate, immigration reform could become a reality in the near future. If this occurs, many undocumented students will become eligible for college admission and financial aid, which suggests that more and more colleges across the U.S. will see an increase in students who have had experiences as unauthorized immigrants. Whether or not such a change occurs, psychotherapists need to be aware of issues related to undocumented immigrants because such individuals are already presenting for psychotherapy in college counseling centers and other settings.

The term *undocumented immigrant* refers to anyone who is not a U.S. citizen, entered the U.S. without authorization, or overstayed a period of authorized stay (Passel, 2005). This includes the approximately 2 million students who are under the age of 18 and are undocumented immigrants (Kim, 2012). For these students, who may have felt a level of inclusion within the public school system, transitioning into adulthood brings about feelings of voicelessness and invisibility (Ellis, & Chen, 2013). The purpose of this article is to provide information about issues of particular relevance to college-aged young adults who are or have been undocumented immigrants and who could possibly become psychotherapy clients in college counseling centers. While the focus of the present article is on psychotherapy for college students, some issues will apply more broadly to undocumented clients in general. This article will consider the different immigration statuses a person may hold, issues specific to the undocumented population, as well as clinical considerations when working with undocumented youths.

Being culturally competent includes possessing group specific knowledge, such as being aware of life experiences and historical backgrounds for the group with which one wishes to become culturally competent (Sue, Arredondo, & McDavis, 1992). Understanding the particular life experiences of those in the U.S. who hold undocumented identities is crucial to begin to understand these clients. However, it is important to remember that not all immigrants are undocumented, and immigrants presenting for psychotherapy may be seeking help for a myriad of concerns unrelated to their immigrant experience.

continued on page 44

Understanding Immigration Laws in the U.S. As psychotherapists, being fully versed in immigration law would be difficult and unnecessary. However, in order to effectively help clients who come from undocumented immigrant backgrounds, it is necessary to understand certain basic terminology, as well as barriers that prevent authorized immigration. Sue, Arredondo, and McDavis (1992), state that psychotherapy occurs in a sociopolitical reality, and that culturally skilled psychotherapists "understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities" (p. 482). Being familiar with common terminology and current legislative acts can help psychotherapists be more empathic in understanding the contexts of their clients and in helping clients feel "seen." Such knowledge relieves the client of the burden of explaining basic immigration laws to the psychotherapist.

First, let us consider the different statuses a person born outside of the U.S. might hold. A person who is lawfully in the United States may fall into any of the following categories[1]: VISA holder, Lawful Permanent Resident, or Naturalized Citizen. A VISA holder is a person who is authorized to reside in the U.S.; however, only for a particular reason (e.g., as a student or visitor), and only for a certain amount of time. A Lawful Permanent Resident is a person who is authorized to reside in the United States without any length restrictions; he or she is the holder of a Permanent Resident Card ("Green Card"). A Naturalized Citizen is a person who was born outside of the U.S. but became a citizen of the U.S. (American Immigration Council, 2010).

Additionally, an immigrant youth might qualify for the Deferred Action for Childhood Arrivals executive action, which became effective on June 15, 2012. This program provides relief from deportation for unauthorized immigrants who are below 31 years of age and arrived in the U.S. before the age of 16 (Passel & Lopez, 2012). To qualify for the DACA students must prove continuous residence in the U.S. since June 15, 2007, as well as physical presence in the U.S. on June 15, 2012. Students must be enrolled in school, have a diploma or GED, and/or have been honorably discharged from the Armed Service or Coast Guard. Lastly, students may not have been convicted of a felony, a significant misdemeanor offense, or three or more other misdemeanors, and the person cannot present a threat to national security or public safety (Passel & Lopez, 2012). Those who qualify for deferred action are shielded from deportation for two years and may qualify to work in the U.S. (if economic necessity for employment can be proven). After the two-year expiration period, two-year renewals can be requested.

Now let us consider one of the main misunderstandings about unauthorized immigration, which is the belief that there is a reasonable pathway to enter the country for anybody who wants to get in line. Generally, to gain lawful entry to live and work in the U.S. one must be highly trained in a field for which qualified workers are in short supply, escaping persecution, or have family already authorized to live in the U.S (Southern Poverty Law Center, 2012). This "get in line" misconception might lead one to believe that unauthorized immigration is just a choice a person makes because he or she does not wish to follow legal pathways to entering the U.S. Further, those who qualify for DACA arrived as youths and as such may have had little (or no) say in whether to immigrate in the first place.

Clinical Considerations

Language sensitivity. As with other marginalized clients, language can be a

continued on page 45

powerful agent in the psychotherapy relationship with undocumented immigrants. Making a conscious decision about the terms we use to engage undocumented clients can help enhance how safe and understood the client feels within the psychotherapy relationship. Let us consider the term "illegal immigrant," a term that has been used in the U.S. rhetoric to identify undocumented immigrants. According to the Southern Poverty Law Center (2011), unlawful residence is a civil infraction and not a criminal offense (the former penalized by deportation and the latter prison). The term "illegal immigrant" or "illegal alien" should not be used in a counseling setting to refer to a client who is undocumented or to others in a similar situation. This term criminalizes the client and could create a barrier to feeling empathy and a desire to engage and understand the circumstances faced by unauthorized immigrants (Furman, Langer, Sanchez, & Negi, 2007).

Discussion of Unauthorized Status in Psychotherapy. While a psychotherapist might believe that a client is struggling with issues related to an immigration status, undocumented clients might perceive a question about their immigration status as threatening, and might disengage from services if asked about their status (Kim, 2012). Thus, it may not be wise to ask clients directly about their immigration status without considering the risk to the therapy relationship. Although a client may not be forthcoming with a description of his or her immigration status, if a client does disclose experiences as an undocumented immigrant, it is important to remember that he or she might still be wary of authority figures, as the client may have lived in fear of being deported (Contreras, 2009). In addition, an undocumented student might choose not to disclose her or his status because they feel embarrassed. Research suggests that experiences of marginalization because of unauthorized status can cause intense feelings of shame (Ellis, & Chen, 2013). For some, the fear of the consequences of being discovered as an undocumented immigrant can affect how they interact with their peers, being cautious about how much information to reveal (Contreras, 2009).

If disclosure does occur, the psychotherapist should be aware of questions that, while commonly used, carry particular assumptions. For example, a person who is born outside of the U.S. might be asked if he or she is a citizen (a common question asked by classmates, friends, and even strangers making small talk). This question can be a difficult one to answer for an unauthorized student, as it assumes that (1) one must be a citizen in order to be in the U.S; and (2) that the student must wish to be a citizen, or (3) that any person who belongs to a visible minority group must be an immigrant/may not be a citizen. This question puts clients in a position to either explain their immigration status, which might be uncomfortable for a number of reasons, or explain why they might choose not to be U.S. citizens.

Clients who disclose their experiences as undocumented immigrants in psychotherapy might do so for a multiple reasons. The client might wish to disclose his or her immigration status to represent him or herself honestly and wholly, something he or she may have been unable to do in daily life. In addition, clients might disclose their status as undocumented because they want a psychotherapist to understand the stressors in their lives fully, including stressors that are unique to the undocumented immigrant experience. Undocumented youths experience a series of exclusions from opportunities that

continued on page 46

would be otherwise available, such as obtaining a drivers license, applying for internships, and traveling (Ellis & Chen, 2013). Clients might feel alienated by being prohibited from taking part in U.S. normative experiences and being unable to engage in such activities might single out the client amongst peers and invite questions.

Research suggests that being undocumented is closely related to a lack of legal protection and social security (Sullivan, & Rehm, 2005), as well as greater poverty (Passel, 2005). Clients who are undocumented immigrants can be considered to have a "triple minority status"—that is, they are a racial and/or ethnic minority, are non-citizens, and come from low socioeconomic backgrounds (Perez, Espinoza, Ramos, Coronado, & Cortes, 2009). In particular, undocumented students face several risk factors, such as health issues stemming from a lack of health insurance, working more than 20 hours a week (Perez et al., 2009), crowded living conditions (Sullivan & Rehm, 2005), constant fear of deportation, financial difficulty (Contreras, 2009), anxiety, loneliness, and depression (Bruno, 2012).

Undocumented students might be nontraditional students, as they are ineligible for state financial aid (Bruno, 2012), federal financial aid under the Higher Education Act of 1965 (Kim, 2012), and generally do not qualify for in-state tuition (with the exception of 14 states as of 2013; Joaquin, 2013). Thus, such students may delay entering college for financial reasons. Dealing with transitioning to the college environment as a nontraditional student might be a major concern for these clients, as they may be unfamiliar with the system and could have difficulty accessing the resources available in college campuses. In addition, many are first generation students, compounding issues related to being first generation students to the stressors they already face as undocumented and nontraditional students.

Another possibility is that the client is the only member of the family who has qualified for the Deferred Action for Childhood Arrivals. In such a position a client may feel guilt for having qualified for deferred action, as he or she might be "leaving" parents or older siblings behind and at risk. As it stands, the Deferred Action for Childhood Arrivals program does not provide a pathway for permanent residency or citizenship (Passel & Lopez, 2012). This means that clients who are beneficiaries in this program will have to contend with future immigration reform, continue applying for two-year renewals, or return to status as unauthorized immigrants. For these clients, exploring feelings surrounding their current status as well as exploring future goals and plans may be important.

An undocumented young adult coming to a college counseling center might be seeking services for a myriad of issues. It is important to remember that, while the client has been or is an undocumented student, this is not necessarily the reason he or she is seeking psychotherapy. Remaining open to the client's particular experience and trying to best understand how he or she has dealt with an undocumented immigrant identity without judgment will allow the client to explore this experience more fully in psychotherapy.

References for articles can be found starting on page 72.

[1] Given the scope of this paper, Refugee and Asylum, Victim of Human Trafficking, and Crime Victim or Witness statuses will be omitted, as they constitute a different range of possible experiences and needs.

Finding Good Mentoring: An Early Career Psychologist's Journey and Creation of Division 29's New Mentoring Program for ECPs

Susan Woodhouse, Ph.D.
Lehigh University

As I look back on the early career psychologist (ECP) phase of my career—the first 7 to 10 years post Ph.D.—I realize that there were many times that I needed good mentoring. Sometimes I was acutely aware of how much I wanted and needed mentoring and at other times I didn't realize how much I needed mentoring until after the fact. Sometimes my need for mentoring did not become clear to me until a good mentor stepped up by surprise and I found out how much I benefitted from that mentoring. Other times my need for mentoring became clear after the fact because I just bumbled through the best I could (for better or for worse); and then later it dawned on me how helpful it would have been to get some guidance.

In this piece I will talk about some of the crucial times I needed mentoring, what separated the good mentoring experiences from the bad or indifferent ones, and talk about an exciting new mentoring program Division 29 (Psychotherapy) has recently developed for Early Career Psychologists. I think this new mentoring program has a number of features that will allow it to be helpful for a wide range of ECPs. Those of us who were involved in developing the mentoring program for Division 29 (Annie Judge, Rayna Markin, Jean Birbilis, Caryn Rogers, and myself) did a lot of thinking about what had worked and not worked well for us in past mentoring experiences. Thus, I think the new Division 29 mentoring program will have a lot to offer ECPs in terms of positive mentoring across a wide range of the activities we are engaged in.

Everyone's career trajectory looks very different, so it is particularly important to find mentoring that is specific to one's own career path. My particular career path involved doing a research postdoc, getting a faculty position, learning how to get grants, and getting tenure. For others, mentoring for a clinical career would be much more important (e.g., how to start up a practice or how to develop a particular specialization). For most of us, though, there are a number of mentoring needs that we would typically have in common. Common areas might include mentoring about getting licensed, dealing with ethical issues that arise, balancing work and life demands, negotiating pay, figuring out which organizations will be most helpful to us, learning to network effectively, and figuring out how we can best serve the profession through leadership or other service roles. So although the particular areas of mentoring ECPs might need could vary, there are some common areas most of us will need. Also, although there may be big differences in the kinds of things mentors may offer ECPs, the qualities of good mentors can be very similar across the different types of mentoring.

Qualities of Good Mentoring
I was going to say that my best mentor-

continued on page 48

ing experiences have been with people who knew me well and really cared about me, but I think that is only partially true. Some of my mentors fit this description, but some of the most interesting mentoring experiences arose spontaneously with people who didn't know me particularly well, but were committed to mentoring the next generation and willing to give of themselves in a particular context. Although some of my best mentors have been long-term mentors who have stayed invested in me over the long haul and across a number of contexts, I have also had fantastic mentors who have invested in me for just a short season, but who had a profound impact on me.

Key examples of this kind of spontaneous mentoring experiences have happened within Division 29. I keep hearing that the new generation of ECPs are wary about joining professional organizations because they are not sure what professional organizations have to offer them. My experience has been that mentoring has been one of the chief rewards of joining Division 29. For example, when I first volunteered to serve as the Chair of the Research Committee in Division 29, I was invited to attend my first Division 29 Board of Directors meeting. I had no idea whatsoever what to expect. But from the beginning the then-President of Division 29 (Dr. Nadine Kaslow) took me and all the "newbies" under her wing and worked with us to create a manual for how to get started in the division. I learned a lot about leadership and felt tremendously supported in the process of getting started in the Division. One of the things that happened, was that each of us was assigned a "meeting mentor" in the Board of Directors who sat next to us during the meeting, helped us get our ideas heard, and helped us learn the ropes of how the meeting worked. It was a very empowering experience. My "meeting mentor" has continued to be supportive and helpful, and has become something of a mentor to me in my roles in Division 29. I have also had wonderful opportunities to talk at length with a number of senior people who have been very helpful to me in my career. It has been a wonderful experience that has provided important guidance.

Two of my most important long-term mentors have been my academic advisor/mentor from graduate school and my post-doc mentor, with whom I still collaborate. One of the interesting things about my postdoc mentor is that she is in a different area of psychology, but one that meshed well with my research and clinical interests. One key reason that I was initially drawn to my postdoc mentor was the fact that she was in an area that I really cared about, but was outside of my area in counseling psychology. Working with her in grad school allowed me to fill in gaps in my training so that I could become more of the psychologist I wanted to be. She is a developmental psychologist, but her research included an applied component, so I was able to get advanced clinical training through working with her—in addition to great research training. I think one factor that helped me develop this very deep mentoring relationship was the fact that I gave my work in her lab my all. I remember one lab meeting telling her that I was having trouble sleeping because I was worried about some aspect of implementing the research. She said that the fact that I was worried about whatever it was helped her sleep at night. I think this is just one example of how much this relationship was a two-way street. I was invested and she was invested. Working hard together toward common goals on a number of projects over time cemented a long-term relationship. Not all mentoring relationships work out this way, but

continued on page 49

that's how this one developed for me. We both care deeply about the same kinds of questions and we've both been willing to give one another all we had that would be useful to the other. Over the years, a very close relationship has developed that is both professional and personal. It's a very enriching relationship that has grown and changed over the years.

Having a shared passion seems to be a great source of mentoring. For my postdoc mentor and me, that shared passion has been attachment theory—both the basic science kinds of questions and applications of attachment theory to psychotherapy. Having that focus has provided the underlying structure for an ongoing mentoring relationship. After a few years of working with her when I was in grad school, she suggested that I write a grant for a nationally-funded postdoctoral fellowship to focus on psychotherapy process in interventions for families with infants. It would never have occurred to me to apply for a grant unless she had said something about it. I wrote the grant and she was kind enough to shred it to bits and give me feedback on the revisions so that it would actually be competitive. I trusted her enough to really listen to her advice and work to make the proposal be the best that it could be. I ended up getting the grant, and was able to do a two-year research postdoc with her focused on psychotherapy process and the psychotherapy relationship. Having gotten that initial funding was key in getting my first faculty position and in getting my first national level-grant. None of that would have happened without the mentoring I got beforehand that helped me get into position to be able to move to the next phase. Also, these early mentoring relationships ended up developing into long-term mentoring relationships that have continued to provide me with support and guidance over the years.

Both my graduate school advisor/mentor and my postdoc mentor ended up providing key mentoring during the job search process, as well as in the negotiation process once I was offered a job. I had no idea how important mentoring would be in the process of accepting a job and making those initial negotiations. That period was so crucially important. My mentors helped me figure out how to lay out what I wanted to do over those initial years as an ECP moving towards licensure and tenure; how to figure out how much start up money, space, computers, and research assistant support I would need; and how to ask for what I needed.

I quickly learned though, that having one or two important mentors is not enough. There were too many things I needed mentoring about, and many of these things required mentoring that was very specific to particular contexts. In my first job two very important mentors emerged: my faculty mentor who guided me through the specifics of the politics in my department, helped me see my role in my program, helped me navigate all the issues related to tenure, helped me understand what was really happening in meetings (both what was said and unsaid), and basically helped me figure out pretty much everything about how to make it in my new life as an assistant professor. I experienced my faculty mentor as a true secure base and "mama bear," who helped me survive and thrive as a young faculty member. I can't believe I was lucky enough to get this kind of mentoring. In this case, the mentoring was less over having the same intellectual interests, as it was the shared commitment to a program. Also, this particular mentor just really valued and cared about mentoring, and was willing to put an incredible amount of energy into mentoring. I was just very lucky.

continued on page 50

The other key mentoring relationships that emerged in my first job grew up around shared intellectual interests. I learned about and asked to join a group of researchers who were all working in similar areas of research. Each person was working on their own projects, but the senior people were willing to provide meaningful feedback on projects. We met as a group (both junior and senior people) twice a month to talk about the projects we were working on and give one another feedback. It led to a vibrant community of people who shared common interests and who mutually supported on another. Most importantly for us ECPs, it provided a great source of mentoring that helped us understand how to find seed money to start our research programs, and led to the development of successful federal grant proposals.

Not all of the mentoring came from these key, deeper relationships, though. I was also able to learn a lot from briefer opportunities offered by my College and University. I took advantage of every opportunity to learn more about the things I needed to advance my work. For example, my College provided the funding to send me to a National Institutes of Health (NIH) workshop to learn about how to submit grants. My College also sent a group of ECPs to meet with a variety of funding agencies in Washington, DC. That trip helped me figure out what agencies would be most likely to fund the kind of research I was interested in doing. My university offered a number of trainings that were very helpful, and I did as many of those as I could. The longer-term mentors helped me get connected with these events and helped me make sense of these experiences and thread them together.

Other important mentoring relationships developed as a result of connections I made by following the advice of my postdoc mentor and my research mentors at my first job. For example, my postdoc mentor suggested that I apply for a fellowship program that would allow me to develop in one of my areas of specialization (intervention with families with young children). Miraculously, I was accepted into the two-year fellowship program, which turned out to be one of the most formative experiences of my life. I was assigned a mentor as a part of this program. This mentor was a very kind person, but I think I spoke with this mentor one time during the fellowship experience. I'm not sure why that mentoring program never took off—but I think it had something to do with the fact that the mentoring program was not well defined. I wasn't sure how much I should ask this formal "mentor" for, or whether I should ask for anything at all. I don't think any particular guidance was given to the mentors in the mentoring program, and it was not clear what I should expect. The mentoring just never happened. In contrast, another clinician/researcher took an interest in me and my goals and she ended up seeking me out, watching out for me, and initiating conversations. This informal mentor ended up providing a ton of important mentoring for me. I'm not sure why that happened—I had just as much in common with my formal mentor in terms of research and clinical interests. But it was only with this informal mentor that things really took off. She just had a passion for the work I was doing and she took an interest in me. I was very lucky that she took the initiative to connect with me and encourage me. I would have been nervous to ask, but because she reached out I was able to really open up and start to ask for what I needed.

Formal mentoring programs don't always work. Another formal mentoring

continued on page 51

experience I had that didn't really take off for me was a mentoring program offered in my first job. I was matched with an interesting and productive person who was very nice to me in our one meeting. But I got the sense that my assigned mentor was pretty busy—and we never met again. I'm sure this person would have responded if I had reached out, but I felt worried it would feel like an inconvenience. So I never asked for anything.

As we worked to design the new Division 29 (Psychotherapy) mentoring program these experiences of mentoring that never took off were very much on my mind. It was clear to those of us who worked on designing the Division 29 mentoring program that simply matching people up with a willing mentor is not enough. And it is not enough to leave it to the mentee to initiate contact. It seemed important that we clearly spell out the amount of time mentees can expect, and that the mentee not have to be the one to ask for things. When we built the Division 29 mentoring program we decided that we needed to remove the burden from the mentee because otherwise mentees might not be sure whether or how to ask for mentoring time. We wanted to take the guesswork out of it by setting clear expectations about when mentors and mentees would meet and for how long. We wanted to get people together in groups over shared interests, because it seems like there is something about having shared interest that really helps relationships take off and begin to take on a life of their own.

We also decided to go with a group mentoring format because, as was my experience with the research group at my first job, it's not just the senior-junior relationships that are important, but also the networking *between* the more junior people that is helpful. Also, when one junior person is asking a more senior person about a particular issue, everyone is learning from that experience. That was my experience in the research mentoring group—when someone else got feedback on their specific project, there was usually something that was relevant to me and my project as well. There is no way to make specific mentors care about specific mentees, but we can help to foster positive mentoring relationships by getting people together with similar interests and make the expectations very clear, so that no one is wondering whether it's okay to ask for something they need.

Realizing It Would Have Been Helpful to Have Mentoring After the Fact

One area that I wish I could have gotten more mentoring around was in the area of attaining licensure. Perhaps my mentoring in this area was a bit less than I would have liked because my path has been primarily a research-oriented track. It was only later that I learned that I could have begun the path to licensure (or even attained licensure) during my research postdoc years, given the state in which I was living and the clinical work I was doing as a part of the research. That was a real missed opportunity that resulted in my having to do a lot of clinical hours while I was simultaneously trying to attain tenure. Later on I was able to get mentoring about licensure in the setting I completed my postdoctoral licensure hours—but I only wish I had known to ask about licensure earlier on in the game.

There are other areas like this in which I wish I had known to ask for mentoring. Examples would include things like putting together conference symposia and developing my teaching. But sometimes it's just not clear until later on. My hope is that the group structure of the Divi-

continued on page 52

sion 29 mentoring program will make it more likely that questions about things one might not even think to ask will come up.

Structure of the Division 29 Mentoring Program

As mentioned earlier, we decided that the mentoring program would have a group format, so as to foster relationships among the mentees as well as between the mentees and the two mentors assigned to each group. Each group will have 2 mentors and 3-4 mentees. The bottom line is that the program is focused on building relationships between the participants, and providing mentoring that helps the ECPs meet their specific goals. Because there would be two mentors involved, the mentors would have each other to share ideas, share the mentoring load, and help to motivate one another. In addition, two mentors would provide the mentee group with different types of expertise and perspectives. The mentee group would provide for professional relationships to build between the mentees as well, which would provide for meaningful interaction and professional support in the future.

In order to provide focus to the mentoring groups and best meet mentees' most pressing needs, we decided that the Division 29 mentoring groups would focus on a particular area of the field of psychotherapy (i.e., practice, research, and teaching/training). Mentees would apply to the mentoring program with a project focused within one of these three areas. Within each group, any topic could be fair game—but the groups themselves would cluster together people who wanted to focus primarily in one of the three areas. So for example, the practice group might focus on starting a new practice—but research or teaching issues might emerge as well. Likewise, the research group might focus on getting a research career off the ground, but getting licensure could be addressed as needed. Thus, mentees apply for the mentoring program with a project proposal relevant to one of the three mentoring program areas (i.e., practice, research, or teaching/training). We thought that asking mentees to apply to the mentoring program with a specific project they would like to work on would help to provide focus on the participants' mentoring needs. The projects can really be anything relevant to the mentee's professional life (except of course supervision, which would not be appropriate in a mentoring group). For example, projects could be something like getting licensed, starting up a private practice, starting up a research program, getting a grant, developing a syllabus for a course, or anything else that would be meaningful to the mentee.

The mentoring groups will meet over the course of a year via videoconference to discuss the projects and other mentoring topics every 2 months (i.e., 6 times/ year). Each of these meetings lasts an hour. The mentoring groups could also set aside time to meet with one another during APA, or other meetings they may attend (e.g., National Multicultural Conference and Summit, Society for Psychotherapy Research). Mentees would also be connected, as relevant, with Division 29 Domain Representatives and Committee Chairs for whom the mentee's project (or other interests) could be relevant. For example, mentees could become part of particular Division 29 committees as a part of their project if relevant and desired. But no matter what, mentees can count on having 6 videoconferencing meetings over the course of the year with their mentors and fellow mentees. The nice thing about videoconferencing is that it will allow for a more face-to-face feeling, without incurring the costs of travel. Later on when you do see members of your group at a

continued on page 53

conference or meeting, you will be able to recognize one another.

Attention to diversity will be infused throughout the three mentoring groups, including the constitution of the mentoring group and topics discussed. Our goal is to have each mentoring group contain at least one member who belongs to an underrepresented group.

I am personally very exited about the new mentoring program and I hope that a lot of ECPs will feel encouraged to apply for the program. Those interested in mentoring should check out the announcement for the Division 29 Mentoring Program in the Psychotherapy Bulletin and the Division 29 website. My own experience is that you can never get too much mentoring.

APF ROSALEE G. WEISS LECTURE FOR OUTSTANDING LEADERS IN PSYCHOLOGY

"Leadership, Mentoring, Service, and How Psychology Can Save America from Itself"

Jeffrey E. Barnett, Psy.D., ABPP

Friday, August 2, 2013

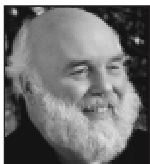
10:00 AM – 10:50 AM

Convention Center room 321B

Jeffrey E. Barnett, Psy.D., ABPP is a Professor and the Associate Chair of the Department of Psychology at Loyola University Maryland and is a licensed psychologist in practice in Maryland. He is a past president of the Maryland Psychological Association and of three APA divisions: Psychotherapy; Independent Practice; and State, Provincial, and Territorial Psychological Association Affairs. In addition to numerous other leadership roles within the profession, he has been the chair of APA's Ethics Committee, Fellows Committee, and Board of Convention Affairs, and he coordinates the Karl F. Heiser APA Presidential Awards for Advocacy. He has numerous publications and presentations to his credit, focusing primarily on ethics and professional practice issues for psychologists and psychologists-in-training. He is an active mentor to colleagues, trainees, and students.

CONGRATULATIONS TO THE DIVISION 29 AWARD WINNERS!

Please join us as we honor our award winners at the Division 29 Awards Ceremony, Saturday August 3rd, Hilton Hawaiian Village Beach Resort, Honolulu Suite II. The awards ceremony will be followed by the Social Hour, where you are cordially invited to join us for refreshments and fellowship.



Division 29 Distinguished Psychologist Award – Dr. Les Greenberg

Les Greenberg, Ph.D. is a Distinguished Research Professor Emeritus of Psychology at York University in Toronto, Ontario. He is the Director of the Emotion-focused therapy Clinic and is one of the world's leading authorities on working **with** emotions in psychotherapy. Dr. Greenberg is a founding member of the Society of the Exploration of Psychotherapy Integration (SEPI) and a past President of the Society for Psychotherapy Research (SPR). He is on the editorial board of many psychotherapy journals, including the *Journal of Consulting and Clinical Psychology* and the *Journal of Marital and Family Therapy.* Dr. Greenberg's integrative work is celebrated by practitioners from diverse camps including cognitive-behavioural, interpersonal, psychodynamic and solution focused approaches.

Dr. Greenberg's professional publications include over 100 peer-reviewed papers, 100 book chapters, and 18 books. Among his most influential writings are Facilitating emotional change with Laura Rice and Robert Elliott (Guilford Press 1993) *Emotion Focused Therapy: Teaching Clients to Work Through Their Feelings* (American Psychological Association, 2002), *Emotion-Focused Therapy of Depression with Jeanne Watson* (American Psychological Association, 2006), the seminal couple therapy book *Emotionally Focused Therapy for Couples with Sue Johnson* (Guilford Press, 1988), and the more recent *Emotion-Focused Couples Therapy: The Dynamics of Emotion, Love and Power with Rhonda Goldman* (American Psychological Association, 2008). More recently he has published Emotion-focused therapy: Theory and practice (2010)**;** Working with Narrative in Emotion-focused Therapy: Changing Stories, Healing Lives. (2011), and Therapeutic Presence (2011) all with APA press.

Dr. Greenberg trains professionals nationally and internationally His workshops have brought him critical acclaim throughout in over thirty countries on all continents of the globe His contributions have been recognized by numerous awards. He has received the 2012 Distinguished Professional Contribution to Applied Research of the American Psychology Association as well as the Carl Rogers Award of the American Psychology Association. He received the Distinguished Research Career award of the International Society for Psychotherapy Research He also received the Canadian Council of Professional Psychology Program Award for Excellence in Professional Training, and the Canadian Psychological Association Professional Award for Distinguished Contribution to Psychology as a Profession.

He lives in Toronto and conducts a private practice for individuals and couples when he is not travelling to train people in the emotion–focused approach.

APF /Division 29 Early Career Award – Dr. James Boswell

James F. Boswell received his Ph.D. in clinical psychology from Penn State University in 2011. He completed his pre-doctoral clinical internship at Brown University Alpert Medical School, and a clinical-research postdoctoral fellowship at Boston University. Dr, Boswell is currently a research assistant professor in the Department of Psychology at Boston University. He will join the Department of Psychology at the University at Albany, State University of New York as an assistant professor in August 2013. As a psychotherapy researcher, Dr. Boswell has published extensively on the process and outcome of psychotherapy, psychotherapy training, and psychotherapy integration. In addition, he has received research awards and grant support from the American Psychological Association, the National Institute of Mental Health, the Society for Psychotherapy Research, and the Society for the Exploration of Psychotherapy Integration.

Division 29 Award for Distinguished Contributions to Teaching and Mentoring – Dr. Laura S. Brown

Laura S Brown received her Ph.D. in Clinical Psychology in 1977 from Southern Illinois University at Carbondale. Although she has taught briefly at SIU, the University of Washington, and the Washington School of Professional Psychology, she has primarily been a psychotherapist, supervisor, and independent scholar and educator in practice since then. She is a diplomate in Clinical Psychology of ABPP, and a Fellow of 10 divisions of APA. She is past-president of Divisions 35, 44, and 56, and of the Washington State Psychological Association.

Dr. Brown's primary areas of focus have been the development of feminist practice, treatment of trauma survivors, and nourishing cultural competence in psychologists and other mental health professionals. She has edited or authored 11 books and 150 chapters and journal articles. Additionally, she has demonstrated her work in several videos produced by APA, including two on gender and trauma treatment, and a six-session DVD, Feminist therapy over time. Her work has been recognized repeatedly by her colleagues, leading to numerous awards, including the Distinguished Publication Award of the Association for Women in Psychology, APA's Award for Distinguished Professional Contributions to Public Service, and the Sarah Haley Award for Clinical Excellence of the International Society for Traumatic Stress Studies.

Having long been involved in work with marginalized people through her social justice activism, Laura founded the Fremont Community Therapy Project in 2006. FCTP offers high-quality low-fee services, both psychotherapy and assessment, to individuals without the means to obtain care in the community, and also provides training opportunities for its staff, which is comprised entirely of doctoral and post-doctoral trainees in psychology. In 2012 she published her first book for general audiences, Your turn for care: Surviving the aging and death of the adults who harmed you, which is the only volume available for adult survivors of childhood maltreatment who are now confronted with the old age of family members who abused them. She has been a student of the martial art of aikido for the last decade, and hold a brown belt.

APF Rosalee Weiss Lecture for Outstanding Leaders – Dr. Jeff Barnett

Jeffrey E. Barnett, Psy.D., ABPP is a Professor and the Associate Chair of the Department of Psychology at Loyola University Maryland and is a licensed psychologist in practice in Maryland. He is a past president of the Maryland Psychological Association and of three APA divisions: Psychotherapy; Independent Practice; and State, Provincial, and Territorial Psychological Association Affairs. In addition to numerous other leadership roles within the profession, he has been the chair of APA's Ethics Committee, Fellows Committee, and Board of Convention Affairs, and he coordinates the Karl F. Heiser APA Presidential Awards for Advocacy. He has numerous publications and presentations to his credit, focusing primarily on ethics and professional practice issues for psychologists and psychologists-in-training. He is an active mentor to colleagues, trainees, and students.

The Distinguished Publication of Psychotherapy Research Award (co-sponsored by John Wiley Publishing)

Michael J. Constantino, Ph.D. is an Associate Professor in the Department of Psychology at the University of Massachusetts Amherst where he directs his Psychotherapy Research Lab, teaches graduate and undergraduate courses on theories and techniques of psychotherapy, supervises clinicians-in-training, and maintains a small private psychotherapy practice with adult outpatients. Dr. Constantino's primary scientific contributions include: (1) the investigation of patient, therapist, and relational processes that influence psychosocial treatments, (2) the development and testing of effective therapeutic interventions that address pantheoretical principles of clinical change, (3) the conduct of effectiveness research in psychotherapy training clinics, and (4) the interface of social and clinical psychology in the service of establishing clinical practice guidelines. Dr. Constantino has published both theoretical and empirical work in leading journals and books in the field, and he has received both internal and external grant support for his research. Dr. Constantino's work has been recognized internationally, including with his receipt of the American Psychological Foundation's 2007 Division 29 (Psychotherapy) Early Career Award, the Society for the Exploration of Psychotherapy Integration's (SEPI) 2007 New Researcher Award, the Society for Psychotherapy Research's (SPR) 2010 Outstanding Early Career Achievement Award, and fellow status (awarded in 2009) in the American Psychological Association (APA) and Division 29 of APA. Among many positions served, Dr. Constantino is a former Early Career Domain Representative to the Division 29 Board of Directors, and he is currently the President of the North American Society for Psychotherapy Research. Dr. Constantino is a Contributing Editor for *Psychotherapy Bulletin* and the *Journal of Psychotherapy Integration*. He is also a Consulting Editor for *Psychotherapy*, *Psychotherapy Research*, the *Journal of Unified Psychotherapy and Clinical Science*, the *Journal of Consulting and Clinical Psychology*, the *Journal of Clinical Psychology: In Session*, and the *Journal of Psychotherapy Integration.*

Specialization in Infant Mental Health: Obstacles in Training Clinicians & Practice

Karalynn Royster, M.A.
University of Denver-Graduate School of Professional Psychology

The field of infant and early childhood mental health is an increasingly specialized field, requiring comprehensive education and training for clinicians wishing to dedicate their clinical work to this area. The importance of development during early life has gained acceptance in the larger psychological community. Proper specialized education is integral, yet well researched, effective, and standardized training programs are not widely available. This paper examines this concern by first providing justification for the importance of infant mental health. Then it will explore proposed and accepted competency guidelines. This will be followed by a discussion of the difficulties in gaining training in early childhood education, assessment, and diagnosis. The current state of the field will be reviewed in order to understand the implications for training.

The Case for Infant Mental Health
To begin a discussion on infant mental health, one must first understand the construct. Fraiberg (1980) defined infant mental health as "the social, emotional, and cognitive well-being of a [child] who is under three years of age, within the context of a caregiving relationship" (as cited by, Finello, 2005). Further, infant mental health practice can be understood as "the unique approach to the understanding and treatment of infants, toddlers, and families…[that] embraces the belief that all babies and young children can benefit from a sustained primary relationship that is nurturing, supportive, and productive" (Stinson,Tableman, & Weatherston, 2000; Shirilla & Weatherston, 2000, as cited in Finello, 2005, p. 5). Generally speaking, the development of infant mental health competencies is specific to women who are pregnant, and children up until the age of three. However, many experts agree the competency domains can be applied to children as old as age six (Weatherston, Kaplan-Estrin & Goldberg, 2009).

The benefits of infant mental health are numerous. With the emphasis on early diagnosis and increased attention to young children in our society, the field of psychology is shifting towards an emphasis on early intervention. Examples of this are young children who have been diagnosed with developmental disabilities, or those who are victims of abuse or neglect (Michael, 2008). Early childhood intervention services can benefit parents who have a limited or misinformed education on the needs of a young child.

It is also during the first years of life that the brain is rapidly developing language, social, emotional skills, behaviors, and much more. (Zero to three: National center for infants, toddlers and families, 2012). The developing mind is rapidly creating connections, learning from the environment, growing and changing. The brain not only responds to direct experience, but also, it is particularly responsive to the environment in infancy (Perry, 2000). Thus intervention

continued on page 58

during this time can be particularly impactful, and it is vital to creating healthy individuals.

"Identification of, and an effective response to, the first signs of social/emotional difficulties and symptoms of serious emotional or behavioral difficulties are essential" (Hoover, 2008 p.1). The basis of infant mental health lies in emotional and social problems discovered in early childhood. These concerns respond best to early, quick, and effective intervention. If effective intervention is provided, the problems may not persist through childhood, school age and, eventually, adulthood. If the problems do persist, the hope would be that the child and family have learned effective coping skills in order to adapt to these behaviors.

The empowering and fascinating aspect of infant mental health is it considers the child in a *relational* context. Diagnosis, treatment, and assessment are focused on the relationships, attachment, and environment of the child (Hoover, 2009; Michael, 2008). Many infant mental health clinicians view their roles as developing relationships (Finello, 2005). Specifically, these are the relationships between the therapist and child, the therapist and family, and developing the relationship between the parent(s) and child.

Another relationship that must develop, and poses a significantly greater challenge for an infant mental health therapist, is the supervisory relationship. Unfortunately, despite increased demand for infant mental health therapists, there are limited supervisors who have the skill sets to teach emerging clinicians. The philosophy of the relationship as the basis of change permeates all aspects of infant mental health, from developing competencies to diagnosis and treatment.

Competency Domains

Mental health clinicians are ethically bound by requirements to practice within their scope of competence. If a clinician is interested in a specific specialization, it is their own task to complete the necessary requirements in order to achieve competency in that domain and claim expertise (American Psychological Association, 1992). In most fields of specialization, including infant mental health, the mental health professional is responsible for gaining the training, skills, and supervision required to meet the specialization competency requirements accepted by the discipline.

Competency for this area of mental health practice is defined by Weatherston, Kaplan-Estrin, and Goldberg (2009) as "the development of a unique knowledge base, clinical assessment and treatment skills specific to infancy and early parenthood, and clinical supervisory experiences that lead to best practice" (p. 650).

The Michigan Association for Infant Mental Health (MI-AIMH) is regarded as one of the first groups of infant mental health professionals to begin examining the need for endorsements and certifications of professionals working in this highly specialized area (Quay, Hogan & Donahue, 2009). MI-AIMH developed competencies for multidisciplinary professionals wishing to specialize in clinical work with young children. The development of infant mental health competencies grew out of a community need for skilled infant mental health therapists (Finello, 2005).

The Michigan Model proposes eight domains for multidisciplinary professionals in the field of infant mental health. These include theoretical frameworks (e.g., family relationships & dynamics, pregnancy, infant development); Law,

continued on page 59

regulation, and Agency Policy (e.g., policy in the agency and the community); systems expertise (e.g., community resources); direct service skills (e.g., assessment, screening, intervention); working with others (e.g., collaboration); and communication; thinking; and reflection (Weatherston, Kaplan-Estrin, & Goldberg, 2009). This model provides mental health practitioners with distinguishable skills to be demonstrated by those seeking this endorsement, as well as, culturally sensitive additions to the competency considerations (Weatherston, Kaplan-Estrin, & Goldberg, 2009).

Quay, Hogan, & Donahue (2009) surveyed infant mental health experts' opinions of imperative competency domains for professionals and provided rankings. Examples of the most vital competencies are the clinician "understands when particular problems manifested by the child require services outside of the therapist's competence [and] establishes and maintains a therapeutic alliance with parents and caregivers" (Quay, Hogan & Donahue, 2009, p. 185). Because infant mental health experts provide these rankings, they illuminate the values of those actively in the field and for training incoming professionals. In addition, Zeanah (2011) outlined principles for clinicians to consider and produced more explanation on the principles through the Levels of Family Involvement for Infant Mental Health Model (LFI-IMH).

At the time of publication, endorsements for early childhood and/or infant mental health are available in Arizona, Colorado Kansas, Michigan, Minnesota, New Mexico, Oklahoma, and Texas (Hoover, 2008). These endorsement programs are developed and approved by the World Association of Infant Mental Health (Hoover, 2008; World Association for Infant Mental Health, 2013). Other models include the California Training Guidelines (Finello, 2005).

It is important to note, competency guidelines cannot be effective until they are adopted, used, and overseen by professionals in the field (Finello, 2005). As mental health is a self-regulating profession, it is those in the field that must adopt, utilize, govern, and train in accordance with standards of practice. Lastly, the competencies need to be solidified into uniform guidelines. This would allow for more congruencies in training and clinical programs nation-wide, and hopefully reach more children effectively.

Obstacles to Specialization Training

The difficulties in gaining specialization in infant or early childhood mental health are numerous. The obstacles for entrance to the field are abundant, and can be difficult to surmount as an early professional. Training programs vary widely in the various forms they can present infant mental health materials including presentations, post-graduate certifications, intensive workshops, mini-courses and entire graduate programs focused on infant mental health (Zeanah, 2011). As Zeanah (2011) points out, if there are not clear standards of practice, not only will training be inconsistent across clinicians, but the endorsement or certification may become null. In spite of the intentions of programs training clinicians in this highly specialized field, if guidelines for practice remain unsolidified, children and families may receive inadequate care.

Students may not be fortunate enough to be in a program offering a specialty in infant mental health. In other circumstances, students may develop an interest in the specialization later in their training. In either situation, students or clinicians may have to piece together course work fitting this sub-discipline, and struggle to meet the competency ex-

continued on page 60

pectations, despite their genuine interest in pursuing the specialization. Students and professionals would benefit from fewer obstacles to formal education in clinical work with young children.

Aside from coursework, practicum and training sites in early childhood work can also be difficult to obtain. With an apparent limitation in sites, variety in training experiences may be restricted. If one is lucky enough to secure an early childhood placement, there may be constraints. At times, these can include limitations in training cases. A bind may be created for training clinicians. Consider the therapeutic skills required to work with infant-parent dyads, for example. These skills are primarily developed through experiential learning. However, because of the level of skills required in these sessions, beginning clinicians may not be encouraged to work with dyads, and therefore be unable to gain the experience prerequisite of dyad work. This can quickly become a frustrating cycle, in which the student does not get their training needs met.

For psychology students, after practicum and course work, comes the challenge of obtaining a pre-doctoral internship and subsequent post-doctoral fellowship. Again, opportunities for advanced training are increasing. Unfortunately, they may not be increasing as abundantly as the field needs them to be. As a professional, continuing education, trainings, and workshops can also supplement a clinician's training.

One can easily see how challenging specialization in infant mental health can be. Depending on the perspective taken, this can be either a positive or a negative. As Finello (2005) stated, "Retraining in this field involves learning new ways of conceptualizing basic frameworks, not just acquiring new information and adding it to adult mental health paradigms" (p. 166). Acquiring this specialization cannot simply involve adapting early childhood techniques to already established methods of treatment for adults or even, older children. It is a completely divergent way of looking at mental health, with an entirely new population. While this poses challenges for training and development of clinicians, the rigors of such demands produce highly trained mental health professionals.

Assessment

Training in assessment of professionals who wish to specialize in infant or early childhood assessment may also be limited. If it is available, it may be presented only briefly, as part of a childhood assessment course. Other times, there is disagreement about the best way to train students on early childhood assessment. Finello (2005) provided an example of the disparities in training on assessment tools with young children: "Should training and course work be divided into the infant-toddler (birth-to-three) period with a separate focus on the preschooler (three-to-five age group) or should training be provided across the spectrum from birth to age five?" (Finello, 2005, p. 53).

The availability of norms, representative of young children, may be another practice obstacle. If young child normative samples are available, they may not be inclusive of presenting concerns (e.g., specific diagnosis) or culturally sensitive (Finello, 2005). Young children may be less interested or engaged in the assessment session, more energetic or fidgety, or require a parent to be present, all of which require a skillful clinician to use non-standardized methods. Of course, most behaviors present during an assessment session provide useful clinical information, but the clinician must be trained in adaptive assessment and have

continued on page 61

the skill set to know what may invalidate a data set.

Diagnostic limitations

Many clinicians agree our current abilities to understand, diagnose, and classify psychopathology are flawed (Evangelista & McLellan, 2004). This is not only limited to adult diagnosis and the Diagnostic and Statistical Manual IV-TR (American Psychiatric Association, 2000). The leading tool for diagnosis in infant mental health, the DC:0-3 (Zero to three, 2005) also has flaws (Evangelisa & McLellan, 2004). While having substantial acceptance, established reliability, and validity in the field it has more empirical support to gain (Evangelista & McLellan, 2004). As Evangelista & McLellan (2004) state, "the DC: 0-3, and indeed every diagnostic system, is primarily devoted to categorizing pathology, rather than cataloguing assets" (p. 170). While the difficulties in categorical diagnosis are not the focus of this discussion, it sheds light on the critical issue of diagnosis of young children and the challenges inherent. Clinicians diagnosing young children need specific training and skills in the use of this tool, as well as, in depth understanding of its limitations.

Clinicians may be uncomfortable with diagnosis to begin with, or have discomfort in diagnosing a child under the age of three with a so-called mental illness. It can be said confidently; those practicing infant mental health share these concerns. Clinicians specializing in infant mental health are largely concerned with the implications of a diagnosis. They also have deep understanding of the benefits of early diagnosis and subsequent interventions. Further, as previously stated, the DC:0-3 is a classification system based in relational frameworks, and therefore seeks to not pathologize solely the child (Zero to three, 2005). Clinicians wishing to specialize in infant mental health ought to be very well versed in these controversies, as well as, aware of their contributions to the larger psychological community on the benefits of early intervention.

Concluding remarks

As the field of infant mental health progresses forward and establishes itself, rapid changes are taking place. Professional's increased interests in the field of infant mental health and enthusiasm for certification standards are welcome. This implies more interest, support, and advocacy on behalf of the young child. It is imperative the field creates clear competencies for mental health clinicians, similar to the wider psychological disciplines of the field. The field must also work towards promoting and supporting training programs with a focus on infant mental health. It is by expanding the expertise of clinicians who work in this specialization that more effective services will be provided to children and their families.

References for articles can be found starting on page 72.

WASHINGTON SCENE

Evolving Professions – Interesting Times

Pat DeLeon, Ph.D.
Former APA President

The 30th Annual American Psychological Association State Leadership Conference (SLC): "Countdown to Health Care Reform," as always, was a truly outstanding event. From my public policy/political perspective, I was particularly pleased with the extent to which those fortunate to attend the conference learned firsthand the intricacies of working with the media at both the local and national level. Former Hawaii Psychological Association (HPA) President June Ching, for example, described her impressive efforts over the years to be "helpful" to our local print, radio, and television colleagues, while always being mindful of her unique expertise. Arthur Evans, Jr., Commissioner of the Department of Behavioral Health and Intellectual disAbility Services for the City of Philadelphia, and Robin Henderson of the Central Oregon Health Council described their visionary efforts to "bend the cost curve," while ensuring that beneficiaries received gold-standard care; i.e., demonstrating that psychology's involvement would bring "added value" to the overall quality of life of their neighbors. David Ballard's exemplary Psychologically Healthy Workplace Awards Ceremony once again highlighted the broad impact of psychology in improving daily lives throughout America.

The presentation on the APA/ASPPB/APIT joint Telepsychology Taskforce demonstrated our profession's responsiveness to the unprecedented challenges occurring within the nation's health care environment. "The Task Force for the Development of Telepsychology Guidelines has completed its work on the 'Guidelines for the Practice of Telepsychology.' The APA Board of Directors will be asked at their June 2013 meeting to recommend that the APA Council of Representatives at its meeting in August 2013 adopt as APA policy these Guidelines. This joint effort has been funded for one additional year (2013) to allow the Task Force to continue its collaborative work to advance model regulatory language and provide guidance on risk management practices (Joan Freud)." On a related note, ASPPB is circulating its draft "E.Passport proposal" for public comment. This will be a mechanism developed by ASPPB (concurrent to the Telepsychology Task Force work) to facilitate interjurisdictional practice for those providing telepsychology services. Each of the 500-plus state psychology leaders present at SLC will undoubtedly have his/her own highlight. SLC is a one-of-a-kind leadership and advocacy training event, which in my judgment is only surpassed by our annual convention (this year being held in Honolulu) in its importance to our professional community.

Katherine Nordal, a former APA Congressional Science Fellow and now Executive Director of the Practice Directorate, in her Keynote Address passionately laid out for the audience the importance of being personally involved and actively engaged in the public policy/political process over the long haul. "At this time last year, the future of the

continued on page 63

Affordable Care Act (ACA) seemed uncertain. Since then, we've had a Supreme Court decision that upheld the ACA and the November reelection of President Barack Obama. The Affordable Care Act has survived, and implementation of the largest expansion of the health care safety net will proceed. The clock is ticking toward full implementation of the law and January 1, 2014 is coming quickly. But January 1st is really just a mile maker in this marathon we call health care reform. We're facing uncharted territory with health care reform, and there's no universal roadmap to guide us. The details of ACA implementation vary from state to state, and so do the key players.

All of you are painfully aware of the difficult health care environment in which we find ourselves these days: *Ever increasing demands for cost containment, declining levels of reimbursement and limits on service delivery. *Greater regulatory requirements. And, *Increasing competition in the psychotherapy marketplace, particularly due to growing numbers of masters-trained mental health providers. Fee-for-service is being replaced by alternative reimbursement mechanisms and marketplace and regulatory developments are encouraging more collaborative and integrated practice models. I see professional psychology facing challenges on three levels: First, there are challenges on the federal level where for starters, there are plenty of unfamiliar faces on Capitol Hill—a total of 94 new House and Senate members in the 113th Congress. There are challenges for the states. A principle example is expansion of Medicaid. Millions of consumers are expected to move into the Medicaid system as the ACA is fully implemented. Medicaid programs in 16 states do not recognize private sector psychologists as providers. For those that do, many place conditions and restrictions on psychologists' participation. For example, requiring physician referral for psychological services. As of 2010, only 25 state Medicaid programs utilized health and behavior codes. In addition to challenges at the federal and state levels, there are challenges for individual practitioners, regardless of practice setting. One of the major ongoing challenges facing many practitioners is the need to adapt to new and emerging systems of care. Looking to the future, viable practice options will vary from one psychologist to another.

"Let's focus on what's happening to address the challenges – beginning with what psychology brings to the table. One of the first steps in positioning for reform is for practitioners to recognize that they bring numerous professional skills and strengths to integrated care settings, including:

- Conducting thorough psychological assessments.
- Understanding environmental factors such as family and community systems.
- Designing, monitoring and evaluating interventions.
- Promoting patient responsibility, resilience and recovery.
- Applying behavioral principles to modify health-risk behaviors and attending to interpersonal barriers to behavior change. And,
- Understanding group dynamics and facilitating teamwork.

These are factors that create 'value-add' for psychologists on health care teams and in integrated, interdisciplinary systems of care. And that's what many of our practitioners increasingly will need to promote: the value and quality they can contribute to emerging models of care. We are a highly educated and talented discipline, and we need to identify and create opportunities to make others

continued on page 64

aware of the skills and strengths we can contribute to health care. I believe that if we are not valued as a health profession, it will detract from our value in other practice arenas as well. So regardless of how we feel about the current state of our health care system, psychology must take its seat at the table and contribute to the solutions needed to fix our ailing system. Psychology will be valued to the extent that we bring our knowledge to bear on the grand challenges of our society. And believe you me, health care is a grand challenge.

"I can sum up in two words what we encourage state leaders to focus on as the countdown to health care reform proceeds: Advocacy and Education. On the advocacy front, we must step up to the plate and insist that psychologists and the psychological and behavioral services we deliver be included in emerging models of care and payment mechanisms. No one else is fighting the battles for psychology… and don't expect them to. We need to look at our advocacy broadly as taking advantage of any opportunity to help others understand and appreciate the value of psychology and psychological services. It's not enough to have a good message. We also need good messengers. Education involves both public education and outreach, along with psychologist education and training needed to prepare the profession for the new practice models that will evolve with health care reform. The skill sets needed for a psychology practice that predominately involves psychotherapy are not necessarily sufficient for practice in integrated care settings. Yes, the clock is ticking toward January 1, 2014. But remember, we're not running a sprint. Health care reform is a marathon – we're in it for the long haul. New models of care and changes in health care financing won't take shape overnight. We can't afford to be left out of health care again (i.e., Medicare) and then have to spend decades playing catch-up. We can't hope to finish the marathon called health care reform if we're not at the starting line. Fortunately, many psychology leaders have embraced our call to action."

Advances Within Professional Nursing: This Spring I had the opportunity to attend two national/international nursing conferences addressing how their profession is responding to our ever-changing health care environment. The American Association of Colleges of Nursing (AACN) 2013 Spring Annual Meeting was entitled "Guiding Change: Technology in Nursing Higher Education." Not surprisingly, there was a focus on exploring challenges inherent in the increasingly technology-dependent environment of nursing higher education, as well as the utility and effectiveness of simulation in nursing education and research-based suggestions for the future. The importance of public policy/political advocacy remained a consistent theme. The Hawaii State Center for Nursing held its annual Pacific Institute of Nursing conference, "Partnership with Parity: The New Paradigm." Two of their speakers described particularly interesting developments for non-physician clinical practice, within the policy context of the 2010 Institute of Medicine (IOM) report "The Future of Nursing: Leading Change, Advancing Health." The IOM noted that with more than three million members, the nursing profession is the largest segment of the nation's health care workforce and recommended that:

- Nurses should practice to the fullest extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

continued on page 65

- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States. And that,
- Effective workforce planning and policy making require better data collection and information infrastructure.

The first recommendation of the IOM was to "…remove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training." Perhaps most intriguing was the call for the Federal Trade Commission and the Antitrust Division of the Department of Justice to review existing and proposed state regulations concerning advanced practice registered nurses (APRNs) to identify those that have anticompetitive effects without contributing to the health and safety of the public. States with unduly restrictive regulations should be urged to amend them to allow APRNs to provide care to patients in all circumstances in which they are qualified to do so.

Attorney Barbara Safreit reported that the National Governors Association (NGA) had recently released a policy document specifically addressing this issue, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care." Highlights include: research suggests that Nurse Practitioners (NP) can perform many primary care services as well as physicians do and achieve equal or higher patient satisfaction rates among their patients (including time spent with patients, prescribing accuracy, and the provision of preventive education). State laws and regulations governing NPs revealed wide variation among the states with respect to rules governing scope of practice, including the extent to which states allow NPs to prescribe drugs, to practice independently of physician oversight and to bill insurers and Medicaid under their own provider identifier. "To better meet the nation's current and growing need for primary care providers, states may want to consider easing their current scope of practice restrictions, as well as their reimbursement policies, as a way of encouraging and incentivizing greater NP involvement in the provision of primary care… None of the studies in NGA's literature review raise concerns about the quality of care offered by NPs."

Cathy Rick, Chief Nursing Services Officer for the Department of Veterans Affairs (VA), described the extraordinary progressive changes in the newest VHA Nursing Handbook, which, in essence, will now provide VA advanced practice nurses with the authority for independent practice, regardless of individual state licensure limitations, unless an individual VA facility limits their scope within that facility. This visionary document has been "cleared" by the relevant legal authorities who will be affirmatively assisting hesitant states in appreciating the federal government's supremacy powers within federal facilities. The handbook notes that research and evidence-based practice have demonstrated the significant and synergistic relationships between delivery of nursing care, patient and resident outcomes, and staff satisfaction as well as process effectiveness and efficiency. It recognizes that nursing care is complex and that paradigms have shifted (and will continue to shift). VHA nursing care delivery will be agile, innovative, and supportive of the Veteran as the driver of their individual healthcare. The basic tenets of VHA nursing are aligned with the ANA Standards of Practice and achieved through evidence-based practice, defined elements of practice, and professional development. Two key underlying components are that the patient

continued on page 66

owns and drives their care based on the information available and nursing interventions are based on the best available evidence and accepted standards of practice. Specifically the Nursing Handbook states:

"Clinical nursing practice varies widely among the States. To ensure safe and appropriate health care to the nation's Veterans, VA has standardized the elements of practice, within VA, for clinical nursing practice other than the prescribing of controlled substances, without regard to individual State Practice Acts. This ensures a consistent standard of nursing care throughout VA's national health care system… Under the Federal Controlled Substances Act… a health care practitioner may prescribe controlled substances only if the practitioner's State license authorizes such prescribing. Accordingly, APRNs, including NPs, may prescribe controlled substances within VA only if they are authorized to do so by their State of licensure or registration and comply with the limitations and restrictions on that prescribing authority. Where VA establishes elements of nursing practice that are more expansive or otherwise inconsistent with State practice standards, VA's practice standards control. VA nurses must follow the VA nursing practice standards established in VA rules, regulations, and policies." Without question this is a most impressive development for our nursing colleagues. The readership should recall that the AACN announced that in October 2004 their member schools voted to endorse moving the current level of preparation necessary for advanced nursing practice from the master's degree to the doctorate-level (i.e., the Doctor of Nursing Practice (DNP)) by the year 2015. Psychology could learn a lot from our nursing colleagues—we are living in "changing times."

Exciting Opportunities To Contribute: One of the most rewarding aspects of being in a university environment is the constant exposure to new ideas and challenges. Steve Brewer recently presented a colloquium on his fascinating research at the Uniformed Services University of the Health Sciences (USUHS). "There is very little research examining the effects of combat deployment on the driving abilities of post-deployment service members. However, there is evidence that service members have an increased risk of being involved in a vehicular accident within the first six months of returning from a combat deployment. Specifically, within the first six months post-deployment there was a 13% increase that all service members (regardless of age/rank) would be in a vehicular accident. Junior enlisted (E1-E4) had a 22% increase and 18-21 year olds had a 25% increase. Also, the number of deployments increased the likelihood of being at-fault in an accident. One deployment meant a 12% increase; two deployments meant a 27% increase; and three or more deployments meant a 36% increase in the likelihood of being at-fault in a vehicular accident. There is also research that describes the effects of PTSD and TBI on cognitive abilities, many of which are required for the safe operation of a motorized vehicle. In order to study the effects of combat deployment on driving abilities, we at the USUHS Ettenhofer Laboratory for Neurocognitive Research ran a pilot study in cooperation with the University of Virginia. We used a virtual reality driving simulator (VRDS) that was designed with multiple testing scenarios. The participants' driving abilities were measured through motor tests and cognitive tests. The findings and feedback from the participants of this pilot study will be used to improve the operational scenarios. These improved scenarios will

continued on page 67

eventually be used to examine the effects of deployment and other variables to establish the safe and unsafe driving characteristics of participants. Scenarios will also be utilized for rehabilitative purposes to assist with improving unsafe driving abilities into safe ones. Such a process could be included in post-deployment training to decrease the incidence of vehicular accidents."

Interesting Life Journeys: Having retired from the U.S. Senate staff after 38+ years, I have become quite interested in learning what colleagues that I have worked closely with over the decades are now doing post-psychology or in expanded roles. Long time VA psychologist visionary Rod Baker has "retired" authoring, co-authoring, and editing three books on the history of psychology in the VA and has just published his fourth book, More Stories from VA Psychology. This latest publication, like a previous one, features career stories written by retired and current psychology leaders whose careers span 61 of the 66 years of VA psychology history that was established in 1946. The career stories add an entertaining first person perspective that expands the reader's understanding of the formal history of VA psychology. Moreover, I recently learned that Rod has a broader writing activity that includes five published articles on the history of the Old West. And, I just finished reading his very enjoyable historical fiction novel, The Rune Master Saga, set in 9th century Norway. Highly recommended—his clinical and developmental perspectives are definitely present. The sequel should be equally intriguing. See his Author page on Amazon.com to learn how Rod became interested in writing fiction.

Kay Daub, Professor of Nursing at the University of Hawaii at Hilo, recently became actively involved in hospice care programs on the Big Island of Hawaii. "Several months ago, I had the opportunity to read a bit about End of Life care and what it means to patients who are dying. I had always been very interested in death and dying, but somehow as way leads on to way, I began my nursing career in telemetry and ICU. Though many cases involved end of life care, my focus had been cure no matter what. So many ethical dilemmas surround the end of life, as I suppose so many ethical dilemmas surround the beginning of life. How does one wrap their head around the concept of comfort care, and let go of the notion of cure no matter how painful, cold, futile, or lonely? I have now taken on this interest and have pursued caring for patients at the end of life; this is in addition to my current busy academic career that removes me from the 'bedside.' What a gift this has been. It is a challenge to go beyond the comfort zone of avoiding communication about a difficult subject. The elephant in the room, what is on my patient's mind; how do I talk about death, active death? I have started meeting the patient and family where they are. I have gotten to hear lovely and sometimes not so lovely stories of memories over a life span. I have even heard a patient talking to someone who died before him. My focus is on comfort rather than cure. My nursing has become more holistic, much more patient and family centered. There is a lesson to be had. Death is our greatest teacher. It does teach us how to live. Death can come at any time in one's life, how wonderful to end with great comfort and reflection."

Reflecting upon the exponential growth and expanding influence of professional psychology over the past four-plus decades, trailblazer Gene Shapiro recently commented: "We need another 'dirty dozen' to fight for the role of tomorrow's providers." As Katherine noted: "No one else is fighting the battles for psychology… and don't expect them to." Aloha.

APA COUNCIL OF REPRESENTATIVES REPORT

Linda Campbell, Ph.D. and John Norcross, Ph.D., ABPP

There is much to report to you from this Council meeting and even though there were not as many actions items on which to vote as in past meetings, many important activities going on in APA were presented. We will report on those subjects of particular interest to our members as well as highlights of the significant activities going on across the association.

Psychotherapy Related Items:
We have good news to report on the efforts that APA, the Education Directorate, and BEA (of which John Norcross is a member and a mover of this initiative) have made in regard to the internship imbalance. We reported to you in August that APA approved the Internship stimulus program which authorized the use of $3 million dollars over the next three years to increase the number of accredited internships. Since that time, Dr. Cynthia Belar, Executive Director of the Education Directorate informed Council that 82 applicants have applied for funding and $593,000 was allocated to 32 programs. There is certainly early evidence that this allocation is opening up additional internship positions. Further, new accreditation categories being proposed of "eligibility" and "accredited on contingency" are meant to facilitate increased positions.

APA has developed a new access to research programs entitled, *Research Alert.* APA members may select topics for a customized alert sent weekly on new research findings based on articles and books in APA databases. Preselected topics include psychotherapy, depression, eating disorders, addictions and others.

The APA Clinical Practice Guidelines Advisory Steering Committee, chaired by Seven Hollon, Ph.D. will oversee guidelines development. Foundational concepts for the guidelines process are transparency, empirical evidence, and multidisciplinary and balanced development panels. Expert panels have been appointed in the three areas of obesity, depression, and post-traumatic stress disorder.

The Good Governance Project (GGP) was commissioned to address the structure and efficiency of governance and to make recommendations for change. The options on the table at this point are (a) Incremental change which retains Council but makes smaller changes, (b) Moderate change which creates an "issues focused" Assembly but would not retain Council representatives for SPTA's and Divisions, or (c) Clean Slate which Is composed of a smaller board and operates with *ad hoc* groups of experts assigned to tasks and decision making. This process has extended across several Council meetings and has been organized by first introducing the degree of change proposed, gathering information from Council members, analyzing the feedback, and presenting summaries of feedback that lead to the next step of decision making. It is likely that draft recommendations may be presented at the August, 2013 Council meeting.

Budget
APA has been successful and healthy in terms of financial stability for several

continued on page 69

years and this year continues that trajectory. Council voted to approve the 2013 Proposed Budget with operational revenues of $108,156,000 and expenses of 108,299,000. The investment portfolio has just recently increased by $4 million dollars totaling now net worth of $32 million dollars. The APA buildings will contribute significantly to operations in 2013 by adding an expected $3.5 million to the budget.

Progress Reports

We are presenting you with highlights and relevant topics for our division that were delivered by Dr. Norman Anderson our CEO, Dr. Cynthia Belar, our Director of the Education Directorate (please see internship report), Dr. Katherine Nordal our Director of the Practice Directorate. And Dr. Gwen Keita (please see gun violent initiative). If you are interested in more detail and additional information on any of these reports, contact either of us and we are happy to provide the full reports.

Dr. Norman Anderson, Ph.D., CEO of APA reported on the new Center for Psychology and Health. The Center is intended to advance APA's participation in the health-care marketplace. The Center will engage in many practice-relevant activities to include: (a) conducting analysis of future demand for psychology workforce needs, (b) expanding the public education campaign to include all of psychology, (c) increasing support for reduction of health disparities, (d) advocating for appropriate reimbursement for psychological services, and (e) improving behavioral health data in electronic health records.

Dr. Anderson also described the involvement of APA in White House and Congressional proposals regarding our response to gun violence. Two APA groups will work on reviewing gun violence prediction and prevention and a third on the role of media in violence.

Dr. Katherine Nordal, Ph.D. Executive Director of the Practice Directorate reported on the activities of both the 501c3 arm of practice and the 501c6 (APAPO). The APAPO has been involved in helping members with the new psychotherapy billing codes and has prioritized for 2013 (a) Medicare and Medicaid reimbursement, (b) "Physician" definition in Medicare to include psychologists, and (c) HITECH incentive payments for electronic health records.

Dr. Don Bersoff, President of APA, presented his Presidential Initiatives:

- Providing services to military personnel, veterans and their families including those who have been sexually harassed.
- Promoting and supporting diversity in doctoral training particularly those programs that have admitted, retained, and graduated students from diverse ethnic cultures.
- Communicating scientifically based psychological knowledge to the public through increased participation from academic and scientist members.

Other Actions

Council approved the invitation to the regional psychological association to send an observer to the APA Council meetings. The regionals include the Eastern, Midwestern, New England, Rocky Mountain, Southeaster, Southwestern, and Western Psychological Associations. The observers would be able to speak to agenda items relevant to their constituents if invited to do so. The funding for the travel would be the responsibility of the regions themselves.

- Council voted to endorse the *Core Competencies for Interprofessional Collaborative Practice*.

continued on page 70

- Council voted to adopt the Guidelines for Prevention in Psychology.
- Council voted to approve the addition of $11,700 to convene a Task Force to develop a policy on the prediction and prevention of gun violence.
- Council received a report on the APA Involvement in the Revision of the ICD-10.

We hope that we have informed our membership of the topics, discussions, and votes that represent the significant activity and trajectory of the Council at this time. Please do contact either one of us if you have any questions, comments, or want more information on any subject (John Norcross at john.norcross@scranton.edu or Linda Campbell at lcampbel@uga.edu). Our goal is to keep you, our membership, informed and involved in decision making in APA.

NOTICE TO READERS

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

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

STUDENT SECTION

La Migra

Daniela G. Dominguez, M.S. and Gabriela Nunez, M.S.
Our Lady of the Lake University

Immigrant psych students wait with prudence,
For immigration reform that would help transform,
Their life, their future, their clients' lives and future.
With hope and pain, psych dreamers await,
For legislation that will help strengthen this nation.
La Migra, La Migra, the scary Migra.
La Migra in the classroom, La Migra in the therapy room,
La Migra in psychology.

With prudence, resilient immigrant psych students await,
For congressional legislation as powerful as therapeutic
intervention.
Will the House? Will the Senate? Will Republicans?
Will Democrats?
Will they facilitate a possible future where immigrant
psych students can legally practice
their craft and art without being marginalized?

With their voice, their story and prudence,
Empowered immigrant psych students battle nativism.
La Migra, La Migra, a misinformed Migra.
We are not outsiders.
We are helping professionals.
Immigration has got to change,
For psych dreamers want to be agents of change.

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