

IN THIS ISSUE

WHAT IS NEW IN PSYCHOTHERAPY AND COUNSELING IN THE LAST 10 YEARS?

13 CE Questions for This Issue

15 Classifieds

16 Calendar

The Pennsylvania Psychologist

Vol. 77, No. 7

JULY/AUGUST • UPDATE

SPECIAL EDITION— WHAT IS NEW IN PSYCHOTHERAPY AND COUNSELING IN THE LAST 10 YEARS?

What Is New in Psychotherapy and Counseling in the Last 10 Years?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
John Gavazzi, PsyD, ABPP

Get 1 CE credit
for this issue!
Also available
online!
Page 13



Dr. Samuel Knapp



Dr. John Gavazzi

Psychologists want to do a good job, but keeping up-to-date with changes in the field is difficult. Neimeyer et al. (2012) estimated that the half-life for the knowledge base of a professional psychologist is 9 years and will soon decline to 7, although the half-life varies across specialty. These articles strive to help psychologists keep up-to-date by encouraging them to reflect on some of the most significant changes in the field of psychotherapy in the last 10 years. Because of space limitations we had to delete reference to many important developments and had to summarize complex issues into a brief

paragraph or a few sentences. These articles are enriched by the feedback of participants in continuing education workshops in King of Prussia, Erie, and Bedford Springs of the same name. We refer to some of their contributions in these articles.

These articles are neither definitive nor final, but they are the basis for more discussion and reflection. Remember the adage “the map is not the territory.” These articles are not the territory; nor do they even purport to be the map. They are only a fragment of the map that readers need to complete for themselves. Furthermore, what we think of as sufficiently important to include in this review is ever changing. It seems like every week we encounter an article, book, or idea that we should add to our review.

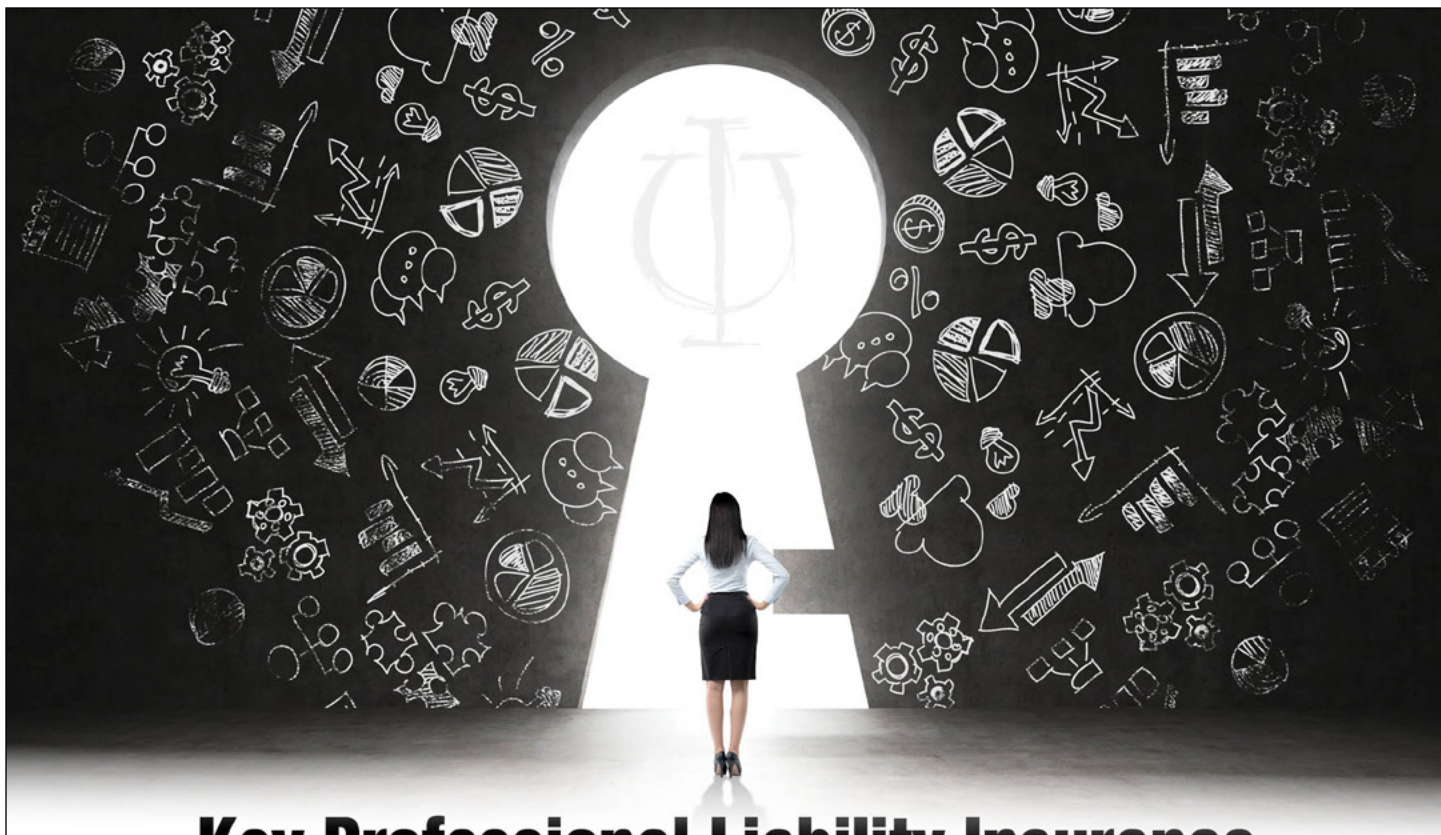
Individual psychologists will differ in what they believe are important developments, in part, because they work within specific subfields of psychotherapy, have different areas of interest, have different theoretical orientations, are exposed to

These articles strive to help psychologists keep up-to date by encouraging them to reflect on some of the most significant changes in the field of psychotherapy in the last 10 years.

different sources of information, or simply know more than we do.

We chose 10 years from our review because it comes close to the 9 years identified by Neimeyer et al. (2012) as the half-life of psychological knowledge. Our 10-year time frame for this review is flexible. What is “new” is a subjective decision. For example, we identify the rise of Motivational Interviewing as new. Although the technique dates to at least 1991, we opine that its use and the evidence supporting its efficacy has increased in the last 10 years. Because we include the increased validation of

Continued on page 4



Key Professional Liability Insurance Protection Throughout Your Career

Insurance coverage is key to your peace of mind.

Along with your training, experience, and expertise, Trust Sponsored Professional Liability Insurance* gives you the confidence to provide psychological services in a host of settings – across your entire career. Even if you have coverage through your institution or employer, it pays to have your own priority protection through The Trust.

Unlock essential benefits.

Along with reliable insurance coverage, The Trust policy includes useful benefits focusing on psychologists – free Advocate 800 consultations, exclusive discounts on continuing education and insurance premiums, and more. See why so many of your colleagues rely on The Trust for their insurance and risk management needs.

Key features you may not find in other policies:

- Insurance premium discounts including CE, early career, part time, group, and more.
- Broad affordable occurrence & claims-made coverage rated A++ by A.M. Best.
- Unlimited confidential consultations with independent risk management experts.
- No sublimit for defense of sexual misconduct allegations and a free extended reporting period or “tail” to insureds upon retirement.
- Case review process for adverse claim decision by insurance carrier.
- Through TrustPARMA, reduced registration fees for continuing education workshops and webinars.



trustinsurance.com • 1-800-477-1200

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and its U.S.-based Chubb underwriting company affiliates. Program administered by Trust Risk Management Services, Inc. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit new.chubb.com. Chubb Limited, the parent company of Chubb, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.

What Is New in the Scientific Basis of Our Profession?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
John Gavazzi, PsyD, ABPP

Much of what we “know” to be true in mental health treatment (including outcomes for pharmacology or psychotherapy) may not be true or may have been inadequately qualified. Many reported treatment effects in health care, including psychotherapy and pharmacology, are based on studies with methodological shortcomings that allow a high risk of false positives.

Concerns about the accuracy of published data are not unique to psychology. The methodological problems associated with psychotropic drug studies are so substantial that some researchers have questioned the efficacy of many commonly used medications. Ioannidis et al. (2013) estimated that perhaps one half of the purported significant effects of drugs may be inaccurate. Kirsch (2014) argued that antidepressant medications may have a greater placebo effect than once believed. Driessen et al. (2015) decreased the effect size by 25% for anti-depressant medication and psychological treatments when they have added unpublished studies to their meta-analyses. Ebrahim et al.

We need to remember that no study is perfect; simultaneously, we need to remain current as to what the preponderance of the research supports.

(2014) found that the re-analyses of data from medical studies sometimes changed the direction of the findings. Furthermore, evidence suggests that the blinded studies of drug effects were not well-blinded. Sometimes as many as 80% of participants could accurately identify whether they were receiving a placebo or active drug (Greenberg, 2017). Finally, what was learned in studies with WEIRD research participants (Western, educated, industrialized, rich, and democratic) may not generalize to other non-Western cultures (or even to subcultures within Western democracies; Henrich, Heine, & Norenzayan, 2010).

The Center for Open Science sought to determine if some recent psychological findings could withstand replication. They coordinated replication studies of 100 published findings and found that less than one half of the replication studies confirmed the positive results found in the original studies (for p values, it was 36% of the replicated studies; for effect size, it was 47% of the replicated studies; Open Science Collaboration, 2015). The rate of successful replications was lower in social psychology journals and higher in cognitive psychology journals. None of the replicated studies dealt with the treatment of mental illness. Despite these problems with replication, psychologists need to continue to review, evaluate, and utilize current research in psychotherapy and other fields (e.g., behavioral economics) because it helps them to deliver high quality psychological services. We need to remember that no study is perfect; simultaneously, we need to remain current as to what the preponderance of the research supports.

Continued on page 4



Pennsylvania Psychological
Political Action Committee (PAC)

Action through advocacy
Learn how you can help the PennPsyPAC today.

WHAT IS NEW IN THE SCIENTIFIC BASIS OF OUR PROFESSION?

Continued from page 3

Critics have called for systemic reforms for publishing psychological studies. Steps to reduce inaccurate or misleading findings include using more appropriate statistics, replicating previous studies, publishing studies with good methodology that did not find significance, sharing data sets, and interpreting results with cultural factors in mind.

Despite the concerns about methodology, we are especially encouraged by the development of practice research networks for studying psychotherapy outcomes and processes. All health care fields have a gap between the latest research of scientists and the actual practice patterns of practitioners in the field—called the scientist-practitioner gap—and psychology is no exception. In the past, many would blame practitioners for this gap, arguing that they were not adequately scientifically trained or sufficiently motivated to learn about the latest scientific findings. Others, such as Dr. Louis Castonguay of the Pennsylvania State University, expressed a more sophisticated perspective and noted, among other things, that sometimes the findings from clinical trials do not generalize to the actual practices of clinicians, or that the problems that clinicians experience are not addressed by psychotherapy researchers. Practice research networks try to generate research that has more direct relevance to the needs of practicing psychologists.

Effective practitioner networks minimize intrusions into the daily routine of practicing psychotherapists. The daily lives of psychotherapists depend highly on structure and routine with little free time for non-essential tasks. The project must have an infrastructure (or resources) to support the studies. Finally, the studies must involve practitioners in every meaningful decision of the research project. They need to avoid “empirical imperialism” (“I am the scientists in the room and you have to do what I

say”). Instead, practitioners must fully participate in the development of the research questions, and in all major decisions throughout the project (Castonguay et al., [2010] describe the experiences of research members).

References

- Castonguay, L. G., Boutsellis, M. A., Nelson, D. L., Chiswick, N. R., Damer, D., Hemmelstein, N. A., Jackson, J. S. et al., (2010). Psychotherapists, researchers or both? A qualitative analysis of psychotherapists' experiences in a practice research network. *Psychotherapy*, 47, 345–354.
- Driessen, E., Hollon, S. D., Bucking, C. L. H., Culpers, P., & Turner, E. H. (2015). Does publication bias inflate the apparent efficacy of psychological treatment for major depressive disorders? A systematic review and meta-analysis of U.S. national institutes of health-funded trials. *PLoS One*, 10 (9), e0137684.
- Ebrahim, S., Schani, Z. N., Montoya, L., Agrawal, A., Thorlund, K., Mills, E. J., & Ioannidis, J. P. A. (2014). Reanalyses of randomized clinical trial data. *JAMA*, 312, 1024–1032.
- Greenberg, R. (2017). The rebirth of psycho-social importance in a drug filled world. *The American Psychologist*, 71, 781–791.
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world. *Behavioral and Brain Science*, 33, 61–83.
- Ioannidis, J. P., Pereira, T. V., & Horwitz, R. I. (2013). Emergence of large treatment effects from small trials—Reply. *JAMA*, 309, 768–769.
- Kirsch, I. (2014). Antidepressants and the Placebo Effect. *Zeitschrift Fur Psychologie*, 222(3), 128–134.
- Open Science Collaborative. (2015). Estimating the reproducibility of psychological science. *Science*, 349, aac4716.341–345.

WHAT IS NEW IN PSYCHOTHERAPY AND COUNSELING IN THE PAST 10 YEARS?

Continued from page 1

older concepts, there may be times that we include something as new that the reader had “known all along,” or thought was common knowledge. Although we focus on psychotherapy and counseling, it is sometimes difficult to separate an advancement in psychotherapy/counseling and from an advancement in another related field of psychology (or another discipline).

We broke up the advances into several articles. In this issue, we will be looking at relevant advances in science; advances in psychotherapy processes, psychotherapy and diversity, advances in specific psychological treatments, and changes in psychotherapy education. In future issues of the *Pennsylvania Psychologist Update* we will look at other developments in the last 10 years. Please feel free to contact us with your comments on what is new in psychotherapy and counseling in the last 10 years (sam@papsy.org; or johngavazzi@aol.com).

References

- Neimeyer, G. J., Taylor, J. M., & Rozensky, R. H. (2012). The diminishing durability of knowledge in professional psychology: A Delphi poll of specialties and proficiencies. *Professional Psychology: Research and Practice*, 43, 364–371.

The Easiest Way to Get Paid!

Take charge of your practice and accept credit cards payments with ease!

- ✓ Increase Business
- ✓ Control Cash Flow
- ✓ Reduce Collections
- ✓ Lower Fees up to 25%

The process is simple. Begin accepting payments today!



Call 866.376.0950 or visit <http://papsy.affiniscap.com>

*AffiniPay is a registered ISO/MSP of Harris, N.A., Chicago, IL.

Member Benefit Provider
Pennsylvania Psychological Association



What Is New in Psychotherapy Processes and Outcomes?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
John Gavazzi, PsyD, ABPP

Good outcomes come from the quality of the therapeutic relationship, the techniques used, and the qualities of the patients. Controversies still exist concerning the relative contributions of techniques versus relationship in determining patient outcomes. Wampold (2015) concluded that specific treatments have an impact on outcomes, although not as much as patient relationships (we understand that other researchers weigh the value of specific treatments than Wampold). We review specific treatments and outcomes in more detail in the article in this issue titled “What is New in the Advances in Psychotherapy?” However, the entire debate between technique and relationship may be misplaced. Good interventions strengthen the relationship and strong relationships facilitate the effectiveness of interventions (Hill et al., 2017). It may be better to ask what techniques combined with what relationship factors produce what outcomes with patients. Markin stated “Contrary to this artificial dichotomy between the treatment and the relationship, research suggests that the client, therapist, relationship, and treatment method all contribute to treatment success and failure” (2014, p. 328).

Most of this article focuses on psychotherapist qualities related to outcome. Some psychotherapists consistently get better than others. Even so, psychotherapist effectiveness may not necessarily cut across all patients and diagnoses. For example, Kraus et al. (2011) found that no psychotherapist was considered highly competent in all 16 domains measured, although some psychotherapists consistently had better outcomes both within and across domains than others.

If some psychotherapists are better than others, then it should be worthwhile to look at their attributes. Psychotherapist effects appear unrelated to years of experience, gender, age, profession, or educational qualifications (Chow et al., 2015). Better outcomes are related to the ability to develop collaborative treatment relationships (build alliances), have a repertoire of effective strategies, and a process to monitor patient progress (Wampold, 2009). In addition, they are more likely to avoid over confidence and express a healthy amount of self-doubt (Wampold, Baldwin, Holtforth, & Imel, 2017).

Psychotherapist effectiveness is likely to improve when they establish a baseline of performance; get feedback on how they are doing; and engage in deliberate practice (Chow et al., 2015). Monitoring patient progress is only effective if the psychotherapists invested in the process sufficiently so that the cost (in terms of time and disruption of the interactions with the patient) do not overtake the benefits (Wampold, 2015). Deliberate practice appears especially important in achieving high levels of expertise (Goodyear et al., 2017; Wampold et al., 2017).

Do Psychotherapists Get Better Over Time?

Orlinsky et al. (1999) found that psychotherapists tended to rate themselves more competent as they grew more experienced. They found that “overall and within every subgroup, perceived therapeutic mastery was positive and significantly related to therapists’ years in practice” (pp. 208-209).

However, the data on improvement over time is not so positive. Goldberg

Some psychotherapists consistently get better than others. Even so, psychotherapist effectiveness may not necessarily cut across all patients and diagnoses.

et al. (2016) found that the outcomes of more experienced psychologists declined slightly, as a group, although some individual psychotherapists improved their outcomes. Huppert et al. (2001) found that therapy experience had a small association with outcomes using cognitive behavioral therapy with panic attacks. Spengler et al. (2015) found that the accuracy of clinical judgments improved only modestly over time.

How do we interpret this conflicting data? The participants in our continuing education workshops strongly believed that they got better with experience and we usually defer to their perspectives. We reconcile these differences in data by theorizing that some psychologists improve over time, some stay the same, and some get worse. In addition, we believe that some psychologists may become more proficient with a wider range of problems over time.

Promoting Self-Reflection

One of the major impediments toward productive self-reflection is the “better-than-average” effect, or a tendency for people to interpret their

Continued on page 6

WHAT IS NEW IN PSYCHOTHERAPY PROCESSES AND OUTCOMES?

Continued from page 5

performance as overly positive. Wal-fish et al. (2012) found that 25% of the psychotherapists that they surveyed rated themselves in the top 10% of competence. None rated themselves in the bottom 50%. They averaged ranking themselves at the 80th percentile. It is possible that more of the better psychotherapists had responded to the survey. Nonetheless, the direction of the responses is so substantial that we think it is unlikely that selection bias accounts for the findings. It appears that many psychotherapists over rate their expertise.

This overconfidence can reduce receptiveness to feedback. Younggren (2007) warned against *professional narcissism* or the tendency to over value one's expertise and knowledge. In contrast, Nissen-Lie and Rønnestad (2016) claimed that humility is an essential ingredient of highly effective psychotherapists. Humility refers to recognition of one's limitations and healthy self-doubt. Psychotherapists who showed humility (combined with self-love and self-tolerance) tended to have better patient outcomes. Perhaps one important ingredient is the willingness to accept feedback.

What Patient Factors Are Related to Outcomes?

All knowledgeable psychologists would agree that treatments need to be tailored to the individual characteristics of the patients receiving them. It is beyond the scope of this short article to summarize all the factors that psychologist should consider when adapting treatments (for one recent review see *Journal of Clinical Psychology: In Session*, Vol. 67 (2)). Across studies, the patient characteristics most closely related to outcomes are resistance/reactance (highly sensitive to being controlled by others), preferences, culture, and spirituality. Also, stages of change and coping style probably related to outcome, and patient expectations and attachment style might be related to outcome although the data is not so clear with them (Norcross & Wampold, 2011b).

What Relationship Factors Are Related to Outcomes?

Some participants in our workshops felt strongly about the importance of building relationships. One participant stated that "nothing knew has been learned since Carl Rogers." While we appreciate the great ground breaking contributions of Carl Rogers, we note that the evidence on effective elements of treatment has expanded upon his triad: congruence, empathy and unconditional positive regard.

A thorough review by a task force of APA's Division 29 (Psychotherapy) and Division 12 (Clinical Psychology) found that the following relationship factors are related to patient outcome: alliance in individual psychotherapy, youth therapy, or family therapy; cohesion in group therapy; empathy; and collecting patient feedback. The following are probably effective: goal consensus; collaboration; and positive regard. The following are promising but not yet definitive given the need for more research: congruence; repairing alliances; and managing counter transference (Norcross & Wampold, 2011a).

The quality of psychotherapy can be informed by identifying factors that linked to lack of patient progress or deterioration. These harmful factors per Norcross and Wampold (2011a) and Castonguay et al. (2010) include: hostile confrontations; negative processes (hostile, pejorative, critical); making assumptions about the patient's perceptions; psychotherapists centrality (failing to obtain patient's perceptions); ignoring patient needs; and rigidity, such as failing to be flexible when implementing protocols.

References

- Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. (2010). Training implications of harmful effects of psychological interventions. *American Psychologist*, 65, 34–39.
- Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, 51, 327–333.
- Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. Y., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology*, 63, 1–11.
- Goodyear, R. K., Wampold, B., Tracey, T. J. G., & Kichtenberg, J. (2017). Psychotherapy expertise should mean superior outcomes and demonstrable improvement over time. *The Counseling Psychologist*, 45, 54–65.
- Hill, C. E., Spiegel, S. B., Hoffman, M. A., Kivlighan, D. M., & Gelso, C. (2017). Therapist expertise in psychotherapy revisited. *The Counseling Psychologist*, 45, 1–53.
- Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. E. (2001). Therapies, therapists' variables, and cognitive behavioral therapy outcomes in a multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology*, 69, 747–755.
- Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research*, 21, 267–276.
- Norcross, J. C., & Wampold, B. E. (2011a). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, 48, 98–102.
- Norcross, J. C., & Wampold, B. E. (2011b). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology: In Session*, 67, 127–132.
- Markin, R. D. (2014). Toward a common identity for relationally oriented clinicians: A plea to hang one's hat. *Psychotherapy*, 51, 327–333.
- Orlinsky, D., Rønnestad, M. H., Ambühl, H., Willutzki, U., Botermans, J.-P., Cierpka, M., Davis, J., Davis, M., & The SPR Collaborative Research Network. (1999). Psychotherapists assessment of their development at different career levels. *Psychotherapy*, 36, 203–215.
- Nissen-Lie, H. A., & Rønnestad, M. H. (2016). The empirical evidence for psychotherapist humility as a foundation for psychotherapist expertise. *Psychotherapy Bulletin*, 51, 7–10.
- Spengler, P. M., White, M. J., Ægisdóttir, S., Maugherman, A. S., Anderson, L. A., Cook, R. S., . . . Rush, J. D. (2009). The meta-analysis of clinical judgment project: Effects of experience on judgment accuracy. *The Counseling Psychologist*, 37, 350–399.
- Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, 110, 639–644.
- Wampold, B. (2009, December 22). How psychotherapy works. American Psychological Association [Press release]. Retrieved from <http://www.apa.org/news/press/releases/2009/12/wampold.aspx>
- Wampold, B. (2015). Routine outcome monitoring: Coming of age—with the usual developmental challenges. *Psychotherapy*, 52, 458–462.
- Wampold, B. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14, 270–277.
- Wampold, B. E., Baldwin, S. A., Holtforth, M. G., & Imel, Z. E. (2017). What characterizes effective psychotherapists (pp. 37–53). In L. Castonguay & C. Hill (Eds.). *How and why are some therapists better than others?* Washington, DC: American Psychological Association.
- Younggren, J. N. (2007). Competence as a process of self-appraisal. *Professional Psychology: Research and Practice*, 38, 515–516.

What Is New in Diversity and Psychotherapy?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
John Gavazzi, PsyD, ABPP

Psychology is continuing to make progress in addressing shortcomings in the delivery of services to patients who have been traditionally marginalized. For example, there is an increased awareness of the extent to which some patients have gender non-conforming behaviors, including transgendered behaviors, and the unique features of psychotherapies designed to help them. Competence remains an issue when working with transgender/gender non-conforming patients, but efforts are being made to improve the quality of services (see for example, American Psychological Association, 2015; Mizock & Lundquist, 2016).

Race or Ethnicity

Many health professionals are *uncomfortable egalitarians* who hold implicit biases that impact behavior, even if they are unaware of them. Implicit prejudice or unconscious bias (Banaji & Greenwald, 2013) can lead to differential treatment of patients by race, gender, weight, age, language, income, attractiveness, etc. Implicit bias may be one reason that Black Americans often receive a lower quality of health care than White Americans as measured by objective standards. Implicit biases can be overcome through multicultural education, perspective taking, and partnership building skills.

The relationship between ethnicity and psychotherapy outcome is complex. On the one hand, Weisz et al. (2017) found that the psychotherapy outcomes for minority youth approximated the outcomes for Caucasian youth. This outcome is consistent with other studies that found that “psychological therapy is efficacious for ethnic minority youths and adults across multiple problem areas, and about equally efficacious for minorities and Caucasians” (p. 93). Nonetheless, the data base for

psychotherapy outcomes with minority youth is substantially smaller than the data base for Caucasian youth. In addition, evidence suggests that outcomes can improve if the psychotherapists are culturally competent and modify treatments accordingly.

Hayes et al. (2015) found that psychotherapists differed in their effectiveness with racial or ethnic minorities. “Cultural competence can be distinguished from general therapist competence” (p. 312). The data on matching psychotherapists and patients on racial or ethnic basis has been mixed (in part because White psychotherapists vary in their effectiveness with racial and ethnic minorities, and in part because of the wide diversity within diversity). “Ethnic matching alone does not ensure cultural competence . . . given within-group diversity related to other cultural experiences and identities . . . clinicians of all ethnic backgrounds and within interracial therapist/client dyads (e.g., Caucasian therapist and African-American clients) can develop effective, culturally competent therapeutic relationships” (Chu, p. 21). A key ingredient is for psychotherapists to be culturally humble and open to discussing cultural issues and learning from their patients (Hayes, Owen, & Nissen-Lie, 2017).

Modifying treatments to culture of patients can be important and lead to better outcomes, although the overall effect is modest (Wampold, 2015). Here is an example of where group-based studies have limitations. It is possible that for some patients—perhaps those who are highly assimilated—the cultural adaptation makes little difference. However, for other patients the cultural adaption is crucial in ensuring any reasonable possibility of success.

Effective treatments also recognize the importance of intersectionality, or the way that race, ethnicity, culture,

Effective treatments also recognize the importance of intersectionality, or the way that race, ethnicity, culture, acculturation, gender, gender identity, socioeconomic status, religion, etc.

acculturation, gender, gender identity, socioeconomic status, religion, etc. interact to influence the behavior or identity of the individual patient. Race or ethnicity alone may be insufficient to fully understand the life experience of any individual. For example, the experiences of a Black male one generation removed from the Caribbean who has a college education and a professional career might differ substantially from the experiences of a Black male of the same age who is a high school dropout and lives in poverty in a major American city. As stated by Rosenthal et al. (2016)

Intersectionality highlights the importance of attending to multiple, interacting identities and ascribed social positions (e.g., race, gender, sexual identity, class) along with associated power dynamics as people are at the same time members of many different social groups and have unique experiences with privileges and disadvantage because of those intersections.” (p. 475)

Religion as an Aspect of Diversity

Religious or spiritual orientation is an aspect of diversity and a question arises as to whether religiously modified

Continued on page 8

WHAT IS NEW IN DIVERSITY AND PSYCHOTHERAPY?

Continued from page 7

treatments can enhance psychotherapy outcomes.¹ Researchers disagree on this issue. Anderson et al. (2015) found many methodological limits in the studies looking at the outcomes with religious or spirituality modified psychotherapy. Some studies found statistical differences, although the practical differences were small. Other reviews (cited in Hook, 2012) are more optimistic about the effects of religious or spiritually accommodated therapy. Both sources agree that religious or spiritually accommodated therapies have results that are, on the average, no worse than standard treatment. Of course, one of the challenges is that religious or spiritual modifications can take many different forms and may have to be tailored to the unique background of the patients.

Those who incorporate religion or spirituality into psychotherapy need to be competent to do so. Vieten et al. (2014) identified 16 required attitudes, knowledge statements, and skills. For example, one of the attitudes was that “psychologists view spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, diversity, gender, and age” (p. 135); one of the knowledge

statements was that “psychologists know that many diverse forms of spirituality and/or religion exist, and explore spiritual and/or religious beliefs communities, and practices that are important to their clients” (p. 135); and one of the skills was “psychologists help clients explore and access their spiritual and/or religious strength and resources” (p. 135). In a follow-up study, Vieten et al. (2016) found wide support for the proposed 16 competencies among practicing clinicians, although few respondents had training in all these areas.

So far, no evidence suggests a consistent benefit in matching patients and psychologists by religion (Cummings et al., 2014). However, no evidence suggests it would be harmful either. We are open to the possibility that research may eventually find benefits to matching, if it increases the alliance between psychotherapists and patient, reflects a patient preference, or reflects appreciation or understanding of world views. Moreover, it is possible that the categories used in research are so broad (e.g., Christian v. non-Christian) that the comparisons are not meaningful.

References

- Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., & McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders*, 176, 183–196.
- Banaji, M., & Greenwald, A. (2013). *Blindspot*. New York: Delacorte Press.
- Chu, J., Leino A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice*, 47, 18–29.
- Cummings, J. P., Carson, C. S., Ivan, M. C., Stanley, M. A., & Pargament, K. I. (2014). A systematic review of relations between psychotherapist religiousness/spirituality and therapy-related variables. *Spirituality in Clinical Practice*, 1, 116–132.
- Hage, S. (2006). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice*, 37, 303–310.
- Hayes, J. A., Owens, J., & Bieschke, K. J. (2015). Therapist differences in symptom change with racial/ethnic minority clients. *Psychotherapy*, 52, 308–314.
- Hayes, J. A., Owen, J., & Nissen-Lie (2017). The contributions of client culture to differential therapist effectiveness (pp. 159–164). In L. Castonguay & C. Hill (Eds.). *How and why are some therapists better than others?* Washington, DC: American Psychological Association.
- Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren D. R., & Utsey S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, 63, 269–77.
- Hook, J. N., Worthington, E. L., & Davis, D. E. (2012). Religion and spirituality in counseling. In N. Fouad (Ed.). *APA Handbook of Counseling Psychology*, Vol. 2 (pp. 417–432). Washington, DC: American Psychological Association.
- Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, 3, 148–155.
- Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist*, 71, 474–485.
- Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lakoff, D. (2014). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality*, 5, 129–144.
- Vieten, C., Scammell, S., Pierce, A., Pilato, R., Ammondson, I., Pargament, K. I., & Lakoff, D. (2016). Competencies for psychologists in the domains of religion and spirituality. *Spirituality and Clinical Practice*, 3, 92–114.
- Wampold, B. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14, 270–277.
- Weisz, J. R., Kuppens, S., Ng, M. Y., Eckshtain, D., Ugueto, A. M., Caughan-Coaxum, R., . . . Fordwood, S. (2017). What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications of science and practice. *The American Psychologist*, 72, 79–117.

¹Religion differs from spirituality, although the concepts overlap. One common definition of religion is “participation in an organized system of beliefs, rituals, and cumulative traditions” (Hage, 2006, p. 303); in contrast, spirituality is “meaning and purpose in one’s life, a search for wholeness, and a relationship with a transcendent being.” (p. 303). The two concepts are not entirely distinct, however. Many individuals express their spirituality through religious activities.



Thursday, October 26 – Friday, October 27

PPA Fall Continuing Education Conference

The deadline for licensure renewal is November 30, 2017. Join us at the Eden Resort in Lancaster, PA, for this two-day opportunity to earn CE credit as you head into the home-stretch for renewing your license!

The Changing Evidence Base for Specific Treatments

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
John Gavazzi, PsyD, ABPP

We have been impressed by the growing evidence for the use of psychological interventions for a wide range of disorders including depression, anxiety, insomnia, substance abuse disorders, post-traumatic stress disorders, borderline personality disorder, eating disorders and others (Society for Clinical Psychology, n. d.). Psychological treatments can also be very effective for serious mental illness as part of a more comprehensive treatment plan. For example, with bipolar disorder, psychological interventions involving “structured psychological treatment emphasizing psychoeducation, effective coping, and monitoring of activities and moods” were an important adjunct to medications. For severe depression, a combination of psychotherapy and medication appears to do better than either one of them alone (Cuijpers et al., 2009).

The popularity of certain psychological treatments has changed in recent years and is expected to change in the future. A Delphi poll (Norcross et al., 2013) found that psychologists predicted that mindfulness, cognitive behavior therapy, integrative therapy, and multicultural therapy, motivational interviewing and dialectical behavior therapy would become more common, while EMDR, Gestalt therapy, Reality Therapy, Jungian treatment, Adlerian approaches, and Transactional Analysis would be less common.

Let us consider some of those treatments in more detail. Motivational therapy is designed to help patients decide about changing. It “is an empirically supported interviewing strategy and delivery style based on the premise that when an individual is adequately motivated, change is likely to occur” (Steinkopf et al., 2015, p. 350). It “is primarily concerned with helping clients to make a decision to change” (Moyers,

Despite the proliferation of interest and research, mindfulness is hard to study because it involves an internal mental state (not overt behaviors that are easier to measure) and can take many different forms

2014, p. 358). It involves two elements: the relationship and then promoting change talk. Apodaca et al. (2016) found that change talk was more likely to occur after open questions and reflections and less likely to occur after giving information or asking closed questions. Motivational Interviewing can be used as a stand-alone technique, incorporated into other modalities, or used as a pre-treatment intervention. It originally was used with alcohol interventions, but expanded to other areas and it can also be used across theoretical orientations.

Mindfulness refers to a cluster of interventions that use nonjudgmental awareness. It can be used as a stand-alone technique or combined with other treatments such as Acceptance and Commitment Therapy, Mindfulness-based stress reduction, etc. As such, it is sometimes considered a transdiagnostic intervention (Dunn et al., 2013; see Statement 5) that can be effective across a wide range of diagnoses in which rumination or excessive self-criticism occur. Khoury et al. (2013) and others reviewed many studies and showed that mindfulness can reduce anxiety, depression, and other symptoms. Participants in our workshops emphasized the contributions of mindfulness and were frequently using it in their psychotherapy sessions.

Despite the proliferation of interest and research, mindfulness is hard to study because it involves an internal mental state (not overt behaviors that are easier to measure) and can take many different forms (making it harder to compare studies to determine the specific elements responsible for improvement). Furthermore, Dimidjian and Segal (2015) describe a continuing problem whereby a program proven effective in a laboratory has diminished effectiveness in the community because of resource limitations lead to its implementation by undertrained practitioners.

In addition, we believe that emotional focused therapy will continue to increase in acceptance. Per emotion focused therapy, the therapeutic relationship allows for a safe environment and helps with affect regulation so that the patients can process emotions. Once an alliance has been established, “the therapist guides clients toward new ways of processing emotion, coaching them to become aware of, regulate, reflect on, and transform their emotions” (Greenberg, 2014, p. 356). The mechanisms of change are awareness of emotions, expression, regulation, reflection, transformation, and corrective emotional experiences. It shares commonalities with other experiential therapies in that it understands emotions as central to a wide range of thoughts, desires, motivations, and memories.

Biological Interventions

We do not believe that researchers have made any significant breakthroughs in biological interventions for mental illness in the past 10 years. Most new drugs are refinements on older medications. Promises of

Continued on page 10

THE CHANGING EVIDENCE BASE FOR SPECIFIC TREATMENTS

Continued from page 9

increasing the effectiveness of medications through genetic matching are controversial. Some claim that the practice implications have not met the promises (Harrison, 2015). In addition to the limitations inherent with medications, Swift et al. (2017) found that patients who were assigned to medication treatment programs had a higher rate if refusing treatment and had higher drop-out rates than patients assigned to psychotherapy. Recent research has focused on the interpersonal nature of prescribing. Even if patients stay within treatment, their actual adherence to the protocol (i.e., taking the drugs as prescribed) will depend largely on the relationship they have with the prescriber; Greenberg, 2017).

However, for other disorders, such as unipolar depression or anxiety, we would recommend that patients be usually offered the psychological treatments first, with medication offered in unusual situations or after a trial of psychotherapy has failed.

Electroconvulsive Therapy (ECT) was a popular intervention during the 1960s and 1970s, but it fell into disuse because of concerns over its side effects and effectiveness. However, ECT treatments have evolved over time in terms of its safety and in limiting the circumstances in which it is used. Evidence in favor of ECT as a secondary or back up treatment for depression is regaining acceptance (Fink, 2014).

Some attention has been given to some unique biological therapies. For example, transcranial stimulation therapies, using concentrated energy to influence brain functioning, hold promise as a treatment for depression

and anxiety. In contrast, deep brain stimulation, a surgical procedure to implant electrodes into the brain, has not lived up to promises as a treatment for psychiatric disorders. "There is insufficient evidence at this point in time to support the use of deep brain stimulation as a clinical treatment for any psychiatric disorder" (Fitzgerald & Segrave, 2015, p. 979). Also, evidence for ketamine for use with treatment-resistant depression is limited. There are some anecdotal successes, but insufficient long-term clinical data to support its routine use.

Psychological Interventions Compared to Biological Treatments

It is difficult to state categorically that psychological treatment is better than biological treatments. Studies with insomnia illustrate the complexity of this issue. Medications are often used as a first-line tool to treat insomnia. The short-term benefit of insomnia medication is justified by the research. However, evidence supporting the long-term use of medications, such as anxiolytics and hypnotics, for insomnia is lacking. A variety of psychological interventions, such as CBT, mindfulness meditation, and sleep hygiene are effective for both acute and chronic forms of insomnia. Increased exercise, decreasing caffeine intake, decreasing food intake prior to bed, and decreasing alcohol intake near bedtime are also important components to a healthy sleep-wake cycle. Some of the effective programs are stimulus control therapy, sleep restriction therapy, relaxation training, paradoxical treatments, CBT, or biofeedback based treatments.

However, for other disorders, such as unipolar depression or anxiety, we would recommend that patients be usually offered the psychological treatments first, with medication offered in unusual situations or after a trial of psychotherapy has failed.

References

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, 70, 832–834.

- Apodoca, T. R., Jackson, K. M., Borsari, B., Magill, M., Lonaabaugh, R., Mastroleo, N. R., & Barnett, N. P. (2016). Which individual therapist behaviors elicit client change talk and sustain talk in motivational interviewing. *Journal of Substance Abuse Treatment*, 61, 60–65.
- Cuijpers, P., Dekker, J., Hollon, S. D., & Andersson, G. (2009). Adding psychotherapy in the treatment of depressive disorders in adults: A meta-analysis. *Journal of Clinical Psychology*, 70, 1219–1229.
- Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist*, 70, 593–620.
- Dowell, D., Haegerich, T. H., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain—United States, 2016. *JAMA*, 315, 1624–1645.
- Dunn, R., Callahan, J. L., & Swift, J. K. (2013). Mindfulness as a transtheoretical clinical process. *Psychotherapy*, 50, 312–315.
- Fink, M. (2014). What was learned: Studies by the consortium for research in ECT (CORE) 1997–2011. *Acta Psychiatrica Scandinavica*, 129, 417–426.
- Fitzgerald, P. B., & Segrave, R. A. (2015). Deep brain stimulation in mental health: Review of evidence for clinical efficacy. *Australian and New Zealand Journal of Psychiatry*, 49, 979–993.
- Greenberg, L. (2014). The therapeutic relationship in emotion-focused therapy. *Psychotherapy*, 51, 350–357.
- Greenberg, R. (2017). The rebirth of psychosocial importance in a drug-filled world. *The American Psychologist*, 71, 781–791.
- Harrison, P. J. (2015). The current and potential impact of genetics and genomics on neuropsychopharmacology. *European Neuropsychopharmacology*, 25, 671–681.
- Khoury, B., Lecomte, T., Fortin, G., Masse, M., Therien, P., . . . Hofmann, S. G. (2013). Mindfulness-based therapy: A comprehensive meta-analysis. *Clinical Psychology Review*, 33, 763–761.
- Moyers, T. B. (2014). The relationship in motivational interviewing. *Psychotherapy*, 51, 358–363.
- Society of Clinical Psychology. (n.d.). Research-supported psychological treatments. Retrieved from <https://www.div12.org/psychological-treatments/treatments/>
- Steinhausen, H. C., Jensen, C. M., & Kauitsen, M. B. (2016). A systematic review and meta-analysis of the long-term overall outcomes of autism spectrum disorders in adolescence and adulthood. *Acta Psychiatrica Scandinavica*, 133, 445–452.
- Steinkopf, B. L., Hakala, K. A., & Van Hasselt, V. B. (2015). Motivational interviewing: improving the delivery of psychological services to law enforcement. *Professional Psychology: Research and Practice*, 46, 348–356.
- Swift, J. K., Greenberg, R. P., Tompin, K. A., & Parkin, S. R. (2017). Treatment refusal and premature termination in psychotherapy, pharmacotherapy, and their combination: A meta-analysis of head-to-head comparisons. *Psychotherapy*, 54, 47–57.

Leadership Circle

Vincent J. Bellwoar, PhD
Lynne DiCaprio, MA
Donald McAleer, PsyD
Catherine McLaughlin, MEd

Larry J. Nulton, PhD
R. Richard Schall, PhD
James W. Selgas, EdD
Charles L. Zeiders, PsyD

Platinum

Dennis Debiak, PsyD
Jane Greenberg, PhD
Albert D. Jumper, MA
Robert H. Justice, PsyD

Bruce E. Mapes, PhD
Brad Norford, PhD
Natalie C. Paul, PsyD
Louis D. Poloni, PhD

Dea Silbertrust, PhD, JD
Daniel Warner, PhD
Mary O'Leary Wiley, PhD

Gold

Margaret N. Baker, PhD
Judith S. Blau, PhD
Robert D. Broderick, PhD
Joseph Cautilli, PhD
Manulyn Citron, PhD
Jenine M. Cohen, PsyD
Michael A. DeStefano, PhD
Maria DiDonato, DEd

Arnold Freedman, PhD
John Gavazzi, PsyD
E. Shireen Kapadia, Ph.D.
Samuel J Knapp, EdD
Gail B. Luyster, Ph.D.
Donald P. Masey, PsyD
Julie Meranze-Levitt, PhD
Ruth Morelli, PhD

Marolyn Morford, PhD
Bradley C. Norford, Ph.D.
Jeffrey Pincus, PhD
Robin B. Risler
Shelley L. Roisen, PhD
Beatrice R. Salter, PhD
Richard F. Small, PhD
Kevin R. Smith, PhD

Silver

John Abbruzzese, Ph.D.
Lamia Patricia Barakat, PhD
Alexandra M. Barbo, PhD
Richard Blackford, PhD
David P. Borsos, PhD
Hazel J. Brown, DEd
Michael Bucell, PhD
Freeman M. Chakara, PsyD
Linda H. Cohen, MEd
Steven R. Cohen, PhD
Joseph T. Connelly, MA
Nina B. Cummings, PhD
Paul E. Delfin, PhD
Andrea M. Delligatti, PhD
Susan T. DeLone, PhD
Edward J. DiCesare, PhD

Vito J. DonGiovanni, PsyD
Patricia A. Donoghue, PhD
Jeffrey L. Eiberson, PhD
Francine A. Fettman, PhD
Thomas E. Fink, PhD
Patricia J. Fox, PsyD
Marion Rudin Frank, EdD, MA
Allyson L. Galloway, PsyD
Rex P. Gatto, PhD
John L. Gerdes, PhD
Rebecca A. Gillelan, MS
Dorothy W. Gold, PhD
Beverly J. Goodwin, PhD
Ruth L. Greenberg, PhD
Eric Griffin-Shelley, PhD
Antoinette Hamidian, PsyD

Patrick S. Hanna, PhD
Neal Hemmelstein, PhD
Paul H. Himmelberg, PhD
Katherine Hammond Holtz, PsyD
C. Wayne Jones, PhD
Ronald S. Kaiser, PhD
David Kannerstein, PhD
Gail R. Karafin, EdD
Mark L. Kilwein, PhD
Philip J. Kinney, PhD
Jerome F Knast, PhD
John G. Kuna, PsyD
Jeffrey D. Leitzel, PhD
Victor J. Malatesta, PhD
David J. Marion, EdD
Arthur S. McHenry, MA

Stephen L. Miksic, PhD
Richard J. Miller, PhD
William R Miller, PhD
Vincent J. Morello, PhD
Judith T. Munoz, M.A.
Maria P. Murphy, PsyD
Andrew Offenbecher, PhD
David E. Payne, PsyD
Brigitte Poirot
Eugene P. Pryor, PsyD
Kenneth M. Ralph, PhD
Naomi Reiskind, PhD
Leslie A. Rescorla, PhD
Vincent Rinella, MA, JD
Wayne Roffer, PsyD
Karyn L. Scher, PhD

Michael N Schneider, PsyD
Arnold T. Shienvold, PhD
Jeanne M. Slaterry, PhD
Deborah L. Snelson, MA
Elizabeth A Soucar, PhD
Juliet Sternberg, PhD
Helena Tuleya-Payne, DEd
Jeffrey M. Verrecchio, MS
Pauline Wallin, PhD
Andrea S. Webb, PsyD
Jeffrey B. Wolfe, PhD
Michelle L. Wonders, PsyD
Allen Zaklad, PhD
Edward Zuckerman, PhD

Other Contributions

Arlene Caban-Pocai, PhD
Amy F. Cades, PhD
Vic Cardinale, PhD
Steven & Sandra Cotlar
Molly Haas Cowan, PsyD
Andrew J. D'Amico, PhD
Michael J. Dolan, PsyD
Linda K Dunn
Susan Edgar-Smith, PhD
Janet L. Etzi, PsyD
Saul Fisher, PhD

Philip H. Friedman, PhD
Richard (Dick) Ganley, PhD
Lawrence M. Glanz, PhD
Lillian Goertzel, EdD
Kyle B. Holsinger, PsyD
Judith Temple Jackson, PhD
Helene S. Katz, PhD
Joanne Krug, MS, DA
Jeffrey L. Lensbower, MS
Theodore C. Lewandowski, MS
Jane S. Mackay, MA

Alison L. Masey, BS
Daniel Materna, PsyD
Jill Materna, PsyD
Mark R. McGowan, PhD
Marie C. McGrath, PhD
D. Jane McGuffin, PhD
Lewis E. Neumann, PhD
Sharon O'Neill
Amy Parenti
Lenore C. Perrott, MS
Jack Porter, Ed.D.

Tracy E Ransom, PsyD
Karen A. Schofield, PhD
Bernard Seif, EdD, DNM
Alex M. Siegel, JD, PhD
Susan Sklaroff-VanHook
Elizabeth Z. Smyser, EdM
Janet B Snyder, PhD
Maria B. Soda, PsyD
Jeffrey M. Walters, PsyD
Beth L. Warms, MA
Mary Ann Katherine Yenason, PhD
Donald J. Zandier, MA



Donations received July 1, 2016 through June 5, 2017.

Leadership Circle

Frank M. Dattilio, PhD

Toni Rex, EdD

Richard F. Small, PhD

Pauline Wallin, PhD

Platinum

Salvatore S. Cullari, PhD

Linda K. Knauss, PhD

David A. Rogers, PhD

Ed Zuckerman, PhD

Gold

J. Audie Black, PhD

Jeanne M. Slattery, PhD

Silver

Robin L. Beaumont, PhD
Vincent J. Bellwoar, PhD
Michael Bucell, PhD
Jane Buhl, PhD
George L. Carey III, MS
Vito J. DonGiovanni, PsyD
Marion Rudin Frank, EdD
Allyson L. Galloway, PsyD
Loretta A. Gephart, MA
Virginia Giannotta, PhD

Shelley Z. Goodman, PhD
Beverly J. Goodwin, PhD
Ruth L. Greenberg, PhD
Jane E. Iannuzzelli, MEd
Richard J. Ievoli, PhD
C. Wayne Jones, PhD
Jeffrey Knauss, EdD
Deborah Kossmann, PsyD
Joanne Krug, MS, DA
Marjory J. Levitt, PhD

Bruce E. Mapes, PhD
Donald McAleer, PsyD
Pamela G. McCloskey, MEd
Julie Meranze-Levitt, PhD
Gregory B. Milbourne, PsyD
David T. Painter, PhD, JD
Janet M. Pawlowski, MA
Michael G. Perovich, PsyD
Lisa A. Phillips, PhD
Jeffrey Pincus, PhD

Louis D. Poloni, PhD
Shelley L. Roisen, PhD
R. Richard Schall, PhD
Karyn L. Scher, PhD
Dea Silbertrust, PhD, JD
Dylan Small
Jeffrey M. Verrecchio, MS
Daniel N. Warner, PhD
Mary O'Leary Wiley, PhD
Jeffrey B. Wolfe, PhD

Other Contributions

Robin Arnold, PsyD
Beatrice Chakraborty, PsyD
Nancy Chubb, PhD, MBA
GSC Counseling Associates
Janice DiLuzio, MS, MBA
Jeanne DiVincenzo, PsyD
Jennifer J. Eldridge, PhD
Francine A. Fettman, PhD
Ann E. Fisher, PsyD
Philip H. Friedman, PhD
Susan L. Gilius, MS
Mark A. Greenberg, PhD

Patrick S. Hanna, PhD
Barry B. Hart, PhD
Cheryl A. Henkel, MS, EdS
Diana R. Henne, PhD
Marianne Herzog, PhD
B. Janet Hibbs, PhD
Gail R. Karafin, EdD
Mark L. Kilwein, PhD
Jerome F. Knast, PhD
Joseph P. Kochansky, MA
Ralph E. Landefeld, PhD
Elisa M. Lang, PhD

Rachel LeMay, PsyD
Carolyn B. Lewis, PsyD
Jane S. Mackay, MA
Rosemarie Manfredi, PsyD
Jerri Maroney, PsyD
Lisa M. May, PhD
Robert T. McElhose, PhD
Kathleen B. McGrath, PhD
Marie C. McGrath, PhD
Leslie Poul Melman, PsyD
Robert J. Milrod, PhD
Lewis E. Neumann, PhD

Cory F. Newman, PhD
Marisa L. Panucci, MS
Cathy C. Petchel, MA
Stephanie K. Phillips, PsyD
Stacey Rivenburg, PsyD
Cheryll Rothery, PhD
Daniel A. Schwarz, PhD
Kathryn M. Sheneman, PsyD, JD
Lynne Siqeland, PhD
Keren Chansky Suberri, PhD
Stephanie E. Yoder, PsyD
David L. Zehrung, PhD

CE Questions for This Issue

The articles selected for 1 CE credit in this issue of the *Pennsylvania Psychologist Update* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of \$20 for members (\$35 for nonmembers) and mail to:

Continuing Education Programs
Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112

To purchase and complete the test online, visit our online store at papsy.org. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before July 31, 2019.

Learning objective: The articles in this issue will enable readers to identify special considerations needed to implement the core competencies in the assessment, management, and treatment of suicidal patients.

What Is New in the Scientific Basis of Our Profession?

1. Much of the research in Western countries is done with WEIRD participants.
True
False
2. Practice research networks are characterized by:
 - a. Practitioners who are involved in every meaningful decision
 - b. A heavily reliance on Bayesian statistics
 - c. A commitment to share data with other researchers
 - d. All the above

What Is New in Psychotherapy Processes and Outcomes?

3. Which of the following predicts being an effective therapist?
 - a. Age
 - b. Years of experience
 - c. Gender
 - d. None of the above
4. Effective psychotherapists tend to:
 - a. Build collaborative relationships
 - b. Have a process to monitor patient progress
 - c. Have a repertoire of effective strategies
 - d. All the above
5. According to the better-than-average effect found by Walfish et al.,
 - a. 25% of psychotherapists rated themselves in the top 10%
 - b. No psychotherapists rated themselves in the bottom 50%
 - c. Psychotherapists rated themselves on the average in the 80th percentile
 - d. All the above
6. The relationship qualities that have been empirically shown to be related to patient outcomes include:
 - a. Empathy
 - b. Alliance between psychotherapist and patient
 - c. Collecting patient feedback
 - d. All of the above
7. Psychotherapist behaviors that are associated with poorer patient outcomes include:
 - a. Hostile confrontations
 - b. Psychotherapist centrality (failing to obtain patient's perceptions).
 - c. Rigid or dogmatic reliance on treatment protocols
 - d. All of the above

What Is New in Diversity and Psychotherapy?

8. Banaji and Greenwald referred to individuals who espoused egalitarian views, but displayed bias in the actual behavior with racial minorities as:
 - a. Racists
 - b. Insidious racists
 - c. Uncomfortable egalitarians
 - d. Aversive racists
9. Research on patients from diverse cultural, ethnic, or racial backgrounds show that:
 - a. Matching patients and psychotherapists from the same racial, cultural, or ethnic background always leads to better outcomes

- b. Psychotherapists who are members of cultural minorities always do better than White psychotherapists when dealing with minority patients
 - c. Psychotherapists differ in their ability to be effective with racial and ethnic minorities
 - d. All the above
10. Research on religion and spirituality has shown that:
- a. Matching patients and psychotherapists to similarity in religious background always leads to better patient outcomes
 - b. Religiously or spiritually modified interventions always show better outcomes than traditional interventions
 - c. Religiously or spiritually modified interventions have outcomes that are, on the average, no worse than traditional interventions
 - d. Talking about religion with patients is always a boundary violation

The Changing Evidence Base for New Treatments

11. The general goal of Motivational Interviewing is to:
- a. Uncover hidden and forbidden impulses
 - b. Improve interpersonal relationships
 - c. Help clients decide to change
 - d. Assist patients in changing their attachment schema
12. Mindfulness is:
- a. Often combined with other treatment modalities
 - b. Useful for patients who have excessive self-criticism
 - c. Has positive outcomes with depression and anxiety
 - d. All the above
13. The professional consensus is that the following would be effective for treating depression?
- a. Deep brain stimulation
 - b. Transcranial magnetic stimulation
 - c. Ketamine
 - d. All the above

Continuing Education Answer Sheet

The Pennsylvania Psychologist Update, July, August 2017

Please circle the letter corresponding to the correct answer for each question.

- | | | | | | | |
|----|---|---|---|---|--|--|
| 1. | T | F | | | | |
| 2. | a | b | c | d | | |
| 3. | a | b | c | d | | |
| 4. | a | b | c | d | | |
| 5. | a | b | c | d | | |
| 6. | a | b | c | d | | |
| 7. | a | b | c | d | | |
- | | | | | |
|-----|---|---|---|---|
| 8. | a | b | c | d |
| 9. | a | b | c | d |
| 10. | a | b | c | d |
| 11. | a | b | c | d |
| 12. | a | b | c | d |
| 13. | a | b | c | d |

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist Update*:

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

Please print clearly.

Name _____

Address _____

City _____ State _____ ZIP _____ Phone () _____


I verify that I personally completed the above CE test.

Signature _____ Date _____

A check or money order for \$20 for PPA members (\$35 for nonmembers) must accompany this form. Mail to:
Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

Now available online, too! Purchase the quiz by visiting our online store at papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

Classifieds

PHILADELPHIA Center City, Fidler Square. — Four beautiful designer-decorated offices, three waiting rooms. Fireplaces, decks, garden, a/c, cathedral ceiling, skylight, kitchen, Wi-Fi, fax, buzzer for each office. Over bridge from U/Penn. Psychiatrists and learning disabilities specialist on premises. Parking option. Flexible arrangements: Full time, day, hour. Reasonable rent. 215-546-2379, marlabisaacs@gmail.com 



Join PPA's Listserv!

The listserv provides an online forum for immediate consultation with hundreds of your peers. Sign up for FREE by contacting:

iva@papsy.org



Employer Benefits:

- Targeted Advertising Exposure
- Easy Online Management
- Resume Search Included with Job Posting

Job Seeker Benefits:

- Searchable Portfolios
- Save Jobs — Apply when ready
- Job Agents



**National Healthcare
Career Network**

*The **right** connections make all the difference.*

[HTTP://CAREERS.PAPSY.ORG](http://careers.papsy.org)

Pennsylvania Psychological Foundation

Enhancing the Future of Psychology

*Make your
contribution
today!*



2017/18 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2017/18, we are looking to expand these options – we hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

October 26-27, 2017

Fall Continuing Education Conference
Eden Resort Inn, Lancaster, PA

April 2018

Spring Continuing Education Conference
Pittsburgh Area

June 13-16, 2018

PPA2018: PPA Annual Convention
DoubleTree Valley Forge, King of Prussia, PA

Webinars and Home Studies

Check out our new Online Learning Portal at papsy.bizvision.com!

Podcasts

Podcasts for CE credit by Dr. John Gavazzi are available on papsy.org.



For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit papsy.org.

Registration materials and further conference information are available at papsy.org.

Home Study CE Courses

Pennsylvania Child Abuse Recognition and Reporting: 2017 (Act 31 Approved)
2 CE Credits

Medicare's 2016 Physician Quality Reporting System (PQRS)
1 CE Credit

The Assessment, Management, and Treatment of Suicidal Patients (approved for Act 74)
1 CE Credit / 3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer, and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

*Competence, Advertising, Informed Consent, and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations, and Ethics**
6 CE Credits

**This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.*

For all Home Study CE Courses above contact:
Judy Smith, (717) 510-6343, judy@papsy.org.