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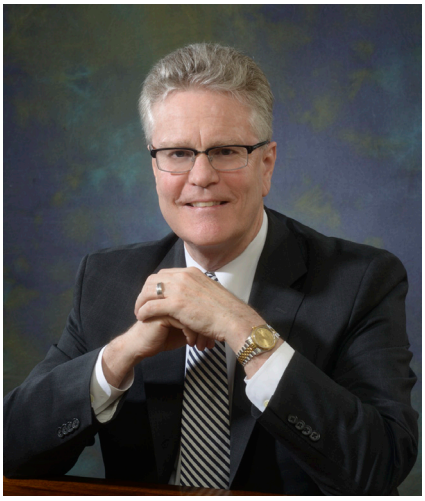

PRESIDENT'S COLUMN

Dignity, Poise, and Restraint: One Response to Hoffman

Terence M. Keane, Ph.D.

Choosing to be a clinical psychologist was one of the best decisions I've ever made. I've enjoyed immensely the opportunities for patient care, program development, teaching, supervising, and science. What a great profession clinical psychology is.

The revelations of the past week do nothing to change my feelings about the career path I chose as a twenty year old. Yet, I am disappointed, discouraged, even distraught by the allegations in the Hoffman report. We all are. I've experienced sleeplessness and shame; I'm not comfortable with this.

There are many ways that we can respond as individuals and as groups. Everyone must choose the optimal way for themselves. The institutional betrayal we are feeling is real and the depths of it profound. We do need to move forward and apply our collective creativity and talents to remediate the problems and change the APA in ways that work for us all. We need to lead our way out of this morass with dignity, poise, and restraint. To regain our footing we need to listen; listen to our membership, to our students, to the public, and to our patients, clients, and other stakeholders. Psychology is a great profession, even if we are reeling from the revelations contained in Hoffman. We now need to decide what to do next. While some discuss leaving the APA, I am committed to redoubling efforts to restore confidence in our people, our work, our profession, and our organization. Please join me in this effort.

For some, the governance of APA is understandably confusing. The Society of Clinical Psychology (SCP) functions in many ways autonomously. Decisions regarding policy and procedures are made by the full SCP Board and implemented by the Executive Committee of the Board. We have our own leadership (a Presidential Triad), independent of APA, our own budget, our own terrific new administrator (Tara Craighead, if you haven't met her yet!), a separate Board of Directors that includes representatives

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from all of our sections, our own journal (Clinical Psychology: Science & Practice), our own newsletter (The Clinical Psychologist), and an amazing, recently updated website. We also have four representatives to the Council of Representatives of APA who advise the SCP Board and who take advice from the SCP Board. We possess our own Committee structure with groups that are doing remarkably good things. We held a Graduate Student Summit at Boston University last October with over 125 students from virtually every clinical psychology graduate school in New England. Plans are underway for another professional meeting focusing on early career psychologists with training in leadership skills. Our educational webinars are ongoing for more than a year and attracting ever greater numbers of psychologists to participate. Moreover, our conference committee did a spectacular job recruiting premier clinical psychologists to lecture on cutting edge findings in the Toronto meetings in August. David Tolin and Evan Forman are working apace to update our Empirically Supported Treatments list and to make them accessible for practitioners.

I must say, I'm very pleased to be a member of the SCP and its President this year. It's not a good, it's a great group. There are so many terrific things going on.

At yesterday's Board meeting, called expressly to discuss the Hoffman Report, virtually all of our members participated. The group generated many ideas but wanted first and foremost to hear from the SCP membership. As a result, we are establishing a place on our website (www.div12.org) for our members to present new directions, thoughts, ideas, or ways to address the faults in structure or function of the larger APA. We see this as a vehicle for all SCP members to respond thoughtfully and constructively to the crisis we are facing. Please take the opportunity to do so. Our goal is to solicit input from all members and to have this information to advise our Council Representatives who will be meeting at the Convention. Please do respond by August 1 so that the Representatives and the Board can integrate your ideas and recommendations.

Other actions we are considering in response to the Hoffman report are: a meeting for members at the annual conference in Toronto, a special section in CP:SP, a panel style webinar for members, and opportunities for us all to reaffirm our values as psychologists, and to strategize for ways to remediate the damage done.

When confronted with complex problems and issues in the past, I've found reflecting and then taking action among the best remedies for enhancing a sense of control and reducing helplessness. The Board encourages you to participate by giving us your feedback. We do welcome it.

You may ask why I included restraint in the title of my communication to you. As clinicians, we all wish that stress would bring us together to formulate effective strategies for change. We all know that stress can yield divisiveness and derision. I do ask our members to read all the Hoffman documents and draw your own conclusions about what did and didn't happen, what allegations were confirmed and which ones refuted, and who was involved with what aspects of things. I've spent the past five days consuming the report in detail, speaking with key people across the country, communicating with APA staff and elected officials all in an effort to understand what happened. The one thing I can conclude for certain is that this represents a crisis for all psychologists and for the public. Exercising restraint in our dialogue about this, remaining humble about our own personal roles in this, and becoming centered on corrective action seems like the best course.

To reflect, I went back to our bylaws to review and reconsider our mission statement and I've included it here:

The mission of the Society of Clinical Psychology is to encourage and support the integration of psychological science and practice in education, research, application, advocacy and public policy, attending to the importance of diversity.

Today, I encourage SCP membership to reread our mission statement, reflect on its timelessness, and to take action to address the problems we are now facing. This mission statement is as appropriate today as it was when written. I do wish to encourage all of us to take time to discuss the issues that led to the crisis, approach problem solving with dignity for the entire community of clinical psychologists, and consider restraint in assigning blame. We do need to move forward with poise and confidence; we need everyone's involvement, ideas, and support to succeed. The goal is to once again regain the trust of the patients and clients we serve, the public who rely upon us, and the psychologists who are a part of our greater community. Stay with us, contribute your thoughts, ideas, and actions to the betterment of our profession. The time is now to reinvigorate our organization. Remember, our Division the motto is: "SCP—You Belong". In our professional lives, there's never been a more important time to act. Please be a part of the solution!

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Weighing in on the Time-out Controversy

An Empirical Perspective

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Abstract: Appropriate implementation of time-out has been shown for decades to produce positive outcomes ranging from the reduction in child problem behaviors to reduced levels of child maltreatment. Although the literature indicating positive outcomes on time-out is abundant, time-out continues to elicit controversy. While this controversy has been long-standing, more recent, outspoken sceptics have contested time-out using widely-viewed mediums. Unfortunately, critics present arguments against time-out without consulting the abundant, empirical literature on its positive effects. Moreover, these misinformed views can have devastating consequences by swaying families away from appropriate time-out implementation who may otherwise benefit. This paper utilizes the breadth of research on time-out to addresses myths surrounding its implementation.

Keywords: time-out, children, parenting, behavior problems, evidence-based treatment

Introduction

The use of time-out with children has been debated for years (e.g., LaVigna & Donnellan, 1986; Lutzker, 1994a; Lutzker, 1994b; McNeil, Clemens-Mowrer, Gurwitch, & Funderburk, 1994; Vockell, 1977). Research indicates that the use of time-out has been recommended to reduce problem behaviors for both typically behaving and clinically referred children (see Everett, Hupp, & Olmi, 2010 for a review; O'Leary, O'Leary, & Becker, 1967). The use of time-out in the classroom has been accepted by the general public for decades (Zabel, 1986), over and above alternative forms of discipline (e.g., spanking; Blampied & Kahan, 1992; Foxx & Shapiro, 1978). This sentiment is still shared in recent community sample perspectives (Passini, Pihet, & Favez, 2014). The use of time-out has been endorsed by the American Academy of Pediatrics, Society for a Science of Clinical Psychology, and American Psychological Association, among others, as an effective discipline strategy for child misbehaviors (American Academy of Pediatrics, 1998; Novotney, 2012; Society for a Science of Clinical Psychology, 2014). However, the implementation of this widely used procedure continues to evoke controversy (e.g., Siegel & Bryson, 2014a).

Lauren Borduin Quetsch

Despite abundant evidence documenting the effectiveness and utility of time-out, highly visible, non-evidence-based cautions and recommendations against its use continue to be written and publicly disseminated. Unfortunately, such unfounded arguments against time-out implementation meaningfully permeate the public discourse. For example, a recent article in Time magazine (Siegel & Bryson, 2014a) publically ridiculed time-out by claiming it negatively affected children's neuroplasticity, isolated children, deprived them of receiving their "profound need for connection" (para. 4), and worsened problem behaviors rather than reducing them. The current article details the important components present in evidence-based practices incorporating time-out. In turn, the authors directly address major concerns raised by opponents of time-out using evidence collected through a rigorous literature search and relevant news articles. Research on the subject is compiled to provide an empirical perspective on time-out myths and controversies.

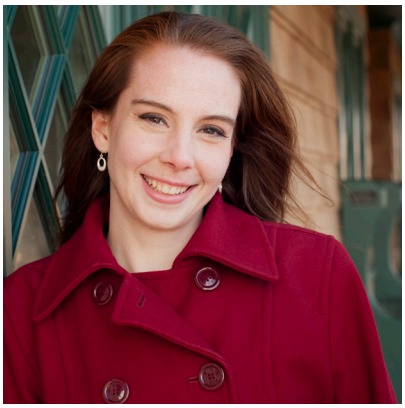
Specifications of Time-out

To address questions concerning the time-out paradigm, we first define the term and operationalize the procedure. Definitional issues are important as research findings from improperly implemented discipline procedures have produced mixed results (Larzelere, Schneider, Larson, & Pike, 1996). The term "time-out" was originally coined by Arthur Staats (Staats, 1971), and is an abbreviation of what many behavior analysts or behavioral psychologists would describe as "time-out from positive reinforcement" (Kazdin, 2001). Time-out "refers to the removal of a positive reinforcer for a certain period of time" (Kazdin,

2001, p. 210). By definition, time-out includes (1) a reinforcing environment, as well as (2) removal from that environment (Foxx & Shapiro, 1978). The positive, reinforcing environment often is established through warm, supportive parenting practices (e.g., praise). Appropriate child behaviors are immediately followed by positive parental attention to increase children's use of the appropriate behavior. Time-out, therefore, is meant to follow an inappropriate response to decrease the frequency of the response (Miller, 1976). Time-out is not meant to ignore a child's essential needs such as hunger, thirst, fear, or distress due to an accident (Morawska & Sanders, 2011). There are three situations that are appropriate for time-out implementation: (1) the presence of inappropriate behavior (e.g., noncompliance to a parental command), (2) the presence of a safety issue associated with the behavior (e.g., child hitting others), (3) when the use of reinforcements by the caregiver is ineffective due to the presence of other maintaining reinforcers in the child's environment (e.g., other children laughing at the behavior in the classroom; Anderson & King, 1974).

Between the years of 1977 and 2007, Everett, Hupp, and Olmi (2010) evaluated the collection of time-out research to operationally define a best-practice time-out procedure. Of the 445 studies collected, the researchers selected the 40 highest quality articles comparing 65 time-out intervention methods. A necessary set of criteria largely accepted across the literature was summarized as a collection of "(a) verbalized reason, (b) verbalized warning, (c) physi¬cal placement, (d) location in a chair, (e) short time durations, (f) repeated returns for escape, and (g) contingent delay release" (Everett, Hupp, & Olmi, 2010, p. 252). In addition, behavioral management principles were largely recommended including "(a) remaining calm dur¬ing implementation, (b) the use of the intervention immediately and consistently following target behavioral occurrence, and (c) appropriate monitoring through which to judge intervention effectiveness" (Everett, Hupp, & Olmi, 2010, p. 252).

Overall, time-out is meant to provide a consistent form of discipline that is delivered in a calm, controlled manner. Psycho-education on the use of developmentally appropriate behaviors is often conducted, thereby helping parents to set appropriate expectations for their child's behavior. Time-out allows parents to set limits when children act defiantly. It can be utilized in conjunction with other parental methods of discipline (e.g., removal of privilege), and is often implemented when a child does not respond to other parenting approaches (Hakman, Chaffin, Funderburk, & Silovsky, 2009). Time-outs are only administered for a pre-specified period of time (e.g., typically 3-7 minutes). Therefore, the child's circle of security is maintained as the parent returns positive attention to the child after completion of the discipline procedure, such that warm, positive words and touches are used to help the child regain emotional control and rebuild the relationship (McNeil & Hembree-Kigin, 2010). A number of evidence-based programs implement a structured time-out protocol adhering to Everett and Hupp's guidelines including Defiant Children (Barkley, 2013), Fast Track Program (Slough et al., 2008), Helping the Noncompliant Child (McMahon & Forehand, 2003; Peed, Roberts, & Forehand, 1977), the Incredible Years (Webster-Stratton, 1984), the Kazdin Method for Parenting the Defiant Child (Kazdin, 2008), Oregon Model, Parent Management Training (Forgatch, Bullock, & Patterson, 2004), Parent-Child Interaction Therapy (Eyberg & Funderburk, 2011; McNeil & Hembree-Kigin, 2010), Positive Parenting Program (Triple P; Nowak & Heinrichs, 2008; Sanders, Cann, & Markie-Dadds, 2003), and the Summer Treatment Program (Chronis et al., 2004). While some argue against time-out practices, families trained in time-out, their children, and the therapists who deliver treatment rate the procedure as appropriate and acceptable to help reduce problem behaviors (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993).



Nancy M. Wallace

The following sections will address five separate myths commonly made by time-out opponents. Within each myth, specific empirical literature will be cited to support each counter argument. The paper will conclude by summarizing key counter arguments and placing time-out in the broader context of the evidence based treatment approaches.

***Myth 1**: Time-out is Counterproductive Because Loving, Positive Parenting is the Most Therapeutic Approach to Alleviating Child Misbehavior*

Some time-out opponents support the perspective that time-out hurts children's emotional development, arguing that parents need to provide love, attention,

Amy Herschell

and reasoning to help children regulate their anger during episodes of misbehavior (Siegel & Bryson, 2014a). In contrast to this perspective, decades of research have validated the notion that optimal child development occurs in the context of both warmth, love, and clear, consistent parental control and direction. In 1967, Diana Baumrind proposed three categorizations of parenting styles: authoritative, authoritarian, and permissive (for reviews, see Baumrind, 1967; Baumrind & Black, 1967). Each style delineated a balance between various degrees of parental responsiveness (warmth) and parental demandingness (control; Baumrind, 1967 & 1978). Baumrind operationalized parental responsiveness as displays of parental warmth, communication, and the encouragement of individual expression (Baumrind, 2005; Areepattamannil, 2010). Baumrind conceptualized parental control as a high degree of demandingness in which a parent may request that a child exhibit or change his or her behavior to better conform to the rules and expectations of society (Baumrind, 2005). While authoritative parents utilize a balance of both responsiveness and consistent control, authoritarian parents employ high levels of control and low levels of responsiveness (Areepattamannil, 2010; Maccoby & Martin, 1983). Although, permissive parents utilize high levels of responsiveness, they also place few demands upon their children (Areepattamannil, 2010; Baumrind, 1996; Maccoby & Martin, 1983). Since such parental typologies were proposed, decades of empirical research have investigated the application of such categorizations with a variety of populations. Specifically, authoritative parenting has been related to positive child health outcomes (Cullen et al., 2000), positive school outcomes (Areepattamannil, 2010) and lower levels of child behavior problems (Alizadeh, Talib, Abdullah, & Mansor, 2011). Conversely, caregivers' consistent failure to set developmentally appropriate limits on children's inappropriate behavior, a primary dimension of permissive parenting, has been associated with suboptimal levels of child development. Furthermore, the permissive parenting style has been related to higher levels of child behavior problems (Driscoll, Russell, & Crockett, 2008), substance abuse (Patock-Peckham & Morgan-Lopez, 2006), and poorer emotion regulation in children (Jabeen, Anis-ul-Haque, & Riaz, 2013).

In addition, the implementation of purely positive parenting techniques alone has been found to be insufficient to obtain significant improvements in child behavior problems (Eisenstadt et al., 1985). These findings indicate that a positive relationship cannot alleviate significant problem behaviors or maintain appropriate levels of behavior without proper limit-setting (Pfiffner & O'Leary, 1987). Eisenstadt and colleagues (1993) evaluated the separate components of positive parenting practices and discipline strategies through a highly structured time-out procedure. Results indicated that children who received only the positive parenting component had slight improvements on oppositionality, but large problem behaviors were not eliminated. The children who received the discipline procedure improved to within normal limits of oppositionality. A separate review of the literature indicated that differential reinforcement alone was not as effective in reducing problem behavior as reinforcement combined with discipline procedures (Vollmer, Irvata, Zarcone, Smith, & Mazaleski, 1993). Discipline procedures are thus important components to positive parenting for all families (Cavell, 2001).

The field of applied behavior analysis has been particularly influential in the translation of behavioral principles to work with children in applied settings. Research in applied behavior analysis indicates that providing immediate attention (e.g., reasoning, hugs) for disruptive behaviors that are maintained by attention will result in increased behavior problems (Cipani & Schock, 2010). Specifically, differential reinforcement of other behavior (DRO), a commonly used behavioral schedule in applied behavior analysis, employs operant conditioning techniques to decrease the frequency and length of inappropriate behaviors otherwise maintained by attention. In contrast, a child in distress from an accident or upset about the loss of his pet should receive warm, understanding attention and emotional validation from his or her caregiver given that the behavior is not problematic, nor is its function negative attention seeking.

DRO is based off of positive reinforcement techniques in which positive behaviors are reinforced, thereby increasing their frequency, while negative and inappropriate behaviors are ignored, thereby reducing their frequency (Gongola & Daddario, 2010). Strictly speaking, other behaviors are reinforced for a

period of time while the negative, target behavior is not provided with any attention. The DRO schedule has demonstrated efficacy across a wide variety of environments and populations in decreasing inappropriate and noncompliant behavior. The DRO schedule also supports a positive environment and is an ethically appealing form of behavior modification (see Gongola & Daddario, 2010 for a review). A childhood tantrum represents a common childhood behavior that often functions as a means by which children may receive negative attention. However, if attention (e.g., reasoning, negotiating, comforting) is provided in this moment, as suggested by some authors (Siegel & Bryson, 2014a), such negative attention seeking behavior will be reinforced and the frequency and intensity of the tantrum will increase. Unfortunately, research and clinical practice indicate that verbal instruction regarding appropriate child behavior alone has not been shown to reduce a child's negative outbursts (Roberts, 1984), indicating a need for additional procedures to successfully modify aggressive and non-compliant behavior. Additionally, such attention may result in progressively escalating emotional exchanges between the parent and child in an attempt to control the situation (Dishion, French, & Patterson, 1995). By ignoring a child's tantrum and enthusiastically engaging in an appropriate activity, a parent is likely to redirect a child's attention away from his or her tantrum. Praise (e.g., for "using your words" or "calming yourself down") and positive touches may then be used to reinforce calm, emotionally regulated behavior. If the timing of such attention is provided after the tantrum has ceased and when the child is calm, the child is less likely to engage in a tantrum for attention seeking purposes in the future, tantrums are likely to decrease in duration and frequency, and instances of emotional regulation may be likely to occur. Time-out therefore, functions similarly to a DRO procedure, in that attention is removed for a specified period of time and reinstated after the allotted time is up, and the child is calm and able to complete the original request.

While typically developing children in the preschool age are likely to display regular levels of noncompliance to assert their independence (Schroeder & Gordon, 1991), most do not develop significant behavior problems because parents already provide both positive attention and appropriate limit-setting. In severe cases of persistent childhood misbehavior, however, a caregiver may be referred for evidence-based parent-training treatment to quickly modify maladaptive parent-child interactions. In such cases, research indicates that families typically enter treatment utilizing inappropriate and inconsistent strategies to handle their children's behavior (Bandura & Walters, 1959; McCord, McCord, & Zola, 1959; McNeil et al., 1994). Evidence-based practices are used to teach parents consistent discipline only after they have mastered positive approaches of interacting with their children including praising and rapport-building between the parent and child (Nowak & Heinrichs, 2008). A compilation of time-out literature concludes that approximately 77% of these research articles utilized time-out in addition to another treatment component, namely parent-child relationship building (Everett, Hupp, & Olmi, 2010). The goal of this treatment is to reduce negative parenting practices and eliminate corporal punishment techniques by the conclusion of treatment (McNeil et al., 1994). Across the time-out literature, research indicates that eighty-six percent of studies used positive reinforcement to increase positive behaviors (Everett, Hupp, & Olmi, 2010). Once an environment is built on positive, warm relationships, the time regularly spent with the child outside of time-out becomes rewarding and reinforcing. As a result, the child is increasingly motivated to avoid time away from parental attention, to work to gain positive attention, and to engage in fewer negative attention-seeking behaviors.

Cheryl B. McNeil

Myth 2: *Time-out Strategies are Manualized and Do Not Address the Individual Needs of Children*

As previously noted, a number of empirically-based parenting programs for children with severe behavior problems specify the use of a clear, step-by-step time-out procedure (e.g., Parent-Child Interaction Therapy, Eyberg & Funderburk, 2011; the Summer Treatment Program, Chronis et al., 2004). In contrast to views that manualized treatments do not address a child's individual needs, the specific components of time-out (e.g., duration, child characteristics, child age, specific behavior problems) have been investigated to maximize efficacy while minimizing the intensity of the procedure for a given child (Fabiano et al., 2004).

Evidence supporting the efficacy of individualized time-out programs within the larger framework of three manualized treatment programs (Summer Treatment Program, Chronis et al., 2004; Parent-Child Interaction Therapy, McNeil & Hembree-Kigin, 2010; Defiant Children, Barkley, 1997) will be presented.

Fabiano et al. (2004) investigated the effect of three time-out procedures of varying lengths for children attending a summer treatment program for Attention Deficit Hyperactivity Disorder (ADHD: a disorder characterized by attention difficulty, hyperactivity, and/or impulsiveness). Time-out conditions consisted of a short (5 minute), long (15 minute) and an escalating/de-escalating procedure whereby a child could increase or decrease the length of the time-out depending on the appropriateness of his or her behavior in time-out. A time-out was only assigned following the occurrence of intentional aggression, intentional destruction of property, or repeated noncompliance. In the final response-cost condition, children only lost points for exhibiting such behaviors and commands were repeated until compliance was achieved. Results supported previous literature, indicating that time-out, irrespective of duration and child's age, was effective in reducing the occurrence of problematic behaviors (McGuffin, 1991). Recognizing that responses to time-out varied by the individual, the authors recommended modifications of the procedure if the initial time-out protocol is rendered unsuccessful. For example, some children may require a more complicated time-out procedure (Fabiano et al., 2004; Pelham et al., 2000). Finally, despite the context of a manualized treatment program with clear time-out procedures, the authors reported that individualized goals and individualized behavioral treatment programs were instated for children whose behavior did not respond well to time-out. The use of such programs indicates a degree of flexibility within the model and a focus on individualized efficacy of the procedure.

Another manualized treatment approach, Parent-Child Interaction Therapy (PCIT), utilizes a variety of procedures based in behavioral theory to individualize treatment to each child and family (McNeil, Filcheck, Greco, Ware, & Bernard, 2001). For example, PCIT begins with a non-standard functional assessment in which the therapist observes parent and child behavior across three situations meant to simulate typical parent-child interactions. The function of both parent (e.g., negative talk) and child (e.g., defiance, complaining) behaviors during these interactions are specifically evaluated (McNeil et al., 2001). Such conceptualizations are used to guide treatment so that caregivers can be taught to use positive interactional skills for attending to specific prosocial behaviors displayed by their children (McNeil et al., 2001). Additionally, individualized, skill-based data from behavior observations conducted at the start of each session are immediately utilized to shape the treatment session (McNeil et al., 2001). The discipline procedures used in PCIT may also be adapted according to the child's age and developmental level (McNeil et al., 2001). Furthermore, time-out is not recommended for toddlers less than two years old in response to noncompliance (McNeil & Hembree-Kigin, 2010). Instead a procedure involving simple words and pointing to what the child should do (e.g., "give me hat") followed by a hand over hand guide and praise for compliance should be used. A short (1 minute) time-out in a safe space (e.g., high chair, playpen) is recommended for aggressive behavior (McNeil & Hembree-Kigin, 2010). In contrast, discipline procedures for older children (7-10 years) include a number of potential steps such as (1) an explanation of the command, (2) an initial "big ignore" upon noncompliance in which a parent withdraws attention from the child for 45 seconds, and (3) a time-out warning. To teach the older child to cooperate with the time-out procedure, a sticker chart may be used to reward either avoiding time-out entirely by complying with parental instructions or accepting the time-out consequence without resistance. A suspension of privilege procedure is introduced late in treatment if children refuse to attend time-out or escape from time-out. Finally, some critics believe that time-out should not be used with children on the autism spectrum as the procedure allows the child to escape from otherwise non-pleasurable demands. However, a core component of effective time-out across evidence based programs is completion of the original command, thereby inhibiting the function of time-out as escape.

Lastly, in Defiant Children, a manualized treatment for non-compliant children, Barkley (1997) also uses a time-out procedure. Similar to PCIT, parents are told to implement time-out initially for noncompliance to commands only. After noncompliance to a warning, children remain in time-out for 1-2 minutes per year of their age and are not allowed to leave time-out until they are quiet for approximately 30 seconds. A child's bedroom is used if the child escapes from the chair before the allotted time is up. The sequence concludes when the child must comply with the original command.

It is well established that manualized treatment procedures support the efficacy of time-out in reducing

child behavior problems (Fabiano et al., 2004). Although a primary time-out procedure is specified in some manualized treatment programs, many also include individualized programs dependent upon the needs and characteristics of the child. Most importantly, time-out procedures often involve more intensive back-up consequences only when a child is unable to comply with the least restrictive consequence. When applied to typically developing children, the higher steps in the procedure may not be necessary. Children are taught all procedures prior to their initiation, and the provision of various backup procedures to time-out is determined by the child's choices. As the foundation of time-out is removing the child from reinforcing events, an integral component of the procedure involves enhancing time-in by increasing the reinforcing value of the parent-child interactions. As such, time-out procedures always fall within the larger context of a warm, positive environment where prosocial child behaviors are encouraged through high rates of social reinforcement.

Myth 3: *Time-out Can Trigger Trauma Reactions Related to Harsh Discipline Practices, Thereby Retraumatizing Children with a History of Maltreatment*

There is considerable debate on the use of time-out for children with histories of trauma. However, a number of research studies spanning multiple areas of psychology shed light on the use of time-out with this specialized population (Chaffin et al., 2004). Physical abuse is likely to occur in the context of the coercive cycle whereby a parent and child use increasingly intensive verbal and behavioral strategies to attempt to control a given situation (Patterson & Capaldi, 1991; Urquiza & McNeil, 1996). Such escalation may result in child physical abuse (CPA). Chaffin et al. (2004) conducted a randomized controlled trial to investigate the effects of PCIT on physical abuse. At the two year follow-up assessment, reports of physical abuse were 19% in the PCIT group as compared to 49% in the community parenting group, suggesting that the use of a time-out procedure may have helped to reduce the occurrence of CPA.

Some may argue that the use of time-out with children who have experienced abuse may result in retraumatization. Retraumatization has been defined as, "… traumatic stress reactions, responses, and symptoms that occur consequent to multiple exposures to traumatic events that are physical, psychological, or both in nature" (Duckworth & Follette, 2012, p. 2). These responses can occur in the context of repeated multiple exposures within one category of events (e.g., child sexual assault and adult sexual assault) or multiple exposures across different categories of events (e.g., childhood physical abuse and involvement in a serious motor vehicle collision during adulthood). According to the Diagnostic and Statistical Manual of Mental Disorders-5, examples of traumatic events may include torture, disasters, being kidnapped, military combat, sexual abuse, and automobile accidents (5th ed., text rev.; DSM–5, American Psychiatric Association, 2013). An individual's response to the traumatic event may be any combination of "a fear-based re-experiencing, emotional, and behavioral symptoms… [an] anhedonic or dysphoric mood state and negative cognitions [and/or] arousal and reactive-externalizing symptoms [and/or] dissociative symptoms" (5th ed., text rev.; DSM–5; American Psychiatric Association, 2013, p. 274). Given such definitions, it seems unlikely that a three minute time-out in a chair would qualify as a traumatic event for a young child. Yet, it remains important to consider whether time-out could serve as a trauma trigger, causing a child to experience intense fear and dissociative symptoms. At the same time, we must consider how to differentiate dysregulated behavior that has been triggered by association with a past trauma (e.g., physical abuse during discipline) versus the typical yelling, crying, and tantrumming seen routinely when strong-willed children receive a limit.

In a typical time-out procedure, a child is issued a command. Following a short period (e.g., 5 seconds), a warning is given indicating that if the child does not do as instructed, then he or she will go to time-out. Following an additional period of silence, the child is led to a time-out chair (Eyberg & Funderburk, 2011). Although such procedures could be potential triggers for recalling prior abuse, time-outs involve setting clear, predictable limits which are essential to healthy growth and development. Without the ability to establish boundaries and enforce predictable limits, caregivers of children with prior abuse histories may resort to a permissive parenting style that (1) lacks the structure needed for children to develop adequate self-control and emotional regulation, and (2) has been shown to lead to poor mental health outcomes (Fite, Stoppelbein, & Greening, 2009; McNeil, Costello, Travers, & Norman, 2013).

A valid concern is that time-out procedures could very well serve as a trigger for previous abuse experiences, particularly those that involved the caregiver becoming physically aggressive during an escalated and coercive discipline exchange. Yet, instead of automatically concluding that discipline battles should

be avoided due to the possible triggering of a trauma response, it is interesting to consider that the time-out procedure could actually be highly therapeutic from an exposure perspective. A primary treatment component for individuals that have experienced trauma involves imaginal or in-vivo exposure to triggers associated with the traumatic event in the context of a safe environment. Through repeated exposure, the individual's anxiety surrounding the trauma decreases. Previous triggers become associated with feelings of safety and predictability, rather than fear and pain. From a behavioral perspective, a previously unconditioned stimulus (e.g., yelling and hitting during discipline interactions) is replaced by a conditioned stimulus (e.g., a calm, clear, and consistent sequence of caregiver behaviors). The previously unconditioned response (e.g., fear) is then alleviated by the feelings of safety associated with predictable consequences delivered by the caregiver (e.g., time-out delivered calmly and systematically). The use of a warning prior to the time-out provides control to children, allowing them to choose a behavioral response and control whether time-out is delivered. Through repeated exposure to consistent, calm limit setting, discipline scenarios are no longer associated with fear and pain, such that prior conditioning is extinguished. Through exposure to predictable and appropriate limit setting, the child develops a sense of control and feelings of safety during discipline interactions.

It is imperative to consider each child's individual abuse history in the context of each step of time-out. For children with histories of neglect or seclusion, an alternative back-up procedure (other than a back-up room) may be considered as a consequence for time-out escape, as the back-up room may have ethical concerns as the exposure may be too intense (more of a flooding experience than systematic desensitization; McNeil & Hembree-Kigin, 2010). In these types of extreme cases, alternative back-ups to the time-out, such as restriction of privilege, may be used to allow a more systematic exposure to the time-out sequence, allowing children to regulate their emotions while maintaining the efficacy of such procedures (McNeil, Costello, Travers, & Norman, 2013). If a back-up space is deemed appropriate, the caregiver is instructed to remain in close proximity (i.e., within two feet of the child) so that the child is aware of the parent's presence, thereby preventing the child from experiencing any sense of abandonment. Following time-out, the parent and child are encouraged to engage in calm, loving interactions, often in the form of play. These warm interactions help to maintain the positive parent-child relationship, while also communicating that the parent loves the child but does not condone the child's defiant and aggressive behavior (McNeil, 2013).

Myth 4: *Time-out is Harmful to Children*

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Some time-out opponents believe that time-out causes children to feel intense relational pain and feelings of rejection from their caregiver. Additionally, some argue that time-out causes children to fail to have a chance to build important social and emotional skills including emotion regulation, empathy and the ability to solve problems (Siegel & Bryson, 2014a). While there is an abundance of research indicating the positive outcomes stemming from time-out implementation, equal importance should be placed on the alternative outcomes if parent training (including both positive parenting skills and discipline techniques) is not delivered to high-risk families. Regardless of the feelings individuals have about the use of "aversive" practices (e.g., time-out), the unfortunate truth is both high- and low-risk families can inflict severe, inappropriate consequences on their children when caught in a coercive process. Passimi, Pihet, and Favez (2014) explored a community sample of highly educated, generally stable families to determine their acceptance of discipline techniques used with their children. Mothers indicated strong beliefs in a warm relationship with their children and agreed with explaining household rules regularly. The use of time-out was also highly accepted, however there was significant variation across parents indicating that strong feelings were present about the appropriateness of various discipline approaches. Discipline techniques such as yelling and spanking received the lowest acceptance by these parents, with spanking practices more accepted than yelling. In spite of their acceptance rates, both yelling and spanking were implemented by the sampled families. Moreover, although yelling was the least acceptable practice rated by mothers, yelling was implemented as frequently as time-out in this sample.

While families can be well-intentioned, parents and children may unknowingly become caught in a negative interaction cycle explained by Patterson's coercion theory (1982). Patterson's theory explains a process of mutual reinforcement between parents and their children in which parents inadvertently reinforce a child's problem behaviors. More specifically, Patterson's (2002) theory posits that a parent may give a command to a child who then resists or becomes frustrated by the request. Such child misbehavior causes the parent to become angrier, the child to become more defiant, and the interaction to escalate. If parents give in to the child at this point in the coercive exchange, it results in the strengthening of the child's problem behavior. The coercive escalation also can lead parents to react with inappropriate discipline strategies to elicit a form of control (Patterson, 1982; Patterson & Capaldi, 1991). When these styles of interaction become the norm, children learn a pattern of defiance, leading to behavior problems that can maintain during the course of development (Granic & Patterson, 2006). Fortunately, the use of time-out interrupts the coercive process between caregivers and children. Evidence-based practices provide parents with specific words and actions to prevent the escalation of problem behaviors (Morawska & Sanders, 2011).

Families referred for parent training have higher rates of physical punishment and inappropriate discipline strategies (Patterson & Capaldi, 1991). In one clinical sample, for example, parents admitted to spanking their children approximately 13 times a week (McNeil et al., 1994). Referred caregivers are more likely to respond to their children's frequent, regular misbehaviors with yelling, critical statements, threats, and physical punishment (Mammen, Kolko, & Pilkonis, 2003). When no positive discipline alternatives are provided to highly stressed parents who are confronted with severe behavior problems, they are likely to resort to spanking out of desperation and frustration. When spanking is unsuccessful, physical punishments may escalate into child physical abuse.

Although some outspoken opponents argue that time-out makes children "angrier and more dysregulated" when children have not "built certain self-regulation skills" (Siegel & Bryson, 2014a, para. 5, 7), the research has in fact indicated that the opposite is true. Time-out represents a safe, effective form of discipline in which a caregiver and child are able to remove themselves from a potentially stressful parent-child interaction and are given the space needed to regain control of their thoughts and emotions. Specifically, recent research indicates promising outcomes using time-out for children with disruptive mood dysregulation disorder. Therefore, implementing a parenting intervention with both relationship-building and discipline (i.e., time-out) components produced significant positive effects such as a reduction in defiance and an increase in a healthier mother-child relationship. Further research supports the notion that time-out is effective in helping children's externalizing and internalizing behavior to come within normal limits, demonstrate greater self-control and achieve better emotion regulation abilities (Graziano, Bagner, Sheinkopf, Vohr, & Lester, 2012; Johns & Levy, 2013; Webster-Stratton, Reid, & Stool-Miller, 2008). Additionally, the length of time-out is short (e.g., approximately 3 minutes or 1 minute per year of the child's age) across most empirically-based

parenting programs (Everett, Hupp, & Olmi, 2010).

Kazdin (2002) argues that, the failure to use appropriate discipline and parenting techniques to protect a child who is acting out may be detrimental, and itself may meet the definition of abuse. If negative discipline procedures escalated to the level of severe physical punishment, abuses such as these have been shown to be associated with a child's increased likelihood of drug dependency, personality disorders, and a number of mood disorders (Afifi, Mota, Dasiewicz, MacMillan, & Sareen, 2012). These negative skills are linked to child psychopathology such as oppositional defiant disorder and conduct disorder (Falk & Lee, 2012). Moreover, Afifi and colleagues (2012) found that harsh physical punishment accounted for 4 to 7% of disorders including intellectual disabilities and personality disorders in addition to 2 to 5% of all other diagnostic criteria for Axis I of the DSM-IV-TR (Afifi et al., 2012).

Parents who have psychopathology themselves are at high risk of using inappropriate discipline strategies when faced with challenging child behavior (Harmer, Sanderson, & Mertin, 1999). More specifically, caregivers with psychopathologies respond at increased rates with hostility, anger, and irregular, unfair discipline techniques despite the child's behavior (Harmer, Sanderson, & Mertin, 1999; Paulson, Dauber, & Leiferman, 2006). Similarly, some children are already predisposed to high risk behavior. For example, researchers have recently concluded that children on the autism spectrum and with ADHD have a weakened sense for danger and more frequently engage in behaviors that place them at risk for harm and even death (Anderson et al., 2012; Barkley, 2005).

Research on parenting styles shows that effective parenting requires a combination of a nurturing relationship and effective limit-setting strategies (authoritative parenting style; Baumrind, 1967). Children raised by authoritative parenting styles score higher in measures of competence, academic achievement, social development, self-esteem, and mental health (Dornbusch, Ritter, Leiderman, & Roberts, 1987; Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Maccoby & Martin, 1983). While slight variation in needs may be present on a cultural level, overall findings indicate successful outcomes across cultural groups when children are raised using an authoritative style of love and limits (Sorkhabi, 2005).

Myth 5: Time-out Skills Should Not Be Taught to Parents Because They Could Use Them Improperly

Some researchers opposed to time-out procedures have noted potential danger in teaching parents to utilize therapeutic discipline practices (Lutzker, 1994b), particularly ones that involve holding preschoolers or carrying children to time-out, for fear that such procedures may be misused. Still others, have argued that highly stressed caregivers may not possess the emotional abilities to express care and concern toward their children (Joinson et al., 2008) and may overly focus on time-out, allowing negative caregiver-child interactions to perpetuate (Morison, 1998). Although it is possible that a given discipline procedure may be misused (Kemp, 1996; Morawska & Sanders, 2011), it is important to consider the multitude of responsibilities that parents in our society take on to ensure the health and well-being of their children. Are we to argue that we should not prescribe potentially helpful medication because the parent may give the child too much? Instead, the implementation of time-out must be considered in the larger context of positive parenting practices (e.g., warmth, sensitivity). For example, one evidence-based practice, PCIT (McNeil & Hembree- Kigin, 2010), has a strict set of guidelines which prevents families from receiving the time-out program until they have mastered the positive "PRIDE" skills (praise, reflection, imitation description, and enjoyment). Families also are not able to graduate from PCIT until they have mastered, under close supervision, the procedures required to implement an appropriate time-out. Defiant Children (Barkley, 2013), another evidence based program, states that the time-out procedure is not implemented until step 5, after parents have learned and practiced a number of positive parenting skills over the course of at least 4 weeks. Such components include (1) education regarding causes of child misbehavior, (2) practicing differential attention in order to reinforce positive behavior, (3) practicing positive play time for homework in order to build warmth and positivity in the parent child relationship, (4) learning to give effective commands, and (5) instating a token economy to increase compliant child behavior.

Time-out procedures taught in the context of parenting programs are based on empirical literature documenting their efficacy. If parents struggling to discipline their child are not taught such procedures under the close guidance of a trained mental health professional, they are at risk of resorting to dangerous physical discipline practices modeled by their own abusive parents. Whereas the risk of harm in teaching an evidence-based time-out protocol is low, there is a

high possibility of harm if dysregulated and stressed caregivers are left to their own devices to discipline children who are displaying severe behavior problems. Finally, when parents are guided through effective time-out procedures, they learn how to conduct a time-out appropriately (e.g., warning statement, unemotional responding, short duration) instead of resorting to popular but ineffective practices, such as reasoning and having a child contemplate their actions (Morawska & Sanders, 2011).

Concluding Thoughts

Opinion pieces in lay periodicals have been published for a number of years arguing against the use of time-out. For example, the recent article by Siegel and Bryson in Time magazine (2014a) was widely distributed. Without regard to the huge volume of high quality research supporting time-out (Wolf, 1978), the authors argued against the practice, resulting in negative perceptions about time-out by nonprofessionals, lay persons, and clients. In this way, a single high-profile story in a magazine can lead to a serious setback in scientific advancement and clinical practice. The negative impact on public opinion is especially concerning as treatments viewed as acceptable by the consumers are more likely to be initiated and adhered to once they are learned by those who need it most (Kazdin, 1980). If inaccurate information continues to be spread without proper filtering, the outcomes could mean large, negative effects for evidence-based practice.

Although the author of this article in Time magazine later responded to criticisms of time-out (Siegel & Bryson, 2014b) by specifying that, "the research that supports the positive use of appropriate time-outs as part of a larger parenting strategy is extensive," the original lack of specification when criticizing time-out implementation quickly did more harm than good for informing the general public (para. 7). As researchers, it is our responsibility to disseminate high-quality findings to the lay public to improve our overall positive public health impact. In this instance, regardless of the researchers' intentions, failing to operationally define time-out and recognize an entire body of research dedicated to "appropriate use" of time-outs did a disservice to a large group of experts who have been conducting this research for decades, while also greatly misleading the public. To protect the public and our profession, we must critically evaluate, interpret, and communicate current literature in such a way that it can be comprehended by lay consumers. Unfortunately, one of the cited articles used in the debate against time-out by Siegel and Bryson was a research article by Eisenberger, Lieberman, and Williams (2003). Siegel and Bryson claimed that findings from this 2003 study indicated social

isolation, which they argued is characteristic of time-out situations, yields similar brain imaging patterns to traumatization or physical pain (Siegel & Bryson, 2014a; 2014b). Eisenberger and colleagues' 2003 study is instead researching brain patterns of college-aged adults socially isolated by their "peers" during a virtual reality ball-tossing game. Interestingly, during times of participation and other periods of unintentional exclusion, individuals showed the same brain imaging patterns. In addition, the Eisenberger and colleagues' study based their argument off of a summary article showing brain patterns of pre-weaned rat pups isolated from their mothers for extended periods of time (Nelson & Panksepp, 1998). As any practiced researcher is aware, these highly disparate concepts should not be used as justification for the illegitimacy of time-out, as the argument lacks scientific validity and leads to false conclusions and misunderstanding.

Rigorous research studies examining the use of parenting programs including time-out demonstrate reduced aggressive behavior, increased child compliance (Eyberg & Robinson, 1982; Pearl et al., 2012), generalization of behaviors across school (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and other environments, and maintenance of effects for several years (Boggs et al., 2004; Eyberg et al., 2001; Hood & Eyberg, 2003). The use of time-out has also been a critical factor in helping children to gain emotion regulation capabilities (Graziano et al., 2012). Furthermore, emotion regulation has been linked to the broader context of self-control, which has been shown to predict a variety of life outcomes (Moffitt et al., 2011).

The use of time-out as a tool to help caregivers set limits has been a critical component of many evidence-based treatment programs such as PCIT, shown to decrease recidivism rates of child physical abuse to 19% in a group of previously physically abusive caregivers compared to 49% in a community treatment sample (Chaffin et al., 2004). Research also demonstrates that PCIT reduces child traumatic symptoms following exposure to trauma (Pearl et al., 2012). In addition to its demonstrated efficacy, PCIT is represented on the Kauffman list of best practices for children with a history of trauma (Chadwick Center for Children and Families, 2004) and is endorsed by the National Child Traumatic Stress Network (NCTSN) as an evidence-based intervention for child trauma (nctsn.org). In conclusion, time-out represents a safe, effective form of discipline which, in the context of a larger environment dominated by positivity, consistency, and predictability, has been shown across hundreds of research studies to be beneficial to the overall emotional and developmental functioning of young children.

References

Afifi, T. O., Mota, N. P., Dasiewicz, P., MacMillan, H. L., & Sareen, J. (2012). Physical punishment and mental disorders: Results from a nationally representative US sample. Pediatrics, 130 (2), 1-9.

Alizadeh, S., Talib, M. B. A, Abdullah, R., & Mansor, M. (2011). Relationship between parenting style and children's behavior problems. Asian Social Science, 7(12), 195-200.

American Academy of Pediatrics (1998). Guidance for effective discipline. American Academy of Pediatrics. Committee on Psychological Aspects of Child and Family Health. Pediatrics, 101 (4 Pt 1), 723-728.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, DC: American Psychiatric Association.

Anderson, C., Law, J. K., Daniels, A., Rice, C., Mandell, D. S., Hagopian, L., & Law, P. A. (2012). Occurrence and family impact of elopement in children with autism spectrum disorders. Pediatrics, 130, 870–877.

Anderson, K. A., & King, H. E. (1974). Time-out reconsidered. Journal of Instructional Psychology, 1(2), 11–17.

Areepattamannil, S. (2010). Self-determination and achievement: Academic motivation, academic self-concept, and academic achievement of immigrant and non-immigrant adolescents. VDM Verlag.

Bandura, A., & Walters, R. H. (1959). Adolescent Aggression. New York: Ronald.

Barkley, R. A. (1997) Defiant Children: A Clinician's Manual for Assessment and Parent Training. New York: Guilford Press.

Barkley, R. A. (2005). ADHD and the nature of self-control. New York: Guilford Press.

Barkley, R. A. (2013). Defiant children: A clinician's manual for assessment and parent training (3rd ed). New York: Guilford Press.

Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. Genetic Psychology Monographs, 75(1), 43-88.

Baumrind, D. (1978). Parental disciplinary patterns and social competence in children. Youth and Society, 9, 238-276.

Baumrind, D. (1996). The discipline controversy revisited. Family Relations, 45(4), 405-414.

Baumrind, D. (2005). Patterns of parental authority and adolescent autonomy. In J. Smetana (Ed.) New directions for child development: Changes in parental authority during adolescence (pp. 61-69). San Francisco: Jossey-Bass.

Baumrind, D., & Black, A. E. (1967). Socialization practices associated with dimensions of competence in preschool boys and girls. Child Development, 38, 291-327.

Blampied, N. H., & Kahan, E. (1992). Acceptability of alternative punishments: A community survey. Behavior Modification, 16, 400-413

Boggs, S., Eyberg, S. M., Edwards, D., Rayfield, A., Jacob, J., Bagner, D., et al. (2004). Outcomes of Parent-Child Interaction Therapy: A comparison of treatment completers and study dropouts one to three years later Child & Family Behavior Therapy, 26(4), 1-22.

Cavell, T. A. (2001). Updating our approach to parent training: The case against targeting non-compliance. Clinical Psychology: Science & Practice, 8, 299-318.

Chadwick Center for Children and Families. (2004). Closing the quality chasm in child abuse treatment: Identifying and disseminating BEST practices. San Diego, CA: Author.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. Journal of Consulting and Clinical Psychology, 72(3), 500-510.

Chronis, A. M., Fabiano, G. A., Gnagy, E. M., Onyango, A. N., Pelham, W. E., Williams, A., et al. (2004). An evaluation of the summer treatment program for children with ADHD using a treatment withdrawal design. Behavior Therapy, 35, 561–585.

Cipani, E., & Schock, K. M. (2010). Functional behavioral assessment, diagnosis, and treatment, second edition: A complete system of education and mental health settings. New York: Singer Publishing Company.

Cullen, K. W., Rittenberry, L., Olvera, N., & Baranowski, T. (2000) Environmental influences on children's diets: results from focus groups with African-, Euro- and Mexican-American children and their parents. Health Education Research, 15, 581–590.

Dishion, T. J., French, D. C., & Patterson, G. R. (1995). The development and ecology of antisocial behavior. In D. Cicchetti & D. Cohen (Eds.), Manual of developmental psychopathology (pp. 421–471). New York: Wiley.

Dornbusch, S. M., Ritter, P. L., Leiderman, P. H., & Roberts, D. F. (1987). The relation of parenting style to adolescent school performance. Child Development, 58, 1244-1257.

Driscoll, A., Russell, S., & Crockett, L. (2008). Parenting styles and youth well-being across immigrant generations. Journal of Family Issues, 29(2), 185-209.

Duckworth, M. P., & Follette, V. M. (2012). Retraumatization: Assessment, treatment and prevention. New York, NY: Routledge.

Eisenberger, N. I., Lieberman, M. D., & Williams, K. D. (2003). Does rejection hurt? An fMRI study of social exclusion. Science, 302 (5643), 290-292.

Eisenstadt, T, H., Eyberg, S, M., McNeil, C, B., Newcomb, K., and Funderburk, B. (1993). Parent-child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome. Journal of Child Clinical Psychology, 22, 42-51.

Everett, G. E., Hupp, S. D. A., & Olmi, D. J. (2010). Time-out with parents: A descriptive analysis of 30 years of research. Education and Treatment of Children, 33 (2), 235-259.

Eyberg S. M., & Funderburk B. W. (2011). Parent–child interaction therapy protocol. Gainesville, FL: PCIT International.

Eyberg, S. M., Funderburk, B., Hembree-Kigin, T., McNeil, C. B., Querido, J., & Hood, K. (2001). Parent–Child Interaction Therapy with behavior problem children: One and two year maintenance of treatment effects in the family. Child & Family Behavior Therapy, 23(4), 1-20.

Eyberg, S. M., & Robinson, E. A. (1982). Parent-child interaction training: Effects on family functioning. Journal of Clinical Child Psychology, 11, 130-137.

Fabiano, G.A., Pelham, W.E., Manos, M., Gnagy, E.M., Chronis, A.M., Onyango, A.N., Williams, A., Burrows-MacLean, L, Coles, E.K., Meichenbaum, D.L., Caserta, D.A., & Swain, S. (2004). An evaluation of three time out procedures for children with attention-deficit/hyperactivity

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disorder. Behavior Therapy, 35, 449-469.

Falk, A. E., & Lee, S. S. (2012). Parenting behavior and conduct problems in children with and without attention-deficit/hyperactivity disorder (ADHD): Moderation by callous-unemotional traits. Journal of Psychopathology and Behavioral Assessment, 34(2), 172-181.

Fite, P. J., Stoppelbein, L., & Greening, L. (2009). Predicting readmission to a child psychiatric inpatient facility: The impact of parenting styles. Journal of Child and Family Studies, 18, 621-629.

Forgatch, M. S., Bullock, B. M., & Patterson, G. R. (2004). From theory to practice: Increasing effective parenting through role-play. The Oregon Model of Parent Management Training (PMTO). In H. Steiner (Ed.), Handbook of mental health interventions in children and adolescents: An integrated developmental approach (pp. 782-814). San Francisco: Jossey-Bass.Foxx, R. M., & Shapiro, S. T. (1978). The timeout ribbon: A nonexclusionary timeout procedure. Journal of Applied Behavior Analysis, 11, 125-136.

Gongola, L., & Daddario, R. (2010). A practitioner's guide to implementing a differential reinforcement of other behaviors procedure. Teaching exceptional children, 42(6), 14-20.

Granic, I., & Patterson, G. R. (2006). Toward a comprehensive model of antisocial development: A systems dynamic systems approach. Psychological Review, 113, 101-131.

Graziano, P. A., Bagner, D. M., Slavec, J., Hungerford, G., Kent, K., Babinski, D., ... & Pasalich, D. (2014). Feasibility of Intensive Parent–Child Interaction Therapy (I-PCIT): Results from an Open Trial. Journal of Psychopathology and Behavioral Assessment, 1-12.

Hakman, M., Chaffin, M., Funderburk, B., and Silovsky, J. F. (2009). Change trajectories for parent-child interaction sequences during Parent-child interaction therapy for child physical abuse. Child Abuse and Neglect, 33, 461-470.

Harmer, A. M., Sanderson, J., & Mertin, P. (1999). Influence of negative childhood experiences on psychological functioning, social support, and parenting for mothers recovering from addiction. Child Abuse & Neglect, 23(5), 421-433.

Hood, K. K., & Eyberg, S. M. (2003). Outcomes of Parent-Child Interaction Therapy: Mothers' reports of maintenance three to six years after treatment. Journal of Clinical Child and Adolescent Psychology, 32(3), 419-429.

Jabeen, F., Anis-ul-Haque, M., & Riaz, M. N. (2013). Parenting styles as predictors of emotion regulation among adolescents. Pakistan Journal of Psychological Research, 28(1), 85-105.

Johns, A., & Levy, F. (2013). 'Time-in' and 'time-out' for severe emotional dysregulation in children. Austalasian Psychiatry, 21(3), 281-282.

Joinson, C., Heron, J., von Gontard, A., Butler, U., Golding, J., & Emond, A. (2008). Early childhood risk factors associated with daytime wetting and soiling in school-age children. Journal of Pediatric Psychology, 33(7), 739 -750.

Kazdin, A. E. (1980). Acceptability of alternative treatments for deviant child behavior. Journal of Applied Behavior Analysis, 13, 259-273.

Kazdin, A. E. (1985). Treatment of antisocial behavior in children and adolescents. Homewood, IL: Dorsey Press.

Kazdin, A. E. (2001). Behavior modification in applied settings sixth edition. Long Grove, IL: Waveland Press Inc.

Kazdin, A. E. (2002). Psychosocial treatments for conduct disorder in children and adolescents. In P. E. Nathan & J M. Gorman (Eds.), A guide to treatments that work (2nd ed.; pp. 57-85). London: Oxford University Press.

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. American Psychology, 63(3), 146-159.

Kemp, F. (1996). The ideology of aversive treatment as applied to clients and colleagues. Child and Family Behavior Therapy, 18, 9-34.

Lamborn, S., Mounts, N., Steinberg, L., & Dornbusch, S. (1991). Patterns of competence and adjustment among adolescents from authoritative, authoritarian, indulgent, and neglectful families. Child Development, 62, 1049–1065.

Larzelere, R. E., Schneider, W. N., Larson, D. B., & Pike, P. L. (1996). The effects of discipline responses in delaying toddler misbehavior recurrences. Child & Family Behavior Therapy, 18(3), 1996.

LaVigna, G. W., & Donnellan, A. M. (1986). Alternatives to punishment: Solving behavior problems with non-aversive strategies. New York: Irvington.

Lutzker, J. R. (1994a). Referee's evaluation of "Assessment of a new procedure for time-out escape in preschoolers" by McNeil et al. Child & Family Behavior Therapy, 16, 33-35.

Lutzker, J. R. (1994b). Assessment of a new procedure for time-out escape in preschoolers: A rejoinder. Child and Family Behavior Therapy, 16, 47-50.

Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent-child interaction. In P. H. Mussen (Series Ed.) & E. M. Hetherington (Vol. Ed.), Handbook of Child Psychology, 4, Socialization, Personality, and Social Development (4th ed.). New York: Wiley.

Mammen, O. K., Kolko, D. J., & Pilkonis, P. A., (2003). Parental cognitions and satisfaction: Relationship to aggressive parental behavior in child physical abuse. Child Maltreatment, 8, 288-301.

McCord, W., McCord, I., & Zola, T. K. (1959). Origins of crime. New York: Columbia University Press.

McGuffin, P. (1991). The effect of timeout duration on the frequency of aggression in hospitalized children with conduct disorders. Behavioral Interventions, 6(4), 279-288.

McMahon, R. J., & Forehand, R. (2003). Helping the noncompliant child: A clinician's guide to effective parent training. (2nd edition). New York: Guilford.

McNeil, C. B. (2013, September). PCIT for children traumatized by physical abuse and neglect: Ethical and philosophical concerns. Presentation conducted at the Parent-Child Interaction Therapy International Convention, Boston, MA.

McNeil, C. B., Clemens-Mowrer, L., Gurwitch, R. H., & Funderburk, B. W. (1994). Assessment of a new procedure to prevent timeout escape in preschoolers: Authors' response to Lutzker's rejoiner. Child & Family Behavior Therapy, 16(4), 51-58.

McNeil, C. B., Costello, A. H., Travers, R. N., & Norman, M. A. (2013). Parent-child interaction therapy with children traumatized by physical abuse and neglect. In S. Kimura & A. Miyazaki (Eds.), Physical and Emotional Abuse: Triggers, Short and Long-Term Consequences and Prevention Methods. Nova Science Publishers: Hauppauge, NY.

McNeil, C. B., Eyberg, S. M., Eisenstadt, T. H., Newcomb, K., & Funderburk, B. W. (1991). Parent-Child Interaction Therapy with behavior problem children: Generalization of treatment effects to the school setting. Journal of Clinical Child Psychology, 20, 140-151.

McNeil, C. B., Filcheck, H. A., Greco, L. A., Ware, L. M. & Bernard, R. S. (2001). Parent-child interaction therapy: Can a manualized treatment be functional? The Behavior Analyst Today, 2 (2), 106-115.

McNeil, C., & Hembree-Kigin, T. L. (2010). Parent–child interaction therapy (2nd ed.). New York, NY US: Springer Science + Business Media.

Miller, L. K., (1976). Everyday behavior analysis. Monterey, CA: Brooks/Cole Publishing Company.

Moffitt, T., Arseneault, L., Belsky, D., Dickson, N., Hancox, R. J., Harrington, H., … Caspi, A. (2011). A gradient of childhood self-control predicts health, wealth, and public safety. Proceedings of the National Academy of Sciences, 108, 2693-2698.

Morawska, A., & Patock-Peckham, J. A., & Morgan-Lopez, A. A. (2006). College drinking behaviors: Mediational links between parenting styles, impulse control, and alcohol-related outcomes. Psychol. Addict. Behavior, 20, 117-125.

Sanders, M. (2011). Parental use of time out revisited: A useful or harmful parenting strategy? Journal of Child and Family Studies, 20, 1-8.

Sanders, M. R., Cann, W., & Markie-Dadds, C. (2003). Why a universal population-level approach to the prevention of child abuse is essential. Child Abuse Review, 12(3), 145-154.

Morison, M. J. (1998). Parents' and young people's attitude towards bedwetting and their influence on behavior including readiness to engage and persist with treatment. British Journal of Urology, 81(3), 56-66.

Nelson, E. E., & Panksepp, J. (1998). Brain substances of infant-mother attachment: Contributions of opioids, oxytocin, and norepinephrine. Neuroscience and Biobehavioral Reviews, 22 (3), 437-452.

Novotney, A. (2012). Parenting that works: Seven research-backed ways to improve parenting. Retrieved from http://www.apa.org/monitor/2012/10/parenting.aspx

Nowak, C. & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P - Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. Clinical Child and Family Psychology Review, 11, 114-144.

O'Leary, K. D., O'Leary, S., & Becker, W. C. (1967).

Modification of a deviant sibling interaction pattern in the home. Behavior Research and Therapy, 5, 113-120.

Passini, C. M., Pihet, S., & Favez, N. (2014). Assessing specific discipline techniques: A mixed-methods approach. Journal of Child and Family Studies, 23, 1389-1402.

Patterson, G.R. (1982). A social learning approach: 3. Coercive family process. Eugene, OR: Castalia.

Patterson, G. R. (2002). The early developmental of coercive family process. In J. B. Reid, G. R. Patterson, G. R., & Capaldi, D. M. (1991). Antisocial parents: Unskilled and vulnerable. In Cowan, Philip A. (Ed.), Family transitions (pp. 195-218). Hillsdale, NJ US.

Paulson, J. F., Dauber, S., & Leiferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. Pediatrics, 111, 659-668.

Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J., & Putnam, F. (2012). Effectiveness of community dissemination of parent–child interaction therapy. Psychological Trauma: Theory, Research, Practice, and Policy, 4(2), 204-213. doi:10.1037/a0022948

Peed, S., Roberts, M., & Forehand, R. (1977). Evaluation of the effectiveness of a standardized parent training program in altering the interaction of mothers and noncompliant children. Behavior Modification, 1, 323-350.

Pelham, W. E., Gnagy, E. M., Greiner, A. R., Hoza, B., Hinshaw, S. P., Swanson, J. M., et al. (2000). Behavioral versus behavioral and pharmacological treatment in ADHD children attending a summer treatment program. Journal of Abnormal Child Psychology, 28, 507–526.

Pfiffner, L. J., & O'Leary, S. G. (1987). The efficacy of all-positive management as a function of the prior use of negative consequences. Journal of Applied Behavior Analysis, 20, 265-271.

Roberts, M. W. (1984). An attempt to reduce time out resistance in young children. Behavior Therapy, 15, 210-216.

Schroeder, C. S., & Gordon, B. N. (1991). Assessment and treatment of childhood problems. New York: Guilford.

Siegel, D. J., & Bryson, T. P. (2014a, September 23). 'Time-outs' are hurting your child. Time, Retrieved from http://time.com/3404701/discipline-time-out-is-not-good/

Siegel, D. J., & Bryson, T. P. (2014b, October 21). You said what about time-outs? Huffington Post, Retrieved from http://www.huffingtonpost.com/daniel-j-siegel-md/time-outs-overused_b_6006332.html

Slough, N. M., McMahon, R. J., Bierman, K. L., Cole, J. D., Dodge, K. A., Foster, E. M., Greenberg, M. T., Lochman, J. E., McMahon, R. J., & Pinderhughes, E. E. (2008). Preventing serious conduct problems in school-age youths: The fast track program. Cognitive Behavior Practice, 15(1), 3-17.

Society for a Science of Clinical Psychology (2014). Time gets it wrong on time-out. Retrieved from http://www.sscpweb.org/Media-Posts/3111497

Sorkhabi, N. (2005). Applicability of Baumrind's parent typology to collective cultures: Analysis of cultural explanations of parent socialization effects. International Journal of Behavioral Development, 29, 552–563.

Staats, A. W. (1971). Child learning, intelligence, and personality: Principles of a behavioral interaction approach. New York: Harper & Row.

Urquiza, A.J., McNeil, C.B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. Child Maltreatment, 1, 134-144.

Vockell, E. L. (1977). Whatever happened to punishment. Muncie, IN: Accelerated Development.

Vollmer, T. R., Iwata, B. A., Zarcone, J. R., Smith, R. G., & Mazaleski, J. L. (1993). The role of attention in the treatment of attention-maintained self-injurious behavior: Noncontingent reinforcement and differential reinforcement of other behavior. Journal of Applied Behavioral Analysis, 26(1), 9-21.

Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52(4), 666-678.

Webster-Stratton, C., Reid, M. J., & Stool-Miller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. Journal of Child Psychology and Psychiatry, 49(5), 471-488.

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. Journal of Applied Behavior Analysis, 11, 203-214.

Zabel, M.K. (1986). Timeout use with behaviorally disordered students. Behavioral Disorders, 12, 15-21.

APA 2015, Toronto
Society of Clinical Psychology
Highlighted Events

Thursday, August 6

3:00 – 3:50 *Should we be treating neuroticism instead of anxiety and depression?*
David Barlow, Ph.D.
Convention Center, Room 104C

Friday, August 7

9:00 – 9:50 *Recent trends and advances in the use of technology to expand the reach and scope of mental health care*
Jonathan S. Comer, Ph.D.
Convention Center, Room 205D

10:00 –11:50 *In search of endophenotypes: Genetic and neural biomarkers of trauma-related pathologies*
Chair: William Milberg
Discussant: Regina McGlinchey
Presenters: David Salat, Jeffrey Spielberg, Jasmeet Hayes, & Mark Logue
Convention Center, Room 206D

4:00 – 4:50 *Is cognitive therapy enduring or are antidepressant medications iatrogenic?*
Steven D. Hollon, Ph.D.
Convention Center Room 206C

5:00 – 6:50 *Awards Ceremony and Social Hour*
Fairmont Royal York Hotel, Tudor Rooms 7 & 8

Saturday, August 8

10:00 – 10:50 *The onset and course of bipolar spectrum disorders: A reward hypersensitivity perspective*
Lauren Alloy, Ph.D.
Convention Center, Room 205D

12:00 – 1:50 *Recent advances in the treatment of PTSD*
Chair: Terence M. Keane
Presenters: Edna Foa, Patricia Resick, Paula Schnurr, Leslie Morland
Discussant: Terence M. Keane
Convention Center, Room 104C

Professional Boundaries in Your Backyard: The Ethics of Practice in Embedded Communities

Adam Fried, Ph.D.
Fordham University

Developing appropriate professional boundaries with clients/patients can be one of the most challenging therapeutic tasks to negotiate, irrespective of one's level of training or experience. Psychologists are well aware of prohibitions against sexual relationships with clients, but evaluating the ethics of non-sexual multiple relationships can be considerably more complex.

Many have written about the unique and increased ethical dilemmas faced by psychologists who practice in smaller communities to which they also have personal connections, such as rural communities where there may be a higher likelihood of contact outside of the of the therapist office. Indeed, empirical research suggests that rural therapists are more likely than suburban or urban therapists to report non-sexual multiple relationships (Helbok, Marinelli & Walls, 2006).

But what about practitioners who are embedded in communities in ways that transcend geographic overlap, in which there may be cultural or other aspects of commonality? How can therapists maintain personal ties to their community and, at the same time, responsibly provide professional services for members of the same community? For example, psychologists who are both personally and professionally active within local LGBT communities may encounter complicated ethical dilemmas when both therapist and client/patient find themselves at centers of social contact for the community (Kessler & Waehler, 2005; Morrow, 2000). In addition to chance (or perhaps more regular) encounters in social settings, community-based activities that raise the potential for repeated out-of-office contact, such as participation in community political, advocacy or other organizations, can also lead to difficult decisions for clinicians. For example, a therapist who has served as a long-standing volunteer at an LGBT youth resource center discovers that a client/patient has begun to volunteer at the same organization. What are the relevant ethical considerations and what is the best way for the therapist to navigate this potential multiple relationship? [1]

Of course, the types of multiple relationship dilemmas will likely depend on the nature of the community, which may be defined by geographical, social, ethnocultural or other community-distinguishing characteristics. Other examples of potential embedded communities include religiously-oriented psychologists who are members of or in positions of leadership in religious congregations (Plante, 2007; Sanders, Swenson & Sneller, 2011) and clinicians active within the deaf community (Smith, 2014).

Limited research suggests that individuals in certain culturally embedded communities may be more likely to encounter and engage in non-sexual multiple relationships. For example, in a survey of 362 Christian licensed mental health professionals, Sanders, Swenson and Sneller (2011) found that those who worked in religious settings were more likely to engage in multiple relationships and may face more frequent and difficult multiple relationship ethical dilemmas than those working in other settings. Examples of potential dilemmas include accepting members or employees of one's church as psychotherapy clients/patients, attending current or former client/patient's religious ceremonies or events, and serving with clients/patients on church committees and boards.

In general, ethical concerns about multiple relationships often center on whether the additional relationship "could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (Standard 3.05, American Psychological Association, 2010).

It's important to remember that not all multiple relationships are unethical. According to the American Psychological Association's Ethics Code (2010), "multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Standard 3.05). Multiple relationships nonetheless remain a concern for all psychologists. While some argue that some non-sexual multiple relationships may hold the possibility for benefit for clients/patients, other multiple relationship may result in serious consequences for the

professional, client/patient and/or their relationship.

When both the client/patient and therapist are members of a common community, negotiating appropriate professional boundaries may be considerably more difficult. For example, some clients/patients may consider shared activities evidence of a friendship or in ways that may otherwise complicate the professional work. In addition, some therapists may hesitate to enforce professional boundaries for fear that they may result in irreparable ruptures to the therapeutic relationship.

Unreasonably rigid rules may serve neither the client/patient's or the therapist's needs. On one extreme, therapists who shun community activities for fear of encountering a client/patient may inhibit their personal and professional development (Everett, MacFarlane, Reynolds, & Anderson, 2013) or even lead to feelings of anger and resentment. On the other hand, therapists who do not consider the ethical and clinical ramifications of potential multiple relationships and/or who do not discuss boundaries with clients/patients may create difficult ethical dilemmas and violations. For example, a therapist who does not discuss appropriate boundaries or how non-therapeutic encounters should be handled may unintentionally violate client/patient confidentiality during unplanned public encounters in any number of ways, including rushing to greet a client/patient/client (rather than letting the client/patient decide whether to initiate contact), introducing oneself to client/patient companions as the client/patient's therapist, or publicly following up on therapeutic areas of concern.

Decision making models (such as those offered by Fisher, 2013 or Barett et al., 2001) are critical to responsible practice, but thoughtful planning before a situation occurs may be the best way to potentially avoid a difficult ethical decision, damage to therapeutic relationship and ethical violations. Of course, many may be unforeseeable, such as chance encounters at social events or community activities, so it's important to consider creating a plan with clients/patients to effectively handle these types of situations.

Below are some considerations for clinicians practicing in embedded communities (of course, many are applicable for all therapist-client/patient relationships), based in part recommendations by Morrow (2000) and Kessler and Waehler (2005):

1. Discuss understandings of the therapist-client/patient relationship. These conversations may help to minimize unreasonable expectations, discourage potentially harmful boundary crossings, and affirm the professional nature of the relationship.

2. If appropriate, it may be helpful to acknowledge the embedded community to which you are both members. These discussions may be particularly advisable when there is community overlap that is known to both of you, such as membership in the same social, political or advocacy groups. The therapist should critically evaluate any sustained non-therapeutic contacts, assessing the risks and benefits of these contacts and paying particular attention to the possibility of therapist impaired judgment and possible client/patient exploitation and/or harm.[1]

These discussions should also include a plan for how you will handle any potential meetings (unanticipated or otherwise). Morrow (2000) and others recommend explicitly giving clients/patients the power to make the decision of whether they want to acknowledge or greet the therapist in an out-of-office encounter and agreement that the therapist will not initiate contact. This may serve to empower the client/patient, lead to discussions about feelings the client/patient may have about therapy, and also reduce the possibility of confusion, hurt feelings or misunderstandings. It may also be helpful to discuss how to address potential questions from partners, friends or other companions as to the encounter.

3. Process out-of-office meetings during the next therapy encounter(s), including a discussion of any feelings of discomfort or concerns that the client/patient or therapist may have experienced, how well their plan worked and any modifications for a possible future encounter.

4. Monitor potential ongoing out-of-office encounter situations. For situations in which there may be repeated contact (such as attendance at scheduled club or organization meetings), regular "check ins" to process encounters, monitor the effectiveness of strategies and revise strategies to prevent boundary crossings and ethical violations may be helpful to build into the therapy session.

Notes:

[1] See Kessler & Waheler, 2005 for a thoughtful discussion on this type of dilemma.

[2] Younggren and Gottlieb (2004) offer helpful guidelines for evaluating the ethics of multiple relationships, including potential harm to the therapeutic relationship, the importance or necessity of the non-therapeutic

relationship, and the ability of the psychologist to objectively evaluate the potential consequences of the relationship.

References:

American Psychological Association (2010). Ethical principles of psychologists and code of conduct with the 2010 amendments. Retrieved from http://www.apa.org/ethics/code/index.aspx

Barret, B., Kitchener, K. S., & Burris, S. (2001). A decision-making model for ethical dilemmas in HIV-related psychotherapy and its application in the case of Jerry. In J. R. Anderson & B. Barret (Eds.), Ethics in HIV-related Psychotherapy: Clinical Decision-making in Complex Cases (pp. 133–154). Washington, DC: American Psychological Association.

Everett, B., MacFarlane, D.A., Reynolds, V.A., & Anderson, H.D. (2013). Not on our backs: Supporting counselors in navigating the ethics of multiple relationships within queer, two-spirit and/or trans communities. Canadian Journal of Counselling and Psychotherapy, 47, 14-28.

Fisher, C.B. (2013). Decoding the Ethics Code, Third Edition. Thousand Oaks, CA: Sage.

Helbok, C.M., Marinelli, R.P., & Walls, R.T. (2006). National survey of ethical practices across rural and urban communities. Professional Psychology: Research and Practice, 37, 36-44.

Kessler, L.E., & Waehler, C.A. (2005). Addressing multiple relationships between clients and therapists in lesbian, gay, bisexual and transgender communities. Professional Psychology: Research and Practice, 36, 66-72.

Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients (pp. 137–156). Washington, DC: American Psychological Association.

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. Journal of Clinical Psychology, 63, 891–902.

Sanders, R.K., Swenson, J.E., & Schneller, G.R. (2011). Beliefs and practices of Christian psychotherapists regarding non-sexual multiple relationships. Journal of Psychology and Theology, 39, 330-344.

Smith, J.A. (2014). Managing dual relationships for rehabilitation professionals who work with clients who are deaf or hard of hearing. Journal of the American Deafness & Rehabilitation Association, 49, 41-52.

Younggren, J.N. & Gottlieb, M.C. (2004). Managing risk when contemplating multiple relationships. Professional Psychology: Research and Practice, 35, 255-260.

BECOME A DIVISION 12 MENTOR

Section 10 (Graduate Students and Early Career Psychologists) has developed a Clinical Psychology Mentorship Program. This program assists doctoral student members by pairing them with full members of the Society.

We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit www.div12.org/mentorship to became a mentor today.

Student Column

Christy Denckla, MA
Adelphi University
Massachusetts General Hospital, Harvard Medical School, Department of Psychiatry

Section 10 (Graduate Students and Early Career Psychologists) of SCP has been interested in building on its diversity and multicultural initiatives because there is a growing awareness that only a fraction of the world's population has access to needed mental health services. A 2001 World Health Organization report suggested that an estimated 450 million people around the world suffered from mental disorders (World Health Organization, 2001); a decade later the global disease burden associated with role impairment subsequent to mental illness exceeded that attributable to physical illness (Ormel et al., 2008). Complicating this picture is the low ratio of qualified mental health practitioners to provide treatment (Saxena, Thornicroft, Knapp, and Whiteford, 2007). Taken together, high rates of mental illness with associated role impairment and little recourse within the service delivery system to address these concerns proactively or after the fact represents a mounting global health crisis that Kleinman (2009) has called a "failure of humanity."

To address this mounting crisis, research has been directed at developing culturally modified psychological and psychiatric interventions in low and middle income countries (LIMC's). The first wave of such studies suggests promising results, indicating that some evidence based interventions can be effective in LIMC's such as Kurdistan, Kenya, and the Congo (Bolton et al., 2003; Kaysen et al., 2013; Papas et al., 2010). Results are promising yet the public health need remains urgent and much more research is needed. We encourage students and early career psychologists interested in pursuing such research to leverage Section 10 resources to advance their research interests in this domain. For example, Section 10 has created a working relationship with the Indonesian Counseling Association, a group that is keenly interested in collaborating with US partners in research on culturally modified interventions for Indonesia's geriatric population. For any interested students, please contact me at cdenckla@mgh.harvard.edu and I will make an introduction. In summary, research that addresses global disparities in mental health services is an emerging yet thriving area of research with many interesting opportunities for students and early career psychologists to become involved.

References:

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., . . . Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. Journal of the American Medical Association, 289(23), 3117-3124. doi: 10.1001/jama.289.23.3117

Kaysen, D., Lindgren, K., Zangana, G. A. S., Murray, L., Bass, J., & Bolton, P. (2013). Adaptation of cognitive processing therapy for treatment of torture victims: Experience in Kurdistan, Iraq. Psychological Trauma: Theory, Research, Practice, and Policy, 5(2), 184-192. doi: 10.1037/a0026053

Kleinman, A. (2009). Global mental health: a failure of humanity. The Lancet, 374(9690), 603-604.

Ormel, J., Petukhova, M., Chatterji, S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., . . . Kessler, R. C. (2008). Disability and treatment of specific mental and physical disorders across the world. Brittish Journal of Psychiatry, 192(5), 368-375. doi: 10.1192/bjp.bp.107.039107

Papas, R. K., Sidle, J. E., Martino, S., Baliddawa, J. B., Songole, R., Omolo, O. E., . . . Maisto, S. A. (2010). Systematic cultural adaptation of cognitive-behavioral therapy to reduce alcohol use among HIV-infected outpatients in western Kenya. AIDS Behavior, 14(3), 669-678. doi: 10.1007/s10461-009-9647-6

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. The Lancet, 370(9590), 878-889. doi: 10.1016/s0140-6736(07)61239-2

World Health Organization (2001). The World Health Report 2001: mental health: new understanding, new hope. Geneva: World Health Organization.

Edited by Kaitlin P. Gallo, Ph.D.

Section II: Society of Clinical Geropsychology

Submitted by Michele J. Karel, PhD

The Society of Clinical Geropsychology (SCG) has several updates, regarding election of new officers, APA Convention offerings, and participation in the SCP webinar series.

Elections. SCG elected **Benjamin Mast, PhD, ABPP** as SCG President for 2017, to serve as President-elect in 2016. Dr. Mast is Associate Professor and Acting Chair, Psychological & Brain Sciences at the University of Louisville. He studies person-centered approaches to caring for persons with dementia, among other clinical geropsychology interests.

SCG elected **Victor Molinari, PhD, ABPP** as the Representative to SCP Board. Dr. Molinari is a professor at the School of Aging Studies, University of South Florida., where he studies mental health outcomes in long term care settings, among other clinical geropsychology interests. He is currently Chair of the Council of Professional Geropsychology Training Programs (CoPGTP) and President of the American Board of Geropsychology (ABGERO). On a personal note, I have been honored to serve as the SCG representative to the SCP Board and will finish my term at the end of this year. Dr. Molinari will undoubtedly be an active and valuable contributor to the SCP Board.

APA Convention. Note that the Office on Aging's Annual compilation of Sessions on Aging Issues at the APA Convention is available at: http://www.apa.org/convention/aging-sessions.pdf. SCG President Dr. Margaret Norris will deliver her Presidential address during a conversation hour on "The aging of the Society of Clinical Geropsychology – Where have we been and where are we going?" on Thursday, August 6, from 12:00-12:50.

In addition, the APA Committee on Aging (CONA) Conversation Hour will focus on the topic "Aging across Boundaries," and will be held in the Fairmont Royal York Hotel, Library. At this session, the 2015 CONA Award for the Advancement of Psychology and Aging will be presented to **Victor Molinari, PhD, ABPP** for his extraordinary leadership across the domains of education, practice, organizational development, and research in geropsychology.

SCP Webinars and Geropsychology. SCG members are contributing to the monthly SCP CE webinar series! On July 8, Dr. Antonette Zeiss presented on "Geriatric Primary Care: Psychologists' Roles on the Interprofessional Team," a broad overview of the critical roles psychologists can play in providing integrated healthcare for an aging population. On October 15, Dr. Jennifer Moye will be presenting on the topic "Promoting Psychological Health after Cancer Treatment."

Reminders:

SCG Website: For more information about SCG, including membership application, see www.geropsychology.org.

GeroCentral: The "GeroCentral" website is on-line at http://gerocentral.org/. GeroCentral is a website clearinghouse of practice and training resources related to psychology practice with older adults.

Section VI: Clinical Psychology of Ethnic Minorities

Submitted by Frederick T. L. Leong, Ph.D.

The year has already proven to be an exciting one for Section VI, Clinical Psychology of Ethnic Minorities! As the 2015 President for the section, I have focused my efforts on my Presidential Theme--Intersectionality and ethnic minority psychology: Recognizing ethnicity, gender and other salient identities as mutually informative, with the goal of broadening understanding of race/ethnicity/culture by encouraging consideration of the ways they are shaped by other key identities, such as gender, sexual orientation and social class. Toward this goal, we are hosting a multi-division discussion at APA on Intersectionality: How race/ethnicity intersects with other important identities to uniquely impact clinical practice, research, and policy. We also have a featured article in our summer newsletter on the ways in which viewing identity through an intersectional lens can improve clinical psychology research and practice (http://clinicalpsychologyofethnicminorities.blogspot.com/).

I invite you to read our summer newsletter, which includes two featured articles, Engaging Cultural Competence: No Way But Through by Dr. Melanie M. Domenech Rodríguez and Intersectionality and clinical psychology: Recognizing ethnicity, gender and other salient identities as mutually informative by Dr. NiCole

T. Buchanan. These articles are both thought-provoking and relevant to discussions on the future direction of the field of clinical psychology. The current newsletter also highlights the work of Dr. Guillermo Bernal and Monica U. Ellis, up-and-coming leader in the field (http://clinicalpsychologyofethnicminorities.blogspot.com/).

Finally, our section's events for APA 2015 feature programs for all clinical psychologists--students, early career and seasoned professionals—regardless of your cultural and racial/ethnic background. We hope to see all of you there!

APA 2015-Division 12, Section VI programming:

Challenges and Success Strategies for Ethnic Minorities in Clinical Psychology. Cheng, Z. H, Kim, J. H. J., Cole-Lewis, Y, Buchanan, N. T., Breland-Noble, A. M, Rodriguez, M. M. D., Leong, F. T. L., Bernal, G., Boyce, C. A. Thu 8/6/2015 1:00 PM - 1:50 PM in the Toronto Convention Centre Room 104D

Navigating your Training as a Woman of Color: A Conversation Hour and Safe Space (co-sponsored by Div 35 and Div 12, Section 8). Kim, J. H. J., Butler, A. M., Robinson, C., Boyce, C. A., Cheng, Z. H., Cole-Lewis, Y., Breland-Noble, A. M., & Joseph, J. A. Thu 8/6/2015 2:00 PM - 2:50 PM in the Toronto Convention Centre Room 103A

Intersectionality: How race/ethnicity intersects with other important identities to uniquely impact clinical practice, research, and policy. NiCole T. Buchanan, Wendi S. Williams, & Ivy Ho. Representing. Friday 8/7/15 11-11:50 am in the Van Horne Suite at the Fairmont Royal York Hotel

Giving an exceptional job talk and academic interview: Planning from day 1 of graduate school and beyond. NiCole T. Buchanan, Isis H. Settles, Kristen Miles, & Nkiru Nnawulezi. Saturday 8/8/15 1-1:50 pm in the Van Horne Suite at the Fairmont Royal York Hotel

Section VI Business meeting and Social Hour. Saturday 8/8/15 12-12:50 pm in the Division 12 Hospitality Suite.

Section VII: Emergencies and Crises

Submitted by Marc Hillbrand, Ph.D.

We welcome Joyce Chu, Ph.D., as the new Section VII Secretary/Treasurer. She currently co-directs the Center for Excellence in Diversity at Palo Alto University, where she is also an associate professor of psychology. She has received grants from a variety of funding agencies including the National Institute of Health and the National Institute of Mental Health to study cultural influences on issues such as suicide, bullying and other forms of interpersonal violence. The Section VII Executive Committee is delighted to have her on board.

At the 2015 APA Annual Convention in Toronto, Section VII will be well represented. Among other offerings, Section founder Phillip Kleespies, Ph.D., along with Susan Lazaroff, Ph.D., from the APA Practice Directorate, will chair a symposium entitled The seriously mentally ill: Perpetrators of violence or victims of suicide and violence? It will be co-sponsored by divisions 9,12,18 and 56 under the Collaborative Programming heading. Erin Poindexter will receive the Section VII Student Award for her impressive work on acquired capability for suicide.

Section VII has embarked on a collaboration with Bruce Bongar, Ph.D., and the Clinical Crises and Emergencies Research lab that he leads. The CCER and Section VII share the goal of disseminating state of the art knowledge about suicide, interpersonal violence and victimization. CCER is currently working on developing a cultural model of suicide, on psychological and social factors involved in suicide terrorism, on culture-specific and other group-specific risk factors for suicide (e.g., among Native-American communities, among Special Obs personnel, among homeless veterans) and on suicide prevention across the globe.

Last but not least, we thank Lillian Range, Ph.D., for her dedicated service as retiring Secretary/Treasurer. Dr. Range oversaw the financial and membership matters of the Section during most challenging years. She showed remarkable tenacity in dealing with vexing financial matters – suffice it to say that banks are just not very accommodating to small non-profit groups like ours.

Stay tuned for collaborative offerings from CCER and Section VII and see you in Toronto!

What's Happening in *Clinical Psychology: Science and Practice?*

Special Series: Defining Competence when Working with Sexual and Gender Minority Populations: Training Models for Professional Development

Volume 22, Issue 2, Pages 101 - 210, June 2015

Edited by Jonathan S. Comer, Ph.D.

Bringing a Professional Development Seminar to Life, Part Two: Games and Activities

Brigitte K. Matthies PhD
California State University, Los Angeles

This article is the second in a two-part series that describes an innovative, modern, and interactive format for a Professional Development Seminar (PDS) that utilizes active learning techniques and includes group discussion, role-playing, presentations of student work, informative games and activities, and didactic presentations. Content is up-to-date and relevant, designed to target multiple core clinical competencies, and extensive enough to span a year-long period. The goal of each session is to increase participants' professional competence, self-awareness, and confidence, and to assist their transition from the role of student apprentice to the role of clinical practitioner. Techniques for maximizing the benefit to participants and handling any personal discomfort that arises are discussed.

Games: Pick from the Cup

In these modules, the session leader writes on small pieces of paper, which are then placed in a cup. Each participant picks one at random, reads it out loud, and gives his or her response. Discussion after each turn is encouraged. Session leaders should be willing to give input as well. Game topics that work well, as well as some suggestions for the papers, include:

What's your policy?

For this session, participants simply have to give their current or anticipated policy on a topic or issue. The opinions of other participants are sought in the ensuing discussion.

Suggestions include:

- Bartering with clients in lieu of payment
- Socializing with clients outside of sessions
- Conducting therapy with a client who is high on drugs
- Giving credit for client fees
- Working with an individual from a very different culture to your own
- Clients who bring young children into the therapy session
- Accepting gifts from clients
- Pro bono work
- Cell phones in sessions
- Missed appointments and late cancellations
- Electronic cigarette smoking in sessions
- Dress code for therapy
- Providing sex therapy for those who are not married
- Extending sessions past fifty minutes
- Clients who are late for their session
- Seeing individuals you also see in couples therapy
- Keeping secrets from individuals with whom you also conduct couples therapy

What do they do?

In this session, participants choose a slip of paper that indicates a professional whose area of expertise is related to the practice of psychology, and must report what they know about their training and scope of practice. Participants conclude by describing a situation that could occur with a potential client that would represent an appropriate referral. Professions to include would be: Speech Pathologist; Acupuncturist; Neurologist; Hypnotherapist; Psychiatrist; Play Therapist; Neuropsychologist; Nutritionist; Biofeedback Specialist; Sex Therapist; Life Coach; Sober Coach; Physical Therapist; Occupational Therapist; Drug Abuse Counselor; Rehabilitation Counselor; Social Worker; and Neuro-Linguistic Programmer. It is important that session leaders have some knowledge of these professions so that they can fill in the gaps as needed.

What's your response?

Here, participants must immediately give their actual verbal response to particular client comments, situations, or issues. It is only in the discussion that follows that they can give their thoughts, concerns, or opinions. Suggested patient comments, situations, and issues include:

- "I'm attracted to you"
- A marijuana cigarette falls out of a client's purse
- "You remind me of my mother"
- "I don't want to come for therapy anymore. You're not helping me"
- "I had a sexual dream about you last night"
- "I don't like you"
- A client hasn't done her homework

Difficult client conversations.

Here, participants talk about how they would introduce and conduct a potentially charged conversation with clients with regard to a particular situation. Discussion is encouraged. Situations to include would be:

- You need to transfer your client due to your sexual countertransference
- You have to make a child abuse report
- You saw a client drinking in a bar but he says he is sober
- Your client makes you feel unsafe
- Your client has body odor
- Your client's issues are not serious enough to require therapy
- You have come to believe that your client is trying to tell you he or she is gay/lesbian
- Your client can clearly afford more than she is paying you on your sliding scale

What about you?

In this session, participants talk about how likely it is that they would commit certain ethical violations. During discussion, the session leader and participants can talk about why these situations are wrong or inadvisable, how and why therapists fall into these behaviors, and share examples of times they are aware of when these things happened either to themselves or others. Suggestions for potential violations include:

- Talk about interesting clients at a cocktail party
- Alter a client's assessment results so they can get SSI/Disability
- Publish the same data twice
- Invite an ex-client to work as your receptionist
- Call yourself "Doctor" before your thesis is defended
- Fake the data for your PhD thesis
- Have a romantic relationship with a client
- Practice without a license
- Use a client's business idea
- Cheat on the EPPP
- Defraud an insurance company
- Provide a service in which you are not fully versed
- Set a client up with a friend or family member, or with another client

Activities

Self-help.

These modules are designed to help participants with their own wellness. Participants are typically provided with a questionnaire that they complete and score during the session, and discussion follows. Topics to include are:

Burnout. The 15-item burnout self-test available at MindTools.com works very well here. Items (e.g., "Do you find that you are prone to negative thinking about your job?" and "Do you feel that you are in the wrong organization or the wrong profession?") are scored as Not at All, Rarely, Sometimes, Often, or Very Often. The scoring key provides one's burnout risk (from Little Sign of Burnout to Severe Risk). Scores typically vary widely among participants – many of whom have the same responsibilities – and many are surprised at just how high their scores are. If participants are comfortable, they will share their scores, and talk about what might be contributing factors (both as to low and high scores). Participants can then engage in a discussion of the importance of wellness behaviors and how to cope with stress and burnout. Borysenko's (2003) "Beating Stress and Burnout: Inner Peace for Busy People" is very helpful in this regard and can be distributed to participants.

Alcoholism and Substance Abuse. These two sessions follow naturally from the discussion on substance abuse in mental health professionals. Participants can take the National Council on Alcoholism and Drug Dependence, Inc. (NCADD)'s Alcoholism Self-Test (Am I Alcoholic?), available on NCADD's website. The test is made up of 26 Yes/No items, including: "Do you sometimes feel uncomfortable if alcohol is not available?" and "When drinking with other people, do you try to have a few extra drinks when others won't know about it?" A "No" is scored 0, and a "Yes" is scored 1. A score of 2 or more indicates a greater risk for alcoholism. Persons who answer "Yes" to between 2 and 8 questions are advised to consider arranging a meeting with a professional who has experience in the evaluation of alcohol problems. A score greater than 8 suggests a serious level of alcohol-related problems requiring immediate attention and possible treatment. Participants can also take the Drug Abuse Self-Test (Am I Drug Addicted?), which is made up of 20 Yes/No questions, including: "Can you get through the week without using drugs?" and "Have you abused prescription drugs?" The scoring key ranges from No Problem to Low, Moderate, Substantial, and Severe levels of problems related to drug abuse.

CV preparation.

This session follows quite naturally from the didactic

on CVs and resumes. Inevitably, there are participants who are in the process of job seeking, and who would like to update and reformulate their CV or resume and are now motivated to do so. Participants can bring in a draft for the group to go over and provide feedback on. This is a difficult but very useful and rewarding exercise for participants that often requires more than one session.

Vignettes

For this module, participants are provided with case vignettes that cover issues of importance to clinical practice. The vignettes are then discussed. The following is a sample vignette entitled: "Got ethics?":

After years of working "damn hard" and paying "way too much" for graduate school, Mindy graduated with a Masters in Clinical Psychology. She decided to set up her practice in her apartment and advertised her services at $400/hour in the local paper, promising value for money. She received a call from a young man, Roger, who said that he wanted help with grief and anger issues following the death of his mother. The young man arrived at her apartment, paid his $400, and the session began. As Roger talked about his mother, he began to cry. Mindy moved to the sofa and put her arm around him, stroking his hair as she imagined his mother might have done. Roger suddenly became angry and began pacing up and down. Realizing she was losing control of the session, Mindy asked him to accompany her to the Emergency Room. Roger suddenly attacked her, dragged her into the bedroom, raped her, and left, taking the $400 with him. Mindy didn't know what to do – she didn't even know Roger's last name.

For this vignette, participants are asked to identify some of the ethical violations suggested, and spend the rest of the session discussing some of the issues raised (e.g., doing therapy out of the home). For this issue, seminar leaders can talk about instances when it is sensible to have a therapy office at home, and the required parameters to make this work (e.g., a separate entrance).

Round Robins

In these modules, all participants get the **same** topic to discuss and must take turns around the table in presenting their comments. All participants must speak. Round robins are therefore more formal than group discussions, particularly as personal views are expected. As discussed before, it is best when the seminar leader goes first. Discussion is encouraged. Possible topics are:

Push-button issues. Participants are asked to identify the issues presented by clients that push their buttons and how they deal with them.

Familiar cultures. Participants are asked to talk about another culture that they are familiar with, including views in that culture about therapy and mental illness, illness presentation, popular treatments, etc.

Cases I like, cases I don't! Participants are asked to think about their current caseload and identify one or two clients who they really enjoy, and one or two who they don't. Participants are encouraged to think about and comment on why they feel this way.

Role-plays

The job interview from Hell.

At the start of this session, participants write down difficult questions that could be asked in a job interview, which are passed to the seminar leader. The seminar leader then briefly interviews each participant and concludes with one of the difficult questions provided, or one of his or her own. Constructive feedback is given on the verbal responses and nonverbal behavior of the "interviewee," such as "you are not making eye contact" or "you sound tentative." Difficult questions suggested include:

- "What sort of salary do you require?"
- "Tell me about a situation you have never told your supervisor about."
- "I notice you have a nose ring – is it a religious thing?"
- "What other jobs have you applied for?"
- "How would you prevent being attacked by a client?"
- "Give me the reasons why this job might not be for you."
- "What personality disorder do you think you come closest to?"
- "What did you score on the MMPI?"
- "Why haven't you decided to go into private practice?"
- "Is that how you plan to dress on the job?"
- "How much student debt do you have?"

Discussion and feedback from the rest of the group follows.

The five secrets of effective communication.

Participants are introduced to David Burns' "Five Secrets of Effective Communication," including the "disarming technique" and "thought empathy" (Burns, 2006). Participants then role-play in dyads how they would use this technique to respond to clients who are hostile, critical, oppositional, overwhelmed, passive, argumentative, or flirtatious (e.g., "I'm not sure how someone from your culture can help me" or "I don't think I need to do the homework. I'm not the homework type.") Effective responses to these types of questions can be found in Burns' psychotherapy eBook: "Tools, not Schools, of Psychotherapy" (Burns, n.d.) and can be shared with participants during the session.

Some Final Words

Many of the sessions presented in this series will take more than one week to complete. It is important not to rush participants or the ensuing discussion. With adequate time, participants will process the material more fully and see more clearly how they are personally affected by the issue and how it can impact their performance as a psychologist.

At the outset of the PDS, some participants express apprehension over being "put on the spot" or about sessions that require being in the "hot seat." However, this discomfort is temporary, and when the seminar is led with a non-judgmental attitude and characterized by sharing and openness, participants have overwhelmingly reported a high level of satisfaction with the seminar, and have underscored the usefulness of the material presented.

Finally, I welcome your feedback and topic suggestions, particularly for practice in specialized settings or with special populations. Please feel free to contact me.

References

Am I drug addicted? (n.d.). Retrieved from the NCAAD website: https://ncadd.org/learn-about-drugs/drug-abuse-self-test

Am I alcoholic? (n.d.). Retrieved from the NCAAD website: https://ncadd.org/learn-about-alcohol/alcohol-abuse-self-test

Borysenko, J. (2003, September). Beating stress and burnout: Inner peace for busy people. Retrieved from http://www.joanborysenko.com

Burnout Self-Test. (n.d.). Retrieved from the Mind Tools website: http://www.mindtools.com/pages/article/newTCS_08.htm

Burns, D. D. (n.d.). Tools, not schools, of therapy. Retrieved from the Feeling Good website: http://feelinggood.com/resources-for-therapists

Burns, D. D. (2006). When panic attacks: The new, drug-free anxiety therapy that can change your life. New York, NY: Three Rivers Press.

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Cultivating Excitement for Professional Practice

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Spalding University

Several years ago, I made the decision to come to the United States from India in search of academic and experiential learning within the field of psychology. I yearned for an intellectually stimulating adventure and personal insights after accumulating a rich array of experiences in India. As I near the end of my graduate training in clinical psychology and contemplate the type of professional I am becoming, I identify my experience at the State Leadership Conference as momentous. I am thrilled to share my experience in the hope that my peers will take a chance in immersing themselves in an avenue that may link them to our profession in a meaningful way.

Around three years ago, I applied for the position of a Campus Representative to work with the Advocacy Coordinating Team (ACT) of the American Psychological Association Graduate Students (APAGS). At that time, I did not know the exact purpose of the position but I felt a need to add a layer to my graduate training and thought that this position would be worth checking out. I implemented a goal of spreading information about Action Alerts and encouraging my peers to respond to them. This started my understanding of the intricate steps involved in implementing change. As a result of this effort, I was nominated to be a diversity delegate at the State Leadership Conference. I did not fully appreciate the impact of this conference until recently when I attended it for the third consecutive time and looked back at the cumulative experience as a soon-to-be early career psychologist.

The State Leadership Conference is a national advocacy training conference sponsored by the American Psychological Association's Practice Organization for the practice of professional psychology. Psychologists from every state of the Unites States and Canada gather annually in Washington DC, to discuss the course of clinical practice and training, and directly advocate with elected representatives, i.e., people in power. Apart from detailing the history and purpose of this conference, Sullivan, Newman and Abrahamson (2007) have also commented on how it creates "synergy" (p. 131),"builds morale and energizing leadership" (p. 132) and offers a "transformative or career-altering experience" (p. 133). In line with these thoughts, there were three highlights of this conference that I believe will continue to shape my professional self.

First, as the only student in a delegation full of psychologists at my first time at this conference in 2013, you can imagine my anxiety and my level of intimidation. However, I was struck by the concerted effort to address and dissolve this hierarchy. In fact, this delegation stood out as the single most empowering space for difficult conversations. The warmth radiating from this delegation served as a perfect backdrop to discuss issues like racism and discrimination in work settings and mandatory diversity CEUs. The discussions were a wholesome mixture of theory, practicality, and humanness. When I returned to the conference over the next two years, I was met with the same warmth (and hugs). Even though people did not remember my name, they recognized me and recreated the sense of community. This year, I attended a poignant session that included stories of micro aggressions from individuals in leadership positions. Not only were these individuals willing to be vulnerable in sharing their experience as the recipients of micro aggressions, but also in sharing situations in which they had microaggressed. This is the type of experience that makes the struggle of pursuing a life in the Unites States worthwhile. The deep sense of connection and understanding in the room was palpable. As a student from an under-represented background, a different country, and a different education system, I felt a sense of acceptance and belongingness that is hard to articulate. Even the thought of leadership became a true possibility for me due to the diversity delegation and this directly motivated me to apply for other leadership positions within my graduate training program and APAGS-ACT.

Second, the Hill visits that happen on the final day of the conference every year highlighted how I could contribute to shape the field I was going into rather than being a passive recipient. More specifically, the culmination of the conference involves various state delegations making trips to Capitol Hill to directly advocate with their elected representatives. I made the Hill visits with the Kentucky Psychological Association, the state in which my graduate program is located. I was struck by the ease with which one could make an appointment with the office of the elected representatives and even more surprised when we actually got to meet some of the elected representatives rather than their aides. I was encouraged by my state association's openness

to include the stories of graduate students. On a side note, it is extremely rare for state associations to sponsor students for this conference. APAGS has been relentless in their advocacy for student attendance. In turn, this has motivated several state organizations to brainstorm ways to bring in students representatives with the intention to create the next generation of informed practitioners and leaders. While in the company of my state delegation, I listened intently to understand the political landscape in the Unites States. I also learned ways to demystify what psychologists do to help the elected representatives understand our services and support legislations for appropriate reimbursement and service accessibility. Simply hearing my delegation share their professional and personal stories has helped me develop nuanced language about these issues and the systems at play. This is a perspective that is more likely to develop during the early career phase rather than during graduate training. There were many emotions for all of us including optimism, disappointment, cynicism, and naiveté. This in turn meant a complex understanding of how our field works. Fighting for our clients' access to care and appropriate reimbursement for our services jolted me into the world of reality about my future practice while I was still belaboring classes and course assignments.

Third, I anticipate that I am likely to need a boost of hope and inspiration now and then to be professionally effective. The number of dedicated and passionate individuals at this conference is energizing! The side conversations that I had with APAGS peers, state delegations, diversity delegation and support staff helped me formulate ideas and observe amazing leadership. In fact, APAGS also organizes spaces to interact with various leaders (including the various executive directors, the president and CEO of APA) who are ever-so patient in discussions with students. Merely being in the company of the individuals who exude passion for our field is exciting! My desire to be involved in at least one avenue to connect with the profession at large has made my training more meaningful than it might have been without these connections.

Recognizing the rich impact of this conference motivated me to join APA's Division 12 (The Society of Clinical Psychology) and Division 31 (State, Provincial, and Territorial Affairs) to experience additional support as I make the transition from a student to a psychologist. I also continue to maintain membership in my state psychological association and have reached out to state associations in the states I may end up in practice. Personally, these connections not only offer a sense of "professional home" for me, but also nurture my investment in our field. I have often heard about "networking" as a term thrown out to encourage participation in professional organizations. While networking may refer to making contact, my experience of being a part of these professional organizations and conferences has been one of finding a fellow professional or an idea to enliven and enrich my practice. Once again, my hope is that my peers will take that one chance just like I did and pursue something that may not seem relevant in the present moment but that has the potential to impact their work in amazingly intangible ways.

References:

Sullivan, M. J., Newman, R. & Abrahamson, D. J. (2007). The State Leadership Conference: A

history and appreciation. Psychological Services, 4(2), 123-134.

Join us at this year's **Division 12 Award Ceremony** at the **2015 Annual Convention in Toronto**!

Please join us for the 2015 APA Annual Convention in Toronto, Canada this Summer. The convention will be held from August 6 to August 9. Visit www.div12.org for more information!

Society of Clinical Psychology

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Friday August 7, 2015 5:00 - 6:50pm

Fairmont Royal York Hotel

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Society of Clinical Psychology - APA Divison 12
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We hope to see you there!!