Professional Psychology
Training and Practice

Association of Psychology Training Clinics
www.aptc.org

The Association of Psychology Training Clinics (APTC) is a professional organization for directors of doctoral-level psychology training clinics and interested associates and affiliates. The organization is affiliated with the American Psychological Association (APA).

APTC has established a multipurpose mission and specifically seeks to:

- ***promote high standards of professional psychology training and practice in psychology training clinics;***
- ***facilitate the exchange of information and resources among psychology training clinics that provide doctoral-level practicum training in professional psychology; and***
- ***interface with related professional groups and organizations to further the goals of APTC, including influencing the establishment of standards and guidelines on service delivery and training of future psychologists.***

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BULLETIN

Nov 2018

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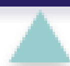
The Association of Psychology Training Clinics is dedicated to furthering cultural awareness, competency, and humility through supportive learning opportunities and environments. We are committed to engaging in training activities which increase an understanding of individual and cultural diversity, and focus on the inter-play between contextual factors and intersectionality among all people. We respect and celebrate awareness, appreciation, and sensitivity toward all and encourage an appreciation of how political, economic, and societal influences affect individuals' behaviors, particularly those from disadvantaged and marginalized groups.



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APTC @ APA 16

Heidi A. Zetzer, Ph.D.
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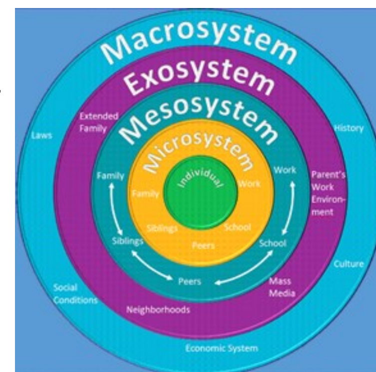
Bronfenbrenner: The Ecology of Everything Human

As psychologists we are fortunate to have a full complement of models and theories to help us understand ourselves and others. I rely on them whenever I am perplexed by a student clinician's choices (i.e., the Integrated Developmental Model), a white colleague's colorblindness (i.e., White Identity Development Model), or a family's resistance to change (i.e., Family Systems Theory). Today, I feel grateful for Urie Bronfenbrenner (1979) who crafted Ecological Systems Theory and designed the circle-within-a-circle diagram. This model reminds us that human development, and perhaps everything human, is multi-determined. For the pessimists among us (and I periodically fall into that group), this may feel overwhelming. There are simply too many variables to consider when designing a plan of action. Where is the best place to initiate change? There are too many possibilities to know where to begin! For the optimists among us (and I periodically fall into that group) this model fosters hope. There are plenty of places to intervene and everything is interconnected, so fostering change in one circle actually impacts the other circles.

I bring this up because we are all periodically battered about by numerous forces and it can be difficult to get one's bearings. What's the best place to initiate the systemic change you want to see?

Luckily, APTC is here to ground you in the moment, remind you of our collective sense of purpose, and to support you as you make decisions that will have their own ripple effect. Here are some ways that APTC can help you and we can help each other:



Bronfenbrenner circle-within-a-circle diagram

Attend the 2019 APTC Annual Meeting, March 21-24, 2019 in Charleston, South Carolina at the Frances Marion Hotel. The theme is *Integrating Research & Practice in Psychology Training Clinics*. The conference is preceded by a one-day Site Visitor training on APA's Standards of Accreditation and the conference itself starts with programming for New Directors. Be sure to request a mentor or sign up to be one and watch for an announcement about the mentor-mentee dinner.

For more info go to: http://www.aptc.org

Nominate someone for an APTC Award! Watch for a call for nominations for the following awards:

Jean Spruill Achievement Award
Friend of APTC Award
Clinic Innovation Award: Training ($500 awarded to clinic)

We are introducing three new awards this year!

Clinic Innovation Award: Social Justice ($500 awarded to clinic)
APTC Mentoring Award
APTC Clinic Research

Enjoy the benefits of, or participate in, APTC Committees!

Diversity (Chairs-Saneya Tawfik & Randy Cox): Building website resources to support training, research, and service that cultivates and incorporates cultural competency, cultural humility, and intersectionality; creating a Diversity Survey.

Supervision (Chair-Stephanie Graham): Devising ways to share supervision resources with APTC members; developing a survey.

Research (Chair-Dani Keenan-Miller): Did a brief survey and enlisted 20 new members interested in developing collaborative projects and sharing resources.

The Website Committee (Chair-Colleen Byrne): Working with our webmaster to refresh our website and add some new features.

International (Chairs-Heidi Zetzer & Judy Hyde): Created a mission statement, collecting and distributing international competency documents.

Survey Committee (Chair-Jim Whelan): Updating 2015 survey for 2019 distribution.

Programming Committee (Chair-Mike Taylor): Getting ready for the APTC Charleston conference!

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All of these activities are taking place in the broader context of education and training in professional psychology. I represented APTC at the Council of Chairs of Training Council (CCTC) and APA's Board of Education (BEA) meetings in Washington, DC in October, 2018 and learned about the latest changes in those organizations.

APA Board of Representatives recently voted to accredit Master's Programs in Psychology. A Task Force is designing a basic plan.

A subcommittee of CCTC members and Division 2 (Teaching of Psychology) is exploring the possibility of making a new APA Division on Graduate & Postgraduate Education and Training (not just health service psychology, but all areas of psychology at all levels including high school).

CCTC, with help from APPIC, will hold a conference in Sept/Oct, 2020 that will assemble leaders from health service psychology (HSP) training councils in order to advance collective efforts to provide socially responsive HSP training. APTC leadership plans on attending.

APTC continues to have a voice in national and international issues related to education and training in professional psychology.

The APTC board endorsed CUDCP's letter to the ASPPB expressing grave concerns about the validity, value, and cost of the EPPP-2. Eight other training councils signed on too. We are anticipating a formal reply from ASPPB.

The APTC EC provided comment to our APPIC liaison, Daniel Hurley, on APPIC's consideration on moving towards requiring APA accreditation of APPIC's internship program members.

The APTC EC raised questions about how sites would pursue APA Accreditation if APPIC approval is no longer a pipeline for APA-Accreditation.

APPIC will formulate a plan and invite more input from training councils.

The Australasian Association of Psychology Training Clinics (AAPTC) and APTC International Committee continues to meet with the goal of educating and supporting graduate level training in professional psychology across the globe.

Each of these efforts will have a ripple effect on education and training programs and training clinics throughout the U.S., Canada, and more broadly, the world. We will get to see the Bronfenbrenner model in action!

NEW DIRECTOR SUPPORT COMMITTEE

Chair: Mary Beth Heller

1. What is the Mission/Purpose for this committee?

The mission of the New Director Support Committee it to provide a warm introduction for new clinic directors/new APTC members, thereby facilitating relationships prior to our annual conference, and to offer support and connection to resources.

2. Who are the members?

Just me! :) Karen Saules is, obviously, our Membership Committee chair, so I work closely with her to identify new members throughout the year.

3. What is your best achievement to date?

Introducing new ice breaker activities at our annual conference and hearing how excited people were about that change.

4. What is your most important aspiration?

That every new clinic director will experience the incredible support and warmth that those of us who have been around awhile associate with APTC, and will feel comfortable utilizing the impressive collective wisdom of this group.

5. What would you say to encourage members to join?

This really is a "committee" of one, as the duties are easily manageable. I would welcome ideas from others about ideas for group activities at our conference and ways we may be better able to encourage new members throughout the year.

Geropsychology Workforce Crisis

Strategies for Creating Student Interest

Magdalene Lim, Ph.D.
University of Colorado, Colorado Springs

The UCCS Aging Center is a community-based non-profit mental health facility and the primary practicum training site for Geropsychology track within the APA accredited clinical psychology Ph.D. program. It is currently one of the few Geropsychology training clinics in the nation linking academic standards of excellence and innovative clinical training with the practical needs of the community. Although some sixty former trainees currently lead training and service programs within VAs, medical centers, and universities, the small number of trained Geropsychologists is insufficient to take care of older adults who make up 15% of the U.S. population.

In order to take care of this workforce crisis, we propose that a model of "Generalists Training on Aging" be encouraged. The training curriculum could include: Ageism in diversity training, Tracking competencies using Pikes Peak Geropsychology Competency Evaluation Tool, and Creating opportunities to build services with community partners. This would help prepare generalists address the vast majority of older adults' needs within their own specialty while funding for Geropsychology training is being challenged. We believe that one of the keys to increase trainees' interest is to provide exposure to the aging population. In our experience, trainees do enjoy the rewards of working with older adults and even more so when it also provides opportunities to conduct brief cognitive assessments for informing treatment and family interventions. For sustainability, it seems most viable to promote collaboration with the medical community where application of the biopsychosocial model has shown to improve health outcomes through management of older adults as whole persons. This workforce crisis must be addressed on an urgent basis if we want to take care of others as well as ourselves.

Supervision and Training Psychological Assessments: So much to do, so little time

Christy Hobza, Psy.D,
Saneya H. Tawfik, Ph.D.,
Mary Beth Heller, Ph.D.

This is a summary of a poster presented at the APTC 2018 conference in Maui, HI.

Doing assessments outside of the classroom for the first time requires a lot of support to produce competent assessments. Common ways to support students are: reading material, didactic training, and individual and group supervision. Less common supports are: having new clinicians work in pairs on a first assessment so that they can support each other's learning, having peer supervisors and postdoctoral fellows provide administration and profession acclimatizing support, having all students watch an expert do a psychological assessment, and having new supervisors engaged in weekly training to support supervisor growth.

Bilingual assessments require extra support to learn the intricacies of cultural competency in addition to other assessment tasks. To address this: 1) establish the language proficiency of the client, student, and supervisor (BICS – basic interpersonal communication skills - about 2 years to establish; or CALP – cognitive academic language proficiency – about 7 years to establish). 2) evaluate the assessment choices based upon availability and size of evidence-base to determine a reliable and valid measure. 3) review mediating factors that affect bilingualism and testing (e.g. previous schooling/school history, level of acculturation, language development in native language, academic success/challenge in native language, age and means of language acquisition, location of birth, and timing of language learning). 4) assess acculturation and cultural influences including migration stress, trauma, family separations, etc.

When given the choice, students often postpone their assessments until late in the semester causing an inconsistent distribution of supervision responsibilities across time. Some ways to address these problems are: Find your allies (e.g. enlist faculty support to require assessment work on a specific day of the week). Be flexible and compromise (e.g. vary the specific weekday each semester). Collaborate with other clinic directors. Encourage students to use their collective voice (e.g. students returning from 2018 internship interviews reported more questions about assessment experience).

Training Newbies: Strategies for Addressing the Unique Training Needs of New Student Therapists

Crystal Dehle, University of Oregon
Jennifer Schwartz, Drexel University
Karen Fondacaro, University of Vermont

Training novice clinicians requires supervisory skills that are responsive to the unique demands associated with the training needs of new therapists. We must provide training that allows supervisees to initiate ethical and effective services with clients while they are still very early in developing clinical competencies. Student therapists approaching their first session with their first client may feel overwhelmed by the enormity and responsibility of the role, and have difficulty tolerating the experience of not knowing all that they might want to know before they begin clinical work with clients.

Our poster provided: (1) recommendations for experiential exercises (using CBT techniques) designed to address the thoughts and worries associated with the heightened anxiety and fear that new clinicians may be experiencing, (2) recommendations regarding the first four steps for increasing cultural awareness, sensitivity and reflection in new clinicians, and (3) recommendations for supervisors who are new to working with novice clinicians. These are summarized below.

Objective 1: Address emotions and thoughts common to new CBT therapists using experiential exercises that reflect and model CBT techniques

Prompt 1: **Identify Automatic Thoughts**

What concerns, worries, and/or scares you about clinical training and seeing your first client?

Prompt 2**: Build on Existing Strengths to De-Catastrophize Worries**

What skills, strategies, or characteristics do you possess that have helped you learn difficult new things before?

Prompt 3: **Perspective Taking**

What do you think your clients are thinking and feeling at their first session?

Prompt 4: **Problem Solving**

How can you make the process of seeking psychological services easier for your clients?

Objective 2: Begin development of cultural competence

Step 1: Expose new students to non-judgmental discussion of experience with Cultural Reflection and Awareness.

Step 2: Define Intersectionality Theory *(the integration of social categories creating interdependent systems of disadvantage and or discrimination).* Discuss examples in daily university life and interactions.

Step 3: Utilize the Power/Privilege Checklist below to illustrate the concept of intersectionality. It is not uncommon for students to be surprised by their relative experience of privilege or the areas in which they lack such privilege.

Step 4: Discuss the impact of completing the questionnaire with the continuation of a non-judgmental discussion. Ideally, time between each step (one week) can be beneficial for increased awareness.

Objective 3: Assist supervisors by providing tips for working with novice clinicians.

1. Know the procedures of the facility you are supervising in. Your supervisees won't know and are counting on your guidance.
2. Normalize their anxiety and recognize how anxious they really are.
3. Define all jargon you use. New students can be hesitant to let you know they don't know what you're talking about.
4. Assume everything is going to take students much longer than you think it will take.
5. Assume they won't tell you how long it is taking them until they hit a point of overwhelm.
6. Evaluate where students are in the competency domains and set purposeful goals for supervision.
7. Think about your goals for training and remind yourself of these goals before each supervision. Then be purposeful in the topics covered in your sessions.
8. Provide a structure for supervision so you know you're getting the information you need and also meeting their needs.
9. Elicit feedback about how they are feeling about supervision, preparation for sessions, and how sessions go.
10. Review video- don't trust that students know what to tell you went well or didn't go well.
11. Operationalize the things you do "naturally" and model, model, model!
12. Beginners need help making connections between what happens in the therapy room and models of behavior change.
13. Beginners do not naturally conceptualize cases or know where to go or what to do next with clients.
14. Don't allow them to get stuck in a notepad instead of present in the room.

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Client Perfectionism & Psychological Symptoms Throughout Psychotherapy

The full article has been published in Psychotherapy Research, 2017, Vol. 11, No. 1, 33-40

Kenneth G. Rice, *Georgia State University*
Clarissa Richardson, Ph.D. *University of Idaho*
Eric Sauer, Ph.D. *Western Michigan University*
Kristin Roberts, M.A. *Western Michigan University*

Abstract

Given the psychological issues experienced by individuals high in perfectionistic concerns (maladaptive perfectionism), or a feeling as if one is never good enough, and discrepancies in the literature as to whether these individuals experience benefits from therapy, it is imperative that research examine whether perfectionism actually improves throughout therapy. The current study improves upon past research by examining changes in perfectionism (both perfectionistic concerns and strivings) throughout therapy, rather than simply measuring perfectionism at pre- and post-therapy. This study also investigates how these changes in perfectionism, if they exist, impact changes in psychological symptoms. In total, 153 adult clients at a psychology training clinic in which a general treatment paradigm was implemented completed the Short Almost Perfect Scale (SAPS; Rice et al., 2014) and Outcome Questionnaire (OQ-45.2; Lambert et al., 1996) prior to intake session and sessions 1, 3, and 5. Multilevel modeling results revealed that there were significant improvements in perfectionistic concerns and symptoms although, as expected, no significant changes in perfectionistic strivings were observed. Additionally, there was a trend effect for changes in perfectionistic concerns being associated with changes in symptoms. Further, results of latent difference score analyses revealed that changes in symptoms throughout therapy preceded changes in perfectionistic concerns. Implications and future directions are discussed.

Discussion

The purpose of this study was to examine whether changes in perfectionism exist throughout therapy and, if so, whether they predict, and possibly even precede, changes in psychological symptoms. Previous studies have reported that perfectionism improves as a result of therapy, but most of the studies have only measured perfectionism at pre-therapy and post-therapy which did not allow for detection of the change process throughout therapy (e.g., Blatt et al., 2010; Lloyd et al., 2015). Prior research also did not allow for testing complex change models to determine whether changes in perfectionism throughout therapy parallel changes in symptoms. This study improved upon previous studies by examining both perfectionistic strivings (Standards) and concerns (Discrepancy). Different from previous studies was the fact that this study included data from a general community sample with various presenting concerns who were receiving different approaches to counseling rather than a specific therapeutic approach. Given that data were collected from a training clinic, therapy was based in foundational, common factors such as the developing and maintaining an effective therapeutic alliance and implementation of microcounseling skills. Although most previous studies examining whether perfectionism improves as a result of therapy have either targeted perfectionism or associated symptoms (e.g., depression) directly (and have shown mixed support for improvements in perfectionism), the current study found support for modest improvements in self-critical perfectionism throughout therapy that used a general treatment paradigm.

Multilevel modeling (MLM) results indicated that, as expected, there were significant linear improvements in self-critical perfectionism throughout therapy, and that personal performance standards did not exhibit significant changes. Further MLM analyses using OQ scores as the outcome variable showed that there were significant linear improvements in psychological symptoms throughout therapy and that, self-critical perfectionism and symptoms were significantly and positively associated throughout therapy. Additionally, there was a trend effect (p = .086) for changes in Discrepancy being associated with changes in symptoms; reductions in perfectionistic concerns throughout therapy were associated with improvements in symptoms. Given that this finding is only a trend effect and not a significant effect, this result should be interpreted with this in mind, and future research is needed to confirm this finding.

Interestingly, although average OQ scores started above the clinical cutoff, they showed a quick improvement by session 5. Lambert (2015; Lambert et al., 1996) reported that, in a community sample, for a score to be considered a clinically significant change, it must cross the clinical cutoff and show an improvement of at least 14 points. In the present study, by the fifth session, we see a clinically significant change. Our average distress at intake is comparable to Lambert et al. (1996) who also used a university outpatient clinic sample, yet our sample showed a clinically significant improvement by session 5 while Lambert et al. reported that the overall sample OQ score at session 7 was still higher than ours at session 5. This quick improvement in our sample might be due to the fact that 56% of the clients reported previous therapy, so this may have expedited improvement and is important to keep in mind when interpreting other results.

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Further, latent difference score analyses (LDS) revealed that, although we had anticipated that changes in perfectionistic concerns would precede changes in symptoms, this was not the case, and instead, the alternative was true. Changes in symptoms preceded changes in perfectionistic concerns. This was inconsistent with research by Hawley and colleagues (2006) that reported changes in perfectionism preceded changes in depression. It is likely that differences in sample and procedures between this study and the study by Hawley et al. account for this discrepancy. For example, the participants in the Hawley et al. study all met criteria for major depressive disorder whereas participants in the current study presented with a variety of concerns. Perhaps among individuals with major depression, it is important to first address perfectionistic concerns in order to see later improvements in symptoms, but among a general sample, it might be important to first assist clients in symptom reduction in order for them to experience later benefits of reduced self-criticism although future research on this is needed. It might also be a function of the quick improvement in symptoms observed in the present study which is likely due to over half of the participants reporting previous therapy. The interpretation of the effect suggested that at low distress at intake, clients improved in their level of Discrepancy from intake to session 1, but at higher levels of distress, clients actually got worse in their level of Discrepancy from intake to session 1. Anecdotally, self-critically perfectionistic clients have mentioned that it is often difficult to begin therapy when they are not doing well because, at least at first, therapy can exacerbate their self-criticism because being in therapy points out the fact that they are not doing well, and they are hard on themselves that they haven't been able to keep their mental health in a positive state. Thus, in regards to this, it makes sense that Discrepancy might get worse from intake to session 1 among those high in distress. Among these individuals high in distress, it is likely important to first address the distress in order for improvements in Discrepancy to eventually occur. A qualitative study on this issue might be helpful to clarify the direction of effect observed in the present study.

Implications

These results have implications for clinical work with perfectionists. It may be helpful for clinicians to assess client perfectionism at the onset of treatment, perhaps using the 8-item Short Almost Perfect Scale (Rice et al., 2014), and to monitor changes in perfectionism during treatment. Knowledge about a client's perfectionism levels might be helpful in discussions with clients regarding realistic expectations of change that is likely during therapy, especially early on. As indicated by Rice et al. (2015), those with higher scores on maladaptive perfectionism enter therapy with higher levels of distress than those higher in adaptive perfectionism, likely because of their delay in help-seeking behavior. Thus, therapists might explain that research supports the likelihood that such higher levels of distress and problematic perfectionism are likely to show some modest declines even within the first five weeks of treatment. Possibly reassuring to some perfectionistic clients, results could also be conveyed that, despite concerns they may have, their strivings to reach high levels of performance need are less likely to decline during therapy. Such discussions with clients might naturally segue into a presentation of more (standards and low self-criticism) and less adaptive (high standards and high self-criticism) aspects of perfectionism. Although a general approach to treatment was used in the present study, future research might explore how much focus on perfectionism and its correlates happened during therapy and how this affected therapy course and outcome. If clinicians are aware of their client's high levels of self-critical perfectionism, they may be better able to tailor treatment. Clinicians working with individuals high in perfectionistic concerns, as well as the clients themselves, may benefit from self-help books that address perfectionism from either mindfulness, compassion-focused, or CBT orientations (e.g., Egan, Wade, Shafran, & Antony, 2014; Mehr & Adams, 2016; Somov, 2010). Other therapy approaches may work as well, such as a general treatment focused on basic microskills as was used in the present study, although future research is needed to confirm that other specific therapeutic approaches (e.g., interpersonal, psychodynamic, acceptance and commitment therapy) are effective for treating individuals high in self-critical perfectionism. However, it is important to note that improvements in self-critical perfectionism occurred in the present study despite a specific focus on the construct in therapy. Future studies may compare therapy course and outcome as a function of whether perfectionism was focused on directly in therapy.

Conclusion

In conclusion, the present study examined whether changes in perfectionism throughout therapy were associated with changes in symptoms. Results indicated that there was a significant decrease in both perfectionistic concerns (self-critical perfectionism) and psychological symptoms as measured by the OQ-45.2, with no changes over time observed for perfectionistic strivings (standards). Additionally, there was a trend effect for the changes in self-critical perfectionism paralleling changes in symptomatology suggesting that improvements in the self-critical tendencies of maladaptive perfectionists are associated with reductions in psychological distress. Further, results latent difference score analyses revealed that improvements in psychological symptoms preceded the reductions in self-critical perfectionism which provides support for first addressing symptom reduction prior to targeting perfectionism in therapy.

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References

Ashby, J. S., Rice, K. G., & Kutchins, C. B. (2008). Matches and mismatches: Partners, perfectionism, and premarital adjustment. *Journal of Counseling Psychology,55*(1), 125-132. doi:10.1037/0022-0167.55.1.125

Bieling, P.J., Israeli, A.L., & Antony, M.M. (2004). Is perfectionism good, bad, or both? Examining models of the perfectionism construct. *Personality and Individual Differences, 36*, 1373-1385. doi:10.1016/S0191-8869(03)00235-6

Bieling, P.J., Israeli, A.L., Smith, J., & Antony, M.M. (2003). Making the grade: The behavioural consequences of perfectionism in the classroom. *Personality and Individual Differences, 35*, 163-178. doi:10.1016/S0191-8869(02)00173-3

Blatt, S. J., Zuroff, D. C., Hawley, L. L., & Auerbach, J. S. (2010). Predictors of sustained therapeutic change. *Psychotherapy Research,20*(1), 37-54. doi:10.1080/10503300903121080

Bludworth, J. L., Tracey, T. G., & Glidden-Tracey, C. (2010). The bilevel structure of the Outcome Questionnaire–45. *Psychological Assessment*, *22*(2), 350-355. doi:10.1037/a0019187

Chang, E., Lee, A., Byeon, E., Seong, H., & Lee, S-M. (2016). The mediating effect of motivational types in the relationship between perfectionism and academic burnout. *Personality and Individual Differences, 89*, 202-210.

Dunkley, D. M., Ma, D., Lee, I. A., Preacher, K. J., & Zuroff, D. C. (2014). Advancing complex explanatory conceptualizations of daily negative and positive affect: Trigger and maintenance coping action patterns. *Journal of Counseling Psychology, 61,* 93-109. doi:10.1037/a0034673

Egan, S. J., Wade, T. D., Shafran, R., & Antony, M. M. (2014). *Cognitive-behavioral treatment of perfectionism*. New York, NY, US: Guilford Press.

Erekson, D. M., Lambert, M. L., 7 Eggett, D. L. (2015). The relationship between session frequency and psychotherapy outcome in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 83*, 1097-1107. doi:10.1037/a0039774

Falkenström, F., Granström, F., & Holmqvist, R. (2013). Therapeutic alliance predicts symptomatic improvement session by session. *Journal of Counseling Psychology, 60,* 317–328. doi:10.1037/a0032258

Grimm, K. J., An, Y., McArdle, J. J., Zonderman, A. B., & Resnick, S. M. (2012). Recent changes leading to subsequent changes: Extensions of multivariate latent difference score models. *Structural Equation Modeling, 19(2)*, 268-292. doi:10.1080/10705511.2012.659627

Grimm, K. J., Ram, N., & Estabrook, R. (2017). *Growth modeling: Structural equation and multilevel modeling approaches*. New York, NY: Guilford

Hawley, L. L., Ho, M. R., Zuroff, D. C., & Blatt, S. J. (2006). The relationship of perfectionism, depression, and therapeutic alliance during treatment for depression: Latent difference score analysis. *Journal of Consulting and Clinical Psychology, 74*, 930–942. doi:10.1037/0022-006X.74.5.930

Hill, R. W., Huelsman, T. J., Furr, M., Kibler, J., & Vicente, B. B. K. C. (2004). A new measure of perfectionism: The perfectionism inventory. *Journal of Personality Assessment, 82(1),* 80–91. doi:10.1207/s15327752jpa8201_13

Heck, R. H., Thomas, S. L., & Tabata, L. N. (2014). Multilevel and longitudinal modeling with IBM SPSS. London: Routledge Academic.

Hewitt, P. L., Mikail, S. F., Flett, G. L., Tasca, G. A., Flynn, C. A., Deng, X., . . . Chen, C. (2015). Psychodynamic/interpersonal group psychotherapy for perfectionism: Evaluating the effectiveness of a short-term treatment. *Psychotherapy,52(2),* 205-217. doi:10.1037/pst0000016

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9 –16. doi: 10.1037/a0022186

Hox, J. (2010). *Multilevel analysis: Techniques and applications* (2nd ed.). New York, NY: Routledge.

Kahn, J. H. (2011). Multilevel modeling: Overview and applications to research in counseling psychology. *Journal of Counseling Psychology, 58(2),* 257–271. doi:10.1037/a0022680

Lambert, M. J. (2015). Progress feedback and the OQ-system: The past and the future. *Psychotherapy*, *52*(4), 381-390. doi:10.1037/pst0000027

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3,* 249 –258. doi:10.1002/(SICI)1099-0879(199612)3: 4249::AID-CPP1063.0.CO;2-S

Lambert, M. J., Kahler, M., Harmon, C., Burlingame, G. M. (2011). *Administration and Scoring Manual Outcome Questionnaire OQ-45.2.* OQ Measures, LLC.

Liu, Y., Mo, S., Song, Y., & Wang, M. (2016). Longitudinal analysis in occupational health psychology: A review and tutorial of three longitudinal modeling techniques. *Applied Psychology: An International Review, 65(2)*, 379-411. doi:10.1111/apps.12055

Lloyd, S., Schmidt, U., Khondoker, M., & Tchanturia, K. (2015). Can Psychological Interventions Reduce Perfectionism? A Systematic Review and Meta-analysis. *Behavioural and Cognitive Pyschotherapy,43*, 705-731. doi:10.1017/S1352465814000162

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Mandel, T., Dunkley, D. M., & Moroz, M. (2015). Self-critical perfectionism and depressive and anxious symptoms over 4 years: The mediating role of daily stress reactivity. *Journal of Counseling Psychology, 62(4),* 703-717. doi:10.1037/cou0000101

McArdle, J.J. (2001). A latent difference score approach to longitudinal dynamic structural analyses. In R. Cudeck, S. du Toit, & D. Sorbom (Eds.), *Structural equation modeling: Present and future* (pp. 342–380). Lincolnwood, IL: Scientific Software International.

Mehr, K. E., & Adams, A. C. (2016). Self-compassion as a mediator of maladaptive perfectionism and depressive symptoms in college students. *Journal of College Student Psychotherapy, 30*, 132-145.

Mueller, R. M., Lambert, M. J., & Burlingame, G. M. (1998). Construct validity of the Outcome Questionnaire: A confirmatory factor analysis. *Journal Of Personality Assessment*, *70*(2), 248-262. doi:10.1207/s15327752jpa7002_5

Rice, K. G., Ashby, J. A., & Slaney, R. B. (1998). Self-esteem as a moderator between perfectionism and depression: A structural equations analysis. *Journal of Counseling Psychology, 45,* 304–314. doi:10.1037/0022-0167.45.3.304

Rice, K. G., Leever, B. A., Christopher, J., & Porter, J. D. (2006). Perfectionism, stress, and social (dis)connection: A short-term study of hopelessness, depression, and academic adjustment among honors students. *Journal of Counseling Psychology, 53,* 524-534. doi:10.1037/ 0022-0167.53.4.524

Rice, K. G., Lopez, F. G., & Vergara, D. (2005). Parental/social influences on perfectionism and adult attachment orientations. *Journal of Social and Clinical Psychology, 24*, 580-605. doi:10.1521/jscp.2005.24.4.580

Rice, K. G., & Mirzadeh, S. A. (2000). Perfectionism, attachment, and adjustment. *Journal of Counseling Psychology, 47,* 238-250. doi: 10.1037/0022-0167.47.2.238

Rice, K. G., & Richardson, C. M. (2014). Classification challenges in perfectionism. *Journal of Counseling Psychology,61(4),* 641-648. doi:10.1037/cou0000040

Rice, K. G., Sauer, E. M., Richardson, C. M., Roberts, K. E., & Garrison, A. M. (2015). Perfectionism affects change in psychological symptoms. *Psychotherapy, 52(2),* 218-227. doi:10.1037/a0036507

Rice, K. G., Richardson, C. M. E., & Tueller, S. (2014). The Short Form of the Revised Almost Perfect Scale, *Journal of Personality Assessment, 96*(3), 368-379. doi:10.1080/00223891.2013.838172

Richardson, C. M. E., Rice, K. G., & Devine, D. P. (2014). Perfectionism, emotion regulation, and the cortisol stress response. *Journal of Counseling Psychology, 61,* 110–118. doi:10.1037/a0034446

Sirois, F. M., & Molnar, D. S. (2016). *Perfectionism, health, and well-being*. Cham, Switzerland: Springer International Publishing. doi:10.1009/978-3-319-18582-8

Slaney, R. B., Mobley, M., Trippi, J., Ashby, J., & Johnson, D. G. (1996). The Almost Perfect Scale—Revised. Unpublished manuscript, Pennsylvania State University, University Park, PA.

Slaney, R. B., Rice, K. G., Mobley, M., Trippi, J., & Ashby, J. S. (2001). The revised Almost Perfect Scale. *Measurement and Evaluation in Counseling and Development, 34,* 130 –145.

Somov, P. (2010). *Present perfect: a mindfulness approach to letting go of perfectionism and the need for control*. Oakland: New Harbinger Publications.

Stoeber, J. (2018). *The psychology of perfectionism: Theory, research, applications*. Routledge.

Stoeber, J., & Otto, K. (2006). Positive conceptions of perfectionism: Approaches, evidence, challenges. *Personality and Social Psychology Review, 10,* 295–319. doi:10.1207/s15327957pspr1004_2

Taylor, S. G., Bedeian, A. G., Cole, M. S., & Zhang, Z. (2017). Developing and testing a dynamic model of workplace incivility change. *Journal of Management, 43(3)*, 645-670. doi:10.1177/0149206314535432

Vermeersch, D. A., Lambert, M. J., & Burlingame, G. M. (2000). Outcome questionnaire: Item sensitivity to change. *Journal of Personality Assessment, 74,* 242–261. doi:10.1207/S15327752JPA7402_6

Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M., & Okiishi, J. C. (2004). Outcome Questionnaire: Is it sensitive to changes in counseling center clients? *Journal of Counseling Psychology, 51,* 38-49. doi:10.1037/0022-0167.51.1.38

Wimberley, T. E., Mintz, L. B., & Suh, H. (2015). Perfectionism and Mindfulness: Effectiveness of a Bibliotherapy Intervention. *Mindfulness, 7(2),* 433-444. doi:10.1007/s12671-015-0460-1

Zeifman, R. J., Atkey, S. K., Young, R. E., Flett, G. L., Hewitt, P. L., & Goldberg, J. O. (2015). When ideals get in the way of self-care. *Canadian Journal of School Psychology, 30(4),* 273-287. doi:10.1177/0829573515594372

A Consultation Team Structure to Case Conferences for Student Self-Care

Nancy Liu, UC Berkeley

Historically, the process and structure of our case conferences have been open-ended. This year, we have introduced a dialectical behavior therapy-informed consultation team structure. Originally developed to manage the high stress and burnout of working with a highly suicidal population, this structure allows students to share their vulnerabilities, normalize burnout, offer support, and model effective clinician behavior. In practice, our weekly meetings begin with a mindfulness exercise, followed by agenda-setting, starting with high-priority issues: high-risk clinical issues, therapist burnout, therapy-interfering behaviors, clinical updates, and good news. When discussing agenda items, students start with a framing question (e.g., "I'd like some help problem-solving" or "I'm just seeking validation"). Some nice byproducts have been 1) students' willingness to admit their fallibility and ask for help, 2) students recognizing when the might be feeling burnt out, and 3) simply bringing our team closer together and supporting one another during more trying clinical times.

Making Policy Manuals More Palatable

Phyllis Terry Friedman, Saint Louis University

Students were glassy-eyed whenever I presented policy, consequently I came up with 3 new approaches:

1. Instead of presenting the Policy Manual in its entirely, I use 10 minutes of a monthly Professional Seminar I conduct to highlight one policy matter. Examples: Abuse reporting, fees for assessments, guidelines for no-shows, intoxicated clients.
2. I give the full Policy Manual (20 pages, mostly narrative) to new students. For the other students I've created a bullet-point version which identifies the critical policy features in short form (6 pages, mostly bullet-pointed), to allow for quick reference.
3. I've posted individual policy topics on our server, again for quick reference. Should a student want to know what our policy is on clients bringing in weapons or duty to warn or what the different type of case notes are, they are listed individually (Weapons, Duty to Warn, Case Notes) and are typically no more than ½ page.

Graduate Student Wellness Committee

Karen Saules, Eastern Michigan University

In the Fall of 2015, we identified a need for greater program emphasis on and support for lifestyle balance, and an ad hoc "Wellness Committee" was formed. Our DTC suggested I should be the faculty advisor for this group, and after determining that the students were comfortable with that plan, I agreed. We set up a system of meeting twice per month, and this has continued to date. Early on, the group decided they wanted to form an official "Student Organization", which required elected student officers along with a designated faculty advisor, so I have stayed involved since this group's inception. As such, I have had something of a birds' eye view into the struggles our student face in terms of juggling many competing professional demands while also preserving time for personal life. I have sometimes been alarmed at their concerns that it is not always "okay" to admit to actually having a personal life, and we have discussed the pressures they feel in this regard, both formally (see below) and informally. I have been impressed with the students' efforts to sustain this group by involving new members each year and doing outreach to foster a sense of community and support across the program.

Regarding the group's specific activities and accomplishments, we have:

- Established a Communication Committee responsible for organizing and issuing correspondence with students who are embarking on major program benchmarks (thesis and dissertation defenses; qualifying examinations) or off site completing internship. This group also solicits donations for "care packages" for current interns each Winter and sends notes of encouragement to those within the program as they complete various milestones or encounter major life events.
- Organized several panel discussions to solicit faculty and alumni experiences and advice regarding maintaining lifestyle balance, making decisions about whether and when to start a family, and how to navigate other times when the personal and professional can collide.
- Established a Retreat Committee tasked with planning periodic Wellness Retreats, which take place at low cost rural properties owned by the University. These retreats have tended to focus on a mix of wellness activities and quiet time to complete academic tasks.
- Organized low cost social "First Friday" events that are open to all graduate students. These include events like skating, visiting cider mills, yoga, kayaking, trivia, movie nights, rock climbing, etc.
- Negotiated with the Counseling Center to reduce barriers to graduate students seeking services in a location where they and/or their peers may work, either in the past, present, or future.
- Organized various graduate student panels to prepare other students for applying to graduate school or working on other professional objectives (effective teaching; better and more efficient writing, etc.)

This group has served to promote greater cohesion amongst our students and sends a message that the program values and supports wellness activities and lifestyle balance. I don't have any data regarding whether it has helped people feel more comfortable admitting to actually having lives outside the program, and I imagine that varies by local context, but it is my sense that our busy students would not be able to sustain this initiative if it had not been of benefit.

APTC AT APA: Our People Present

- William Rae, Poster
  Relationship between Gender and Informant Reports for Adolescent Internalizing Symptoms

- Jordan Wright, Workshop
  Psychological Assessment Report Writing: Producing Meaningful Reports

- Alisha Wray, Symposium
  Addressing Complex Care Needs for Service Members and Veterans

- Erica Wise, Supplemental APA CE Workshop
  Joyful and Sustainable Professional Practice: The Ethics of Self-care

- Erica Wise, Symposium
  Translating Psychological Science and Personal Passion Into Social Justice Advocacy on Campus

- Jessica Reinhardt, Poster
  Division 16 School Psychology: Early Career Endeavors and Opportunities

- Jessica Reinhardt, Symposium
  Mentoring Across Developmental Levels and Contexts to Underrepresented Trainees and Professionals: The Importance of Mentoring in Fostering Diversity Competence of ECPs

- Jessica Reinhardt, Collaborative Program
  Walk a Mile---Understanding Challenges Faced by Families Struggling to Find Assessment and Treatment: School Psychologists Role in Helping Families Navigate the Diagnostic System

The Society of Clinical Psychology, Division 12 of APA would like to congratulate the new Initial and Current Fellows effective January 1, 2019:

Initial Fellows:

Dr. Robert Ammerman
Dr. Gretchen Brenes
Dr. Joanne Davila
Dr. David Mccord
Dr. Peter Norton
Dr. Kim Penberthy
Dr. Kelly Rohan

Dr. Erica Wise

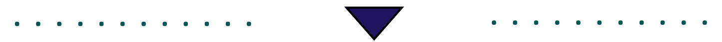
APTC QUIZ:

Before We Were A Clinic, What Were We?

Once upon a time, before our clinics were clinics, they were something else. Match the University clinic with the building it was formerly:

1. **University of Arkansas**
2. **University of the Rockies**
3. **Saint Louis University**
4. **Virginia Tech**
5. **University of Delaware**
6. **Sam Houston State University**
7. **Eastern Michigan University**

- **A. Bank**
- **B. Former Church**
- **C. Historical House**
- **D. Railway Station**
- **E. Billiard Hall**
- **F. Historical House**
- **G. Law School**



APTC and APA Leaders Heidi Zetzer and Erica Wise at APA. With life-size horse???

Answers:

1 E; 2 D; 3 G; 4 F or C; 5 F or C; 6 B; 7 A