Contra Costa Psychological Association

2012 Spring Newsletter

The President's Message

Our Evolving Field

By Susan O'Grady, Ph.D.

For several years every spring I have spoken at Career Day at our local high school and middle school. Men and women representing many diverse jobs assemble in the multi-purpose room for coffee in the morning before being dispersed to the assigned classrooms to speak with high school students about our jobs. To my delight, on each occasion the Psychologist profession had the largest turnout.

One of the most common questions asked is, "Why did you choose to become a psychologist?" I love this question. It challenges on many levels. Being careful to not discourage, I avoid the words HMO, managed care, reimbursement and collection problems. I also tread lightly when discussing the different degrees and licenses of those who work in mental health. I refrain from talking about unpaid internships and the cost of graduate school. Those in the room are clearly interested in our profession—they are learning about themselves, learning how they are like or unlike others, discovering the patterns that underlie the complexities of how we think and feel. I see in these kids the excitement that launched me, and others like me, into a career in psychology.

We are indeed a privileged profession. In each person who comes to us, there lies a story to be found. The story usually has universal motif and a theme distinctive to that individual life. When I describe our work to students, I often use the image of having a stack of books on my table, and each hour I take down a different volume, open to a chapter that flows from the previous hour a week apart. Most men and women who come to us for therapy seek wholeness, and the stories that unfold bit by bit, hour by hour, nourish the thirst for, as Dante wrote, "the love that moves the sun and the other stars."

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CONTRA COSTA PSYCHOLOGICAL ASSOCIATION

2012 Spring Newsletter

Our field is rapidly changing with the addition of neurocognitive sciences, and changes in diagnostic criteria and treatment strategies for a number of disorders. Research is continually evolving and our access to information and databases is unparalleled. It is exciting to see the eagerness of high-school students, and graduate students as they explore the field of psychology.

The Contra Costa Psychological Association welcomes graduate students and early career psychologists to our organization. We have seasoned and accomplished members who are working on mentoring. Both the California Psychological Association and the American Psychological Association have made great efforts to help younger psychologists to find work. These organizations offer programs in mentorship, leadership, grant writing, and free legal and ethical hotlines. In addition, they provide tangible, value-added resources such as financial planning, debt reduction and loan repayment. Resources such as these are immensely valuable at a time when job stability is tenuous.

CCPA is strong. We have a large and growing membership and our coffers are full. Our board is dedicated, and our monthly meetings are efficient yet lively. We invite anyone interested in joining the board, or just sitting in on a meeting, to show up on the second Tuesday of each month, 11:30 at the office of Dr. Andy Pojman. ◊

FAQ 2013 Mandatory Continuing Education for Psychology (MCEP) Regulation Change and You

Q: When does the change take place?

A: January 1, 2013. That means if your license renewal is due in 2012, you will continue to report your CE credits to the MCEP Accrediting Agency as you have done for the past 15 years. If your license renewal is due any time on or after January 1, 2013 you will be responsible for keeping your own continuing education certificates and you will be asked to **self certify** that you have met your CE requirement on the license renewal form. Self certification means you are asserting, under penalty of perjury, that you have met the minimum requirement for continuing education during the two-year period of licensure.

Q: What actually changes in 2013?

A: The Board of Psychology will implement a random audit process to verify compliance with the CE requirement. This means that you will no longer be required to send your certificates to the MCEP Accrediting Agency. It also means that you are responsible for keeping these records in case you are selected for an audit. CPA approved CE sponsor courses can also be used (as well as APA and ACCME/CME) to accrue hours. The BOP will no longer waive the CE requirement for out-of-state licensees.

Q: Does this mean that I am no longer required to earn 36 CE credits each licensing period?

A: No. There is **no change** to the 36 hour CE requirement for license renewal.

Q: Do I send my CE certificates directly to the Board of Psychology or send them in with my license renewal form and payment?

A: **Neither**. **Do not** include any CE certificates with your renewal form or send them to the Board of Psychology until or unless you are selected to be audited. At the time of an audit, the Board will send you all the instructions to comply with their request.

Q: What should I do with my CE records?

A: It is important to keep your CE records in a safe place so you can produce them when requested to do so. You might consider using a 3rd party CE Tracking Service to maintain your records if you have concerns about record safety or ready availability.

Q: How long do I need to keep them?

A: CE records should be kept for a minimum of two to three renewal cycles (5-6 years.) If you practice in an area where a complaint could be filed at an even later date (e.g., child custody evaluators) we recommend that you keep records for a longer period of time.

Q: Where do I go for further information or updates?

A: There is more information available on the Board of Psychology's website (www.psychboard.ca.gov), the MCEP website (www.mcepaa.org) and the California Psychological Association's website (www.cpapsych.org).

Q: What happens if I reported some of my hours to MCEP and don't have copies of the CE Certificates.

A. The BOP will accept an MCEP Educational Record documenting those hours were reported and accepted by the MCEP Accrediting Agency. If you do not have a copy of your educational record, request one from the MCEP Accrediting Agency before they close on Dec 31, 2012. ◊

Announcement

On Friday, May 20, the second day of the 2012 CPA Convention at the Monterey Marriott, there will be a dinner to benefit the PAC. If you cannot make the dinner, you could sponsor a student or help send another psychologist.

The cost is $250. If interested, contact Ryan McElhinney, work 916-286-7979 ext. 107, rmcelhinney@cpapsych.org

CPA Corner

Sunset Bill

The Board of Psychology is currently requesting a five year extension to the law that gives it the authority to oversee licensing, disciplinary action, and consumer advocacy. On 12/31/2012, the BOP will dissolve due to a measure in the law known as a sunset measure (or sunset bill.)
A sunset bill is a measure within a law that says that the law will cease to be in effect after a certain date unless further action is taken to extend it.

Without the BOP, one single board would not only manage matters affecting psychologists but all masters level therapists. If this were to occur, one or two psychologists would sit on a larger board as opposed the five of nine ratio that characterizes the current board.

With the financial backing of the state's psychological community, the CPA-PAC is in the position to support politicians who recognize the importance of preserving the BOP and can vote for the extension. The PAC is the **only** organization that represents California psychologists who can make such donations.

At this point, California is ranked as having one of the lowest PAC contribution rates of any state in the country. At this point, we contribute around $2 per capita!

So, please consider making even a small donation to the PAC. Think of what influence we would have if each California psychologist was to contribute $50. Let us all consider how vital it is to have someone working to protect the scope of practice for our profession. ◊

P A C

Reasons to Contribute

Only one organization in California is making sure lawmakers who understand the importance of psychology are supported: **The CPA-PAC**. Anyone and everyone with an interest in psychological well being, including psychologists, psychological grad students, vendors, suppliers and consumers should donate to the CPA-PAC.

California's elected officials can and do have a major impact on our profession. In today's expensive campaign climate, where a state assembly race can cost as much as $3 million, it's important to make sure we support candidates who are pro-psychology. Without your support they cannot pay for campaign costs such as direct mail or TV and radio ads.

A great way to build relationships with your local legislators is to attend a fundraiser for them in your area. You could also offer to help these legislators and their staff better deal with their constituents. Some of these constituents may be distressed and could create a difficult situation. CPA has published "A Legislator's Guide: Communicating with Distressed Constituents" that will assist legislators and their staff effectively communicate with these constituents. Included in this pamphlet are general guidelines for interacting with distressed constituents and suggestions for an

appropriate response to six types of distressed constituents.

Do you have a bill that you would like to introduce concerning psychology or practice issues? If so, the CPA-PAC can help.

California psychologists have the largest scope of practice of any state with the exception of prescription privileges. If we are to maintain this status and to be able to do what we are specifically trained to do in the practice of psychology, we need a strong voice in Sacramento. That is where the CPA-PAC can help, but only with your donation.◊

Letter from the Editor

The CCPA newsletter is a forum for sharing information. I invite submissions about 1) groups that you offer, 2) reviews of workshops you have attended or book that you have found useful or 3) a variety of other topics relevant to the community. Occasionally, I include an interview with a CCPA member,, so if you would like to respond to a list of questions about yourself and your practice, please contact me. It is a great way to be better known within the organization.Please consider contributing to future newsletters. The following dates are deadlines by which I must have your submission. Thank you in advance!

July 15, 2012- Summer edition
October 15, 2012- Fall edition
January 15, 2013- Winter edition

The following prices are in effect for advertisements:
¼ Page Ad $30 ½ Page Ad $60 ¾ Page Ad $100

Note: Advertisements for office space are free to CCPA members. All professional advertisements are free on the listserv for CCPA members. Email submissions by the deadline to sarahewoodphd@yahoo.com ◊

Advertisement

Lovely Lafayette therapy office, easy parking, available

Tues., Thurs., Fri. & weekends.

$175/ mo/day, discount for multiple days.

Pam Rudd 650 348-8829.

Contra Costa Psychological Association

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Calendar of Events

Mark Your Calendars!

Workshop – What Every Psychologist Should Know About Infertility, Egg and Sperm Donation and Surrogacy

Presenter: Dr. Madeline Feingold, Ph.D.
Topic: What every psychologist should know about infertility, egg and sperm donation and surrogacy
Cost: $50. Members / $60. Non-Members
CEU's: 2.0
Time: 6 -9-PM
Date: **June 7, 2012**
Place: Lafayette Park Hotel, 3287 Mount Diablo Blvd. Lafayette, 94549
Contact: Dr. Alissa Scanlin, PHONE: (925) 283-3902 EMAIL: drscanlin@pacbell.net

Workshop – Prodromal Signs of Schizophrenia

Presenter: Dr. Dale Watson
Topic: Prodromal Signs of Schizophrenia
Date: **Fall 2012 TBA**
RSVP to: **Dr. Alissa Scanlin** 3468 Mt Diablo Blvd, Ste. B203, Lafayette, CA 94549 PHONE: (925) 283-3902 EMAIL: drscanlin@pacbell.net Include your Name, Address, License#, Phone and Email (All event locations are wheelchair accessible. Please let me know if you need any special accommodations.)

CCPA Annual BBQ

Date: **TBA**

Professional Networking Group

Date: 3rd Friday of every month (see listserv for specific dates)
Time: Noon
Place: The office of Dr. Goldberg-Boltz 2930 Camino Diablo, #305, Walnut Creek
Contact: Dr. Goldberg-Boltz (925) 788-7888

Early Career Group

Date: 2nd Friday of every month
Time: 5- 6 or 6:30 pm
Place: ATC, 61 Moraga Way, #6 in Orinda.
Contact: Dr. Candia Smith (925) 254-7823

Any suggestions for topics and speakers can be sent to:
ccpaboard@yahoogroups.com / Alissa Scanlin or Marc Kamori-Stager

List of Groups

A Healthy Divorce/Separation Group

Meeting Day: Monday's
Meeting Time: 6:00 – 8:30pm
Group Leader: Shendl Tuchman, Psy.D.
Contact Number: 510-201-3435
Email: dr.tuchman@earthlink.net

Breakthrough Weight Loss and Maintenance Group

Meeting Day: Wednesday's
Meeting Time: 6:00- 7:30pm
Group Leader: Candia Smith, DMH
Contact Number: (925) 254-7823
Email: candia.smith@comcast.net

Introduction to Meditation for Stress Relief

Meeting Day: 1st and 3rd Tuesday of each month
Meeting Time: 6 -7 pm
No fee, small donation toward rent asked
Group Leader: Candia Smith, DMH
Contact Number: (925) 254-7823
Email: candia.smith@comcast.net

Men's Group

Meeting Day: Monday's
Meeting Time: 7:30 -9:00pm
Group Leader: Bruce H. Feingold, Ph.D.
Contact Number: (925) 945-1315

Meeting Day: Wednesday's
Meeting Time: 6:00-7:30 pm
Group Leader: Bruce H. Feingold, Ph.D.
Contact Number: (925) 945-1315

Mindfulness-Based Stress Reduction Class

Group Leader: Susan O'Grady, Ph.D.
Contact Number: 925-938-6786

Women in Sobriety

Meeting Day: Wednesday's
Group Leader: Sara E. Fisher, Ph.D.
Contact Number: (925) 256-8280
Email: saraefisherphd.com

Over 50 Relationship Focused Process Group (ages from 50 to 65)

Meeting Day: Wednesdays
Meeting Time: 5:00-6:30pm
Group Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: (925) 962-0060
www.PsychotherapyTools.com

Chronic Pain/ Illness Support Group (ages 30-65)

Meeting Day: Wednesdays
Meeting Time: 12:15-1:45pm
Group Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: (925) 962-0060
www.PsychotherapyTools.com

Consultation/ Support Group for licensed psychotherapists

Meeting Day: Bimonthly Thursdays
Meeting Time: 10:45am-12:15
Group Leader: Ann Steiner, Ph.D., MFT, CGP

Contact Number: (925) 962-0060
www.PsychotherapyTools.com

Therapy group for psychotherapists (ages 28-60)

Meeting Day: Thursdays
Meeting Time: 9:00am-10:30
Group Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: (925) 962-0060
www.PsychotherapyTools.com

Dialectical Behavior Therapy Group (ages 19+)

Meeting Day: Tuesday
Meeting Time: 5:30-7 PM
Group Leaders: Elizabeth Rauch Leftik, Psy.D.
Sarah E. Wood, Ph.D.
Contact Numbers: Dr. Rauch (415) 531-7638
Dr. Wood (925) 680-1844

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Dialectical Behavior Therapy Group (ages 13-18)

Meeting Day: Tuesdays
Meeting Time: 3:30 – 5:00 PM
Group Leaders: Elizabeth Rauch Leftik, Psy.D.
Sarah E. Wood, Ph.D.
Contact Numbers: Dr. Rauch (415) 531-7638
Dr. Wood (925) 680-1844

Breaking Through: Coping with Dementia in Someone You Love

Meeting Day: Saturdays
Meeting Time: 11:00 am – 12:00 pm
Group Leader: George Kraus, Ph.D., ABPP
Contact Number: 925.238.6466
Email: joy@GeorgeKrausPhD.com
No Fee

2012 Board of Directors & Committee Chairs

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Colleague Assistance Program (CLASP)

Professional Self Care

By Barbara Peterson, Ph.D.
CLASP Co-Chair

My CLASP Co-Chair, Ellin Sadur, Psy.D. and I led a discussion at the meeting of the Early Career Psychologists last week on the topic of "Professional Self-Care". We were delighted to know that concepts such as "compassion fatigue", "vicarious trauma", and "burnout" are routinely addressed in graduate and clinical training programs. The field of psychology has come a long way in recognizing that the healers must take care of themselves if they are going to successfully continue to care for others. Though there have been articles in this newsletter and other publications in recent years on this topic, I thought a brief outline of the general principles of self-care might be a useful reminder for all of us.

The APA Board of Professional Affairs' Advisory Committee on Colleague Assistance (ACCA) recently published a summary of recommendations on self-care. The first paragraph presents a critical shift in attitude toward stress among psychologists:

> *"Because of the nature of the work, every psychologist is at risk for occupational stress. Over the course of time, the interaction between events in the personal and professional life of a psychologist is certain to create stress, likely distress, and possibly impairment. This vulnerability to stress is not a reflection of pathology in the psychologist, but a reality of the challenge of our work."*

What are some indications that you are experiencing occupational stress? ACCA suggests the following:

- Loss of pleasure in work
- Depression (Sleep or appetite disturbance, lethargy, negative mood)
- Inability to focus or concentrate; forgetfulness
- Anxiety
- Substance use/abuse or other compulsive behaviors to manage stress
- More frequent clinical errors
- Less contact with colleagues
- Workaholism
- Persistent thoughts about clients and their clinical material Intrusive imagery from clients' traumatic material Increased cynicism, over-generalized negative beliefs Increased isolation from or conflict with intimates
- Chronic irritability, impatience
- Increased reactivity and loss of objectivity and perspective in work
- Suicidal thoughts" (ACCA, 2000)

How can we protect ourselves from Occupational Stress?

First and foremost, make self-care a priority! Recognize that using ourselves as a therapeutic tool requires that we keep ourselves in the best physical and psychological shape as possible. Much like professional athletes care for their bodies year-round, so too must psychologists care for their psychological health and well being on an ongoing basis. We do it with our clients; we can do it for ourselves. Here are a few tried and true strategies (thanks to the ECP Group for their input!):

- Make and maintain professional connections. This includes formal and informal consultative relationships. The key is to have relationships that are conducive to openly discussing the unique features of our work.
- Use formal consultation for specific ethical and clinical dilemmas. This can be an ongoing consultation group, or periodic use of resources available through local, state and national organizations, such as CPA's ethics hotline, or APAIT's legal consultation services.
- Balance caseloads: try to balance work with more challenging, complex populations with those that are less demanding. This helps to limit vulnerability to vicarious traumatization and compassion fatigue. Recognize when you are beginning to feel overly taxed, and take steps to improve the balance in your workload.
- Work to maintain work/life balance: pursue opportunities to attend to your emotional and spiritual well-being regularly.
- Identify multiple layers of sources of support. The concept of a "professional buddy" is quite useful. This is someone you can pick up the phone and call for a short "debrief" or "check-in" and who can do the same for you. Have several of them!
- Take care of your body: Get enough sleep, watch your nutrition, get some exercise.
- Relax, and meditate.
- Take regular vacations. (my personal favorite)

CCPA offers many opportunities to increase connections with colleagues from our CE meetings, to social gatherings, to the newly developed Networking and Early Career groups. Want to learn more about professional self-care? Check out the CPA CLASP materials on the website: www.cpa.org (you do not have to be a CPA member to access this material). There are references, self-care tips, self-assessments, and articles about burnout, compassion fatigue, and vicarious trauma. APA also has information: www.apapracticecentral.org/ce/self-care/acca-promoting.aspx.

References:

Board of Professional Affairs' Advisory Committee on Colleague Assistance. (2000)
Professional Health and Well-being for Psychologists. Web Page. ◊

"The Efficacy of Psychodynamic Therapy"

By Jonathan Shedler

A Review and Comments by Bruce H. Feingold, Ph.D.

In the last twenty years the field of clinical psychology has hotly debated the nature of evidence-based treatment and which are the most effective psychotherapy models (Duncan, Miller, Wampold, and Hubble, 2010; Barlow, 2000). Cognitive- behavioral treatments and manual based therapies have had a tremendous influence on the practice of psychotherapy, and there has been less emphasis on psychodynamic practice. However, psychotherapy integration theory, especially the common factors model, offers a powerful alternative to evidence-based treatment and understanding the fundamental nature of effective psychotherapy. Jonathan Shedler's groundbreaking article, "The Efficacy of Psychodynamic Therapy," published in the *American Psychologist* in 2009, sheds light *both* on the effectiveness of psychodynamic therapy and common factors theory.

Shedler (2009) addresses the following questions:
1) What is the effectiveness of therapy in general and specifically, what is the effectiveness of psychodynamic therapy?
2) What are the distinctive features of psychodynamic therapy? and
3) How are the distinctive features of psychodynamic therapy related to the "common factors" of effective psychotherapy?

Shedler (2009) demonstrates, "Considerable research supports the efficacy and effectiveness of psychodynamic psychotherapy" (p. 98). Furthermore, he describes the key features of dynamic therapy as "common factors" in effective psychotherapy which I believe are worthy of our attention and thought.

The Effectiveness of Psychotherapy

Shedler (2009) reviews the outcome research on the effectiveness of psychotherapy. The first meta-analysis of psychotherapy outcome research by Smith, Glass and Miller (1980), a review of 475 studies, showed an "overall effect size (various diagnoses and treatments) of 0.85 for patients who received psychotherapy compared to untreated controls" (p. 100). An effect size of 1.0 means that treated patients are one standard deviation healthier than untreated controls; .8 is considered a large effect. The meta-analysis of psychotherapy research continue to replicate that psychotherapy is highly effective. As a point of reference Shedler (2009) points out that meta-studies on anti-depressants show an effect of about .3!

This is good news for psychologists: psychotherapy is a highly robust intervention. I imagine that most psychologists believe what I do: patients gain from their work with me; however, it is also important to validate that scientific research supports our subjective experience.

I believe that these results are important from the perspective of sitting in our offices with patients. Successful therapy depends on hope and begins with our conviction that we help patients meet challenges and discover how to live in a better way. There is probably no better way to start our work each day, for ourselves and our patients, than with optimism borne from *both* clinical experience and scientific research that therapy is effective because we may then convey a profound sense that we can be helpful.

The Effectiveness of Psychodynamic Therapy

One of the biggest controversies in our field is the relative effectiveness of psychodynamic versus cognitive-behavioral therapy. Shedler (2009) reviews meta studies on cognitive-behavioral therapies which show a robust "median effect size of 62." (p. 100). By comparison, how effective are dynamic psychotherapies? Shedler (2009) reviews a 2006 rigorous meta-analysis study of short term psychodynamic therapy (less than 40 sessions) which showed an effect size of .97 for general symptom improvement; hence, psychodynamic psychotherapy stacks up very well compared to cognitive-behavioral therapy. Also, interestingly, when patients were assessed nine months after treatment the effect size increased to 1.51. In other words, after psychodynamic treatment, patients continued to improve, a research finding not replicated in cognitive-behavioral treatments. Finally, two recent meta-analyses showed similar results for long term psychodynamic treatment

Shedler (2009) points out that psychodynamic practitioners and researchers have done a poor job demonstrating the effectiveness of dynamic therapies. Psychodynamic therapists were slow to embrace empiricism, and it is easier to research behavioral treatment strategies and manual driven treatments. However, if you know the psychotherapy outcome research and integration theory, you would not be surprised that dynamic therapies compare favorably to other treatments.

Psychotherapy Outcome Research, the Dodo Bird Verdict and Common Factors

Since the 1970's psychotherapy researchers have consistently found that, regardless of the claims of the superiority of one type of therapy over another, all forms of psychotherapy are successful for a wide variety of mental disorders (see the Heart and Soul of Change, Second Edition, Edited by Duncan et al, 2010, for a comprehensive summary of this research and the common factors perspective). This finding has been known as the "Dodo Bird" verdict since Luborsky, Singer, and Luborsky (1975), pioneers in the field, referenced the Dodo bird's proclamation in Alice in Wonderland, "Everybody has won, and all must have prizes," to explain that every school of psychotherapy demonstrated positive outcome results.

Some integration theorists (Duncan et. al, 2010) explain the "Dodo Bird" effect by advocating that there are common factors underlying different kinds of psychotherapy which are the core features of successful therapy. It is my contention that these common factors *potentially* link psychologists from different schools of therapy together, and given the challenges in the marketplace it is important we seek common ground.

Shedler (2009) describes the research that demonstrates that while psychotherapists attribute patient change to their theoretical orientation, research suggests that change mechanisms are often not what therapists think they are. Forinstance, current evidence *refutes* that the main mechanism of change in cognition therapy is shifts in cognition. Shedler (2009) references Kazdin's (2007) conclusion in a comprehensive review in the *American Psychologist*, "Perhaps we can state more confidently now than before that whatever may be the basis of change with CT, it does not seem to be the cognitions as originally proposed" (p. 103).

Furthermore, outcome therapy research has demonstrated that successful therapy correlates to four factors: therapeutic relationship (30%), extra therapeutic issues (40%), placebo (15%) and the specific psychotherapy technique (15%) (Duncan, et al. 2010). In other words, the therapeutic relationship is a better predictor of successful outcome than specific technique.

Like many integration theorists Shedler (2009) asserts that whatever form of therapy a therapist *says* he is practicing, successful outcome is highly related to a positive working alliance; he goes further to show that many core dynamic processes, such as exploring feelings (especially avoided ones), identifying recurrent intra and interpersonal themes, adopting a developmental focus and exploring the therapeutic relationship, underlie successful psychotherapy irrespective of one's putative orientation. In essence, Shedler proposes psychodynamic processes are common factors of successful therapy.

Distinctive Features of Contemporary Psychodynamic Therapy

Shedler (2009) summarizes Blagys and Hilsenroth's (2000) review of empirical studies of psychodynamic therapies, which were composed of actual sessions and transcripts. Using this study, Shedler proposes seven distinctive features of contemporary psychodynamic therapy. Examining this list helped me reflect upon what I *actually* do in psychotherapy. Whatever your specific orientation, I hope it will encourage you to consider which of these therapeutic approaches you draw upon in your daily practice.

Focusing on affect and expression of feelings

Dynamic therapists help patients explore feelings which they don't understand and encourage them to articulate affective experience. They particularly focus on conflictual, threatening feelings which are troubling and avoided. In this way dynamic therapists help people experience feelings which hold them back and lead them to discovering healthy but suppressed wishes and needs. I believe that for many patients understanding and expressing their feelings and conflicts is wonderfully therapeutic in itself. They understand who they are and what they truly desire in life. As opposed to *intellectual* insight, meaningful insight is an *emotional* experience.

Exploring the avoidance of distressing thoughts and feelings

Exploring avoidance, fear and anxiety is another principle of dynamic therapy. Dynamic therapists help people identify avoided feelings and thoughts, and by doing so, patients begin to realize, confront and integrate suppressed aspects of themselves.

Identifying recurring themes

Dynamic therapists help patients identify patterns of how they feel and think about themselves and how they relate to others. Whatever one's theoretical perspective, I believe all good therapists help patients focus on key patterns, which makes therapy coherent and comprehensible.

Discussing Past Experiences

Dynamic psychotherapy encourages patients to explore how early relationships affect their current sense of self and relationships to "help patients free themselves from the bonds of the past experience in order to live more fully in the present" (Shedler , 2009, p. 99). Self-exploration is not for its own sake but to gain greater awareness into current problems.

Focusing on interpersonal relations

Dynamic therapies focus on relationships, both current and past, and how problems with attachment and early relationships are woven into the fabric of the self. This is an important theoretical difference with cognitive-behavioral models. While both dynamic and cognitive models identity adaptive and non-adaptive ideas about the self and others, the dynamic model focuses on how early relationships and the self are intertwined.

Emphasizing the therapy relationship

Exploration of the relationship between the patient and therapist (transference) is one of the signature differences between dynamic therapy and other therapies. By examining the therapy relationship, a patient may experience powerful emotions in *the here-and-now* and understand how he or she repeats unsatisfying relational patterns. The goal of exploring the transference is to help patients expand their repertoire of interpersonal relationships for greater satisfaction and meaning.

Exploring wishes and fantasies

Unlike directive therapies, dynamic therapy encourages the exploration of wishes and fantasies which is based on the belief that "free association" may deepen the patient's self-understanding.

After reading Shedler's description of the core mechanisms of dynamic therapy, I appreciated his emphasis on the modernization of psychoanalytic therapy. First, Shedler's description of the dynamic theory relies more on attachment and relational theories, than on aggression and sexuality. Second, the therapeutic stance appears more interactional in comparison to the "silent" therapist of the olden days. Finally, Shedler stresses helping patients discover greater meaning and satisfaction in life, concluding that dynamic therapy, "may foster inner resources and capacities that allow richer, freer, and more rewarding lives" (p. 107). In this way, I believe dynamic theorists and practitioners heard the critique of humanistic psychology that analysis focused too much on psychopathology and symptom reduction and not enough on adaptivity and human growth.

Prototypical Dynamic and Cognitive-Behavioral Treatment Models

Shedler (2009) highlights the prototypical differences between dynamic therapy and cognitive-behavioral therapy, which is useful to reflect upon when considering your own approach. Dynamic therapy is unstructured and exploratory, focuses on feelings (especially warded off ones), examines the person's defenses and emphasizes the interconnection of current and past relationship, including exploring transference. In contrast, cognitive-behavioral therapy is more structured and stresses thoughts and behavior; the therapist is more didactic and advice-giving and pays less attention to the therapeutic relationship. Shedler references several studies which show that a positive working alliance and adherence to dynamic model predicted positive outcome and that *rigid and singular* adherence to a cognitive-behavioral model predicted *poor* outcome.

Clinical Example

To amplify some of the fundamental psychodynamic processes I have been discussing, consider a brief clinical anecdote from the treatment of an adolescent girl. She was referred due to conflict with her parents and behavioral acting out. She felt unworthy and experienced her parents as poorly attuned to her identity and autonomy. Her sense of self was poorly defined, she was non-assertive and compliant, and then she would act out. During treatment she had been exploring feelings of poor self-worth, becoming aware of her negative judgments about herself and understanding how her compliance led to negative behaviors.

One week she told me she needed to cancel her next session due a scheduling conflict, and I asked if she wanted to re-schedule; she said she did. However, I later received a call from her parent that she really hadn't wanted to re-schedule. During our next session I brought up her parent's phone call and suggested that maybe she had agreed (complied) with me but hadn't truly wanted to re-schedule. Upon my interpretation she laughed, and spontaneously, I laughed with her, as the transference interpretation brought an intra and interpersonal theme to her immediate

attention. This interaction was one of those small but significant moments of expanded awareness in therapy, when an individual experiences a truth about herself in the here-and-now.

Concluding Remarks

If you are dynamically oriented you may feel upbeat that there is empirical support for how you work. You might also consider Shedler's distinctive dynamic factors and reflect upon your own therapy practices. I have felt that under pressure from managed care and short term models many dynamic therapists have become more didactic and directive. For example, how much do you trust the therapeutic value of exploration compared to the use of directive methods of teaching and advice-giving? How much do you focus on the relationship as a learning experience and make transference interpretations?

I would remind all of us that research demonstrates that successful therapy depends on a positive therapeutic relationship and the working alliance. Patients are much more likely to incorporate new skills when we have a mutual, collaborative and trusting relationship. We are clinicians, not technicians. Techniques are *not something we do to a patient*; *therapy is something we do with a patient*. I believe (and research confirms) that successful therapists integrate the relationship factor, even if it is not explicitly addressed in their model. Finally, therapy is powerful not because patients intellectually understand their thoughts and beliefs (otherwise we could simply give patients a self-help manual); therapy is compelling when patients have a deep awareness of themselves, associated with strong emotional experiences.

Given the emphasis of managed care and insurance carriers more on medication and on short term fixes, I think it would be wiser for us to discuss the common factors of psychotherapy, which link us together, rather than fight among ourselves about the superiority of our model. Psychotherapy is a special kind of professional relationship because we use our clinical knowledge and skills within the crucible of a human relationship, and in a society which is increasingly less personal, relational psychotherapy can help our patients develop their integrity and humanity.

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