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BULLETIN

In This Issue

Integrative Psychotherapy
The Case of Rachel: An Integrative Psychotherapy for Panic Disorder

Psychotherapy Research
Beyond Dissemination and Translation: Practice-Based Participatory Research

Ethics In Psychotherapy
Complementary and Alternative Medicine for Psychotherapists: The Basics and Beyond

Diversity
Diversity, Outcome Measures, and Implementing Regulation C-24

Early Career
Reflections from Your New Division 29 Early Career Psychologist (ECP) Domain Representative: Opportunities for ECPs in Division 29 and Seeking Research Funding

2011 VOLUME 46 NO. 1

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CONTENTS

President's Column 2

Editor's Column 6

Integrative Psychotherapy 8
The Case of Rachel: An Integrative Psychotherapy for Panic Disorder

Psychotherapy Research 15
Beyond Dissemination and Translation: Practice-Based Participatory Research

Ethics In Psychotherapy 19
Complementary and Alternative Medicine for Psychotherapists: The Basics and Beyond

Diversity 30
Diversity, Outcome Measures, and Implementing Regulation C-24

Early Career 33
Reflections from Your New Division 29 Early Career Psychologist (ECP) Domain Representative: Opportunities for ECPs in Division 29 and Seeking Research Funding as an ECP

Washington Scene 38
Interdisciplinary "Health Psychology"

Candidate Statements 44

References 54

Membership Application 59

PRESIDENT'S COLUMN

Elizabeth Nutt Williams, Ph.D.
St. Mary's College of Maryland

It is an honor to begin my year as President of Division 29 and to write my first presidential column. The Division of Psychotherapy is an exciting, ground-breaking, and forward-thinking organization where those who have a passion for psychotherapy (practice, research, training, advocacy) can gather, exchange ideas, collect and disseminate cutting-edge research, and connect with one another. I am so humbled to be in a position to lead the Division for the coming year, and I do so with a full and grateful recognition that I do not do so alone. As such, I'd like to take a few paragraphs to acknowledge the many individuals who have and continue to contribute to the vibrancy of the Division.

First, I have learned so much being on the Board of Directors over the past seven years (first as the Early Career Representative, then as the Membership Domain Representative, and most recently as President-elect). In particular, I have learned what great leadership looks like up close from our recent Past Presidents: Linda Campbell (2004), Leon VandeCreek (2005), Abe Wolf (2006), Jean Carter (2007), Jeff Barnett (2008), Nadine Kaslow (2009), and Jeffrey Magnavita (2010). They are a spectacular group of individuals, all of whom made unique and lasting contributions to the Division. They are also wonderful mentors, who selflessly give of their time and provide invaluable institutional memory. I have benefited from their wisdom, and I hope to continue the tradition of encouraging newer professionals to be connected with the Division, to hone their leadership skills, and to step forward to serve. I very strongly urge those of you who are contemplating how to get started in the Division to contact me (libbynuttwilliams@comcast.com). I would love to hear from you and help connect you with the areas of the Division that inspire you most.

I also want to acknowledge our outgoing and incoming Board members and committee chairs, without whom we would not have the momentum in our Division that we currently enjoy. I am so thankful for having worked on the Board with Mike Constantino (out-going Early Career Rep [see Mike's article in the last Bulletin on the transition from early to mid-career]), Sheena Demery (out-going Student Representative, well on her way to transitioning from student to early career professional), Norine Johnson (outgoing Council Representative and past President of the American Psychological Association), and Nadine Kaslow (Past President and mentor to many in the Division). Their insight, integrity, diplomacy, and great humor will be missed. Luckily, we have wonderful new Board members who began their terms in January: Marv Goldfried (President-elect), John Norcross (Council Representative), Doug Wilson (Student Representative), and Susan Woodhouse (Early Career Domain Representative). With our continuing Board members (Norm Abeles, Rosie Adam-Terem, Miguel Gallardo, Annie Judge, Sarah Knox, Erica Lee, Jeffrey Magnavita, Caryn Rodgers, Steve Sobelman, and Jeff Younggren), plus our exceptional Office Administrator Tracey Martin, we have a great year to look forward to.

continued on page 3

We also have highly energetic Committee Chairs, including Jean Birbilis (Membership), Jim Fauth (Psychotherapy Research), Jairo Fuertes (Education and Training), Rod Goodyear (Continuing Education), Rachel Smook (Early Career), Barbara Thompson (Psychotherapy Practice), and Jeff Zimmerman (Finance). In particular, I want to thank Shane Davis (Program Chair) and Clara Hill (Fellows Chair), who began their jobs in the fall and will wrap up their important tasks early this year. I am grateful for the willingness of all our new chairs to jump right in with new projects and at our Board meeting in February.

Finally, I would like to thank the members of the Publications Board (Laura Brown, Ray DiGuiseppe, Beverly Greene, Andrew McAleavey, Jon Mohr, Bill Stiles), with particular thanks to past Chair Jean Carter and current Chair Jeff Barnett. There are a number of significant Pub Board issues before us. You will see a new look for the Journal (size, color, and title) along with our new Editor Mark Hilsenroth. We look forward to his guidance for our Journal and give thanks for the excellent leadership of our former Editor Charlie Gelso. I would also like to thank our outgoing Bulletin Editor, Jenny Cornish, and welcome incoming Editor Lavita Nadkarni. To me, it makes great sense to begin this first column with an acknowledgement of the *many* people who guide the success of our Division. After all, our divisional slogan is "Be Connected" … and, we are! I encourage us to connect in wider, deeper and more meaningful ways during the rest of the year.

One way that I encourage you to connect with the Division is through our programming at the American Psychological Association (APA) Convention—this year in Washington DC, August 4-7, 2011. My first presidential initiative was to create a program theme for Convention this year—"Psychotherapy's Role in Fostering Resilience." I will be hosting an invited symposium entitled "Psychotherapy, Resilience & Social Justice: Implications for Youth, Disaster Relief, Immigration, & Poverty" with Ray Hanbury, Caryn Rodgers, Laura Smith and Oksana Yakushko as presenters. I am excited about our continued emphasis on social justice initiatives, our ability to focus on disaster relief (as the APA Convention comes just a month prior to the 10-year remembrance of 9-11), and our convergence with APA President Melba Vasquez's presidential priority on immigration. We also have an excellent array of symposia and posters scheduled, and I highly encourage you to go to all of them. I also want to highlight our Awards Ceremony, Social Hour, and our Lunch with the Masters for Graduate Students and Early Career Professionals (now in its fifth year). We will announce the complete schedule of events in a future Bulletin when we have confirmation from APA about times and locations, but please do start thinking about attending the Convention and putting these activities on your schedule.

What else is planned in 2011? Quite a bit, actually. In addition to creating a theme for our Convention this year, one of my other presidential initiatives will be to ask the Division to engage in strategic planning. It has been my experience that, while we have a wonderful mission statement in our bylaws (see below), unbelievably visionary initiatives (such as our new $20,000 Norine Johnson Research Award), and a large and psychotherapy-dedicated membership, we could benefit from re-examining and refocusing on our long-range goals and on our ability to fully explain our purpose (to the public, to our members, to our-

continued on page 4

selves). I would like to see us clarify and codify some of our planning. While each new president brings new initiatives, there is also a long-term consistency to our existence as a Division. As we are launching important initiatives in promotion of diversity, in support of research, in pursuit of social justice, I would like us to do so with an eye to the future and with clarity of purpose. To begin this process, I have asked Dr. Tom Botzman to provide a workshop for the Board on the nuts and bolts of strategic planning. Dr. Botzman holds a PhD in business administration and Master of Arts in economics from Kent State University. He has been a frequent presenter to the American Council on Education Fellows Program, the Office of Women in Higher Education's National Leadership Forum, and the North American Economics and Finance Association. At our Board meeting in February, we will launch a year-long process of strategic planning so that as we move forward into the future with advocacy, member support, and promotion of psychotherapy research, practice, and education in the public interest, we do so as a coordinated effort.

Relatedly, my third initiative is taking an eye to the past. While I want us to be connected in the present and look forward with strategic vision to the future, I also think it is valuable to understand and honor the past. Thus, I will be forming a task force to gather archival information about our division and recommend ways to best sort, store, and make the information available to our members. I would like the task force to consider whether we should create a follow up to Mathilda B. Canter's (1993) "A History of the Division of Psychotherapy." I will also ask them to consider ways we might put more historical/archival information on our website and find other ways (in the world of social networking) to help our history inform our present and our future. I am excited to see what recommendations come from the task force.

In addition to these three new initiatives, I am thrilled to continue the work of those who came before me. For example, we will continue to advertise and recruit applications for our research awards: the Charles Gelso Psychotherapy Research Grant and the new Norine Johnson Psychotherapy Research Grant for studies of the psychologist psychotherapist. Our unprecedented support for psychotherapy research dovetails nicely with our abiding connections with The Society of Clinical Psychology (APA Division 12), The Society of Counseling Psychology (APA Division 17), and the Society for Psychotherapy Research (SPR). We will continue to emphasize the importance of diversity and international perspectives in all that we do. We will continue to fine-tune our cyber presence and offer unique electronic experiences to our members, such as the new *Psychotherapists Face-to-Face* Video Series launched by Jeffrey Magnavita.

Further, we will continue to foster connections with other practice divisions in APA. For example, Miguel Gallardo has been working on the Multicultural Toolkit, a cross-divisional project with APA's Division 42 (Psychologists in Independent Practice), to assist practitioners in developing more successful, culturally diverse practices. And we will continue to collaborate with other divisions on current and controversial topics and dilemmas, such as focusing on telepsychology and training issues in doctoral psychology.

I am excited for this year and for the momentum we are experiencing in Division 29. I think there is much we can accom-

continued on page 5

plish and many new and creative projects we have yet to discover. To borrow a phrase from President Barack Obama's January 2011 State of the Union address, I ask Division 29 members "Is this our Sputnik moment?" Yes, there is a lot to accomplish, but we have a team of highly energetic and passionate people who love psychotherapy and who work diligently for our Division. But more – more people, more diverse perspectives, more as-yet-undiscovered ideas – is needed. So, in addition to all the tasks I outlined above, I'd like to, in the spirit of the President's challenge to the nation, offer a challenge to all Division 29 members – get involved in the Division. Contact me or a member of the governance, join a committee (see the contact information for our committee chairs on page 2 of this issue of the Bulletin), offer to write an article for the Bulletin, join us in DC at Division 29 activities. Before our Convention in August, do one thing related to the Division that is new, that moves you, and that helps you be connected. I'll look forward to seeing you at Convention—you can tell me about your "one thing" and who you connected with. Thanks in advance for taking the challenge!

Bylaws, Article I: B
"mission statement"

The Division of Psychotherapy is an educational and scientific institution, the purposes of which shall be to foster collegial relations among its members who are individuals interested in psychotherapy, to stimulate the exchange of scientific and technical information about psychotherapy theory, research, practice and training, to encourage the evaluation ad development of the practice of psychotherapy as a psychological art and science, to educate the public regarding psychotherapy and the services of psychologists who are psychotherapists, and to promote the general objectives of the American Psychological Association.

The Psychotherapy Bulletin is Going Green:

Click on
www.divisionofpsychotherapy.org/members/gogreen/

EDITOR'S COLUMN

Lavita Nadkarni, Ph.D.
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As I begin my term as Editor of the *Psychotherapy Bulletin*, I would like to publicly thank Dr. Jennifer Cornish, who ably served as the Editor for the past three years, for her wisdom, grace and collegiality. She, along with her predecessors, shaped the *Bulletin* so that it achieved the mission and goals of the Division 29 members. Furthermore, their vision for the *Bulletin* fostered a sense of community for those of us who promote and practice psychotherapy, and gave voice to a stimulating dialogue.

It is with great enthusiasm, humility and honor that I embark on this journey with you all. My vision for the *Bulletin* is to offer Division 29 members informative and thought provoking articles. While we are promoting GoGreen (our online version of the *Bulletin)*, the articles will hopefully capture your attention and be useful for you as you conduct your psychotherapy practice. The vision for the *Bulletin* is to foster community and collegial relations among members of the APA who are interested in the practice, teaching, and research of psychotherapy and to provide a forum for the exchange of information about psychotherapy. Toward this end, the *Bulletin* serves to inform Division 29 members about psychotherapy, but is also informed by its members.

Your contributions are always welcome. In addition to relying on our talented contributing editors and domain representatives, all members are encouraged to submit work that you believe would provide interesting, scholarly, timely and useful information to the membership. The 2011 Contributing editors and Domain representatives are as follows: Erica Lee and Caryn Rogers (Diversity), Susan Woodhouse and Rachel Galliard Smook (Early Career), Jairo Fuertes and Sarah Knox (Education & Training), Jean Birbilis and Annie Judge (Membership), Miguel Gallardo and Barbara Thompson (Professional Practice), Norman Abeles and James Fauth (Psychotherapy Research, Science, and Scholarship), George Stricker (Psychotherapy Integration), Rosemary Adam-Terem (Public Interest and Social Justice), Doug Wilson (Student Features) and Patrick DeLeon (Washington Scene). Thank you to all of the contributing editors and domain representatives; well deserved praise and gratitude go to Tracey Martin, who has guided me through this first issue, and to Jessica del Rosario, a talented doctoral student at the University of Denver's Graduate School of Professional Psychology and my Editorial Assistant.

In this issue, another first is Elizabeth Nutt Williams' first column as Division 29 President. Her article welcomes you to her presidency with open arms and hope for the future. There is an informative and engaging case study written by Barry Wolfe on the treatment of panic from an integrative psychotherapy framework. James Fauth and George Tremblay have provided a compelling argument for practice-based participatory research. In expanding our knowledge of complementary and alternative medicine, Allison Shale and Jeffrey Barnett provide us with ways in which we

continued on page 7

can accentuate our psychotherapy practice. Jean Birbilis asks us to examine Implementing Regulation C-24 and consider its impact on diverse clients. Another first for this issue is Susan Woodhouse's article as newly elected Early Career domain representative. Finally, with pleasure, are Pat DeLeon's insights in the Washington Scene (and from Puerto Rico).

Please consider adding your voice to the *Bulletin* by contacting me at:

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The Case of Rachel: An Integrative Psychotherapy for Panic Disorder

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In a previous article in this journal, I briefly described an integrative etiological and treatment model of anxiety disorders (Wolfe, 2006). The etiological model hypothesizes that anxiety disorders are based in specific "self wounds." Self-wounds may be directly experienced as a damaged sense of self, or known conceptually as negative beliefs and propositions about the self. These painful self-views may be specific memories that a person has experienced with a significant other or may represent a generalized self-view constructed out of a series of such painful experiences.

Self-wounds result from the interaction of damaging life experiences and the cognitive and emotional strategies designed to protect individuals from their feared catastrophes. These strategies, however, keep the person from facing his or her fears and self wounds head-on. The contexts in which self-wounds develop usually entail some existential dilemma that is unbearably painful to face. The self-wounds and the contexts in which they develop make it extremely difficult for individuals to confront similar existential dilemmas in the future. These existential dilemmas involve unavoidable human experiences that are experienced initially as feared catastrophes inferred from the direct experience of anxiety. The precise nature of the dilemma becomes clear when an individual directly confronts his or her self-wound.

The Existential Dilemmas. One patient suffering from panic disorder, for example, discovered through a focusing technique that his panic symptoms were rooted in his terror associated with growing old. Employing the same technique, a patient suffering from obsessive-compulsive disorder discovered that he lived in terror lest his intrusive violent thoughts would result in causing harm to a loved one. Another patient's public speaking phobia was traced to the individual's inability to tolerate humiliation and failure. Yet, it is an unavoidable reality that we all grow old, hurt the ones we love, fail and humiliate ourselves sometime in our lives. In addition to the above-mentioned fears, the overwhelming existential dilemmas have included:

- Difficulty in accepting one's mortality.
- Difficulty in accepting the inevitability of loss.
- Difficulty in accepting personal responsibility for one's thoughts, feelings and actions.
- Difficulty in tolerating painful affects.
- Difficulty in "facing the void" when one's life plan is destroyed.
- The fear of committing one's life to another human being.(See Wolfe, 2008 for a fuller list).

The integrative psychotherapy for anxiety disorders, most simply put, combines a symptom-focused treatment with later effort to identify and modify the behavioral, cognitive, and emotional strategies that prevent the patient from

continued on page 9

confronting their specific self wounds and associated existential dilemmas. The final step in the treatment is a supportive and process-directive experiential therapy that helps patients to face, process, and ultimately heal their self-wound and solve their existential crisis. The following brief case description involves a young woman who was eventually able to identify and resolve a series of existential crises that were the triggering conflicts in the development of her panic disorder.

The Case of Rachel

Rachel was a 30 year-old woman who initially presented with frequent panic attacks, generalized anxiety, and symptoms of depression. The panic attacks typically began with tightness in her chest, which she imagined was a heart attack. She also felt funny sensations in her head, which made her think she was mentally ill. Subsequent to these initial panic attacks, every uncomfortable bodily sensation made her think she was having a nervous breakdown. She has been married to her husband, Glen, for five years. He works odd hours at his family's seafood business. The two appear to be good friends but have an unsatisfactory sexual relationship. He is troubled by moderate-to-severe premature ejaculation and, partly because of this, she has rarely had a good sexual experience. More broadly her growing dissatisfaction with her husband is based on his inability to be empathically attuned to her feelings for more than the briefest span of time. They have two children, a four year-old boy and a two-year old daughter who was born with a bi-lateral cleft lip and a cleft palate. The daughter's cleft palate and lip possessed major significance for our therapy in two different ways. The first was its impact on building the therapeutic alliance. I also was born with a cleft palate and lip and when Rachel saw me for the first time, she realized this about me. This gave her the impression that our meeting and working together was fated and therefore an excellent omen. Secondly, the strength she showed in processing the shock of her daughter's unexpected birth defect and in her subsequent parenting of this child revealed reservoirs of inner strength that belied her experience and concept of self as a fragile little girl about to shatter into pieces. The disparity between her self-image and her actual capabilities became a major theme of the depth-oriented phase of our therapeutic work.

The Symptom Reduction Phase of Therapy

The symptom reduction phase of the integrative therapy included building the therapeutic alliance and employing a modified CBT for anxiety management.

I. Building the alliance: This was easily achieved for three reasons. First, during our initial phone contact, I was able to talk her down from a panic attack. The second reason was that I shared the same birth defect as her daughter. Finally, a rapidly appearing father transference, catalyzed by the fact that I am about her father's age and bear some physical resemblance to him, appeared to make it easy to be open with me about her most tender concerns. Once it was clear that she trusted that I had her best interest at heart, we moved to the second phase of treatment.

II. Managing the anxiety symptoms: I taught Rachel Diaphragmatic Breathing which she found very useful. I next supplied some psycho-education about the nature and course of panic attacks followed by a focus on her catastrophic thinking. Every uncomfortable or unknown bodily sensation was a sign that she was having a "nervous breakdown" and that she was suffering from a seri-

continued on page 10

ous mental illness. Whenever she "cogitated" about the meaning of these bodily sensations, her cogitations quickly turned into catastrophic fears. She began substituting the breathing work for the catastrophic thinking. Every time she had an uncomfortable bodily sensation, she would begin doing the diaphragmatic breathing and remind herself that she is not "going crazy." After three months, the frequency of panic attacks had been significantly reduced.

The Depth Oriented Phase of Therapy

Now that she had some tools for reducing the anxiety when it occurred, we agreed to work on the underlying determinants of her anxiety. The first step in this phase of the therapy is to elicit the self wound(s).

III. Eliciting the self-wounds: To elicit the underlying determinants of an anxiety disorder, I usually begin with a focusing technique that was described in my previous article in this journal (See Wolfe, 2006, pp 33-34). An intense focus on the location of the feared bodily sensations has proven to be an efficient means for eliciting painful feelings associated with the patient's experience and concept of self. If progress is made with focusing, it serves as a gateway for other productive imagery-based and experiential therapeutic techniques. Focusing initially revealed that Rachel had been warding off intense painful feelings about her disappointments with her father, her doubts about her ability as a mother, her guilt over not being a good-enough daughter, particularly in relationship to her mother, and her growing disappointment with her husband. In another session, focusing brought up painful feelings of sadness about her daughter's birth defects. For the first time, she had emotionally accepted that her daughter in fact possessed these defects that will require multiple surgeries over the next 15 years to correct. These emotional realities were extremely difficult for Rachel to allow herself to experience and process. But the core self-wound was her view of herself as fragile and that she would shatter if she allowed herself to experience the full range of her emotional pain.

IV. Healing the self-wounds: Rachel's relationship with her father was a major focus of our work during the first year of therapy. Her father is an alcoholic who constantly disappointed her. The only time she received attention from him was when she was sick or anxious. At an implicit level, Rachel had developed an intense identification with her father. As she once put it, "If he is damaged, how can I be whole?" When he went into detox once again, she experienced an increase in her anxiety, a return of the panic attacks, and a return as well to her cogitating the anxiety into a catastrophic fear. At the same time, she single-handedly arranged an intervention in which her mother and sister joined her to convince her father to go into detox. This experience helped make explicit for her the conflict between her self-image as a fragile little girl and her actual strength that she employed in her life on a daily basis.

Because the focusing proved useful, Rachel was amenable to trying some Empty Chair work with her father. During the first Empty Chair session, she expressed her hurt that he had not really tried to get to know her. She tearfully told him in several different ways that she was *worth* knowing. Rachel felt very good after the Empty Chair work despite her initial fear of it. In a second Empty Chair session, she was able to tell him that she was strong enough and capable enough to carry on even though she did not get what she needed from

continued on page 11

him. This initiated a lengthy process of her sorting out her feelings and differentiating her authentic feelings from those that she had internalized from her father. Both the focusing work and the empty chair work convinced her that her anxiety was not about her fear of becoming mentally ill, but rather was more about her efforts to fight off painful feelings. In yet another Empty Chair session, she expressed her long denied anger at her father. She also shared her realization that she no longer needs what he was unable to give her when she was a child—love and attention. But when she confronted the possibility of letting go of her hope that one day he will love her and make a serious attempt to get to know her, she became panicky, afraid that letting go will somehow damage her father and leave the responsibility for her life totally in her hands. In the next session, what was initially suggested by her imagery work a few sessions ago now became very clear—that she held two contradictory views of the self simultaneously, the old fragile self and the new more competent solid self. When I challenged the fragile self with numerous examples of her competency (particularly as a mother), she was surprised by the realization that she had been functioning as a competent adult.

As the imagery work continued, Rachel became more adept in letting in the pain of external events, such as dealing with the reactions, inanities, and shocked facial expressions of children and adults when they first encountered her daughter's birth defect. Over time, Rachel's access to her emotions—positive and negative—improved substantially. By the end of the first year of therapy, she was clearly experiencing herself as separate from her father. She had also come to the realization that his problems and deficiencies were not hers. The more she was able to recognize and accept her separate existence from her father, the more she could tolerate the everyday stresses of her life. In one imagery-based session, I had her imagine that her "adult" self had taken the "little girl Rachel" under her wing and that she was soothing her younger self. In a later consolidating session, focusing produced the following painful realizations: (1) she is ashamed of being her alcoholic father's daughter; (2) she is having great difficulty accepting the reality of her father's illness; (3) she had drawn the improper conclusion that his personal deficiencies necessarily made her a damaged person; and (4) that her playing the damaged little girl role was an ineffective way of trying to get his attention. These themes were explored in subsequent sessions during which I kept challenging her sense of fragility. As she began to let go of her sense of self as fragile, she began to experience intense grief over the loss of her hope that her father would one day love and care for the little girl inside her. This led to her being able to set limits with her father. For example, she made it very clear to him that he would need to call before dropping in on her because she was no longer comfortable with his showing up anytime he wants. This act was a significant part of the separation and individuating process. Once she had set those limits, she began to feel stronger and more self-accepting. The final Empty Chair session with her dad culminated in her expressing the apt metaphor "I just moved out of my parent's house and into my own."

Experiencing a core conflict: Her father had broken her heart and she never wanted that to happen again. This puts her in a "damned-if-you-do, damned if-you-don't" conflict. She wants to be close to men, but becomes terrified when she sees herself doing so.

continued on page 12

When she turned 33, she said she felt more like an adult than she ever had before. She now knew at a deep level that she was responsible for her own behavior. Over the course of the next six months, as she allowed in more feelings and more painful realizations, it became clear that she was no longer in love with her husband, if in fact she ever was. After constructing so many scenarios by which they might improve their relationship, (e.g., convincing her husband to go into individual therapy), she finally realized she did not want to stay married to him indefinitely. One session she arrived very anxious with chest pains and difficulty breathing. She knew these feelings were related to her problems with her husband because he would not talk to her about his feelings and did not know how to listen to hers. Although these feelings were very difficult for Rachel to let in, it became increasingly clear to her that she wanted to end the marriage. This provoked some grief as well as relief that she no longer had to play the old role as wife, but she also grieved the loss of the illusion of her marriage and her role in it. The marriage had provided her with financial security and physical safety. This period led to a deep exploration of how she really felt about her life, and her marriage. She was also very frightened about the impact of the split on her two children. She got a job and for the first time since she had been married brought in some income. Ironically, her husband improved in his empathic ability and in his acceptance of her as she is. But this was too little too late. At one point, *she half-facetiously wished for her panic attacks back*, rather than having to face the reality of her feelings. A further phase of processing her feelings about the marriage ending involved her being clear the marriage was over, but very fearful of making a mistake and about what the future will hold for her financially and romantically. Once she told her husband she wanted out, she had to deal with his reactions. And by and large, they were not pleasant. Toward the end of our therapy, she faced one more challenge—having to help her daughter through two surgeries within three months. Her husband was not available to help, therefore the responsibility was solely on her shoulders to care for her convalescing daughter. During this period, she defined herself for the first time as tough rather than fragile.

The Process of Change

Change for Rachel as it is for most patients followed an oscillative pattern. Even as she made gains, she often reverted to her old pattern of dealing with stress. In a later session, for example, she became very panicky and was catastrophizing very frequently.

Focusing brought up an ocean of tears about her daughter's cleft palate and lip, her fear of failing as a mother, and her feeling the weight of responsibility as the primary parent for both of her children. Throughout the duration of the first two years of therapy, Rachel would move in and out of the "wounded bird" state of mind, particularly during times of increased stress. This state of mind was basically a cognitive-emotional retreat from the painful reality of her feelings. By the beginning of our third year of therapy, she was feeling more and more like an adult woman who could accept imperfections in her life, self, and other people. The fragile self-image had mostly disappeared. Our work on allowing and accepting feelings without judging them on the one hand, or acting them out on the other increased the rapidity with which she could access her authentic feelings. By now, she is doing a better job of quickly recognizing the psychological underpinnings of her somatic sensations.

continued on page 13

The Therapeutic relationship
Although we maintained a good working alliance, she had difficulty throughout the first two years accepting how she felt about me, how much she had let me in, and that I was the only man she had ever completely trusted. Her feelings for me were never erotic, but the issue of trusting me was even more challenging for her. Initially, I was a father figure, but later more of a trusted confidant. She was happy about my support but sad that her father could never give her the same kind of support and affirmation. We had one therapeutic rupture, which related to my response to her husband's comment during an argument that they were having. She felt I was taking his side and not really understanding her dilemma. This briefly led her to doubt my caring for her. During the next session, I reprised his remark and its effect on her trust in me. She eventually was able to feel the support behind my comment and was able to regain her trust in me.

Outcome
At termination, Rachel was free of panic attacks and had made significant progress in healing her core self wound. She no longer viewed herself as fragile and possessed a greater recognition of her capacities and her strengths. She also had achieved a much greater tolerance for painful affects. She is currently navigating a rough transition as her marriage comes to an end. She is anxious about what the final divorce settlement will look like, about her future financial situation, about the impact of the pending divorce on her children, and about what she can expect by way of co-parenting from her husband. This anxiety seems to possess more of a base in reality and she rarely reverts to misinterpreting her bodily sensations and to catastrophic cogitating about her mental health.

Summary
This integrative psychotherapy combined a symptom-focus phase that helped Rachel develop some control over her anxiety and panic with a depth-oriented phase in which her core self-wound was elicited and to a significant extent healed. Most simply put, her wound had convinced her that she did not have the inner resources to cope with either her authentic feelings or with external reality. Because of her identification with her father as a damaged personality, she experienced and thought of herself as a fragile being who would shatter in response to any life difficulty. This self-percept and concept has shattered instead.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

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Beyond Dissemination and Translation: Practice-Based Participatory Research

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Dissemination and translation don't work

Efforts to enhance the responsiveness of routine clinical practice to scientific evidence—or, less often, vice versa—have foundered repeatedly on the assumption that practitioners would absorb and enact the findings from clinical trials. From traditional mental health treatment contexts such as private practice and community mental health to emerging practice areas such as integrated primary care, the traditional strategies for improving practice via research—dissemination, diffusion, and translation of randomized clinical trial evidence—have failed to appreciably shift practice (Institute of Medicine [IOM], 2006).

We argue that it is the dominant practice change strategies—not the practitioners - that are deficient. As depicted in Table 1, the traditional strategy for informing practice through research has been the dissemination of research findings via journal articles and guidelines. The scientific community's contemporary strategy (e.g., translation) takes better account of the complexities inherent in effectively incorporating evidence-based models in standard settings of care, including the need to develop more systematic methods for adopting and tailoring evidence-based models in local treatment contexts. Though the contemporary translation strategy clearly represents a step in the right direction, and may well lead to increased sophistication about the critical ingredients of evidence-based practice change, early returns suggest that successful translation of evidence based models in standard settings of care will continue to prove elusive.

Table1. Evolving Science – Practice Relationship

Scientific Stance	Practice Change Strategy
Traditional We know best, do as we say	Science → Practice: Dissemination (Articles, Guidelines)
Current We still know best, but get that it is hard—we'll show you how	Science → Practice: Translation (Demonstration Projects)
Future What do you need to learn, and how can we help?	Science → Practice: Translation, Formative Evaluation, Faciliation; Practice-Based Participatory Research

Dissemination and translation fail to offer a compelling invitation to learn

The traditional and contemporary strategies fall short in 1) over-relying on evidence that is neither credible nor compelling in the eyes of the practice community and 2) offering the practice community primarily a one-down position in the science-practice relationship. In terms of the former, the evidence underlying the evidence-based models comes largely from randomized clinical trials (RCTs). Certainly, the RCT is a powerful methodology for determining

continued on page 16

the efficacy of new and promising treatments under relatively ideal conditions in which the target population, assignment to treatment conditions, provision of treatment, and the treatment environment are controlled (Essock, Drake, Frank, & McGuire, 2003; Schwartz, Trask, Shanmugham, & Townsend, 2004). Legitimate quibbles about the extent to which key RCT assumptions are violated in the context of "socially complex services"(Wolff, 2000, p. 100) notwithstanding, the RCT has justifiably become the gold standard in determining the potential of new treatments.

Unfortunately, the findings and methods of RCTs have limited bearing on typical practice contexts. While it is true that RCTs have been tremendously beneficial in identifying a few treatment models that appear to be ineffective or downright dangerous, for most clinical conditions of interest they have revealed equal efficacy between bona fide models and the primacy of common factors - hardly compelling reason to shift from one's preferred treatment modality (Beutler, 2009; Wampold, 2001). As a result, the literature is replete with knowledge about efficacious models of treatment, but lacking in procedural knowledge about how psychotherapy practice can or should be improved in local clinical environments (Institute of Medicine, 2006; Schwartz et al., 2004).

Even if the evidence were more compelling, dissemination and translation would still fall short. Indeed, when practitioners can neither recognize their clinical reality (their patients, settings, resources, constraints) in the research context, nor feasibly mimic the protocols of the RCT, it's simply not clear what they stand to learn from the results. For instance, in RCTs, the allocation of treatment tends to be governed by relatively narrow, rigorously assessed inclusion criteria. In naturalistic settings, however, practice systems must make decisions about the allocation of care under conditions of uncertainty, and are hard pressed to justify limiting specific forms of psychotherapy to narrowly defined patient groups, or training a constantly shifting workforce to competently deliver them (Coyne, Thompson, Klinkman, & Nease, 2002; Pincus, 2003; Essock et al., 2003; Korsen, Scott, Dietrich, & Oxman, 2003). It should come as no surprise that the dissemination of RCT evidence has often failed to shift practice, because the design was never intended to directly answer the questions critical to improving psychotherapy in settings of usual care.

Even more insidious has been the top-down, pejorative stance inherent in the scientific community's traditional and contemporary practice change strategies, and the resulting unfortunate dynamic that has set up with the practice community. As these strategies have failed, both sides have predictably blamed each other, with the practice community being labeled as unscientific and resistant to change, and the scientific community tagged as clinically naïve and out of touch. It is hard to imagine the idealized scientist-practitioner integration ever coming to pass without an approach that offers a more positive relational framework for both.

A way forward: Practice-Based Participatory Research

Rather than continue to lament the imperviousness of practice to the evidence collected by researchers, we propose a new strategy—Practice-Based Participatory Research (PBPR)—that directly engages practice stakeholders as partners in generating and using data that rests on the scholarly literature *and* is directly relevant to improving their work. What distinguishes PBPR is a focus on cultivating a learning orientation in routine clinical set-

continued on page 17

tings (rather than the adoption of an a priori evidence based model), and taking an open and curious (rather than pejorative) stance toward practice-based departures from evidence-based models (Litaker, Tomolo, Liberatore, Stange, & Aron, 2006). The essential elements of PBPR, described in greater detail below, are eliciting, following, and refining practitioners' learning priorities; collecting data about those priorities; feeding the resulting data back to the practitioners for interpretation and incorporation into quality improvement (QI) plans; and evaluating the outcome of the resulting QI initiatives.

PBPR is strongly influenced by research and theory on experiential learning and intuitive expertise, which tells us that the essential ingredients of a learning system are a motivated learner, engaging in deliberative practice, under conditions of high validity (i.e., with corrective feedback; Kahneman & Klein, 2009). PBPR offers a partial antidote to the uncertainty that surrounds so many decisions in naturalistic settings. By reducing ambiguity where it presents the greatest threat to effective practice, PBPR empowers practitioners and enhances their desire to learn. In PBPR, the engagement and expertise of practice stakeholders is cultivated and incorporated from the outset, thereby ensuring the relevance of the resulting data to their work. The credibility of the evidence is a critical factor in the degree to which it will get utilized; hence the focus in PBPR is on engaging stakeholders in the development of the evaluation plan and answering high leverage practice-based questions (Stetler et al., 2006).

Table 2. PBPR Phases

PLANNING PHASE
- Create Learning Context
- Identify Information Gaps
- Develop pilot evaluation plan

PILOT PHASE
- Assess feasibility
- Improve discovery plan

DISCOVERY PHASE
- Address Information Gaps
- Identify QI opportunities

QUALITY IMPROVEMENT PHASE
- Address QI opportunities
- Evaluate QI intervention

The core PBPR strategy is the facilitated utilization of formative evidence by implementation teams

In PBPR, external facilitation, feedback and utilization of formative evaluation, and development of implementation teams form a synergistic strategy for evidence-based practice improvement. The primary responsibility of the researcher in PBPR is *external facilitation,* which has been described as a "deliberate and valued process of interactive problem solving and support" (Stetler et al., 2006). This definition captures the ongoing, dialectic negotiation of competing needs that is central to successful science-practice partnerships: support/challenge; relationship/tasks; science/practice. While *formative evaluation* can be adapted to suit a wide range of evaluation goals, whatever its form, the central purpose is always to inform and improve performance within the local evaluation context. The *feedback, utilization, and incorporation of formative evidence* has proven to be a powerful driver of individual and system change in a number of disciplines and settings (L. S. Fuchs & D. Fuchs, 1986; Grimshaw et al., 2006; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). For instance, providing formative feedback about patient progress to therapists reliably increases the effectiveness and cost-effectiveness of psychotherapy, with effect sizes superior to those typically produced by more

continued on page 18

expensive practice improvements efforts (e.g., training in an evidence-based model) (Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009; Lambert, 2003). In PBPR, *implementation teams* are the primary internal conduit for practice improvement. Implementation teams include representation from key clinical stakeholders (e.g., patients, providers, administrators, staff), clinical champions, formal and informal leaders, and others with skills or expertise critical to the success of the project. Implementation teams, with ongoing consultation from the external facilitators, maintain the priority of the project, maintain effective external and internal communication, proactively seek and solve problems, utilize formative evidence, and develop and implement quality improvement plans. Recent research highlights the critical importance of implementation teams in the complex process of successfully establishing new programs in practice contexts (Fixsen et al., 2005).

Learning unfolds systematically within PBPR

PBPR unfolds systematically across four phases (Planning, Pilot, Discovery, and Quality improvement (QI) designed to achieve nine objectives. During the Planning Phase, the first priority is to establish a positive learning environment by seeking practice contexts ripe for change and engaging with key stakeholders from the inception and throughout the project. Next, the practice models (treatment as usual) and evidence-based models are juxtaposed to reveal "high leverage" information gaps using a method known as diagnostic evaluation (Curran, Mukherjee, Allee, & Owen, 2008). The Planning phase closes with the identification and prioritization of these information gaps, and the development of a pilot evaluation plan. In the Pilot phase, the pilot plan is implemented, feasibility is assessed, and the plan is improved. The Discovery phase commences with implementation of the improved evaluation plan. Following formative data collection, the second part of the Discovery phase entails initiating a data-informed, stakeholder-driven QI planning framework (Catalyst Community, 2007; Imm et al., 2007; Helfrich, Li, Sharp, & Sales, 2009; "QUERI Implementation Guide," n.d.). This leads to the development of an explicit quality improvement plan, which is implemented and summatively evaluated in the QI phase.

In sum, PBPR engages practitioners in a learning context; invites stakeholders to perceive the ways in which their practices deviate from evidence-based models as high leverage learning opportunities; addresses this information vacuum with local evidence; facilitates utilization of that evidence to develop and implement stakeholder drive quality improvement initiatives (QI); and evaluates the summative impact and meaning of those changes. This type of learning cycle requires a set of resources (time, expertise) that is not readily available in most clinical settings. We believe that establishing clinical learning systems - the systematic and cyclical collection, feedback, and utilization of practice-based evidence - represents a particularly high-leverage, valued added science-practice partnership, and a promising next step in the evolving quest for evidence-informed practice.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

Complementary and Alternative Medicine for Psychotherapists: The Basics and Beyond

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Part I: CAM and Psychotherapy

What is CAM?

The field of Complementary and Alternative Medicine (CAM) is rapidly growing. According to the 2007 National Health Interview Survey (NHIS), sampling over 23,000 adults and over 9,000 children, approximately 38% of adults and 12% of children reported using at least one form of CAM (NCCAM, 2010f). The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as "a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine" (NCCAM, 2009b, para 2). While complementary and alternative medicine are often considered one field, they are actually two separate forms of treatment; complementary medicine is utilized in addition to traditional medicine while alternative medicine is utilized in place of it. The NCCAM is the leading organization that is conducting research on CAM and it has a three-part mission: 1) To "explore complementary and alternative healing practices in the context of rigorous science;" 2) Train complementary and alternative medicine researchers; and 3) "Disseminate authoritative information to the public and professionals" (NCCAM, 2010c, para 2).

Within CAM there are four subcategories by which the modalities are organized: Mind-Body Medicine, Biologically Based Practices, Energy Medicine, and Manipulative and Body Based Practices. Additionally, Whole Medical Systems are included as parts of CAM. Techniques such as meditation, prayer, music, and movement therapy fall under the heading of Mind-Body Medicine as they all aim to strengthen the mind in order to improve symptoms (NCCAM, 2009b). Whole Medical Systems are full systems of alternative medicine, such as Traditional Chinese Medicine, Naturopathy, Homeopathy, and Ayurveda. These systems have been in existence for thousands of years and are rooted in longstanding traditions and practices. Despite being complete systems, they incorporate a variety of techniques that fall into different categories of CAM. The Biologically Based Practices are what most people associate with *natural remedies*, including treatments such as dietary and herbal supplements. Energy Medicine includes Reiki and qi gong, both of which use the body's natural energy to heal. Lastly are the Manipulative and Body Based Practices, such as chiropractic techniques and massage, which work through manipulation or movement of the body (NCCAM, 2009b).

Why Do Psychotherapists Need to Know About CAM?

Some may wonder why knowledge of CAM is of any relevance to psychotherapists. But, with the use of CAM on the rise, it is becoming increasingly clear that psychotherapists should hold basic knowledge of these modalities because

continued on page 20

an increase in usage means that there is likely also an increase in the possibility that clients may request or report using various forms of CAM. Further, as responsible professionals, it is our job to be aware of treatments that our clients may be utilizing so that we can be prepared to adjust our treatment decisions accordingly or make referrals when necessary. Additionally, psychotherapists are in a position to provide suggestions for treatment and since there is a considerable amount of research documenting the effectiveness of a number of CAM modalities for a wide range of disorders and difficulties, it is important to recognize when to make a referral for one of these forms of treatment.

Further, having knowledge about CAM is not enough; it is recommended that each psychotherapist ask specifically about CAM use during the intake process with every new client, regardless of presenting problems or referral questions. This recommendation is supported by the findings in one recent study of 626 psychotherapy clients, in which 64% reported using at least one CAM modality; only 34% of these CAM users reported that they had disclosed this information to their psychotherapist (Elkins, Marcus, Rajab, & Durgam, 2005). Thus, with many psychotherapy clients utilizing various forms of CAM and only a small percentage of them likely to spontaneously disclose this information, it becomes each psychotherapist's responsibility to inquire about CAM use at the outset of treatment; being knowledgeable about widely used CAM modalities makes the process easier. Additionally, as research provides increasing support for the efficacy of various forms of CAM, psychotherapists may wish to incorporate some of these modalities into their ongoing work with clients. Further, psychotherapists may increasingly find clients specifically requesting CAM as part of or instead of traditional psychotherapy.

Ethical Considerations

With this knowledge and the increasing possibility of needing to incorporate aspects of CAM into practice, attention needs to be paid to specific ethical issues. While it is important to uphold the standards of the American Psychological Association's Ethics Code (2002), there are certain aspects of the Code that deserve specific attention; most importantly is competence. Because there are so many different areas within CAM, psychotherapists must be sure to only practice within the areas in which they have been appropriately trained. Standard 2.01, Boundaries of Competence, clearly states that psychologists may only practice in areas for which they are deemed competent "based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2002, p. 1066). Another aspect of the Code that merits attention is the need for cooperation with other professionals. With the possibility that a client is utilizing a form of CAM under the guidance of another practitioner, it may be helpful to work with other professionals "in order to serve…effectively and appropriately" (APA, 2002, p. 1065). But, without adequate competence in CAM (e.g., knowing the appropriate uses of a particular CAM modality, relative risks and benefits, training needed to provide it, etc.) one cannot carry out effective consultations with CAM practitioner colleagues for the client's benefit.

An additional, yet related issue is that of making appropriate CAM referrals. At times, clients will benefit from referrals to CAM practitioners. This may occur at the client's independent request or as a result of the psychotherapist's assessment of the client's ongoing treatment needs. To be able to ethically and appropriately make such referrals, psychotherapists will need knowledge

continued on page 21

about these CAM modalities as well as knowledge about relevant professional standards, training, and credentialing in each modality. Further, psychotherapists will need to be knowledgeable of community resources so that the best possible referrals can be made.

When working with CAM, it is also necessary to be aware of professional boundaries and the potential for inappropriate multiple relationships. Considering these factors, psychotherapists must assess if it is appropriate to serve as both a client's psychotherapist as well as their CAM treatment provider. There are certain CAM modalities that are conducive to this, such as integrating progressive muscle relaxation or aromatherapy into psychotherapy treatment. But, CAM modalities that involve more physical contact, such as massage therapy, will probably be viewed as less appropriate due to their likely impact on the psychotherapy relationship and process. Thus, it is important to always consider the client's comfort and well being in a situation and whether or not a secondary professional relationship would be harmful. Psychotherapists must be particularly cautious that taking on the role of CAM provider does not impact one's "objectivity, competence, or effectiveness in performing his or her functions" as the client's psychotherapist (APA, 2002, p. 1065).

Another area that is essential with regard to CAM is informed consent. While many think of informed consent as providing relevant information about the treatment to be provided, it also should address "alternative treatments that may be available" (APA, 2002, p. 1072). Thus, while many of the ethical standards reviewed here are related to clients who are currently using CAM, it is also important to be prepared to inform those who may not know that CAM treatments are available; the informed consent process is a valuable opportunity to provide information these alternatives and their relative risks and benefits.

The standards highlighted here are not meant to be a comprehensive list of the ethical obligations of psychotherapists working within the field of CAM but rather are intended to raise awareness of psychotherapists with regard to CAM. Other areas to consider include conflicts of interest, appropriate advertising and public statements, confidentiality, avoiding harm, as well as the General Principles that are seen as aspirational in nature.

Part II: Essential Information on CAM Modalities

What Basic Information about CAM Modalities Do Psychotherapists Need to Know?

As has been mentioned in Part I of this article, there exists a range of treatment modalities that fall under the heading of CAM. Below is information about some of the most popular and widely used modalities; this list is not meant to comprehensive in terms of all modalities in existence or in terms of the wealth of information available about each of them. Within each topic area, there is information regarding each modality's uses, integration into psychotherapy, appropriate training and referrals, as well as additional resources.

Aromatherapy

Aromatherapy is "the art and science of utilizing naturally extracted aromatic essences from plants to balance, harmonize and promote the health of body, mind and spirit" (National Association for Holistic Aromatherapy (NAHA), 2009, para 2). There are a variety of essences that can be used in aromatherapy and different oils are chosen for dif-

continued on page 22

ferent reasons. For instance, lavender is often associated with a calming sensation and is thus used to treat high blood pressure, agitated behavior, and pain management, among other things (Brooker, Snape, Johnson, & Ward, 2007; Hur et al., 2007; Louis & Kowalski, 2002). Aromatherapy has also been used to treat anxiety and low self-esteem.

Aromatherapy is an area that psychotherapists may choose to integrate into practice or refer out. Currently, there is not one standard method or form of certification in the United States for this treatment, and thus many people incorporate the use of aromatherapy under another professional license; it is important to be aware of specific state regulations as to what work can be done under a particular license. At this point, those interested in using aromatherapy can become a "Registered Aromatherapist" (RA). To become an RA, one must take the certification exam offered by the Aromatherapy Registration Council (ARC). Information regarding qualifications can be found at: http://www.aromatherapy-council.org/howtoapply.html. Additionally, some psychotherapists may be interested in taking courses about aromatherapy as opposed to becoming formally certified; there are also a variety of continuing education opportunities provided through ARC (ARC, 2009).

In terms of integrating aromatherapy into psychotherapy, it is particularly important to be aware of potential side effects and counterindications. While aromatherapy may not be used during a session, it is possible that clients will request using it in addition to their treatment. If you as the psychotherapist are not competent in this area, it is particularly important to be in contact with their aromatherapist, if the client allows that, to ensure that their use is being monitored and is not interacting negatively with other treatments they may be receiving. Additional resources can be found through the NAHA's website (http://www.naha.org/index.html). Also, Price and Price (1999) published a book titled *Aromatherapy for health professionals (2nd ed.)*, which psychotherapists may find valuable. Lastly, information regarding education and certification in aromatherapy can be found at http://www.naha.org/education.htm.

Hypnosis

Hypnosis is a process by which "one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behavior" (APA-Division 30, n.d., para 1). It is often used to treat ailments such as pain, fatigue, and anxiety and thus is a technique that psychotherapists may want to directly incorporate into practice. But, while there are a variety of professional organizations that support and promote hypnosis there is not currently one standard form of certification. The American Society of Clinical Hypnosis (ASCH) does offer certification on two levels: entry-level hypnotists are said to have obtained *certification* while those at the advanced level are labeled as *approved consultants* (ASCH, 2010a). To obtain either level, one must hold at least a master's degree in a health related field and must also be licensed in the state that they are practicing.

Despite offering these levels of training, the ASCH makes note that "certification does not automatically imply competence or guarantee the quality of a practitioner's work" (ASCH, 2010b, para 1). But rather, it indicates that they have an advanced degree, they are licensed, and that they have met the minimum guidelines laid out by the ASCH. Practitioners

continued on page 23

interested in obtaining training through the ASCH can find further information about these certifications at http://www.asch.net/Professionals/CertificationInformation/CertificationApplicationandRenewalForms/tabid/176/Default.aspx.

Progressive Muscle Relaxation

Progressive Muscle Relaxation (PMR) works to increase clients' ability to relax by learning to control muscle groups throughout the body (Hayden, 2008). It is often used to reduce stress, anxiety, and other signs of tension; these symptoms can be seen in many conditions, both medical and psychological, and thus it may appear beneficial for some psychotherapy clients as these symptoms can be found in a variety of illnesses.

PMR is a technique that often fits nicely into psychotherapy as the clinician can utilize a standard script in order to help the client through their initial PMR sessions. These sessions involve directing the client to systematically tense and relax various muscle groups; eventually they can use the technique on larger muscle areas and increase overall relaxation (Davis, Eshelman, & McKay, 2000). After assisting a client through the initial sessions, it may be helpful to provide them with an audio recording in order to allow them to utilize PMR outside of their sessions. There are a variety of books that provide relaxation scripts, one of which is titled, *30 Scripts for relaxation, imagery and inner healing, volume 2* (Lusk, 1993). Training in PMR is not standardized although a variety of health care professionals may have had PMR training incorporated into their formal education. Additionally, there are a variety of hospitals that provide courses on PMR. Further, there are numerous books and online resources that offer further education in the area (Breastcancer.org, 2008).

Reiki

Reiki is a state of meditation in which a trainer practitioner works to transfer energy from his own body to the body of a client. The practitioner holds specific hand positions over the clients body "until the practitioner feels that the flow of energy—experienced as sensations such as heat or tingling in the hands—has slowed or stopped" (NCCAM, 2010d, para 7). Reiki has been used to increase relaxation, reduce stress, as well as stress management; the overarching goal is to improve overall well-being (NCCAM, 2010d). According to the 2007 National Health Interview Survey, nearly 1.2 million adults reported having used Reiki or another form of energy medicine (NCCAM, 2010d).

In terms of training, Reiki is unique in that those interested do not need to have a specific level of formal education; one can only learn Reiki from a Reiki Master. The training occurs on three levels, with each involving one or more activations or attunements, which are "believed to activate the ability to access Reiki energy" (NCCAM, 2010d, para 13). The first level of training allows for practitioners to use Reiki on themselves and others, the second level allows them to treat from a distance, and the third level, which is the Master status, lets the practitioner teach Reiki to other students; this level of training takes many years to acquire.

If a client is asking to potentially incorporate Reiki into treatment, it is important that they know what to look for in a practitioner. Clients must ask questions regarding training and treatment and the International Center for Reiki Training offers a list of sample questions at http://www.reiki.org/reikinews/questiontoaskareikimaster.html. In terms of additional resources, the NCCAM pro-

continued on page 24

vides an overview of Reiki, its history, uses, training process, effectiveness, and safety, among other things, which can be found at http://nccam.nih.gov/health/reiki/. The International Center for Reiki Training also provides a list of a variety of resources that are available, many of them online, about Reiki; this can be found at http://www.reiki.org/FAQ/NetResourceLinks.html

Biofeedback

Biofeedback involves training "people to improve their health by controlling certain bodily processes that normally happen involuntarily, such as heart rate, blood pressure, muscle tension, and skin temperature" (Ehrlich, 2007, para 1). Clients are hooked up to electrodes, which then provide feedback about these bodily functions. Ultimately, "the presentation of this information — often in conjunction with changes in thinking, emotions, and behavior — supports desired physiological changes" (Biofeedback Certification International Alliance (BCIA), 2010b, para 1). The hope is that over time, the client can learn to monitor and adjust these processes without the aid of electronic feedback. There are three common types of biofeedback: electromyography (EMG), focusing on muscle tension, thermal biofeedback, focusing on skin temperature, and neurofeedback or electroencephalography (EEG), which focuses on brain waves (Ehrlich, 2007). Biofeedback is often used to treat high blood pressure, pain, muscle tension, and headaches, among other things.

In terms of training, clinicians do not need to be formally certified in biofeedback to utilize it. But, the Biofeedback Certification International Alliance (BCIA), formerly known as the Biofeedback Certification Institute of America, was "created to establish and oversee standards for practitioners who use biofeedback and to certify those who meet these standards" (BCIA, 2010a, para 5). Through the BCIA, practitioners can become certified in General Biofeedback, Neurofeedback, and Pelvic Muscle Dysfunction Biofeedback. Those certified in General Biofeedback can use any of the available techniques while those certified in Neurofeedback can only utilize that specific form. Those obtaining the Pelvic Muscle Dysfunction Biofeedback Certification can only use biofeedback to treat pelvic pain. Further information on biofeedback certification can be found at http://www.bcia.org/displaycommon.cfm?an=1&subarticlenbr=9

Biofeedback is an area that psychotherapists could likely incorporate into traditional psychotherapy although it is possible that some may look to make a referral to a certified practitioner. The BCIA has a practitioner search tool: http://www.resourcenter.net/Scripts/4Disapi6.dll/4DCGI/resctr/search.html?

Movement Therapy

Movement therapy, often referred to as dance/movement therapy (DMT), is the "psychotherapeutic use of movement to promote emotional, cognitive, physical, and social integration of individuals" (American Dance Therapy Association (ADTA), 2009d, para 1). Because of that focus, DMT is often used to treat eating disorders or other symptoms related to body image; it can also be used for pain and stress management. The American Dance Therapy Association (ADTA) was founded in 1966 by Marion Chace, a longtime dancer and choreographer who worked diligently to integrate DMT into a variety of hospital settings (Stanton-Jones, 1992). The ADTA works to promote the advancement of all aspects of the field of DMT (ADTA, 2009c). Additionally, it supports its use in a variety of treatment settings as well as a treatment for "developmental, medical,

continued on page 25

social, physical and psychological impairment" (ADTA, 2009b, para 2).

With relation to psychotherapy, the National Board of Certified Counselors (NBCC) recognizes DMT as "the appropriate counseling specialty credential in dance/movement therapy" (ADTA, 2009a, para 1). To practice DMT, practitioners must obtain a Master's degree; they can then either become a Registered DMT, which is the title given to an entry level professional who has completed a 700 hour supervised internship. The Board Certified-Dance/Movement Therapist (BC-DMT) acknowledges advanced certification, which requires 3640 hours of supervised work as well as passing a written examination (ADTA, 2009b).

In many cases, the aims of DMT, which include improving self-esteem and gaining insight, often support the goals of psychotherapy clients. Additionally, in DMT, the client-therapist relationship is of the utmost importance; this is also consistent with many forms of psychotherapy (Penfield, 1992). Considering this, many psychotherapists may seek to integrate DMT into treatment. When assessing the appropriateness of DMT, clients must be comfortable using their body as a way of expressing their emotions in therapy, and that is not something that all clients may desire. In terms of resources, the ADTA website (www.adta.org) is an informative starting point and provides a variety of links to information surrounding training, research, and the history of DMT. Additionally, they provide a dance/movement therapist international search tool at http://www.adta.org/Default.aspx?pageId=378067

Spirituality, Religion, and Prayer

In many cases, spirituality, and religion are grouped together but they are in fact two separate entities that can play distinct roles in a person's life and in their treatment. Spirituality is more often associated with an individual's personalized feelings while religion tends to be associated with a more organized set of beliefs and structured practices. Additionally, it is possible for a client to have one in their life without the other. While most techniques in psychotherapy do require a commitment on the part of the client, spirituality and religion rely on this factor even more. Clients must find themselves in a mindset where they are able to incorporate their faith and beliefs into their treatment. Some clients may be interested in using their existing beliefs to shape treatment while some may want to use prayer during a session. Sadly, it appears that there are still many clinicians who, despite feeling that training in spirituality and religion is important, do not have training in these areas incorporated into their formal education (Young, Wiggins-Frame, & Cashwell 2007). When integrating into practice, spirituality, religion, and prayer have been incorporated into treatment for addictions, with the most well-known being Alcoholics Anonymous. Additionally, some patients may use spirituality, religion, and prayer more generally as a way of improving overall health.

Referrals within spirituality and religion are particularly interesting in that there are a variety of options. Some clients may choose to speak with their spiritual leader or advisor, while others may want to work with a pastoral counselor. As mentioned earlier, the use of spirituality and religion can greatly vary based on a client's comfort, preferences, and beliefs.

Whole Medical Systems

Whole Medical Systems are "built upon complete systems of theory and practice. Often, these systems have evolved apart from and earlier than the conventional

continued on page 26

medical approach used in the United States" (NCCAM, 2009b, para 7). The most well known systems still being practiced are Traditional Chinese Medicine (TCM), Naturopathy, Homeopathy, and Ayurveda. TCM is based on the idea that the body is a part of nature and thus subject to its forces (Yanchi, 1988). With that, the idea is that the body's energy, known as qi, flows along 12 meridians throughout the body. As it flows, it allows for communication between different areas and symptoms occur when the qi cannot flow freely. Herbal remedies and acupuncture are the most well-known forms of TCM although other forms of treatment, such as massage, dietary therapy, and mind-body therapies such as tai-chi are also considered part of TCM (NCCAM, 2010e).

Naturopathy, as its name suggests, is a whole medical system focusing on nature and its natural healing power (Ehrlich, 2009). The focus here is more on disease prevention, healthy living, and general education as opposed to fighting disease (Ehrlich, 2009). Techniques used in naturopathy include herbal remedies, exercise, massage, and dietary supplements (NCCAM, 2010b). Homeopathy is based on the principle of similars, which means that diseases can be cured by the same substances that create the illness's symptoms (Ullman, 1995).

The final Whole Medical System that will be discussed here is Ayurveda, "the oldest existing system of traditional medicine" (Brooks, 2002, p. 453). The focus of Ayurveda is that treatment and prevention are based on "the holistic development of both mind and body" as opposed to focusing on specific symptoms (Brooks, 2002, p. 455). Treatments commonly incorporated into Ayurveda include yoga, meditation, and herbal medicines, among others (White, 2000).

In terms of integration into psychotherapy, each area has a specific course of training. But, as one can seem, many CAM modalities that are generally considered individually, such as acupuncture, aromatherapy, and dietary supplements, are often incorporated as parts of these systems. Thus, a practitioner may obtain training in one specific area as opposed to the entire medical system. Despite the variety of systems, most aim to improve the overall well-being of the client. Again, specific symptoms can be treated using a variety of modalities that are incorporated within the system.

Chiropractic

Chiropractic focuses on the relationship between a body's structure and its functioning. It utilizes various spinal manipulations in order correct any dissonance between the two, with the belief that when the spine is in alignment, the body functions optimally. While many people think of chiropractic as a method to relieve back pain, it is also used to treat more generalized pain, as well as stress, headaches, and high blood pressure.

Chiropractic is one area of CAM that will likely always necessitate a referral to integrate it into a client's treatment, since to become a chiropractor, one must hold a Doctor of Chiropractic Degree which takes between four to five years to obtain, post-college (American Chiropractic Association (ACA), 2010). Thus, being aware of the uses and the efficacy associated with chiropractic as well as how to make appropriate referrals is particularly important to psychotherapists. The ACA provides a significant amount of information regarding history, uses, and training. Additionally, they have a "Find a Doc" link that allows searching for chiropractors by city and state which can be found at: http://www.acatoday.org/search/memsearch.cfm.

continued on page 27

Acupuncture
Acupuncture is a process by which needles are inserted into the skin at specific points along various meridians, or pathways, in the human body (Motl, 2002). It is traditionally grouped as a part of the Whole Medical System known as Traditional Chinese Medicine as it adheres to the idea that energy, known as qi, flows along these meridians. When the qi cannot flow freely, there are negative symptoms and it is believed that by inserting needles at specific points, the qi can move freely again (NCCAM, 2009a). A client's initial examination "reveals which points and meridians need to be stimulated in order to treat" their specific symptoms (Motl, 2002, p. 432). Acupuncture commonly treats headaches, depression, anxiety, nausea, and fatigue.

The requirements to practice acupuncture vary but many states require certification by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in addition to an acupuncture license (NCCAOM, 2008). It is possible to be both a licensed psychotherapist as well as a licensed acupuncturist, although specific care needs to be given to the potential for boundary issues as well as problems related to multiple relationships. In addition to licensed acupunctures, doctors of oriental medicine and medical doctors with additional, specified training can practice acupuncture. More information regarding certification in acupuncture can be found at http://www.nccaom.org/applicants/certifications.html. In order to find appropriate referrals, the American Academy of Acupuncture has an online search resource: http://www.medicalacupuncture.org/findadoc/index.html.

Dietary Supplements
A dietary supplement is a product that is taken in addition to one's regular diet. It is taken orally and must include at least one dietary ingredient such as a vitamin, herb, or mineral (Office of Dietary Supplements, 2009). Most commonly, people associate the term dietary supplements with herbs such as St. Johns Wart or ginseng, or different vitamins. Many of these supplements can be used as either complementary or alternative forms of treatment; they can be treat anxiety, depression, and sleep disorders, among other symptoms.

Because there are so many different supplements, with each having varying uses, psychotherapists need to pay particular attention to the risks, side effects, and possible counterindications associated with specific dietary supplements. Additionally, since the Federal Drug Administration (FDA) does not regulate supplements as strictly as they regulate over-the-counter and prescription medications, it is important for clients to be aware of the possibility that what is being advertised on the label does not match what is actually being provided in the supplement (NCCAM, 2010g). In terms of resources, the Office of Dietary Supplements provides detailed information on a variety of supplements at http://ods.od.nih.gov/Health_Information/Information_About_Individual_Dietary_Supplements.aspx.

Yoga
Yoga involves moving the body into specific positions with the hope of increasing relaxation as well as balancing ones mind, body, and spirit; it is commonly used to relieve symptoms of stress and anxiety (NCCAM, 2010h). With yoga sharing many traditions and ideals of both Hinduism and Buddhism, it is not surprising that it focuses on "the task of transforming oneself" (Levine, 2000, p. 81). It was initially developed to help people gain spiritual enlightenment. While there are a variety of schools of yoga, "the *Sutras*

continued on page 28

outline eight limbs or foundations of yoga practice that serve as spiritual guidelines: 1. *yama* (moral behavior); 2. *niyama* (healthy habits); 3. *asana* (physical postures); 4. *pranayama* (breathing exercises); 5. *pratyahara* (sense withdrawal); 6. *dharana* (concentration); 7. *dhyana* (contemplation); 8. *samadhi* (higher consciousness)" (NCCAM, 2010h, para 6). Hatha yoga is the most commonly practiced form of Yoga and it focuses on breathing and postures; according to the 2007 National Health Interview Survey, yoga was found to be one of the 10 most common forms of CAM used by adults (NCCAM, 2010a).

Training in yoga is not standardized and different programs can last between a few days to a few years (NCCAM, 2010h). Additionally, those interested can be trained as either a yoga teacher or a yoga therapist. While a yoga therapist works to address a specific problem and a yoga teacher works more generally, there are no differences in terms of their training (Isaacs, 2010). With the lack of standardization, some are worried that there is also a lack of respect for the field; the International Association of Yoga Therapists (IAYT) supports research and education in Yoga with the goal of establishing "Yoga as a recognized and respected therapy" (IAYT, 2010, para 1). The Yoga Alliance offers certifications to become a Registered Yoga Teacher (RYT); information on this process can be found at: http://www.yogaalliance.org/Standards.html.

Yoga is an area that some clinicians may consider directly integrating into practice as it may be helpful to begin a session with a series of postures, or as an assigned activity between sessions, to promote relaxation. Some clients may want more extensive training, though, and thus a referral could be made. The Yoga Alliance provides a search tool to find a RYT: http://www.yogaalliance.org/teacher_search.cfm.

Massage Therapy

Massage therapy utilizes "manipulation of muscles and ligaments, typically using hand and elbow motions, to improve circulation, muscle tone, and range of motion" (Field, 2009a, p. 23). Massage therapists use a variety of techniques such as applying pressure, kneading, and vibrating (Field, 2009a). While many people recognize the utility of using massage to relieve muscle tension, it has also been shown to be effective in treating anxiety, depression, and a variety of cardiovascular, pulmonary, and physical symptoms (Field, 2009a).

Regulations surrounding massage therapy vary from state to state. Currently, 43 states regulate massage; most require "a minimum number of hours of training, passing an exam to demonstrate competency," such as the Massage & Bodywork Licensing Exam (MBLEx) or the National Certification Exam (NCE), and continuing education to practice (American Massage Therapy Association, 2010, para 1).

As mentioned in the section on ethics, this is an area that is likely inappropriate for a psychotherapist to perform on a client. Consideration needs to be taken with regard to the impact that prolonged physical contact with a client could have on the therapeutic relationship. Thus, even if a psychotherapist is appropriately trained in massage, it is recommended that s/he make a referral as opposed to serving in both roles for one client. A referral resource is provided through the American Massage Therapy Association: http://www.amtamassage.org/findamassage/locator.aspx. Additionally, information on how to become a certified massage therapist can be found at: http://www.amtamassage.org/students.html

continued on page 29

Meditation
While there does not seem to be one standard for what meditation must involve, there are a variety of ideas that are often incorporated with the technique. For instance, there is often a focus on self-regulation in order to increase attention and awareness; it is believed that the increase in awareness will help bring "mental processes under greater voluntary control and thereby foster general mental well-being and development and/or specific capacities such as calm, clarity, and concentration" (Walsh & Shapiro, 2006, p. 229). There are a variety of different types of meditation but most of them maintain the goal of learning to focus one's attention. Meditation has been used to treat a variety of symptoms such as anxiety, depression, pain, panic, phobias, insomnia, and stress.

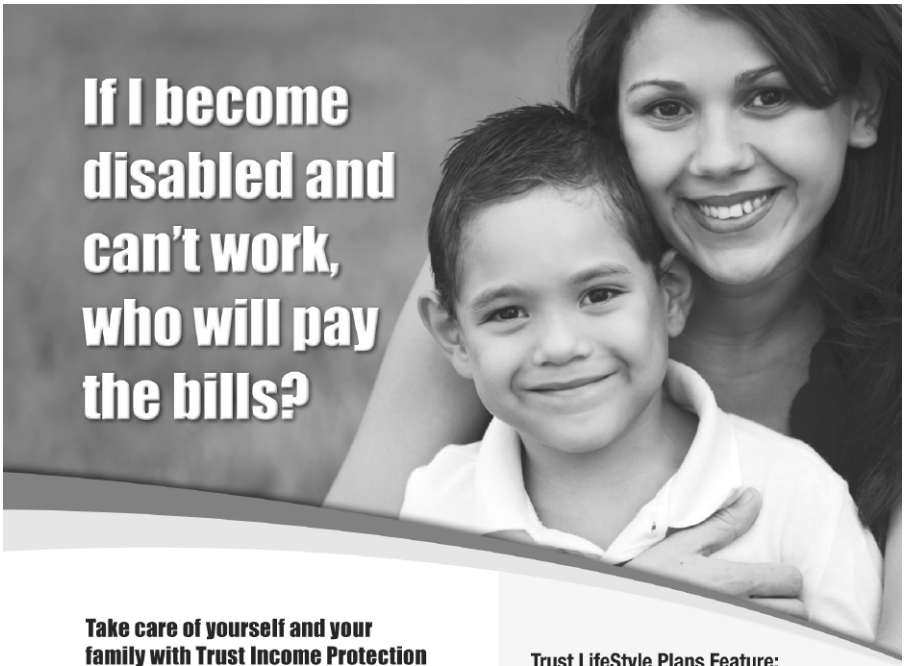
Meditation is an area that tends to work well in conjunction with more traditional psychotherapy. It is something that can be practiced during psychotherapy in addition to being utilized by clients outside of sessions. Some forms of meditation focus on breathing while others focus more on relaxing the mind; ultimately, the aim is to become "more mindful, and more present, and more compassionate, and more awake" (Kornfield, 2004, p. 12). The American Institute of Health Care Professionals provides a variety of resources related to certification and education surrounding meditation: http://www.aihcp.org/meditation.htm.

Music Therapy
Music therapy is the "use of music interventions to accomplish individualized goals within a therapeutic relationship" (American Music Therapy Association (AMTA), 2009a, para 1). On the whole, it aims to have clients "use the expressive experiences of music to improve or enhance their level of physical, psychological, and socioemotional functioning" (Field, 2009b, p. 81). Music therapy has been shown to be effective for a variety of symptoms, such as anxiety, depression, various forms of pain, and schizophrenia, to name a few (Field, 2009b).

Music therapy can be incorporated into psychotherapy on a basic level. For instance, a client may find listening to a specific type of music to be relaxing and thus having it played during a session may be helpful. Other clients may require a more focused and directive form of music therapy and thus a referral to a certified music therapist should be made. There are educational opportunities in music therapy on the bachelor's, master's, and doctoral level. Upon completing an AMTA-approved program, students can sit for the certification exam given by the Certification Board for Music Therapists; upon passing, they are given the label of Music Therapist – Board Certified (AMTA, 2010b). More information on training can be found through the American Music Therapy Association (AMTA). Additionally, to find a certified Music Therapist, an email request for a list of qualified professionals can be sent to findMT@musictherapy.org.

Conclusion
As can be seen, within the field of CAM there are a variety of tools, techniques, uses, and training opportunities. While the information provided here was not meant to be exhaustive, it was intended to help psychotherapists recognize how important the field of CAM is. It is hoped that this brief introduction will stimulate psychotherapists to seek further education and develop comfort with incorporating certain techniques and/or making referrals for other areas within CAM.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org



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Diversity, Outcome Measures, and Implementing Regulation C-24

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The recent Implementing Regulation, "C-24, Empirically Supported Procedures/Treatments," from the APA Commission on Accreditation, November 2009, states that it "…is intended to clarify the expectations of the CoA with regard to language currently present in the doctoral and internship *Guidelines and Principles* (G&P)…" in Domain B.3.c and Domain B.4.a. The Implementing Regulation states:

"…Training in empirically supported procedures/treatments should focus on assisting students and interns to acquire knowledge, skills and attitudes that promote the integration of science and practice. Training in empirically supported procedures/treatments does not require exposure to any specific system of therapy, nor does it eliminate the need for students/interns to understand or attend to common factors.

Through this training, students and interns should:

1. Be conversant with the most common methods used to examine outcomes of therapeutic factors and interventions (e.g., efficacy studies; effectiveness studies; meta-analytic studies) and the conclusions drawn from this research;
2. Obtain supervised experiences that enable them to implement treatment that is cogently defined, supported by scientific evidence, and consistent with the program's model;
3. Be provided with supervised experience in collecting quantitative outcome data on the psychological services they provide; and
4. Not be trained in interventions known to be harmful or ineffective."

The net effect of C-24 so far has included efforts by training programs to make the collection of outcome data a requirement of practicum. While this effort is a step forward in making sure that students learn how to systematically assess the outcome of psychological services, it is not without potential drawbacks, particularly for clients from diverse backgrounds. Consider, for a moment, the suggestion by Sue (1992) that cultural responsiveness may entail using different techniques instead of applying one particular technique in a different way to clients from diverse backgrounds. Granted, if educational and training programs are deliberate in their efforts to establish protocols for outcome data collection, they will attend to the possibility that different assessment techniques may need to be applied to clients from different backgrounds, with the appropriate attention to validity and norms. Nevertheless, the question remains regarding whether or not quantitative outcome data (see #4 above) will be collected to the exclusion of qualitative data, which in turn may be more appropriate to the cultural norms and values of some populations [e.g., those who are collectivistic and do not adhere to individualistic and autonomous principles of mental health (Ryan, Lynch, Vansteenkiste, & Deci, 2011)].

continued on page 32

Furthermore, early efforts by one professional program in psychology to address C-24 (see the National Council of Schools and Programs in Professional Psychology's listserv posting for the procedures) suggest that cost may become a determinant in the selection of instruments, with a preference for non-proprietary tests in order to keep costs down. Arguably, non-proprietary tests could have less research associated with their reliability, validity, and norms than proprietary tests, with the possible result that a disproportionate amount of attention could have been given to the dominant culture in the research that was done.

Compounding these concerns is the issue raised in conjunction with outcome assessment in general, i.e., that the focus on outcomes may orient educators and trainers of psychotherapy students towards "teaching to the test [psychological technique]." One could surmise that if students are taught to focus on achieving outcomes derived from the results of the assessment instruments used to gather quantitative data, they will emerge from their training with the perspective that those are de facto the desirable outcomes of psychological services. While there is no reason to yet believe that students will be taught to view outcomes with such exclusivity, the emphasis in C-24 on quantitative data to assess outcomes associated with empirically supported procedures/treatments embeds possible bias in the implementation regulation that could unduly influence students' theoretical orientations and/or ultimate professional identities.

To be fair, C-24 states, as noted above, that, "…Training in empirically supported procedures/treatments does not require exposure to any specific system of therapy, nor does it eliminate the need for students/interns to understand or attend to common factors..." However, this wording falls short of mandating an understanding of and attention to common factors, instead suggesting that there is a *need* (my emphasis) for such understanding and attention. If, for example, students and interns are to be taught to value and intentionally cultivate and use the therapeutic relationship, they will benefit from incorporation of the relationship in non-quantitative outcome assessment.

Thus, this is a call to psychotherapy researchers to explore the impact of Implementing Regulation C-24 from the APA Commission on Accreditation on educational programs' and training sites' choices for clinical outcome measures and, in turn, on students' and early career psychologists' selections of theoretical orientations, treatment goals, interventions, and outcome assessment modalities after leaving their educational and training programs. A particular emphasis should be placed on the impact of these selections on clients from diverse backgrounds. This is an opportunity to be at the leading edge of an aspect of education and training of psychotherapists that may impact their professional identities, as well as the characteristics of sites offering training and psychological services.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

EARLY CAREER

Reflections from Your New Division 29 Early Career Psychologist (ECP) Domain Representative: Opportunities for ECPs in Division 29 and Seeking Research Funding as an ECP

Susan S. Woodhouse, Ph.D., Pennsylvania State University

This past January I took over as the newly elected Early Career Psychologist (ECP) Domain Representative for Division 29, so I thought that I might take this opportunity to introduce myself and write about some of my own reflections about being an early career psychologist, and also mention some of opportunities available to ECPs through Division 29. I would like to start by thanking Mike Constantino for his past service as the ECP Domain Representative. I would also like to thank Rachel Gaillard Smook, who will be continuing this year as the Chair of the ECP Committee, and Jay Cohen, who will be stepping into the role of Associate Chair of the ECP Committee. In addition, I am grateful to the members of the ECP Committee, including Jade Logan, Patricia Gready, and Joshua Swift. Many thanks to all of you and I look forward to working with you.

Opportunities for ECPs in Division 29

There are some very exciting opportunities available for ECPs in Division 29. One opportunity that would be relevant for any ECP would be the Division 29 Lunch with the Masters, designed for graduate students and early career psychologists at APA. This is now an annual tradition for Division 29. Last year about 55-65 graduate students and ECPs attended the lunch along with 6 masters: Drs. Jeffrey Magnavita, Jeff Barnett, Florence Kaslow, Louise Silverstein, John Norcross, and Judith Beck, as well as other Division 29 members. Each year we have a new slate of masters who volunteer to be a part of the lunch. Lunch is provided and there is an annual raffle of books written by Division 29 members. ECPs get to have a great experience talking face to face with the masters.

Another new feature for ECPs that was started by Mike Constantino and Rachel Gaillard Smook is the Early Career Mentoring interactive column for the Division 29 webpage (http://www.divisionofpsychotherapy.org/continuing-education/early-career-mentoring-column/). This interactive column provides a place to ask any questions related to early career issues or concerns. The column provides a safe place to ask questions anonymously, and to receive feedback from a more senior Division 29 "mentor." This fall the website was in transition for a period, but recently the interactive column has become active again. We hope that ECPs will find the column a helpful place to ask questions.

I would also like to invite ECPs to write about their own experiences for the ECP column in *Psychotherapy Bulletin*. Please let me know if you would be interested in writing a piece (ssw10@psu.edu). I'm sure that others would benefit greatly from hearing about your experiences as an ECP, whatever your career path may be.

Finally, before I move into talking about my own ECP experience, I would also

continued on page 34

like to invite ECPs to get involved in Division 29 in general. Let us know if there is a way that you'd like to be involved. There are many opportunities to get involved on a number of different committees.

My own experience seeking research funding as an ECP

As an assistant professor at Pennsylvania State University, my journey has been one of an ECP in academia. I very much enjoyed Amy Przeworski's recent article in *Psychotherapy Bulletin* entitled "Lessons Learned in the Path to Academia." I thought her article captured much of the advice I would want to pass along to those headed towards a career in academia. When I think about the additional advice that I would like to pass along, there are a number of aspects of my experience being an assistant professor that might deserve attention, including big issues such as attaining licensure or becoming a parent while on the tenure track, or surviving a program closure. However, one area that I think ECPs interested in psychotherapy research do not get to hear very much about is how to go about obtaining funding for research. For that reason, I decided to focus my reflections on the process of seeking grant funding for psychotherapy-related research.

I have been very fortunate to have senior mentors who have supported me in learning about the process of obtaining national-level funding for my research, but most of those mentors have been from outside the area of research on psychotherapy. I thought it might be helpful to describe the process I have gone through to pursue funding for my research because I know a lot of students and ECPs believe that it would not be possible for them to someday obtain grant funding for psychotherapy-related research. The National Institutes for Health (NIH) are not the only source of funding psychotherapy-related research, but it is the route that I have pursued so it is the route that I know and will describe.

I had excellent doctoral training from amazingly productive counseling psychologists, but during my graduate training I did not know of many other counseling psychologists who had national-level funding for their psychotherapy-related research. When I went to conferences, I would hear about researchers who had obtained funding for their projects but I had no idea how to become one of those people. Because one of my core interests was in the area of attachment theory and research, I ended up working as a graduate research assistant in a developmental psychology lab with the well-known attachment researcher, Jude Cassidy, at the University of Maryland. Dr. Cassidy had two major grants through the NIH. The first grant focused on attachment in adolescents, and the second was for a randomized, controlled trial of an attachment-based, psychotherapeutic, home-visiting intervention for mothers and infants. Working with Dr. Cassidy as a graduate research assistant gave me the opportunity to develop a very close working relationship with her. One recommendation for graduate students might be to consider working as a graduate assistant outside of your main program area if an opportunity opens up that could help you advance in your research activities.

While I was on my clinical internship at the University of Delaware, Dr. Cassidy suggested that perhaps I could apply for an Individual Postdoctoral Fellowship through the NIH Ruth L. Kirschstein National Research Service Award (NRSA) program (information about the NRSA programs is available on the NIH website at http://grants.nih.gov/train-

continued on page 35

ing/nrsa.htm). The NRSA program includes opportunities for individuals at the pre-doctoral, as well as at the post-doctoral stage. There are both individual postdoctoral fellowship opportunities (that individuals apply for, as I did) and institutional grants (that mentors apply for and then use to fund mentees). In order to get an NRSA postdoctoral fellowship, I had to identify a research mentor who was willing to work with me to design a research study and work closely with me as a postdoctoral mentor through the duration of the project. Because I wanted to work with Dr. Cassidy, I also had to clearly specify in my grant proposal why it would make sense for me to remain at the University of Maryland (where I had gotten my doctorate) to complete my postdoc, rather than move to a new university. The NIH is a little leery of people who just want to stay in the same place unless there is a very good reason. In my case, remaining at the University of Maryland was easy to justify. Dr. Cassidy was in a separate program in a different area, so her mentorship would allow me to gain additional training in developmental psychology and integrate two areas of research: developmental psychology and psychotherapy research. Interdisciplinary work is particularly valued in the NRSA program, so one way to build a rationale for a proposal is to talk about how the project would allow you to integrate two different approaches to better shed light on a question of interest.

The project I proposed was to add a psychotherapy research component to Dr. Cassidy's randomized, controlled trial of an attachment-based intervention for mothers and their irritable infants. The goal of that intervention was to use a brief psychotherapy model that integrated psychodynamic, cognitive, behavioral, and psycheducational approaches in helping mothers become more aware of and responsive to their infants' needs for attachment and exploration. My postdoctoral project aimed to examine the ways in which the psychotherapy relationship and psychotherapy process helped to explain differential outcomes for the infants. I decided to submit my NRSA application to the National Institute for Child Health and Human Development (NICHD) because of my focus on prevention of insecure attachment in infants. Other topics might be better suited to the National Institute for Mental Health (NIMH), National Institute on Alcohol Abuse and Alcoholism (NIAAA), or National Institute on Drug Abuse (NIDA). One of the key decisions that needs to be made is which institute is the best fit for the particular area of research. It can be very helpful to take a close look at the websites for each potential institute, to discuss the decision with a senior mentor who has national-level funding, and to speak with a program officer in the institute about your project idea. One thing that ECPs may not be aware of is that if you have a research idea, it is very important to talk with a program officer who works with investigators in your area of interest at the institute to which you are thinking of submitting. A senior mentor is crucial in helping you figure out how to get started and which institute might be a good fit (and in fact, which specific panel might be the best to submit to).

I spent the spring semester during my internship year writing both my dissertation and my grant proposal. Funding decisions through the NIH take a fair bit of time, so in the fall, while I waited for a funding decision, I began a research post-doc with Dr. Cassidy through funding she had available. My second year of the post-doc was then funded through my NRSA individual postdoctoral grant.

continued on page 36

Although I obtained my postdoc funding through an NRSA postdoctoral fellowship, the NIH also has other programs for ECPs at a variety of stages. For example there are Career Development Awards (K Awards) that aim to provide support, and three to five years of protected time, for an intensive, mentored career development experience (more information is available at the NIH website at http://cnx.org/content/m19394/latest/). A K Award might be a good choice for an assistant professor. Another possibility for an ECP might be to write a small grant to piggyback on a larger project by a mentor (for example, to write an R03 grant to add to a mentor's larger R01 grant; see the NIH website for more information about R03 grants at http://grants.nih.gov/grants/funding/r03.htm).

Another possible route for ECPs is the route that I have taken since beginning my position as an assistant professor, which is to seek funding for a larger grant (an R01; see http://grants.nih.gov/grants/funding/r01.htm). In order to get an R01 through the NIH as an ECP it is crucially important to have senior collaborators who have obtained funding through the NIH. NIH reviewers like to see senior collaborators in order to be assured that there is sufficient expertise and experience to ensure that the project will be completed well. Also, it is crucially important to get feedback from senior people, who have previously received funding,on the application you write. They will best be able to help you understand what reviewers are looking for in a proposal.

Because building relationships with senior investigators who can collaborate with you and provide mentorship is so important, it is to your advantage to seek out these kinds of individuals and build relationships with them. If you are lucky, you are in an institution that makes that process easy because senior people reach out to ECPs, take them to lunch, and ask about research interests. I've been particularly lucky because Penn State is like that. It is a very interdisciplinary institution that understands how the grant-getting process works and supports connections between ECPs and senior researchers. I belong to the Parenting at Risk Research Initiative through the Child Study Center at Penn State. This is a group of researchers (both senior and ECP) who meet every other week to talk about our research ideas, build collaborations, provide feedback on one another's grant proposals, and get advice about our projects. I've been able to build important collaborations and mentoring relationships through this group. Being an active member of this group of researchers has supported my research and has helped me get connected with other researchers in my area. Some people have potential mentors and senior collaborators that they can work with at their own institutions—but if not, it is a good idea to seek to collaborate with others in your area elsewhere.

If you are interested in NIH funding, one very important resource that you can take advantage of is the NIH Regional Seminar on Program Funding and Grants Administration (see the NIH website for more information: http://grants.nih.gov/grants/seminars.htm). Every year the NIH offers two Regional Seminars. These seminars do an amazing job of demystifying the grant writing process, clarify the funding mechanisms that are available, and help attendees understand how grants are reviewed and awarded. They explain how important it is to talk with a program officer before you submit, and explain how the whole process works. Some institutions may have funds available to send ECPs to the seminar. Often institutions will have briefer work-

continued on page 37

shops on applying for grants, but I found that the NIH Regional Seminar was well worth the extra investment of time because it covered almost all the information I needed (other than the more specifically-tailored information that only an experienced mentor can provide).

Another important step to consider if you are interested in getting a grant is to conduct pilot work to show the feasibility of what you would like to propose to do. I was able to get internal funding through my start up money and through some opportunities at my institution to compete for internal seed money for pilot work. You might think about finding out if there are opportunities to apply for seed money at your institution. NIH likes to see that you have done pilot work, so it can be extremely helpful to get some smaller seed funding to make that pilot work possible. Another benefit of pilot work is that you can begin to build relationships with the community in which you will be doing your research. Then when it is time to submit your grant proposal, they will be able to write letters of support that, along with the pilot data, will demonstrate the feasibility of what you are proposing to do. Division 29 also has two small grant programs that can be used to fund smaller psychotherapy-related research projects: the Charles J. Gelso Grant (information available at http://www.divisionofpsychotherapy.org/call-for-proposals-charles-gelso-psychotherapy-research-grant/) and the Norine Johnson Grant (information available at http://www.divisionofpsychotherapy.org/call-for-nominations/). Personally, I was able to find opportunities to compete for seed money both at the College level and at the University level. These programs were extremely helpful in making my grant proposal competitive.

One thing I found very encouraging is that NIH is trying to increase the number of ECPs they fund. NIH has set a target for the number of award to New Investigators (i.e., those who have never had a large R01 grant), and there is a special Early Stage Investigator (ESI) designation for those who are New Investigators and who completed their terminal research degree within the past 10 years. The ESI applications are reviewed together (i.e., not compared to the senior investigator applications). This is very helpful.

The process of submitting a grant and going through the review process is a long one. Typically one does not get the grant the first time around, so one has to plan on resubmitting in the next round of deadlines (information on the standard submission dates can be found at http://grants.nih.gov/grants/funding/submissionschedule.htm). If a proposal is scored, then you also get feedback from the reviewers about what they would like to see changed or clarified about the proposal. NIH gives investigators two chances to submit (the initial submission plus a resubmission). If your proposal is not funded the second time around, in order to submit again you must change the proposal in some substantive way—you can't submit the same grant again.

The bottom line if you are interested in getting funding for your research is (a) to find senior mentors and collaborators, (b) to learn as much as you can about the funding agencies that you are interested in, and (c) consider whether it would make sense to collect some pilot data. Finally, the last bit of advice would be to leave plenty of time to write your proposal and get lots of feedback on each draft from people who have gotten grants in the past. Good luck!

Interdisciplinary "Health Psychology"

Pat DeLeon, Ph.D.
Former APA President

A Global Perspective: Over the decades that I have had the opportunity of participating in the development of our nation's health care workforce from the vantage point of Capitol Hill, I have become increasingly impressed by the extent to which new ideas, which at the time might seem to be far-fetched and impossible to implement, are in fact establishing the foundation for fundamental change within the foreseeable future. The vision demonstrated by those serving on the Pew Health Professions Commission of 1998 serves as an example. President Obama's landmark Health Care Reform legislation of 2010, the Patient Protection and Affordable Care Act (PPACA), contains a number of far-reaching provisions that reflect suggestions proffered by the PEW Commissioners. Language was included which will significantly increase the nation's primary care and public health workforce, promote preventive services, and strengthen quality measurement. A Public Health Services track was established to train health care professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response. Of considerable long term significance was the establishment of a National Commission to study projected health workforce needs. The law also established a mechanism for developing a national strategy for quality improvement. Impressive additional resources (a total of $11 billion over five years) were provided for the nation's federally qualified community health centers (FQCHCs), as well as authorization for new Teaching Health Centers Development grants, a Graduate Nurse Education Demonstration Program in Medicare, and new grants to fund the operation of Nurse-Managed Health Clinics (NMHCs). Yet, many of our colleagues remain unaware of the magnitude of change that is coming and of the extensive foundation behind these changes, which have been established over the years.

"We never saw the storm coming."

The Pew Health Professions Commission Recommendations

- Change professional training to meet the demands of the new health care system. In spite of the dramatic changes affecting every aspect of health care, most of the nation's educational programs remain oriented to prepare individuals for yesterday's health care system.
- Ensure that the health profession workforce reflects the diversity of the nation's population.
- Require interdisciplinary competence in all health professionals.
- Move education into ambulatory practice.
- Encourage public service of all health professional students and graduates.
- Enact legislation that facilitates professional mobility and practice across state boundaries.

One recommendation that the President has not yet embraced, but which could eventually have considerable implications for psychology and the other health professions, was that Congress should establish a National Policy Advisory body that would research, develop,

continued on page 39

and publish national scopes of practice and continuing competency standards for state legislatures to implement. Until national models for scopes of practice can be developed, states should develop mechanisms for the existing professions to evolve their existing scopes of practice and for new professions or previously unregulated professions to emerge. Significant overlap of practice authority exists among the health professions. Driven by a number of factors (the professions themselves, new information and technologies, and innovation in the workplace), traditional boundaries—in the form of legal scopes of practice—between the professions have blurred. "Work in interdisciplinary teams. Researchers are beginning to confirm what many caregivers have suspected intuitively for a long time: the coordinated efforts of practitioners from many disciplines provide the best outcomes for the sickest patients."

The Future of Nursing: Leading Change, Advancing Health was released last year by the Institute of Medicine (IOM) in partnership with the Robert Wood Johnson Foundation (RWJF). Noting that there are more than 3 million nurses and that they are the largest segment of our nation's health care workforce, the IOM proffered that: "(W)orking on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs." There are over 250,000 advanced practice registered nurses (APRNs) who possess master's or doctoral degrees and have passed national certification examinations. As the PEW Commissioners noted, because licensing and practice rules vary across states, the regulations regarding the scope-of-practice of these clinicians vary in different parts of the nation and within public sector agencies. Some states allow nurse practitioners to see patients and prescribe medications without physician supervision; others do not. The clinical services APRNs are authorized to provide are thus determined not by their education and training but by the location and political environment in which they practice. This makes little clinical sense. The IOM has called for nursing to practice to the full extent of their education and training, as well as to achieve higher levels of education and training through an improved education system that promotes seamless academic progression. And, as recommended by PEW, an improved data collection and information infrastructure should be utilized to develop a more effective and rational workforce planning and policy-making environment. We would suggest that organized medicine's traditional non-physician "public health hazard" allegations will ultimately be replaced by reliance upon objective determinations of what actually constitutes quality care.

Clinical Pharmacy's Maturation: In the Spring of 2009, the late-Senator Edward Kennedy and his Veterans Affairs Committee colleagues Senators Akaka and Murray hosted a Congressional briefing on "Lessons learned from the VA: Pharmacists' impact on health care quality." Inappropriate medication use was estimated to cost our nation close to $2 billion annually in preventable medication-related problems. The VA was viewed as a leader in ensuring the appropriate and safe use of medications through the utilization of pharmacists in a non-dispensing role. Broadening access to these types of programs has the potential to improve the health of hundreds of thousands of patients and to reduce overall health care costs through optimal medication use. "For every $1

continued on page 40

invested in clinical pharmacy services, $4.81 was realized through lower costs or another economic benefit." The Agency for Healthcare Research and Quality (AHRQ) reported data from two error reporting studies, which found that pharmacists prevented nearly half of the errors that did not reach the patient. The IOM: "(I)t is impossible for nurses and doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource…Thus, access to his or her expertise must be possible at all times."

A follow-up memorandum from the American Pharmacists Association (APhA), which represents over 62,000 members, provided a broader health policy perspective for the Capitol Hill audience. "The VA utilizes pharmacists for traditional dispensing and quality assurance roles as well as non-traditional roles that reflect the value that a pharmacist's clinical expertise can bring to a patient's health care team." This includes: providing recommendations to prescribers; collaborating with health care teams (inpatient and ambulatory care settings); pharmacists prescribing under protocol, like certain nurses; managing anticoagulation, hypertension, diabetes, pain, psychiatry, etc.; providing preventive medicine in the areas of immunizations, smoking cessation, polypharmacy assessment, and medication reconciliation; participating in the VA's home-based primary care/geriatric care program; playing a critical role in health information technology by establishing file structure, clinical guidelines and pathways, and prescribing templates to assist providers in being more efficient and improving medication safety; and managing the VA drug formulary.

Patients need help managing their medication therapy. Regardless of the practice setting, the economic benefit of clinical pharmacy services is well in excess of the costs required to provide the service. Quality of care is high; a review of 600 pharmacist recommendations in the outpatient, inpatient, and nursing home settings found that 92% of the recommendations were accepted by the providers. This led to improved clinical outcomes in over 30% of the patients in each setting and most impressively, avoided harm in 90% of the cases. The services are well received by beneficiaries with a pharmacist-provided immunization service improving access for veterans and increasing patients immunized in medical provider clinics by 29% in the first quarter and 49% in the second quarter of the program. "The data is clear. Most patients need and all patients deserve the benefit of the pharmacist clinical services that VA beneficiaries get today. As you look to improve our health care system—whether your goals is to expand access to services, improve the quality of services, or reduce the cost of our system—we recommend considering and incorporating elements of the VA's successful programs that recognize and fully utilize the clinical skills of pharmacists."

Pharmacy's educational leaders, like those of nursing, have been actively exploring dual-degree initiatives. "While post-PharmD residency education and training continues to be a common and popular pathway for approximately 20% of PharmD graduates, a significant number of colleges/schools of pharmacy are offering and pharmacy students are choosing alternative educational pathways to expand their post-PharmD career options in both pharmacy and the healthcare industry." The most recent data indicates that a total of 41 pharmacy colleges/schools report anticipating a total of 51 dual degree programs in cooperation with non-

continued on page 41

pharmacy colleges/schools. The underlying model is that of the NIH Medical Scientist Training Program (MSTP), established in 1964, that encourages medical schools to educate and train a cadre of physician scientists by providing a joint MD/PhD degree. Pharmacy dual-degree programs currently include providing the Masters of Business Administration, Masters of Public Health, and Masters of Public Administration. The incoming President of the American Association of Colleges of Pharmacy (AACP) has practiced in the mental health field for over a quarter of a century. During a recent Deans' meeting in Tucson, the importance of developing closer relationships between pharmacy and the various mental health specialties, including psychology and social work, was raised. "The numbers of dual degree programs offered by colleges/schools of pharmacy have been rapidly expanding." As our nation's health care environment steadily evolves under President Obama's landmark health care reform legislation, we will increasingly experience interdisciplinary and cross-disciplinary collaborative practice patterns. Isolated "silo-oriented" models of care will steadily become relics of the past.

Psychotherapy Bulletin editor Lavita and I recently had the opportunity to attend the 2011 **National Council of Schools and Programs in Professional Psychology** (NCSPP) Mid-Winter Conference, "NCSPP 2025: Leap Into The Future." APA Past-President Carol Goodheart and Education Directorate Executive Director Cynthia Belar provided visionary addresses, placing the fundamental changes occurring within our nation's education and health care environments into a historical context and highlighting APA's ongoing efforts to be responsive. As NCSPP President Steve Lally noted, our profession is steadily moving from one in which private practice has been the predominant locus of service delivery (often in solo or small group practices) into a health care environment in which future generations of practitioners will be expected to appreciate the clinical contributions of colleagues in different disciplines, provide data-based gold standard care, and especially, be comfortable with the ever-evolving changes occurring within the communications and technology fields as they are systematically applied to health care (i.e., Health Information Technology (HIT)). Again, historically comfortable isolated "silos" of education and treatment will no longer be acceptable. One must appreciate that change is always unsettling for many and often takes far longer to accomplish than one might expect, especially if the change is transformational.

Our professional training leaders were collectively challenged to "think outside the box" and to explore what changes might be instituted in their programs to ensure that psychology would remain relevant to society's needs, and especially to consider how they could more actively embrace the notion of Primary Care Psychology, with its emphasis upon educated consumers, enhancing wellness, providing a priority for behavioral health, and stressing interdisciplinary care, all of which are key foundations of President Obama's Health Care Reform legislation. The President's initiative will provide 32 million previously uninsured Americans with access to care, at a time when there is a shortage of health care providers, especially in rural areas. PPACA is patient-centered, not provider-centric. Tomorrow's training programs must take into account the changing demographics of our nation, the critical importance of providing culturally sensitive care, and appreciate the extent

continued on page 42

to which their students will have grown up in a more "technologically connected" environment than most faculty.

Will our educational leaders accept their societal responsibility to provide visionary leadership and affirmatively advocate for obtaining psychology's fair share of society's substantial training resources? Do we believe in the importance of psychology's contributions to health care? The educational leadership of nursing and pharmacy are increasingly expanding their efforts to offer their students integrated and co-taught joint degrees that are directly relevant to the 21st century health care environment—will psychology seriously consider this as well? In tomorrow's practice environment, access to the knowledge-base of business, economics, law, public health, informatics, and religion would seem highly relevant for those future colleagues willing to seek leadership roles. To cite an example, with our nation's ever-aging population, psychology should be systematically increasing its emphasis on training those interested in serving the elderly and making sure that they are aware of that subpopulation's unique health care needs, as well as the contributions other disciplines are already making. The vision, enthusiasm, and appreciation for the need to fundamentally change our training institutions demonstrated by the Mid-Winter conference attendees was very refreshing. These are truly interesting times. Aloha,

Pat DeLeon

WANTED:

CLINICIANS TREATING SOCIAL ANXIETY

As part of an ongoing collaborative initiative to establish a two-way bridge between research and practice, the Society of Clinical Psychology (Division 12 of the American Psychological Association) and Division 29 of the American Psychological Association, have created a mechanism whereby practicing therapists can report on their clinical experiences using empirically supported treatments (ESTs). Much in the way that the Food and Drug Administration (FDA) provides physicians with a method for giving feedback on their experiences in using empirically supported drugs in clinical practice, we have established a procedure for practicing therapists to disseminate their clinical experiences. This is not only an opportunity for clinicians to share their experiences with other therapists, but also can offer clinically based information that researchers may use to investigate ways of improving treatment.

We started with the treatment of panic disorder, and some of you may have been taken that survey—for which we are grateful. The findings of the panic survey appear in *The Clinical Psychologist*, the newsletter of the Society of Clinical Psychology [American Psychological Association (APA) Division 12 Committee on Building a Two-Way Bridge Between Research and Practice (2010)]. You can get a copy of this on page 10 of the newsletter by either clicking, using control+click, or copy and pasting the following:

http://www.div12.org/tcp_journals/TCP_Fall2010.pdf#page=10

We would now ask you to complete a very brief survey of your clinical experiences in using an EST—specifically CBT—in treating social anxiety. By identifying the obstacles to successful treatment, we can then take steps to overcome these shortcomings.

Your responses, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 and 29 Web sites at a later time. The results of the feedback we receive from clinicians will be provided to researchers, in the hope they can investigate ways of overcoming these obstacles.

The social anxiety survey is short—it should take 10 minutes, appears in a popular survey format, and can be found by clicking, control+click, or copy and pasting the following:

http://www.surveymonkey.com/s/6L9CLHN

Thank you.

Jeffrey Hayes, Ph.D.

Psychotherapy is the central focus of my professional life, Division 29 is my home within APA, and I would be honored to serve the Division of Psychotherapy as your President. I have conducted psychotherapy in private practice since 1992, and as a Professor at Penn State University, I teach courses on psychotherapy, provide psychotherapy supervision, and conduct research on psychotherapy. I am a fellow of Division 29, and I received the Jack D. Krasner Early Career Achievement Award from the division as well. I have become familiar with the organization, structure, and functioning of Division 29 by serving in a variety of capacities during the past decade or so. I have served as a member of the Committee on Student Development (2000-2002), chaired the Committee on Education and Training (2002-2005), co-chaired the Taskforce for the Advancement and Advocacy of Psychotherapy (2003-2005), and both co-chaired (2008) and chaired the Fellows Committee (2009). I have also served on the editorial board of our journal, *Psychotherapy*, since 2004. As a result of the various roles in which I have been involved, I have come to know many members and leaders of Division 29, and I have a sense of the direction, needs, and multiple strengths of the division.

I believe strongly in the connections between clinically-relevant research and evidence-based practice. My own research has focused primarily on psychotherapist factors that influence the process and outcome of therapy, and recently I have been involved with the creation of a practice-research network of more than 150 college counseling centers. This practice-research network, known as the Center for Collegiate Mental Health, is yielding data on tens of thousands of clients that will advance both the practice and scientific understanding of psychotherapy. In my mind, research and practice ought to benefit one another, and one of my goals as Division 29 President is to support the creation and maintenance of additional practice-research networks to foster evidence-based psychotherapy for clients from diverse cultures, with various presenting concerns, and who are treated in any of a number of modalities.

One of the ways I would accomplish this aim would be to draw upon existing relationships with the Society for Psychotherapy Research (SPR). Previous leaders of Division 29 have reached out to develop connections with SPR, and I intend to continue to do so. As former President of the North American Chapter of SPR and having served for six years as Associate Editor of SPR's journal, *Psychotherapy Research*, I have relationships with many SPR colleagues. I believe that Division 29 and SPR can work collaboratively and synergistically to help meet our common goal: to advance the practice of psychotherapy.

I appreciate your consideration of my candidacy, and I look forward to the possibility of serving Division 29 as President.

William B. Stiles, Ph.D.

Psychotherapy is at the center of many psychologists' professional identity, and Division 29 is the center of psychotherapy within the American Psychological Association. Division 29 is an important and prosperous division within APA, with a large membership and a substantial income from its successful journal, *Psychotherapy*.

I have been a member of Division 29 since 1979. In recent years, I have served as chair of its Research Committee (2004-2008) and as a member of its Publication Board (2008-2011).

In my view, the main purposes of the Psychotherapy Division are communication and advocacy. As Division President, I would work to enhance communication—personal, print, and electronic—among Division members, between practitioners and scientists, with the rest of APA, with other clinicians and scholars, and with external decision makers and the public. I would do my best to advance the interests of Division 29's members within the organization and beyond.

About me:
In January, 2011, I become Professor Emeritus at Miami University in Oxford, Ohio, where I taught and supervised psychotherapy in the clinical psychology doctoral program for many years and served for 5 years as Director of its Psychology Clinic. Previously, I taught at the University of North Carolina at Chapel Hill, and I have held visiting positions at the Universities of Sheffield and Leeds in England, at Massey University in New Zealand, and at the University of Joensuu in Finland. I am licensed to practice in Ohio and in North Carolina.

I have been President of the Society for Psychotherapy Research and Editor of its journal, *Psychotherapy Research*. I am currently Editor of *Person-Centered and Experiential Psychotherapies* and Associate Editor of *British Journal of Clinical Psychology*. I have published over 250 journal articles and book chapters, mostly dealing with psychotherapy theory, research, practice, and training.

http://www.users.muohio.edu/stileswb/

Barry Farber, Ph.D.

A quick biography: I received my BA from Queens College in 1968, a masters degree in Developmental psychology from Teachers College (Columbia University) in 1970, and my PhD in clinical-community psychology from Yale University in 1978. I've been a full-time faculty member of the clinical psychology program at Teachers College (TC) since 1979, beginning as an Assistant Professor and now as Full Professor. Since 1990, I've been Director of Clinical Training at TC, and along the way I've also served two stints as Department Chair.

I'm a strong believer in the science-practitioner model and have been both a researcher and practitioner for over 30 years. My early research focused on the effects of psychotherapy on the therapist, including therapists' vulnerability to stress and burnout. In more recent years, I've studied (with my colleague Jesse Geller) the ways in which patients and therapists construct and use representations of the other to further the work of therapy; the extent to which patients and therapists do and don't disclose to each other; the implications of attachment theory for psychotherapy; and the importance of therapists' providing positive regard and support to their patients. I'm proud of the fact that I've published a good deal of my work in *Psychotherapy*, a journal (among a few others) on whose editorial board I also serve. In addition to the time I spend on administration, research, and teaching, I've maintained a small private practice of therapy. Among other hobbies, I collect examples of what I consider psychologically astute rock lyrics, and I published a book on this topic (*Rock 'n Roll Wisdom*) in 2007. My other books have been on self-disclosure in psychotherapy, burnout, and the psychotherapy of Carl Rogers.

My professional career has, for the most part, been focused on the needs of the clinical psychology program at Teachers College. Now, however, I'd like to be a greater part of the national community of psychotherapy researchers and practitioners, and help with the increasingly significant and politically critical tasks that lie before us. To that end, I'd welcome the opportunity to serve as secretary of this enormously important and influential APA Division.

Eugene Farber, Ph.D.

I am honored to be nominated for secretary of the Division of Psychotherapy and welcome this chance to continue my service to the Division. I served on Division 29's Education and Training Committee from 2008 to 2010, serving as chair in 2009. This experience afforded me the opportunity to work with fellow committee members on topics pertinent to psychotherapy education and training based on consideration of key issues in the psychotherapy field. Examples included competency based psychotherapy, culture and diversity, systems of clinical case formulation, and psychotherapy integration. In addition to this work with Division 29, I am serving currently on APA's Committee on Psychology and AIDS.

As an Associate Professor in the Emory University School of Medicine Department of Psychiatry and Behavioral Sciences, I direct a community based HIV mental health services program with a strong emphasis on psychotherapy. I have served as a principal investigator or co-investigator on federally funded service, research, and training grants. Additionally, my publication portfolio includes articles on psychotherapy practice, especially as pertains to HIV-related psychotherapy. Reflective of my particular interest in psychotherapy training, I had the opportunity to co-edit a 2010 special section of *Psychotherapy: Theory, Research, Practice, Training* focusing on psychotherapy competencies in training and supervision from multiple theoretical perspectives. My clinical, academic, administrative, and community experiences have afforded multiple viewpoints in considering issues key to the psychotherapy field—viewpoints that I hope would benefit the work of Division 29.

Because psychotherapy is at the heart of my professional activities, I have a strong commitment to Division 29's mission to support the work of psychologists via advancement of the art and science of psychotherapy. As a candidate for secretary, I am enthusiastic about the possibility of sharing my skills and experiences in serving the important purposes and aims of the Division.

Armand R. Cerbone, Ph.D.

In dedicating a domain to social justice Division 29 has not only recognized the relationship between the rights and needs of the underserved to appropriate healthcare, it has committed its resources to securing quality mental health services for all. With the passage of national healthcare reform and parity for mental health services, our Division has important responsibilities and roles to play. Equally important are emerging international opportunities and challenges facing healthcare. Division 29 can be a voice to promote fair access to appropriate care.

If elected Domain Chair, I would bring to the table a long career as an effective champion for culturally competent care to misunderstood and mistreated groups. I have co-authored the APA's LGBT Guidelines for Psychotherapy and our policies on gay marriage and families, and co-chair of the first international conference on LGBT issues.

As president of the Illinois Psychological Association I initiated mandatory education for psychologists as much to educate the public to the competent care provided by psychologists as to insure quality care. That initiative became law in 2009.

I have a distinguished history in APA governance from the APA Board of Directors to chair of the Board for the Advancement of Psychology, to division president (44: LGBT Issues) to chair of many caucuses and committees. My record reflects seasoned skills and effectiveness in leadership. The confidence of my peer in my abilities is reflected in my standing as a Fellow of five divisions, as an ABPP in clinical psychology, and in the awards I have received for contributions to the advancement of psychotherapy in the public interest.

In my judgment, psychotherapy is the heart of our science and practice and social justice is its soul.

As a former Division Secretary, I know the Division well. It would be an honor to rejoin our team.

Arpana Inman, Ph.D.

It is an honor to be nominated as a candidate for Division 29 Public Interest and Social Justice Domain Representative. The advocacy of marginalized communities and the promotion of social justice has been an integral part of my personal and professional life. I see my involvement with social justice and public policy within Division 29 to be a natural extension of my professional work in the field of psychotherapy supervision and training and membership within APA. As an academic and researcher, focused on understanding the influence of social contexts/conditions (e.g., immigration, discrimination, violence) and cultural identities (e.g., gender, class, age, disabilities, sexuality) on one's wellbeing, I see access to culturally responsive services and resources to be a key barrier in psychotherapy services. Further, experiences are increasingly impacted by federal and state government policies (e.g., immigration status, civil unions versus marriage) but the impact of such policies are not equally applicable to all groups. The globalizing trends, political-social-economic –interpersonal unrest, the related trauma and its impact on identity, relationships, and wellbeing call for action. As such, I see the dialectic intersection between social justice and public policy to be foundational to our work as educators, researchers and practitioners of psychotherapy. It would be my privilege to enhance and expand the mission of social advocacy and equity in the psychotherapy field and Division 29.

DIVISION OF PSYCHOTHERAPY BOARD OF DIRECTORS MEETING

OCTOBER 16, 2010

Division 29 2010 President Jeffrey Magnavita and Division 29 2008 President Jeff Barnett present Lindsay Klimek with a certificate for outstanding service for her research on the TOPPS project

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NOTICE TO READERS

Please find the references for the articles in this *Bulletin* posted on our website: divisionofpsychotherapy.org

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Brief Statement about the Grant:

The annual Norine Johnson, Ph.D., Psychotherapy Research Grant provides $20,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Eligibility: Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: May 15, 2011

Request for Proposals

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Description
This program awards grants for research projects in the area of research on psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Program Goals
- Advance understanding of psychotherapist factors that may impact treatment effectiveness and outcomes through support of empirical research areas to include: type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.
- Encourage researchers with a successful record of publication to undertake research in these areas.

Funding Specifics
One annual grant of $20,000

Eligibility Requirements
- Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
- The selection committee may choose not to award the grant in years when no suitable nominations are received

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals

- Description of the proposed project to include goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans
- CV of the principal investigator
- Format: not to exceed 3 pages (1 inch margins, no smaller than 11-point font)
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted). The budget should clearly indicate how the grant funds would be spent.
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information

- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion.
- Grant funds that are not spent on the project within two years of receipt must be returned.
- When the resulting research is published, the grant must be acknowledged by footnote in the publication.

Submission Process and Deadline

Submit a CV and all required materials for proposal (see above for proposal requirements) to: Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net

Deadline: May 15, 2011

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Jim Fauth at jfauth@antioch.edu), or the Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Norman Abeles at abeles@msu.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net

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PSYCHOTHERAPY BULLETIN

Psychotherapy Bulletin is the official newsletter of Division 29 (Psychotherapy) of the American Psychological Association. Published four times each year (spring, summer, fall, winter), *Psychotherapy Bulletin* is designed to: 1) inform the membership of Division 29 about relevant events, awards, and professional opportunities; 2) provide articles and commentary regarding the range of issues that are of interest to psychotherapy theorists, researchers, practitioners, and trainers; 3) establish a forum for students and new members to offer their contributions; and, 4) facilitate opportunities for dialogue and collaboration among the diverse members of our association.

Contributors are invited to send articles (up to 2,250 words), interviews, commentaries, letters to the editor, and announcements to Lavita Nadkami, PhD, Editor, *Psychotherapy Bulletin*. Please note that *Psychotherapy Bulletin* does not publish book reviews (these are published in *Psychotherapy*, the official journal of Division 29). All submissions for *Psychotherapy Bulletin* should be sent electronically to jcornish@du.edu with the subject header line *Psychotherapy Bulletin*; please ensure that articles conform to APA style. Deadlines for submission are as follows: February 1 (#1); May 1 (#2); July 1 (#3); November 1 (#4). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.divisionofpsychotherapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or Division 29 should be directed to Tracey Martin at the Division 29 Central Office (assnmgmt1@cox.net or 602-363-9211).

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