Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.divisionofpsychotherapy.org

BULLETIN

In This Issue

2012 VOLUME 47 NO. 1

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Marvin Goldfried, Ph.D.
Psychology
SUNY Stony Brook
Stony Brook, NY 11794-2500
Ofc: 631-632-7823
Fax: 212-988-4495
E-mail: marvin.goldfried@sunysb.edu

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William B. Stiles, Ph.D.
P.O. Box 27
Glendale Springs, NC 28629
Phone: 336-877-8890
E-mail: stileswb@muohio.edu

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Dept of Counseling & Clinical Psych
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Ofc: 212-678-3125
Fax: 212-678-8235
E-mail: farber@tc.columbia.edu

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Baltimore, MD 21224-4889
Ofc: 410-583-1221
Fax: 410-675-3451
E-mail: steve@cantoncove.com

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Libby Nutt Williams, Ph.D.
St. Mary's College of Maryland
18952 E. Fisher Rd.
St. Mary's City, MD 20686
Ofc: 240-895-4467
Fax: 240-895-2234
E-mail: libbynuttwilliams@comcast.net

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Public Interest and Social Justice
Armand Cerbone, Ph.D., 2012-2014
3625 N Paulina St
Chicago, IL 60613
Ofc: 773-755-0833 / Fax: 773-755-0834
E-mail: arcerbone@aol.com

Professional Practice
Miguel Gallardo, Psy.D., 2010-2012
Pepperdine University
18111 Von Karman Ave Ste 209
Irvine, CA 92612
Ofc: 949-223-2500 / Fax: 949-223-2575
E-mail: miguel.gallardo@pepperdine.edu

Education and Training
Sarah Knox Ph.D., 2010-2012
Department of Counselor Education and Counseling Psychology
Marquette University
Milwaukee, WI 53201-1881
Ofc: 414-288-5942/ Fax: 414-288-6100
E-mail: sarah.knox@marquette.edu

Membership
Annie Judge, Ph.D. 2010-2012
2440 M St., NW, Suite 411
Washington, DC 20037
Ofc: 202-905-7721 / Fax: 202-887-8999
E-mail: Anniejudge@aol.com

Early Career
Susan S. Woodhouse, Ph.D. 2011-2013
Department of Counselor Education, Counseling Psychology and Rehabilitation Services
Pennsylvania State University
313 CEDAR Building
University Park, PA 16802-3110
Ofc: 814-863-5726 / Fax: 814-863-7750
E-mail: ssw10@psu.edu

Science and Scholarship
Norm Abeles, Ph.D., ABPP, 2011-2013
Dept of Psychology
Michigan State University
110C Psych Bldg
East Lansing, MI 48824
Ofc: 517-337-0853 / Fax: 517-333-0542
E-mail: abeles@msu.edu

Diversity
Caryn Rodgers, Ph.D. 2011-2013
Prevention Intervention Research Center
Albert Einstein College of Medicine
1300 Morris Park Ave., VE 6B19
Bronx, NY 10461
Ofc: 718-862-1727 / Fax: 718-862-1753
E-mail: caryn_rodgers@yahoo.com

Erica Lee, Ph.D., 2010-2012
80 Jesse Hill Jr.
Atlanta, Georgia 30303
Ofc: 404-616-1876
E-mail: edlee@emory.edu

APA Council Representatives
John Norcross, Ph.D., 2011-2013
Dept of Psychology
University of Scranton
Scranton, PA 18510-4596
Ofc: 570-941-7638 / Fax: 570-941-7899
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Linda Campbell, Ph.D., 2011-2013
Dept of Counseling & Human Development
University of Georgia
402 Aderhold Hall
Athens, GA 30602
Ofc: 706-542-8508 / Fax: 770-594-9441
E-mail: lcampbel@uga.edu

Student Development Chair
Doug Wilson, 2011-2012
419 N. Larchmont Blvd. #69
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E-mail: Tammi.Vacha-Haase@ColoState.EDU

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Department of Education and Counseling
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800 Lancaster Ave
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E-mail: rayna.markin@villanova.edu
Ofc: 610-519-3078

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Department of Educational and Counseling Psychology
220 University at Albany/SUNY
1400 Washington Ave.
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E-mail: mfriedlander@uamail.albany.edu

Finance
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333 Westchester Ave., Suite E-102
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Ofc: 914-595-4040
E-mail: drz@jzphd.com

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University of St. Thomas
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E-mail: jmbirbilis@stthomas.edu

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Centers for Disease Control and Prevention
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Atlanta, GA 30341
Ofc: 770-488-5726 Fax: 770-488-5848
E-mail: spdavis@cdc.gov

Psychotherapy Practice
Chair: Barbara Thompson, Ph.D.
3355 St. Johns Lane, Suite F.
Ellicott City, MD 21042
Ofc: 443-629-3761
E-mail: drbarb@comcast.net

Psychotherapy Research
Chair: Michael Constantino, Ph.D.
Dept of Psychology
University of Massachusetts
Tobin Hall - 135 Hicks Way
Amherst, MA 01003-9271
Ofc: 413-545-1388 Fax:413-545-0996
E-mail: mconstantino@psych.umass.edu

Social Justice
Rosemary Adam-Terem, Ph.D. 2009-2011
1833 Kalakaua Avenue, Suite 800
Honolulu, HI 96815
Ofc: 808-955-7372 Fax: 808-981-9282
Cell: 808-292-4793
E-mail: drrozi@yahoo.com

Liaisons

Federal Advocacy Coordinator
Bonita Cade, Ph.D.
63 Ash St
New Bedford, MA 02740
Ofc: 508-990-1077 Fax: 508-990-1077
E-mail: drbcade@gmail.com

PSYCHOTHERAPY BULLETIN

Published by the
DIVISION OF PSYCHOTHERAPY
American Psychological Association

6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

EDITOR
Lavita Nadkarni, Ph.D.
lnadkarn@du.edu

ASSOCIATE EDITOR
Lynett Henderson Metzger, Psy.D.
lhenders@du.edu

CONTRIBUTING EDITORS

Diversity
Erica Lee, Ph.D. and
Caryn Rodgers, Ph.D.

Education and Training
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PSYCHOTHERAPY BULLETIN

Official Publication of Division 29 of the American Psychological Association

2012 Volume 47, Number 1

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PRESIDENT'S COLUMN

Marvin R. Goldfried, Ph.D.
Stony Brook University

The governance structure of our Division is set up in such a way so that the President-Elect participates in both the Executive Committee and the Board of Directors before actually assuming the role of President. During my year as President-in-waiting, it became very evident to me as to how fortunate I was to be working with such dedicated and competent colleagues. What they do is very clearly a labor of love, and is done with admirable competence. In particular, I would like to acknowledge our current Past-President, Libby Nutt Williams, for serving as a wonderful role model, and I will do all I can to continue to keep the high standards of leadership that has characterized her efforts and the efforts of all the others involved in governance.

During the forthcoming year, one of my priorities will be to do what I can to close the gap between research and practice. I fully realize that this can be a daunting undertaking, and has been an open challenge for as long as I can remember. Indeed, my concern about the gap between practice and research started when I was in graduate school. To be sure, there was relatively little in the way of research that informed what we did clinically way back in the 1950s. However, even with the dramatic increase in psychotherapy research findings since that time, the gap continues to exist. Given the increased pressures for accountability, the need to close this gap is greater than ever.

Accountability and Best Practices

Within recent years, our division has become increasingly aware of the importance of having a research foundation for what we do therapeutically. I suspect that this growing recognition of the importance of research is not only a function of the greater research emphasis placed in training settings, but also the very real fact—indeed harsh reality—that our field is facing growing pressures for empirical accountability. The notion of "pay for performance" has been discussed at length by both governmental policymakers and insurance companies, whereby health workers (which include psychotherapists) who engage in accepted clinical practice and who are in fact clinically effective would receive a financial "bonus." Although principles of reinforcement clearly constitute the underlying premise for this practice, a little bit of thought can lead one to recognize that there are potential dangers involved—not the least of which is that health care workers could refuse to see more difficult patients. Over the past few years, it appears that the notion of pay for performance has been labeled in a much more socially acceptable way, now being called "quality assurance." However more benign this phrase may sound, the concept is very much the same.

A major issue in the move toward accountability is the question of who is to make the judgment as to what procedures constitute "best practices." It is clear that the argument can no longer be made on the part of us as clinicians that

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therapy is effective simply on our own say so. Even though there has been a dramatic increase in research on psychotherapy over the past few decades, producing findings that can offer the practicing therapist with helpful guidelines, there is much that goes on the practice of psychotherapy for which there exists little or no research (e.g., What are the causes of patient resistance, and what are the most effective ways of overcoming it). Having professional familiarity with both the world of research and the realities of clinical practice, I firmly believe that neither vantage point tells the whole story. Thus the demands for accountability from governmental agencies and third party payers make the need for greater collaboration between researcher and clinician more important now than it has ever been before.

Interestingly enough, this is an issue that is a concern among many within the medical field. In an interview with Dr. Jerome Groopman appearing in the December 17, 2009 issue of the *New York Review of Books,* he offers his impassioned view on this topic. Groopman, a researcher and practicing physician, argues for the importance of research evidence, but also the need to be cautious in concluding that research findings tell the whole story. As he puts it:

> I'm a scientist. I'm a professor at Harvard. I've done the clinical trials in my own field that have led to such "evidence." But I'm also acutely aware of their limitations. Statistical analysis is not a substitute for thinking. . . . there is a very powerful group with an ideology emphasizing evidence-based medicine, what they call "best practices." That is a wonderful term, because how can you argue with best practices? (p. 22).

Noting that research findings from clinical trials do not always inform the physician on what to do with an individual patient, Groopman goes on to say:

> Many people do not realize that in general the committees that draw up clinical guidelines force a consensus, and there are often experts who disagree with some aspects of the guidelines or contend that they are flawed (p. 24). . . . [Moreover,] a recent analysis of more than a hundred evidence-based conclusions about clinical practice reported that after two years more than a quarter of the conclusions were contradicted by new data, and that nearly half of the "best practices" were overturned at five years. This shows that guidelines are not gospel from a scientific point of view (p. 24).

I find it particularly interesting that this gap between research and practice also exists in medicine, which clearly has been around a lot longer than the practice of psychotherapy. Still, they have mechanisms that not only allow for the researcher to inform the practicing physician, but also for the physician to inform the researcher. Thus even after a drug has been approved for clinical use on the basis of clinical trials, there is a way that practicing physicians can report back to the Food and Drug Administration on their experiences in using that drug clinically. Division 29, together with Division 12 (the Society of Clinical Psychology), has recently established such a feedback mechanism for therapy procedures that have been backed by clinical trials—whereby practicing therapists can report on their ex-

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periences in using empirically supported treatment in their clinical practice. More about this collaborative initiative of Building a Two-Way Bridge Between Research and Practice in a future column.

The *Psychotherapy Bulletin* is Going Green:

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NOTICE TO READERS

References for articles appearing in this issue can be found in the on-line version of Psychotherapy *Bulletin* published on the Division 29 website.

EDITORS' COLUMN

Lavita Nadkarni, Ph.D.
Lynett Henderson Metzger, Psy.D., J.D.
University of Denver – Graduate School of Professional Psychology

Welcome to the first issue of the *Psychotherapy Bulletin* for 2012. We are again pleased to present you with papers that you should find informative and helpful. We are thankful to have our previous talented team of contributing editors, domain representatives, division administrator Tracey Martin, and Editorial Assistant Jessica Del Rosario, and welcome our new contributors. We continue under the able leadership of Jeffrey Barnett and the Publication Board. The 2012 Contributing editors and Domain representatives are as follows: Erica Lee and Caryn Rogers (Diversity), Susan Woodhouse and Rayna Markin (Early Career), Jairo Fuertes and Sarah Knox (Education & Training), Jennifer Erickson Cornish (Ethics), Jean Birbilis and Annie Judge (Membership), Miguel Gallardo and Barbara Thompson (Professional Practice), Norman Abeles and Michael Constantino (Psychotherapy Research, Science, and Scholarship), George Stricker (Psychotherapy Integration), Armand Cerbone and Rosemary Adam-Terem (Public Interest and Social Justice), Doug Wilson (Student Features) and Patrick DeLeon (Washington Scene).

In this issue, we welcome Marvin Goldfried's first column as Division 29 President. There is an engaging article written by Jennifer Sermoneta and George Stricker on the evaluation of risk in the mother-infant dyad and the creation of an integrative assessment tool for measuring such risk. James Boswell has provided a compelling argument for the use of the Unified Protocol for the treatment of emotional disorders. We are once again privileged to have the psychotherapy practice musings of Barbara Thompson and Barbara Vivino. Jenny Cornish provides us with an inside look into the workings of the APA Ethics Committee, after having served for a three year term. Zachary Bruback and Charles Waehler offer us a fresh perspective on the teaching of empirically supported treatments. Pat DeLeon is back with his insights in the Washington Scene. Finally, we offer a tribute to Norine Johnson.

In our attempt to provide *voice* to the next generation of psychotherapists, we are inviting students to add their creative input to the *Bulletin*. In this issue, Lauren Palazzolo, a first year doctoral student at Loyola University Maryland, allows us a glimpse into her experiences of her first semester, through the medium of poetry.

As usual, please contact us with your ideas, suggestions, criticisms, and comments. Your contributions are always welcome. All members are encouraged to submit work that you believe would provide interesting, scholarly, timely and useful information to the membership

Lavita Nadkarni
(303-871-3877, Lnadkarn@du.edu) and
Lynett Henderson Metzger
(303-871-4684, lhenders@du.edu).

Integrating Concerns of Mothers and Infants: The Sermoneta Checklists of Mother-Infant Risks and Strengths (SC-MIRS)

Jennifer Sermoneta, Psy.D., Private Practice, Bethesda, Maryland
George Stricker, Ph.D., Argosy University, Washington, D.C.

Vignette – A postpartum mother and infant

Esperanza, a Spanish-speaking postpartum mother in her late 20's, presented at our clinic one Friday. She was tearful and concerned about her depressive and anxious symptoms and her (ego-dystonic) thoughts of harm to her five-month-old baby. She showed no evidence of plan or intent to harm, and her mental status appeared adequate apart from the intrusive thoughts. Her baby, who she had brought to the session, was clean, pudgy, sleepy and expressionless. Her 7-year-old son, who appeared to be developing normally, also came with her.

Esperanza reported having a supportive and employed husband, a helpful mother-in-law, and a consistent work history. She gave no evidence of current, historic, or familial mania, psychosis, or child abuse. She described her thoughts of harm as "frightening" and "uncomfortable," and "incomprehensible" because she would "never do anything to harm" her children.

After our session, and consistent with clinic procedures, I (JS) sent her to her medical clinic, "Clinic B" with her Edinburgh Perinatal Depression Screen (EPDS) and a brief note stating she was feeling sad and anxious and wanted to discuss starting medication. They immediately sent her to the emergency room on the basis of her "homicidal thoughts." I spent the weekend vacillating between anger and panic. I speak fluent Spanish and had felt comfortable with the intake, but maybe I had missed something: was this woman homicidal, at risk of harming her baby? Or had Clinic B unnecessarily separated a mother from her child--adding to family stress, harming attachment, and incurring heavy emotional and financial costs on the family and the county? Was Clinic B right, or just playing it safe for its own benefit? Should I have done the same?

Unlike Clinic B's clinician, I (JS) had judged this mom to be one of the 41% of women with postpartum depression (PPD) who have ego dystonic thoughts of harm to their baby (Jennings, Ross, Popper, & Elmore, 1999), but would not actually harm the baby. Why did I make this judgment? At the time, my judgment was based more on intuition and overall feeling than may be safe. In retrospect, I can identify the ingredients of my decision, as summarized above. I was concerned about the mother and child's well-being, but for reasons noted above, I was not alarmed about any potential for harm.

The following Monday, I (JS) found out which hospital Esperanza was in and went to talk with her and the doctors. The psychiatric ward's attending psychiatrist told me that, since no Spanish-speaker had been available on the busy Friday night she had arrived, they com-

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mitted her given the referral of *"Something about thoughts of harming her infant."*

Was this commitment necessary?
Perhaps if Esperanza had brought along a more complete discharge note or written intake specifying the strengths and weaknesses of the mother-infant dyad, Clinic B or the Emergency Room would have been able to make a more informed decision. But our clinic's time constraints did not permit a full write-up; another patient was waiting right behind Esperanza.

The need
This patient's experience highlights the need for an organized and efficient approach to perinatal assessment. The standard approach to assessing perinatal mothers is to look for PPD using the ten-question EPDS. While extremely useful, the EPDS is designed as a screen for PPD: it is not concerned with other important mother-infant risk factors such as abuse, psychosis, family history, situational dangers, any type of thoughts of harm to the baby, or substance use. As clinicians, we need a way to quickly but thoroughly assess a patient: what will yield maximum therapeutic benefits, and what are potential risks that need management. We also need to document the process and communicate efficiently about it. And it is important that we be able to accomplish those as easily and quickly as possible. I (JS) decided to create a checklist.

How the checklist responds to the need: The Sermoneta Checklist of Mother-Infant Strengths and Weaknesses (SCMIRS) provides a method to make the assessment process explicit, thorough, and easy to document and communicate.

Although clinicians may sense whether a patient is at immediate risk, we may not have the detailed reasons available in an explicit, conscious way. Or we might, occasionally, forget a detail. Or it might take too long to write them all down. A checklist provides a detailed and explicit structure for thinking, reviewing, and communicating; a safety check. Although checklists cannot guarantee safety, they have been found highly effective in medicine (Gawande, 2009) and, likewise, a checklist offers an organized and inclusive approach to reviewing the key risk factors for mother-infant pairs.

A meaningful checklist must incorporate three broad concepts. First, perinatal risk factors include not just risks to immediate safety, but also to longer-term issues like the health of the mother-child bond and the child's social, cognitive, and behavioral development (Blehar, Lieberman, & Ainsworth, 1977; Bowlby, 1951, 1958; Cicchetti & Cohen, 2006; Feldman, 2007 ; Forman et al., 2007 ; Sanders, 1999; Swain, Lorberbaum, Kose, & Strathearn, 2007; van der Horst & van der Veer, 2010). Second, certain factors are indicators of dyad strengths (Alink et al., 2009; Baumrind, 1968; Locke & Prinz, 2002; Priest, Austin, Barnett, & Buist, 2008; Sanders, 1999; Stern, 2004, 2005; Winnicott, 1971). Finally, it is important to look at both mother and infant factors, and see the two as a pair, rather than seeing the mother as the patient and the baby as an at-risk extension of her. Combining elements of risk, strength, and viewing the mother and baby as a dyad helps provide a framework for developing a step-by-step way to consider the pair's well-being.

Practitioners should keep in mind, however, that while it seems reasonable to assume that a preponderance of strengths, or certain particular strengths, can help offset some of the risks, it is unfortunately not clear whether that is the

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case. Perhaps by studying strengths and risks in combination we will learn more.

Other uses of the checklist

- Identifying risk factors affecting pregnant patients, even before they give birth
- Helping to train people who work with perinatal women (Psychologists, nurses, nurse practitioners, midwives, obstetricians, psychiatrists, pediatricians, counselors, social workers, and other clinicians involved with mothers and infants)
- Measuring treatment outcomes by monitoring change in the mother-infant dyad over treatment or time
- Increasing salience of multiple factors in clinicians' minds
- Helping the clinician structure his or her thinking in preparation for
- Consultation
- Supervision
- Communication with another clinician or member of the treatment team
- Consultation with the patient or family
- Providing another clinician or supervisor with an efficient and broad way to review a case
- Helping the clinician organize and "hold" complex details about a case, allowing her to focus therapeutic attention on the patient and the relationship, rather than on the details.

Creating the checklist: An integrative process

The checklist began with factors the perinatal literature or clinical experience identified as contributing to risks and strengths, broadly defined. The items began as a laundry list of disconnected characteristics, symptoms, and concerns. Over time, patterns emerged. We saw the outlines of dimensions and saw how groupings of factors could be organized. The dimensions can be seen as individual checklists or as parts of the whole.

Bits of knowledge or lore led to different parts of the literature. For example, the belief that family factors, such as having a supportive partner, can decrease chances of postpartum depression led to Bronfenbrenner (Bronfenbrenner, 1977, 1986, 1990a, 1990b, 2005; Bronfenbrenner & Ceci, 1994) for a perspective on context. The finding that maternal warmth can moderate harsh discipline (Alink, 2009) led to attachment theory. Additionally, questions about how the individuals–mother and baby, not just mother–contribute to the wellbeing of the dyad led to Stella and Chess (Goldsmith et al., 1987) and Kagan (Kagan, 2001, 2006; Kagan, Reznick, & Snidman, 1988; Kagan, Snidman, & Arcus, 1998) to consider temperament. The checklists integrate a wide range of research and theory not typically used together: developmental, infanticide, attachment, and ecological theory.

But integrating these disparate components required two crucial components. The first was Ainsworth's (Ainsworth, 1969) down-to-earth, detailed, training instructions for her Baltimore study's observers of "maternal sensitivity." Clear, compelling, and useful, her instructions slid into place perfectly as an armature on which to arrange the rest of the findings, allowing the work to be integrative rather than accumulative. The second crucial piece was literature on infanticide, which yielded vital information about consistent risk factors (Comtois, Schiff, & Grossman, 2008; Freeman, 2007; Friedman, Horwitz, & Resnick, 2005; Friedman, Hrouda, Holden, Noffsinger, & Resnick, 2005a, 2005b; Gjerdingen & Yawn, 2007 ; Kauppi, Kumpulainen, Vanamo, Merikanto, & Karkola, 2008; Kinniburgh, Morrow, & Lipscomb, 2004; Koenen & Thompson Jr., 2008; Lewis &

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Bunce, 2003; Overpeck et al., 1999; Overpeck, Brenner, Trumble, Trifiletti, & Berendes, 1998; Papadopoulos et al., 2009; Resnick, 1969; Viguera, Cohen, Baldessarini, & Nonacs, 2002; West, 2007).

Having assembled a basic tool, we tried to guard against "blame" of either the mother or the father. For example, although merely intended as neutral shorthand, the belief that having a supportive partner decreases risk of post partum depression (PPD) implies that PPD might occur because a partner is not "supportive enough." However, what if the partner is also experiencing anxiety, depression, situational stressors, illness, or grappling with difficult reactivated childhood schemas? Or what if the origin of the mother's PPD is primarily endocrinal? Or what if a partner who is trying to be supportive is rejected, or simply not experienced as supportive? The "un-blaming" process is ongoing.

The organization of the Checklists:
The SC-MIRS checklists are comprised of factors that research and clinical observation suggest contribute to the well-being of the mother-infant dyad. Well-being is defined as the mental health of the mother and infant, and the health of their relationship. The SC-MIRS has separate versions for prenatal and postpartum uses.

High-risk items are consolidated into a single checklist, even if they relate to other dimensions. This constitutes the first checklist, and is the only one intended to be reviewed before the patient's departure. Other, more circumspect, considerations are in the checklists. These non-immediate risks and strengths can help a clinician gain a broader understanding of the patient dyad and context, and may thus assist with conceptualization and treatment planning.

The checklists are followed by prompts for consideration of the results, as well as some suggestions for responses in case of high risk and suggestions for treatment in non-emergent cases. The checklists are not currently normed or validated, but you are encouraged to try them out by requesting them from the first author. Your comments and experiences would be very welcome.

The ten dimensions of the SC-MIRS are:

1. High Risk;
2. Current Context;
3. Current Social Support Systems;
4. Family Relational History;
5. Individual History of Mother/Pregnant Woman;
6. Individual Factors of the Baby and Birth/Attitude of Pregnant Woman Toward Pregnancy;
7. Current General Functioning of the Mother/Pregnant Woman;
8. Current Parental Functioning of Mother (no parallel for prenatal version);
9. Relational Characteristics (attachment) between Mother & Baby (no parallel for prenatal version); and
10. Clinician Countertransference.

The dimensions progress from the broadest perspective—the context of the dyad—to the more immediate supports and family, and then to the individual characteristics of the mother and the baby. This order is intended to ground the clinician in a perspective that considers stressors and strengths the dyad is facing together, rather than encouraging us to place blame by seeing problems as stemming from the mother's or, in certain cases, the infant's individual character.

Next, the checklists look at current functioning of the pregnant woman or

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mother to identify strengths that might be leveraged or shortcomings the pair might need help with. After this, the relationship between mother and infant is assessed as much as possible given the age and developmental level of the infant.

The next step includes four prompts to encourage the clinician to think through his or her own reactions to the dyad and their emerging relationship.

Finally, the tool helps clinicians synthesize their thoughts about strengths, weaknesses, and areas of multiple unknowns in the domains above, and offers a few suggestions for follow-up actions.

The factors draw primarily from bioecological and attachment theories, integrated with the filicide and child abuse literature. The checklists identify observable factors, but go beyond a functional or behavioral perspective. The factors were studied in their primary research, but the checklists have not yet been studied as a tool, though we would like to do that in the future. The tool still needs validation and clinician input would help strengthen it as well.

Applied perinatal work typically focuses either on a medical or cognitive behavioral approach, or on the attachment outside of a contextual perspective. The SC-MIRS, by comparison, unites and tries to integrate emphases on relationship, ecological, behavioral, and dynamic elements. In addition, the SC-MIRS tries to incorporate the idea that patients' strengths facilitate treatment: while much perinatal screening looks only at concerns, the SC-MIRS emphasizes strengths as well.

The SC-MIRS would have been useful with Esperanza's situation: mother and infant presented with problems that were anxiety-provoking for clinicians as well as patients, but the SC-MIRS might have helped the therapist justify and communicate about a decision to not hospitalize, and could have helped formulate a more effective treatment path instead. In this case, Esperanza was released after three nights in the psychiatric ward, but the experience left her confused and distrustful about asking for help in the future. It threw her into a labyrinth of hospital bills, and kept her, her mother-in-law, and her husband out of work for three days. It deprived her of sleep and peace. Finally, and most ironically, it took her away from her infant and child.

Thus far, using the SC-MIRS for cases has helped us organize a lot of ambiguous case information, develop ideas for interventions, and focus on the clinical relationship. It has facilitated the use of a dual thought-process, going back and forth between analysis of detail and synthesis of meta-level content, with each enhancing the other. The SC-MIRS has contributed to tracking contradictory narratives and information; therapeutically managing childhood abuse; gauging patient growth; contextualizing the dyad; monitoring specific parenting behaviors; and observing attachment patterns and parallel processes.

We hope that the SC-MIRS will help clinicians accurately identify and treat those who need more intensive help. In Esperanza's particular case, it also might have helped prevent an unnecessary hospitalization.

References for this article can be found in the on-line version of the *Psychotherapy Bulletin* published on the Division 29 website.

The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders

James F. Boswell, Ph.D., Boston University

The field's movement toward developing, testing, and disseminating highly operationalized intervention strategies has had a tremendous impact on psychotherapy practice, research, and training in recent decades. Numerous evidence-based psychological treatments have been developed to target specific anxiety and mood disorders (Nathan & Gorman, 2007; Roth & Fonagy, 2005). However, this emphasis has led to a proliferation of treatment manuals focused on narrowly defined problems and techniques (Norcross, 2005). The abundance of increasingly specific treatment manuals, many of which have only trivial variations in treatment procedures, has had the paradoxical effects of increased burden on practicing clinicians and trainees, and significant strain on transportability and dissemination (McHugh & Barlow, 2010).

A key impetus for the psychotherapy integration movement has been the identification and consolidation of core treatment principles and mechanisms of change that underlie different treatments and diagnostic categories (Boswell & Goldfried, 2011; Castonguay & Beutler, 2006). Such information can be used to improve existing treatments or to develop more efficient interventions. Current evidence strongly supports this effort in the treatment of emotional disorders (see Barlow, Allen, & Choate, 2004; Mansell, Harvey, Watkins, & Shafran, 2009). For example, research has shown a considerable degree of overlap among various anxiety and mood disorders, particularly in relation to diagnosis, in which high rates of current and lifetime comorbidity have consistently been observed (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; McGlinchey & Zimmerman, 2007).

The substantial comorbidity could be explained by the presence of common underlying factors related to the development and maintenance of emotional disorder (or general neurotic syndrome; Wolfe, 2011), with manifest differences (e.g., the focus of fear being social evaluation versus contamination) representing relatively superficial variations of the same process. In fact, research in the areas of neuroscience (Etkin & Wager, 2007), emotion science (Fellous & Ledoux, 2005), and psychopathology (Brown & Barlow, 2009) has begun to elucidate common, higher-order dimensions of temperament that underlie emotional disorders, most significantly, negative/positive affect and behavioral inhibition/activation (Brown, 2007). These dimensions are closely linked with other shared factors, such as cognitive-emotional processing biases (Beck & Clark, 1997; McLaughlin, Borkovec, & Sibrava, 2007) and increased emotional reactivity and cognitive-behavioral avoidance (Brown & Barlow, 2009; Campbell-Sills, Barlow, Brown, & Hofmann, 2006).

These findings point to the importance of developing treatments that target the underlying features of emotional disorders. In addition to being more parsimonious, such *transdiagnostic* treatments (see Norton & Philipp, 2008) may prove to be more powerful and generalizable in terms of their effects (e.g., influence

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comorbid conditions), as they involve the integration of core therapeutic principles of change aimed at addressing shared etiological and maintaining factors (Harvey, Watkins, Mansell, & Shafran, 2004). As one example, the *Unified Protocol* for the Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et. al, 2011a; Barlow et al., 2011b) is an emotion-focused cognitive-behavioral treatment (CBT) that applies to all anxiety and unipolar mood disorders, as well as other disorders with strong emotional components (e.g., somatoform and dissociative disorders). In this paper, I will briefly describe the development and components of the UP, review recent research findings, and present relevant ongoing and future research efforts.

The Unified Protocol

The UP represents an integration of common principles of human functioning and therapeutic change found in evidence-based treatments for emotional disorders (e.g., Barlow & Craske, 1989; Beck, Rush, Shaw, & Emery, 1987), as well as research on emotional processing (Campbell-Sills et al., 2006; Mennin, Heimburg, & Turk, 2005). It is anchored by common CBT strategies, such as the restructuring of maladaptive cognitive appraisals, changing action tendencies associated with problematic emotional responses, preventing emotion avoidance, and utilizing emotion exposure procedures, yet is also distinctly emotion-focused in its emphasis on the functional nature of emotions (Greenberg & Watson, 2006), facilitating emotional approach and tolerance (Greenberg, 2008), and emotion regulation (Gross, 1998). Although earlier versions of the UP exist (see Allen, McHugh, & Barlow, 2008; Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010), the current version, recently published in a client workbook (Barlow et al., 2011a) and companion therapist guide (Barlow et al., 2011b), is designed to be carried out in 12-18 sessions and includes five core modules, an introductory module, a motivational enhancement module, and a relapse prevention module. The following is a brief description of each sequential treatment module (excluding the introductory session).

Motivational Enhancement/Treatment Engagement. This module focuses on motivational strategies to enhance patients' readiness for behavior change and to increase self-efficacy (Arkowitz, Westra, Miller, & Rollnick, 2008). Ambivalence regarding behavior change is marked, and the patient is guided to weigh the pros and cons of both changing and staying the same. The patient is also assisted in establishing concrete treatment goals as well as specific steps for achieving these goals.

Psychoeducation and Tracking of Emotional Experiences. This module includes psychoeducation regarding the nature of emotions, with an emphasis on their adaptive, functional nature. Patients learn about and begin to monitor the physical, cognitive, and behavioral components of their emotional experiences, as well as maintaining factors.

Emotion Awareness Training. This module focuses on continued identification of emotions and emotion-response patterns, and the practice of non-judgmental, present-focused awareness of emotional experiences. Patients are taught skills that allow them to observe all components (thoughts, physical sensations, and behaviors) of their emotional experience more objectively through mindfulness (e.g., Segal, Williams, & Teasdale, 2002) and emotion induction exercises.

Cognitive Appraisal/Reappraisal. This module focuses on the role of maladaptive automatic appraisals in emotional experience. Two overarching categories of thinking traps are targeted: overestimating the probability of negative

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events occurring and catastrophizing. Patients learn to identify thinking patterns, practice cognitive reappraisal, and practice thinking more flexibly about their emotions and triggering situations.

Emotion Avoidance and Emotion-Driven Behaviors. This module focuses on maladaptive behavioral responses in the context of distressing emotions. Patients learn to identify patterns of emotion avoidance and problematic emotion-driven behaviors (EDBs) that are central to the maintenance of emotional disorders due to negative reinforcement and the disruption of new learning. After learning about these patterns (including short and long-term consequences of avoidance), patients work to replace these action tendencies with more adaptive behaviors.

Awareness and Tolerance of Physical Sensations. In this module, patients learn to become more aware of and to better tolerate the physical sensations inherent in strong emotional experiences. Based on models of panic disorder and panic treatment (e.g., Craske, 1991), the therapist leads the patient through a series of interoceptive exposure exercises designed to elicit intense physical sensations that are similar to those associated with his or her most distressing emotional experiences. These sensations are then further integrated with other emotion components (thoughts and behaviors) to promote additional learning about the dynamic nature of emotional responses.

Interoceptive and Situation-Based Exposures. This module involves systematic and repeated exposure to both internal and external emotional triggers. These exposures are aimed at increasing the patient's tolerance of emotions and practicing the consolidation and implementation of previously learned skills in contexts that are most emotionally relevant. Over the course of several sessions, the therapist assists the patient in working through a constructed emotion avoidance hierarchy.

Relapse Prevention. The final component involves a review of the treatment concepts and discussion of patient progress. The therapist and patient develop a plan for continued practice and anticipate future difficulties. Efficacy is reinforced and post-treatment short and long-term goals are established.

Empirical Support

The UP was developed based on both basic and applied research. Although each of the core treatment components is anchored in well-established cognitive-behavioral treatments for various emotional disorders, specific evidence for the efficacy of the UP package is emerging. Early versions were piloted in two open trials with patients presenting with diagnostically heterogeneous anxiety and depressive disorders (Ellard et al., 2010).

In the first trial (n = 18), clinically significant pre-post treatment effects were observed across disorders on a variety of outcome measures, with 56% of patients responding and 33% achieving high end-state functioning (HESF). Based on these results, the protocol was further developed before conducting a second open trial (n = 15) with similarly heterogeneous diagnostic representations (Ellard et al., 2010). Outcomes were more robust in this second trial, with 73% of patients responding and 60% achieving HESF. In addition, 64% of patients achieved both responder and HESF on comorbid disorders. These results were maintained at 6-month follow-up, with 85% responding and 69% achieving HESF for principal diagnoses, and 80% responding and over 50% achieving HESF on comorbid disorders. Preliminary evidence was also gathered for changes in hypothesized

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underlying transdiagnostic dimensions. Using the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988), results indicated that 67% of patients achieved scores within the normal range on the negative affect subscale at post-treatment, and 82% had scored within the normal range at 6-month follow-up.

Based on these results, as well as patient and therapist feedback, the protocol was further developed and tested in a larger randomized controlled trial (RCT; Farchione et al., in press). Thirty-seven patients presenting with heterogeneous anxiety and depressive disorders, and a high degree of cormoridity, were randomized to either immediate UP treatment or to a waitlist/delayed UP condition. Moderate-to-large pre-post between condition effect sizes were observed for the primary outcome measures. Pre-post within treatment effect sizes for the primary outcome measures were also moderate to large, with most of these effects maintained or enhanced at 6-month follow-up. Approximately 60% of patients responded and 52% achieved HESF on principal diagnoses at post-treatment; 38% responded and 41% achieved HESF on comorbid diagnoses. Higher percentages were observed at 6-month follow-up, with 71% responding and 64% achieving HESF on principal diagnoses, and 62% responding and 72% achieving HESF on comorbid diagnoses. Significant pre-post and pre-follow-up effect sizes were also observed on the PANAS Negative (NA) and Positive (PA) affect subscales. Taken together, these results suggest that the UP is efficacious and durable in the treatment of various anxiety and depressive disorders. It has also evidenced promising effects on comorbid diagnoses.

Current Research Efforts and Future Directions

Several additional current and ongoing research efforts include (a) examining hypothesized mechanisms of change and process-outcome relationships in the UP, (b) conducting case studies to preliminary test the UP's effectiveness in the treatment of other disorders involving emotion dysregulation, and (c) investigating the process and impact of training in transdiagnostic CBT treatments. For example, we are investigating if changes in quality of life, intolerance of uncertainty, and emotional willingness are predictive of outcome. In addition, we are examining the process and impact of including interoceptive exposures in the treatment of individuals without principal panic disorder, as well as the association between readiness to change and outcome. Single case designs are also being conducted to examine the UP's effectiveness in the treatment of depression in bipolar disorder, principal posttraumatic stress disorder, and borderline personality disorder, as well as to further examine effects in principal unipolar depression.

We are also in the process of conducting a larger-scale RCT to further examine the efficacy of the UP in comparison to active treatments. Specifically, we are conducting a non-inferiority clinical trial directly comparing the UP to single diagnosis CBT protocols (SDPs). This will begin to establish whether the UP can be considered at least as efficacious as SDPs in the treatment of diverse anxiety disorders. If evidence for equivalency is obtained, the UP would represent a possibly more efficient and effective strategy for treating emotional disorders and comorbid conditions, in comparison to the current reliance on SDPs. In turn, this may positively impact, or at least simplify, training and dissemination efforts.

References for this article can be found in the on-line version of the *Psychotherapy Bulletin* published on the Division 29 website.

Teaching with Greater Clarity by (Re) Gaining a Broader Perspective on ESTs

Zachary T. Bruback
Charles A. Waehler, Ph.D.
The University of Akron

Everyone we know—students and professionals alike—is in favor of increasing the empirical support for psychological interventions. As an advanced doctoral student, Zac sees the benefits from advancing empirical support for psychology as an important tool to train and educate early career psychology professionals. He wants to know that the training and education he receives as a graduate student will prepare him with empirical support for evaluating and implementing psychological interventions. As an academic training professional, Charlie yearns to increase the credibility and merit of the psychological interventions in which he trains students and which he hopes will sustain the future of our profession in the face of decreasing resources. He also recognizes that educating students in ESTs (Empirically Supported Treatments) is mandated as part of APA accreditation for doctoral programs (APA, 1996).

What we also recognize is that there is a dispiriting devil in the details when a strong evidence basis for treatments is sought. An over-focus on these details has, at times, seemed to reduce what could be a constructive dialogue about important issues into an acrimonious take-no-prisoners debate. Although the details are important, too often attention to them seems to obscure the greater good and confuse and frustrate people who are not fully immersed in these specifics. Too often we hear from students and professionals that they do not want to join in the EST journey to explore an inviting landscape because the focus is on the trees, and even the bark on the trees, which turns off those people who are more inclined to first see the overall wonders of the whole forest.

Wachtel (2010) articulated eloquently the dangers of becoming focused on the details regarding training in ESTs. He stated that one consequence of educational programs focusing their training on the narrow definition of an "EST" is that "it will skew training in a direction that has problematic implications for public health. By focusing training efforts on brief manualized treatments for very narrowly defined complaints, it would skew training toward treatments designed to meet the mental health needs of only about 20% of the overall population seeking clinical assistance (see Westen et al., 2004)" (p. 262). Additionally, he stated that there has been "confusion between the broad concept of evidence-based practice and the narrower set of criteria that have been employed in designating certain treatments as 'empirically validated' or 'empirically supported'" (p. 251).

In this brief statement, we will suggest that the EST movement and its construc-

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tive pursuit of increasing the scientific support for applied psychological interventions could benefit from entertaining a broader perspective in this area. That is, in the debates over the details (e.g., one intervention as superior to another, which evidence is acceptable), we see the narrow focus of attention as obscuring the important endeavors of many well-minded professionals. Although the merits of discussing differences has its place, attempting to claim singular victories of one sort or another does not. As such, we will revisit a set of principles regarding ESTs, (adopted by APA Division 17, the Society of Counseling Psychology [SCP], in 2002) which offer the kind of perspective which can be useful in the continued education about ESTs.

We hope to add to the voices calling for consensus rather contention, discussion rather than debate, and the position of "and" rather than "either/or" in order to train thoughtful consumers and distribution agents who can add value to their services. We reiterate that there is a place for the focus and critique of specific details within the EST discussion—what we want to reinforce is that education in this area can best be brought about by promoting both narrow and broad views: seeing the leaves, trees, and the forest can best promote the sustained ecology of the entire system.

A Broader Perspective on ESTs

In 2001, a Special Task Group (STG) within APA Division 17, cognizant of the problems with ESTs, chose not to develop specific criteria that would lead to identified treatments, nor prescribe what constitutes an EST, nor specify what constitutes scientific "evidence," nor how to claim one intervention as superior to others (Wampold, Lichtenberg, & Waehler, 2002; 2005). Instead, a broader perspective was created to address the narrow view of evidence promulgated within the origin work of the Division 12 task force (Task Force, 1995). The Principles for Empirically Supported Interventions (PESI) attempted to more fully encompass psychological interventions meant to address the full range of the human experience rather than simply disorders which fit neatly into specific (and discrete) DSM criteria. A second desire was to move away from the small number of studies needed to empirically support a treatment at the exclusion of potentially broader information about an intervention or set of interventions. In this vein, counseling psychology wanted to ensure that all available evidence was considered and appropriately weighted to make inferences about practice rather than allowing conclusions to be made from a subset of the available evidence (Wampold, Lichtenberg, & Waehler, 2002; 2005). Third, PESI tried to not overlook the important variable of the person as the provider because the results from the research has shown that the proportion of variation in psychotherapy outcomes due to therapists within treatments has been shown to be an order of magnitude greater than the proportion due to treatments (e.g., Crits-Christoph & Mintz, 1991; Wampold, 2001).

As opposed to developing specific criteria that would lead to identified treatments, the STG "develop principles to guide researchers and practitioners in the hope that reviews of research would elucidate practices of psychologists that were justified by the evidence and thereby informed by science" (Wampold, et al., 2005, p. 30). These principles, as accepted by the Society of Counseling Psychology, and thereafter published in *The Counseling Psychologist*, are summarized below, and was meant to produce summary reviews which reveal what is known about general and specific interventions as well as what work is still needed to be done regarding areas of service. In adopting these

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principles, the Society accepted that their broad perspective requires "greater reliance on the cognitive complexity of the practitioner to apply them in varied contexts to specific people" (p. 36-37).

Principle 1: Level of specificity should be considered when evaluating outcomes

Evidence for scientifically based interventions can exist at multiple levels, four of which are proposed as a guide to examining and collecting evidence for supporting a particular intervention. The first level describes looking at broad categories (psychotherapy, supervision, etc.), with the second level looking at more specific major approaches or modalities (CBT, group counseling, etc.). The subsequent two levels look at applying the major modalities/approaches to specific areas or populations, with each being considered at the most specific level. This principle does not dictate that research progresses in a way that level one evidence is needed before moving on, but rather the goal is to focus the search for empirical evidence without being limited to only one level of specificity.

Principle 2: Level of specificity should not be restricted to diagnosis

DSM diagnoses are one way to categorize clients, but diagnosis represents only one domain and ignores many other very important client variables (ethnicity, gender, attitudes and values, preferences for type of treatment, purity of the disorder or problem, etc.). This principle encourages an emphasis on health rather than pathology, recognizing diversity-related issues and respect for client attitudes and values.

Principle 3: Scientific evidence needs to be examined in its entirety and aggregated appropriately

Reviewing results of research would be much more straightforward if the "evidence" produced by research findings were less conflicted. As that is not the case, it is vital that the aggregation of research be done by using the appropriate methods to measure evidence at the chosen level of specificity. This principle encourages the examination of the entire body of evidence regarding a psychological intervention and the use of a method that can, without bias, determine the efficacy of an intervention program (often meta-analyses). These results of the "whole picture" can often provide a more comprehensive view of an intervention as opposed to looking at the results of a particular study independent of the accumulated evidence. We have recently seen on a list-serve the idea of having a "portfolio of evidence" or a "family of evidence" to support claims made about psychological interventions, and this concept resonates with us.

Principle 4: Evidence for absolute and relative efficacy needs to be presented

Identifying interventions that are superior to others for a given presenting concern can remain a goal; however, this principle aims to ensure that we avoid confusing absolute efficacy with relative efficacy. The freedom of clients to choose among efficacious programs should not be withdrawn without persuasive evidence that a particular intervention is discernibly superior to other potential choices. That is, with treatments that demonstrate a similar level of efficacy, we should not limit the ability of clients (and potential clients) to choose a treatment that better suits them personally.

Principle 5: Causal attributions for specific ingredients should be made only if the evidence is persuasive

Due to the complex nature and mix of ingredients present within interventions, identifying the particular aspects of interventions that are responsible for outcomes is exceptionally difficult. The

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interpersonal context present when delivering interventions is unique from instance to instance and differs from client to client. A plethora of research has suggested that the common factors are an important ingredient in psychotherapy and need to be recognized when considering treatment outcomes (see: Wampold, 2000; Lambert & Barley, 2001; Imel & Wampold, 2008). In order to indicate that particular actions or components are necessary for change or growth, the scientific evidence should be strong and employed reasonably.

Principle 6: Outcomes should be assessed appropriately and broadly

This principle suggests outcomes should take into account factors such as the costs and benefits of the interventions, and how one's perspective or general life functioning may influence outcomes. Illustrating the complex nature of assessing outcomes, specific and definitive results are difficult to establish, even when there is a clear-cut presenting concern in psychotherapy. This principle highlights the need for assessments to include more than an examination of symptom reduction from a single perspective, focusing especially on including quality of life issues.

Principle 7: Outcomes should be assessed locally and freedom of choice should be recognized

The premise of this principle is that science should inform practice, not dictate it. Interventions that have consistently resulted in outcomes that are inferior or those not demonstrating effectiveness should be avoided, as should those interventions for which there is a dearth of scientific investigation. With that being said, particular interventions should not be mandated unless the evidence for the superiority of those treatments is clear and convincing. In many ways, this principle seeks to maximize the science and practice connection through an interwoven system as well as respect individual differences and preferences of both providers and consumers. Within these principles, it is imperative that clinicians continually learn through experience and make a point to stay clinically informed by science.

Final Thoughts

In referring to the dissemination of the principles in *The Counseling Psychologist,* Dianne Chambless (2002) observed "Division 17's focus on empirically supported interventions is a very welcome addition to this movement and should increase counseling psychologists' awareness of the scientific bases of their practice" (p. 307). Sol Garfield (2002) also stated, "I respond quite positively to the article by Wampold et al. (2002). They provided a good critical appraisal of the published material on empirically supported therapy from the Division 12 committee" (p. 293).

We also see overlap between the PESI and the guidelines promulgated by the Presidential Task Force on Evidence-Based Practice, which created a policy statement that says, in part, "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 284). This statement reflects the three components that help direct successful therapeutic interventions: empirical evidence (broadly defined); clinical expertise; and client characteristics. The position taken by PESI also seems consistent with Wachtel's (2010) synthesis of a range of writers and researchers when he suggested that "we move beyond the 'horse race' and 'certifying' approach of the 'EST' movement and focus instead on the principles and processes that under-

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lie effective therapeutic work" (p. 265).

To come full circle we suggest that effective teaching in EST land benefits from both narrow and broad perspectives. Zac surmises that, as a graduate student who is relatively new to the field of psychology, learning about EST's sometimes feels like standing in the middle of the woods surrounded by trees in every direction. When discussing the specifics of ESTs, the individual structure and composition can be interesting, but lack context. What the PESI perspective provides is a chance to be airlifted above the forest to grasp the overall picture and see how the forest is composed and fits into the larger scale of a profession, while still allowing for explorations into the individual differences of the biology of various trees.

References for this article can be found in the on-line version of the *Psychotherapy Bulletin* published on the Division 29 website.

Musings From the Psychotherapy Office: What We May Be

Barbara J. Thompson, Ph.D., Private Practice, Ellicott City, Maryland
Barbara L. Vivino, Ph.D., Private Practice, Berkeley, California

[*One} who as a physical being is always turned toward the outside, thinking that [their] happiness lies outside [them], finally turns inward and discovers that the source is within [them].*

Soran Kierkegaard

When we think back to the people who have had a profound influence on our lives—teachers, therapists, friends—we realize that there was something similar in those relationships. These individuals believed that we had the capacity to achieve our goals and dreams! They saw in us potential for big things and the ability to do what we wanted. They helped us to reach for the stars but also helped us keep our feet on the earth. In other words, they helped us to believe in our vision and also to work out the practical details so that it was actually achievable.

The clients that we see all have a strong desire to do something more or to be someone more. We find that when we help facilitate the pursuit of their dreams, symptoms of depression and anxiety often diminish. Frequently, this requires uncovering a long lost goal or dream that has been buried under beliefs of inadequacy and impossibility. Thoughts like, "I can't," "dreams aren't practical and don't make money," "what if I fail," and "what will other people think of me" often prevent people from even considering a dream. When a person begins to believe that a goal is possible, he or she often experiences a large amount of energy and positive emotions like joy, appreciation, and well-being. Moving forward in life without the inspiration of a goal is like driving a car with the emergency brake on.

The recent interest in positive psychology and the burgeoning field of coaching suggest that people are eager for an approach that focuses on potential and well-being rather than deficits. The "positive" approach to psychology is actually not new and has deep roots in the history of psychology. Alfred Adler, William James, the Humanistic psychologists like Rogers and Maslow, and the Human Potential Movement, all were involved in conversations about human potential, positive emotions and "self-actualization." However, these approaches have often been eclipsed by clinical models that tend to focus on pathology rather than well-being.

A recent film, "A Dangerous Method," highlights two different approaches to psychological health and healing. In this portrayal of the relationship between Freud and Jung, Jung analyzes a young woman named Sabina Spielrein. Although the movie examines some questionable boundaries between the two, Jung also constructively encourages Sabina to pursue her dream of becoming a doctor and an analyst herself. Again and again, when Sabina feels like she can't do it, he tells her she can until she successfully graduates from medical school and becomes an analyst. Jung's interest in helping his patient follow her dreams and aspirations clashed with Freud's deterministic belief system. This

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is still a controversy in psychology and has resulted in reluctance for many therapists to focus outside of a client's symptomatology. The use of insurance to fund psychotherapy with the managed care requirement of "medically necessary treatment" has reinforced and in some ways mandated this focus. This has created a negative connotation about psychotherapy in many peoples' minds and has forced clients to turn to other professions like coaching and empowerment courses for help in realizing their dreams and aspirations.

Fortunately, there has been new research in psychology on positive emotions and well-being that is finding its way into mainstream psychotherapy. The research on happiness suggests that there are some basic steps to achieving happiness such as focusing on gratitude, having a strong community, having a spiritual belief system (Diener and Seligman, 2002, Emmons, 2008). However, we believe one important dimension of happiness is a feeling coming from deep inside when we are doing what is authentic to our self. Rather than focusing on gratitude, creating social relationships or going to church, being happy requires something more. The inner relationship with oneself is essential to happiness. When a person is authentic, it is like a plant in the right soil and environment. A cactus doesn't survive in Vermont and a maple tree can't live in the desert. Flourishing requires knowing who we are and pursuing the things that help us to thrive.

How do we facilitate our clients' relationship with themselves and help them recognize, believe in, and achieve their dreams? Deep non-judgmental listening to a client is essential. It models to the client how to listen to his or her thoughts and feelings and to value them. The attitude and belief system of the therapist is also important. If we as therapists actually believe clients can be more than who they presently are and can achieve their goals then it becomes more possible in the belief system of the clients as well. Helping clients to sort through their thoughts and feelings to find what they truly want is essential. Believing in and helping clients attain their dreams can lead to greater self-esteem and happiness for clients. This helps clients be more authentic or true to themselves and to pursue the right climate or soil in which to grow.

The importance of encouraging clients to follow their dreams and strive for authenticity is well illustrated in the case of Mary. "Mary" came to see me (BV) full of hopelessness and despair. Our initial work dealt with her fears about finding a partner before she was too old to have a baby. Like many clients who feel stuck, Mary had conflicting core beliefs. She both felt she needed a relationship to be happy and at the same time felt that for some reason, this was an impossible goal. She believed she was never attracted to the men who liked her and conversely that the men to whom she was attracted would not like her. She was also afraid of experiencing any more rejection because each failure made her more fearful of being hurt again.

In addition to focusing on core beliefs, our work focused on helping Mary to compassionately and nonjudgmentally understand, accept, and validate at a deep level her innermost longings and feelings. She learned to sit with her suffering without running away and also how to move past it to follow her dreams. Mary began to realize that, in addition to dreaming of being a mother, she also had creative impulses that were separate from child bearing. She began to experiment with expressing herself through different artistic mediums and then gradually became more and more involved with poetry. She realized that

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the desire to have a baby was somewhat symbolic. She wanted to "give birth," but to a poetic expression of herself not just to an infant.

Helping Mary to move in the direction of knowing herself and her dreams provided productive material for our work together. She was able to acknowledge and soothe the fears that surfaced and also to challenge the limitations that she placed on herself. She began to feel complete in herself and realized that some of her longing for a child was due to societal and family expectations rather than solely to her own desire. It was easy to see Mary achieving her goals and it was important as her therapist to stay with this mindset rather than buying into her self-imposed limitations. We worked with body image issues, perfectionism and unearthed the source of her unproductive relationship patterns and beliefs by exploring her family of origin. As our work progressed, Mary began to relax into herself and feel more comfortable in her skin. Rather than searching for happiness, she realized that happiness was an "inside job." Mary began to like and listen to herself more and her sense of desperation subsided. She began to shift from hopelessness and despair to authenticity and wellbeing.

Eventually, Mary met a man at a poetry slam and they dated for a year before the relationship ended. In facing the end of yet another serious relationship, Mary used her newfound relationship with herself and sense of authenticity to pursue Plan B, which was to create her own family through artificial insemination. Against the odds, she easily became pregnant. However, achieving half her dream was not enough for Mary. She decided to look for a partner too. Her online ad on a popular dating site revealed that she was pregnant but still looking for a loving partner. She met a wonderful man, they fell in love and he assisted during the birth of her child. They married, he adopted the baby and they now have another child conceived naturally. Currently, Mary not only has two children but she also has two books of published poetry!

This story has a happy ending, however, life continues and with it the challenges. Mary achieved her goals and she developed a connection with herself that will carry her through the next set of challenges. By learning how to acknowledge and work with her thoughts and feelings, Mary is able to listen to and know herself. She has a sense of authenticity and integrity and generally feels happy.

We are always evolving and expanding. Having goals and inspired ideas is part of this creative growth process. By following our dreams, we are able to keep up with who we have become. We have come to realize that believing in our clients' potential, helping them dream and aspire to be more than they presently are, is one of our greatest gifts as therapists. Therapist compassion seems to allow clients to tolerate their own suffering while being comforted that the suffering will end. Similarly, the belief that clients have the capacity to grow and change, and to achieve their dreams seems to help clients dismantle limitations and self sabotage in order to hear and believe in their inner urgings, attain their aspirations and experience wellbeing. The therapists' attitudes towards their clients, their willingness to allow their clients to dream and their belief that the clients can attain their goals can play a pivotal role in helping clients achieve a sense of authenticity and happiness.

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In consultation with the Division 29 Board of Directors, the Division 29 Research Committee is seeking nominations for The Distinguished Publication of Psychotherapy Research Award. This award recognizes the best empirical (i.e., data-based) published peer reviewed article on psychotherapy in the preceding calendar year. Articles appearing in any journal (i.e., they need not have appeared in the Division's journal) are eligible for this award.

We ask members of the Division to nominate articles for consideration by **April 1**. Nominations should include the complete citation for the article, and should be emailed to the Chair of the Research Committee, Dr. Michael Constantino mconstantino@psych.umass.edu

A selection committee appointed by the Chair of the Research Committee, in consultation with the President of the Division, will evaluate all nominated articles, and will make a recommendation to the Division's Board of Directors by May 1. Upon approval by the Board, the author(s) of the winning article will be notified so that they may be recognized and receive the award at the upcoming APA Convention. Accompanying this award is a plaque.

All methods of research will be equally valued (experimental, quasi-experimental, qualitative, descriptive/correlational, survey). Current members of the Research Committee and the Selection Committee will not be eligible for the award, so no articles by members of the Research Committee will be considered. Also, committee members will recuse themselves from voting on articles by current or former students, as well as collaborators. Self-nominations are accepted.

The criteria for the award appear below:

- the rationale for the study and theoretical soundness
- the methods
- the analyses
- the explanation of the results
- the contribution to new knowledge about psychotherapy (e.g., the work is innovative, creative, or integrative; the work advances existing research in a meaningful way); greater weight will be given to novel/creative element than to methodological/statistical rigor
- relevance to psychotherapy practice.

The Distinguished Publication of Psychotherapy Research Award is accompanied by a $500 cash award sponsored by Wiley and Sons.

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ETHICS IN PSYCHOTHERAPY

APA Ethics Committee

Jennifer A. Erickson Cornish, Ph.D., ABPP
University of Denver GSPP

The American Psychological Association (APA) is the largest organization of psychologists in the world (APA, 2010). The association is governed by the Council of Representatives, consisting of representatives from the 54 divisions, the U.S. states and Canadian provinces, and the Board of Directors. The work of the APA is conducted by both paid personnel and volunteers. Employees staff the executive office, office of the general counsel, the education, practice, public interest, and science directorates, governance affairs, publications and databases, public and member communication, and IT services. Volunteers serve on the many boards and committees, usually on a staggered basis for three-year terms.

One of the most important tasks for APA is to consult on ethical matters for psychologists, especially related to the *Ethical Principles of Psychologists and Code of Conduct* which applies to "psychologists' activities that are part of their scientific, educational, or professional roles as psychologists" (2002, amended 2010, p. 2). Consistent with the organization of the APA, ethical issues are considered by the Ethics Office staff members, and by the volunteer members and associates of the Ethics Committee.

As I recently rotated off the Ethics Committee, it might be worthwhile to share my experiences with the readers of the *Psychotherapy Bulletin*. It is important to note that this brief paper is not meant to be a comprehensive review, and reflects only my personal reflections and opinions, and not those of the Ethics Committee or the Ethics Office in any way.

APA Ethics Office

There are seven staff members in the Ethics Office, including the director, deputy director/director of adjudication, two ethics investigative officers, ethics coordinator, governance coordinator, and adjudication coordinator. In addition, the APA general counsel and associate general counsel serve as consultants to the Ethics Office and the Ethics Committee. In all, three staff members are attorneys (the director and deputy director are both psychologists and attorneys), along with the two attorneys from the Office of the General Counsel. Each staff member shows considerable patience dealing with the endlessly changing group of volunteers on the Ethics Committee, consistently going above and beyond any job requirements in answering our many questions and helping us to understand complex legal and ethical issues. Each also shows admirable thoughtfulness, restraint, and diplomacy in dealing with the many controversial problems in the field.

APA Ethics Committee Members

The Ethics Committee consists of eight members (including seven psychologists and one public member) and two associates (psychologists who are appointed by the committee). Nominations for the committee may be submitted by anyone; the committee selects three people per slate, and the Council of Representatives then elects the members. The

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committee includes a chair and vice chair; the associates do not vote on adjudication matters, and the chair votes only in a tie situation.

Ethics Committee Activities

The committee meets twice a year in Washington D.C., with occasional telephone conferences, and most members and associates also participate in the annual APA convention, where staff organize an annual Invitational Ethics Breakfast, two awards presentations (one for an ethics educator and one for a student ethics paper), and various symposia (e.g., Hot Topics in Ethics). The work of the committee is described in the Rules and Procedures of the Ethics Committee (2001), and includes ethics adjudication, education programming, ethics consultation, and special projects. Generally, the first day of a committee meeting centers on adjudication; on the second and third days the focus moves to education programming, consultation, and special projects.

Immediately prior to the committee meetings, members and associates receive a sizeable amount of reading material, including the non-confidential and confidential agendas, which may include several boxes of case files. Throughout the year, members receive intermittent Friday mailings consisting of membership applications that may not require an in-person discussion but do require a mail vote. The workload is large (e.g., in 2009, we reviewed 12 cases, four membership-related actions, six case-related confidential agenda items, 10 non-case-related confidential agenda items, and 52 non-confidential agenda items, not including membership items that were reviewed throughout the year between meetings), but manageable thanks to the considerable organizational skills of the Ethics Office staff.

There are three types of ethics adjudication cases: Show Cause, Sua Sponte, and Complainant. A Show Cause case is opened upon notice from an authoritative body (e.g., a state licensing board) of a serious action. Sua Sponte cases arise from the committee's own initiative (e.g., a newspaper article about an ethical violation committed by an APA member), while Complainant cases are from third parties, such as clients. In addition, membership cases are considered when an applicant has experienced an ethical problem or is reapplying after having left APA due to an ethics problem.

The Ethics Office and either the Ethics Committee Chair or Vice Chair review all matters; matters that are not dismissed or closed due to the member resigning under ethics investigation become cases that are sent to the Ethics Committee for further review. Of course, only cases that involve APA members are reviewed by the committee, as it has no jurisdiction over other psychologists.

Before adjudication cases come before the committee, they have been thoroughly investigated by the Ethics Office staff members. In each case, the committee may vote to dismiss, remand for further investigation, or may impose sanctions including reprimand, censure, stipulated resignation, or expulsion from membership, and may choose among many available directives such as a cease and desist order, supervision, continuing education credits, tutorial, writing a paper, evaluation, psychotherapy, and so on. In addition, the committee may vote to notify other organizations of its decision related to a case (e.g., a state licensing board, state psychological association, the Association of State and Provincial Psychology Boards, the National Register, and the American Board of Professional Psychology). Aggravating and mitigating factors are carefully reviewed, and the

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committee takes considerable time before voting, as it is crucial to balance the rights of the APA member with the need to protect clients, students, the association, and the profession. The committee conducts paper reviews only; all recommended expulsions and Show Cause cases are reviewed by the APA Board of Directors, and respondents may request an Independent Adjudication Panel/Formal Hearing Committee for Sua Spontee and Complainant cases, depending upon the level of sanction.

Educational programming is an important role for the Ethics Committee and includes providing education for psychologists, students, and the public. As an example, committee members and the Ethics Office Director gave several workshops at the 2011 National Multicultural Summit and Conference, including one on the ethics of assessing multicultural competence. The committee receives eight hours of APA convention programming, and often adds preconvention workshops and additional symposia in collaboration with APA divisions and other groups. The Ethics Committee also receives education, often related to multicultural awareness (e.g., a presentation on the ethics of deafness as an aspect of diversity).

Ethics consultation is a daily activity for the Ethics Office, with the Ethics Committee often involved either during the in-person meetings or on telephone conferences. Current issues have included telepsychology, the use of social networking, and recent developments related to the implications of student religious expression and sexual orientation for graduate training in psychology.

Finally, the Ethics Committee is involved in many special projects. For instance, each year the committee reviews many student ethics paper submissions and chooses one to win the Graduate Student Ethics Prize. Ethics committee members help edit the prize winning paper, and sometimes one or two other papers to be published in a peer reviewed journal. Several committee members are also involved in various task forces (e.g., a joint APA/ASPPB task force regarding challenges common to ethics committees and licensing boards). One of the most memorable special projects during my time on the committee was our work on amending the Ethics Code; we recommended to Council (and they voted to approve) that the last two sentences of the final paragraph of the Introduction and Applicability section, and Ethical Standards 1.02 and 1.03 be changed to make it absolutely clear that psychologists must adhere to basic principles of human rights.

Summary

It was an honor to serve on the Ethics Committee, as well as to work with and learn from the talented members and associates on the committee and the knowledgeable and compassionate Ethics Office staff members. It was a heavy responsibility to adjudicate cases, and a humbling reminder of the difficulties associated with being a psychologist. It was an incredible experience that reinforced my commitment to "act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems" (APA, 2002, amended 2010, p 3).

References for this article can be found in the on-line version of the *Psychotherapy Bulletin* published on the Division 29 website.

STUDENT FEATURE

Reflections on the First Year in a Doctoral Program

Lauren Palazzolo, M.A.
Loyala University Maryland

I've been journaling for many years, and every now and then have been unexpectedly inspired to write poems. When I began the doctoral psychology program this past fall at Loyola, I was pleasantly surprised by a series of poems that came alive on paper. I'd never considered myself a poet until one of my professors, Dr. Jeffrey Barnett, invited me to share my poems in the Psychotherapy Bulletin. "Wow," I thought, "maybe I AM a poet!" Any poems I write seem to "pop" out of nowhere when the inspiration comes. The intention behind my poems is usually to capture an experience of some sort. These are a selection of the poems I wrote during the first few months of beginning the grand adventure of doctoral studies.

STUMBLES

I've been walking lately,
Forward,
Into and through unknowns,
And stumbling,
Tripping,
On things that visibly aren't there.

"What are they?"
I ask myself.

Old wounds.
Pain bodies.
Shadows of past hurts,
Creeping up through uneven ground,
'Cause they are familiar to me,
And I am in unfamiliar territory-
Starting graduate school,
Far from home,
Away from loved ones.

Perhaps this is when my old wounds
sneak up the most.
Grabbing and wrapping around my
feet and toes.
Creeping their way upward,
Around me,
As I give them life.

They *are* my stumbles.
My fears.
My pain.
My uncomfortable comforts-
Being good enough
Being wanted
Being liked
Being a "part of"
Being included.

I question and doubt myself.
Feel lacking and insecure.

Past wounds thrive on this like oxygen
to their every cell.

"So now what?"

First, I notice them.
Their presence.
And acknowledge them,
For what they are,
And what they represent.

Then, I will them away,
Back to sleep below the Earth.
Unwrapped from my body,
Dried up and withered.

I step forward,
And keep stepping forward.
Letting only the ground support me,
And the loving Light from above to
guide me.

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Lastly, I thank these old familiar wounds,
For bringing into my awareness,
The pains that are still present for me,
Now and then,
To guide me and bring insight.
To present me with the opportunity,
To again choose NOT to be controlled or tripped up by them.

For I must know when they're there,
In order to choose them to leave.

GRADUATE SCHOOL

Whoa.
Grad school!
"This is a bit intense,"
You think to yourself.

A little, perhaps a lot, of fear creeps in,
As you jump ahead in your mind,
Taking in what is to come,
When it's all due,
And how you'll get it all done.

Not only done,
But done well,
And on time.

"What can I get away with not doing?"
you ponder.
And there are lots of "firsts,"
That bring maybe excitement,
Maybe nervousness,
Maybe both.

"Undergrad was easier!"

Be on time,
Dress professionally,
Remember this,
Remember that,
Don't do this,
Don't do that.

You're here for a reason though.
You were specifically and intentionally selected,
With Faith that you'd succeed.

And help is all around!
You can ask questions,
Voice confusion,
Seek advice.

So break it down,
Day by day,
Or in grad school,
Perhaps week by week.

Take a few breaths,
And tune in to your undeniable ability to succeed!

THE BALANCING ACT

Here you are,
Sitting on a teeter-totter.
Yet it's an odd teeter-totter,
With three, four, maybe five seats,
And you must balance them all!

One seat for this class,
One seat for that class,
One seat for clinics,
One seat for somehow everything else.

But wait!
There are more seats than that!
It's like an octopus of seats,
'Cause "everything else" actually doesn't sit alone on one seat-

It spreads apart,
And as you look around you realize-
Your family has a seat
Your social life
Your self-care
Your partner
Your work.

Shit!
There's a lot of seats here!
How am I supposed to keep them all teetered in the air at once?!

You're not.

Instead you must be fluid,
Willing to sit on one for a while,
Then get up and move to another one,

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And so on.
The trick is not to stay in one seat for too long.

But what if you did?

Then you'll feel it.
A pressure-
Perhaps guilt,
Perhaps a palpable pull to get up off the seat you're on,
And move to another.

It's a balancing act!
Which of course you know,
'Cause you're living it as we speak.

So listen closely,
And move with ease,
From seat-to-seat-to-seat-to-seat-to-seat.
You can do it!
You *will* do it!

You may also choose,
Here and there,
To get rid of some seats all together.

'Course you may feel overwhelmed.
This is normal,
Perhaps inevitable at times.

But wherever you sit,
And however long you sit there,
The ground is always beneath you,
Holding and supporting you.

It's there if you fall off a seat.
It's there when you can't see it.

STATUS UPDATE #1

It's sunny and chilly,
On this mid-December day,
With finals just around the corner,
And a few assignments due as well.

My head is filled with what's due,
What needs to be done,
And by when.

"Take a breath,"
I say to myself,
"One thing at a time."

Is that even possible in grad school?
One thing at a time?
Really?!
'Cause there's like three more papers due,
Two forms to submit,
And finals to study for,
All within the next 10 days.
No, wait,
Nine days!

"One at a time my ass,"
I reply to my previous self-assuring thought.
But wait, I'm journaling right now,
And obviously not getting any work done,
Or doing anything else.

It truly is easier doing one thing at a time,
When it doesn't come to school commitments.

"Am I procrastinating?"
I ask myself.
Perhaps.

Well…yes,
Yes I am procrastinating.
I should be working on my next paper.
I even blocked this time off in my schedule
To, "Write Theories paper."
But journaling is so much more enjoyable!

You know what would also be enjoyable?
Being done with all my schoolwork for the semester!
Feeling studied and prepared for finals.
Getting things done, one thing at a time.
Or maybe two,
So I can switch back and forth as

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I lose interest,
Or as my brain temporarily shuts
down on a particular class.
I hate when that happens.

But you know what?
I love this program!
Because ultimately it supports my
greater aspirations.

I knew it'd be difficult.
Tedious.
Time-consuming.
Multiplied by about a thousand.

But I wanted this!
I sought it out!
In fact, I sought it out two years
in a row,
Until I got accepted into a program
that fit for me.

Hey, what do you know?
I just managed to motivate
myself to study,
So I'll talk to you later.

WHINE-ALS

Defined as the whining of finals.

Yes, finals truly can be stressful,
And yes,
That's a ridiculous understatement.

Finals are,
Well,
They're just so final!
It's like our whole grade could be
ripped out from under us,
If we don't do well on finals!

(Maybe we need the ABC's for this one
to check for distorted thoughts)

Nonetheless, when it's time for finals,
There's some strange heightened
power
That supercharges our supposedly
rational ego,
And exerts its force mischievously
and deceptively.

I can only describe that ego-driven
force as pressure.
Ugly pressure,
With all the bad ingredients mixed up,
Nice and ugly.

Tension.
Fear.
Expectation.
Perhaps perfectionism.

Late nights.
Early mornings.
Resentment-
Toward being asked to do anything but
study.

Don't people "get" that it's finals week!
I have to study!
That's all I'm gonna do for at
least the next week,
So nothing else should be
expected or asked of me.
And if it is,
I'll feel like you don't understand or
aren't being supportive.

Yes, I realize I'm now being a
bit unreasonable,
But I'm stressed out and can't help it!

Which brings us back to whine-als.
The beautiful, pointless, art
Of whining about finals.

That all the classmates totally "get"
'cause many of us do it.
But that no one else "gets."
And we feed off each other's stress,
fear, pressure, anxiousness,
Worrying endlessly about all the
studying we need to do.
Essentially whining,
And whining,
And whining some more.

What does it *do* for us anyway?
Truly?!
How do whine-als help us?

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I can only speak for myself on this one,
But whine-als gets me all twisted up inside,
Stressed out,
Sleep deprived,
Malnourished,
And tensed up-
Like a snapper turtle hanging on for dear life
(or maybe hanging on 'cause he's pissed you stuck a twig in his face for pure entertainment value).

It's a bitch,
No matter how I look at it.
Whine-als is a deliberate stance in a big circle on the floor marked "Negative,"
With words and phrases like "Fear,"
"Hard"
"You better do good"
"Don't fail"
"Study or else"
"Pressure"
"Tension"
"Be perfect"
"Don't screw this up."

But hey!
There's another spot on the floor.
What's it say?
I can't see it very well
Through all this grey cloudiness I'm standing in.

Oh!
It says "Positive."
Hmm…
I think I'll walk over there just for the hell of it and see if I feel any better.

Okay,
So now I'm standing in a circle on the floor,
Looking down at the word "POSITIVE,"
Written in **BRIGHT**, PLaYFuLL, LOUD letters.
With words and phrases like,
"You can do it!"
"Relax"
"Breathe"
"Capable"
"Confidant"

Wow, this is *much* better!
I think I'll stand in this circle for awhile.

'Course there's still that pull-
That ugly, yanking pull back to the "Negative" space,
That devious ego space that wants only to ignite fear.

But screw that!
It doesn't have to hold power over me.
I can hold power over it!
So I'll will it away,
And surround myself,
Fill myself,
With the Positive.

Goodbye Whine-als.
I'm gonna go kick ass on some tests!

THE IN-BETWEEN

Those oh so precious times,
Even if just for a moment,
But hopefully longer,

Of space.

It's like lightness,
Surrounding you,
Almost lifting you up.

You can stand a little taller,
Expand your chest a little broader,
Unclench your tension,
And let your shoulders fall.

They were tense, weren't they?
Of course they were!
How could they not be!

Four months just went by of nothing but studying, reading, writing, presenting, assessing, interpreting, comprehending, rushing, sometimes cramming, researching,

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And of course, more reading and writing and reporting and studying,
And oh, it doesn't stop!

But wait!
It stopped.
Seriously,
It *really* stopped!
First semester literally ended,
With no work until next semester begins.

Breathe that one in for a second.
Actually, breathe it in for at least five minutes.
That's the least you can do for yourself.

And in those breaths,
Tune into Now.
Right Now.
"I'm done."
You're done!
For now.

Imagine school settling away into the background,
Blurring slightly as its distance grows.
And feel this space you're in.

Welcome to the in-between.
Of semesters, that is.

This space here is quite precious,
And should be used wisely.
And no,
I don't mean "wisely" as in get a head start on next semester.
Tsk Tsk!

I mean *live* in this in-between for a while –
With school behind and school ahead,
But school-less in this in-between.

And fill your in-between with absolutely whatever nurtures you,
Rejuvenates you,
Brings you smiles and laughter,
Leaves you feeling charged, relaxed, and ready.

We spoke of self-care all semester,
Often in the context of how we needed more of it.
So here's another pretty-wide open opportunity,
To really give it a shot.

So *BE* in the In-Between.
Fully.
Proudly.
You've done well.
We all have!

Now if you excuse me,
I'll be in my in-between for the next few weeks.
I'll meet you back at the outer edge,
When school convenes again.

NOTICE TO READERS

References for articles appearing in this issue can be found in the on-line version of Psychotherapy *Bulletin* published on the Division 29 website.

The Administration's Vision

Patrick Deleon, Ph.D.
Former APA President

Earlier this year HHS Secretary Kathleen Sebelius highlighted the ability of President Obama's Patient Protection and Affordable Care Act (ACA) to significantly curtail the ever escalating costs of health care. As she stated,

> "The rising cost of health insurance coverage has imposed a heavy burden on our nation….If health-care costs continue to rise unchecked, they will threaten America's ability to compete and will become unaffordable for most families. One of the major reasons we passed [ACA] was to bring down costs… tackling the underlying cost of medical care…. [ACA] gives us tools to reduce costs by promoting better health and providing better care, especially in Medicare and Medicaid, which can be tremendous forces for positive change across the entire health-care system. The law emphasizes prevention because we know it is far less expensive to prevent disease than to treat it….The health-care law gives us dozens of tools to improve chronic-disease management, coordinate care among multiple providers and foster innovation. Experts who have studied the law, from the Medicare trustees to the independent Congressional Budget Office, agree that it will put the brakes on skyrocketing Medicare costs. And last January, 272 of America's top economists wrote to the House Budget Committee that the ACA 'contains essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending.' It won't be easy and it won't happen overnight. But at a time when some claim that our only options are to allow health-care costs to continue to skyrocket or to make some of the most dramatic cuts to our health-care programs ever proposed, the Affordable Care Act provides a better way forward."

It is important for all of the health care professions to appreciate the magnitude of change that our nation's health care environment will soon be experiencing. Watching the President's State of the Union Address every practitioner should understand that unprecedented change is coming. "I will not go back to the days when health insurance companies had unchecked power to cancel your policy, deny you coverage, or charge women differently from men. And I will not go back to the days when Wall Street was allowed to play by its own set of rules…." From our perspective, significant policy decisions will evolve at both the local and national level. Are we sufficiently engaged?

ACA is fundamentally patient-centered, heralding a major commitment, over time, to data-based decision making. "What objectively works and under what conditions?" might be seen as its underlying orientation. And yet, given the intensity of efforts being made by various health interest groups (includ-

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ing professional associations), one must expect that active engagement in the public policy/political process will become a major element of decision making. Will, for example, the conceptualized "medical home" require physician direction under an historical "captain of the ship" philosophy or will it embrace true interdisciplinary care, facilitating each discipline practicing to the fullest extent of its training? One factor will undoubtedly be the extent to which the various non-physician professions are successful in modifying federal statutes (e.g., Medicare and Medicaid) to ensure that their training institutions and practitioners have ready access to the same resources that medicine has historically possessed (e.g., financial support for implementing electronic medical record systems and telehealth/telepsychology reimbursement). In the abstract, moving from historically isolated silos of practice and training to interdisciplinary care makes sense, especially under ACA. How to accomplish this monumental change in orientation will be the evolving question.

A Renewed Focus: I recently accepted the exciting opportunity to join the faculty of the Uniform Services University of the Health Sciences (USUHS) of the Department of Defense. I will be located within the School of Nursing and the Department of Psychology, the latter having been on the forefront of the Health Psychology movement thanks to the vision of former APA President Joe Matarazzo, as a member of the Board of Regents. The chair of the Department is David Krantz, another of the original visionaries. I will have the opportunity to become increasingly familiar with the culture and literature of our health profession colleagues. For example, how do they (and perhaps psychology) address the needs of the growing number of individuals with chronic diseases? The Centers for Disease Control and Prevention (CDC) estimates that 7 of 10 deaths among Americans each year are from chronic diseases, with obesity becoming a major public health concern (almost 1 in every 3 adults being obese; as is almost 1 in every 5 youth, between the ages of 6 and 19). Seventy-six percent of Medicare spending is currently on patients with 5 or more chronic diseases. By 2020, our nation is projected to spend $685 billion a year in direct medical costs for individuals with chronic diseases.

David and I visited the USUHS Center for Deployment Psychology (CDP) which was established five years ago, after considerable involvement by the APA Education Directorate (Cynthia Belar and Nina Levitt). Since 2007, the Center has trained more than 20,000 mental health providers working throughout the deployment cycle. The Deputy Director, Bill Brim, is a health psychologist with over a decade of service within the USAF. Former APA Congressional Fellow Paula Domenici is the Director of Training Programs, overseeing several initiatives educating mental health providers about the unique needs of service members, veterans, and their families; and the best strategies to assist them. Since many veterans seek help from community-based clinicians, both immediately and years after their deployment, CDP trains military and non-military providers who care for the warriors and their loved ones. One of CDP's hallmark offerings is *Addressing the Psychological Health of Warriors and Their Families*, a one week course that has been presented in 27 cities, including Honolulu, San Diego, Albuquerque, Minneapolis, Austin, Nashville, and Pittsburgh, to reach civilian audiences across the country. Through this program, over 2,300 psychologists, social

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workers and other professionals have learned about military culture, the deployment experience, and evidence-based psychotherapies to treat PTSD. Congressman Tim Murphy, a clinical psychologist, emphasized the value of CDP's mission after completing this course: "Although PTSD is treatable, we simply do not have enough trained military and civilian clinicians to meet the needs…. These (CDP) courses provide solid foundations in that critically important training." [www.DeploymentPsych.org].

Clinical Pharmacy: The USPHS Report to the Surgeon General from the Office of the Chief Pharmacist is entitled: *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice*. "The 2011 Report provides rationale and compelling discussion to support health reform through pharmacists delivering expanded patient care services. In collaboration with other providers, this is an existing, accepted, and additional model of improved health care delivery that meets growing health care demands in the United States. Health care delivery (including preventive or supportive care) in the United States is challenged by demands of access, safety, quality, and cost. These challenges are amplified by provider workforce shortages and dramatic increases in primary and chronic care visits. Projections suggest worsening of this situation. New or additional paradigms of care must be implemented to reduce these burdens. Current health care demands provide an opportunity for health leadership to recognize and adopt additional and significant health care delivery models…."

"The federal sector has already implemented and embraced such a health care delivery model through physician-pharmacist collaboration. This collaboration, through extensive performance data, has demonstrated that patient care services delivered by pharmacists can improve patient outcomes, promote patient involvement, increase cost-efficiency, and reduce demands affecting the health care system. For over forty years, federal pharmacists have collaboratively managed disease through medication use, and other cognitive and clinical pharmacy services. Although these models are accepted in the non-federal sector, utilization is often impeded due to policy, legislation, and compensation barriers…."

Once a diagnosis is made by the primary care provider, pharmacists *do* manage disease and provide primary care. Pharmacists engage in the following activities to manage patient care: perform patient assessment (subjective and objective data including physical assessment); have prescriptive authority (initiate, adjust, or discontinue treatment) to manage disease through medication use and deliver collaborative drug therapy or medication management; order, interpret and monitor laboratory tests; formulate clinical assessments and develop therapeutic plans; provide care coordination and other health services for wellness and prevention of disease; and, develop partnerships with patients for ongoing (follow-up) care. Under ACA, HHS has considerable flexibility in defining "preventive services" and "essential health benefits" as broadly as desired. Those following psychology's prescriptive authority (RxP) quest will not be surprised to learn that in 1996, the then Director of the Indian Health Service (IHS) issued a Special General Memorandum (SGM 96-2) recognizing Clinical Pharmacy Specialists (CPSs) as primary care providers with prescribing authority. The Dean of one of the nation's leading schools of pharmacy emphasized that clinical

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pharmacists must complete a four-year postgraduate program focusing on managing complex medications and are extraordinarily cost-effective. At Kaiser Permanente Colorado, pharmacists worked with physician-approved protocols targeting patients with coronary artery disease and hit their blood pressure and cholesterol targets. They achieved an 89% reduction in their patients' overall mortality and nearly $22,000 annual savings in health care costs per patient. Similarly, targeting city employees with diabetes, pharmacists were successful in reducing the annual direct medical costs per worker, on daverage, by $1,200 to $1,872—an estimated savings of $4 for every $1 invested. Not surprisingly, the agency has since expanded this program to cover other chronic diseases, including hypertension and asthma.

Looking Forward: Having retired from the U.S. Senate staff after 38+ years, I have become quite interested in the experiences of senior colleagues. Reflections from Ed Sheridan, a pioneer in Health Psychology and now Professor/Senior Vice President & Provost Emeritus, University of Houston:

> You certainly are correct that most of us do not think much about retirement until we decide to do it. One reason seems to be that we are among the first generations to be free to work or retire while previous generations had mandatory retirement at age 65 (if you lived that long!). I have only a few suggestions to offer that may be important. If there is a prominent mistake couples seem to make, it is they do not spend enough time in discussing what each person wants from retirement before deciding to retire. Since couples likely will spend much more time together, especially if they retire at the same time, it is essential they share what they desire and what each hopes the partner will want to do. These discussions need to include each partner's strongest wishes for a quality life, whether each finds the other's desires compatible, what to do with potential challenges (e.g., caring for a very ill parent), and what household duties each will agree to accept. Additionally, couples especially need to discuss what they want as a life style in the next few years. There are lots of choices. One consideration is to downsize one's home and use that money for other initiatives (e.g., seeing more of the grandkids, traveling, developing new interests or improving on former ones—bridge, tennis, dancing, etc.—teaching part time, consulting). In my case, I find teaching undergraduates (something I did very little of in my first 35 postdoctoral years) is real fun. It is like having an unlimited number of eager grandchildren. Even with such discussions, couples need to realize that retirement requires that each person be willing to be very flexible since no one anticipates all the challenges that eventually will come with this new lifestyle.

Speaking of homes, I find many couples decide to own two homes, one in a warm environment for the winter and one near the grandchildren. Most eventually realize this was a mistake. As the grandchildren get older, they only desire a limited amount of time with the grandparents and the grandparents find they are spending a lot of money on the upkeep of two homes and this limits travel and other opportunities for stimulation. Most people wonder what they will do with 'all their free time.' Actually, I find there still is not enough time to accomplish what I wish to do. I sus-

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pect our colleagues will find the same. The one big change is that you have more control over your time but it still is not enough.

Having read some literature on financing retirement from organizations like AARP, I did not find their predictions were helpful to us. One common proposal was a couple needs about 80% of their preretirement income. In our case, we spend as much in retirement as we previously spent. One reason may be that as a Dean and Provost, I had almost every lunch and most dinners paid for. I also had a free car. In addition, we received free tickets to most sports events, plays, musicals, etc. and now we pay for these items. One item that does cost less is clothing. In terms of finances, I do think it is important to talk with a financial planner who has no stake in how you invest and get good direction on how you can achieve your income goals. We were fortunate in that we anticipated the Bush fiasco and we were not hurt. However, we have numerous friends who lost 20%-35% of their retirement income by not anticipating the downturn. It also is hard to anticipate what your needs will be if you live 30 or more additional years.

Healthcare opportunities also are an important topic for consideration. Kathy and I always intended to retire to Kauai (we already had land there to build a home). Then, having spent decades working closely with the leadership of the various health professions, we realized that we would not want to rely on obtaining care at Wilcox Hospital with its considerable rural challenges, while the closest medical center was on Oahu. We understand that subsequently the leadership of Maui Memorial Medical Center has been seeking to fulfill this historical neighbor island gap. Nevertheless, making the decision to be near good health care has paid important dividends for us and we are very appreciative that we recognized this need. Aloha.

FEATURE

Norine Johnson: In a League of Her Own

Linda Campbell, Ph.D.

Norine Johnson, Ph.D.

Linda Campbell, Ph.D.

The moving tributes to Norine on the listservs and e-mail give evidence that Norine has touched many of her colleagues' lives in unique and empowering ways. My words of admiration for Norine would be humbled by the richness of Dorothy's and others' memories who have had extended friendships with Norine while my relationship with her began in relatively recent years. I realized just today, however, that I did have a unique bond with Norine that I could share with you and that is that we served together as the two and only two Council Representatives from the Division of Psychotherapy from 2008-2010. What a ride that was! I fastened my seat belt and held on for what would be an invaluable learning experience and the nurturance of a valued friendship.

Norine Johnson, Linda Campbell and Katherine Nordal

Norine had been President of APA in 2001 and had also held many other posts in APA which gave her a view 20,000 feet up, but also a view down in the weeds. Sitting with Norine during those Council meetings felt much like participating in a strategic arms meeting, a family reunion, and a reality show, all at the same time. Many people can speak strategically but Norine listened strategically. She heard people make statements they didn't realize they had made, until she reflected it back to them. Norine knew everyone and they all had something to say to her and therefore a professional version of a family reunion would always ensue around our section of the table at Council. If we think of Council as a stage on which many important professional decisions are played out, Norine could be counted on to bring the reality part to those conversations that had taken on a life of their own. Norine really new how to punctuate a sentence figuratively and did so every time she rose to speak on Council.

Norine would often look attentive but not reactive and suddenly with great vigor say to me, "Did you hear that?" And she would with great energy respond, "The discussion just ignored what that new Council member said

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and she has never spoken at Council before. I imagine she feels not heard." Norine would then get up and go to the mike and say, "I want to call our attention to what our new Council member said and I don't think we have given it the credence it deserves." Norine was, of course, modeling for us but also giving a gesture of support to the new Council member.

Norine would also monitor the transactions not for tactical reasons of her own interests in a business item itself, but to track the health of our interactions, significance of an item to our values, and to safeguard against microaggressions and marginalization of individuals as well as to protect our valued egalitarian approach to decision making. When she would start to rise out of her chair and say to me, "I'm not going to sit still for that one," I knew she was going to speak on the floor of Council to what she thought was an injustice, mistreatment, or power gesture toward an individual or a shared value that we were ignoring in the moment.

We all know and have in our hearts those people who laugh easily and will give us a hearty and genuine laugh if we say something that is even half way funny or amusing. Norine was one of those people. Norine even laughed with her bright blue eyes and they always told the story on how she felt and what was going on. The last communication I had with Norine was during an afternoon when she was playing princess with her granddaughter. Norine Johnson will remain a princess to many of us and when I think of her, I will always picture her with a magic wand in her hand.

Division of Psychotherapy (29)
American Psychological Association

Enter the Annual Division of Psychotherapy Student Competitions

The APA Division of Psychotherapy offers four student paper competitions:

- The Donald K. Freedheim Student Development Award for the best paper on psychotherapy theory, practice or research.
- The DiversityAward for the best paper on racial/ethnic gender, and cultural issues in psychotherapy.
- The Mathilda B. Canter Education and Training Award for the best paper on education, supervision or training of psychotherapists.
- The Jeffrey E. Barnett Psychotherapy Research paper Award for the best paper that addresses 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 of psychotherapists' personal characteristics.

What are the benefits to you?

- Cash prize of $250 for the winner of each contest.
- Enhance your curriculum vitae and gain national recognition.
- Plaque and check presented at the Division 29 Awards Ceremony at the annual meeting of the American Psychological Association.
- Abstract will be published in the Psychotherapy Bulletin, the official publication of the Division of Psychotherapy.

What are the requirements?

- Papers must be based on work conducted by the first author during his/her graduate studies. Papers can be based on (but are not restricted to) a masters thesis or a doctoral dissertation.
- Papers should be in APA style, not to exceed 25 pages in length (including tables, figures, and references) and should not list the authors' names or academic affiliations.
- Please include a title page as part of a separate attached MS-Word or PDF document so that the papers can be judged "blind." This page can include authors' names and academic affiliations.
- Also include a cover letter as part of a separate attached MS-Word or PDF document. The cover letter should attest that the paper is based on work that the first author conducted while in graduate school. It should also include the first author's mailing address, telephone number, and e-mail address.

Submissions should be emailed to:

Doug Wilson
Chair, Student Development Committee, Division of Psychotherapy
E-mail: dougcwilson@msn.com

Deadline is April 1, 2012

Raymond DiGiuseppe, Ph.D.

I am honored to receive the nomination of president-elect of the Division of psychotherapy. This division has played an important history in Psychology and serves as the model organization for promoting the science and practice of Psychotherapy. Psychotherapy is at a crossroad. Fewer people are seeking psychotherapy services, while more are receiving pharmacotherapy for psychological problems. Despite the popularity of medication treatments, our field has much to offer. Several problems continue to confront us. Our field lacks the financial backing of large advertising campaigns to inform the public of our effectiveness. In addition, we have often failed to speak in one voice. Psychotherapy has been a tribal enterprise, with many different schools and theories. Over the years, we have not always respected each other, or valued the contribution of different perspectives. If elected, I will work at helping us shape and speak with one unified voice.

To speak to the public in one voice for Psychotherapy we need to speak more to each other and find the common ground that unites Psychotherapy. We need to have more communications among those with different opinions within psychotherapy. I want to make Division 29 the home of all psychologists interested in Psychotherapy. I want to provide discussions of the important topics in our field. Such debate will help us learn the different processes and interventions that lead to effective treatment and the different mechanism that may account for clients' growth. Our field has been divided between the researcher, academics, and the practitioners. We have made great strides recently in fostering communications among these groups. I will work to continue this dialogue so can learn what effective psychotherapy is and to present that information to the public policy makers and the public.

The division of Psychotherapy has been my home within APA for more than 35 years. I have served two terms on the Division's Publication Board, and served as its chair, as a member of its convention program committee, as a member of the editorial board of the our Journal, and I received the Division's Jack Krasner Award for early contribution to the field in 1985.

During my career, I have worked in full time private practice and I continue to see clients and supervise students on a weekly basis. My present work focuses on developing effective interventions for angry clients by expanding our understanding of these problem and researching new interventions. I have worked as an educator and supervisor and trained numerous graduate students and professionals around the world. This experience has helped me understand the development of psychotherapists and how to nurture future generations of psychologists in our field. I think I have the leadership and administrative skills to move the division forward at this time. I have chaired a large university academic department, administered a psychotherapy training institute, and served as president of a large professional organization. I look forward to serving the division in the future. ■

Steven A. Sobelman, Ph.D.

Thank you for the opportunity over the years to serve Division 29. I would be honored to be your President. As my second three-year term as the Division's Treasurer ends, I am pleased to report that even during the economic downturn, the Division is in very good financial shape. As Treasurer, I have worked with six Division Presidents and served on the Executive Council. I believe that I have a good sense of where the Division has been and what challenges we face in a rapidly changing environment. In my multiple roles I have served as CE Chair, chair of the technology committee, and as member on the Finance Committee. You will see that my past experiences and commitment to the Division have provided me with a strong foundation to lead us through rapid changes in health care reform, practice, science, and technology.

My professional life has dealt with two worlds—psychology and corporate America. Psychologists have not always been able to operate effectively because we often lack the skills necessary for running organizations effectively. I bring a strong history of organizational experience and entrepreneurial leadership to the role.

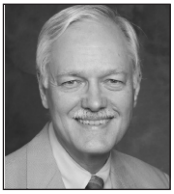
I have spent many years teaching, practicing, and advocating for psychology where I have enjoyed various leadership positions. I served as President of Division 49 of the Maryland Psychological Association. I currently serve as the Chair of the Maryland Board of Examiners of Psychologists. I also maintain a private psychotherapy practice and was a fulltime faculty member and director of graduate programs in psychology at Loyola University where I am now an Emeritus Professor of psychology. I was founder and clinical director of a large private mental health facility in the Baltimore Metropolitan area. I have a breath of experience in both the public and private sector from which I can draw as your President.

I am the CEO of a mid-sized and growing IT company specializing in Electronic Medical Records. I've had significant experience with investor relations and venture capital exploration and have learned fiscal responsibility. This experience has been invaluable to me in the role as the Division 29 Treasurer.

As your President, I will continue to bring a vigilant and progressive approach to maintaining a strong Divisional presence within APA and the professional community. I propose the following initiatives: (1) create a more streamlined and fiscally responsible organizational structure; (2) provide fiscal responsibility to the membership; (3) explore approaches for increasing non-dues revenue, e.g., online CE workshops; (4) increase member and student scholarships and awards; (5) explore incentives for value added services to the membership; and (6) reach out to the membership to find ways to make your dues worthwhile.

I strongly believe that if you want to get something done, you give it to a busy person with a track record of effective leadership. I am willing to be that busy person with a track record of achieving results and effective leadership. Thank you for your consideration and I welcome and appreciate your vote. ■

Robert Hatcher, Ph.D.



Division 29 is a very special division in APA, whose broad membership represents the heart of the profession, with a strong commitment to excellence in practice, research, and education. I've been a member of the Division for many years, and a fellow since 2009. It would be a real pleasure to contribute to the Division as your treasurer. Although it would be a challenge to follow Steve Sobelman's masterful performance, I have had extensive experience managing budgets large ($3.5M) and small ($5K), and have been president and continue on the executive committee of the Association of Psychology Training Clinics, serving as its representative to the Council of Chairs of Training Councils. I have been an active psychotherapy researcher (alliance, interpersonal measurement), psychotherapist, and educator for a long time, serve on a number of editorial boards (Psychotherapy, Psychotherapy Research, Journal of Counseling Psychology), and am an associate editor of Training and Education in Professional Psychology. I've been a leader in the emerging competencies movement in professional psychology. I'm currently a member of the graduate faculty in psychology and director of the Wellness Center at the CUNY Graduate Center, where we train externs, conduct psychodynamic, CBT, and integrative therapies, and track progress with the OQ-45. As treasurer, I would want to continue the Finance Committee, watch the stock portfolio carefully, and build on Steve's work to enhance non-dues revenues. I would especially enjoy working with the executive group of Division 29 to serve the interests of our members. ■

Jeffrey Zimmerman, Ph.D.

Your Division 29 is financially strong. This is especially important in today's economic times. Presently, in my second term as Division 29's Finance Chair, I am excited about the opportunity to serve as Treasurer and build on the good work of those that have worked thoughtfully and diligently to reach this point. I also bring to this position my experience on Division 42's Board of Directors and as Managing Partner of a group practice for 22 years.

A key strategy during times like this is to be calm, not get over confident, and stay the course. My first priority is to help the Board preserve and build on the Division's financial strength. We need to make sure your dues dollars and the other assets of the Division are put to good work in line with the Division's interests and mission.

I am looking forward to the possibility of your vote and the privilege of serving as Treasurer. ■

CANDIDATE STATEMENTS
Diversity Domain Representative

Beverly Greene, Ph.D., ABPP

I am a candidate for Member at Large, Diversity Domain Rep, on the Divisions' Executive Committee and would be honored to serve in this capacity. I have participated broadly in APA governance at both national and divisional levels as well as on many working groups and task forces addressing issues deemed important to the association. That participation was directly relevant to research, professional training and practicing psychotherapy. As an educator, scholar and practitioner both my professional work and personal identities are representative of a wide range of diverse settings, constituencies and interests in the context of psychotherapy research and practice. I bring those interests and the breadth of my experience to this position. The ability of practitioners to deliver competent services to all clients but particularly uninsured and vulnerable populations is challenged by a continued struggle for parity for mental health services as well as diminished funds for research and the rigorous training of future psychologists in this depressed economic climate. As a division we can and do assume a leadership position in the dissemination of cutting edge research relevant to psychotherapy and its importance in the overall scheme of interventions that contribute to better health outcomes. I would like to continue to serve the division by contributing to our efforts to seek solutions to those problems and view psychotherapy as an endeavor that can make powerful contributions to the pursuit of social justice. ■

Amit Shahane, Ph.D.

I am honored to be a nominee for Division 29's Diversity Domain Representative. I believe my experience in the area of psychotherapy as a clinician, supervisor, and researcher will enhance my ability to promote Division 29's commitment to diversity. My clinical and research activities focus on the implementation and evaluation of behavioral health services for persons living with HIV/AIDS. My clinical and research work is conducted within a large urban hospital committed to serving diverse, disenfranchised, and underserved individuals. This commitment to diversity is consistent with my values as a psychologist, and can be exemplified in the populations I serve and my emphasis on culturally competent clinical practice and research.

Currently, I am a full time Assistant Professor in Emory University School of Medicine's Department of Psychiatry and Behavioral Sciences and work within Grady Memorial Hospital's Infectious Disease Program. As a faculty member, I am involved in psychotherapy training and supervision of practicum students, interns, medical students, and psychiatry residents. In addition, I participate in various committees ensuring professional and collaborative relationships across university and hospital settings. Through these experiences, I believe I have gained the necessary leadership, organizational, and communication skills to serve effectively as Diversity Domain Representative.

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Within Division 29, I enjoy serving as the current committee chair for the Diversity Domain. As committee chair, I have worked to build collaborative relationships with other Division 29 domains, and further the values and mission of the Diversity Domain. I hope to continue my relationship with the Diversity Domain and expand my role as Domain Representative. As an Indian American male, I am especially dedicated to the awareness of and sensitivity to diversity issues as they relate to psychotherapy at all levels.

If elected, I would work to further enhance awareness of diversity-related issues across all Division 29 domains, as well as advocate for diversity perspectives in all APA and Division 29 initiatives. Thank you for your consideration and I would greatly appreciate the opportunity to serve as Diversity Domain Representative. ■

CANDIDATE STATEMENTS
Education & Training Domain Representative

Jairo N. Fuertes, Ph.D., ABPP

Dear Colleagues,
I have been nominated for the position of Domain Representative for Education and Training within Division 29. I appreciate the nomination and agreed to stand for the position because I believe that I now know the work and responsibilities of the committee and the role of the committee in the broader context of the division. I have served as Chair of the Education and Training Committee for a little over a year now. I served as Chair-elect for a few months in 2010 before assuming the position of Chair of the committee in 2011. The position of Chair is normally one year, but I was asked by Marv Goldfried in the fall of 2011 to consider serving one more year as Chair of the Committee, which would take me through 2012. I agreed to do so. Our work in the committee has been very much collaborative in nature and I have been fortunate to be able to work with several outstanding professionals, including three wonderful student representatives. The current Domain Representative, Dr. Sarah Knox, has been extremely helpful to all of us. As Domain Representative I would continue to ensure the good work of the committee, including working closely with the Editor of the Bulletin, Dr. Lavita Nadkarni, to identify authors who can provide timely and well-written articles that pertain to issues of education and training in psychotherapy. I would also work with the new Chair of the committee to ensure that summaries of articles are uploaded onto the division website, as has been done for a few years now. I would also ensure a timely and efficient process with the selection of award recipients and would work closely with the committee to select new representatives to the committees as others finish their terms. As Domain Representative I would also understand the need to advocate for education and training issues within the board. ■

Jesse Owen, Ph.D.

Jesse J. Owen is an Assistant Professor in the Counseling Psychology Program in the Educational and Counseling Department at the University of Louisville. I am an Associate Editor for Psychotherapy and the Journal of Counseling Psychology and I also serve as a consulting editor for Training and Education in Professional Psychology. Within Div. 29, I am currently a member of the Education and Training Committee and for Div 17. I am the Secretary for the Society for the Promotion of Psychotherapy Research. My scholarly efforts have resulted in over 50 articles and book chapters on psychotherapy process and outcome, diversity issues, and training issues. I am dedicated to better understanding psychotherapy processes, including technical and relational components, to help inform education and training. There are many current challenges to the practice of psy-

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chotherapy, and the evolution of of our field will require integrative, informed and innovative perspectives on how best to approach training of psychologists. My philosophy is to build on previous foundations of practices while also searching to enhance the effectiveness of our education practices of psychotherapists. We need to utilize the voice of our Division to empower our clients, psychotherapists, training institutes, and licensing boards. Ultimately, my goal is to be a vigorous advocate for practices in education and training in psychotherapy, while providing leadership for key concerns that our field will face in upcoming years. ■

CANDIDATE STATEMENTS
Professional Practice Domain Representative

Meghna Patel, Ph.D.

I am honored to be nominated as a candidate for the Professional Practice Domain. I received my PhD in clinical psychology from the University of Missouri-St. Louis and completed my internship and fellowship at Emory University School of Medicine at Grady Health System. I am currently working at the Atlanta VA Medical Center in the Trauma Recovery Program, where I truly enjoy providing psychotherapy for veterans presenting with a history of military sexual trauma. My primary research interests include assessing the effectiveness of varied trauma focused therapies and developing culturally competent interventions for specific populations. My interest in culturally competent treatments developed while providing individual and group therapy and participating in research studies with the Nia Project, a grant funded project examining intimate partner violence and suicide among low-income African-American women. As demonstrated by my research and clinical endeavors, I am passionately committed to forging a strong relationship between science and practice. Towards this effort, I am dedicated to training the next generation of psychologists in psychotherapy and thus serve on the VA's training committee. Psychology's future is heavily reliant on how well practitioners and researchers collaborate and integrate information to effectively meet the growing mental health needs of a diversifying public. It is the obligation of those in our field to further educate the public about mental health and promote a more positive public perception of psychotherapy than the one that is conveyed by mainstream media. To help work towards these goals, it is imperative that we work not only with our colleagues, but also with those from different disciplines. It would be my distinct pleasure to serve Division 29 and believe that my clinical, research, and administrative experience would aid me well to represent, promote, and advance the professional practice of psychotherapy. Thank you for your consideration. ■

Barbara J. Thompson, Ph.D.

I am honored to be asked to run as a Candidate for Division 29's Professional Practice Domain. I am just beginning my second year as the Chair of the Professional Practice Committee and am eager to expand my involvement in Division 29. Even before starting my graduate studies, I was fascinated by psychotherapy and how people change. I completed my doctorate in psychology at University of Maryland where I grew to love psychotherapy research. For many years I have been a reviewer for Psychotherapy Research and conducted research that is relevant to psychotherapy practice (e.g., therapist compassion). My clinical experience has ranged from working with mentally ill, running intensive programs for children and adolescents, and maintaining a private

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practice working with adults. From an integrative theoretical perspective, I encourage clients to aspire to fulfill their dreams and live authentic lives. I strive to stay on top of current innovations in psychotherapy, using my strong affiliation with psychotherapy research as a base. I am continually open and amazed by what my clients show me and use their feedback to inform my practice. For several years, I have also been teaching graduate counseling courses which, along with student supervision, helps me stay proficient as a therapist.

There are many challenges in today's world (e.g., cultural diversity, evidence-based treatments, and the DSM) that affect psychotherapy. If elected as the Professional Practice Representative, I will advocate for psychotherapists' interests in Division 29 and will promote Division 29 to psychologists and other clinicians in private practice who may not realize the benefits of being a member of Division 29. I believe my passion for psychotherapy together with my experiences in teaching, researching, and practicing psychotherapy is a solid base from which to sensitively engage in, promote, and advance the field of psychotherapy. ■

CANDIDATE STATEMENTS
Membership Domain Representative

Jean Birbilis, Ph.D.

This is a win-win election. Both Annie and I are committed to growing the membership of Division 29, and we will both continue to work together to draw new members in and retain existing members, whoever is elected to this particular position. I have been focussing my attention during my time as the chair of Division 29's Membership Committee on identifying ways to attract more people with Psy.D.s to the Division. As a faculty member of a Psy.D. program, I believe there is a particular fit between the mission of Division 29 and the professional identity and training of Psy.D.s, yet only about 150 of our current members have this identity and training. As we continue to strive to grow and diversify, we will benefit from maximizing our outreach to psychotherapists from all walks of life. As I continue to serve Division 29, I will continue to look for ways to be as inclusive as possible and to join Annie and Libby in their slogan that this the Division that makes it possible for psychotherapists to "Be connected!" ■

Ann B. Judge, Ph.D.

I am honored to be nominated for the Membership Domain Representative position. I currently serve in this role, and I look forward to the possibility of continuing to do so. I believe that my responsibility is to ask questions such as "What can Division 29 do for its members? How can the Division attract a wider, more diverse membership? What do our members need? How can we be a Divisional home for members so that they stay and benefit from it for years to come?"

These questions are important to ask, and coming up with answers is crucial as well. Membership activities and initiatives are meant to allow members to "Be Connected" with each other and the Division's Board. We will be asking members more about what they need so that the Division can provide (or continue to provide) outstanding benefits and services. For example, if you want more continuing education offerings, I want to hear that. If you want a greater web presence, I want to hear that, too. If you want more offerings geared toward ECPs, let me know. Whatever your thoughts about what the Division can do for you, I not only want to hear it, I want to try to make that happen. If I am given the opportunity to continue in my capacity as Membership Domain Representative, I will be sure to be that voice on the Board that reflects members' needs and wishes, and I believe that greater cross collaboration with other Domain Representatives will increase the likelihood that these needs are met. ■

CHARLES J. GELSO, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Brief Statement about the Grant:
The Charles J. Gelso, Ph.D., Psychotherapy Research Grant, offered annually to qualifying individuals, provides $2,000 toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

Eligibility: In alternating years, graduate students/predoctoral interns or doctoral level psychologists/postdoctoral fellows will be eligible for the Charles J. Gelso Grant. In 2012, graduate students in psychology and predoctoral interns who are in good standing at an accredited university will be eligible. In 2013, doctoral level psychologists, including postdoctoral fellows, will be eligible. The grant will rotate biannually between graduate students/predoctoral interns and doctoral level psychologists/postdoctoral fellows, such that nominations will be accepted in even number years for the former group and odd number years for the latter group.

Submission Deadline: April 1, 2012

REQUEST FOR PROPOSALS

Charles J. Gelso, Ph.D. Grant

Description
This program awards grants for research projects in the area of psychotherapy process and/or outcome. In alternating years the grant is awarded to graduate students or doctoral level psychologists.

Program Goals
- Advance understanding of psychotherapy process and/or psychotherapy outcome through support of empirical research
- Encourage talented graduate students towards careers in psychotherapy research
- Support psychologists engaged in quality psychotherapy research

Funding Specifics
One annual grant of $2,000 to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see *Additional Information* section below).

Eligibility Requirements
- In alternating years, graduate students/pre-doctoral interns in psychology (even-numbered years) or psychologists/postdoctoral fellows (odd-numbered years) will be eligible
- In 2012, graduate students/pre-doctoral interns who are in good standing at an accredited university will be eligible
- In 2013, doctoral level psychologists and postdoctoral fellows will be eligible
- Demonstrated or burgeoning competence in the area of proposed work

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- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The same project/lab may not receive funding two years in a row

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, title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal. This will be a blind review so please exclude identifying information.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (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.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows
- Graduate students, predoctoral interns, and postdoctoral fellows should refer to the section immediately below for additional materials that are required.

Additional Proposal Requirements for Graduate Students, Predoctoral Interns, and Postdoctoral Fellows
- Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work
- Graduate students and pre-doctoral interns must also submit 2 letters of recommendation, one from the mentor who will be providing guidance during the completion of the project (note that this letter must indicate the nature of the mentoring relationship)
- Postdoctoral fellows must submit 1 letter of recommendation from the mentor who will be providing guidance during the completion of the project (note that this letter should indicate the nature of the mentoring relationship)

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Additional Information

- After the project is complete, 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 must be returned
- When the resulting research is published, the grant should be acknowledged
- All individuals who directly receive funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st)

Submission Process and Deadline

- If the grant is to be used to support a thesis or dissertation, the thesis/dissertation proposal must be approved by the thesis/dissertation committee (this should be noted in the letter of recommendation from the mentor)
- All materials must be submitted electronically
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours, which will provide you with an assigned application number. If you do not receive confirmation, your proposal was not received, then please resubmit.

Deadline: April 1, 2012

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Michael Constantino at mconstantino@psych.umass.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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NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Brief Statement about the Grant:

The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually to qualifying individuals, provides $20,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, including 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: April 1, 2012

REQUEST FOR PROPOSALS

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Description

This program awards grants for research on psychotherapist factors that may impact treatment effectiveness and outcomes, including 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
- Encourage researchers with a successful record of publication to undertake research in these areas

Funding Specifics

One annual grant of $20,000 to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see *Additional Information* section below).

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

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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 title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal. This will be a blind review so please exclude identifying information.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (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
- All individuals directly receiving funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st)

Submission Process and Deadline

- All materials must be submitted electronically
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
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(address, phone, fax, email)
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DEADLINE: APRIL 1, 2012

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Michael Constantino at mconstantino@psych.umass.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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Connect with other psychotherapists so that you may network, make or receive referrals, and hear the latest important information that affects the profession.

☐ OPPORTUNITIES FOR LEADERSHIP

Expand your influence and contributions. Join us in helping to shape the direction of our chosen field. There are many opportunities to serve on a wide range of Division committees and task forces.

☐ DIVISION 29 LISTSERV

As a member, you have access to our Division listserv, where you can exchange information with other professionals.

☐ VISIT OUR WEBSITE

www.divisionofpsychotherapy.org

MEMBERSHIP REQUIREMENTS: Doctorate in psychology • Payment of dues • Interest in advancing psychotherapy

Name _____ Degree _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Email _____

Member Type: ❑ Regular ❑ Fellow ❑ Associate
❑ Non-APA Psychologist Affiliate ❑ Student ($29)

If APA member, please provide membership #

❑ Check ❑ Visa ❑ MasterCard

Card # _____ Exp Date _____/_____

Signature _____

Please return the completed application along with payment of $40 by credit card or check to:

Division 29 Central Office, 6557 E. Riverdale St., Mesa, AZ 85215

You can also join the Division online at: www.divisionofpsychotherapy.org

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 Nadkarni, 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 lnadkarn@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); August 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).

DIVISION OF PSYCHOTHERAPY (29)
Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net
www.divisionofpsychotherapy.org

DIVISION OF PSYCHOTHERAPY
American Psychological Association
6557 E. Riverdale St.
Mesa, AZ 85215

www.divisionofpsychotherapy.org