Psychotherapy Research
Change in Defensive Functioning During Group Psychotherapy for Women with Binge Eating Disorder

Education and Training
An Insider Perspective: Developmental Challenges Moving from Graduate School to Internship and Beyond

Psychotherapy Practice
Musings from the Psychotherapy Office: A “Cool” Clinical Approach

Diversity
What Defines Culture?

APF Rosalee G. Weiss Lecture for Outstanding Leaders in Psychology
Leadership, Mentoring, Service, and How Psychology Can Save America from Itself
Division of Psychotherapy ■ 2013 Governance Structure

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This is my fourth and last President’s column. I’m going to address two aspects of participation in Division 29: First, some Bylaws changes require your vote. The description is lengthy, but your vote is important. Second, I ask whether Division 29 should meet and propose a new sort of meeting: small local meetings to discuss presentations about psychotherapy practice or theory or the practice-research interface.

Bylaws Changes: Non-APA Member Affiliates
The Division 29 Board—which consists of all of the Division’s elected officers—has unanimously recommended several changes in our bylaws. Changing the bylaws requires a vote of the membership. So if you are a member, please have a look at what follows and VOTE.

Election of division officers is now conducted online by APA, but this is the first time Division 29 has used online voting to decide a policy issue. Details of the procedure are still being worked out. It appears that if you are eligible to vote, you will be notified in an email message that will include a link to the ballot.

The full text of the bylaws, indicating the proposed changes, are posted on the Division’s website, along with the PRO and CON statements (which I describe below).

The Proposed Changes
The main changes simplify and broaden the criteria for becoming a Non-APA Member Affiliate of the Division. Here is the proposed wording:

Section II. E. The minimum qualification for election to the category of Non-APA-member Affiliate shall be an earned doctoral degree in Psychology or a professional credential that entitles them to practice psychotherapy independently.

A further change simplifies and clarifies the rights and privileges of Affiliates.

Section III. D. Non-APA-member Affiliates of The Division shall be entitled to all the rights and privileges of full members except that they are not eligible to vote in Division elections and they are not eligible to hold elected office in the Division.

The criteria for full membership would remain unchanged, as would the rights and privileges of full members. Full membership, with the right to vote in elections and hold elective office, requires APA membership. The Division also offers three other categories of membership: Fellow, Associate Member, and Student Affiliate. No changes are proposed for any of these categories.

Discussion of the changes
The wordings of these changes have been discussed and honed over several months of discussion. Here are some key points:

1. The current criteria for Affiliates require “an earned doctoral degree from a program recognized on the designated doctoral programs in psychology list jointly maintained by the
National Register of Health Service Providers in Psychology and the Association of State and Provincial Psychology Boards. This National Register/ASPBP designation program is now being phased out. Thus, some change is necessary.

2. Mindful of the steadily declining membership in the Division, many have advocated opening Affiliate membership to a wider group. The PRO statement on the website, argues that there would be mutual benefit in affiliating with others who share our professional interest in psychotherapy. The revised bylaws (section II.E) would offer Affiliate membership to a broader range of professionals: psychotherapists who are not psychologists and psychologists who are not psychotherapists, including those from countries overseas where credentialing systems are different from American ones. By opening up Affiliate membership, the Division might expand its influence globally, as well as enlarging its financial base.

3. The proposed wording requires only that Affiliates have “an earned doctoral degree in Psychology or a professional credential that entitles them to practice psychotherapy independently.” The CON statement points out that this wording does not define what is meant by a “professional credential” and raises the possibility that applicants’ training may not have included the content, knowledge, and experiential training required of professionals who are full members.

4. On the other hand, as the PRO statement suggests, further specific criteria and definitions can be spelled out in the Policies and Procedures Manual. The Board’s plan for administering the new criteria includes asking applicants for Affiliate membership to specify their professional credentials along with the granting institutions or agencies, so appropriate decision can be made.

5. The change in section III.D. would simplify the description of affiliates’ rights and privileges. However, it would make only minor substantive changes. As a simplification, the proposed changes would eliminate the current prohibition on being appointed as chair of a standing committee. However, all such appointments are made by the President and require approval by the Board, all members of which are elected.

The change would not alter how decisions are made in Division 29. Only full members can vote or run for office, and full membership in Division 29 is open only to APA members. As now, affiliates would pay the same dues as regular members. They would receive the journal, and have the other benefits of membership except that they could not vote in division elections or serve in elective office.

6. For the last few years, we have had only 20-30 Affiliate members. I, for one, hope that broadening and simplifying the criteria will increase this number.

7. In addition to the substantive change in criteria for Affiliate membership, several housekeeping changes in the Bylaws are proposed to simplify and clarify them. Some are grammatical corrections. Some change percentages to numbers in specifications of how many members are required to take certain organizational actions. Others bring descriptions of procedure in line with practice, including removal of some detailed specification of committee memberships, which have

continued on page 4
seldom been followed closely and in any case are more appropriate for the Division’s Policy and Procedures manual. These additional changes did not seem controversial, and the Board decided to include them in the vote on the substantive changes in Affiliate membership. Here is a list of the changes.

ARTICLE II, SECTION D – editing to clarify the student affiliate membership qualifications

ARTICLE II, SECTION E – substantive changes to the non-APA affiliate membership qualifications (this is the important change)

ARTICLE III, SECTION D – changes to the non-APA affiliate member rights and privileges

ARTICLE IV, SECTION B – clarifications regarding dues payments

ARTICLE VII, SECTION C.5 – changes to allow electronic submission of nomination ballots

ARTICLE VII, SECTION D – changes to the percentage of votes required to be automatically placed on the ballot

ARTICLE VII, SECTION G – editing to accommodate the change in section D

ARTICLE IX, SECTION A – changes to the percentage of votes required to bring a referendum to the board of directors

ARTICLE XI, SECTIONS C and D – changes in how committees are appointed

ARTICLE XI, SECTION G – changes in the composition of some of the standing committees

ARTICLE XIII, SECTION A & G – change in the percentage of members required to form and dissolve a section

ARTICLE XV, SECTION A – change in the percentage of members required to amend the bylaws

I encourage you to look at the full text of the Bylaws showing these changes, posted on the Division website:

If you would like to comment on any of them, please write to me or any member of the Board or post your comment on the Division’s listserv. If you have not yet joined the listserv, you can do so at: http://www.divisionofpsychotherapy.org/members/list-serv/

8. One further change, to ARTICLE XV, SECTION C, would amend the requirement for pro and con statements for bylaws changes to allow the Board to decide whether such statements are needed. The Board unanimously supported this change as well, but they felt it was sufficiently substantive to require a separate vote. This change was stimulated by the large number of non-controversial housekeeping changes described in the preceding point. (In this case, the Board has sidestepped the issue by including the housekeeping changes along with the substantive change in Affiliate membership criteria and has provided pro and con arguments only for the main substantive issue.)

The relevant sentence replaces “shall” with “may, as determined by the Board” as follows:

The ballot to vote on the proposed bylaws amendment(s) [shall] may, as determined by the Board, include statements that specify the arguments for and against the proposed amendment.

Personally, I support the all of these changes. But, whatever your judgment, I urge you to follow the link and vote when you receive your notification. 

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Shall We Meet?
Currently, Division 29 meets only in the few hours of program time granted us at the annual APA convention. For many years, the Division held a Midwinter Meeting, often in conjunction with other divisions. In these meetings, one or a few well-known psychologists made workshop-like presentations, and participants could earn Continuing Education credits. These meetings were popular and successful for a time, but attendance gradually declined. The last two Midwinter Meetings, in 2002 and 2005, were poorly attended and lost a good deal of money.

Would Division 29 members attend meetings organized in some other way?

For purposes of discussion, here’s an idea: Small local or regional meetings organized for perhaps 20-40 participants who live within driving distance.

The conference might last one day or perhaps two days over a weekend. The content would be presentations (papers, panels) by participants about psychotherapy practice or theory or the practice-research interface. Specific topics would depend on local interests and the expertise and experience of participants. I picture a schedule that allows generous amounts of time for discussion.

Each such meeting would require local organizers and a program committee. With some thinking and preparation, the Division could help with coordination, expertise, publicity through the website, and perhaps a little start-up funding, to be repaid from modest fees.

Would you attend such a mini-conference? Would you pay modest fees to attend? Would you volunteer to be a local organizer? To answer or to comment on this idea or to propose a different idea, please write to me at <stileswb@miamiho.edu> or post the comment on the Division’s listserv. If you are not a member of the listserv, you can join at: http://www.divisionofpsychotherapy.org/members/list-serv/
It is hard to believe that we are reaching the end of another year, presenting you here with the last issue of the Psychotherapy Bulletin for 2013. Not only is this the final issue for the year, but this is also Lavita's last as Editor. We are excited to announce that our Associate Editor, Lynett Henderson Metzger, will assume the role as Editor as of the first issue of 2014, with Ian Goncher as Associate Editor.

The last three years have seen significant changes and opportunities in the field, with technology continuing to positively impact access to mental health care and enriching our global perspective. Lavita has greatly appreciated the support from Jeffrey Barnett, the Publications Board Chair, Tracey Martin, Central Office Administrator, and the Board, Contributing Editors, authors, and Domain representatives who have submitted a wide range of articles for your reading pleasure. Being a part of this team, ably assisted by Lynett and our Editorial Assistant, Jessica del Rosario, has been a professional highlight for Lavita.

Once again, the Psychotherapy Bulletin editors are privileged to offer a wonderful array of excellent articles in this issue. There are six papers authored (or co-authored) by students on important topics including perspectives on diversity, early career transitions, and innovative and evidence-based therapeutic approaches with clients across multiple systems. It is incredibly exciting for the field that our diverse student voices are supported and represented. In case you were not able to hear Jeffrey Barnett’s award presentation in Hawaii, we know you will want to read his sage advice on leadership and mentoring. There are two articles on psychotherapy practice, both reflecting on the changes in and future of psychology. Of course, the Washington Scene provides us with unique political insight. In this issue, you will find President Bill Stiles’ final column, with thoughts and action steps related to increasing Division involvement. Please express your gratitude to him for his outstanding tenure and leadership role in this effort.

Having worked closely with Lynett for many years, I know you will greatly benefit from her wisdom, wit, and creative energy. We have both enjoyed working together to ensure that Division 29 members receive current information on theory, practice, training, and research in psychotherapy. As someone who has a passion for the training of students and creating a community allowing for diverse voices, Lynett is delighted to promote the D29 domain structure in the Bulletin and to foster our coming together as a community. As an Assistant Clinical Professor at the University of Denver’s Graduate School of Professional Psychology, Lynett draws on her background in both law and psychology, and has editorial experience in the legal and mental health fields. Please welcome her to this new role.

Wishing everyone a healthy and happy holiday season, and a wonderful new year in 2014.

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Defense mechanisms are psychological processes that work to manage internal conflict and stress by altering how these events are perceived. Adaptive defenses typically maximize awareness of internal states and result in positive outcomes, whereas less adaptive defenses work to restrict awareness of internal states and conflict, thus limiting positive outcomes (Perry et al., 2009; Vaillant, 1994). Scales that measure defense mechanisms typically arrange the defenses on a hierarchy. Defenses often are ordered based on adaptive function and psychological health, and range from adaptive to maladaptive. Individual defenses are typically clustered together into defense levels based on the adaptive function and conceptual characteristics of a given defense (Constantinides & Beck, 2010).

Several studies have examined the relationship between defensive functioning, psychopathology and treatment outcome. Lower levels of adaptive defensive functioning are associated with higher levels of anxiety, depression, interpersonal problems and greater impairment in psychological functioning in patients with various psychiatric illnesses seeking individual therapy (e.g., Hilsenroth et al., 2003). Higher defensive functioning predicted better outcomes six months after the start of individual therapy (Høglend & Perry, 1998). Defensive functioning can also change in response to therapy. Several studies found that patients shifted from a maladaptive defense style to a more adaptive style by the end of treatment, and the change in defensive functioning was stable up to one year post treatment (e.g., Johansen et al., 2011).

There are several studies that have examined the relationship between eating disorders (specifically anorexia and bulimia nervosa) and defensive functioning. The results consistently indicate that an eating disorder diagnosis is associated with greater maladaptive defensive style compared to non-eating disordered controls (e.g., Bond, 2004). To date there is not a single study on the defensive functioning of those diagnosed with binge eating disorder (BED). Binge eating disorder is characterized by consuming a large amount of food in a short discrete period of time, with a sense of loss of control during the episode of over eating. The binge episode is not followed by compensatory behaviour, such

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**PSYCHOTHERAPY RESEARCH**

Change in Defensive Functioning During Group Psychotherapy for Women with Binge Eating Disorder

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Defense mechanisms are psychological processes that work to manage internal conflict and stress by altering how these events are perceived. Adaptive defenses typically maximize awareness of internal states and result in positive outcomes, whereas less adaptive defenses work to restrict awareness of internal states and conflict, thus limiting positive outcomes (Perry et al., 2009; Vaillant, 1994). Scales that measure defense mechanisms typically arrange the defenses on a hierarchy. Defenses often are ordered based on adaptive function and psychological health, and range from adaptive to maladaptive. Individual defenses are typically clustered together into defense levels based on the adaptive function and conceptual characteristics of a given defense (Constantinides & Beck, 2010).

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as over-exercise or vomiting. A binge may function to reduce feelings of anxiety and conflict by the experience of soothing or of distraction that comes with consuming a large amount of food (Tasca et al., 2005). In both the interpersonal model of binge eating and the psychodynamic view, a relational conflict or deficit produces negative affect, which results in binge eating (Ansell et al., 2012; Tasca et al., 2005).

Group Psychodynamic Interpersonal Psychotherapy (GPIP; Tasca et al., 2005) is a therapeutic method designed for treatment of patients with BED. GPIP combines aspects of psychodynamic, interpersonal, and group therapy theories. In GPIP, the patient is encouraged to explore more adaptive interpersonal patterns in a cohesive group environment that the therapist helps to establish early in therapy. In the middle stage, therapists disrupt patients’ problematic interpersonal patterns and encourage patients to replace them with more adaptive patterns. Hence, patients can satisfy their relational and attachment needs better, which will in turn, reduce negative affect and the urge to binge (Ansell et al., 2012; Tasca et al., 2005). The late stage of the group is focused on consolidating gains. Results from treatment trials found a reduction of the number of days binged and depressive symptoms following GPIP compared to a wait-list control (Tasca et al., 2006). Further, Tasca and colleagues (Tasca, Balfour et al., 2006; Tasca et al., 2011), demonstrated that patients who experience predictable fluctuations in relational patterns and group cohesion across the early, middle, and late stages of group therapy reported improved symptoms post-treatment. Such patterns were consistent with a stage model of psychotherapy (Tracey et al., 1999).

Consistent with previous individual therapy research using the DMRS, we expected that participants with BED in the current group therapy study will show improvement in defensive functioning from early to late group therapy sessions, and that the improvement will be associated with decreased depressive symptoms and episodes of binge eating. Further, and consistent with a stage model of psychotherapy, we predicted that change in defensive functioning will be best represented by a non-linear function in which adaptive defensive functioning will increase early in group therapy, followed by a plateau or decrease in middle sessions, followed by further increases in the late stage.

Hypotheses

Hypothesis 1: Defensive functioning score changes will show linear increase across group treatment.

Hypothesis 2: Linear increases in defensive functioning will be associated with pre to post treatment improved depressive symptoms and binge eating episodes.

Hypothesis 3: Improvement in defensive functioning will be best modeled by a cubic function, in which immediate improvement early in therapy will be followed by a decrease or plateau during the middle stage, and then further improvement at the end of group treatment.

Method

Participants

Adult women were recruited through advertisement in local newspapers and through referrals from an eating disorder treatment center. Participants met diagnostic criteria for BED based on the *DSM-IV-TR*, and had a Body Mass Index (BMI) greater than 27 (i.e., were overweight). Prospective participants were screened and excluded if they reported: current or past incidences of inappropriate compensatory behaviour (such as laxative use or... continued on page 9
vomiting), recent alcohol or drug abuse, weight management medications, and/or a diagnosis of bipolar or any psychotic disorder. Detailed sample characteristics and procedures are available in another publication (Tasca et al., 2013).

**Measures**

**Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977).** The CES-D is a 20-item self-report measure of depressive symptoms. Scores greater than 16 indicate that an individual experiences at least moderate depressive symptoms. Alpha coefficient for the CES-D was $\alpha = .93$ at pre-treatment and $\alpha = .92$ at post-treatment.

**Eating Disorder Examination (EDE; Fairburn & Cooper, 1993).** The EDE is a semi-structured interview to assess days binged in the past 28 days. Inter-rater reliability of days binged was tested using a two-way random effects model intraclass correlation (ICC). The ICC was .98, indicating excellent agreement between raters.

**Defense Mechanism Rating Scale (DMRS; Perry, 1990).** The DMRS is an observer rated measure of defense mechanisms comprised of 27 defenses organized into seven levels, which are weighted from low adaptive to high adaptive. Higher defensive functioning scores indicate better adaptive functioning and low scores indicate less adaptive functioning (Perry & Høglend, 1998). The mean overall defensive functioning (ODF) scores for treatment seeking patients diagnosed with a psychiatric disorder in several studies range from 4.41 (SD = .82; Perry & Høglend, 1998), 4.97 (SD = .70; Hilsenroth, Callahan, & Eudell, 2003), and 4.41 (SD = .65; Johansen et al., 2011). A one-way random effects model ICC(1, 1) was used to test for reliability among pairs of raters in this study. The ICC(1, 1) in this study was .70 when reliability was calculated using ODF scores based on 5 or more coded defenses per person ($n = 44$), thus indicating “good” agreement between raters (Landis & Koch, 1977). Hence, for subsequent analyses, we retained only data for participants who had 5 or more ODF scores during any group treatment session.

**Procedure**

Each participant received 16 sessions of GPIP, and each session was video recorded to ensure adherence to the treatment manual. Six female therapists (two psychiatrists, three psychologists, and one masters level advanced practice nurse) each conducted two 16-sessions therapy groups. Participants completed questionnaire packages at pre-and post-treatment, including the CES-D, and the EDE interview. Five sessions were transcribed (sessions 1, 3, 8, 12, and 16) and coded for defensive functioning. Thirty-six sessions, each lasting approximately 90 minutes, were coded on the DMRS by pairs of reliable raters. Raters included two psychologists, two advanced graduate students in psychology, one psychiatry resident, and one undergraduate student in psychology. Therapy sessions were de-identified to mask the session number.

**DMRS Coding**

Each rater received 30 hours of training on use of the DMRS for coding defensive functioning. Training occurred over the course of several months by an experienced psychologist trained in use of the DMRS. Raters and trainer also met regularly throughout the coding process to reduce rater drift. Only those raters who attained an adequate level of reliability, based on the standards of good reliability (ICC > .70), coded transcripts. The entire 90-minute GPIP session was coded using video and transcripts, and each rater completed an ODF scoring sheet for each participant in a given session.

One hundred and two adult female participants with BED began treatment.  

*continued on page 10*
Seventy-seven participants had ODF scores based on five or more defense mechanisms in at least one therapy session. Analyses were completed with N = 77; however, due to missing data, multilevel models were run with N = 72.

Results
The data were tested for outliers (univariate and multivariate), skewness, and entry errors prior to analysis. Missing data patterns were analyzed for each variable tested and there was no effect of completer status or any missing data pattern on the DMRS slopes. Therefore the data were missing at random. Mean defensive functioning scores measured at each session were: session 1: 4.59 (SD = .79); session 3: 5.04 (SD = .64); session 8: 5.09 (SD = .71); session 12: 4.92 (SD = 4.93); and session 16: 5.50 (SD = .78).

Hypothesis 1 predicted a linear increase in ODF scores during group treatment sessions. Multilevel modeling modelled within person change at level one and between person variance in the change at level two. The linear multilevel model was significant indicating positive linear change in ODF scores across sessions (Table 1), with the addition of the linear parameter significantly improving model fit, $p < .001$.

A 2-Level model was also used to test the second hypothesis that linear increase in defensive functioning would be associated with reduced depressive symptoms, and binge episodes from pre-treatment to post-treatment. Pre to post residual change scores of depressive symptoms and binge eating episodes were entered as predictors of level two of the multilevel model. The model testing the relationship between linear change in ODF scores and residual change in depressive symptoms was significant ($\beta_{11} = -.01, SE = .002, t = -2.52, df = 69, p = .014$), and accounted for 12% of the ODF linear parameter variance. The model testing the relationship between linear change in ODF scores and residual change in binge episodes was also significant ($\beta_{12} = -.01, SE = .003, t = -2.11, df = 69, p = .04$), and accounted for 15% of the ODF linear parameter variance.

To test hypothesis three, we sequentially added a quadratic and cubic time parameter at level one of the multilevel linear model. The quadratic model was not significant, but the cubic model was significant indicating that a cubic trend best fit the data (Table 1), and addition of the cubic parameter significantly improved model fit, $p < .001$. ODF scores initially increased from session 1 to 3, decreased slightly from sessions 8 to 12, and increased again by session 16.

Discussion
This is the first study to assess the growth of defensive functioning in a group therapy context among women with BED. Defensive functioning significantly improved during group treatment. The linear change in ODF scores

<p>| Table 1: Unconditional growth model parameters for Overall Defensive Functioning scores. |
|----------------------------------------|------------------|--------|--------|--------|--------|</p>
<table>
<thead>
<tr>
<th>Model</th>
<th>Level 1 Parameter</th>
<th>Coefficient (SE)</th>
<th>$t$</th>
<th>$df$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>$\beta_{00}$</td>
<td>4.96 (.06)</td>
<td>78.93</td>
<td>71</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Linear Slope</td>
<td>$\beta_{10}$</td>
<td>.19 (.03)</td>
<td>6.91</td>
<td>70</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Quadratic Slope</td>
<td>$\beta_{20}$</td>
<td>.002 (.02)</td>
<td>.13</td>
<td>70</td>
<td>.90</td>
</tr>
<tr>
<td>Cubic Slope</td>
<td>$\beta_{30}$</td>
<td>.07 (.03)</td>
<td>2.26</td>
<td>70</td>
<td>.027</td>
</tr>
</tbody>
</table>

$N = 77$. SE = standard error. Each parameter is derived from 4 different sequential multilevel models.

continued on page 11
was consistent with previous research that found change in defensive functioning in response to different types of individual therapy (Hilsenroth et al., 2003, Johansen et al., 2011; Perry, et al., 2008; Presniak, 2010). Defensive functioning likely changed because of GPIP’s focus on emotion regulation and on changing interpersonal patterns (Tasca et al., 2005). In addition, improvements in defensive functioning co-occurred with improved binge eating and depressive symptoms. This is consistent with the GPIP model that conceptualizes binge eating as a maladaptive response to negative affect, and that improvements in coping will result in reduced binges.

As indicated, not only did ODF scores improve in a linear manner, but the pattern of change across sessions was best represented by a cubic function. That is, ODF scores improved from sessions 1 to 3, declined slightly from sessions 3 to 12, and then showed a precipitous improvement again from sessions 12 to 16. This is consistent with a stage model of GPIP in which early sessions focus on developing a cohesive group, middle sessions involve therapists and group members confronting maladaptive interpersonal patterns, and late sessions are devoted to consolidating gains (see Tasca et al., 2011; Tracey et al., 1999). Not only is the rate of improvement in defensive functioning important to achieve positive outcomes, but the pattern of defensive functioning improvement across time also may be important. In other words, the findings suggest that the development of therapeutic stages as defined by GPIP and indicated in part by a pattern of improvement in defensive functioning may be necessary to achieve good outcomes in group psychotherapy.

Limitations
This study was based on a small sample size. Of the 102 participants who began treatment, only 77 had enough coded defenses in any one session \( n \Rightarrow 5 \) to be included in the analyses. There was a relatively large amount of missing ODF data at each session. Missing data pattern analyses indicated that the data were missing at random for ODF and outcome variables, hence the parameters are likely reliable. Nevertheless, the findings should be interpreted with caution, as the resulting sample size reduced statistical power and precision of the standard errors. The current study participants were predominantly middle-aged Canadian-European women with BED. Expanding the scope of future treatment studies to include other eating disorders, other mental illnesses, or individuals with diverse characteristics would increase the generalizability of the results.

Clinical Implications
The findings support the use of the DMRS as a potentially useful clinical tool to evaluate individual defensive functioning in a group context. For example, a group therapist who identifies that a patient is engaging in Passive Aggression as a defense can use that knowledge to avoid engaging in negative counter-transference (Bond, 2004), or to help other group members not to engage in scapegoating or counter-hostility toward the patient (Yalom & Leszcz, 2005). Patients using defenses characterized by Disavowal may be helped by gradually increasing a focus on their affect, and the impact of denial or projection on their relationships and symptoms. Finally, being mindful that changes in defensive functioning during group treatment reflect the stage model of psychotherapy can help focus the clinician on the therapeutic tasks of those stages. For example, the early stage may focus on developing cohesion rather than confronting defenses. The middle stage may require greater focus on confronting the maladaptive nature of the defenses. Finally, the late stage may need to be devoted to consolidating improvements that were made in defensive functioning and symptoms.

References for this article can be found in the on-line version of the Psychotherapy Bulletin published on the Division 29 website.
The road to becoming a professional psychologist is long, but one tangible milestone along the way is the transition from graduate school to internship. In this article, we describe this transition from our perspectives as interns, mark the developmental challenges that we believe the transition presents, and link these challenges to the current state of education and training in professional psychology. The expertise we claim regarding this transition is practical; over the past year, we wrote essays, cover letters, tallied client contact hours, and moved interstate. We serendipitously matched to the same predoctoral internship program after becoming close friends while attending the same doctoral program in clinical psychology. Despite our similarities, we have had very different paths and experiences. Julia focused on sexuality, and is in a generalist internship track. Sommer focused on neuropsychology, and is in a neuropsychology internship track. In our experience, transitioning to internship involves consolidating who you have been as a graduate student, clarifying who you would like to be as a professional, and bridging the gap between the two.

DEVELOPMENTAL CHALLENGE #1: Becoming an expert.
Transitioning to internship requires students to develop confidence in their hard-earned expertise. “Imposter syndrome” is pervasive among graduate students (and early career professionals); only patience and experience will ease its sting. We each started feeling less fraudulent calling ourselves “psychologists” sometime over the past year. We wrote essays and cover letters indicating that we had developed expertise in our respective areas of interest and could communicate that knowledge appropriately and effectively in a variety of settings. Internship interviews also helped us consolidate these identities, particularly describing ourselves in our own words to strangers. As we transitioned to internship, our “imposter syndromes” flared up again briefly, before adjusting to our new environments. As far as we and our fellow interns can tell, this is normative.

The difficulty of identifying and owning one’s expertise is that it sometimes feels like pigeonholing, a feeling that can arise from the assumptions of others. Julia was asked by another psychologist if she feels as comfortable addressing depression and anxiety as she does addressing sexuality, when she has pursued training in settings ranging from inpatient psychiatric units to long-term existential therapy with the worried well. Sommer had a supervisor assume that her difficulty building rapport with an ambivalent client was because her neuropsychology training underemphasized the importance of the therapeutic alliance, when she has thought deeply about how to quickly establish rapport to obtain appropriate effort from patients and provide therapeutic feedback continued on page 14
to them. One’s quest to develop expertise can also lead to neglect (intentional or not) of more general competencies and training experiences. We know neuropsychology students who avoid therapy practica, and students who pursue training exclusively in one theoretical orientation. If you’re feeling pigeonholed, talk to a trusted mentor outside of your specialization about diversifying your training to support your professional goals and educating others about the generalizable skills you have already developed. If you’re feeling cozy in what you suspect might be a pigeonhole, we can only say that our experience of internship has been a continuous exercise in preparing to work flexibly with whomever walks in the door.

DEVELOPMENTAL CHALLENGE #2: Stepping out of your comfort zone.
Palpating the bounds of your competency requires comfort with your knowledge and willingness to be uncomfortable exploring the unknown. Internship is a chance to have experiences you may not have another opportunity to pursue. Sommer provides therapy to one particularly underserved community in our city, and Julia conducts occasional neuropsychological assessments. Such exploration has many benefits, including better understanding the diverse environments in which psychologists work and equally diverse roles they fill, building strong skills both generally (whether or not you are a “generalist” per se) and to interact effectively with other professionals, and clarifying one’s own interests. Branching out can be difficult, however, because students are asked to specialize early in their developmental trajectory to maximize expertise. Downsides to this trend are that less focus is given to generalist training and students may feel locked into one particular trajectory. This specialization also holds true for theoretical orientation. We may inadvertently ask students to choose a theoretical orientation before entering graduate school; Heatherington and colleagues (2012) found that, at clinical science programs such as our own, an average of 80% of faculty members identified as cognitive-behavioral.

Despite barriers, shifts can and do occur. One friend with a doctorate in developmental psychology returned for specialization in counseling psychology. Another sought postdoctoral training in neuropsychology after receiving her doctorate in counseling psychology. Both capitalized on skills from their previous area of expertise to excel in their new career paths. Change also occurs later in development; several mentors describe feeling tremendously rejuvenated by shifting their career focus. We all “contain multitudes,” as Walt Whitman might say; the challenge is being neither confined by specificities, nor overwhelmed by possibilities. Such shifts can certainly have costs, but we believe that there are benefits to making healthy adaptations to life’s circumstances, and to being true to one’s heart.

DEVELOPMENTAL CHALLENGE #3: Knowing (and being) yourself.
Personal and professional development are intimately intertwined in psychology (Pascual-Leone, Rodriguez-Rubio, & Metler, 2013). To informally summarize psychotherapy research literature, factors “nonspecific” to therapies, but “specific” to individual therapists, appear to be the magic pixie dust that makes therapy therapeutic (e.g., Baldwin, 2007). The best way to understand such factors is knowing what you bring into therapy with you. The early developmental challenge of figuring out who you are, especially interpersonally with others, is critical. As students, we dove headfirst into the edict to “know thyself.”
self,” and enjoyed doing so. Crafting internship essays, however, evoked a strong impulse for positive impression management. Not every qualified applicant “matches” for internship, and it is tempting to believe that you can ascertain what internship sites want and craft appealingly well-fitting images. The resulting feedback on our first essay drafts was that they sounded canned, and did not represent our individuality. Sommer started over, ignoring adages about “good” essays in favor of speaking more authentically about her views. Julia did similarly, and hoped she was on the right track when her writing felt riskier; that is, she had to confront her fear that it might not be possible to talk about the influence of yoga in her life and clinical work without sounding too “woo woo.” In the end, our essays accurately portrayed our beliefs and passions about psychology. They were also personal, however, and perhaps that is why our revisions felt risky. We, and many others, feel compelled by psychology for reasons above and beyond pure academic interest. Putting a professional identity down on paper for scrutiny is scary, but doing the same with your personal identity ups the ante. Nonetheless, having matched at a place that is a genuinely good fit for both of us, the lesson we learned is this: be yourself. Be yourself when choosing training experiences, applying to internships, and throughout internship. A good internship site will be invested in your developmental goals. This can be hard advice to follow in the anxiety-ridden process of applying, but our sage mentors had an excellent point: if you don’t sound like yourself, who exactly do internship sites think they are recruiting?

Knowing and being true to oneself is important throughout professional development. Many factors can tip psychologists towards burnout (Barnett, Baker, Elman, & Schoener, 2007); lacking passion for one’s work cannot help. From the trenches of forging professional identities, we believe that embracing the struggle to create professional identities allows us to be more genuine and enriches our authenticity as clinicians. Clients often face life circumstances requiring astounding self-acceptance; surely this requires that clinicians also actively work towards self-acceptance.

DEVELOPMENTAL CHALLENGE #4: Resisting the “research versus clinical” dichotomy.

One systemic challenge to creating professional identities is the apparent schism between research and clinical professions, a false dichotomy that often feels real in graduate school. Coming from a scientist-practitioner model, we believe that balancing the two ensures that clinicians are informed consumers of research and researchers utilize current clinical issues to inform useful research. Structural aspects of training, however, increase contact with psychologists who lean strongly one way or the other, at least early in graduate school. University faculty members find tremendous satisfaction in research-focused careers, clinicians supervising graduate students in their first practicums find tremendous satisfaction in clinically-focused careers, and both types of psychologists understandably often encourage students to consider career paths like their own. It seems common for psychologists to blend both research and clinical in their careers, but our spheres of mentors shifted slowly, and we have seen this seamless integration most readily on internship.

This false dichotomy also excludes other important roles of psychologists, including consultation, program evaluation,
policy work, and advocacy. Many psychologists work to promote psychology and the professional interests of psychologists. These roles are as important to psychology as clinical practice and scientific research. Where will our field be if psychological services are eschewed by insurance providers and primary care services in favor of medication? How can we expand our professional roles without having a seat at the table in healthcare reform, and being available in settings where people in need of services are most likely to be? Psychology is broader than we perceived when entering graduate school, and all these roles are important. Incorporating this view more thoroughly into training would give students greater freedom to find their own niches, and enable us to think more openly about the future of psychology. We could say we wish we had “psychology career days” earlier in graduate school, to better open our eyes to the myriad ways psychologists balance research and clinical work. In reality, we probably would have groused about the impingement on our time. Internship thus presents a good opportunity for expanding students’ awareness of psychology as a profession, and we greatly appreciate our site’s efforts to do so.

DEVELOPMENTAL CHALLENGE #5: Finding work-life balance.

Transitioning to internship and beyond also has pragmatic dilemmas. We used to tell ourselves that our schedules were crazy because “We’re in graduate school.” This, however, could be a perpetual refrain: “My schedule is crazy because I’m an intern/postdoc/early-/mid-/late-career psychologist.” Psychologists at all stages struggle with work-life balance to some degree because it requires purposeful effort. Leaving graduate school presents a useful opportunity to critically examine these issues. How many hours a week do you want to work? What kind of job do you want to have? Are your two answers at odds? We were both pleasantly surprised to see psychologists leaving work at a VA by 5 o’clock. We also know psychologists who find an 8-to-5 schedule stifling, and still others who live primarily by the next grant deadline. All are choices that can be made.

We have also seen peers meet their partners, marry, and have children; our profession is only a fraction (albeit a large one!) of our lives. Focusing on training works in certain phases of life, but when partners delay their career goals or itch to start a family, personal and professional goals can be at odds. We know people who have moved for graduate school, internship, post-doctoral training, and again for a job! This model is particularly unkind to relationships in which both partners have strong professional ambitions. For example, Sommer’s spouse is a tenured university faculty. She attended graduate school in the same city as her spouse, but no neuropsychology internship or postdoctoral fellowships exist in the area. Her experience is not unique; many students and early-career psychologists make difficult compromises. We do not raise these issues to suggest that there are easy answers to them. Travel pursued or required in these ways can broaden perspectives in meaningful ways. Such broadening is not without costs, however, such as those associated with anxiety and finances. These issues are, unfortunately, also still gendered in such a way that complacency cannot be justified. Two friends of ours (one male, one female) travelled widely for internship interviews. The woman had recently given birth, and put careful thought into timing her pregnancy (not under perfect control under any circumstances) and whether it was safe to dis-
close any information about her family. She met another applicant who confessed to hoping she had successfully concealed her current pregnancy. The man, who has four children, did not feel similar pressures. On a positive note, however, we applaud APPIC’s new guideline encouraging remote interview formats to reduce the travel burden for postdoctoral applicants (http://www.appic.org/About-APPIC/Postdoctoral/APPIC-Postdoc-Selection-Guidelines). This is a small systemic step, but one that can save thousands of dollars at the individual level.

DEVELOPMENTAL CHALLENGE #6: Thinking outside the box when career planning.

Novoteny (2013) argued that flexibility is key to a psychologist’s satisfaction in personal and professional domains (we recommend the read particularly for those with or planning to raise children). The developmental trick is getting comfortable with how unstable flexibility can feel. Psychology training is increasingly regulated and specialized as the field moves toward board certification to confirm competence. This is particularly evident in neuropsychology, where completing an approved Association of Postdoctoral Programs in Clinical Neuropsychology postdoctoral fellowship (or its equivalent) is required for certification in clinical neuropsychology by the American Board of Professional Psychology. Unlike choosing graduate or internship programs, postdoctoral training is highly individualized. One fellow intern is pursuing research-focused postdoctoral fellowships to shape his vitae for an academic career. Another is looking for postdoctoral fellowships offering a variety of clinical experiences to gain clarity regarding which of her diverse clinical interests she would like to pursue. Another will cobble together part-time supervised clinical positions while she waits to gain citizenship. Sommer is taking the arduous step of creating an “unofficial” neuropsychology fellowship that allows her and her husband to live together and start a family.

We see a wealth of diversity in the career paths of our mentors. As the field evolves, psychologists must continue to adapt, by imagining and creating new career paths. We believe that effective psychology training should scaffold students engaging in this process, particularly to counter increasing pressures to specialize. We believe “diallectic” accurately describes the balance between depth and breadth that a successful career in psychology requires.

It has been therapeutic to outline our thoughts on the developmental transition from graduate student to internship and preparing for transition to professional psychologist. We hope this will also be useful for others to read. It has become clear to us that these transitions are embedded within a context of transitions in the field of psychology itself. We still regularly encounter individuals who are not ready to consider psychology a science, and there are clinicians who remain resolutely convinced that psychotherapy is wholly an art. Change is nonetheless afoot. The Affordable Care Act, for example, addresses Mental Health Parity. This and other shifts are exciting challenges. We hope psychologists can embrace these transitional processes and illuminate and spark discussion about the personal, professional, and systems-level challenges faced by psychologists at all levels of development.

References for this article can be found in the on-line version of the Psychotherapy Bulletin published on the Division 29 website.
The curious paradox is that when I accept myself just as I am, then I can change.

Carl Rogers

Recently, I had an opportunity to attend a “meet and greet” at a local University Counseling Center where I had worked more than fifteen years ago. We broke out into small groups and were asked to introduce ourselves and talk about our theoretical approaches. As we went around the group of therapists who were more recently licensed than me, I became aware that things had changed in the world of psychotherapy. Everyone seemed to be into some cool new clinical approach. The words post-modern, constructivist, feminist, mindfulness, positive psychology, DBT, culturally sensitive, contextual, pluralistic, evolutionary, relational were the buzzwords. When I quietly mentioned that I used client-centered approaches and had been influenced by Rogers, I couldn’t help but notice the look of disbelief that was on the faces of these next generation therapists.

Many therapists do not identify their theoretical orientation as client-centered, which is often viewed as old-fashioned or outdated. However, many of the concepts implicit in client-centered therapy are so much a part of clinical thinking that we are unaware of its origins. If you asked these same clinicians if they valued the therapeutic relationship, empathy, understanding, a non-judgmental and non-pathologizing attitude towards clients, they would agree and assume that was the norm. It is as if these therapist attitudes were inherent characteristics of counseling and therefore did not need to be named as a theoretical orientation. It reminds me of how my 17-year-old daughter and her friends use phrases like “cool” and “that’s a drag” all the time, not realizing that its contextual basis is from the 1960s.

When younger clinicians hear the name Carl Rogers, they often think of the “Carl Rogers counseling Gloria” video that they saw in graduate school. Maybe it is because of Rogers’ 1960s suit or the odd glasses or the dated introductory music, but it now seems quintessentially old-fashioned and obsolete. This seems to have resulted in many people confusing the message with the messenger. Yet client-centered approaches are evident in our society wherever relationships are important. Mediation, marriage therapy, parent education, non-violent communication, and talking with teens are modalities that incorporate principles from person-centered therapy yet often do not, or minimally, credit Rogers with their origin.

It seems that a lot of the new clinical approaches are recycled versions of Rogers’ ideas. An old newspaper can be transformed into an egg crate, and although it looks and feels different, it is substantially the same. A lot of the

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therapies that are currently en vogue secretly incorporate principles of person-centered therapy. When Positive Psychology surfaced in the late 1990s, it seemed like a brand new approach to many, but; wasn’t Rogers saying something similar in the 60’s? Positive Psychology focuses on positive human functioning and flourishing and Rogers encouraged living “A rich full life”. Flourishing and Self-actualizing seem comparable. Rogers (1961, p 196) said, “This process of the good life is not, I am convinced, a life for the faint-hearted. It involves the stretching and growing of becoming more and more of one’s potentialities. It involves the courage to be. It means launching oneself fully into the stream of life.” Flourishing has been described as optimal human functioning (Fredrickson, 2005).

The current trend of incorporating Eastern philosophical traditions into psychology has made the word “mindful” more fashionable in psychotherapy circles today than Rogers’ 1961 terminology, “live fully in each moment (p. 188),” but they speak to the same thing. Mindfulness has been defined as, “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 1994, p.4). This sounds similar to Rogers (1961), “To open one’s spirit to what is going on now (p. 89).” Similarly, the word compassion, which is prevalent in Buddhist literature, seems more hip in psychotherapy now than the older word empathy, which is associated with Rogers.

Over the past 10 to 15 years, there has been a resurgence in research and clinical writing that highlights the importance of attachment theory in psychotherapy (Wallin, 2007). Rogers’ fundamental ingredients or therapist conditions may also be thought of in attachment terms. It is not difficult to see the links between providing a secure base, as most therapists strive to do, by being emotionally present, resonating and responding to the client in kind, and nonjudgmental manner (this notion of “presence”) as being echoed in the client-centered constructs of empathy, unconditional positive regard, congruence, and genuineness. We even now have neurobiological evidence that supports the value, for clients, in therapist presence or mindful awareness, attunement, and resonance in creating a healing environment (Siegel, 2010).

MacDougall (2002) provides an excellent review of Rogers’ work as it applies to multicultural psychotherapy. Becoming a more multiculturally competent therapist is facilitated by staying open fully to the experience of the other, without assumptions, being grounded in one’s understanding of self, and empowering the client while acknowledging the very real world in which the client lives. Many people may not know this, but prior to his death in 1987, Carl Rogers was nominated for the Nobel Peace Prize for his work in reducing world conflict. One would imagine that Rogers, if he were here now, would embrace and champion these efforts and the multicultural research that has enriched the field since his time.

Long before the current understanding of the importance of the therapeutic relationship, Rogers was emphasizing this and the components that made this effective.

Rogers thought that congruence or genuineness was essential for effective counseling and that forming a relationship is the core of the change process. Current psychotherapy researchers have come to the conclusion that it is the relationship that is the most salient component for successful psychotherapy.

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I often think of my old therapist and how the relationship with him changed me. I used to think that it was his training at the Jung institute in Zurich and how we worked with my dreams in therapy that was so influential. Although the therapy experience with him was over 20 years ago, I recently have had some new insights into the aspects of that relationship that influenced me so deeply. I realized that it was because he had warmth, genuineness and unconditional (almost) positive regard, and he continually nudged me toward self-actualization. My old therapist had studied directly with Rogers and had Rogerian values implicit in his approach. The years of being the recipient of his gaze as he viewed me in all my potential worked its magic on me. Often now when I go through periods of self-doubt, I access his belief in me and I can pick myself up and go on.

Does it really matter what the theory is called as long as it incorporates fundamental components that work? Perhaps the essential truth at the core of these approaches is irrepressible and will keep surfacing over time in different forms with different labels. The form that surfaced through Rogers does not seem to be trendy anymore, but it contains many of the factors that are valued by young clinicians today. So maybe it is time to dust off client-centered therapy and repackage it in more modern terms, but maintain the heart of it for it is, essentially, a cool clinical approach.

References for this article can be found in the on-line version of the Psychotherapy Bulletin published on the Division 29 website.
While there is no consensus when it comes to what defines culture, many people have attempted to establish their own in order to arrive at a definition that exemplifies the concept as it relates to their nationality, ethnicity, race, and religion. Many people are becoming social beings by engaging in interactions, and establishing a cultural identity serves as a means of satisfying the psychological needs for relatedness and closeness (Reeve, 2009). From a general perspective, culture is understood to be a broad term that refers to certain factors such as race and ethnicity. These factors have the ability to exert different and, at times, significant influences on the lives of individuals within culturally diverse groups (Schneider, Gruman, & Coutts, 2005). To be more specific, culture can also be viewed as a dynamic, ever-evolving system that entails implicit or explicit rules that have been established by groups as a means of ensuring their survival, and this can involve the attitudes, values, beliefs, norms, and behaviors that are shared by the group (Matsumoto & Juang, 2008). These ideals of what encompasses each culture tend to remain stable as time progresses, and are typically communicated from one generation to the next. (Gardiner & Kosmitzi, 2008).

The process of providing effective counseling to culturally diverse populations has not always been a reality in the field of psychology as diverse cultures have historically been forced to adopt the traditions of the reigning culture. Counseling and psychotherapy are currently recognized as legitimate processes of interpersonal interaction, communication, and social influence that should be made available to any and all individuals despite their cultural background (Sue & Sue, 2008). When it comes to addressing the issues that are specifically related to a client’s culture, it is important for a therapist to be culturally competent and have awareness when discussing those issues (Ivey, Ivey, & Zalaquett, 2010). The growth of multicultural counseling and therapy has transformed into a process in which therapists address the issues of people who originate from cultures different from their own (Sue & Sue, 2008). Many issues of marginalized groups were ignored in the past, whether it was the reality of racism, sexism, or homophobia, because of the discomfort that some therapists felt with discussing these issues or simply based on the fact that these subject matters where unknown to them. Additionally, racial and ethnic cultures were often pressured to adopt the ways of the dominant culture even though this was not an accurate representation of who they were as a people. The cultural deficit model tended to view culturally diverse populations as having dysfunctional value systems and beliefs, so they were made to feel ashamed of this and to overcome these supposed deficits (Sue & Sue, 2008). Throughout the 1970s, therapists chose to use traditional counseling and psychotherapy approaches that were based on the dominance of the reigning culture.

DIVERSITY – STUDENT FEATURE

What Defines Culture?

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in Western European constructions, but often times these approaches were inappropriately applied to cultural, racial, and ethnic minorities. Even though therapists may have had the desire to help clients of color or culturally diverse backgrounds resolve their problems or reach their goals, many eventually realized that the process of counseling and psychotherapy did not always coincide with the life experiences and cultural values of their clients. It became important for a therapist to have good working knowledge of the events that are considered to be significant to a client’s culture in order to appropriately address their problem (Hay, 2008).

The history of counseling and psychology has brought about both negative and positive outcomes for culturally diverse groups. For Chinese Americans who might find themselves living in a predominantly White western society there was the practice of some members of American society invalidating their life experiences by defining their cultural values, beliefs, and or differences as being deviant, thus requiring them to change. The denial of their culture in favor of the dominant culture could bring about feelings of depression and low self-esteem as a result of the unhealthy societal forces (Sue & Sue, 2008). The traditional definitions of counseling and psychology ignored the importance of the Chinese culture in the way that they conceptualized effective counseling. A culturally diverse group’s dimension of human existence was not factored into the process, which decreased the probability of achieving positive therapeutic outcomes. Being that the concepts of counseling and psychology tend to have European American origins, there are some that believe strongly that all people are the same, so the goals and techniques that are associated with counseling and therapy can be equally applied across all groups. Fortunately, there are also those that believe that people are unique, so the approaches that are utilized to address client problems should be individualized. Within Asian cultures, there is a saying that no individual is like the other, which is gradually being taken into consideration as counseling and psychology are moving away from the monocultural and ethnocentric norms that were previously known for excluding certain cultural groups (Hay, 2008).

The cultural deficit model developed on the heels of the Genetic Deficit theory and Darwin’s concept of evolution during the 1990s. The controversy surrounding this model was based on its theory that certain groups were intellectually inferior to others, specifically when compared to the dominant culture. Based on this notion, culturally diverse groups were also viewed to be inferior to mainstream Euro-Americans because their cultural, social, and economic environment deprived them of those elements that were necessary for them to succeed. As a result, their abilities and skills were downplayed by other members of society. Additionally, this led to the justification of placing certain groups who were prone to low intelligence scores into vocational classes, rather than administering comprehensive testing (Hess & Shipman, 1965). This practice did not provide certain groups with the same academic and occupational opportunities as other groups, thus limiting their abilities. On the other hand, the benefits that culturally diverse groups have observed with regards to the cultural deficit model include the strong warnings that have emerged about the danger of stereotyping and making invalidated assumptions about certain populations. As a result of this awareness, careful consid-

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eration is being used to provide counseling and therapy in a more culturally respectful manner, as well as with maintaining awareness of their diverse background and experiences when it comes to performing assessments, testing, or providing counseling.

Within the realm of counseling and psychotherapy, culturally diverse groups may also receive informal treatment, such as addressing clients by their first names. This can be associated with a lack of respect in certain traditional Latino and Asian cultures. In the United States and many other countries, counseling and psychotherapy is used primarily by the middle and upper class populations, so it is possible that therapists might not be aware of the differences in values and characteristics that can be observed with treatment, development of therapeutic goals, and the processes of therapy (Sue & Sue, 2008).

There are a variety of strategies that therapists can employ to engage in a culturally competent assessment, including recognizing the cultural norms of the client, using the client’s cultural history and background to increase one’s understanding of the client and how that history might correlate with their presenting problem, asking the client how he or she views his or her own problem, and making sure that there is a distinction between pathological and non-pathological behaviors and beliefs (Hays, 2008). In order for counselors and therapists to perform a successful culturally competent assessment, they must be involved in their own cultural self-assessment along with learning other cultures (Hays, 2008; Sue & Sue, 2008). There must be recognition of the significance of diverse cultural identities, and it is through this awareness that counselors and therapists are able to make necessary adjustments to the therapeutic process. Ultimately, when it comes to performing a culturally competent assessment, a strength-oriented approach should be taken because this can assist with decreasing the potential cultural barriers that a therapist might face during the therapeutic process. With time and more experience with culturally diverse populations, a therapist can develop a standardized, culturally competent approach that can be employed to ensure that the sessions lead to a successful therapeutic outcome (Sue & Sue, 2008).

The process of becoming culturally competent can contribute to therapists’ level of effectiveness because they can possess the knowledge about the cultural background of any client that comes into their office, and would make it a point to develop specific interview questions that would be best suited for gathering as much pertinent information as is needed from the client (Goldfinger & Pomerantz, 2009). Also, being culturally competent can contribute to predicting some of the reactions and behaviors that a person from a different cultural background may have to a question that is posed to them, as opposed to a reaction that might be typically expected (Ivey, Ivey, & Zalaquett, 2010). When it comes to the accuracy of observations, this can be improved with an understanding of various cultures because therapists will be less likely to allow their stereotyped views and perceptions to overshadow any unbiased clinical judgments. The awareness of various cultures will allow therapists to be more open-minded and more likely to be receptive to all of the information that is provided during a session versus being selective about what one wants to hear or what a therapist believes is important without taking the client’s input into consideration. By understanding the different viewpoints continued on page 24
of each client that comes into any practice setting, a therapist can select a more appropriate therapeutic approach based on cultural factors that can increase the chances of achieving more positive therapeutic outcomes.

Lastly, being culturally competent is becoming more and more prevalent within our society, so as a counselor or therapist, one must learn to adapt to the changing times in order to be able to make a substantial contribution to his or her particular specialty. Each practicing therapist can be viewed as a cultural being and so the therapeutic process can bring up cultural issues that therapists must be able to address in an accurate and efficient way. According to American Psychological Association’s Ethical Principles and Code of Conduct (2002), psychologists who plan to provide services, teach, or conduct research that is new to them must undertake relevant education, training, or consultation to ensure competency. This also applies to being aware of the cultural background of clients that come in for help with their problems and issues.

References for this article can be found in the on-line version of the Psychotherapy Bulletin published on the Division 29 website.
Psychologists are not just in one of the learned professions, as APA Past-President Pat DeLeon has said, but we are also in one of the privileged professions. As psychologists, we are so fortunate, having both opportunities and obligations. As Chairman of the Federal Reserve, Ben Bernanke, stated in his recent Princeton University commencement speech, citing the gospel of Luke:

“From everyone to whom much has been given, much will be required; and from the one to whom much has been entrusted, even more will be demanded” (Luke 12:48, New Revised Standard Version Bible).

I believe that as psychologists we have been given much and have had much entrusted to us. Psychologists have the unique and powerful ability to help others individually and systemically. We have the ability, and opportunity, to improve others’ lives and to truly make the world a better place.

Leadership: Inspirational Leadership
As I learned in my military training and as I hopefully have lived since my first day in Officer’s Basic Training, “Lead by example.” I believe that inspirational leaders lead through their actions and deeds. It is how we live and what we do that inspires others. Our actions and way of living shows others what is possible. We serve as role models for everyone around us. To me, this is a responsibility to take seriously. Yet, it does not have to be work; it can come naturally as the manifestation of how we choose to live. One of the credos of Jesuits is “Strong Truths Well Lived.” To me, that is what leadership is all about. Leadership is something done day in and day out; it is how we choose to live. Hopefully, doing so in a way that impacts those around us positively and that makes the world a better place. It is also hoped that our efforts are inspirational to others and that they will seek to follow in these footsteps.

Effective leaders are inspiring but also are inspired by others. We are mentors, but we actively seek out the mentoring of others. We are role models, but we also seek to be inspired by our role models. Effective leaders live with integrity and effective leaders seek to positively impact the world around them; looking beyond their own personal goals and needs. Effective leaders also do not wait for others to take the initiative or to motivate them to action.

Mentoring
Effective leaders hopefully are effective

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and inspiring mentors. To me, mentoring is one of the greatest joys in my life as a psychologist. I truly believe in what my friend and colleague, Brad Johnson, has described as transformational mentoring. Mentoring is a two-way street. Highly effective mentors do not see themselves as “the expert” or the all-knowing sage who pontificates and shares pearls of wisdom to pilgrims seeking their wise counsel from on high. Rather, great mentors enter into meaningful connections with their mentees or protégés, real relationships in which they genuinely respect and value their mentees, seeking the value of the mentoring relationship to themselves as well. Transformational mentors transform others through these meaningful and highly valued relationships, being truly invested in the professional and in the personal growth and development of their mentees. These mentors create what Winnicott described as a safe holding environment; a place where the mentee can truly be her or himself, not fearing evaluation or rejection, but able to experiment and try new things with the encouragement of the mentor; resulting in growth in a safe, validating, and trusting environment.

Great mentors believe in their mentees, perhaps seeing things in them that the mentees are not yet aware of. I believe this has been the case with my great mentors. By believing in me, and by expecting much of me, they inspired me to achieve more and to be more than I had initially thought possible. Beyond their important impact on us, these great mentors are transformed by these mentoring relationships as well. They have the ability to be open, honest, and genuine with their mentees, they are able to convey respect and caring to their mentees, and they are able to form deep, meaningful, and lasting connections with their mentees. When these relationships work, they transform both parties for life. I know that this has been the effect on me with both the great mentors I have had and the great mentees I have had as well.

Service
To me, being a psychologist is about service to others. While this is relevant to mentoring and leadership, and it is of course relevant to the professional services we provide, it also is relevant to taking an active role to enhance, improve, and advance the profession of psychology. As such, I strongly believe in being an active participant in our profession, taking personal responsibility for its future growth and development. While it is true that psychology provides many of us with a very nice living, the actual viability and integrity of this profession rests on our active work to protect and improve it.

At a minimum, this means participation in two important activities (there are certainly others, but I don’t want to create too long a “to do” list for you today); these are active involvement in the profession itself and active involvement in advocacy work. Involvement in the profession may range from serving on a task force or committee on the local, state, or national level to chairing a task force or committee, and running for and serving in elected office in these organizations. Through these service activities we are provided the opportunity to improve and advance the profession that gives us so much. Professional association involvement also provides us with connections with colleagues, it combats professional isolation, and it often leads to lifelong friendships, and gives us the opportunity to contribute to our profession.

Involvement in advocacy work on behalf of our profession is essential to the integrity and viability of the profession and is essential for ensuring its future. This

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advocacy work also is essential to ensure that the recipients of our professional services have unfettered access to the valuable services we may offer them. As I tell my graduate students, every aspect of our profession and our professional functioning is directly impacted by laws and regulations. And, if we do not take an active role in ensuring that these laws and regulations protect and preserve our ability to practice our profession, then other individuals with potentially very different goals and agendas will fill this void and do this for us.

A contemporary example is Applied Behavior Analysts. In multiple states this past year and repeatedly each year in recent years, this group of colleagues has sought to have licensing laws and scope of practice regulations altered so that only this group and those certified by them can apply the clinical technique of applied behavior analysis with autism spectrum clients. In essence, their goal is to create licensure based on a technique, not based on a profession and professional training, experience, and competence. If their efforts were successful, numerous competent licensed psychologists would not legally be allowed to practice fully within the scope of their license, needing instead to seek credentialing and approval to use a specific set of techniques from Masters-level clinicians whose decision-making on this may be impacted by some self-serving biases and turf protecting motivations.

It is vital that we not leave the legislative and regulatory fate of our profession to others. This active ongoing engagement in advocacy is essential from a self-serving perspective to preserve the integrity of our profession, our livelihoods, and our careers. But, perhaps even more importantly, active ongoing engagement in advocacy activities is essential for the public we serve to help ensure they have unfettered access to care, that high professional standards are in place to ensure they are evaluated and treated by competent professionals, and to ensure that their rights are protected.

With regard to leadership, mentoring, advocacy, and service, Rabbi Hillel is quoted as saying: “If I am not for myself, then who will be for me? And if I am only for myself, then what am I? And if not now, when?” Thus, we must advocate for ourselves as well as for others, we cannot wait for others to step up and do this important work, and we must each take action now, and on an ongoing basis.

Saving America From Itself

Now, to get to the part of the title of this article that may have been most intriguing to you when you saw it; how the profession of psychology and psychologists can save America from itself. Let’s hope that I actually have some tangible suggestions for accomplishing this colossal feat, and that it wasn’t just me using a catchy title for this talk to entice you read this article. ... While that’s partially true, I do have some very serious thoughts to share with you.

America is the land of independence. This independence enables us to make our own decisions about how we live our lives. Unfortunately, many of these decisions are driven by responses to advertising, manipulation of our taste buds, access to numerous resources, and a desire to exercise our own decision-making and not be told what to do or how to live our lives. Of course, there are many other forces that impact us and our lifestyle decision-making on a daily basis, but thus far, the results are quite troubling.

America is an unhealthy country and Americans are killing themselves by their daily lifestyle choices and decisions.

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Nearly 800,000 people die in the U.S. each year from cardiovascular disease, accounting for 1 in 3 deaths and more than $300 billion in direct medical costs and lost productivity. CDC is working with other Million Hearts™ public and private partners to prevent 1 million heart attacks and strokes by 2017. CDC continues to focus on helping Americans improve their heart health by encouraging greater collaboration between clinical practice and public health. (CDC, 2013 at www.cdc.gov)

The leading causes of death in U.S. in 2011 are:

- Heart disease: 597,689
- Cancer: 574,743
- Chronic lower respiratory diseases: 138,080
- Stroke (cerebrovascular diseases): 129,476
- Accidents (unintentional injuries): 120,859
- Alzheimer’s disease: 83,494
- Diabetes: 69,071
- Nephritis, nephrotic syndrome, and nephrosis: 50,476
- Influenza and Pneumonia: 50,097
- Intentional self-harm (suicide): 38,364

CDC (2013) at www.cdc.gov

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<th>Cause</th>
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<td>Tobacco</td>
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<tr>
<td>Poor Diet and Physical Inactivity</td>
<td>300,000</td>
<td>400,000</td>
</tr>
<tr>
<td>Alcohol Consumption</td>
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<td>85,000</td>
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<td>Microbial Agents</td>
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<td>Toxic Agents</td>
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<tr>
<td>Motor Vehicle Crashes</td>
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<td>Incidents Involving Firearms</td>
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<td>Sexual Behaviors</td>
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These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating health care costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US health care and public health systems has become more urgent. (JAMA, 2004; p. 1238)

It is reported that diabetes (most frequently a consequence of obesity) increases stroke risk 12x for those under 65 (Khoury et al., 2013). BBC News recently released an article: “Rise in child obesity-related hospital admissions” by Helen Briggs. Obesity has been linked with serious illnesses during childhood and an increased risk of developing conditions, such as type-2 diabetes, asthma and breathing difficulties during sleep. There has been a four-fold increase in the number of children and teenagers admitted to hospitals for obesity-related conditions in the last decade. It is estimated that behavioral (lifestyle) and mental health related factors account for between 60% and 80% of the causes of

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health difficulties in the United States today.

Obese children are more likely than those who are not overweight to report poorer health; more disability; a greater tendency toward emotional and behavioral problems; higher rates of grade repetition, missed school days and other school problems; ADHD; conduct disorder; depression; learning disabilities; developmental delays; bone, joint and muscle problems; asthma; allergies; headaches; and ear infections. (2007 National Survey of Children’s Health)

Americans under age 50 die earlier and live in poorer health than their counterparts in other developed countries. American men ranked last in life expectancy among the 17 wealthiest countries, and American women ranked second to last. The United States had the second-highest death rate from the most common form of heart disease, the kind that causes heart attacks, and the second-highest death rate from lung disease, a legacy of high smoking rates in past decades. American adults also have the highest diabetes rates. The United States has the highest infant mortality rate among these countries, and its young people have the highest rates of sexually transmitted diseases, teen pregnancy and deaths from car crashes. Americans lose more years of life before age 50 to alcohol and drug abuse than people in any of the other countries. Americans also had the lowest probability over all of surviving to the age of 50. The U.S. ranks near and at the bottom in almost every health indicator in comparison to other industrialized nations (Institute of Medicine and the National Research Council, 2013).

Amenable mortality remains an important contributor to premature mortality in 16 high-income countries, accounting for 24% of deaths under age 75. Amenable mortality continues to fall across high-income nations, although the USA is lagging increasingly behind other high-income countries. In 2007, amenable mortality in the US was almost twice that in France, which had the lowest levels (Nolte, 2013; RAND Europe).


A new Canadian study says there are five things killing Ontario residents more than seven years earlier. These bad lifestyle choices include:

- Smoking
- Drinking alcohol
- Poor diet
- Lack of physical activity
- Stress

Researchers found 60 per cent of all deaths in Ontario can be blamed on these five unhealthy habits. (http://www.cbc.ca/news/health/story/2012/04/02/ontario-unhealthy-lifestyle-choices.html)

**Conclusion**

Our nation needs to change from an expensive and ineffective disease management system to a health promotion system. Psychologists and organized psychology can play key roles in this change. So much of what is needed is what we have to offer. As researchers, educators, and clinicians, we are ideally positioned to take the lead in this effort. And, as the data presented hopefully demonstrate, this is a dire situation and the time for action is now.

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Perhaps all this seems quite daunting. But, I have one additional quote to share with you that I hope is relevant. Margaret Mead said: “Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it’s the only thing that ever has.” So, I am hopeful that psychology’s inspirational leaders will in fact lead the way toward a much healthier America.
Multidisciplinary, inter-disciplinary, trans-disciplinary, multispecialty, integrated, interrelated, interprofessional, and collaborative. These terms suggest the concept of teams of health care providers working together offering comprehensive, quality, affordable health care. The idea is not new. “The concept of medicine as a single discipline concerned with only the restoration of individual health from the diseased state should be replaced by the concept of ‘health professions’ working in concert to maintain and increase the health of society as well as the individual” (Coggeshall, 1965; Mills, 1966).

APA’s recently published “Core Competencies for Interprofessional Collaborative Practice” (APA, 2009) defines “interprofessional” or “Interprofessionality” as “the process by which professionals reflect on and develop ways of practicing” that provide “an integrated and cohesive answer to the needs of the client/family/population.” These concepts involve continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patient’s participation. Interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working. (APA, 2009)

Barriers to Interprofessionalism
Although the need for collaborative approaches to health care delivery is clear, barriers exist which hinder implementation. One of the biggest barriers to accessing behavioral health services is the critical shortage of treatment capacity. Currently, 55% of U.S. counties have no practicing psychologists, psychiatrists or social workers (NAMI, 2011). Another barrier can be legislative. A remnant of the 19th century, the Corporate Practice of Medicine Doctrine holds that physicians should make medical decisions autonomously. The logic was that if businesses owned by non-physicians controlled the delivery of health care, health care could be decided based on a profit motive, rather than the best interests of the patient. The Doctrine prohibited “lesser licensed” providers from controlling or directing health care. This limitation is particularly onerous in an era of technological advances including electronic health records, computerization and the need for capital to grow a business. Because states vary in the application, requirements and limitations of the doctrine, it is costly for providers wanting to practice interprofessionally to navigate this legal minefield. Violating the doctrine can put providers at risk of running afoul of licensing laws. Twenty-two states currently allow differently licensed health care providers to form corporate entities, while five jurisdictions have some flexibility to do so; the remainder of the states do not allow these entities (Nessman, 2011). Other barriers to interprofessional practice include: hierarchical

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attitudes, differential and declining reimbursement rates for similar services, lack of understanding of the advantages of interprofessional care, fear of change, risk aversion and the challenge of developing an entrepreneurial spirit. These challenges, coupled with most psychologists having little formal business training, hinder the transition to interprofessional mental health care delivery. While innovation and interprofessional groups are the cutting edge of mental health care delivery, according to an APA Practice Survey of Practitioners (2011), of over 2500 respondents, fewer than 12% reported working in a group practice, while 49% indicated they were solo practitioners. Those solo practitioners with established practices, or with niche practices, will likely continue to thrive as health care reform unfolds due to supply and demand and having an established referral base, while many other psychologists will move into groups with interprofessional practice opportunities. Early Career Psychologists will be challenged as they compete in a crowded and confusing marketplace.

The Group Practice Turnkey Model: Rainier Behavioral Health, PLLC: A Thriving Model of Interprofessional Practice
Rainier Behavioral Health, in Tacoma, Washington, was established in 1985 as an interprofessional mental health clinic. We currently see approximately 18,000 patient visits yearly, with almost two thousand new cases each year. Initially configured as a partnership due to existing Corporate Practice of Medicine Doctrine laws preventing a psychologist and psychiatrist from incorporating, the partnership had extensive liability exposure. In 1995 the Washington State Psychological Association, in partnership with allied health providers, lobbied successfully to repeal the Corporate Practice of Medicine Doctrine. Over the years, as the value of interprofessional care became acknowledged as an effective approach to mental health provision, the clinic evolved into its current complement of 17 therapists, including four physicians, a pediatric ARNP, eight psychologists and four social workers. The practice is incorporated as a Professional Limited Liability Company (PLLC).

Organizational Structure of Rainier Behavioral Health
There are eight full time and two part time support staff. Two full time support staff handle triage, insurance verification and authorization, and initial appointment scheduling. Front desk staff are responsible for patient check in, rescheduling, co-payment collection, phone calls, faxing and file management. Billing support staff handle billing issues and insurance submission, while the part time bookkeeper manages accounts payable, payroll, tax filing and benefit management. Therapist and support staff benefits include: health insurance; a flex benefit plan; retirement plan access; life, disability and accidental death and dismemberment insurance; optional dental and vision coverage; and vacation and sick leave. Prescription refills, supplies, equipment maintenance contracts, repairs and support staff management are handled by the office manager.

Employees are W-2 employees. The practice pays malpractice, a yearly continuing education allowance, Social Security, Medicare, unemployment and other mandated taxes, furniture, office supplies, Internet and telephone access, utilities and maintenance. Our philosophy is that Rainier Associates hires well trained, quality therapists who can work as a team in providing excellent mental health care in an interprofessional environment. Our motto is: “Quality is Econ-
omy.” Each therapist who joins the group automatically qualifies as a member of the insurance panels we contract with, as we have clinic status. Early career psychologists have an advantage in this regard, as panels that might exclude them because of inexperience or panel closure include them as part of our group. Therapists are paid a percentage of what they collect, with more revenue yielding a higher percentage. There are no set working hours, no set vacation periods, no micromanaging of time on site. While we hope that productivity will be high and that therapists will work full time (defined as 20 to 25 weekly billable patient hours), we understand that life happens, and that productivity varies over the course of a therapist’s career. Because we are a large group, when a therapist is out, we cover for each other, maintain referral, scheduling, billing and continuity of care. Insurance companies only have to deal with one tax ID number, one point person for credentialing, and one payment to the group. Insurance companies are businesses, too, and efficiencies of scale matter.

Group practices can provide a valuable and viable model for interprofessional practice. This article briefly describes Rainier Behavioral Health’s turnkey model as an example. Rainier Behavioral Health does not have rigid controls on productivity, a competitive work environment, or the lowest overhead costs. What Rainier Behavioral Health offers, however, is a collegial interprofessional mental health clinic model that maximizes the therapists’ skills and training, while benefitting from its larger scale in both insurance collections and the value of support staff.

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

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**Bulletin ADVERTISING RATES**

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**Deadlines for Submission**

- February 1 for First Issue
- May 1 for Second Issue
- August 1 for Third Issue
- November 1 for Fourth Issue

All APA Divisions and Subsidiaries (Task Forces, Standing and Ad Hoc Committees, Liaison and Representative Roles) materials will be published at no charge as space allows.
CALL FOR NOMINATIONS
DIVISION 29 EARLY CAREER AWARD

About the American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people’s lives.

APF encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the Division 29 Early Career Award
This program supports the mission of APA’s Division of Psychotherapy (Division 29) by recognizing Division members who have demonstrated outstanding promise in the field of psychotherapy early in their career.

Amount ~ One $2,500 award

Eligibility Requirements & Evaluation Criteria
Nominees should demonstrate and will be rated on the following dimensions:
• Division 29 membership
• Within 7 years post-doctorate
• Demonstrated accomplishment and achievement related to psychotherapy theory, practice, research or training
• Conformance with stated program goals and qualifications

Nomination Requirements
• Nomination letter written by a colleague outlining the nominee’s career contributions (self-nominations not acceptable)
• Current CV
• Nomination must be submitted as a single PDF document

Submission Process and Deadline

Please be advised that APF does not provide feedback to applicants on their proposals.

Questions about this program should be directed to Samantha Edington, Program Officer, at sedington@apa.org.
Obesity is a public health concern with an estimated annual societal cost of at least $147 billion, according to the Centers for Disease Control (CDC, 2011; Low, Chew Chin, & Deurenber-Yap, 2009). However, it has only been in recent years that it has begun to receive widespread attention in the United States; highlighted by the First Lady’s obesity initiative and the recent decision by the American Medical Association to classify obesity as a disease that requires treatment. Indeed, the figures are hard to ignore: 78 million or about one-third of Americans adults meet criteria for obesity (CDC, 2011; Mitchell, Garcia, De Zwaan, & Horbach, 2012). However, it has only been in recent years that it has begun to receive widespread attention in the United States; highlighted by the First Lady’s obesity initiative and the recent decision by the American Medical Association to classify obesity as a disease that requires treatment. Indeed, the figures are hard to ignore: 78 million or about one-third of Americans adults meet criteria for obesity (CDC, 2011; Mitchell, Garcia, De Zwaan, & Horbach, 2012). Beneath the figures, though, are the individual lives affected by obesity, a stigmatizing condition that directly and indirectly impacts quality of life.

According to the World Health Organization (WHO), the classifications of overweight and obesity are determined by an excessive fat accumulation in the body, which poses several health concerns (WHO, 2000). The heightened risk for medical illnesses associated with obesity are well-known – Type 2 diabetes, heart disease, liver and gallbladder disease, stroke, some cancers, and reproductive complications – to name a few (CDC, 2011). Yet, less recognized, assessed, and treated are adverse mental and behavioral health problems, such as decreased sexual functioning - a vital domain in one’s quality of life. Given that mental health is a key element in the prevention and treatment of obesity and with the advent of the Affordable Care Act, which expands coverage of behavioral care to more Americans and emphasizes prevention, psychologists will likely play an even greater role in the assessment and treatment of obesity. As with all of our patients, a central goal for us will be to improve quality of life, which is often decreased in obese populations in general, and sexual quality of life in particular.

The poorer quality of life seen in obese populations are associated with lower self-esteem, impaired social functioning including sexual relationships, and increased mental and behavioral health difficulties (e.g. depressive symptoms, sleep) (Assimakopoulos et al., 2006; CDC, 2011). Of these problems, the issue of sexual functioning among obese popula-
tions, regardless of marital status or sexual orientation, is often overlooked (Al-Hasani & Zohnl, 2008). Thus, our aim is to heighten clinicians’ awareness of the intersection of obesity and sexual functioning and briefly provide empirical based treatment options. It is highly likely that many clinicians work with someone who is obese and also just as likely that the issue of sexual functioning is avoided in sessions (Pope Sonne, & Greene, 2008). It is important to address a patient’s concerns with sexual functioning in a safe and healthy environment because sexuality is a major component of human life (Assimakopoulos et al., 2006) and is associated with one’s own perception of body image (Camps, Zervos, Goode, & Rosemurgy, 1996).

Sexual Functioning Among Obese Populations
Healthy sexual functioning refers to the biological sequencing of sexual practices comprised of desire, arousal, and orgasm, whereas sexual dysfunction is the impairment or interference in one of these stages (Wincze & Carey, 2001). Obese individuals often report a lack of enjoyment of sexual activity, difficulties with sexual performance, heightened avoidance of sexual opportunities (Koltokin et al., 2006), lower frequencies of orgasms, and lower frequency of sexual activities (Kinzl, Traveger, Trefalt, & Biebl., 2001). In Koltokin et al.’s (2001) study of over 800 obese adult men and women participants enrolled in either an intensive weight loss and lifestyle modification residential program, in the Utah Obesity Study seeking bariatric surgery, or independent obese participants not seeking bariatric surgery, several significant findings were reported. They found that obesity resulted in higher rates of sexual difficulties and that a higher BMI was associated with greater impairments in sexual quality of life, both findings more pronounced among women. The researchers also found higher levels of impairment in sexual quality of life among individuals seeking weight loss surgery relative to those not seeking surgery. Consequently, while both men and women experience impairments, there appears to be some differences in sexual functioning and dysfunction by gender, manifested by the varying disorders for which they meet criteria as defined by the DSM-IV-TR.

For obese men, erectile dysfunction, lower sexual satisfaction, and penile vascular impairment are common (Kolotkin et al., 2006). While the empirical data for women is not as strong, there is some existing evidence that sexual arousal, desire, orgasm, and pain are commonly reported by women (Esposito et al., 2008). The mechanisms underlying these issues are complex, however, a biopsychosocial understanding can be inferred (Wincze & Carey, 2001).

Epidemiology
Biologically, obesity affects various aspects of the physical body, including fatigue, sluggishness, low desire for physical activities, difficulty reaching orgasm, and the ability to maneuver the body for satisfying sexual positions (Larsen, Wagner, & Heitmann, 2007). When an individual has excess body fat developed from the imbalance of the intake and disbursement of energy, metabolic rates decrease, thus continuing a cycle of low physical activity and increased weight gain (Zunker & King, 2012). Since obesity is comorbid with other health ailments including diabetes, endocrine malfunction, metabolic syndromes, sleep apnea, and psychological problems, such as depression and anxiety, (Bocchieri, Meana, & Fisher, 2002), these additional issues may factor for the biological aspects that lead to sexual dysfunction (Larsen et al., 2007). There are also matters of natural and expected sexual functioning issues, including aging and hormonal changes (Wincze & Carey, 2001). These health is-

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sues impacting sexual functioning may inevitably be leading to psychological disturbances.

With respect to psychiatric disorders, many obese individuals present with high rates of lifetime depressive disorders, anxiety disorders, eating disorders, and substance use disorders (Hayden, Dixon, Shea, & O’Brien, 2011). It has been reported that up to 84% of morbidly obese individuals seeking weight loss surgery have had a lifetime history of major mental disorders, as well as 39.5-72% of personality disorders (Herpertz et al., 2003) and a history of taking psychotropic medications (Collazo-Clavel et al., 2006). More specifically, disturbances in reality testing, Major Depressive Disorder, and severe anxiety disorders have been implicated in the epidemiology of sexual dysfunction (Wincze & Carey, 2009). In a study that included 228 participants, Kalarchian et al. (2007) concluded through multiple valid assessment forms, that participants with lifetime and current Axis I diagnoses had significantly higher BMI scales and a lower functional health status than those without such disorders. When Masters and Johnson (1970) were developing sex therapy, they found that anxiety played a significant role in the development and maintenance of sexual dysfunction. The cognitive interference caused by either general anxiety, sexual anxiety, or performance anxiety play a significant role in sexual dysfunction (McCabe et al., 2010). Additionally, some obese individuals with past sexual abuse histories have been theorized to possibly use obesity as a defense mechanism to protect themselves from sexual advances and social admiration (Ray, Nickels, Sayeed, & Sax, 2003). Moreover, the overt and covert societal discrimination as well as societal and internal stigma present among obese populations is also postulated to have an effect on the sexual functioning of individuals because of their own perceived body image and attractiveness to partners.

In the past decade, weight discrimination has increased over 66% (Puhl and Heuer, 2010), in the forms of unequal treatment in institutional settings and within interpersonal relationships (Andreyeva et al., 2007). With such open forms of discrimination, where obese individuals often internalize such biases, obesity is one of the last acceptable forms of prejudice in our world (Sogg & Gorman, 2008). Social messages via media, the internet, and daily interactions indicate that what is sexually desirable in a person is thinness and responsibility of one’s physical health (Schwartz & Brownell, 2004). Thus, the anti-fat messages that obese individuals encounter may be leading to internalized discrimination, low self-esteem, and body image issues (Puhl & Heuer, 2010), possibly decreasing the desire to engage in sexual activities due to fear of rejection and ridicule by sexual partners (Bess, 1997).

Assessment of Sexual Dysfunction
Clients of all populations may shy away from speaking about the social and mental health consequences of obesity with health care providers, especially sexual functioning, which is still viewed as a taboo topic in many segments of today’s culture, making it uncomfortable to discuss (Pope et al., 2008). Complicating an open discussion about sex and disclosure of sexual functioning is shame and fear of being judged and ridiculed (Camps et al., 1996).

A comprehensive assessment of sexual functioning includes both clinical interviews and self-report questionnaires to gather medical, psychosocial, and psychophysiological information to utilize for treatment planning and goals. It would be less threatening to use sexual functioning self-report measures as an early step in collecting information, since it can be included as part of a general battery, thus patients perceiving it

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as a routine (Wincze & Carey, 2001). Some of the most commonly used assessment measures are the 15-item International Index of Erectile Function (IIEF) for men (Wincze and Carey, 2001), and the 19-item Female Sexual Function Index (FSFI) for women (Assimakopoulos et al., 2006). The IIEF is psychometrically appropriate and addresses several domains of male sexual functioning including erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction (Rosen et al., 1997). The FSFI is also psychometrically sound and assesses 6 domains of desire, subjective arousal, lubrication, orgasm, satisfaction, and pain (Rosen et al., 2000).

If a mental health professional determines that sexual functioning issues are existent for a patient, several precautions should be taken, as recommended by Wincze and Carey (2001). First, a referral for a medical evaluation may be necessary to determine if there are any other underlying medical conditions such as the side effects of medications or the abuse of substances. Second, a healthy rapport should be built with the patient in order to assure a comfortable and safe space for them to share their sexual dysfunction issues truthfully. Third, the professional should share their credentials and expertise in the area of sex therapy and provide psycho-education on the role of sexual functioning in quality of life. Fourth, the professional should choose an appropriate, relevant, and ethical treatment method for each case, especially for patients who may not have a steady partner. Ideal treatment for improving the sexual functioning among obese individuals is to increase physical activity and decrease body weight (Esposito et al., 2008), thus suggesting empirically based cognitive-behavioral therapy (CBT) techniques be utilized. The most common empirically based treatment methods for sexual dysfunction for both men and women are sensate focus therapy, also known as sex therapy (McCabe et al., 2010).

Sex therapy begins with psychoeducation of the treatment method to the patient(s). These beginning sessions help explain the rationale for the treatment, an overview of sexual education, and a suggested ban on sexual intercourse (Wincze & Carey, 2001). Proceeding sessions include homework exercises, communication exercises, and reducing anxiety revolving sexual dysfunction (Kuile, Both, & Van Lankveld, 2010). There are also group intervention programs where sexual education, couple sexual intimacy-enhancing exercises, communication and emotional communication skills, sexual fantasy training, and cognitive restructuring are provided (Kuile et al., 2010). Since CBT is a theoretical orientation that has been adapted for patients with varying levels of education, socioeconomic status, ethnic and cultural identities, and developmental stages (Corey, 2009), it would be appropriate to use with such a heterogeneous population. CBT may positively affect this population and provide them with the healthy mindset, assertiveness, and confidence needed to alter lifestyle choices and improve sexual dysfunction issues.

Now is an exciting time for psychologists to address the obesity epidemic as behavioral care is a key component in treatment. This may be especially true now with the emphasis on prevention and expansion of coverage to more Americans through The Affordable Health Care Act. It is imperative that we are prepared to meet the needs of our patients, especially for obese, adult populations.

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

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All members of the Division of Psychotherapy are encouraged to participate in voting on revisions to the division’s bylaws. West’s Encyclopedia of American Law (2008) describes bylaws as the “The rules and regulations enacted by an association or a corporation to provide a framework for its operation and management. Bylaws may specify the qualifications, rights, and liabilities of membership, and the powers, duties, and grounds for the dissolution of an organization.” Thus, bylaws are important for the effective functioning of any organization. Periodically, they are updated and revised as the mission and functioning of an organization changes to better meet its members’ needs.

If you are a voting member of the Division (regular, associate, and fellow member), you are asked to participate in the current updating of the Division of Psychotherapy’s bylaws. Student and non-APA Psychologist Affiliate members are not eligible to vote. Please visit www.http://www.divisionofpsychotherapy.org/division-29-bylaws-for-review/.com to see the division’s current bylaws, the proposed changes, and pro and con statements that explain the rationale for and against these proposed changes. The changes proposed to the bylaws have been approved by the division’s Board of Directors and are now presented to you for your vote on them. Pro and con statements are provided as is required in the bylaws. Thank you in advance for participating in this important process by visiting www https://www.surveymonkey.com/s/LYD6ZG5.com and voting on the proposed Division of Psychotherapy bylaws revisions.

If you prefer to vote via mail, you may use the mail in ballot provided in this issue of the Psychotherapy Bulletin.

Thank you
William Stiles
President

ARTICLE II SECTION E – CRITERIA FOR PROFESSIONAL AFFILIATE MEMBERSHIP

Statement in favor of the change

1. We are required to change the criteria for Affiliate membership because the National Register of Health Service Providers in Psychology, specified in the current bylaws, is being phased out.

2. The Board unanimously saw mutual benefit in affiliating with psychologists and psychotherapists who are not APA members but who share our professional interest in psychotherapy. The revised bylaws would offer Affiliate membership to a broader range of professionals, such as psychotherapists who are not psychologists and psychologists who are not psychotherapists, including those from countries overseas where credentialing systems are different from American ones. To achieve this, the proposed wording requires only that Affiliates have “an earned doctoral degree in Psychology or a professional credential that entitles them to practice psychotherapy independently.” Further specific criteria and definitions are more appropriately spelled out in the Policies and Procedures Manual that the division implements to carry out our bylaws. That level of specificity is not appropriate for bylaws. By opening up Affiliate membership, we might also expand our influence globally, as well as our financial base.
3. The proposed changes do not alter how decisions are made in Division 29. In both the current and proposed bylaws, Affiliates cannot vote in Division elections or run for elective office. Only full members can vote or run for office, and full membership in Division 29 is open only to APA members.

As now, affiliates would pay the same dues as regular members. They would receive the journal and have the other benefits of membership except that they could not vote or run for elective office. As a simplification, the proposed changes would eliminate the current prohibition on being appointed as chair of a standing committee. However, all such appointments are made by the President and require approval by the Board, all members of which are elected.

4. In addition to the substantive change in criteria for Affiliate membership, several housekeeping changes are proposed to clarify and simplify the Bylaws. Some are grammatical corrections. Some change percentages to numbers in specifications of how many members are required to take certain organizational actions. Others bring descriptions of procedure in line with practice, including removal of some detailed specification of committee memberships, which have seldom been followed closely and in any case are more appropriate for the Division’s Policy and Procedures manual. These additional changes did not seem controversial, and the Board decided to include them in the vote on the substantive changes in Affiliate membership. Here is a list of the changes included in the vote.

- ARTICLE II, SECTION D – editing to clarify the student affiliate membership qualifications.
- ARTICLE II, SECTION E – substantive changes to the non-APA affiliate membership qualifications (this is the important change)
- ARTICLE III, SECTION D – changes to the non-APA affiliate member rights and privileges.
- ARTICLE IV, SECTION B - clarifications regarding dues payments
- ARTICLE VII, SECTION C.5 – changes to allow electronic submission of nomination ballots
- ARTICLE VII, SECTION D – changes to the percentage of votes required to be automatically placed on the ballot.
- ARTICLE VII, SECTION G – editing to accommodate the change in section D
- ARTICLE IX, SECTION A – changes to the percentage of votes required to bring a referendum to the board of directors.
- ARTICLE XI, SECTIONS C and D – changes in how committees are appointed.
- ARTICLE XI, SECTION G – changes in the composition of some of the standing committees.
- ARTICLE XIII, SECTION A & G – change in the percentage of members required to form and dissolve a section.
- ARTICLE XV, SECTION A – change in the percentage of members required to amend the bylaws.
Statement against the change
It is certainly understandable that Division 29 wishes to be more inclusive in its affiliate membership. However we should recognize that many members of the general public still do not know the difference between psychiatrists and psychologists. They are probably even less likely to be aware of the fine distinction between affiliate members and regular member of our division. The bylaws amendment as currently written does not define what is meant by a “professional credential.” Is this issued by a state? A foreign country? A professional organization? Is relevant content knowledge and experiential training required? It appears that some members of the public are likely to be confused. If we simply want to include all individuals who are interested in affiliate membership regardless of background we should simply say so. In its present form, this amendment appears to be flawed.

ARTICLE XV, SECTION C – MANDATE TO INCLUDE PRO AND CON STATEMENTS WITH PROPOSED BYLAWS CHANGES

Statement in favor of the change
Some changes to the Bylaws involve only housekeeping—minor editing, clarifying, or updating the text. These are uncontroversial and do not require PRO and CON statements. These are exemplified by the large number of housekeeping changes that were packaged with the substantive change in Affiliate membership criteria also now under consideration. (The Board could not find an opponent to write a CON statement.) The proposed change does not alter the requirement that all Bylaws changes require an affirmative vote by two-thirds of those voting.

The availability of the Division listserv offers the opportunity for any member who sees points of controversy to bring these to the attention of the voting membership.

Statement against the change
The current requirement for PRO and CON statements should not be abandoned. Democratic principles suggest that the best decision emerge from advocacy by opposing sides. Even moving a comma can change the meaning of a clause, so any change deserves scrutiny. Truly minor housekeeping changes can be packaged with more substantive changes, reducing the need for numerous PRO and CON statements for housekeeping changes, as was done with the concurrent vote on Affiliate membership criteria.

Changing the criteria for non-APA Affiliate membership

☐ YES  ☐ NO

Changing the requirement for publishing pro and con statements for proposed bylaws changes

☐ YES  ☐ NO
Life insurance can play a key role in supporting the life events of your loved ones should you die prematurely. Trust Group Term Life Insurance¹ can give you the assurance that once you're gone, your loved ones won't be left wondering how to pay the bills.

Every life has its own story, and The Trust can help you choose the right coverage to meet your needs throughout your journey.

Great Coverage at Affordable Premiums Including:

- **Inflation Safeguard** — designed to prevent changes in the cost of living from eroding your death protection.²
- **Living Benefits** — allows early payment of death benefits if you become terminally ill.
- **Disability Waiver of Premium** — pays the premium if you become totally disabled.

¹ Available in amounts up to $1,000,000. Coverage is individually underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. Rates have limitations and exclusions, and rates are based upon attained age at issue and increase in 5-year age brackets.

² Inflation Safeguard offers additional insurance coverage and the premium will be added to your bill.
Although there are many chronic diseases experienced by children, asthma is particularly noteworthy due to its high prevalence and life-threatening nature. While asthma can be manageable, it is a chronic inflammatory disease of the airways characterized by excessive bronchoconstriction, mucus production, airway edema, and a remodeling of the airway walls. Patients suffer from periodic exacerbations, with symptoms of shortness of breath, wheezing, and coughing (Davis & Wasserman, 1992; Ritz, Meuret, Trueba, Fritzscbe, & von Leupoldt, 2012). It is the most common chronic illness found in children in the United States. The acute and episodic nature of asthma necessitates (sometimes frequent) interactions with doctors and other health care professionals who focus on individual symptom reduction and management. Because asthma often occurs at a young age, effective treatment of pediatric asthma requires parental understanding, support and management in developmentally appropriate ways (Kaugars, Klinnert, & Bender, 2004).

Having an asthmatic child can have a significant impact on caregivers’ quality of life and the level of stress they experience. Fortunately, a growing body of research highlights the importance of supporting parents and recognizing that having a child with asthma can be incredibly challenging. Parents of children with asthma might have to deal with recurrent hospitalizations, emergency department visits and school absences (Crespo et al., 2011). Similarly, Crespo et al. cite several studies (Brown et al. 2008; Everhart et al. 2008; Marsac et al. 2006; Van Gent et al. 2007) “that consistently show that children with asthma and their parents/caregivers are at risk for decreased psychological functioning” (Crespo, Carona, Silva, Canavarro, & Dattilio, 2011, p. 179). Furthermore, even beyond the burden of managing the child’s illness, the diagnosis of asthma can negatively impact the way a parent thinks about their child. As Stepney et al. discussed:

Parents have often developed a picture of the ideal child, consisting of impressions and hopes...When a child is diagnosed with a chronic illness, this ideal image may shatter; the diagnosis represents a turning point for the family where parents may no longer view their family as healthy. (Stepney et al., 2011, p. 341)

Therefore, there is a distinct need to include mental health professionals in thinking about the care for a child with asthma and for the child’s caregivers. Competent mental health interventions can have a positive impact on the course of the illness and medical adherence, as well as contribute to a better quality of life. Thus, particular competencies are required to ensure the highest quality of care for parents of children with asthma. Stepney et al. present a possible three-
phase model of coping that a parent goes through after a child is diagnosed with a chronic illness like asthma. These phases include: 1) Emotional Crisis; 2) Facing Reality; and 3) Reclaiming Life. It is imperative that mental health professionals are competent enough to help the parents of children with asthma feel more empowered, gain information about the illness, and take steps toward coping with the diagnosis. These interventions are especially important because research shows there is a bidirectional relationship between family characteristics and asthma outcomes (Kaugars et al., 2004). Competently helping to alleviate parental negative feelings can have a positive impact on the happiness of the family and the quality of the relationship between the parent and the child, and can even have positive effects on symptom reduction and disease management.

Thus, the question this qualitative study poses is: What competencies are necessary for mental health professionals to possess in order to maximize their therapeutic impact on parents of asthmatic children? “What competencies are needed?” is a timely question for practitioners in the field of psychology. Over the past several decades, there has been significant research focused on defining competencies to ensure best practices when working with specific populations. One of the most cited models of defining competencies is Rodolfa et al.’s (2005) Cube Model. The Cube Model proposed 12 core competencies that were conceptualized as either foundational or functional competencies (Rodolfa et al., 2005). Foundational competencies include the knowledge, skills, attitudes, and values that underlie the functions a psychologist is expected to perform. For instance, knowledge might include understanding of legal and ethical issues, interdisciplinary systems, scientific knowledge and methods, developmental issues, sociocultural populations and contextual factors (Rodolfa et al., 2005). Functional competencies include the major applied functions that a psychologist is expected to perform, such as assessment, intervention, teaching, administration, and advocacy (Fouad et al., 2012). These require thoughtful integration of the foundational competencies in problem identification. (Madan-Swain et al., 2012). For the purposes of this study, the Merriam-Webster online dictionary was also consulted regarding the definitions of knowledge, skills, and values/attitudes. The following definitions are used for the data analysis: Knowledge: “The fact or condition of knowing something with familiarity gained through experience or association, acquaintance with, understanding, range of one’s information or understanding.” Skills: “The ability to do something well, expertise, having a particular ability.” Values: “The regard that something is held to deserve; the importance or preciousness of something.” Attitude was defined as “a settled way of thinking or feeling, typically reflected in a person’s behavior” (merriam-webster.com).

In order to utilize these definitions to develop an understanding of the competencies needed to work with parents of children with asthma, seven highly accomplished mental health clinicians in the Division of Pediatric Behavioral Health at National Jewish Health were consulted. National Jewish Health has been ranked the #1 Respiratory hospital in the United States by U.S. News and World Report for 15 consecutive years. The Division of Pediatric Behavioral Health is a multidisciplinary team comprised of eight clinicians: four doctoral level psychologists, three masters level clinicians, and one medical psychiatrist. 

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The staff is composed of three males and five females, ranging in age from about 30 to 50 years old. With the exception of the psychiatrist, each of the clinicians was asked to participate by this author in person during one of their clinical meetings. The psychiatrist was not asked to participate due to his limited availability. Internal Review Board (IRB) approval was obtained from both the University of Denver and National Jewish Health to ask the clinicians the following five questions: 1) What knowledge is important to have as a clinician working with parents of children with asthma? 2) What skills are important to have as a clinician working with parents of children with asthma? 3) What are the important values or attitudes for a clinician to have when working with parents of children with asthma? 4) How can mental health providers help parents of children with asthma adapt to their child’s diagnosis and help successfully manage symptoms? 5) What specific training, in addition to the general clinical training, do mental health providers need to work with parents of children with asthma? The participant’s answers were transcribed for later compilation and analysis. During the analysis phase, the answers were coded and organized into categories of knowledge, skills and attitudes/values.

The themes that resulted from interviews created a pyramid of knowledge that ranged from a wide base of solid general mental health skills to a point of asthma-specific knowledge. The clinicians all began by acknowledging the importance of having a strong general clinical foundation. Most clinicians acknowledged obtaining this foundation during their graduate school training. This knowledge included having a sturdy understanding of development, assessment, diagnosis, and treatment of children, adults, and family systems. As the clinicians’ professional paths narrowed to specialize in the pediatric population, they acknowledged that they began to look for more specific information. An understanding in navigating the medical model was mentioned as crucial when working with the pediatric population. Parents potentially interface with numerous professionals and departments within a hospital. Mental Health providers who have the sophistication to help decode the medical system or to help parents advocate for their child can mitigate overwhelming, confusing, and stressful feelings for families. The interviewees also identified themes of knowing about common parental and familial reactions to pediatric illness (similar to those explored by Stepney et al., 2011, as discussed above), and an understanding of body/mind interactions. Finally, as clinicians narrowed their focus even more to work with specific diagnostic issues, the Pediatric Behavioral Health team at National Jewish highlighted the significance of obtaining an extensive understanding of asthma, including associated symptoms, medical regimens, prognosis, and potential resources. The team identified that this level of specificity was attained in their post-graduate work or once they began working at National Jewish Health.

The clinicians interviewed also noted a similar progression from general psychology skills to more definitive abilities geared toward working specifically with parents of children with asthma. They cited the foundational skills of being able to gather an accurate assessment, providing effective therapy (including adult, child, and family) and obtaining skills in psychoeducation and advocacy services. Specific therapeutic skills mentioned were: the ability to build rapport and form connection with clients; the

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ability to utilize reflective listening skills; and the ability to provide support, attunement, and validation to clients. There was not a consistent theoretical skill set identified; however, providers referenced their use of CBT, biofeedback, and psychodynamic theory. The importance of creating specific treatment goals while keeping in mind mental and physical health concerns was also noted. Clinicians reported that they must also be able to effectively provide psychoeducation regarding a child’s illness, medical adherence, navigating the medical system, child development, and parenting skills. Finally, the theme of being able to empower parents to advocate for their child, both with doctors and school personnel, was discussed. Therapists can help parents set realistic expectations for their child’s academic, social, and extra-curricular activities, and help parents advocate for their child to obtain necessary resources to ensure optimal and satisfying involvement in all facets of their life. Each provider stressed their appreciation of gaining “on the job” training in order to further their practical and setting-specific skills. They each sought practicum, internship or post-doctoral fellowships within a medical setting in order to gain the core skills needed to bridge the gap between being a competent general psychologist and a competent pediatric psychologist specifically able to work effectively with parents of children with asthma.

Finally, to summarize the attitudes and values necessary, the clinicians highly valued the overarching theme of appreciating and respecting parents and children’s individual experiences and values. Clinicians emphasized working from respectful, optimistic, flexible, and empathic value systems in order to best facilitate their patients’ processes towards finding optimal functioning, health, and happiness. Likely a reflection of the culture and general philosophy of National Jewish Health, each clinician also communicated their pride, genuine concern, and regard for the patients and families with whom they work. It was clear through the interviews that each clinician believed in his or her ability to make a positive difference in the lives of their patients and families.

In order to provide the highest level of care, hospitals and mental health agencies must make it an expectation and requirement that their clinicians maintain current competencies. Attaining and maintaining competencies is a developmental and continuous process that must be assessed, evaluated, and sustained across a career. Making this a priority for each clinician will have a positive impact on the lives of parents of children with asthma because clinicians will have the specific knowledge, skills and values required to provide informed, comprehensive and empathic care to their patients and their patients’ family.

References for this article can be found in the on-line version of the Psychotherapy Bulletin published on the Division 29 website.
Motivational Interviewing (MI) is a promising and relatively new counseling approach that integrates a humanistic client-centered therapeutic relationship with more goal directed and behavioral approaches. MI has most recently been defined as “a collaborative person-centered form of guiding to elicit and strengthen motivation for change” (Miller et al., 2009). Since the development of MI in the early 1980s, more than 200 clinical trials have been published (Miller & Rose, 2009), making it one of the most widely researched evidence-based practices used in the treatment of substance abuse, as well as to promote health behavior change in healthcare settings. MI has also been shown to be effective as an adjunct to other psychotherapies, in order to strengthen client engagement and encourage behavior change (Hettema at al., 2005). In a recent meta-analysis, MI was found to require less time than other evidence-based interventions, while proving to be generally as effective, and often more effective at treating addictive and health behaviors (treatment adherence, changes in diet, exercise, etc.). The studies included in the meta-analysis reported a duration of treatment ranging from fifteen minutes to twelve hours, with a mean of two hours (Hettema et al., 2005).

Carl Rogers (1961, p. 351) believed that human beings have an inherent inclination towards growth in the direction of health that he termed the “actualizing tendency.” He strongly believed that this tendency was at the heart of human motivation and drive, even when thwarted or warped by experience. According to Rogers (1979), to manifest optimally the actualizing tendency required certain “necessary and sufficient” interpersonal conditions for facilitating change (1957), particularly empathy, congruence, and unconditional positive regard. Congruence and unconditional positive regard are often used interchangeably with the synonymous terms genuineness and acceptance. These relational components were intended to create an atmosphere of safety in the therapeutic relationship wherein clients could openly, honestly, and assuredly explore their thoughts and feelings about their behaviors. These relational components themselves were also believed to promote positive change in clients (Miller, 1983). This relational approach to encouraging change was in stark contrast to the more confrontational approaches that were often prescribed for the treatment of substance abuse at the time of MI’s formulation. The majority of research has since shown that a confrontational approach is at best not particularly effective and at the worst can be harmful. One study found that increased levels of confrontation predicted increased levels of substance usage in a treatment population (Miller et al., 1993).

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terpersonal conditions, most importantly empathy, congruence, and unconditional positive regard. Given this perspective on growth and change, one way of viewing the therapist’s role in MI is not as an agent of change, but rather as one who provides the right conditions for change to be possible.

MI also includes a technical component which largely consists of differentially responding to client verbalizations with the goal of encouraging clients to develop and voice their own arguments for change (“change talk”), rather than those of the therapist. Client change talk, specifically expressions of commitment to change has been found to be a strong predictor of behavior change in MI (Apodaca & Longabaugh, 2009). As originally conceptualized by Miller and Rollnick (1983), the relational and technical components of MI were not seen as being disparate, but as compatible and intrinsically related. The specific techniques utilized in MI were envisioned to function optimally and synergistically within the context of a therapeutic environment characterized by a client-centered interpersonal climate.

In recent years Miller and Rollnick (2009) have expressed concern that MI is commonly misunderstood as simply a set of techniques one can use to encourage behavior change, in a way that is divorced from the client-centered philosophical underpinnings of MI. Miller and Rollnick (2009, p. 131) likened the use of MI techniques without manifesting the interpersonal spirit of MI to being “like the words without the music of a song.” The common overemphasis on MI techniques without taking into account the relational component is often unwittingly perpetuated in the body of research on MI. Most research has focused on specific techniques and treatment outcomes while largely ignoring treatment processes, which are more difficult to capture in research. As a result there is a dearth of research on the contribution of the relational component to MI’s effectiveness. This bias in research may have unintentionally given the false impression that the power of MI lies mainly in the technical component of MI, with the relational component being merely a recommended add-on.

Despite considerable research on MI, its mechanisms of action are poorly understood. A meta-analysis performed by Hettema et al. (2005) found that while MI has proven to be effective in most clinical trials, the variability in effectiveness across studies and therapists is quite large, even when focused on the same problem domain. This persists even among well controlled multi-site trials. The uneven findings among studies of MI may partly be the result of variability in the embodiment of client-centered relational variables among different therapists, which likely plays heavily into treatment outcomes. Most MI studies aggregate the outcomes of the therapists in the study and often do not include these relational variables to begin with.

One recent study investigated the impact of brief MI on clients’ drinking behavior at a 12-month follow up. The study’s overall findings were null, yet a closer examination of individual therapist effects revealed that the most empathic and accepting therapist showed a drastic reduction in the drinking behavior of their clients, while the least empathic and accepting therapist showed an overall increase in the drinking behavior of their clients.

While the research within MI on the role of client-centered relationship variables on treatment outcomes is sparse, there is a vast amount of research on the relationship variables of empathy, uncondi-

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tional positive regard (acceptance), and congruence (genuineness) in the psychotherapy literature outside of MI. Due to the large body of research in this area, the divisions of Clinical Psychology and Psychotherapy of the American Psychological Association (APA) jointly sponsored a task force (Norcross et al., 2011) to summarize and disseminate these findings. Several meta-analyses were commissioned to look at the role of individual relationship variables in therapy outcomes (Bohart et al., 2011; Farber & Doolin, 2011; Kolden et al., 2011). Overall the task force concluded, based on this large scale review of the literature, that these three relationship variables make substantial contributions to treatment outcomes across various theoretical orientations and presenting problems. The contribution of these relationship variables were found to account for as much, if not more, of successful treatment outcomes than specific interventions or treatment methods. The task force went so far as to conclude that efforts to promote any evidence-based practice without adequately representing the substantial contribution of the relationship are “incomplete” and “misleading” (Norcross et al., 2011).

It was not specified if MI studies were included in these meta-analyses, but it seems plausible that the client-centered relationship variables which played such a large part in the conceptual formulation of MI would have an even greater contribution to MI treatment outcomes. A recent MI study showed a correlation between therapist empathy and acceptance and change in client’s drinking behavior to be as high as r=.44 and r=.61 respectively (Gaume et al., 2009). This is significantly higher than the correlation between empathy, acceptance, and treatment outcomes found in the meta-analyses conducted by the Norcross et al. (2011) task force (r=.33 and r=.27 respectively). It is difficult to draw conclusions based on the findings of one study (Gaume et al., 2009), but this highlights the need for more investigations into the contribution of client-centered relational variables to MI specific treatment outcomes.

While it is clear that the therapeutic relationship is an important factor in the success of any form of therapy, client-centered relational variables may play an especially important role when addressing the problem domains that MI has shown the most success with, addictive and health behaviors (Hettema et al., 2005). One possible reason for this may be the stigmatized nature of addiction and maladaptive health behaviors and the shame that individuals often harbor as a result of this. Several studies have documented the high correlation between client shame and addictive and health behaviors (Conradt et al., 2008; Dickerson et al., 2004; O’Connor et al., 1944; Potter-Efron, 1989). A proposed reason for this is the threat to social status that one perceives due to the many negative attributes made about these behaviors (Dickerson et al., 2004). Many who struggle with addictive behaviors, as well as destructive health behaviors, become accustomed to frequent judgments that they are weak willed, careless and self-destructive. It is common for these individuals to experience mistrust towards others and a general feeling of social alienation (Dickerson et al., 2004). The client-centered relationship at the heart of MI may in and of itself have a palliative effect on this aspect of the client’s experience, as well as fostering an openness and willingness to address these issues with a treatment provider. In fact, it has been found that MI works best with clients who are especially defended and seemingly resistant (Hettema et al., 2005).

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As evidenced by a growing body of literature, the therapeutic relationship has a greater contribution to treatment outcomes than is often given credit in either the research on MI or treatment settings that utilize MI. There are likely multiple factors that contribute to the efficacy of MI, one of which is certainly the relational component. There is no doubt that the client-centered relationship at the heart of MI is considered a crucial component of MI by its creators and proponents, and it appears to be coming into greater focus as researchers search for the active ingredients of MI. A clearer explication of the contribution of the relational component of MI to treatment processes and outcomes will allow for more focused training in MI, as well as greater effectiveness in its delivery in treatment settings.

Given the foundational nature of the interpersonal climate in MI, clinicians should pay close attention to these client-centered relationship variables when utilizing MI. This could mean frequent self-reflections to assess one’s level of empathy and acceptance with individual clients, as well as exploration of and resolution of the clinician’s barriers to the experience of empathy and acceptance. Furthermore, empathy and acceptance may also be more likely to flow from a positive view of human nature consistent with MI, making a self-assessment of a clinician’s assumptions about human nature especially important in this regard.

More important than therapists’ own determinations of their level of these relational variables are clients’ perceptions of the same, as this is a stronger determinant of treatment outcomes (Bohart et al., 2011). Monitoring the client’s engagement and responsiveness during an MI session can be one barometer of the extent to which the client perceives the therapist as being empathically attuned (Boardman et al., 2006; Moyers et al., 2005). Additionally, verbal check-ins may also provide valuable information regarding the client’s perception of the therapeutic relationship, and allow for the opportunity to work through conflicts and obstacles to understanding.

References for this article can be found in the on-line version of the Psychotherapy Bulletin published on the Division 29 website.
The Importance of Addressing Stigma:
One of the most consistent themes heard during today’s policy deliberations surrounding the consequences of integrating behavioral health services within primary care is the potential for addressing the historical stigma attached to receiving mental health and/or substance abuse care. There clearly is no quick and easy solution. Senior colleagues might recall the almost universal silence associated with receiving a cancer diagnosis during their parents’ time—just a few decades ago—prior to the significant advances in treatment which are heralded today. The impressive public engagement efforts of the American Cancer Society, the Susan G. Komen Walks, Department of Defense cancer funding initiatives, etc. are relatively recent phenomena. Perhaps during the coming decade the particularly debilitating barrier of stigma will also be successfully overcome; especially, we would suggest, with the unprecedented advances occurring seemingly daily within the communications and technology fields. The Fiscal Year 2014 budget for the Substance Abuse and Mental Health Services Administration (SAMHSA) includes $13.6 million for an exciting Public Awareness and Support (PAS) initiative.

The Administration: The rapidly changing healthcare environment, the critical role behavioral health plays in achieving national health status objectives, and advances in communications technology provide new opportunities to change the way behavioral health is viewed and services are delivered in the United States. The unmet need for prevention, treatment, and recovery support services provides a vast untapped market for SAMHSA products and services. Opportunities to prevent or intervene early to reduce disability and death associated with mental and substance abuse disorders are often missed. The Departments of Health and Human Services (HHS) and Education are working to facilitate a national dialogue on the mental and emotional health of young people. About 60% of adults experiencing a mental disorder did not receive treatment and nearly 90% of people who needed substance abuse treatment did not receive care, according to the 2010 National Survey on Drug Use and Health. For children and adolescents, only about 1 in 5 receives the treatment they need for diagnosable mental health and substance use disorders. Expenditures on mental and behavioral health and substance use treatment for children and adolescents alone approximate $12 billion annually.

By learning to recognize the signs and symptoms of mental illness and substance abuse, friends and family members can help their loved ones take action and seek care. Trained health professionals can also work with patients and families to identify problems early. By confronting fear and misunderstanding with facts, raising awareness about the effectiveness of prevention and treatment, and improving knowledge about
when and where to seek help, SAMSHA can bring mental illness and addictions out of the shadows and help the nation achieve the full potential of prevention and treatment for mental illnesses and substance abuse. The SAMSHA Office of Communications, through the Communications Governance Council (CGC), is charged with setting the strategic direction and policy for SAMSHA’s public communication activities. The CGC is working to assure research based approaches are used to influence behavior change for the sake of improving health, preventing injuries, protecting the environment, and/or contributing to the community. Individual behavioral change involves five basic steps: knowledge, approval, intention, practice, and advocacy. To employ the best communication practices and technologies that focus on creating and sustaining behavior change, SAMSHA is putting into place a new science-based life cycle approach for public education communications efforts. The lifecycle provides a five step process for planning, creating, disseminating, promoting, and evaluating educational information produced and distributed by SAMSHA.

SAMHSA’s Public Engagement Platform (PEP) and Project Evolve, SAMHSA’s web consolidation and modernization project, are funded through the Public Awareness and Support budget line. These two initiatives provide the wide infrastructure required to advance Strategic Initiatives by engaging audiences in a meaningful way. The internet is the primary way people engage with the government. SAMHSA has prioritized the internet as a strategic business and communications asset and launched Project Evolve to consolidate and modernize SAMHSA’s web presence. Elimination of redundant web development efforts is a key objective for this project and the installation of a Web Content Management System will result in lower overall costs, greater efficiency, increased effectiveness, and improved service for visitors. Related project activities include audience analysis, usability testing, and planning for the prioritized migration of information from other sites to a consolidated SAMHSA.gov site.

Consistent with the draft Federal Digital Strategy, the project is working to support the development of quality content and effective communications governance, and the use of modern communications platforms all to increase efficiencies in SAMHSA’s web based communication efforts with the long term goals of improving customer satisfaction and achieving cost savings to the agency. SAMHSA’s PEP provides the agency’s programs a consumer-oriented fulfillment system. SAMHSA’s online store (http://store.samhsa.gov) is it’s most highly visible customer interface and works in concert with a call-in contact center, warehouse, email updates, exhibit program, and strategic partnerships to fulfill the publication needs of public and health services providers. The various channels of communication managed by the Office of Communications generated more than 24 million customer interactions last year and enabled SAMHSA to gather data that illuminate the “voice” of SAMHSA customers and how well they are being served by the agency.

Through its Knowledge Management System, SAMHSA integrates content, operations, and data collection and analytics on all PEP customer interactions. These touch points annually include about 500,000 inquiries to the contact center; 143,400 publication orders; 21.3 million publication copies shipped; 1.7 million SAMHSA Store visitors; 530,000

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PDF documents downloaded; 11.9 million email updates delivered; and 12,000 exhibit booth visitors. SAMHSA’s email update service has grown to nearly 193,000 subscribers. PEP also distributes a bi-weekly electronic resource entitled SAMHSA Headlines that provides the behavioral health field with the latest news, upcoming events, resources, and a quarterly newsletter, SAMHSA News, that provides in-depth information on key SAMHSA developments and findings.

Just as Americans are aware of the connection between hypertension, stroke, and heart disease and accordingly take action to monitor their blood pressure they can become aware of the connection between mental and substance use disorders and physical health and take action to prevent and treat these conditions. SAMHSA’s PEP and new Web Program provides prevention, treatment, and recovery support programs the communication channels need to reach public and professional audiences with critical behavioral health information.

The Public Awareness and Support Initiative (http://www.samhsa.gov/publicAwareness/) continues to be driven by research with SAMHSA stakeholders — including web-based public engagement strategies/platforms—and applies the communications and marketing principles of customer research and audience segmentation, message development and evaluation. Because it is based on consumer needs and input, the Initiative is dynamic and continues to evolve based on the shifting landscape of communications technologies and government involvement with the public. It strengthens the agency’s role in “Supporting the field with Information/Communications” by conducting and sharing information from national surveys and surveillance; vetting and sharing information about evidence-based practices (e.g., National Registry of Evidence-based Programs and Practices [NREPP]); using the Web, print, social media, public appearances, and the press to reach the public, providers (e.g., primary, specialty, guilds, peers), and other stakeholders; and listening to and reflecting the voices of people in recovery and their families. The requested budget will aid SAMHSA’s efforts to research the best methods of collaboration with its stakeholders, which will improve its messaging and marketing; and as a result, more accurately reflect the voices of people and families in recovery.

Interesting Developments in Other Health Professions: Being primarily located, by choice, in my “new career” in the Daniel K. Inouye Graduate School of Nursing at the Uniformed Services University of the Health Sciences (USUHS) (DoD), I have become increasingly aware of changes evolving within the broader health professions community. I have been impressed by the continuing growth of dual degree opportunities involving Schools of Nursing and, for example, public health, business, informatics, law, religion (hospice care), as well as nursing’s systematic efforts to fully implement the recommendations of the Institute of Medicine (IOM) report The Future of Nursing: Leading Change, Advancing Health. This includes ensuring that professional nurses will be able to practice to the full extent of their education and training; achieve higher degrees of education and training through an improved education system that promotes seamless academic progression; be full partners in redesigning health care in the United States; and, requiring better data collection and information infrastructure for developing effective workplace planning and policy making. In essence, our colleagues in nursing should be actively involved in playing a fundamental role in the transformation of our nation’s health care system. At the

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visionary Fall Semiannual Conference of the American Association of Colleges of Nursing (AACN), the participants were asked to develop the “capacity to wonder” how they might continue to make outstanding contributions to the nation. Lt. General Patricia Horoho, the first woman and first ever non-physician military Surgeon General, urged the audience to “think differently” and “change the fundamental conversation,” asking the Deans: “How much health is actually included in today’s curriculum?”

This Fall, the Tri-Regulator Leadership Collaborative met to review issues of mutual concern and set an agenda of work for the ongoing collaboration between the Federation of State Medical Boards (FSMB), the National Association of Boards of Pharmacy (NABP), and the National Council of State Boards of Nursing (NCSBN). The schedule of work agreed upon included: Preparation for a historic, joint meeting of the governing boards of each organization in February, 2014. A proposed position statement on interprofessional team-based care for adoption by each organization. Assessing the public protection issues related to practice between and among countries and other international issues related to the regulation of health care practice. Encouraging regular dialogue between U.S. medical, pharmacy and nurse licensing boards, including facilitation of dialogue with board members of each respective organization. And, Planning for the second Tri-Regulator Symposium to be held in 2015. The FSME, NABP, and NCSBN formalized their advocacy partnership in 2011 with the creation of the Collaborative. Together, their various state member boards regulate a combined 5 million physicians, pharmacists, and nurses in the United States. Also this Fall, Rutgers University announced the establishment of a dual doctorate in Pharmacy/Medicine at the Robert Wood Johnson Medical School and Ernest Mario School of Pharmacy. The new PharmD/MD program will be the first of its kind which “could become a model to better prepare the experts who will drive national health-care policy in the wake of the Affordable Care Act.” Those who enroll in the program are expected to take 10 years to obtain their degrees.

**USUHS:** “At USUHS we have a health policy seminar dedicated to exposing students to the many professions that interface with public policy, such as psychology, nursing, and education. The seminar features speakers who informally discuss their journeys to policy-related fields and how policy experiences influenced their career trajectories within military and civilian sectors. Speakers discuss the different skills necessary to work within policy, including building interpersonal relationships, being persistent, and focusing upon the ‘big picture.’ A recent speaker, Anthony Principi, twice serving as Secretary of the Department of Veterans Affairs, discussed his vision and rationale for the difficult decision to consolidate and restructure the VA hospital system in 2004. Stephen Trachtenberg, author and former President of The George Washington University, shared stories from the perspective of a visionary university president, highlighting the successes and difficulties of working within the education policy system. Another speaker, Clyde Hart, current communications director of the American Bus Association and former U.S. Senate confirmed Maritime Administrator and Capitol Hill staffer, encouraged students to take advantage of any opportunity to work on Capitol Hill, identifying it as the one place where he learned the most simply by listening and watching. Since the class includes students in both psychology and nursing, we are able to engage continued on page 56
in interdisciplinary dialogue related to many areas within policy. Towards the end of the quarter, students are encouraged to do a field site visit. Past site visits have included visiting the American Psychological Association (APA), the federal or state offices of Congress (my mother and I visited our local Congressman in Mississippi), and the Health Resources and Services Administration (HRSA). Through the seminar discussions and field experiences, students are exposed to the ways policy impacts every aspect of our lives and how we will be able to utilize our knowledge, skills, research, and clinical expertise to inform policy decisions [Omni Cassidy].”

Although there are steadily increasing numbers of public policy courses and relevant texts being offered/published within schools of nursing, this is not the case within psychology’s educational institutions. Perhaps a relevant analogy – Today, psychology is progressing nicely on addressing the complex issues surrounding Telepsychology. Yet, in 2003, the Kaiser Family Foundation reported that “About 80% of U.S. residents who use the Internet have searched the Web to seek out health information, and most say doing so helps improve their quality of care.” Psychology’s next generation must become more responsive to the changing times. Some definitely are: “We met at the 2011 APA Convention in DC at the Speed mentoring opportunity for students and Early Career Psychologists. After much ambivalence, I’m finally taking the plunge. My colleagues in the Indian Health Service (IHS) and Steve Tulkin have encouraged me to pursue RxP authority. In January 2014, I’ll start the Alliant University Postdoctoral Masters in Clinical Psychopharmacology program. I do like to believe that you planted the seed those few years ago. Wish me luck. Thanks. [Casey McDougall].”

The IOM Forum on Global Violence Prevention: Our nation’s Capital hosts many exciting policy discussions, which can be transformational. A new summary brochure produced by the IOM Forum on Global Violence Prevention details the origin, operation, and accomplishments of the Forum. Established in 2010, it has brought together global experts from all areas of violence prevention and mitigation to facilitate multisectoral dialogue and exchange on a range of cross-cutting global violence prevention issues. Several times per year, the Forum convenes expert workshops that explore these issues and opportunities for advancing proven or evidence-informed prevention efforts. Violence is a major global public health problem, with multisectoral consequences for business, law enforcement, and other sectors, the impact of which is borne not only by the victims, but also by families, communities, and societies. In 2001, violence accounted for 45 million disability-adjusted life years lost, with low- and middle-income countries bearing the largest burden. The exact costs of violence, which include adverse health outcomes, lost productivity and economic opportunity, community deterioration, and effects on the next generation, are difficult to determine, but there is little doubt that the direct and indirect costs are great. As quoted by the Forum’s co-chair Mark Rosenberg from the Taskforce for Global Health: “In most people’s minds, violence is seen as unmitigated evil, something that we have had to live with since time immemorial, and not something that we can prevent.” Nevertheless, violence can be prevented.

The past quarter-century has witnessed a shift in thinking about violence – from the assumption that violence is inevitable to an emerging scientific under-
standing among many different stakeholders that, through effective approaches, prevention is possible. Violence is complex, whether interpersonal, self-directed, or collective, and, when not prevented, fosters more violence. Effective prevention requires cross-sectional approaches developed through dialogue and collaboration among researchers, practitioners, and policy-makers whose perspectives reflect different disciplines and experiences.

During its first three operational years, the Forum explored different but related aspects of violence in a series of public workshops. The existence of linkages and common risk factors within types of violence, as well as between different types of violence, was a constant thread through all the workshops and related activities. Understanding these relationships is critical to preventing violence. The Workshop on Preventing Violence Against Women and Children, for example, found the following key themes:

- The value of research and interventions that address violence against both women and children rather than treating them as “siloed” types of violence.
- The intergenerational transmission of violence.
- The need to address gender norms and roles of men and boys as part of the solution.
- The research and intervention gap in low- and middle-income countries.
- The need for responses that are multisectoral and are cross-cutting fields of violence prevention. This workshop was webcast globally, allowing for the inclusion of more than 300 remote participants in more than 20 countries.

Key themes from the Workshop on Communications and Technology for Violence Prevention were:

- The ability of information and communications technologies (ICT) to facilitate cross-sectoral solutions.
- The potential of ICT as a platform for scaling up effective interventions.
- The need for new methodologies for effective evaluation of interventions utilizing rapidly changing ICT. And,
- The opportunity for ICT as a tool to better reach vulnerable populations and address health disparities.

Following the momentum of this workshop, one of the Forum’s sponsors, the Avon Foundation for Women, partnered with the IOM in a global mobile- and Web-based app challenge: Ending Violence @ Home. The challenge brought together individuals from the fields of domestic violence prevention and communication technologies, raising awareness about and helping prevent domestic violence against women and children. This was a globally-issued challenge, and teams from both the United States and abroad entered. The numerous submissions covered a wide array of innovative approaches to prevent violence at home. The four winning submissions showcased three different approaches: changing cultural attitudes about violence against women, preventing dating violence on university campuses, and equipping health care providers to detect and prevent domestic violence. Other workshops include: Social and Economic Costs of Violence, Contagion of Violence, Evidence for Violence Prevention Across the Lifespan and Around the World, and Elder Abuse and Its Prevention [www.iom.edu/globalviolenceprevention]. There is tremendous potential for the behavioral sciences to contribute to a healthier society. Aloha.
REQUEST FOR PROPOSALS
RANDY F. GERSON MEMORIAL GRANT

About the American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people’s lives.

APF encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the Randy Gerson Memorial Fund
The Randy Gerson Memorial Fund awards grants for graduate student projects in family and/or couple dynamics, and/or multi-generational processes. Work that advances theory, assessment, or clinical practice in these areas is eligible. Preference will be given to projects using or contributing to the development of Bowen family systems. Priority will also be given to those projects that serve to advance Dr. Gerson’s work.

Program Goals
• Advance systemic understanding in the above topic areas through empirical, methodological, or theoretical contribution
• Encourage talented students toward careers in specified areas

Amount
One $6,000 annual grant

APF does not allow institutional indirect costs or overhead costs. Applicants may use grant monies for direct administrative costs of their proposed project.

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REQUEST FOR PROPOSALS, continued

Eligibility Requirements
Applicants must:
• Be a graduate student in psychology enrolled full-time and in good standing at an accredited university
• Have demonstrated competence in area of the proposed work
• IRB approval must be received from host institution before funding can be awarded if human participants are involved

Evaluation Criteria
• Conformance with stated program goals
• Magnitude of incremental contribution in topic area
• Quality of proposed work
• Applicant’s competence to execute the project

Proposal Requirements
• Description of proposed project to include goal, relevant background, target population, methods, anticipated outcomes, and dissemination plans (Format: not to exceed 7 pages double-spaced, 1 inch margins, no smaller than 11 point font)
• Timeline for execution
• Full budget and justification (funds cannot be used for stipends)
• Current CV
• Two letters of recommendation
• Proposal must be submitted as one PDF document

Submission Process and Deadline
Submit a completed application online at http://forms.apa.org/apf/grants/ by February 1, 2014.
Please be advised that APF does not provide feedback to applicants on their proposals.
Questions about this program should be directed to Samantha Edington, Program Officer, at sedington@apa.org.

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org
CALL FOR NOMINATIONS

AMERICAN PSYCHOLOGICAL FOUNDATION
GOLD MEDAL AWARDS

About the American Psychological Foundation
APF provides financial support for innovative research and programs that
enhance the power of psychology to elevate the human condition and advance
human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for
students and early career psychologists as well as research and program grants
that use psychology to improve people’s lives.

APF encourages applications from individuals who represent diversity in race,
ethnicity, gender, age, disability, and sexual orientation.

About the Gold Medal Awards
The Gold Medal Awards recognize life achievement in and enduring contribu-
tions to psychology. Awards are conferred in four categories:

Gold Medal Award for Life Achievement in the Science of Psychology
recognizes a distinguished career and enduring contribution to advancing
psychological science.

Gold Medal Award for Life Achievement in the Application of Psychology
recognizes a distinguished career and enduring contribution to advancing the
application of psychology through methods, research, and/or application of
psychological techniques to important practical problems.

Gold Medal Award for Life Achievement by a Psychologist in the Public In-
terest recognizes a distinguished career and enduring contribution to the ap-
plication of psychology in the public interest.

Gold Medal Award for Life Achievement in the Practice of Psychology rec-
ognizes a distinguished career and enduring contribution to advancing the
professional practice of psychology through a demonstrable effect on patterns
of service delivery in the profession.

Eligibility Requirements
Eligibility is limited to psychologists 65 years or older residing in North
America.

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CALL FOR NOMINATIONS ~ GOLD MEDAL AWARD, continued

Nomination Requirements
Nominations letters should indicate the specific Gold Medal Award for which the individual is being nominated and should include the following:

• Nomination statement that traces the nominee’s cumulative record of enduring contribution to the purpose of the award;

• Nominee’s current vita and bibliography;

• Letters in support of the nomination are also welcome, but please refrain from sending supplementary materials such as videos, books, brochures, or magazines;

• All nomination materials should be coordinated and collected by a chief nominator and forwarded to APF in one package.

Submission Process and Deadline
The deadline for receipt of nomination materials is December 1, 2013. Please e-mail materials to sedington@apa.org or mail to: American Psychological Foundation, Gold Medal Awards, 750 First Street, NE, Washington, DC 20002-4242.

Please be advised that APF does not provide feedback to grant applicants or award nominees on their proposals or nominations.

Questions about this program should be directed to Samantha Edington, Program Officer, at sedington@apa.org

NOTICE TO READERS

References for articles appearing in this issue can be found at the end of the on-line version of Psychotherapy Bulletin published on the Division 29 website.
Brief Statement about the Grant:
The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three $5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

Eligibility: All graduate students, predoctoral interns, postdoctoral fellows, and doctoral-level researchers with a promising or successful record of publication are eligible for the grant. The research committee reserves the right not to award a grant if there are insufficient submissions or submissions do not meet the criteria stated.

Submission Deadline: April 1, 2014

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.

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
Three annual grants of $5,000 each 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. A researcher can win only one of these grants. (see Additional Information section below).

Eligibility Requirements
• Demonstrated or burgeoning 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 same project/lab may not receive funding two years in a row
• Applicant must be a member of the Division of Psychotherapy. Join the Division at www.divisionofpsychotherapy.org

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REQUEST FOR PROPOSALS, continued

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 two 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 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 and 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 and this letter should indicate the nature of the mentoring relationship

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REQUEST FOR PROPOSALS, continued

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 must 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

- 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; please resubmit.

DEADLINE: APRIL 1, 2014

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Cheri Marmarosh at cmarmarosh@gmail.com), or the incoming Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at woodhouse@lehigh.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net.
Thank you so much for the opportunity to represent Division 29 at the Education Leadership Conference 9/28–10/1. The theme of the conference this year was Ethics; both the content and the discussions that emerged were uniformly excellent and it was a privilege to participate.

With respect to issues that are directly applicable to our Division, two prominent focal areas are particularly notable. The first area pertains to supervision practices with graduate trainees. While informed consent is a clear expectation for working with clients, it seems that consenting trainees to supervision is quite rare and may result in considerable confusion among trainees about the nature of supervisory relationships. In general, trainers appear to have consensus that supervision is not confidential, though good judgment and discretion are to be expected. In contrast, trainees are not uniformly clear on whether supervision is / is not confidential, the conditions under which a supervisor may be reasonably expected to disclose sensitive information, or the role of information obtained during supervision in appraisals of their professionalism or competencies. It might be worth considering the development of a model supervision disclosure notice that could be disseminated (via the Division website) to programs for consideration of tailoring / adoption in their own polices. I suggest a disclosure notice, rather than informed consent, because some of the discussion centered on when informed consent would need to occur to be truly useful (e.g., before being offered admission? What if after admission, a trainee refuses to consent to supervision?).

The second notable focal area for our Division was on the topic of trainees who refuse to see specific clients on the basis of religious beliefs. The Julea Ward case was reviewed in some detail by APA legal counsel as a precursor to discussion. Mitch Prinstein was kind enough to put a few resources from APA into his public dropbox for downloading if you are interested. These documents may help individual programs develop their policies: https://dl.dropboxusercontent.com/u/36131315/Diversity%20Training%20Preparing%20Flow%20chat.pdf and: https://dl.dropboxusercontent.com/u/36131315/Diversity%20Training%20statement.pdf

Finally, the last day of ELC involves visits to Capital Hill for advocacy. This year our efforts were concentrated on the Garrett Lee Smith Memorial Act Reauthorization of 2013. This legislation was first introduced in 2003 by a then-Senator whose 19-year-old son had recently committed suicide while away at college. The purpose of the monies under this act is to foster suicide prevention and improve mental health services among colleges, universities, tribes, states, and university counseling centers. Unfortunately, our visit to Capital Hill coincided with the first day of the federal partial shutdown. Nevertheless, most offices remained open and I was able to visit with staffers of 2 Senators and 5 Representatives. In addition, I met with 1 Representative (not his staff) who provided a fist pump when told the legislation already has bi-partisan support and has been scored as budget neutral. That felt pretty good. Attached, for your viewing pleasure, is a picture of me at the locked door of Senator Ted Cruz during the early hours of the shutdown. Ultimately, a staff came out a side door to usher us in for a meeting.

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The Diversity Research Grant for pre-doctoral candidates is established to foster the promotion of diversity within Division 29 and within the profession of psychotherapy.

The Division may award annually a $2,000 Diversity Research Grant to a pre-doctoral candidate (enrolled in a clinical or counseling psychology doctoral program) who is currently conducting research that promotes diversity, as outlined by the American Psychological Association (APA). According to the APA, diversity is defined as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.

The Diversity Research Grant is expected to be used to support the completion of a pre-doctoral candidate’s dissertation work. The grant may be used to fund: (1) supplies used to conduct the research; (2) training needed for completion of the research; and/or (3) travel to present the research (such as at a professional conference). The applicant must be a student member of Division 29 or commit to becoming a student member if the award is made. The recipient of the grant will be expected to present his or her research results in a scholarly forum (e.g., presentation at an APA Annual Convention, the Division 29 Journal, Psychotherapy, or other refereed professional journal) and acknowledge the award.

One annual grant of $2,000 will 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. All grant recipients will be required to complete an IRS form W-9 before funds are issued.

A complete application must be submitted by email to both Diversity Domain Representatives:

Beverly Greene, PhD (bgreene203@aol.com) or Jairo N. Fuertes, PhD (jfuertes@adelphi.edu)

by midnight, April 1, 2014.

Incomplete or late application packets will not be considered.

The application must include:

• A 1-2 page cover letter describing how the applicant’s work embodies the Division’s interest in promoting diversity in the profession of psychotherapy and how the funding will be used to support the applicant’s dissertation work;

• A 1-page document outlining a detailed budget;

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• A 5-10 page research proposal (alternatively, a Dissertation Proposal may be submitted, preferably less than 30 pages not including references or appendices);
• 1 letter from the applicant’s dissertation advisor or director of clinical training certifying that the applicant is currently in the process of completing research for the dissertation.

Once a complete application has been received (on or before the deadline), selections will be made using the following criteria:
• Consistency with the Diversity Research Grant’s stated purposes;
• Clarity of the written proposal;
• Scientific quality and feasibility of the proposed research project;
• Budgetary needs for data collection and completion and presentation of the project;
• Potential for new and valuable contributions to the field of psychotherapy; and
• Potential for final publication or likelihood of furthering successful research in topic area.

Additional Information
• After the project is complete (do we specify the length of the project, 2 years for example), 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 must 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).

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org
REQUEST FOR NOMINATIONS

APF DIVISION 37 DIANE J. WILLIS EARLY CAREER AWARD

About the American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people’s lives.

APF encourages nominations from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the APF Division 37 Diane J. Willis Early Career Award
The APF Division 37 Diane J. Willis Early Career Award is named after Dr. Willis, to honor her life-long advocacy on behalf of children and families. Dr. Willis’s work cuts across many areas including clinical child, pediatric, developmental and family psychology. Through her publications, clinical work, and mentoring/teaching she has changed policy at the local, national and international level. She has advocated for children’s rights at the United Nations, developed programs on prevention and early intervention for Native American children living on reservations, and established services promoting the wellbeing of children with developmental disabilities, chronic illness, and those who have suffered from maltreatment.

The APF Division 37 Diane J. Willis Early Career Award supports talented young psychologists making contributions towards informing, advocating for, and improving the mental health and well-being of children and families particularly through policy.

Program Goals
- The APF Division 37 Diane J. Willis Early Career Award
- Advances public understanding of mental health and improve the well-being of children and families through policy and service.
- Encourages promising early career psychologists to continue work in this area.

Funding Specifics ~ One $2,000 award

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Eligibility Requirements
Applicants must be:
• psychologists with an Ed.D., Psy.D., or Ph.D. from an accredited university
  no more than 7 years postdoctoral

Evaluation Criteria
Nominations will be evaluated on:
• Conformance with stated program goals and qualifications stated above
• Magnitude of professional accomplishment in advancing public understanding of mental health and improves the well-being of children and families through policy and service.

Nomination Requirements
• Nomination letter outlining the nominee’s career contributions
• Current CV
• Two letters of support
• Nomination must be submitted as a single PDF document

Submission Process and Deadline
Submit a completed application online at http://forms.apa.org/apf/grants/

Please be advised that APF does not provide feedback to grant applicants or award nominees on their proposals or nominations.

Please contact Samantha Edington, Program Officer, at sedington@apa.org with questions.
Note from the Susan S. Woodhouse (Early Career Psychologists Domain Representative):
Mentoring Early Career Psychologists is an important focus for Division 29 (Psychotherapy). We want to help ECPs get what they need to have a great start. Please apply for this program if you are and ECP—and if you are more senior, help get the word out the ECPs you work with to let them know about this fabulous opportunity for support and mentoring. We’ve extended the deadline, so it’s a perfect time to apply. Don’t let the idea of applying with a “project” seem intimidating—the idea of a project is really just the goal you would like to meet through the mentoring process. The “project” can be anything—it can be to get licensed and start a practice or really anything at all that is important to you. So go ahead and apply before January 15 and be a part of our first cohort of ECP mentees! I can already tell you that we’ve got some wonderful mentors already lined up.

Early Career Psychologists Mentoring Program:
Deadline Extended to January 15, 2014

This one-year mentoring program provides mentoring for Early Career Psychologists (i.e., within 10 years of completion of the Ph.D. or Psy.D., regardless of the number of years in the field prior to attaining the doctoral degree). Mentoring is provided in mentoring groups comprised of two senior, experienced mentors and up to 3-4 mentees. Three mentoring programs are offered:

Mentoring: Psychotherapy Practice Issues
The practice mentors will aid their mentees in issues related to practice such as licensure, the business of establishing a private practice, or professional and ethical issues related to being a licensed psychologist. Practice mentees may elect to work on developing new areas of competence, developing skills with diverse clientele, or addressing mental health care disparities. The program does not provide clinical supervision, but does provide mentoring to support mentees in reaching their professional goals.

Mentoring: Psychotherapy Research
The research mentors will work closely with their mentees on their psychotherapy research. Psychotherapy research mentees may elect to work on any aspect of their research program (e.g., setting a research agenda to working, developing successful grant applications, engaging diverse communities in psychotherapy research, and research as a part of success in the tenure process).

Mentoring: Teaching and Training
The teaching mentors will help their mentees to improve on areas related to lecturing/teaching in psychotherapy-related classes and may, if applicable, provide support to help new professors as they embark on the track to tenure. Teaching mentees may work on topics such as addressing diversity in the class-

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room, engaging students in the classroom, creating effective syllabi, teaching helping skills, and growing as an instructor.

Three or four applicants will be selected for each of the three areas, and will be assigned to a mentoring group that focuses on that specific area. Each mentoring group will meet by web-based video conference six times per year (every 2 months) to discuss mentee projects and other mentoring concerns.

**Program Goals**
- Provide support and mentoring to promising early career psychologists
- Help early career psychologists to establish and further their careers
- Build positive and supportive relationships between mentees and more experienced members of the Division of Psychotherapy
- Build positive professional relationships between mentees within each group and mentoring cohort
- Support diversity in psychotherapists, scholars, educators, and professional leaders interested in psychotherapy
- Support attention to diversity in psychotherapy practice, psychotherapy research, and teaching about psychotherapy
- Encourage early career psychologists to step into leadership roles in the field of psychotherapy practice, research, or training

**Program Structure and Benefits**
- Selected mentees will work on their individual projects with support and feedback from the mentors and the rest of the mentoring group
- Selected mentees will meet as a group via web-based video conference for 1 hour every 2 months (6 times/year) for mentoring
- During the mentoring meetings, mentees will discuss their projects and any other mentoring concerns with the mentoring group and the mentors
- Mentors would work as a sounding board for new ideas and offer unique perspectives to help shape and refine the ideas of their mentees.
- Mentors will help connect mentees with other Division 29 members working in areas relevant to the mentee’s work.
- Mentors and mentees would have the opportunity to meet in person at the annual APA Convention at the Lunch for the Masters (if desired, not required).

**Funding Specifics**
The there will be no cost to mentees/mentors for participating in the 6 web-based video conferences.

**Eligibility Requirements**
- Eligibility criteria that apply to all three mentoring programs:
- Must be a member of Division 29 (Psychotherapy)—information for joining the Division of Psychotherapy is available at the following website: http://www.divisionofpsychotherapy.org/members/membership-application/
- Must have graduated from the Ph.D. or Psy.D. programs within 10 years

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from the time of their application (Note that some applicants may have had many years in the mental health field prior to attaining the doctoral degree—time from graduation is calculated only from graduation with the Ph.D., Psy.D., or other doctoral-level degree).

Eligibility criteria that apply only one of the three specific mentoring programs
• **Mentoring: Psychotherapy Practice Issues.** Individuals must articulate their interest in psychotherapy practice, be invested in future clinical work, and articulate how a mentor should help him or her with professional development issues
• **Mentoring: Psychotherapy Research.** Applicants must demonstrate that they have a clear research agenda and plan in an area of psychotherapy and demonstrate research competency consistent with their level of training and experience
• **Mentoring: Teaching and Training.** Individuals must demonstrate a particular interest in building a career in teaching/academia or be involved in teaching or training future psychotherapists as a part of their professional lives. Applicants should have an interest in approaches to teaching psychotherapy, supervision, or issues related to training.

Information on Mentors
• Mentors will be experienced members of Division 29 to serve as mentors (two in psychotherapy practice, two in psychotherapy research, and two in teaching/training).
• The mentors agree to serve as mentor for a period of one year.

Evaluation Criteria
• Conformance with goals listed above under “Program Goals”
• Clarity with which the applicant articulates the way in which the mentoring program could help the applicant attain the goals stated in their application
• Clarity with which the applicant articulates the proposed project to be completed with the support of the mentors and mentoring group
• Applicant’s ability/competence to execute the project

Application Process
All applicants (regardless of type of mentoring program sought) should submit
• a CV
• 1 letter of reference from someone who is familiar with the applicant’s work in a professional or academic context
• A statement of purpose (no more than 1 page, single-spaced, no smaller than 12-point font, 1-inch margins on all sides).

Statement of Purpose Requirements Vary by Mentoring Program Desired: **Mentoring: Psychotherapy Practice Issues.**

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Interested individuals should explain their area of clinical interest, discuss the work done thus far in clinical practice, and future plans to practice psychotherapy. Applicants should clearly delineate which areas they are requesting mentoring group support, and why. Describe the specific outcomes that are expected from the mentoring process (e.g., establishment of competence in a new area of practice or in practice with a new population, specific skill-building, specific practice development plans, etc.). Please note that no clinical supervision is provided through the mentoring program.

**Mentoring: Psychotherapy Research.**
Applicants must explain their program of research and future research plans. Applicants should specify a project that they would like to work on in the coming year with the support of the mentoring group.

**Mentoring: Teaching and Training.**
Applicants must submit a statement demonstrating a serious ongoing interest in teaching courses related to psychotherapy or being involved in training of future psychotherapists. The statement of purpose should include a description of teaching strategies and philosophy, a summary of any available documentation of teaching effectiveness, and a plan for an innovative teaching/training endeavor that the mentee would work on developing with the mentoring group.

- Applicants may reapply in subsequent years; reapplications are permitted.
- Applicants may only submit one application for each year (i.e., one may not apply for the teaching and the research mentorships in the same year).
- Anyone who has been awarded the mentorship is barred from applying in the future.
- Only complete applications will be reviewed.

**Submission Process and Deadline**
- All materials must be submitted electronically via e-mail.
- All materials (including CV) may be submitted in MSWord or PDF format.
- Submit all required materials for proposal to: Division 29 Early Career Domain Representative (Susan S. Woodhouse, Ph.D. at woodhouse@lehigh.edu)
- You will receive an electronic confirmation of your submission within 48 hours. If you do not receive confirmation, your proposal was not received; please resubmit.

**DEADLINE: FEBRUARY 15, 2014**
Questions about this program should be directed to
Susan S. Woodhouse, Ph.D. at woodhouse@lehigh.edu or Rayna Markin, Ph.D. at rayna.markin@villanova.edu
NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT
for Early Career Psychologists

Brief Statement about the Grant:
The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually to Early Career Psychologists (within 10 years of earning the doctoral degree), provides $10,000 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: Early Career (within 10 years of earning the doctoral degree) Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: April 1, 2014

Request for Proposals

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 $10,000 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
• Early Career (within 10 years of earning the doctoral degree), 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

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• The selection committee may choose not to award the grant in years when no suitable nominations are received
• Researcher must be a member of the Division of Psychotherapy. Join the division at www.divisionofpsychotherapy.org

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

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• 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. Please resubmit.

Deadline: April 1, 2014

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Cheri Marmarosh at cmarmarosh@gmail.com), or the incoming Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at woodhouse@lehigh.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net.
President Bill Stiles presents Pal Ulvenes with the Journal Most Valuable Paper Award

Congratulations!
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 Diversity Award for the best paper on issues of diversity in psychotherapy. The APA defines diversity as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.
- 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 $500 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.
- All applicants must be members of the Division of Psychotherapy. Join the Division at www.divisionofpsychotherapy.org
- Applicant must specify for which award he/she is applying. Applicants can submit multiple papers for awards, but an individual paper may only be submitted for a single award.

Submissions should be emailed to:
Meg Tobias, M.S.
Chair, Student Development Committee, Division of Psychotherapy
E-mail: mrtobias@loyola.edu
Deadline is April 1, 2014
**MEMBERSHIP REQUIREMENTS:** Doctorate in psychology • Payment of dues • Interest in advancing psychotherapy

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**JOIN DIVISION 29 AND GET THESE BENEFITS!**

- **FREE SUBSCRIPTIONS TO:**
  - *Psychotherapy*
    This quarterly journal features up-to-date articles on psychotherapy. Contributors include researchers, practitioners, and educators with diverse approaches.
  - *Psychotherapy Bulletin*
    Quarterly newsletter contains the latest news about division activities, helpful articles on training, research, and practice. Available to members only.

- **EARN CE CREDITS**
  - *Journal Learning*
    You can earn Continuing Education (CE) credit from the comfort of your home or office—at your own pace—when it’s convenient for you. Members earn CE credit by reading specific articles published in *Psychotherapy* and completing quizzes.

- **DIVISION 29 PROGRAMS**
  - We offer exceptional programs at the APA convention featuring leaders in the field of psychotherapy. Learn from the experts in personal settings and earn CE credits at reduced rates.

- **DIVISION 29 INITIATIVES**
  - Profit from Division 29 initiatives such as the APA Psychotherapy Videotape Series, *History of Psychotherapy* book, and *Psychotherapy Relationships that Work*.

- **NETWORKING & REFERRAL SOURCES**
  - 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](http://www.divisionofpsychotherapy.org)

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**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](http://www.divisionofpsychotherapy.org)
An Insider Perspective: Developmental Challenges Moving from Graduate School to Internship and Beyond


**Psychology Practice in the Health Care Reform Era: Developing and Thriving in an Interprofessional Practice**


**Musings from the Psychotherapy Office: A “Cool” Clinical Approach**


Change in Defensive Functioning During Group Psychotherapy for Women with Binge Eating Disorder


Tasca, G.A., Foot, M., Leite, C., Maxwell, H., Balfour, L., & Bissada,


**Competencies Needed By Mental Health Professionals Working With Parents of Children With Asthma**


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).