Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

BULLETIN

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The Unseen Diagnosis: Substance Use Disorder

Focus on SMI: Treatment for Mental Health Court Clients

VOLUME 37 NO. 1 SPRING 2002

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PSYCHOTHERAPY BULLETIN

Published by the
DIVISION OF PSYCHOTHERAPY
American Psychological Association

6557 E. Riverdale
Mesa, AZ 85215
602-363-9211

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Official Publication of Division 29 of the American Psychological Association

Volume 37 Number 1 Spring 2002

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PRESIDENT'S COLUMN

What is Psychotherapy?

by Robert J. Resnick, Ph.D., ABPP

More than two decades ago, when I was deposed in the antitrust suite I filed against Blue Cross/Blue Shield, the question was asked by opposing counsel, "What is psychotherapy?" I replied it is "a treatment modality" and did not elaborate. I was too anxious to say anything more!

I put this same question on the Division 29 Board of Directors listserve. A reasonable question I thought since they are the governance of the Division of Psychotherapy. Surely, they would know what we are all about. I put the same question to the membership via the listserve. A quick digression for an historical note: Hugo Munsterberg, in 1909, wrote what may have been one of the first books addressing treatment entitled, "Psychotherapy." And was, among the first treatises describing psychologically based interventions.

Back to the question posed. From the governance listserve: "Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that participants deem desirable."

From the membership listserve: "(The) practice that empowers clinicians to aid patients in implementing changes that will improve the quality of the patient's life..." and, "psychological treatment of mental disorders and of the psychological complications arising from physical disease, trauma and disability."

And lastly, from an introductory psychology textbook: "Psychotherapy is a treatment of psychological disorders by methods that include a personal relationship between a trained therapist and a client"(Kalat, 2002, p. 589).

From these descriptions, is this what we do? I believe it is all of the above and much, much more. Psychotherapy subsumes treatments such as "coaching", workplace interventions, school and home-based interventions, hospital and nursing home interventions in addition to the traditional outpatient practice. Thus, our treatments permeate home, work, personal lives, social lives, leisure time and even religion/spirituality. The interventions can be long term, short term and/or episodic/intermittent. The "psychotherapy" can be individual, couples, family, group or play. From major personality reorganization to family systems and dynamics to behavioral and cognitive to making the world more adaptable to the person and/or making the person more adaptable to the world; we do it all. And we do it everywhere: outpatient offices, on the job, hospitals, nursing facilities, schools and homes. Our treatments impact individuals across the lifespan. So while we may not be great at defining what we do(N=3), we do it everywhere. And that maybe why it is difficult to define what we do as psychotherapists. "Psychotherapy" may not quite capture the essence of what we do in our practice, training and research endeavors. Perhaps, it is time to enlarge or modify what our division is called to represent the broad range of activities we do under the rubric of psychotherapy. Somehow, it doesn't capture all that we are and do. What do you think? If you were going to expand or change the name of the Division 29, Psychotherapy, what would you call it? Be creative. The Executive Committee and the Board of Directors will be discussing this issue. Give me the benefit of your thinking: rresnick@rmc.edu.

Before concluding this column let me state that I have intentionally not mentioned the personal and national tragedies on and after September 11th. We cannot forget those events and we are forever changed by them. The scars on the individual and national psyches will be present for gener-

Continued on page 30

STUDENT COLUMN

Gary R. Hann, M.S.Ed., Student Liaison

Remember the first student column? You know, the riveting one, where I made all kinds of promises and projections for our field and provided you with numerous insights into the metaphysical world. I thought that would ring a bell. Anyway, in that first edition I mentioned bringing you an interview with some of the leading voices in psychology who could speak directly to us, the students of psychology. Soon after I made this "promise" I attended the APA convention in San Francisco—a man on a mission you might say. I needed an interviewee. I approached the Executive Committee of the Division in search of an interested party and Dr. Ron Fox, past APA President, coolly agreed. "Now," I thought, "If I could just find someone to do the actual work for me…"Insert Anna McCarthy, a Division 29 student member and colleague from California, who artfully conducted the following interview with Dr. Fox. I hope you enjoy their fascinating exchange.

An Interview with Dr. Ron Fox, Division 55 President and APA Past President

By Anna McCarthy, M.A.

ANNA:
Dr Fox, I, and many of my peers, have felt that the graduate school process (from admissions to internships) is, at times, analogous to walking through a dimly lit tunnel, with a small light at the end of it. Asking professors/professionals to share their memories of these times is one way for students to feel less "kept in the dark." I hope you can recount some of your memories of life as a student to us, to aid us on our graduate school journeys.

But before we get to your graduate school experiences, I'd like to ask you a little background information. You have been at the forefront of psychology for over 40 years, during which time you have, among other things, served as the President of APA, received a Lifetime Achievement Award from the Society for the Psychological Study of Ethnic Minority Issues, and been appointed by the U.S. Department of Health and Human Services to serve on a national advisory council. Where did your passion for psychology come from? You were born in Conover, North Carolina, did your community have psychologists in its midst?

DR FOX:
Conover was a town of 1000 people, if everyone was home – there were no psychologists or psychiatrist there. But my father was partly responsible for my career choice. He was a small businessman, and prior to doing business with people, he would ask me what I thought about them – their personalities and character. He stimulated my curiosity about people.

ANNA:
But in college you studied English as an undergraduate, what made you switch to psychology?

DR FOX:
I took more Psychology courses than English courses—I found them more interesting. Then I took a class with Dorothy Atkins-Wood. She asked what I was going to do for a career, and when I told her, she replied that I had the ability to think, and that I shouldn't p*** it away. She told me I should go to graduate school, and after a year I was hooked. She caught me at a teachable moment; that is what we do in psychotherapy, we catch people at a time when they are ready to be taught.

ANNA:
What was the most invaluable piece of advice you received when applying to graduate school?

DR FOX:
I didn't know that applying was a problem. I had a cheerleader in my corner—Dorothy was the chair of the program—she got me in. In fact, I didn't know what Clinical Psychology was. Somebody asked me if I was in the clinical program, and I said "yes." I figured I could always change my mind later. The most important thing was that I had a cheerleader—a good match between a faculty member and a student.

ANNA:
When you initially undertook doctoral training, did you ever doubt your ability to succeed? Did you ever wonder if the admissions committee had made a mistake when they accepted you into the program? (many of us have had these feelings, but none of us like to admit them).

DR FOX:
Sure. All the other students seemed bright to me. They'd all been somewhere. I'd never been anywhere but North Carolina. But, I talked to my peers. They were a very good support group, and I had older students to mentor me – they guided me, showed me the next step.

ANNA:
How did you maintain balance in your life during your PhD years? Doing a PhD is, by definition (piled deeper and higher), not the most balanced of lifestyles.

DR FOX:
I had a wide circle of friends in the program—a varied group of people (in terms of SES, geography etc.). We saw each other socially. We didn't have any money, so we went to each other's homes. A lot of them were married and had families.

ANNA:
I know you are married and have three children. Was that the case in graduate school? If so, how did you manage all those roles (father, husband, student etc.)?

DR. FOX:
I had two children during graduate school, and an outstanding wife. I also had parents, and parents-in-law to provide emotional and financial support.

ANNA:
"ABDs"…a small percentage of graduate students never complete their degrees, because producing a dissertation becomes an insurmountable obstacle. Why do you think this occurs? How can people avoid falling into the ABD trap?

DR FOX:
I knew I needed to find a professor with a definite idea about where to start. The world is a big place, but I found a professor who had a number of research projects to work on—he had definite ideas. He helped me get my own project down to size. That's one of the problems students run into—they have monumentally big projects – but dissertations don't have to be monumental, they have to be manageable. I had professors who helped me think things through. They didn't impose. I went to them and asked. I was fortunate the professors I worked with really liked teaching, and really liked students, and really liked their work. That's not always the case. Some professors don't like what they're doing, and sometimes, good matches between faculty and students don't happen.

ANNA:
I've heard horror stories about students who cannot find internships. Why is this happening? How can people increase their chances of being accepted for internships?

DR. FOX:
Its not as bad as people think. The trouble is that there is a shortage of locations people want to go to. People want to go to New York, or Los Angeles. They don't want to do an internship in Fargo. Students need to apply to a reasonable range of placements, and shouldn't get

locked into a location—they aren't applying to enough places. Another problem is that students apply to internships that aren't a good match for them. One of my brightest graduate students failed to get an internship the first time around because she applied to places that she wanted to go to, not to places that matched her background and experience. Its like applying to a place that is psychoanalytically oriented, and you have no training in that area—you're not going to get accepted.

ANNA:
You have received accolades for your lifetime dedication to minority issues. I think it is fair to say that psychologists have become more aware of cultural and ethnic issues over the years, but what still needs to be done? What should graduate training programs focus on in the future?

DR. FOX:
Society is much more diverse nowadays. But diversity needs to be defined more broadly—a whole lot of things make people different (geography, race, gender etc.). Before too long we will be a nation of minority groups, and this means there will be diverse populations for clinicians to work with. I'm not suggesting that you have to be male in order to help a man—nobody can get into somebody's skin and know exactly what its like, but students can learn to look at their assumptions, and be sensitive to other people's needs. When I was in graduate school there was discrimination against women. The assumption was that women would go off and have babies, and drop out of the picture. But that has long since gone by the board. Programs can't afford to discriminate against women, since women now make up the majority of graduate students in psychology. But there still is a mismatch between the composition of faculty and student bodies. Faculty have a slow turn over rate, but eventually it will take care of itself.

ANNA:
What directions do you see psychotherapy practice and research moving in over the next decade? And how can graduate programs better equip us to meet these needs? For example, the debate over prescription privileges for psychologists is a hot topic at the moment—since I see you will be President of Division 55 of the APA (The Society for the Advancement of Pharmacotherapy) in 2002, I'm guessing you're in favor of prescription privileges.

DR. FOX:
I was asked to write on this topic, and published a paper, 15 years ago. I just laid out the pro's and con's, and when I was through I had convinced myself. It makes a lot of sense, but it's not for everybody. There is so little academic training in med school for psychiatrists—a big chunk is hands on clinical experience. We can provide psychologists with the training.

As for the future of graduate training… we've moved too fast to briefer approaches. "Evidence based treatment" is a totem catchphrase. People want empirical evidence for the efficacy of treatments, and aren't interested in analytical, qualitative, or case studies. But not all problems can be solved in six sessions. I also think we need to do more in terms of electronic/ distance treatment. Nowadays, we can perform some surgeries long distance. Things are going to move very rapidly in this area—we need the training and exposure. I spend half my day providing therapy to CEOs of companies over the telephone. We don't have to be in the same room as each other anymore. I also think we spend 75% of our time training graduate students to deal with 10% of the population – those with "mental disorders." We have an illness-based model—a dichotomy between the mentally ill and "normal" people. We need to focus on how to help people be effective in their relationships—how to improve the effectiveness of human nature. I see it as a continuum, not a

dichotomy. People define our profession in very limited ways, but we need to focus on a whole range of human behaviors.

ANNA:
I read a great article by Dr. Raymond Fowler about the future of psychology in the last edition of the APA Monitor, which was written in the form of a letter to his grandson. What would you tell your grandchild?

DR. FOX:
The next century belongs to us. We've taken care of all the big infectious diseases. Now seven out of the top ten killers are the consequences of our behavior, not disease. And as psychologists, we are experts in behavior. And in our places of employment we don't produce cookie cutter, assembly line workers anymore. Everybody is not the same. The challenge is getting unique individuals to work together. Psychology is great, challenging, and diverse—there are so many directions we can go in as psychologists.

ANNA:
Anything else you would like to add?

DR FOX:
Graduate school is a tough grind, and it is uncertain. It is just like life. You're almost all the way through it before you realize what is going on. But don't be afraid to not have all the answers, and don't be afraid to ask. Celebrate the small victories—it is what got you into graduate school in the first place…

Social Hour • August 26, 2001

Susan Corrigan, Robin Gurwitch, Beverly Funderburk, Diane Willis, and Jan Culbertson

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Andy Horne and Roberta Nutt

WASHINGTON SCENE

AND THE BEAT GOES ON....

by Pat DeLeon, APA Past President and Past President of Division 29

As the year 2001 gradually came to a close, there remained considerable activity (e.g., productivity) within the APA. During one weekend alone, Ron Levant's Task Force on Distance Education met with representatives from the Committee on Accreditation, in order to explore how the extraordinary advances occurring with the communications arena might ultimately effect professional education, including its potential impact upon internship and post-doctoral training. Rochelle Jennings convened a special meeting of psychopharmacology (RxP-) experts—including New Mexico's Elaine LeVine (recently elected to the Committee on Rural Health) and *Bulletin* Editor Linda Campbell (recently elected to the Ethics Committee)—to flush out the specifics of APA's vision for implementing the required "minimum of 100 patients, for whom the trainee assumes direct clinical responsibility or participates in case conferences" of the supervised psychopharmacology experience (e.g., the "hands on" practicum) of APA's model RxP- curriculum. The APA model was approved by the Council of Representatives in August, 1996. Since that time, a number of high quality didactic training programs have evolved; as has the national examination developed by the APA College of Professional Psychology. The time has now come for the next step of our RxP-maturation. A report from DoD Prescribing Psychologist Morgan Sammons:

Progress towards prescriptive authority—Psychologists are moving steadily towards the goal of acquiring prescriptive authority. As we do so, more and more psychologists are, even prior to the passage of enabling legislation, enrolling in training programs that impart the fundamental knowledge base required for safe and effective provision of psychotropics. Those who have designed such programs have learned that construction of the classroom or didactic portion of education is not overly challenging. The knowledge domain is defined, and the required elements of instruction are easily accessed.

"But the acquisition of clinical training for those who have completed the didactic portion of psychopharmacology training has always been more of a challenge. In part this is due to the fact that this is a new area of practice for the profession, and we therefore do not have the benefit of historical models to draw from. It is true that psychiatric models of pharmacotherapy service exist, but it is important that training for psychologist providers not mimic a system that we believe to have fundamental flaws. In other words, it is vital to the success of the prescriptive authority movement that we train our practitioners in what APA Practice Director Russ Newman has called the 'psychological model' of pharmacotherapy—a contextually based model, based in behavioral principles, that utilizes medication as an adjunct, not a mainstay, of treatment.

Recent steps have been taken to clarify what training in a psychological model should look like. Under Russ' guidance, the Practice Directorate convened a working group to develop the outlines of a recommended clinical practicum in psychopharmacology. The group, which consisted of educators, trainers, and prescribers has now produced a draft guideline that will assist psychologists, educational institutions, state and provincial associations, and licensing boards in devising and evaluating practicum experiences for prescribing. The group looked at a number of factors, including prerequisites, qualifications of supervisors, ethical con-

siderations and numerous other points that require attention in devising sound training programs. The document has been forwarded for further review within the organization, promising that formal guidance on the development of the clinical practicum in psychopharmacology will soon be available to psychologists who seek the challenge of prescribing." [As always, Morgan's thoughts are personal and not those of the Department of Defense (DoD) or the U.S. Navy]. Morgan's DoD Prescribing Psychologist colleague Debra Dunivin; Alliant (formally CSPP) University's Steve Tulkin; and long time Council Representative John Linton also participated in the meeting, which was chaired by Russ. As this was the last weekend that I attended APA governance meetings as a member of the APA Board of Directors, I want to take this opportunity to express my deepest appreciation for the vision and dedication which Russ has demonstrated over the years on behalf of all of professional psychology, and particularly the RxP- agenda. Mahalo.

THE FUTURE IS NOW: Professional psychology's active involvement within our nation's community health centers; post-doctoral training; telehealth and distance education; and effectively addressing society's needs in a culturally sensitive fashion are the key to survival in the 21st Century. A critical element for our profession is the active involvement of APAGS and our recent graduates. For they are our future. A front-line report from John Myhre, DoD post-doctoral fellow and Native Hawaiian: "Providing rural psychological services to the isolated and largely Native Hawaiian town of Hana, Maui is a unique opportunity that is as challenging and rewarding as it is enjoyable. The first impression when flying into Hana comes from the exotic beauty and mystique of the blue Pacific Ocean, where rolling waves violently thunder into the cascading sheer black lava rock cliffs of the East Maui coastline. This violence is tempered by the tranquility of the pristine waterfalls that cascade from the coastline cliffs into the sea. Sitting majestically above the coastline is the dormant volcano Haleakala (House of the Sun), which gives refuge to an exotic green topical rainforest below that harbors the infamous Hana highway. The road to Hana encompasses 52 miles of winding road and several one-lane bridges that traverse the canyons below. The beauty and majesty of the journey to Hana is daunted by realization that beauty can harbor isolation and treachery that necessitates caution, and oftentimes guests of Hana are heard remarking of 'surviving the Hana Highway experience.'

Upon landing at the Hana airport, the sense of beauty and majesty gives way to the reality of relative isolation and the realization that many of the comforts of society, such as running water and electricity, are often unavailable. Settling Hana are about 2500 residents that are comprised largely of Native Hawaiians whose traditions and way of life go back some 1500 years. More recently, Hana was once home to several sugar plantations that succumbed to foreign competition, and the economy of Hana radically changed from an agricultural community to one that depends upon natural resources and tourism. Needless to say that paradise has a price, as many residents find ways of making to do with what they have or making do without. The need for self-sufficiency breeds a strong pioneer-like spirit. However, Native Hawaiians have the highest incidence of chronic disease in the nation. The reasons for which are not clear. It has been hypothesized that the change in their health status is due in part to a loss of a traditional diet that was low fat, high protein and contained complex carbohydrates consisting of fish, sweet potato and taro to the high fat, high sugar, processed foods American diet. Another plausible explanation is that many Native Hawaiians live in rural areas where access to healthcare is very limited. [And some postulate that chronic depression from loss of sovereignty has had a major impact upon all facets of Native Hawaiian life.]

As a Native of Hawaii (Native Hawaiian) and a psychology post-doctoral fellow at Tripler Army Medical Center (TAMC), I have been fortunate to participate in a Congressionally mandated program which allows Native Hawaiian Scholars to provide direct patient services in health psychology to remote and rural areas of Native Hawaii as part of a training program. This program necessitated a great deal of forward thinking by the leaders of TAMC and its Department of Psychology to provide services to Native Hawaiians, while maintaining the integrity of their military readiness mission. On the surface while these tasks seem incompatible, TAMC is currently training fellow civilian doctoral psychology trainees of Native Hawaiian descent in cutting-edge health psychology. The benefits are mutual, as military and other civilian psychologists receive a great education in cross cultural training. Likewise, the long-term benefit is to increase doctoral providers that are Native Hawaiian. Native Hawaiians account for 20 percent of the State's population but less than one percent of psychology providers in Hawaii are of Native Hawaiian decent.

I realized early on that the meaning of the word 'culture' in the city is decidedly different from the application of culture to daily living in Hana. In the city, culture is often regarded as an acculturation process that often times provides dissonance before resolution that results in a sufficient change of identity, so that a person can function in society. Whereas, in Hana, culture is synonymous with a lifestyle of fishing, farming and relating that provides for the essentials for life. Thankfully, this basic lifestyle does not require a significant amount of money, because there is little to go around. (In fact, the main bank in Hana is open for only two hours a day.) Rather, the wealth of a person is measured by their relationships as the cooperation between family and friends enables life. Therefore, the notion of family is extended. Mothers are often young (in their teens and twenties) and on average have four children. Children are viewed as the resources of the future, as opposed to obligations of time and debt. Time is present rather than future oriented, as status is often times ascribed by birth so that personal long-term achievement is often secondary to the present needs of the family. Therefore, normative identity is externally controlled. Wellness is in part defined by good interpersonal relationships, and illness can be thought of when jealousy, spite or interpersonal dysfunction occurs. The land and the ocean are not resources that can be owned or lawfully and rationally exploited. Rather, nature provides for life and is central to wellness as a spiritual consciousness flows between all things. Western medicine is coming to understand the mind-body relationship, while Native Hawaiian wellness integrates the spirit with the mind, the body, the other and nature, such that the balance of proper functioning is the evidence of wellness.

In Hana, we practice a new breed of health psychology right from the primary care setting. This close relationship between physician and psychologist enables the patient the immediate benefits of completely integrated healthcare. As an example, long-term chronic illness such as diabetes is best treated from both a medical and a behavioral perspective. The medical perspective is interested in measuring A1c blood-levels, obtaining daily blood sugar readings and adjusting insulin; while the behavioral perspective focuses on changing personal lifestyle. We try to change but one behavior at a time, often asking the patient the golden question: 'What is one thing that you could reasonably change that would benefit your health?' In basic terms, behavior that is rewarded is repeated. The patient needs to be able to measure change. They can track a single behavioral change, whereas changing lifestyle is more difficult to track and reward. Making enough single changes across time, keeps patients engaged in treatment and at some point eventually constitutes a change of lifestyle.

The benefits of treating mental illness in primary care also have exponential rewards. The referral time between physician and psychologist is eliminated. As psychologists, we are trained to think of cognitive and behavioral interventions first. Sometimes all it takes is a new perspective or a modest behavioral intervention to create a significant amount of positive change. The new breed of health psychologist is also trained in psychopharmacology. Placing a person on a medication is as much of an art as it is a science, as titration schedules often affect outcome, as does choice of medication. Health psychologists practice behavioral pharmacology, as we are keenly intuitive about observed behavioral change and the effects that a medication has upon behavior. The benefit is good and reliable feedback to the physician who can use this information to titrate doses. Another patient benefit is the integration of healthcare as the physician can readily predetermine the interactions of drugs as most Native Hawaiian people seen in Hana have very complicated treatment regimes due to multiple long-term illnesses.

When it comes to medications, behavioral pharmacology has another clear advantage especially for the patient with anxiety. As an example, many patients with panic are given a SSRI, which sometimes aggravates symptoms (increasing the frequency, intensity or duration of panic) before bringing relief. The problem then arises as a patient begins to pair panic with taking a SSRI (that is eventually going to help them). The predictable result is generally the termination of pharmacotherapy before enough time has elapsed to assess the efficacy of the medication. The unsuspecting primary care physician will often restart another SSRI along with a benzodiazepine. The usual problem with this strategy is that the patient begins to pair relief with the benzodiazepine and not the SSRI. If unchecked it can cause long-term problems with iatrogenic addiction. Rather, if a patient is kept on a strict behavioral plan that titrates a limited amount of benzodiazepines downward across the course of 10 days, the relief experience is more often behaviorally associated with the SSRI that increases in dose across time. The close behavioral regulation of pharmacotherapy again alleviates reliance on a benzodiazepine. When evaluating the cascade of cognitive and physical events that lead to a panic attack, it is clear that by the time a benzodiazepine gets into the patient's blood, the panic attack is long-gone. Therefore, it is better to develop internal cognitive and behavioral control of the antecedents of a panic episode than it is to externally rely on a pill to control behavior that could otherwise be self-controlled. The long term benefit once the SSRI is removed from treatment about a year later remains to be determined. However, by teaching self-reliance on cognitive and behavioral techniques early on, the patient should have a greater self-efficacy to deal with panic episodes should they return.

The primary care model of behavioral health integrates the knowledge of psychology and medication into a collaborative team-treatment approach that can optimally manage most mental health problems in the fast paced world of time-managed primary care. Allowances are made for many Native Hawaiians who culturally like to 'talk story.' Therefore, allowances have to be made so that sufficient time is allotted to build a trusted therapeutic alliance. This clearly means that the psychologist will not see every patient the physician sees; however, the physician also becomes less afraid of asking questions that may have emotional or behavioral underpinnings, because if the response becomes involved, the physician can immediately refer the patient to a 'colleague'. The psychologist handles the 'crisis' leaving the physician free to take care of physical disease. Aloha. [As with Morgan, John's views are personal and not those of the DoD or U.S. Army.]

A UNIQUE PERSPECTIVE: The last time that the U.S. Capitol was attacked by

enemy forces was during the War of 1812. September 11th and its aftermath has changed our lives in ways that will take years to appreciate. On a personal level, I had to pause when the *Washington Post* recently reported that: "Both the Hart Senate Office Building and the Brentwood postal station were contaminated with far greater amounts of anthrax spores than earlier estimates had shown, with some workers inhaling perhaps 3,000 times the lethal dose...." I know exactly where I was at that moment; watching an unsuspecting Capitol Hill policeman, with his hand on his gun.... Interesting times, to put it mildly.

Each year we have a DoD nurse Congressional Fellow assigned to our office. This year's assignee, Lt. Col. Doug Jackson, is a U.S. Army family nurse practitioner who had previously been assigned to Tripler Army Medical Center. Doug's thoughts: [As with his DoD colleagues, personal and not those of DoD or the U.S. Army.] "On November 27th I had the good fortune of attending a fascinating forum on emerging infections. It was presented at the National Academy of Sciences by the Institute of Medicine (IOM). Also during that week I attended the Labor, Health and Human Services, and Education Appropriations hearing on 'Funding for Bioterrorism Preparedness.' The IOM's program was titled 'Biological Threats and Terrorism: How Prepared Are We? Assessing the Science and Response Capabilities.' There were over 60 forum members and presenters who represented such institutions as medial schools, national pharmaceutical companies, the Centers for Disease Control and Prevention (CDC), WHO, scientists investigating anthrax, the list goes on and on. Besides the distinguished forum members there were 70 invited guests who came from many of the same institutions noted above, but also a significant number were staffers from Capitol Hill, which is why I attended. The workshop included presentations and discussions which explored the current understanding on threatening pathogens and current measures which are in place to identify, monitor, prevent, and respond to any out break from one of these organisms or their by-products. The Appropriations hearing witness panel included among others: the Directors of CDC and NIAID, and the President of Advanced Biosystems.

"It was agreed that as part of our country's national defense we needed to be sure our military personnel had the best protection against a chemical or biological threat, but along with our armed forces so too should our civilians receive that same level of protection. The increased concern for civilian protection stems from this new type of war being waged on America's soil where it is civilians who are targeted as much, if not more, than our military forces. As a nurse, using one of the basic tenants in nursing, I feel a preventive intervention is the best way to intervene and protect our country's populace. It is cheaper to vaccinate Americans than to treat the ill or worried well. I worked in the Senate Hart Building where the Daschle Letter was opened and had first-hand experience over a three day period of personally culturing hundreds of people from the different Capitol Hill Buildings. Of the hundreds who came to be tested and receive Cipro, so many people were (dare I use the term) obsessed with their need to have this test done and receive Cipro, although to others it almost seemed faddish. When you consider that the Daschle anthrax contaminated letter that made it to Capitol Hill delivered very little anthrax, could you imagine if there had been a more effective, wider, stealthier method of delivery? More people would have certainly died and an exponentially larger group of people would be in acute need of psychological intervention because of real or perceived threat. During the IOM forum and Appropriations hearing I head NO discussion of mental health issues that occurred or could occur in a bioterrorist attack. For anyone who has participated in mass casualty exercises, these types of patients are present and require a significant amount of your manpower and expertise.

Participants in the IOM forum noted one of the serious defects in America's capacity to deal with biological agents that could be used in a terrorist attack is our inability to adequately vaccinate our population. There are multiple reasons for this problem, but there are interventions that we as a nation can make to resolve our lack of vaccines to protect us. At present there are only four major vaccine manufactures in the world today; fortunately two of them are in the United States. Twenty years ago there were 16 manufactures of vaccines, but for economic reasons our nation's ability to produce these critical pharmaceuticals has fallen to the wayside as a result of more faddish and lucrative opportunities in science and the business world. Today in America there is only a single licensed anthrax vaccine product available from a single plant. Sadly, this solitary plant has been closed for renovations for over two years because the FDA had identified problems in the manufacturing process during an inspection of the plant. The only anthrax vaccine currently available is what was left over from before 1998. The IOM Council recommended that the Department of Health and Human Services become active and develop an authority to help companies to do in-house vaccine related research and development for vaccines that will not be able to be produced by existing public or private companies."

FINAL REFLECTIONS: As members of the Board of Directors retire, it is traditional for one last "roast." As ably expressed by Gerry Koocher—"WHEREAS, the American Psychiatric Association has expended more funds in response to Dr. DeLeon's initiatives than the American Psychological Association; and WHEREAS, his office has recently been fumigated for anthrax spores, but the Department of Defense prescribing psychologists still cannot write him a prescription for Cipro...." APA has truly been extraordinarily good to me. – Mahalo.

Lillian Comas-Diaz, Ph.D.

Selected as the APF Rosalee G. Weiss Lecturer 2002 APA Convention

The Division of Psychotherapy recognizes and honors Lillian Comas-Diaz, Ph.D. in the Division of Independent Practice selection of her for the Rosalee G. Weiss Award. The prestigious Rosalee G. Weiss Award is given through the American Psychological Foundation every year in a shared recognition by the Divisions of Independent Practice and Psychotherapy. Dr. Comas-Diaz is a member of the Division 29 Publications Board and is an active and valued member of our division. Congratulations, Lillian, for a very well deserved recognition of your contributions.

FEATURE

Dear Colleagues,

I am looking forward to an exciting and challenging year ahead as the new President of APA, and will enjoy working with— and for— you.

Below is a new essay that was just published in the SF Chronicle on 12 30, it is part of my mission to present Psychology as a vital force in our society, and to do that we must develop more effective relationships with all the media. I have just been made the psychological consultant to NBC, and hope to use that position to spread the word about all the good we are doing.

Philip G. Zimbardo, Ph. D.

S.F. Chronicle "Insight"Year-End Special Edition, Dec. 30, 2001, p. D6
(Full version of condensed published essay)

THE PSYCHOLOGY OF TERRORISM: MIND GAMES AND MIND HEALING

Philip G. Zimbardo, Ph. D.
President of the American Psychological Association

As the war in Afghanistan winds down and the relentless hunt for Osama bin Laden continues, our government is gearing up for what is promised to be a long battle against the shadowy, ubiquitous enemy of world wide Terrorism. Leaders from the corporate, scientific and technical sectors of our country are collaborating to develop strategies for combating almost every conceivable kind of terrorist attack - bio-terrorism, cyber-terrorism, nuclear-terrorism, terrorism against our reservoirs, grain stores, food delivery systems, and of course airlines, tunnels and bridges. They are working on the assumption of international enemies with sophisticated technologies and ample resources to deliver lethal attacks that would cripple our nation's functioning. Putting their big security plans into operation will cost billions of "better safe now than sorry later" taxpayers' dollars. Given the current state of national angst over the devastating attacks on the World Trade Center and Pentagon, along with the anthrax mail contamination, most Americans are ready to pay almost any price for greater security.

But what is missing in this big view of the demonic, technologically savvy Enemy bent on mass destruction? Missing is the recognition of the less obvious psychological perspective on what terrorism is all about. Terrorism is the process of inducing fear in the general population by means of acts that undercut an established sense of trust, stability and confidence in one's personal world. Unpredictable, dramatic acts of seemingly random violence are the terrorist's signature. Our fear is a realistic emotional response to events that can harm us, and we react to fear by fleeing or fighting it, or freezing in its presence. Fear becomes anxiety when it generalizes beyond the specific danger situation to become a more pervasive feeling of personal vulnerability to things that are not intrinsically dangerous, but are linked

symbolically or historically to danger. Anxiety may be triggered by current events that link to unresolved earlier conflicts, to feelings of loss of control, or to childhood states of inadequacy. The actual danger of most terrorist attacks is relatively small compared to on-going dangers in our every day lives, such as accidents, stress-induced heart attacks, obesity-induced diabetes, or disability and death from smoking. It is the irrational anxiety that terrorists are able to spread wide and deep that amplifies their impact. Kill one president, make everyone feel threatened. Torture and rape a few and make many feel insecure. Destroy a building and have citizens worry that theirs will be next. The terrorists' omnipresent weapon is exaggerated fear that spreads into action-crippling anxieties, especially when delivered repeatedly by television and print media. It is more likely that terrorists would suicide bomb some urban subways or time bomb a few rural school buses than poison our water or food supply. The key to combating terrorism is adopting their minimalist mind set of the rippling impact of singularly dramatic deeds, not using the lens of our grand vision of what major calamity we would inflict given our power — if we were terrorists.

In a profound sense, everything of terrorism is about psychology. Beyond their mind games is the way we cope with their threat. When national leaders repeatedly issue alarms for hyper-vigilance, they ignore all the psychological research about the negative effects of non-specific warnings without any action focus - only making us more paranoid and less mindfully alert. Many of the victims of the Sept. 11 attacks have turned to psychologists for counsel, therapy and aid to help with their overwhelming personal and family grief and stress, and we have continued to give them our services freely. Psychology is also at work in the remarkable transformation that has been taking place in communities throughout the United States. We have changed since our initial sense of feeling victimized as the hated enemy of unknown forces, as being vulnerable in a way Americans have never felt on our homeland. We are developing a more thoughtful, mature outlook on life, sensitive to the preciousness and fragility of all life, and aware of the need to connect more deeply to family and friends. Research shows that reinforcing one's social support network is the single most powerful act any of us can do to improve our health and longevity. There seems to a be a shift away from our preoccupation with future goals and materialistic ambitions towards a better blending of our time frames to include present joys and indulgences as well as embracing past links to our roots and spiritual values. In volunteering money, blood and services, more Americans than ever before are reaching out to help our near and distant neighbors. We have all been the beneficiaries of learning of the sacrifices of so many ordinary men and women in police, fire and emergency forces at Ground Zero, who have become the nation's new breed of hero, replacing celebrities and the idle rich and famous.

The losses of Sept. 11 still hurt and sadden us, but we are emerging as wiser, and are collectively discovering new sources of resiliency that are apparent only when our resolve and courage are put to extreme tests. We are going beyond simplistic patriotism, with its songs and slogans, to question how much of our basic freedoms we are willing to surrender for an illusion of security? We are becoming aware that there are not simple, immediate solutions for complex problems that have been in the making for decades. We can be proud of the ways in which most Americans have demonstrated tolerance for the ethnic and religious diversity that so enriches our national purpose. We can now better appreciate the depth of resiliency that has always been the hallmark of people of color and the poor in our nation, learning from them that a sense of community and

kinship helps transcend suffering and victimization.

Psychology is all about making the human connection, about understanding and contributing to enriching human nature. And it is about our enduring televised imprinted memory of September 11. Vibrant lives of thousands of people from New York City and its neighboring Global Village are now images held tenderly in the arms of our million memories. Psychology is about thinking, feeling and acting — sometimes to create a bit of hell and sometimes a bit of heaven on earth.

Mathilda B. Canter, Ph.D.

RECIPIENT OF THE

American Psychological Foundation
Gold Medal For Lifetime Achievement
In the Practice of Psychology

Matty Canter, Ph.D. is being honored this year with this most prestigious American Psychological Foundation award. The Division of Psychotherapy also wishes to honor and acknowledge Dr. Canter for the invaluable contributions she has made and continues to make to the regulation and practice of psychology. Matty's impact in the Division is noted by her Presidency (1983-84), Council Representation, author of the official *History of the Division of Psychotherapy* and her continued service in writing the by-laws. Her significant influence within the profession was acknowledged in 2000 by her selection for the APA Award for Distinguished Contributions to Applied Psychology as a Professional Practice and her leadership on the APA Ethics Committee and Revision Subcommittee for the 1992 Code of Ethics.

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RESEARCH CORNER

by Clara E. Hill, Ph.D.

I am delighted to be taking over the leadership of the Research Committee for Division 29 from Marvin Goldfried, who did a wonderful job as the first Chair of this committee. I am also delighted to introduce the committee who will be working with me: Robert Elliott from the University of Toledo, Sarah Knox of Marquette University, Jenny Lowry of Loyola College of Maryland, and Bill Stiles of Miami University.

I agreed to chair this committee because I am convinced of the need for psychotherapists and psychotherapy researchers to work together. Psychotherapy researchers very much need the cooperation of psychotherapists to participate in our studies so that we have real world examples of psychotherapy (rather than all of our research being simulations in the laboratory with introductory psychology students). Psychotherapists need research to provide evidence to the world that what we are engaged in is legitimate and also so that we can determine if what we are doing is effective.

Perhaps because my husband is a full-time psychotherapist, I have always been able to see both worlds and how we need each other. I have also been impressed over the years with the overlap between psychotherapy researchers and practitioners. Most psychotherapy researchers I know see a few clients and feel that it is crucial to keep practicing so that they know about clinical issues firsthand. And most therapists I know are good personal scientists, studying what works with each client/ patient in the therapy session (albeit not always with standardized measures and methods) and keeping abreast of the clinical literature (albeit not always the research literature).

Several years ago, there was much concern that psychotherapy research was not relevant to practice (see Elliott, 1983; Hill & Corbett, 1993; Morrow-Bradley & Elliott, 1986). I am pleased to say that the tide has changed (see Soldz & McCullough Vaillant, 1999; Talley, Strupp, & Butler, 1994). Much of our current research is clinically relevant to practitioners. For example, we have recent research on exciting therapeutic topics such as insight, managing client anger, dreams, emotions, responsiveness to clients, focus, transference and countertransference, gift-giving, and therapist self-disclosure and confrontation, to mention just a few. I think we are starting to ask and answer some of the questions about how to do therapy that practitioners are interested in. Furthermore, we have stretched ourselves to use new methods, such as descriptive and qualitative approaches, that are more amenable to investigating therapy process.

We are not doing enough, however, in terms of communicating our research results to practitioners. In this column during my term, I will continue Marv Goldfried's excellent lead of asking prominent psychotherapy researchers to write about their findings in user-friendly language so that practitioners can benefit from what we are learning.

From the other side, it is important to open a dialogue between practitioners and researchers about the important research questions. I would admit that we researchers sometimes get too removed from the realities of life in the practice world. So help us out. What topics would you like to see us pursuing more in our research? Please take a few minutes and respond to the following survey. Email your responses to me at hill@psyc.umd.edu or send it to Dr. Clara E. Hill, Department of Psychology, University of Maryland,

College Park, MD 20742. Our committee will carefully consider your suggestions and develop a list of research priorities to distribute to researchers.

1. What topics related to psychotherapy would you like to see researched?
2. What are your gripes about psychotherapy research?
3. What would you like to see changed about psychotherapy research?
4. How can we encourage more psychotherapists to participate in research projects?

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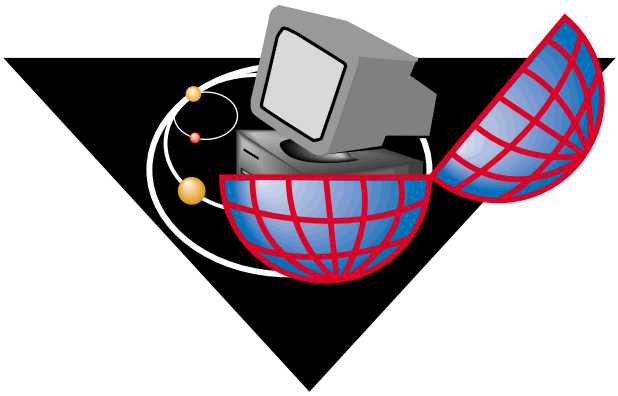

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DIVISION OF PSYCHOTHERAPY

Board and Committee Meetings /APA Convention
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John Norcross, Abe Wolf and Wade Silverman

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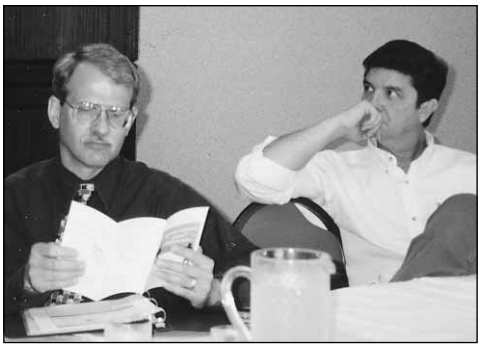

Doug Snyder and Jon Perez

Beverly Funderburk and Sheila Eyberg

James Bray and Alice Rubenstein

Linda Campbell, Matty Canter
and Ron Fox

PRACTITIONER REPORT

Terrorism and Psychology's Response

Ronald F. Levant, APA Recording Secretary

We are at war with "Islamic terrorists." But how many of us really know what that means?

It is clear that Osama bin Laden and the al-Qaeda terrorist network have been at war with us for a decade, going back to the gulf war (Bergen, 2001; Bodansky, 2001). Their intentions have become chillingly clear following the unspeakably barbaric and murderous acts that they perpetrated on us on September 11, 2001. It is also likely that this war could last quite a long time, and perhaps involve us in conflict in and with many other nations. Thus we seem to be facing a threat as serious as we faced in World War II.

The nature of this war is fundamentally psychological. This is not stated to minimize the tremendous death and destruction that has taken place, nor the fact that we are in combat in Afghanistan at the time that I am writing this. Rather, this is stated to highlight the fact that the aim of the terrorists is to create crippling fear and psychological debilitation in the populace in order to force the U.S. to get out of all Muslim lands.

The psychological impact has been very significant. We all felt and still feel to some extent the shock and grief that came in the immediate aftermath of the attacks on 9/11. We are beginning to experience the worst of the trauma responses to the attacks, which occur months after the traumatic event. In addition there are fears resulting from the escalating spate of anthrax incidents and the growing specter of biological and chemical terrorism. We also have the copycats, hoax perpetrators, and domestic terrorists, who have increased their activities (e.g, the mailing to family planning clinics of suspicious, but thankfully not anthrax infected, envelopes). In addition to these very serious threats, the daily fabric of our life is being disrupted. As some have said, the terrorists are putting sand into the gears of every day life. U.S. citizens now have to cope with increased difficulties and disruptions in air travel, postal deliveries, building evacuations, and the like. Clearly, the psychological toll of this war is likely to considerable.

The APA Board of Directors Subcommittee on Psychology's Response to Terrorism is looking at what psychologists can contribute to the efforts to address both the threat as well as the impact of terrorism, and thus be a key element of the response. I have written about the Subcommittee's plans elsewhere (Levant, 2001).

Like some readers of this column, I have recently tried to inform myself about the situation we are in, reading books on the Islamic world (Naipual, 1981), bin Laden and the al-Qaeda (Bergen, 2001; Bodansky, 2001), and the Taliban (Rashid, 2000). Although my knowledge of these matters is still quite limited (based as it is on popular books and news and magazine articles), there are some observations that are worth making, if only to put them forth as hypotheses for further investigation.

One other caveat: In this column I am writing specifically about the al-Qaeda terrorist network and other like-minded groups and individuals, which constitute a specific segment of Islamic society, a segment which I later define using the term "Islamist." My comments thus should not be taken as a reflection on Islamic culture as a whole, which I understand to quite diverse.

Some Observations About The Terrorists

Is This A Religious War?

Sullivan (2001) suggests that, despite our strategically wise protestations to the contrary, this is a religious war. It is not a war of Islam vs. Christianity and Judaism, but rather "it is a war of fundamentalism against faiths of all kinds that are at peace with freedom and modernity" (p. 45). He is referring to a particular kind of fundamentalism, one that is committed to an Islamic worldview dating back to the 7th century. The followers of Islamic fundamentalism are not unlike the "true believers" described by Eric Hoffer. For example, bin Laden stated that "Our call is the call of Islam that was revealed to Muhammed" and that this is a religious war against "unbelief and unbelievers" (Sullivan 2001, p. 45).

Religion and Politics

Islamic fundamentalism has been termed by some "radical militant Islamism" (Bodansky (2001, p. x). This term highlights the fusion of politics and religion that characterizes Islamic fundamentalism. This fusion is evident in bin Laden's goal (in addition to forcing the West out of all Islamic Countries) to topple most current Islamic regimes (particularly Saudi Arabia and Egypt, whom he considers "apostates"), and to replace them with theocracies such as existed in Iran under Ayatollah Khamanei or Afghanistan under the Taliban. This is clearly one major point of the culture clash between Islamism and the West, in that our civilization is based on the separation of church and state.

Islamism and Science

Another one major point of the culture clash between Islamism and the West concerns science. Islamism is anti-science. Iranian scholar Hoveyda argues that Islamic civilization has essentially been frozen in the 12th century as a result of the confrontation with Christianity that began with the crusades (cited in Bodansky, 2001). I am not sure how accurate or appropriate such sweeping generalizations are. However it does seem clear that contemporary Islamic fundamentalism is anti-science. Bodansky (2001, p. xi, emphasis added) noted that the Islamist subscribes to the principal that "The Koran contains all the truth required in order to guide the believer in this world and open for *him* the gates of paradise." From the Islamist perspective, the *Sharia* or Islamic law, based on the teachings of the Koran and related sacred writings, cannot be changed, only reinterpreted. Thus Islamism is a worldview in which the text of the Koran and its interpretations drive daily living and where there is no spirit of free inquiry nor of empiricism. Nobel prize winner V.S. Naipaul (1981, p. 46) in his book, *Among the Believers*, captures the essence of the Islamist worldview in his description of the course of study at the University of Qom in Iran under Khamanei's rule: "…there was Arabic itself; there was grammar in all its branches; there was logic and rhetoric; there was jurisprudence…; there was Islamic philosophy; there were the Islamic sciences—biographies, geneologies, 'correlations,' traditions about the Prophet and his close companions." This "science" curriculum clearly reflects a worldview in which knowledge can only be garnered from religious, as contrasted with empirical, study.

A Paradox

Despite the Islamist rejection of science and technology, bin Laden and the al-Qaeda make heavy use of contemporary technology such as satellite phones, laptop computers and fax machines. Atta and his collaborators learned to fly jet planes and somewhere in the world terrorists are probably hard at work making biological, chemical and nuclear weapons. In addition, many members of the leadership of al-Qaeda have received Western educations in science and technology, unlike either the uneducated Palestinian suicide bomber, or earlier terrorist groups whose members' education was in Islamic law. So what gives? Bergen

(2001), a CNN Journalist who interviewed bin Laden in a cave in Afghanistan, stated that "This grafting of entirely modern sensibilities and techniques to the most radical interpretation of holy war is the hallmark of bin Laden's network" (p. 28). While this comment describes the paradox, it does not explain it. Nor can I explain it. How do the al-Qaeda rationalize using modern technology while condemning the culture that produces it?

Islamism and Women

In the quote on the Koran above, I emphasized the word "him" to underscore the patriarchal and misogynistic character of Islamism. This is perhaps viewed in its most visible and unapologetic form in the Taliban-ruled Afghanistan, in which women were essentially banned from public life. Rashid (2000, p. 105) describes a religious edict that was issued in 1997: "'Stylish dress and decoration of women in hospitals is forbidden. Women are duty-bound to walk calmly and refrain from hitting their shoes on the ground, which makes noises,' the edict read. How the zealots could even see women's make-up or their shoes, considering that all women were now garbed in the head to toe *burkha* was mystifying."

Islamist misogyny goes way beyond the highly visible tactics of the Taliban to include the brutality of some Islamic fundamentalists in Pakistan and Kashmir "that specialize in throwing acid in the faces of unveiled women" (Ehrenreich, 2001, November 4), as well as the practice of "female circumcision" (a euphemism at best for such brutal practices as clitorectomy and infibulation) that is widespread in some parts of the Muslim world (Glazov, 2001, October 18).

Ehrenreich (2001, November 4), rejects the idea that the rampant misogyny is simply a result of the Islamist rejection of the West and modernity. She speculates that it might also have roots in globalization: "Western Industry has displaced traditional crafts—female as well as male—and large-scale multinational controlled agriculture has downgraded the independent farmer to the status of hired hand. From West Africa to Southeast Asia these trends have resulted in massive male displacement, and frequently unemployment." Hence she sees it as part of a world-wide masculinity crisis (Levant, 1997).

Islamism and Sexual Freedom

Islamists reject Western notions of sexual freedom as "sick" (Naipual, 1981). Yet there remains an interesting fascination with sexuality, as reflected perhaps most enigmatically in Mohamed Atta's spending his last night alive, before crashing a plane into the World Trade Center the next day, at a strip-joint. Why would a soon-to-be martyr, who believed that he would, upon his imminent death, become *shaheed* and immediately ascend to paradise, to be greeted there by 70 doe-eyed virgins and given non-ebriating wine, want to commit what appears on the face of it to be a huge violation of his religious principles? Was he trying to fortify his resolve to commit such a heinous act by convincing himself that the West was indeed sick? Or was he greatly ambivalent about his own sexuality, which he was required by Islamic law to suppress?

Perhaps herein lies an explanation for some aspects of the misogyny. We know from research on male batterers (Levant, 1995) that some of them form narcissistic self-object relationships (Kohout, 1971) with their victims, and explain the beatings they administered by saying that they "lost control of themselves." This explanation doesn't bear up when they are interviewed and cannot answer questions such as: Why did they stop the beating when they did? Why didn't they break bones, or send the victim to the hospital, or even kill her? Clearly there was some self-control. What these batterers really mean when they say they lost self-control is that they feared they were losing control over their victims, whom they have incorporated into their sense of self as a result of their narcissistic way of forming relationships.

Could it be that a similar process is at work in the Islamist treatment of women? That is, do Islamist men take no responsibility for the control of their sexual urges but instead impute that to women, whom they regard as great temptresses? Perhaps something like this is at work, but there is also a larger factor, which is, simply speaking, male power. This is seen in the Islamist requirement to control sexuality outside of marriage, but yet permit men to have multiple marriages.

The Islamist Reaction to the West

Immediately after the September 11 attacks on the World Trade Center and the Pentagon and the crashing of a hijacked plane in Pennsylvania, Palistinians were shown on TV dancing in the streets for joy. Commentators asked: "Why do they hate us so much". I am not sure that the question is framed correctly, for the Islamist reaction to the West is surely more complex than simple hatred. For example, Sullivan (2001, p. 47) observes: "If you take your belief from books written more than a thousand years ago, and you believe in these texts literally, then the appearance of the modern world must truly terrify. If you believe that women should be consigned to polygamous, concealed servitude, than Manhattan must appear as Gomorrah. If you believe that homosexuality is a crime punishable by death…, then a world of same sex marriages is surely Sodom. It is not a big step to argue that such centers of evil should destroyed or undermined, as bin Laden does…."

As always, I welcome your thoughts on this column. You can most easily contact me via email: Rlevant@aol.com

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Biographical Sketch

Ronald F. Levant, Ed.D., A.B.P.P., is Recording Secretary of the American Psychological Association. He was the Chair of the APA Committee for the Advancement of Professional Practice (CAPP) from 1993-95, a member of the Board of Directors of Division 29 (1991-94), a member of the APA Board of Directors (1995-97), and APA Recording Secretary (1998-2000). He is Dean, Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, FL.

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FEATURE

The Unseen Diagnosis: Substance Use Disorder

by Marilyn Freimuth, Ph.D.
The Fielding Graduate Institute

Marilyn Freimuth is on the faculty of the Fielding Graduate Institute and has a private practice in New York City where she works primarily with people in recovery from additions. She began to study this topic about 14 years ago after an addictions counselor began referring her patients in early recovery. Working with this population stimulated her interest in better understanding how to treat addictions within a private practice setting and how the addiction treatment model and psychotherapy can be integrated.

Until 12 years ago, I had never seen an addicted patient in my private practice. Not that I didn't have patients with substance use problems, I was just blind to them. This changed one afternoon when a 46 year old CEO and mother of two told me that, for most of the 18 months we had been working together, she had been taking a bottle of wine to bed with her each evening. I never thought this dynamic and successful women had a drinking problem. I began to wonder who else in my practice had an addiction that I was not seeing.

There was the 22 year old, recent college graduate, whose meteoric rise within his company indicated a bright future. In our initial sessions, he had freely referred to having an occasional "joint" on weekends but it was not until I asked more directly that he revealed that he relied on tranquilizers and alcohol to make it through any social occasion. There was also the suburban mother of three with strong depressive features who smoked marijuana most every afternoon.

Like many other psychologists I received no formal training in assessment and treatment of addictions during graduate school. This is surprising given that up to 30% of persons presenting with mental health problems have a co-occurring substance use disorder, especially those with symptoms of anxiety and depression (Evans, 1998). Among those with bipolar disorder or schizophrenia the lifetime prevalence for substance use disorders rises close to 50% (Wolford et al., 1999).

I was not alone in my failure to recognize addiction. Addictions are the most commonly missed diagnosis. Among college counselors, who one would expect to be attuned to drug and alcohol problems, half their intake reports did not mention concerns about alcohol use when the students' self-reported use was worthy of concern (Matthews, Schmid, Concalves & Bursley, 1998). While such data are not available for psychologists, primary care physicians routinely fail to recognize alcohol problems in up to 90% of their patients (J.G. Johnson et al., 1995).

I began to wonder why I had not listened to my patients for evidence of substance abuse problems. Was it simply a matter of not having been trained in the appropriate assessment techniques? Research suggests there is more to it than acquiring knowledge. In the medical field, 82% of physicians indicated that they "avoid" or are "hesitant" to raise issues about addictions with their patients. (The Recovery Institute, 1998). Even when a drinking problem was suspected, over half the physicians found it difficult to ask the patient about the problem directly (Thom and Tellez, 1986).

To further explore the source of these discomforts I have begun an interview study in which mental health professionals are asked why they do not assess for addictions on a routine basis. Preliminary findings

indicate that many are more comfortable asking for a detailed sexual history than inquiring about how much alcohol a person drinks each day. Others have said it feels out of character ("more like a social worker" as one person put it) to do a structured assessment. Several other therapists said that it seemed "impertinent" to ask a well dressed articulate person sitting in the room about his/her drinking patterns. Why is this? The interview data indicate that erroneous beliefs, misrepresentations, and uncertainties about substance use disorders hinder appropriate assessment.

STEREOTYPES

Beliefs about who has such problems is one factor hindering a psychologist from adequately assessing for addiction What does the typical drug addict or alcoholic look like? The typical drug addict is described as disoriented, unhealthy, thin, low class, male, "hippie" (Dean and Rud, 1984). Some would say that this clinical picture only describes patients who are about to enter a detoxification or rehab. center. Even then, this stereotypic picture is far from accurate in characterizing the person with addiction problems.

Who is most likely to be addicted? A diagnosis of alcohol dependence is more likely for men than women, whites than nonwhites and unmarried than married persons (Grant, 1997). Among women, drug and alcohol abuse is independent of economic status (Goldberg, 1995). Despite these demographic distinctions it is essential to remember that most alcoholics will have a job and family.

Can a physician, lawyer or financially successful person be addicted? I would easily answer this question with a yes. And yet, reflecting on my experience, I realize that a patient's high level of functioning blinded me to signs of addiction. You may begin to wonder how your own stereotypic notions affect your ability to recognize substance use disorders. Schottenfeld (1994) concluded from a review of the literature that substance abuse is most likely to be misdiagnosed or undetected when the person is employed, married, White, insured or a female. On a more personal note, one interviewee realized that "the more a patient's demographics fit my own, the harder it is for me to think that their substance use patterns are problematic."

In addition to our stereotypes about who is addicted, we hold beliefs about what an addicted person is like. It is well documented that a diagnosis of addiction is associated with negative connotations (Hanna, 1991). The stereotypic alcoholic is described as "uncontrolled, negligent, insensitive, irresponsible, self -centered..." (Forchuk, 1984, p.57). Given that we usually like the people we see in therapy, we may avoid asking questions which could reveal that a patient belongs to a group with these negative characteristics.

A more specific manifestation of how negative attributes associated with alcoholism can impede diagnosis has emerged in the data I am collecting. Two clinicians, both women who work in clinic settings where substance use assessments are mandated, expressed being uncomfortable when asking a patient how much s/he drank. Both expressed strong concern that the patient would feel insulted given that such a question implied that the person potentially had these negative attributes. In the case of male patients, they worried that if he were indeed alcoholic he would get angry, lose control and become violent in the session. These responses made me wonder how many clinicians have similar worries but remain unaware of them because they are not mandated to assess for addictions.

DENIAL

Few patients enter psychotherapy announcing that an addiction is their problem. Therefore, it is necessary to listen carefully for signs of problematic substance use or ask about it directly. Among clinicians, there is a sense that it is useless to ask a patient about his/her substance use because, as the literature emphasizes, addicts often engage in denial.

There is no doubt that some patients with a history of substance dependence are quite skilled at finding alternative explanations for their problems. Other patients have a strong motivation to hide their addiction given the negative consequences if such information were revealed (e.g., loss of a job, lack of access to a medical procedure). It is worth noting that, as psychotherapists, we may unwittingly contribute to this denial. We want to believe our patients and thus may find it difficult to challenge the carefully crafted alternative explanations that patients develop to hide their addiction. Given a lack of training, negative attitudes toward addictions and the sense that such problems are resistant to treatment, many professionals may feel that they don't want to treat addictive behaviors or that it is outside their scope of practice to do so. In such cases, therapists may be motivated to not full recognizing a patient's addiction behavior because it would would mean losing the patient who would be referred to some one better able to provide treatment. Psychologists who feel this way should be made aware of Miller and Brown's article (1997) which carefully explains why psychologists are prepared to treat substance use problems.

Since removing my blinders to "seeing" addiction, I find that denial is less common than I expected. Most patients are quite willing and often open to answering questions about the substances they use. In the process of doing a substance use assessment, the therapist along with the patient might discover that the problems that brought the patient to psychotherapy are a consequence of substance use. The adolescent whose parents bring him to therapy because of declining grades turns out to be involved with drugs. A man seeking treatment for his "midlife crisis" reflected in his apathy about his work and disinterest in his wife is fueled by an increasing use of marijuana and abuse of pain killers initially prescribed for a neck injury. As the mother and CEO mentioned above became sober, she realized how much more attuned she was to the emotional needs of those around her—especially her children but also her colleagues at work. As a result, the problems with her children, which had brought her to therapy, improved greatly.

Many patients are not in denial as classically defined. Rather they have not yet connected the problems in their lives to their drug and alcohol use. Making such connections can provide the patient with immediate benefits; research has shown that patients reduce or cease alcohol use simply by being made aware of the negative consequences (Tracy et al., 1992). Making such connections may also benefit the therapy; a frequent negative outcome of an undiagnosed addiction problem is the ultimate failure of psychotherapy itself.

Diagnostic Ambiguity

How much is too much? Is it a problem if a person takes three or four tranquilizers a week such as Xanex or Ativin that have been prescribed by their general practitioner? What distinguishes normative adolescent experimentation and a substance use problem? If one uses drugs and alcohol heavily every weekend but never uses any substances during the week, does this binge method qualify for a diagnosis? Where does one draw the line between social drinking, problem drinking, abuse and dependence? The diagnosis is more easily made for the person whose addiction has continued to the point that the economic, legal, and social consequences outlined in the DSM IV are apparent.

The ambiguity around how much is too much is especially problematic when the person being assessed is a high functioning professional. Determining whether this person has a drinking problem may raise questions about whether one's own substance use, or that of someone close, is within acceptable limits. While I don't have this information for psychologists, addiction issues are likely to hit close to home; nineteen percent of physicians and 38% of counselors indicated that someone in their immediate family was alcoholic (The Recovery Institute, 1998).

How one's family or personal history with addictive substances affects a mental health provider's ability to recognize an addiction has yet to be fully studied. In one recent interview, a psychologist acknowledged that her own father's alcoholism had clouded her clinical acumen when it came to addiction. She laughed when recalling how 25 years ago when opening her practice she had not questioned herself when telling her referral sources, "No schizophrenics and no alcoholics."

Making a diagnosis of a substance use disorder involves more than giving a label to a problem; it is telling the patient they have a problem which society at large views in a pejorative manner. Some practitioners may avoid making this diagnosis because it is associated with a sense of hopelessness; many therapists still believe that treatment for such problems is rarely effective. Making a diagnosis is further complicated by the difficulty delineating recreational use, problematic use, abuse, and dependence. This article's second installment will discuss assessment practices that can help avoid the discomforts associated with these diagnostic ambiguities and connotations.

SUMMARY

In 1997 a seminal article appeared in the *American Psychologist* calling for psychologists to treat alcohol and drug problems (Miller and Brown, 1997). To support this expansion in practice, the APA devoted its first specialty certification to the treatment of alcohol and other psychoactive substance use disorders. Still, many psychologists have been treating substance abusing and dependent patients for years—they just don't know it! What is needed now is more than a mere call to treat addictions. Psychologists need to begin to do routine assessments for substance use problems with all their patients. To accomplish this goal will require more than simple educational training. Psychologists need to be aware of the emotional and attitudinal blocks described above which get in the way of doing routine substance use assessments. Hopefully once psychologists become aware of such blocks, they will be more receptive to the benefits associated with better recognition of addiction. The enormous loss to society of undiagnosed addiction will be curbed. Lives will be saved. The suicide rate among alcoholics is 20 times the norm. The quality of family life will be improved. Child and spousal abuse will decline. Psychotherapy will benefit. An accurate diagnosis will insure that the correct problem is being treated (e.g., the presenting depressive symptoms are not psychologically driven but reflect marijuana dependence). In turn, treating the correct problem increases the likelihood that psychotherapy will be effective.

A neutral inquiry into a person's substance use patterns conveys to a patient that this is a topic you are willing and open to discuss. In some cases, the patient will be in denial and not ready to acknowledge a problem. Your interest and concern will make it more likely s/he will return to the topic when ready to deal with it. In other cases, such inquiry can bring to light the beginnings of a substance use problem, which, if gone unnoticed, could develop into abuse or dependence. As noted above, simply asking about patterns of use can decrease use.

Such substance use assessments can have an influence beyond the patient in the consulting room. Asking patients about the types and frequency with which substances are used often makes them wonder about the substance use of those around them. For any given person there is a 43% chance they have a spouse or blood relative with an addiction issue (The Recovery Institute, 1998). While the patient may not have an addiction problem, your questions may bring to light another's problem.

Doing a routine assessment for substance use problems should be part of all beginning treatments. Asking about substance use is more important than ever. Since the World Trade Center tragedy, alcohol sales are up which suggests that people are like-

ly using alcohol, as well as other substances, to self medicate the resulting anxiety and depression. The second installment of this article will discuss a number of different approaches to assessment including objective and subjective options, structured and unstructured methods.

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The author would like to communicate with those readers who do not routinely assess for addictions. If interested, please e-mail her at mfreimuth@fielding.edu.

President Message, from page 2

ations. And for many of us; because of what we do, psychotherapy, will help the wounds heal. There is nothing more to say that has not already been stated.

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EDUCATION & TRAINING CORNER

by Jeffrey A. Hayes, Ph.D.

I am honored and excited to serve Division 29 as the new chair for the Committee on Education and Training. By way of introduction, I am Associate Professor and Training Director of the doctoral program in Counseling Psychology at Penn State University. I received my Ph.D. in Counseling Psychology from the University of Maryland at College Park, where I worked with Charlie Gelso. My primary scholarly focus is in the area of countertransference, and I am also interested in the interface between psychology and spirituality. Last year I received the Jack D. Krasner Early Career Award from Division 29 and the Early Career Achievement Award from the Society for Psychotherapy Research. I maintain a part-time private psychotherapy practice in State College, Pennsylvania, where I live with my wife and three children.

As you may already know, the responsibility of the Committee on Education and Training is twofold: to monitor APA policy on education and training, and to forward to the Board of Directors proposals designed to promote and enhance training. In future issues of this column, I hope to keep you informed of APA policy issues that affect the training and education of psychotherapists, and to generate ideas that will promote psychotherapists' professional development. If you would like to serve on the Education and Training Committee or simply share your thoughts with me, I welcome your input. Please feel free to contact me at (814) 863-3799 or jxh34@psu.edu.

FEATURE

Focus on SMI: Treatment for Mental Health Court Clients

by Ronald F. Levant, Ed.D., ABPP and Lenore Walker, Ed.D., ABPP

Statement of the Problem

We have been advocating for some time that psychology become more involved in the public sector care and treatment of patients suffering from serious mental illness, such as schizophrenia, bipolar disorders and major depression.

This large and very vulnerable population receives substandard care, as we all know. Deinstitutionalization, which was conceived in the humanitarianism and the idealism of the Community Mental Health Movement, has been a stark failure overall (although there have been some success stories here and there). With the clarity of 20/20 hindsight, we can see that there was insufficient investment in community-based care and psychological rehabilitation to make it work. There was also an over-reliance on psychoactive medications, which (again in retrospect) was terribly short-sighted given the lack of adequate care systems designed to prevent relapses due to non-compliance. In the end, the de-institutionalization movement succeeded in emptying the beds of the state mental hospitals and filling the streets and jails with chronic mental patients. Indeed, a recent article in the *New York Times* described the jail as the "new mental hospital."

To give you some sense of the scope of the problem, consider these statistics. The Center of Crime, Communities, and Culture (1996) reports that 670,000 mentally ill people are admitted to U.S. jails each year, nearly eight times the number treated in public mental hospitals. The Department of Justice reports that nearly 12.5 percent of all prison inmates have serious psychiatric problems which require intermittent care, and that 7 percent have serious mental health problems (Federal Register: November 26, 1999). Other statistics indicate that 11% of the national female jail and prison population have serious mental disorders, with 70% of them demonstrating multiple problems including substance abuse and dependence, and that sixty percent (60%) are victims of abuse at some time in their lives prior to arrest.

Mental Health Courts have arisen in response to this "trans-institutionalization" process, whereby the state hospitals were replaced by jails and prisons as the repositories for folks suffering from serious mental illness. Mental Health Courts are a new concept, arising out of the therapeutic jurisprudence movement, is similar to drug courts. The idea is to divert non-violent misdemeanants who are diagnosed with a serious mental illness into treatment programs.

A recent federal resolution has called for the creation of a network of 100 Mental Health Courts across the nation based on the several successful model programs now in existence. The bill originated in the House, sponsored by Ted Strickland (D, OH), and was passed (but not funded) in the last Congressional session as S. 1865, sponsored by Senators DeWine and Domenici.

This is a very important step. However, it doesn't go far enough. Although Mental Health Courts can be effective in diverting mentally ill individuals who commit minor crimes from the criminal justice system, there is a dismal lack of resources to treat these people once they have been diverted. These folks have already been failed multiple times by state and local public mental

health care systems, and as a result have only become much harder to treat. For example, consider a person diagnosed with schizophrenia in her early 20's who is not adequately treated, goes on and off medication, exhibits unconventional behavior and refuses to follow rules, gets thrown out of housing, winds up living on the street, occasionally becomes so psychotic that she is sent to hospitals and crisis stabilization units and gets put back on medication for a short time, mostly self-medicates with alcohol and street drugs, prostitutes on occasion to gain money, gets victimized many times, and gets hits in head multiple times. Now we have a quintuply-diagnosed person: schizophrenia, substance abuse, post traumatic stress disorder, brain injury, and HIV/AIDS. How can anyone assume that the public sector care system that failed her at earlier and more treatable points in this trajectory can effectively treat her at this stage, following her diversion from jail?

We urgently need specialized treatment programs to care for these fragile and complex persons who are now the subject of therapeutic jurisprudence and are being diverted from jails by mental health courts. The South Florida Medical Corrections Options (OPTIONS) program was one such program — one that could develop models for other communities. OPTIONS focused on women, who are the most vulnerable and least well-served sector of this population. OPTIONS was funded by the Bureau of Justice Assistance. Unfortunately, funding was discontinued for FY 2001.

At a time when the nation is about to embark on the creation of a large number of mental health courts, I thought it might be useful to report our experience with the first mental health court in the country and the OPTIONS program.

The Development of the Mental Health Court

We found that the situation in Broward County was, if anything, more severe than that in the rest of the country. The Broward Sheriff's Office (BSO) indicated over 2700 of the 4600 defendants housed in the four BSO facilities were seen for psychiatric consultation and 3500 were placed on psychotropic medication during the last six months of 1999. As in the rest of the nation, recidivism of mentally ill women defendants in Broward County is a serious problem with 40% having been arrested one or more times prior to the current arrest.

In June 1997, after recommendations made by a committee of concerned professionals and citizens, including representatives from Nova Southeastern University (NSU), the Chief Judge of the Broward County Courthouse, issued an administrative order creating the first Mental Health Court in the United States. The mission was to provide access to treatment for the seriously mentally ill who were arrested for non-violent and non-drug related misdemeanor crimes. Like jails and prisons all over the United States, Ft. Lauderdale, Florida was detaining the mentally ill, sometimes because there was no other place for them.

The Mental Health Court sees approximately 150 women per year, many of whom could use the services provided in the OPTIONS program. Their crimes were those often committed by the poor and homeless—trespassing, loitering, walking with an open bottle, public intoxication, getting into an argument, shoplifting and stealing food, etc. Many were from the minority communities with few resources. Some were recent immigrants from other countries, often having been exposed to wartime trauma. They often were abandoned by their families and had no friends or social support system. Those arrested who appeared mentally ill or had a history of mental illness were offered the opportunity to be transferred into the Mental Health Court where they could voluntarily agree to follow the judge's orders into appropriate treatment. Within a short period of time it became clear that many of those

arrested and diverted into treatment had major psychological needs. The public sector care institutions in our community, like in other communities around the country, were simply unable to properly treat the seriously mentally ill, particularly when they had multiple problems that included exposure to trauma and abuse, substance abuse, neurological complications, and medical conditions. The fragmented health and social systems had abandoned many of these clients, particularly women whose mental illnesses were often hidden under their depressions.

Development of the OPTIONS Program

Recognizing the imperative need for a new kind of intervention program for women who were seriously mentally ill, the Center for Psychological Studies at NSU designed the South Florida Medical Corrections OPTIONS program. Our doctoral-level psychology students were already assisting the judge and attorneys in screening for mental illness, substance abuse, trauma responses and other diagnoses during the daily early morning appearances before the Magistrate through an assignment with the Broward Public Defenders Office and Courts. The OPTIONS program began in January 2000, funded by the Edward Byrne Memorial State and Local Law Enforcement Assistance Program, Bureau of Justice Assistance, U.S. Department of Justice. A demonstration project, it was designed to: 1. Divert mentally ill adult women from the criminal justice system; 2. Provide innovative mental health treatment designed especially for this community through careful evaluation; and arrange for medical treatment including psychopharmacological evaluation for this population; 3. Conduct research, outcome evaluation and cost benefit analysis, and 4. Disseminate program information to other communities.

The program was a success with the community from the outset. Although designed with referrals from the Mental Health Court in mind, the OPTIONS program began to be deluged with requests from a variety of others in the court and mental health community. Probation officers referred clients needing similar treatment who had other contact with the criminal justice system. Parole officers referred clients being discharged from prison. Mental health workers referred clients being discharged from the psychiatric hospitals including the "Cottages", a program designed for those within the Mental Health Court system needing immediate hospitalization. Judges inquired about referring women whose non-criminal cases were in front of them for dependency and neglect of children or even custody and access to children disputes in family court.

NSU's Center for Psychological Studies had the ability to design an innovative and integrated treatment program for a population that had been abandoned because of the difficulty in treating them. Homeless women often blend into the community, not being seen until there is a problem. While they may seek treatment at certain times, they may be unable to remain on stable medication routines without support. They may medicate themselves with alcohol and other drugs, often keeping away the pain from intrusive memories of abuse and trauma. They keep medical and mental health appointments when in crisis but are sporadic in their compliance when there are no critical problems. They live all over our community and rarely have transportation to get to the program if it is not provided for them. But, they liked the structure of our programs, were beginning to come regularly, and were empowering themselves by taking some responsibility for participating in their own health maintenance.

Results of the OPTIONS Program

We worked with 64 women in our first year of operation even though our grant called for working with only 40 women. We began testing out new intervention tech-

niques that provide comprehensive psychological, psychiatric and neuropsychological evaluation (comprehensive evaluation is critically important with a population this complex), integrated treatment including outpatient therapy, psychopharmacology, rehabilitation, and integration into the community. Our initial results are very positive. To effectively test all of our methods, we need a period of time of uninterrupted funding. The first five months the program was opened we had 38 clients ranging in age from 19 to 60 years old. Together they had 43 children although 14 women had none. Some who were still using alcohol and drugs were sent to a community detoxification center before they began the OPTIONS program. We are in the process of gathering outcome statistics on the total group. Very few of our women were rearrested after they began attending our program. Our staff helped the clients establish supportive relationships in the community. We work with the local chapter of the National Alliance for the Mentally Ill (NAMI), families of our clients, and the other agencies in our community. Staff attend court hearings with clients and help them meet the conditions they may have agreed to with the judge.

The OPTIONS program is a critically important addition to dealing with this very difficult problem. The statistics cited above remind us that the mentally ill are in jails and prisons today and will not go away without treatment. Their recidivism rate is higher than in most other groups. Many are the silent women who do not cause problems although the rate of violence in the female population in the detention centers is reportedly increasing. In any case, there is great need for model programs that can both provide direct services and train new providers in a cost effective way. One of our students did part of her internship in the Seattle, Washington Mental Health Court. We anticipate working with Hawaii to collaborate with a university and court there to develop a similar program. NSU's Center for Psychological Studies offers the advantages of a university-based program to design and develop such models. OPTIONS can serve as a model program that can be adapted by the 100 new mental health courts that were authorized by Congress this year.

As always, we welcome your thoughts on this column. You can most easily contact us via email: Rlevant@aol.com and DrLEWalker @aol.com.

This column is based on a CE program that the authors presented at the Div 42 Midwinter meeting earlier this year in Miami Beach. In the program we included a role for independent practitioners in clinical and forensic psychology in the program.

Biographical Sketches

Ronald F. Levant, Ed.D., A.B.P.P., is in his second term as Recording Secretary of the American Psychological Association. He was the Chair of the APA Committee for the Advancement of Professional Practice (CAPP) from 1993-95, a member of the Board of Directors of Division 42 (1991-94), a member at large of the APA Board of Directors (1995-97), and APA Recording Secretary (1998-2000). He is Dean, Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, FL.

Lenore E. Walker, Ed.D., A.B.P.P. is currently President of APA Division 46, Media Psychology and President-Elect of APA Division 42, Society for the Independent Practice of Psychology. She was on the APA Council of Representatives elected from APA Division 35, Society for Women in Psychology from 1984–89 and 1994–98. She served on the APA Board of Directors from 1989-1990 when she chaired the APA Committee on Child Abuse Policy. She was Chair of the APA Presidential Task Force on Violence and the Family from 1994-1996 and continues to be an advisor to the ACT program in the Public Interest Directorate. She is currently Professor and Coordinator of the Forensic Psychology Concentration in the Center for Psychological Studies at Nova Southeastern University.

CANDIDATE STATEMENTS

President Elect

Jeff Younggren, Ph.D.—

I am very pleased to have been nominated to run for President Elect of Division 29 of APA. I have a long history of involvement in professional psychology at both a state and national level. I have been both a member and chair of the Ethics Committee's of the California Psychological Association and APA and I currently sit as a member of APA's Committee on Accreditation. Coupled with these activities, I am a fellow of APA, and ABPP in Clinical Psychology and I have served as a Hearing Officer for the American Psychological Association. I have been a consultant for various licensing boards throughout the nation on standards of care for psychologists and I am currently a Public Member on the National Board for Certification of Occupational Therapy. In addition, I have contributed articles to the Division's journal and currently serve as Divison 29's member on the APA's Task Force on Managed Care and Health Policy.

While I am currently in full-time private practice, my interests in psychotherapy have also been educational in nature. I am currently an Associate Clinical Professor of Psychology at the University of California Los Angeles where I supervise residents and present various seminars. In addition, I am also a consultant to the Insurance Trust of the APA (APAIT) and I am one of two individuals who have the responsibility for presenting the Risk Management Workshops sponsored throughout the nation by APAIT. In that capacity, I recently presented a workshop at Division 29's mid-winter meeting in Phoenix, Arizona.

I have also demonstrated my leadership skills in having served 33 years as a psychologist with the U. S. Army in both an active and reserve capacity. While in the Army, I was an active supporter of prescription privileges for psychologists and I was privileged to work with psychology's first successful prescription privileges program at Walter Reed Army Medical Center. I retired from the Army with the rank of full colonel and I finished my military experiences serving as the Army Reserve's Clinical Psychology Consultant to the Surgeon General of the Army.

I see psychology as an exciting profession filled with opportunity and I have a strong fundamental respect for the practice of psychotherapy. I also am well aware of how our professional has been damaged and unfairly constrained by managed care. In spite of the negative effects of managed care, I believe that change is on the horizon and the future is bright for our profession. However, this will only happen if we stay unified and focused on bringing about necessary changes in health care policy at both a state and national level. Much has been done by our strong past leadership and we need to continue to build on that legacy. I believe I am a person who is well qualified to do so and I am most willing to serve in the leadership of our division.

President Elect

Linda F. Campbell, Ph.D. —

The Division of Psychotherapy has been my home and has been dear to my heart for a good many years now. I owe my professional involvement and development to the Division and its members and will, in fact, never be able to repay what I have learned and gained from my affiliation with all of you. I am honored and humbled to be running for your presidency and I hope that my commitment to work hard for you during that time will, in a small way, give back some of the invaluable experience I have had here.

My vision for the Division is to promote and foster exciting and important directions for us. We are the only division among the 55 divisions of APA that is dedicated to the practice, training, and research of psychotherapy and very importantly we are still the vanguards for the preservation of psychotherapy in psychology. If I were honored to become your president, the following are some of my major goals for the division:

- Under the effective leadership of recent presidents, the Division has actively promoted the support and integration of practice, training, and research in psychotherapy. This is an initiative of vital importance. We must support our practitioner members in their endeavors to broaden the scope of practice of psychotherapy. We must collaborate with our research members in their continued work in psychotherapy process/outcomes studies and to work together with our practitioners to implement their findings. We must encourage our training programs to continue anticipating the future of psychology and preparing our students for a continually changing world.
- The scope of practice, research, and training of psychology is expanding. It is vital that we insure psychotherapy as part of that expanding practice. Psychotherapy is changing faces as the profession is. There is a place for psychotherapist/psychologists not just in the traditional setting but on primary care teams, in forensic setting, in business and corporate arenas, disabilities and rehabilitation and so many more. We must make sure that psychotherapy is viewed as a central component of our profession. This includes public education for politicians, policy makers, other health care professions, and the public.
- We value our founding members, recent members, and our students members, all. We must make every effort to retain our longstanding members while also recruiting new members. We currently have a dynamic membership initiative and we must pledge resources to maintain this effort. The membership is the lifeblood of the division.
- To insure that the Division of Psychotherapy is a vital and comfortable home for all of those mentioned above is of great importance to me. I want our division to be the meeting place for those of ideas, goals, and visions for the present and future of psychotherapy.

My experience in the Division includes editor of the *Psychotherapy Bulletin*, member of the Board of Directors, Ex-officio member of the Executive Committee and the Publications Board, editorial consultant for our journal, *Psychotherapy* and member of several committees. In 2000, I was most honored to receive the Division's Distinguished Psychologist Award. I am very excited and motivated about serving the Division further and hope that you will be able to support my candidacy with your vote.

Secretary

Kal Heller, Ph.D. —

I want to begin by thanking the Division's nominating committee for considering me worthy of being a candidate for the office of Secretary. My career has largely been spent as a clinician in private practice, starting out solo in 1973 and then building a very successful group practice. The latter is based on the principles outlined in my book, "Strategic Marketing." My expertise in applying the principles of business to the practice of psychology has been the primary factor that lead me from being only a "local psychologist" to someone who began to become active on state and national levels. I began doing workshops on marketing for the Massachusetts Psychological Association, then for Divisions 42 and 29. I was appointed as Marketing Chair of Division 29 and served in that capacity from 1999–2001. Meanwhile I became Division 29's Marketing Coordinator for the highly successful Brochure Project in 1998 and continue in that role.

I am very committed to the mission of the Division and the need to continually improve the integration of research and clinical practice. But the challenge is that the research needs to relate to what clinicians actually do in their offices. I am eager to find ways to increase our membership and achieve greater involvement of students. I also want to help ensure that our work as clinicians recognizes the increased diversity of the communities that we serve and that we are adequately trained to address these issues in our work.

Secretary

Abe Wolf, Ph.D.

Abe Wolf is Associate Professor of Psychology at the Case Western Reserve University School of Medicine. He is Associate Director of Adult Outpatient Services in the Department of Psychiatry at MetroHealth Medical Center and Director of Psychology at Parma General Community Hospital. He is a Fellow of Division 29 and his service includes one term as Division Secretary, Chair of the Student Development Committee, Publication Board member, Member-at-Large, Mid-Winter Convention coordinator, Internet editor, editorial consultant to the journal Psychotherapy and Publication Coordinator for the Division 29/42 Brochure Project. He was honored with the Division's Jack Krasner Award in 1996.

The Division of Psychotherapy is my home. As one of the oldest APA practice divisions, its inclusiveness of individuals and orientations reflects the diverse history and promise of our field. The Living Legends workshops of our past Midwinter Convention honored the best of what psychotherapy has been in the 20th Century. Our publications present the best of what psychotherapy will be in the 21st Century. Our members are active in promoting the practice of psychotherapy and defending the rights of psychotherapists. I am committed to preserving Division 29's character as a holding environment of clinical wisdom, a vanguard in clinical science and an advocate for our profession. It has been a home for past generations of psychotherapists; it will continue to be a home for future generations.

My past service has familiarized me with the important issues facing our Division. I look forward to continuing this service as Secretary.

Member-at-Large

Craig N. Shealy, Ph.D.—

All 4000 of us are in this together…what do we want to do?
I am honored to be nominated for Member-at-Large, and enthusiastic about what might be accomplished for Division 29 in the context of this role. As Director of Clinical Training for an APA-Accredited doctoral program and Associate Professor of Psychology at James Madison University in Virginia, I understand what we must do to educate and train a new generation of psychotherapy practitioners, scholars, and supervisors (in fact, Division 29 is sponsoring a symposium on these very issues at APA this August…please join us if you can).

For the past 1 1/2 years, I have also served as Membership Chair for Division 29. What seems clear from my discussions with many of you, is that we must make at least two fundamental changes if Division 29 is to remain vital and compelling over the long term:

1) **we must recruit a new generation of psychotherapy practitioners, scholars, and trainers;**

2) **we must create a more relevant and reciprocal connection with current members.**

Why these two objectives, and how can they be achieved?
For a number of years, Division 29 has been losing members at the rate of about 300-400 per year (our biggest roster was over 7,000…we're at about 4,000 now). Moreover, we have not been attracting new members at a rate that can offset our losses. Exacerbating matters, aside from our two superlative publications and CE opportunities, our members consistently report that they really don't know who we are or what we do.

As Membership Chair—and with much help and support—I initiated a comprehensive student recruitment campaign in 2001. **Thus far, this initiative has attracted over 70 new student members; according to APA, we had about half that number of paid new members during the previous membership year!** Although I hope we will continue this campaign and other outreach activities, new members won't stay with us if we are not responsive to their needs. Therefore, if you select me to be Member-at-Large for Division 29, I will work hard to:

1) **help new and current members connect with and participate in the initiatives of our Division (e.g., through task forces, committees, conferences);**

2) **help the Division tap into the ideas and creative energy of its members as we determine—together—what we want to do in the months and years to come.**

Thank you for your consideration.

Patricia Hannigan-Farley, Ph.D.—

No information available

Member-at-Large

Norman Abeles, PhD, —

WHAT WE NEED TO DO: Division 29 and APA itself are in crisis! Membership is leveling off and funding shortages exist. We need to be proactive to maintain activities in our Division on a regional and national basis. I am currently chairing a task force appointed by our past President, Norine Johnson, designed to evaluate the APA convention and this will of course impact our Division also. We need to demonstrate that our Division stays relevant to our members and continues to attract new members. We need to reach out to our practitioners and our academic colleagues and demonstrate to them that our Division is productive. Our Journal, Psychotherapy receives many excellent submissions. We need to continue to present relevant continuing education so that all interested members will benefit from advances in our field! We need to especially reach out to our graduate students and APAGS members because they are the lifeblood of our Division and they are our future. I am firmly convinced that we can be successful in strengthening the Division of Psychotherapy and will do all I can on the Board of Directors to achieve these aims.

I am a past president of Division 29 and a past President of APA and currently serve on the Committee on International Relations. My research focus is on aging and there is a real need for more work in this area by both practitioners and researchers. I am pleased that interest in psychotherapy for older adults is beginning to evidence itself among our graduate students.I hope you will elect me to the Division 29 Board of Directors so I can continue to be helpful to our Division.In the meantime if you want to contact me feel free to do so at abeles@pilot.msu.edu

Jon Perez, Ph.D. —

I am honored to be nominated for Member at Large of Division 29. I have been a member of the Division since earning my Ph.D. in 1990. At that time, I co-chaired the Division's Task Force on Trauma Response and Research, which developed a model for psychological interventions in large scale disaster/traumatic events that is still in use by various organizations internationally. The Task Force was especially commended for its work during Operation Desert Storm and following the Los Angeles Civil Unrest. It is currently involved in response efforts begun after the September 11th attacks. Also, for the last two years, I have chaired the Continuing Education Committee.

My experience in the profession is wide and varied. I have practiced in settings from individual private practice to public health. For several years I have developed and directed programs for Native Americans in the US Public Health Service, and I am currently serving in that capacity as Chief of Behavioral Health Services at Phoenix Indian Medical Center. My professional interests are multicultural psychology; disaster psychology; and redefining psychotherapy as profession and practice.

As Member at Large I would be committed to advocating for psychotherapy as the primary instrument for behavioral change as well as furthering psychotherapy as a profession. Psychotherapeutic practice has changed significantly in the last decade and the Division must take the lead in supporting us and the special enterprise to which we have devoted our professional lives. As Member at Large, I could help make sure that it does.

Council Representative

Alice F. Chang, Ph.D. —

After nearly three decades in clinical practice, I have a substantive understanding of the professional and marketplace issues that effect my fellow psychotherapists. I have direct experience with the impact of profit obsessed managed so-called "care" corporations on our healthcare system and on the public we serve. As Division 29 Council Representative I will use my experience in effective advocacy for our profession, gathered through work with the Kansas and Arizona Psychological Associations and in previous service on Council and the Board of Directors, to promote APA's continued vigorous response to this encroachment on effective healthcare and the integrity of our profession.

Emerging technologies provide opportunities for service delivery unimaginable even a decade ago. We must develop institutional mechanisms to move us ahead of the curve as technology continues to expand. As psychologists adapt their skills to the emergence of telehealth services, we should closely track their experience to inform our responses to other opportunities and challenges presented by rapid advances in communication technologies. Psychologists also have a unique role in assessing and addressing the impact of the Internet — its potential for benefit and its potential for harm — on individuals and on society as a whole.

I remain firmly committed to assuring that professional psychologists attain prescription privileges and the training to incorporate that additional tool into responsible clinical practice.

APA must continue its efforts to promote the value of psychology in the public consciousness. Vigorous public education and advocacy must also continue to promote the doctorate as the necessary minimum standard of care.

Finally we must position our profession to seize the opportunities that abound in all aspects of our changing national demography. In addition to developing culturally appropriate services, we should look toward unmet needs across the lifespan, especially among children and seniors.

Council Representative

Diane J. Willis, Ph.D. —
Professor Emeritus, Department of Pediatrics, University of Oklahoma Health Sciences Center. She is a voting member of the Kiowa Tribe. Dr. Willis is past president of the Division and began the *Updates on Psychotherapy*, published by selected state psychological association newsletters. She is a past journal editor, author of over 50 articles and chapters, and editor of several books. She is the recipient of the Nicholas Hobbs Award from Division 37 and the Distinguished Professional Award from Division 12. Dr. Willis maintains a practice at a rural clinic. She and a colleague in Oklahoma were instrumental in obtaining the first reimbursement under Medicaid for psychologists, and set the precedent for later coverage nationwide.

"As a past president of the Division, I am extremely familiar with issues that concern our members. As your Council Representative, I would participate in the important policy decisions brought before Council and unwaveringly represent our membership. When opportunities arise to support prescription privileges, proposals to enhance children's mental health, or advance diversity issues within APA governance, I can be counted on to suport these issues. I am extremely concerned about managed care and governmental policies that decrease our status as practicing psychologists and will advocate for standards of practice that promote and enhance our profession. Finally, as APA hires a new CEO, change may be in the air for our organization. Thus, having an experienced person as your Council Rep will be important to assure that our membership is well represented within the governance and policies of APA. Your vote would be appreciated."

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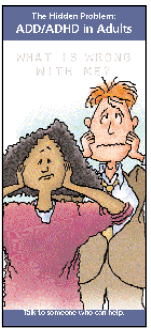

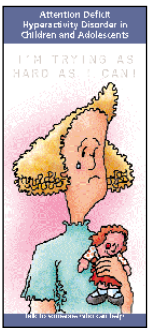

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This new quarterly, a collaboration between Wiley Publications and Division 29, will focus on a clinical topic and offer discussion by a group of experts. We are very excited about this format and are pleased that Division 29 members will have the opportunity both to subscribe AND to earn CE credits at a reduced rate.

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