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BULLETIN

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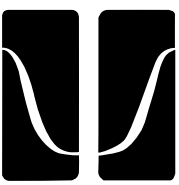

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PRESIDENT'S COLUMN

Patricia M. Bricklin, Ph.D.

I am writing this column the first week in April, 2003. I'm in Washington, D.C. at the APA building. There are signs of spring everywhere. The cherry blossoms are out. This is the season of growth and development. Relationships strengthen. In the midst of this seasonal rebirth we are at war. There is violence, hurt, and pain. There is also courage and strength and a need for healing. The need for the healing power of psychotherapy in all its forms is all around us. It is always there but the need is intensified in troubled times. We must be ready to meet such a need.

Several months ago Linda Campbell, our president elect, and I began some long conversations about the state of the field of psychotherapy in terms of research, teaching and practice in psychology. What do we know in each of these areas? What are psychologist psychotherapists excited about? Where are the innovations? What are graduate students in psychology being taught about psychotherapy? What do the changing demographics of our society tell us about the need for diverse models of psychotherapy to meet the needs of diverse populations? What are the external challenges, political, economic? Is psychotherapy practice for psychologists in danger of slipping away from us?

Our conversations increased in length and excitement. At the most recent Division 29 Board meeting we continued the conversation with others. People commented "We haven't talked this way in a long time—about the research, the teaching and practice—the content, the ideas, the future." Linda and I began to formulate what would be our joint presidential initiative. We would begin to gather data, informal and formal, about the state of the field of psychotherapy in psychology, the issues and challenges raised by our continuing conversations. We would welcome all of you into the conversations. The current and future role of psychotherapy in psychology is an ambitious endeavor but it is one in which we are already involved whether as researchers, academics or practitioners. We can proceed in this endeavor thought fully and planfully. We can discover and organize where we are and move from there.

I know the economic challenges of managed care have created a depressive, pessimistic perspective in many psychologists. This is real but I also know that when we have the conversations about substance and content people are energized.

As I watched TV, read the paper, talk to students, patients and colleagues, here and now in April, 2003, I know the world is a different place from when Linda and I started to talk. I cannot find a place in the world where we as psychologists doing psychotherapy are not sorely needed whether it is psychotherapy in health promotion, psychotherapy to cope and prevent world crisis, psychotherapy to heal and psychotherapy to live more fully. We are needed.

Despite the challenges how can we as psychologists-psychotherapists let such a valuable tool of healing and health such as psychotherapy slip through our hands? Please join us in saying, "we can't and we won't."

STUDENT COLUMN

When Are We Competent Enough to Kiss Student Status Goodbye and Embrace the Professional World?

Anna McCarthy

Anna McCarthy is currently the Graduate Student Liaison for Division 29, and a first year student in the clinical psychology Ph.D. program at the University of Houston. Prior to moving to Houston she graduated from California State University, Long Beach, with a master's degree in psychology. Additionally, she had spent nearly half a decade working in inpatient and outpatient settings with children, adolecents, and adults with a broad range of mental health problems. Anna intends to write her dissertation on the effects of maternal depression on children of depressed mothers, and to pursue a career as a clinician and researcher.

When do we stop being a student and become an employable being? When does this metamorphosis occur and what knowledge areas, skills, and values define the "competent" professional psychologist? How do we assess the presence of such competencies? What competencies are "core" to all professional psychologists? A recent conference at APPIC, entitled "Future Directions in Education and Credentialing in Professional Psychology," attempted to formulate answers to these and related questions. Chaired by Nadine Kaslow, Ph.D., ABPP, the Competencies 2002 Steering Committee assembled working groups comprised of some of the country's leading psychologists—and representing a wide spectrum of relevant constituencies—to discuss ten dimensions that were determined (via survey information) to be at the core of competency for professional psychologists. The deliberations of these ten working groups (listed in bold below)—and subsequent discussions by various training councils in our field—may well shape the future of graduate training programs and the nature of graduate student evaluations. This article is a thumbnail sketch of some of the key points to emerge from the conference (see www.appic.org for additional information).

1. **Scientific Foundations and Research** emphasized the need for a scholarly foundation to the practice of psychology, while also recognizing that science occurs within a specific socio-cultural context. I interpreted this to mean that studies based on white male college students won't suffice, and that cross-cultural differences are being taken seriously. Further, the group proposed that professional and scientific psychologists communicate with each other. This is an interesting point. It seems that academic psychologists view a career as a clinician as the poor relative of psychologists, while clinicians frown on academic psychologists for conducting research that frequently lacks clinical significance. However, the working group wisely suggested that an exchange of ideas, reciprocity, is a necessity.

2. **Ethical, Legal, Public Policy/ Advocacy, and Professional Issues** concluded that training should be formative (ongoing) rather than summative (a single ethics exam), and in vivo (in the "real world") in addition to classroom-based education. Again there was emphasis on the fact that legal/ethical issues take place within a multicultural context, thereby making it essential that professional psychologists understand their own values and biases. A final, most interesting, recommendation from this group was for students to be exposed to good modeling throughout their training programs—professors, supervisors, and advisors must practice what they preach. Although this sounds like a moot point, the reality of training programs is often far removed from such an ideal. From

false advertisement when recruiting new students to substandard patient care at internship sites, it seems that the "ideal" does not always trickle down from the textbook to the trainers.

3. **Supervision** grappled with issues regarding those who supervise students and students who are learning to supervise. The group decided that legal and ethical issues must be of the utmost concern, in addition to viewing supervision as a life-long process whose goal must be proficiency rather than mere competence. This, in turn, brings up the issue of the nature of graduate training. Many graduates go on to supervise people in some form or other, yet little focus is paid to the development of supervision skills in graduate programs. Just as many graduate programs assume their students spontaneously acquire teaching skills, so to do they assume that their students spontaneously acquire supervision skills.

4. **Psychological Assessment** proposed that students should be competent in the use of multiple methods of assessment and evaluation in a manner that is sensitive to the individuals, families and groups being tested. This requires students to have a basic understanding of psychometric principles; the flexibility to assess multiple domains of human functioning; an understanding of the importance of assessing treatment outcomes; and of the interplay between psychologists and clients, and assessments and interventions. They questioned whether students are receiving the training they need during graduate school to be viable competitors in internship and professional realms. Undoubtedly, assessment skills are important, marketable, and constitute the historical essence of psychological practice. In an age of managed care, and of justifying diagnoses, the appropriate application of reliable and valid assessment tools can only be an asset.

5. **Individual and Cultural Diversity** considered multiple issues such as the euro-centric bias in psychology, the idea that culturally salient aspects of a client can change from situation to situation, the overarching need to demonstrate necessary and sufficient self-awareness, the importance of professional psychologists recognizing their own value-laden judgments and fears when working with diverse populations, and the importance of educating oneself about specific groups of people. Being educated in an environment full of diversity is a first step to addressing many of these issues. Faculty and students with a range of backgrounds, abilities, histories, and ethnicities makes for an enriched learning experience.

6. **Intervention** emphasized the importance of keeping abreast of relevant scientific literature, the need to be familiar with innovative and empirically supported treatments, the importance of self-awareness (a consistent theme throughout the conference), and the overlap between intervention and assessment among many other areas. They proposed that treatment should stem from a theoretically solid base, and should encompass self- and client- evaluations during treatment. An interesting topic discussed was what constitutes a sound measure of competence in this arena. Is competence having the knowledge, skills and values to enable employment as a professional psychologist? Is it the amount of income and professional psychologist generates? Is it the number of clients retained over a given period of time by a professional psychologist? Although no consensus was reached, this question is certainly worthy of further thought.

7. **Consultation and Interdisciplinary Relations** agreed that good consultative and inter-professional relationships (across the practice areas in psychology, and with allied disciplines) were core components of professional competency. Indeed, there has been growing minority of psychologists who hypothesize that the future of our field entails greater

respect, appreciation, and exposure to the different practice areas in our own field as well as professionals from other disciplines—so that, for example, interdisciplinary teams of psychologists, medical doctors, psychiatrists, and social workers located in the same office space will be used to provide more integrated and holistic treatment for individuals in need. Among other recommendations, this group suggested that graduate students engage in in-vivo experiences, role-plays and "pre-practice" pertaining to consultations.

8. **Professional Development** focused on issues pertaining to professional development, broadly defined to include social judgment and critical thinking skills. The group acknowledged that there is much overlap between competencies in social judgment and cultural diversity (previously discussed by the 5th working group). The group proposed that professional development was most aptly conceptualized as a capacity to engage in certain behaviors, rather than a defined set of skills. Further, they suggested that such development is synonymous with "professional socialization" and "professional identity development"—an all-encompassing state of "thinking, doing, and being." A pertinent suggestion from the working group on ethics and legal issues is certainly applicable here: that students need to be exposed to exemplary role models throughout their training. Just as children are shaped by their parents' behaviors, so too are students shaped by their trainers' behavior.

9. **Specialties and Proficiencies** developed a wonderfully intricate "competencies cube"—a diagrammatic representation of their summations. The height of the cube depicts stages of professional development (i.e., education, internship, post-doctoral positions etc.), the width depicts "functional competencies" (i.e., the roles professional psychologists can assume), and the length depicts "foundational competencies" (i.e., the knowledge, skills, values, and attitudes professional psychologists have). As with many of the other groups, Specialties and Proficiencies also noted that these core competencies would be expected of all professional psychologists, and that "additional preparation" beyond the post-doctoral level "is required for specialty practice." In addition to other recommendations, they also indicated that the three practice areas of clinical, counseling, and school psychology should be "identified as general health service practice in psychology."

10. **Assessment of Competence** discussed the overarching issue of how to assess the attainment of overall competence in professional psychology—the aforementioned metamorphosis from being a student to an employable being. They reiterated the need for formative assessments (across the student and professional lifespan) and summative assessments (such as licensing exams). Ethical, multicultural, and professional values issues were revisited. However, the group also suggested that "personal suitability or fitness to the profession" (both inherent and taught) is an important domain to add to an assessment of competence. They also proposed that more research is needed on the assessment of professional competence in all of its multiple forms.

In conclusion, this article attempts to provide a thumbnail sketch of the many hours of discussion that took place at the Competencies Conference (go to www.appic.org for further information). It was offered as food for thought, and a tool with which to evaluate your own training. Obviously, many questions remain untouched. How do you, as a consumer, evaluate someone's level of competence? What qualities, traits or elements do you admire in professional psychologists close to you? Lastly, and most importantly, when you kiss student status goodbye and embrace the professional world what characteristics and competencies will you embody?

RESEARCH CORNER

When is a Case Study Scientific Research?

William B. Stiles
Miami University

William B. Stiles is a professor of clinical psychology at Miami University in Oxford, Ohio. He is a psychotherapy researcher and a psychotherapist. He received his Ph.D. from UCLA in 1972. He taught previously at the University of North Carolina at Chapel Hill, and he has held visiting positions at the Universities of Sheffield and Leeds in England, at Massey University in New Zealand, and at the University of Joensuu in Finland. He is the author of Describing Talk: A Taxonomy of Verbal Response Modes. *He is a past president of the Society for Psychotherapy Research, and he is currently North American Editor of Psychotherapy Research.*

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I propose this answer to the title question: When observations of the case are explicitly brought to bear on a theory. I will first try to describe briefly what I mean by *scientific research* and how case studies can fit the description. Then, as an illustration, I will describe the assimilation model, a theory of how people change in therapy (Stiles, 2001, 2002; Stiles et al., 1990), and give some examples of how case studies have been brought to bear on it.

In this article, I focus on the scientific purposes of case studies. I acknowledge, however, that case studies may be interesting or enriching independently of their contribution to scientific theory (Stiles, in press).

WHAT I MEAN BY SCIENTIFIC RESEARCH

Scientific research compares ideas with observations. In good research, the ideas are thereby changed. The observations may be said to *permeate* the ideas (Stiles, 1993, in press): Sometimes the observations simply confirm or disconfirm the ideas and make them stronger or weaker. More often, the observations lead to extensions, elaborations, modifications, or qualifications of the ideas. The ideas change to better fit the observations; in effect, aspects or qualities of the observations become part of the ideas. Science is cumulative because observations permeate ideas in this way.

Theories are ideas stated in words (or numbers or diagrams or other signs), which communicate ideas between people—between author and reader in the case of research reports. To the extent that communication is successful, the reader experiences something similar to the author's understanding. Empirical truth—the goal toward which theoretical statements strive—can be understood as a correspondence between theories and observed events. Of course, it is a nonsense to suppose that the words in a theory (e.g., print on a page, spoken sounds) literally correspond to the concrete objects or events described. However, both the words and the events are experienced by people; that is, they produce ideas and observations. Because both of these are human experiences—composed of the same stuff—they can be compared and judged as similar or different (Stiles, 1981).

Empirical truth is never general or permanent because different people experience words and events differently, depending on their biological equipment, culture, life history, and current circumstances.

Nevertheless, it is often possible to distinguish better from worse theories or decide which parts of theories need changing, based on their experienced correspondence with events. As new observations permeate at theory, the theory changes to better match the observations. For example, the theory may be explained differently, using different words or perhaps using the new observations as illustrations.

To summarize my view: Theory can be considered as the principal product of science. The work of scientists can be considered as quality control, insuring that the theories are good ones by comparing them with observations. Good theories are useful. By accurately representing the process of psychotherapy, for example, a good theory can help practitioners understand their clients and how to be effective in helping them.

TESTING THEORIES WITH CASE STUDIES

In contrast to statistical hypothesis-testing research, case studies characteristically yield results mainly in words rather than numbers, use empathy and personal understanding rather than detached observation, place observations in context rather than in isolation, focus on good examples rather than representative samples, and sometimes seek to empower participants rather than merely to observe them (Stiles, 1993, in press). I suggest that case studies, as well as statistical hypothesis-testing research, can permeate scientific theory and contribute to quality control.

In statistical hypothesis-testing research, an investigator extracts or derives one statement (or a few statements) from a theory and attempts to compare this statement with a large number of observations. If the observed events tend to match the derived statement (that is, if the scientists' experience of the observations resembles their experience of the statement), then people's confidence in the statement is substantially increased, and this, in turn, yields a small increment of confidence in the theory as a whole.

In a case study, instead of trying to assign a firm confidence level to a particular derived statement, an investigator simultaneously compares a large number of observations based on a particular individual with a correspondingly large number of theoretically-based statements. Each statement that describes some aspect of the case in theoretical terms represents a comparison of the theory with an observation. At issue is how well the theory describes the details of the case. For a variety of familiar reasons (selective sampling, low power, potential investigator biases, etc.), the increase (or decrease) in confidence in any one theoretical statement may be very small. That is, isolated descriptive statements drawn from a case study can't be confidently generalized. Nevertheless, because many statements are examined, the increase (or decrease) in confidence in the theory may be comparable to that stemming from a statistical hypothesis-testing study. A few systematically analyzed cases that match a theory in precise or unexpected detail may give people considerable confidence in the theory as a whole, even though each component assertion may remain tentative and uncertain when considered separately. I think the most convincing support for the assimilation model has been the detailed fit between the model and observations in a series of intensive case studies (e.g., Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Knobloch, Endres, Stiles, & Silberschatz, 2001; Stiles, 1999b; Stiles, Meshot, Anderson, & Sloan, 1992; Stiles et al., 1991; Varvin & Stiles, 1999).

CASE STUDY RESEARCH ON THE ASSIMILATION MODEL

At the core of the assimilation model is an observational strategy: identifying problems and tracking them across sessions, using tape recordings or transcripts (Stiles, 2001, 2002; Stiles & Angus, 2001). Drawing cases from a variety of therapeutic approaches, we have observed how expressions of a problem differ from time to time, we have inferred a process of change, and

we have developed concepts to describe this process.

According to the model, people's experience leaves traces, which can be re-activated by events that have related meanings. That is, thoughts, feelings, and actions, tend to re-emerge in related circumstances, and they then be come linked to the traces of the new experiences. As a result, traces of related experiences occurring at different times tend to form interlinked constellations, providing the experiences are unproblematic. We call the traces of experience *voices* to emphasize that they are active agents, which can act and speak (Honos-Webb & Stiles, 1999; Stiles, 1997, 1999a, 2002). The process of interlinking is called *assimilation*. Assimilated voices serve as a repertoire of resources, drawn upon to deal with life's demands. For example, cooking skills (traces of previous cooking experiences) tend to emerge, appropriately, in the kitchen.

Some experiences are problematic, however, for example, traumatic events or destructive important relationships. The problematic traces, or voices, are not smoothly integrated, but are treated as unwelcome or foreign. Triggering them is signaled by negative emotion. Psychotherapy, according to the assimilation model, is a process of turning such problematic experiences into resources. For example, in one case (Debbie; Stiles, 1999b), an angry, rejecting voice that was responsible for violent verbal and physical outbursts was assimilated and gradually transformed into a capacity for appropriate assertiveness.

On their way to becoming resources in successful therapy, problematic experiences appear to pass through a sequence of stages or levels of assimilation, described in the Assimilation of Problematic Experiences Scale (APES). As shown in Table 1, the APES includes 8 levels numbered 0 through 7. Applied to passages from therapy, each APES rating characterizes the degree of assimilation of particular problematic content. The names of the levels describe the state of the problematic voice (traces of a problematic experience) from the viewpoint of the community. In case studies, the APES has typically been used not by independent raters but by investigators who have used APES ratings to precisely convey their context-informed assessment of each problem's degree of assimilation. Using *assimilation analysis* (Stiles & Angus, 2001; Stiles & Osatuke, 2000), investigators become familiar with a case, identify a problematic voice, excerpt passages representing that voice, and then use the APES to help describe whether and how it was assimilated. The APES is a summary of our current understanding of the sequential process of assimilation, and the scale continues to evolve.

Although there have been some statistical hypothesis-testing studies addressing the assimilation model (see Stiles, 2002, for a review), the model has grown mainly from the case studies (e.g., Honos-Webb et al., 1998; Knobloch et al., 2001; Stiles, 1999b; Stiles et al., 1990, 1991, 1992; Varvin & Stiles, 1999). The gradual development of the APES illustrates how the case observations have permeated the model, refining, elaborating, and clarifying it:

The development of the APES began with a list of immediate therapeutic impacts (Stiles et al., 1991), which were derived from clients' open-ended descriptions of helpful and unhelpful events within therapy sessions (Elliott, 1985; Elliott et al., 1985). Based on our initial case observations, we listed the impacts in sequence to reflect our understanding of the assimilation process, and we modified and expanded the impact descriptions to construct the anchored eight-point scale. As an example of modification and expansion, although the original "personal insight" impact category was characterized as a "task impact" (Elliott et al., 1985, p. 622), we observed that therapeutic insight events were accompanied by intense but mixed (posi-

tive and negative) emotion in the first cases we studied (Elliott et al., 1994; Stiles et al., 1990). Consequently, we included affective features in our characterization of APES level 4, understanding/insight (see Table 1). As another example, although APES level 2 was originally called simply "vague awareness" (Stiles et al., 1991, p. 199), even early case studies showed a quality of emergence at this level (e.g., describing the case of Joan at APES level 2: "the intense psychological pain signaled the emergence of the unwanted thoughts"; Stiles, 1991, p. 202). As this pattern was repeated across cases, the term *emergence* was eventually added to the name and description of level 2 (see Table 1).

If a case fits the theory in a great many respects but fails to fit it in a small and specific way, this can point to something in the theory that needs changing, as in the following example: In the earlier versions of the APES (e.g., Honos-Webb et al., 1998; Stiles et al., 1991, 1992), which were based mainly on studies of depressed but otherwise well-functioning clients, the APES level 0 was called simply *warded off*. More recently, in considering cases with borderline features, we observed material that was clearly problematic and unassimilated but not warded off. On the contrary, these unassimilated voices emerged all too forcefully in state switches, in effect, taking over the person. Despite this discrepancy, there were many aspects of these cases that fit the model's account well. For example, the opposing states were at first mutually inaccessible, encounters between them tended to be emotionally painful, and in successful therapy, they seemed to go through the sequence described in Table 1. Thus, the observations did not justify abandoning the theory, but instead led to some alterations (e.g., Osatuke & Stiles, in preparation, Stiles, 2002), such as the addition of the term "dissociated" in the label of APES level 0 and rewriting of the level 0 description (Table 1). This reformulation also offered an improved fit with dissociated traumatic experiences, which, when triggered, may emerge in flashback phenomena, such as film-like reliving of the trauma (Varvin & Stiles, 1999). Thus, the alteration based on new case observations strengthened the model.

SOME IMPLICATIONS

In summary, I suggest that case studies offer an alternative that can complement hypothesis-testing research. By simultaneously bringing many observations to bear on a theory, case studies offer both a way to test and an opportunity to improve the theory. I acknowledge that other people may mean something by *scientific research* besides comparing ideas with observations. My meaning implies that, for example, Freud's case studies, such as Dora (Freud, 1905/1953) and Schreiber (Freud, 1911/1958) qualify as scientific research. In my view, Freud's case studies permeated psychoanalytic theory (that is, the theory was altered by them), and the detailed fit between the theory and the cases helped increase confidence in the theory. In the same way, our assimilation case studies have both changed the assimilation model and built our confidence in it.

An implication of my argument is that case study authors can make their research scientific by articulating their case's detailed relation to an explicit theory. In principle, this could be a new theory, developed from the case at hand, as long ago suggested in the grounded theory approach (Glaser & Strauss, 1967). Arguably, psychoanalysis and many other theories of therapy began as accounts of cases. Constructing a new theory for each case, however, forgoes the benefits of cumulative improvements, and fewer readers may be interested in a theory developed for one-time use.

Of course, neither Dora, nor Schreiber, nor the assimilation case studies, nor any single piece of scientific research—case study or otherwise—can overcome all the ambiguities and doubts in a theory. Like other theories, the assimilation model is far from a precise or complete account; I hope and

expect it will continue to be permeated by observations on new cases. All good scientific theories, I believe, remain open-ended, stimulating new research while they accumulate, summarize, and convey previous observations.

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Table 1
Assimilation of Problematic Experiences Scale (APES)

0. Warded off/dissociated. Client is unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms, acting out, or state switches.

1. Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.

2. Vague awareness/emergence. Client is aware of a problematic experience but cannot formulate the problem clearly. Problematic voice emerges into sustained awareness. Affect includes intense psychological pain—fear, sadness, anger, disgust—associated with the problematic experience.

3. Problem statement/clarification. Content includes a clear statement of a problem—something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.

4. Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.

5. Application/working through. The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. Resourcefulness/problem solution. The formerly problematic experience is a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

Note. Assimilation is considered as a continuum, and intermediate levels are allowed, for example, 2.5 represents a level of assimilation half way between vague awareness/emergence (2.0) and problem statement/clarification (3.0).

FEATURE

The Added Value of RxP Training

John L. Caccavale, Ph.D., M.S. Clinical Psychopharmacology

John Caccavale, Ph.D. is a licensed, clinical neuropsychologist practicing in Downey, CA in an injury practice and is the managing partner at The California Occupational Injury Center. His doctoral degree is from the University of Southern California and he has since completed an M.S. in clinical psychopharmacology from Alliant University. His current projects include writing in the area of adverse drug events and psychotropic medications and recently published in the Journal of Clinical Psychology *on prescriptive authority.*

The true added value of psychopharmacology training (RxP) may be difficult to ascertain at this time because training is relatively new and the number of psychologists who have completed level II training are relatively few. Perhaps, four to five hundred, at best. Nevertheless, the experiences of individual psychologists can provide a sort of template showing trends that no doubt will be shared among those who will complete RxP training and integrate psychopharmacology into their practices. From personal experience and those of psychologists similarly trained, I have concluded that RxP training can be the single most factor to benefit both practitioners, patients and psychology. I have delineated several key areas where I personally have experienced the added value of RxP training: Increased Patient Safety; Enhanced Patient Services; Professional Growth & Recognition; Enhanced Practice Revenues; and Reduced Treatment Costs. There are other factors beyond these that can also be attributed to RxP training, such as the impact of training on mental health policy. However, I'll leave that for another time.

INCREASED PATIENT SAFETY

I am a partner in an injury practice and I integrated psychopharmacology into my practice in 1995. All of my psychology partners are trained in psychopharmacology. The physicians and other medical specialties that we deal with generally have no further training in psychopharmacology beyond medical school and residency. Typically, the patients I see have at least three other specialties providing treatment. Many times there may be in excess of seven providers. Invariably, all these specialties prescribe one or more medications and rarely know what the others have prescribed. Generally, my patients have no idea of even why they were prescribed any one medication let alone several. Because of my RxP training and because I am the one specialty who actually sees the patient on a regular basis, I am in the unique position of being able to evaluate the drug-drug interactions and the medication errors of the many medications being prescribed for an individual patient. It is the norm that I find potential and real harmful side effects due to interactions. Medication errors are frequent. I am able to communicate this information to the patients and to the other specialties. I am able to recommend which medications should be discontinued or changed. The majority of times physicians ask me to monitor and manage the medication regimen. Without RxP training both my patients and myself would be at a terrible disadvantage. RxP training has helped me to become a far better practitioner. I am sure that this experience extends to many others who have completed psychopharmacology training.

ENHANCED PATIENT SERVICES

Because I now integrate psychopharmacology factors into my evaluations, I am able to provide a needed and valuable service to my patients. My evaluations are more complete. I provide every patient who is taking a medication with a simple state-

ment showing the interactions and side effects of their medication regimen. I have found that few patients read or understand the literature given to them by pharmacists. I am a fluent Spanish speaker and over 85% of my patients are Spanish speaking, I provide them with important health information that they have difficulty getting elsewhere. I can say that many of these patients are prescribed medications without the benefit of anyone being able to communicate with them. I have seen janitors "translating" for physicians. In the world of English speaking practitioners anyone who can read a menu can be a translator. While all patients benefit from psychopharmacology training, under served populations greatly benefit from having a psychologist trained in psychopharmacology. There are many other examples that I can cite with respect to increased patient services but for now these should suffice.

PROFESSIONAL GROWTH & RECOGNITION

Anytime a professional can obtain an added proficiency, professional growth is enhanced. However, with RxP training there is the added value of being recognized by both peers and other specialties, particularly physicians. Medications is the currency of communication with the medical profession. When a non-physician can communicate using this currency the artificial line separating the two becomes much smaller. In some cases it even disappears. On a daily basis, I am called upon by physicians to evaluate and recommend psychotropic medications. After a contact, I always follow up with a simple report, many times only one page, showing the particulars of the medication discussed.

I have been requested by physicians to recommend medications to their family members. Clearly, these physicians have access to psychiatrists but my experience is that non-psychiatric physicians prefer to speak and deal with a psychologist trained in psychopharmacology. This is the type of recognition that we will need to realize our national RxP goal. Besides the recognition obtained from medical practitioners, psychologists trained in psychopharmacology can expect being consulted by other colleagues and new referrals from existing patients. This is particularly true in areas lacking a diversity of other specialties. RxP training has also given me the opportunity to speak and write on subjects from a different perspective. All of these have contributed to both my personal and professional growth. My discussions with other RxP trained psychologists indicates that all have enjoyed what I am experiencing.

ENHANCED PRACTICE REVENUES

From an economic perspective, I have long ago recovered my investment in RxP training. I calculate that my RxP training accounts for an additional 35% of my overall revenues on a yearly basis. I base this on increased referrals, additional charges for medication recommendations, increased fees for my forensic evaluations, increased visits for patients on medications, and the development of novel services, e.g., performing medication case reviews for insurance companies of patients that they suspect are not getting the right medications. With RxP training one can expect seeing increased revenues from the above sources as well as any number of other areas depending upon geographical location, type of practice and other training. However, no matter how one looks at the issue, RxP training will allow one to recoup their investment. I know that there are some critics who believe that this is the main thrust for prescriptive authority. The fact that we can recoup our investment is great. There should be no shame in earning a good honest living. The fact that RxP also pays is just another added value.

REDUCED TREATMENT COSTS

Overall treatment costs, whether paid by an insurance carrier, employer or individual, can be significantly reduced when a psychologists is trained in psychopharmacology. RxP training greatly reduces over-

all office visits to physicians because the patient gets diagnosed appropriately and quicker. They get an appropriate recommendation for medications, when necessary. Many studies have already demonstrated that it can take a significant amount of time for general practitioners to correctly diagnose and subsequently appropriately treat patients with depression and anxiety. The costs associated with this no doubt are significant.

If one were to factor all the costs, including the impact on the national economy from absenteeism and other down time, we could probably fund and extend full health insurance coverage to the uncovered from these savings. RxP training has the potential to significantly reduce the costs associated with bad diagnoses and adverse drug events associated with medication errors, which is estimated by the FDA to be in the range of 72 billion to 120 billion dollars annually. RxP training can significantly reduce costs associated with symptoms resulting from side effects from polypharmacy and inappropriate medication regimens.

RxP training can significantly reduce overall costs for mental health because those so trained know when medications are appropriate. For the year ending 2001, the combined costs for all medications in the United States exceeded 132 billion dollars. RxP trained psychologists can significantly reduce this expenditure because experience shows that we tend to recommend reducing or discontinuing overall use of psychotropic medications. In practice, this can also equate to better efficiency and effectiveness. Its a "win-win" situation.

In conclusion, from whatever perspective one looks at the issue, RxP training presents a lot of added value to any psychologist choosing to make the relatively small sacrifice associated with training. The gains to patients, practitioners, psychology, and society as a whole, can be significant. Although I have addressed only a few of the issues associated with the value of RxP training, I am sure that many more will surface as we proceed to enter into an area that is the proper domain of psychology. The public interest is served with RxP and I strongly recommend and advocate to all psychologists that they take the time to investigate the many programs now available to become trained and gain a proficiency in an area vital to our patients and profession

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APA COUNCIL REPORT

Report on APA Council Meeting of February 14–15, 2003

By John C. Norcross, Ph.D.
Council Representative Division 29

The APA Council of Representatives met on February 14 and 15, 2003 in Washington, DC. Dr. Alice Chang, Dr. Jack Wiggins, and myself — the Division 29 team — represented the Division of Psychotherapy.

The original plan called for a 20-hour packed agenda across three days; however, a raging snowstorm reduced it to 16 hours across two days. We managed to escape the ravages of the weather on Saturday afternoon, but many of our colleagues were not as fortunate. They were stranded in the District of Columbia for two additional days due to airport closings.

Here are 10 highlights of Council's agenda and actions:

- Heard President Bob Strernberg review his 2003 initiatives, principally his central priority of fostering unity within psychology.
- Applauded Dr. Norm Anderson's approach to his new position as APA CEO.
- Reaffirmed APA's commitment to the designation of health-service psychologists as primary health care providers in relevant regulations and in funding programs.
- Approved the final 2003 APA budget containing a modest surplus, after several years of serious deficits.
- Devoted several hours of discussion to APA's financial situation and to the recognition that the reduced number of APA staff will not be able to accomplish as much as in prior years.
- Approved the recognition of Sport Psychology as a proficiency and the Assessment & Treatment of Serious Mental Illness as a proficiency in professional psychology.
- Honored psychologist Dr. Daniel Kahneman for his recent receipt of the Nobel prize in economics.
- Approved the impressive refinancing of APA's two Washington, DC buildings at lower mortgage rates.
- Held extended discussions in Council and in the breakout groups on the continued plans for a shorter APA convention and cluster programming.
- Discussed plans for the 2004 APA convention to be held in Hawaii. Now is the time to prepare for this exciting opportunity in July 2004!

As always, please contact Alice, Jack, or myself directly (norcross@scranton.edu) if you would like to speak about the actions and directions of the APA Council of Representatives.

DIVISION 29 SOCIAL HOUR

John Norcross and Don Freedheim

Larry Beer and Bob Resnick

Matty Canter and Harry Wexler

Jim Calhoun, Marv Goldfried, Georgia Calhoun, John Dagley, Clara Hill, Andy Horne, Linda Campbell, Louis Castonguay, and Charles Gelso

PRACTITIONER REPORT

The Problem of Licensure Mobility

Ronald F. Levant, Ed.D., ABPP
Nova Southeastern University
APA Recording Secretary

Ronald F. Levant, Ed.D., A.B.P.P., is a candidate for APA President. He 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 29 (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.

Psychologists seeking to obtain a license in another state, whether for purpose of relocation, for a multi-state practice, or for engaging in tele-health, might find themselves facing a real nightmare. The Board of Psychology in the new state might ask the psychologist to jump over many hurdles, such as producing notarized supervision forms, when some of the supervisors have retired or passed on. As former APA President Pat DeLeon (2000) has observed, "few psychologists realize how difficult it is to get relicensed in a new state."

The problem arises because each state determines the qualifications for professional licensure. By 1977, all states had enacted a psychology licensure law, however with a great deal of variation in the requirements. The APA Practice Directorate, using the APA Model Licensure law, has attempted to reduce some of this variation in order to promote mobility. However, many variations remain.

Other professions have addressed this problem. The National Council of State Boards of Nursing has endorsed a model based on the driver's license, in which mechanisms exist for mutual recognition and reciprocity. Licensure is recognized across state lines, with the nurse subject to the laws and rules of the new state. So too, the pharmacists facilitate mobility through uniform licensure requirements and a clearinghouse program which transfers the pharmacists license to the new state, verifying background information and screening for disciplinary actions.

APA has been attempting to address this problem. The APA Council of Representatives at the February 2001 meeting gave formal approval to an ongoing strategic plan developed by the Committee for the Advancement of Professional Practice (CAPP) for helping to provide a climate within which existing mechanisms for professional mobility can continue to develop.

CAPP, at Council's request, had been implementing a strategic plan to provide a supportive environment for giving visibility to the existing mechanisms for professional mobility available through the National Register of Health Service Providers in Psychology (National Register), the Association of State and Provincial Psychology Boards (ASPPB), and the American Board of Professional Psychology (ABPP). CAPP conducted programs at the annual State Leadership Conference, disseminated invited articles to state and provisional psychological association newsletters, and took other strategic actions. In February, Council approved the continuation of this plan, and as a result, additional articles on the status of the various mobility mechanisms have

been, and will continue to be published, as appropriate, in APA and Practice Directorate publications (e.g., Smith, 2001, Sullivan, 2000-01), additional conference programs will be arranged, and meetings among parties of interest will be facilitated. In addition, the author and Jay Benedict, Associate Editors of the journal, *Professional Psychology: Research and Practice,* are preparing a special section on this issue.

BACKGROUND

The information in this section of the column has been drawn from various APA governance documents. In February 2000 Council suspended its rules and approved a new business item, titled "Reciprocity of Licensure Among States", introduced by Dr's. Carol Goodheart, Ron Levant, and 20 other Council Representatives. This item affirmed that the attainment of reciprocity of licensure and other mechanisms for professional mobility are urgently needed. It directed CAPP, as the lead group, and BPA to work in collaboration with ASPPB to develop a plan to achieve this goal.

In March, 2000, CAPP and the Practice Directorate made time available before the start of the State Leadership Conference for representatives of state psychology licensing boards and state psychological associations to meet to discuss mobility, in a forum coordinated by ASPPB. This was the second consecutive year for this particular forum.

At its meeting later in March, 2000, CAPP discussed the Council item and decided to convene a conference call among representatives of CAPP, BPA, and ASPPB to determine what would be most helpful in promoting mobility. This call took place in June, 2000. It highlighted several relevant issues, including the type of support that APA could provide, the potential implications of technology changes and tele-health for licensure, and the recognition that other organizations have also developed initiatives to facilitate licensure for psychologists moving to different states. Of considerable importance, the participants on the call noted that there are two different mechanisms for promoting professional mobility: **Reciprocity**, which refers to agreements between jurisdictions in which states are willing to recognize each other's licensees based on comparable requirements for licensure, and **Endorsement**, which is a vehicle to recognize individuals as having met a high standard qualification, such as the Certificate of Professional Qualification (CPQ) developed by ASPPB which is accepted by jurisdictions as meeting most of the qualifications for licensure. In the past 10 years only 10 states have entered into reciprocity agreements. This makes endorsement the more promising mechanism for promoting mobility since more than two dozen states are in various stages of recognizing the more recently developed CPQ.

In July, 2000, CAPP continued discussion of this issue with representatives of ASPPB and the National Register. CAPP noted that decisions about licensure reciprocity and mobility are not the province of APA but rather of state and provincial psychology boards. CAPP also noted that BPA has a work group examining tele-health issues, and that these issues are clearly relevant to any consideration of reciprocity and mobility. CAPP felt that it could take two additional actions supportive of reciprocity and mobility at the present time: 1) provide a climate and create an environment in which existing mechanisms for mobility can flourish, by informing members about the various mechanisms for mobility offered by ASPPB, the National Register, and the American Board of Professional Psychology (ABPP); 2) inform Council of the distinctions between reciprocity and endorsement, and the status of the latter as being the mobility mechanism more widely accepted by states and provinces.

As part of providing a climate to support existing mechanisms for mobility, CAPP offered to compile and disseminate to state and provincial psychological associations

(SPPAs) invited articles written by ABPP, ASPPB, and the National Register about the various mechanisms and initiatives each has developed to promote licensure reciprocity and mobility. Each of the organizations was contacted and agreed to prepare a brief article suitable for publication in SPPA newsletters. These 3 articles were circulated in September, 2000, and have been reprinted in various SPPA newsletters.

In October, 2000, CAPP reviewed the progress made in publicizing the various mechanisms for promoting mobility and the increasing acceptance which these mechanisms are receiving, and decided that a continuation of the current strategy would be recommended to the Board and Council. In December, 2000, the Board of Directors approved the strategic plan prepared by CAPP.

MECHANISMS TO MOBILITY: IMPLICATIONS FOR PRACTITIONERS

At this point in time it seems clear that the need for mobility for psychologists will continue to increase. However, since we really don't know how events will unfold in the future, all of the vehicles for increasing psychologists' mobility should be supported. We need all of our "oars in the water," so to speak. Readers are encouraged to contact the sponsoring organizations to learn more about each of the mobility mechanisms: the National Register, the ASPPB , and ABPP.

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

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FEATURE

In Conversation With Dr. Al Mahrer:
Innovations in psychotherapy - having your own therapeutic session

Howard Gontovnick, Ph.D.

If I were to ask you, what is it you do on a regular or irregular basis to become the person you can become? In other words, what is it you do to helps you grow or develop as a person? Is there some particular thing or activity that aids you in what some might call—personal transformation? Then again, maybe this question has little meaning to you since you do not practice or engage in any transformational activity? Whatever your reply, I invite you to read this interview and consider the possibilities of a new development in understanding and enhancing personal self-transformation. Whether you are somewhat interested or genuinely curious, I hope you at least take a moment to consider these ideas herein as just another possibility how one can engage in a kind of self-transformation.

As you will learn from this interview, Dr. Alvin Mahrer is confident that each one of us can learn a great deal about who and what we can be, by having our own therapeutic session. The method described below is based on years of his extensive work in experiential psychotherapy cumulating in his current work *Becoming The Person You Can Become: The Complete Guide To Self Transformation* (Bull Publishing, 2001). For Alvin Mahrer, this way of having an experiential session is just another option for personal transformation. His encouraging confidence simply invites others to discover what he himself has found helpful.

Alvin R. Mahrer is a Professor Emeritus of the School of Psychology, at University of Ottawa. He is the author or 12 books and more than 200 publications. Recently he has been acknowledged as one of the "Living Legends in Psychotherapy" and recipient of the American Psychological Association Division of Psychotherapy's Distinguished Psychologist Award. Dr. Mahrer is "internationally renowned either as a visionary or as psychotherapy's Don Quixote." His endeavors in personality theory, psychotherapeutic training, experiential psychotherapy and more recent sessions of self-transformation are always thought provoking and innovative.

(**HG** = Howard Gontovnick
AM = Dr. Alvin Mahrer)

HG: Dr. Mahrer, for the past few years you have been working with a four step method to help a person have their own session during which they could discover what they have the capability of becoming? This being the case, what was your thinking behind this idea of having one's own therapy session alone? And could you describe what is involved in order for one to do this?
AM: Let me see, I have a session by myself for two reasons. First, I think it is possible for me to become much more the kind of person I'm capable of becoming. In this way, I would like to be a qualitatively new person. Does this make sense to you?
HG: So far, so good.
AM: I want to have my own session and by the end of that time I hope I can become a lot more of this kind of person —whatever it is—that I am capable of becoming. That means I am willing to become a whole new person if that what happens. That's one thing. The other is, there are all sorts of times when I feel rotten, I mean really rot-

ten, scared, depressed or something. I have lots of ways I can feel terrible. And when I am done with a session, what I want to do is to be free of those times when I feel so rotten. If those scenes or if those times are still in my life, like crossing a street or driving a car or something, I do not want to have such rotten feelings in those scenes. So those are the two things I want to accomplish in every single session.

HG: Here is what I understand so far. I can picture you teaching a group of people just how to discover a deeper quality about themselves. An important consideration and question you ask these people is—are they ready and willing to really do this? Would they like to become a whole new person? It also seems clear, that by having this kind of session, a person can learn how to eliminate an awful feeling that has been associated with a particular past scene? How is this done?

AM: In each session or a time when you would set aside to do this, one of the first things that you can do is to close your eyes, sit back and look deep down inside yourself and find qualities, things about or things that are possible for you to experience. Things you weren't even aware of and that's the first maybe scary thing you discover something about yourself. Here is an example from a session that I've just had by myself a couple weeks ago. At that time, I came across a sense, a quality, possibility in me of being really alone by myself, away from people, totally isolated. This was one thing that scared me and was sort of new. And that's the first thing you do in a session. You discover something that you probably did not know about, a feeling that is new and different. Something you are able to undergo, to experience. It is akin to an opportunity to be different.

HG: As I think about what you have just said, a question comes to mind that I am sure is often asked. What about the scenario when there is a person who is inexperienced or unprepared to discover something about them self? Is there a sense of hesitancy or scariness to change such a situation?

AM: Your question is one that I have often here when I speak in public or every now and then it pops up at the workshops I give in other different countries. They often say, "that's scary right?" And all I can do is say look; if the whole idea of probing down within yourself and discovering something that you don't know is deep inside you is scary, then maybe you shouldn't do it. You don't have to do it. If it's scary to you stay away from it. I'm not forcing people to do this, but rather it's like as an opportunity. If you are interested in discovering more about your self and your own abilities, then this may be something for you.

HG: Very simply, what you are talking about is an opportunity for a person to learn how to help them self and that's all. This being the case, let's talk more specifically on the method. How does one actually go about doing this?

AM: The best place to start learning about having your own session is to read my new book: *Becoming The Person You Can Become—The Complete Guide to Self Transformation* (Bull Publishing, 2001). In the first step, you will use scenes of strong feelings to discover something deeper inside you, like the quality I discovered in my session of being really alone. It was something like being separated or apart from everyone. Being all by your self. This is something that I discovered a couple of weeks ago in me. That was the first step. In the second step, after discovering this new quality you try to welcome this new feeling by putting your arms around this quality and saying; "my God, you're not so bad"—"I like this new quality." It is a big step to at least admit that there is something like that is deeper inside you. You probably spent your whole life hiding it, or not knowing anything about it. Well now you have a chance to say, "hello, I know you, you're pretty nice, I like you." This then becomes an opportunity for you to kind of accept this new quality you discovered. Now, does that make any sense?

HG: Yes, in the first two steps you discover a new and deeper quality about one self, followed by a time to get to know what it is like to be this way. To welcome this new aspect as a real part of who one is and the possibility of what can be. So let's go on to the third next step.

AM: OK, in the next step the person having a session is going to have do something really big. Here is where you have to let go of who you are, while you get ready to playfully wallow in or throw yourself into becoming what you had previously discovered deeper inside you. And you do that in the context of past scenes of situations that may have happened yesterday, last week, or even two years ago or earlier in your life.

HG: In other words, you are looking for some past time when you might have been like this or maybe a little like this newly discovered quality. Is that what your saying?

AM: Yes, your right. You have to essentially let go of the kind of person you are and drench yourself, wallow, play being, this whole other person that you discovered earlier. That's the third step. Ok?

HG: Yes. Now I guess everything comes together in the fourth and final step?

AM: That's right. The forth step is the last one. Now at this point you're being a whole new person and your ready to essentially face the world outside the room that you are in. In this step you can live in specially created moments when you see what it is like to actually be this way in situations more in line with your actual world. In this step, you have an opportunity to pretend and experience what it is like being this whole new person in a real world. Whether it is 10 minutes after you open your eyes or an hour after the session, the experience of what it's like, what it can be like to be a whole new person in a realistic setting is a very powerful event! For example, to experience being this newly discovered quality of someone who loves to be alone, being all by them self in this playful reality provides a taste of what it is like to actually be this qualitatively new person. Being separated from everybody or whatever you find inside you in the real world. For a few minutes, or forever. And if you could do this and do it well, then by the end of that session whatever scene you started with originally that may have been scary or frightening, bothersome and made you feel rotten, will disappear. The bad feeling is gone—it's out of your world, finished. You're really a totally new changed person. Now I'm scaring myself, that really ambitious isn't? Its being totally transformed to whatever extent your ready to be totally transformed in one session. To become this way, you would playfully practice being this new person within the context of some imagined situation where you are this way. You would create these possible hypothetical scenarios while having the opportunity to live in these circumstances. To practice being this way and seeing what it is like to be this new person.

HG: I'm intrigued, what a powerful and transforming exercise. How would a person learn to do something like this?

AM: Right now there are several ways to learn how to have a session by and for oneself. First and most important way, is one should read "Becoming The Person You Can Become..," this is essential. Other options such as attending a workshop where someone will show you how to have a session or listening to audio-tapes of someone having a session can be enhancements, once you have first read the book.

HG: That sounds easy enough. Yet how do I know if I am going about having a session in the right manner?

AM: Once you have tried having your own session, a nice thing that a lot of people do is to send me an audio recording of the session. I will listen to tape and then send my comments back to you with things like you did this pretty well. Or you didn't do this pretty well try this. That's what I can do to help you learn how to do this.

HG: Looking ahead in the future at a hypothetical situation. What if this idea of having a session were to become quite popular and really take off, would the role of the psychotherapists become obsolete?

AM: Let me tell you what I think. I train doctoral students and give workshops where there are a lot of professionals, social workers, psychologist, psychiatrist, etc. And my first invitation is—instead of doing therapy on your clients or patients, how about doing something to make you feel better. To help you become what you can become. So the first thing I want to do, is to take all the therapists in the world and see how many of them want to learn how to have their own experiential sessions. That's the first thing. More importantly, I would really like a fair proportion of psychotherapists to start having their own experiential sessions for the rest of their lives. And that's a lot of people learning how to have their own experiential sessions. Look, if you don't like the idea of having your own experiential session then maybe something else appeals to you. Maybe you would like to learn how to do meditation or something else you can do regularly by yourself so that you can really feel better and become whatever sort of person you are capable of becoming. Not feeling so rotten, scared, depressed, tense or whatever it is.

HG: All this considered, how did you come about developing this? How did it come to you?

AM: This new method didn't just come out of the blue, it kind of evolved over time. During my university years, when in the doctoral program I wasn't so concerned about becoming a psychotherapist. I went into the psychology program to discover how to feel better. So from the beginning I just wanted to find some way I could learn to feel better and become whatever I am capable of becoming.

HG: If you could isolate one important outcome of having your own session, what would, should or could it be?

AM: If I had to choose one goal? It would be to enable the person, in each session, to become more of the person that the person is capable of becoming. Find a deeper potential for experiencing, and allow it to become an integral part of a qualitatively new person.

HG: If a person was interested in contacting you with comments or questions, how could they go about it?

AM: Please write to Dr. Alvin R. Mahrer, School of Psychology, University of Ottawa, Ottawa, Ontario, K1N 6N5 Canada. Or e-mail: amahrer@uottawa.ca.

HG: Thank you for taking the time to talk about this and explain your current work. Now, I think I am ready and willing to go and have my own experiential session.

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DIVISION 29 MID-WINTER MEETING

Tracey Martin, John Norcross and Jean Carter

Alice Chang, Norman Abeles, and John Norcross

John Norcross, Leon VandeCreek, Wade Silverman, Pat Bricklin and Matty Canter

Kal Heller, Andy Steinbrecher, and Bob Resnick

FEATURE

Clinical Coaching: A paradigm for supervision

Lori S. Katz, Ph.D.

Dr. Katz is a staff psychologist at the Long Beach VA Medical Center,s, women,s health clinic. She is the military sexual trauma coordinator and specializes in treating issues of trauma. She is currently writing a book, "Holographic Reprocessing: A cognitive-experiential psychotherapy for the treatment of trauma" which will be published by Brunner-Routledge in 2004. She may be reached at: lori.katz@va.med.gov

Clinical coaching is a paradigm for supervision designed to address evaluative aspects of traditional supervision that can interfere with training. Eight pre-doctoral interns (seven female, one male) and two practicum students (one female, one male) from university-based psychology training programs gave verbal and written comments about their opinion of clinical supervision. Although this is a small sample of trainees, five of them independently voiced that they felt they were in a double bind as recipients of clinical supervision. On the one hand, they needed to appear competent since they were being evaluated, and yet on the other hand, they needed help from their supervisors. This conflict promoted anxiety and a constriction of self-expression. Trainees also reported feeling unsafe to personally disclose or disagree with some supervisors.

Trainee: *"I felt that downplaying the personally difficult aspects of being a therapist (e.g., lack of confidence and feelings of counter-transference) was necessary to earn positive evaluations. I felt that I could not express my true thoughts and feelings about my work, my patients or the quality of the supervision that I was receiving for fear of being perceived negatively."*

The ten trainees have had multiple supervisors and felt that regardless of therapeutic orientation, their supervisor's personality was the most important factor in making the experience more or less comfortable. Outcome studies on supervision concur that the quality of the supervisory relationship is the most important factor to predict effectiveness of supervision (Unger, 1996; Kilminster & Jolly, 2000; Sloan, 1999; Shanfield, Heatherly, & Matthews, 2001). There appears to be two categories of attributes that predict positive outcomes: 1) trainees feel a sense of autonomy, control, and input into their training (Unger, 1996; Kilminster & Jolly 2000), and 2) supervisors are supportive, committed to supervision, good listeners as well as provide knowledge and guidance (Sloan, 1996; Shanfield, Heatherly & Matthews, 2001).

The proposed paradigm of clinical coaching incorporates these positive outcome findings by shifting the role of passive trainee to an active participant in the training process and shifting the role of supervisor to that of a coach. Coaching as a form of training is not new and is traditionally thought of as a model to train athletes. Typically, the athlete engages in a sport while the coach advises, trains, and gives feedback to the athlete. A coach recognizes that athletes have different strengths and weaknesses and encourages each athlete to achieve his or her personal best. Similarly, in training psychology students, what is taught depends on the uniqueness of the trainee. Clinical coaching allows trainees to enhance their own identity, style, and skills. This is particularly important for more advanced trainees such as pre and post-doctoral interns who are transitioning to an independent professional role.

Clinical coaching can best be understood in contrast to traditional models of training, namely supervision and mentoring. The definition of a supervisor in the Random House College dictionary is "a person who is responsible for and oversees a process, work, or workers during a performance." A supervisor monitors, evaluates, and makes sure there are no difficulties or problems. A supervisor ensures that certain minimal standards or criteria are met. The goal for a supervisor is for a trainee to meet the requirements for competency as well as to handle clinical issues in a satisfactory manner.

A mentor is defined in the Random House College dictionary as "a wise entrusted counselor, advisor, guide, or guru." A mentor cultivates a "watch me-follow me" or "be like me" relationship. This is similar to an apprentice model where a novice is paired with a highly skilled person to learn a trade. A trainee and mentor may co-lead a group or therapy session where the trainee observes the master and then emulates him or her. The mentor may correct the trainee by saying how he or she would have done it differently. The goal for a mentor is one of emulation.

It may seem that the difference between coaching and these other styles is merely semantic. However, to make such an assumption denies the impact of these words. "Supervisor" and "mentor" assume a hierarchical relationship that can easily be entrenched in criticism, evaluation, and domination. These roles make trainees compliant, passive, and submissive and by the nature of the relationship, may hinder independent thought. In contrast, clinical coaching assumes a mutually accountable relationship where both participants actively create the experience of education. The role of coach as "educator" is well summarized in Paulo Freire's "*Pedagogy of the oppressed*" (1997), *"(The educator's) efforts must coincide with those of the students to engage in critical thinking and the quest for mutual humanization. (The educator's) efforts must be imbued with a profound trust in people and their creative power. To achieve this, they must be partners of the students in their relations with them."*

Of course, it is appropriate for a clinical coach to incorporate aspects of traditional clinical supervision and mentoring. However, these can be added in a context of mutual agreement without the added pressures associated with the other styles by emphasizing individual development and valuing the trainee's personal experience. For example, it is appropriate for a coach to supervise and ensure certain criteria are met. As in sports, clinical trainees must follow certain rules and standards in order to participate. Also, it is appropriate for a coach to model techniques for a trainee to observe and emulate, but not demand that this is the only or best technique. Whitman & Jacobs (1998) stated that supervisors have to balance the hierarchical and collaborative aspects of the supervisory relationship. They suggest offering evaluations in an educational framework and for supervisors to responsibly self-examine their supervision to foster this balance.

Coach: *"Two interns were struggling to participate in a group that we co-led because they felt too intimidated to "perform." I asked them to imagine that they hired a coach to give them pointers. I said, 'think of me as your clinical coach. I am here for your benefit, so take advantage of all that I can offer you. I am working for you.' This simple reframe, empowered the trainees to take a more active role in their training."*

HOW TO BE A CLINICAL COACH, FROM THE PERSPECTIVE OF HOLOGRAPHIC REPROCESSING

Holographic Reprocessing (HR) (Katz, 2001) is a cognitive-experiential psychotherapy, based on Epstein's cognitive experiential self-theory that distinguishes

two processing systems: the rational system (logical and linear) and the experiential system (imagistic, associative, and emotional) (see Epstein, 1991, 1998). In HR, information about maladaptive patterns is accessed and reprocessed in the experiential system. HR supports a coaching approach to supervision as it focuses on the experience of the client and promotes individuality and creativity on the part of the trainee. The HR clinical coach focuses on training the following five steps:

Step 1: Teach the "Don't Know" attitude
Step 2: Teach how to be an "Experiencing Therapist"
Step 3: Teach how to "listen instead of fix"
Step 4: Teach how to "elicit information"
Step 5: Encourage trainees to develop their own techniques

1) **The "Don't Know" attitude.** Novice therapists are often afraid of being found out that they really do not know what to do. In HR, "not knowing" is reframed as a strength. Adopting the Don't Know attitude encourages therapists to focus on generating questions rather than on producing answers (or looking good, competent, and all-knowing).

"Trainees are asked to imagine that they are driving in a place where they are not sure which direction to go. What do they do? They pay attention, ask for directions, and explore different routes. When lost in therapy, it is the perfect opportunity to pay attention, ask questions, and explore different routes."

2) **The Experiencing Therapist.** If trainees adopt the Don't Know attitude, then they need to rely on "road signs" along the therapy path for guidance. The Experiencing Therapist reads these signs by staying in the moment and sensing, feeling, imagining, and associating right along with the client. This facilitates rapport and deepens the level of communication.

3) **Listening instead of fixing.** Instead of quickly addressing presenting symptoms, trainees are coached to resist the urge to fix or be helpful in the first few sessions. Instead, trainees are taught to listen and label the communication that is being presented. For example, trainees are asked to discern if a client's communication is about an implicit belief, a compensation strategy, or an avoidance strategy.

4) **Eliciting information.** Clients may not be able to verbally communicate significant information that keeps them blocked or trapped in maladaptive patterns. HR coaching encourages therapists to elicit such information, by exploring emotions, images, and associations experienced by the client. According to HR, therapists can focus on here and now events or events from childhood as both sets of events would bare a similar "fingerprint" or repeating theme of a maladaptive pattern.

5) **Techniques**. Choosing which technique to use and when is part of developing clinical instinct as well as personal style. Trainees are encouraged to learn a variety of clinical techniques as well as to create variations of their own using information that is relevant for the client (i.e., their own images, metaphors, and assignments). This encourages trainees to listen and be present, rather than focusing on "performing."

Other Coaching Tips:

1. **Offer feedback on a frequent basis**. A coach offers feedback on a frequent basis. Constructive feedback is honest, direct, and couched in a growth-oriented context without judgment. Positive feedback is also valuable and a coach can be generous with both.

2. **Explore trainees' experience of being coached.** Ask trainees about their experience of being coached. Encourage per-

sonal reflection and ask how their training can be enhanced.

3. **Explore supervisors' experience of being a coach.** The supervisor's experience is often overlooked, as typically there are no structured opportunities for discussion, reflection, or exchange of ideas. Ideally, training programs would facilitate this. Nonetheless, clinical coaches have the responsibility to engage in self-reflection and seek to improve their coaching skills.

4. **Show respect for cultural contexts and personal differences/preferences.**

Everyone has a different set of life experiences and someone else's preferences or the meaning of someone's actions cannot be assumed.

Trainee: *"Instead of making assumptions about me (and my culture), and then imposing those assumptions on my training, I appreciated when my (coach) made an effort to find out my perspective."*

In conclusion, clinical coaching is offered as a paradigm that values collaboration and mutual respect. Both coach and trainee are responsible and accountable for the training experience. The success of this model depends on both participants' willingness to actively participate, give and receive feedback, seek opportunities for skill enhancement, and engage in self-examination of one's own performance.

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CANDIDATE STATEMENTS

PRESIDENT-ELECT

William Fishburn, Ph.D.

I am especially honored to be a president-elect nominee for Division 29. I seek your support and vote in order that I may provide a continuation of the outstanding past president leadership. I want to promote the strongest possible role for Division 29 in APA and in the larger public sector in issues essential for the involvement and development of doctoral level psychologist psychotherapists. I will promote psychotherapy contributions to the well being and quality of life in health service, personal growth and development experiences, specific problem resolution, and specific behavioral changes. I am committed to Division 29 as the primary voice for the integration of psychotherapy practice, training, and research in APA. It is imperative that we are involved in a concerted public relations/educational effort to inform the public that psychotherapy is better provided by well-trained doctoral level psychologist psychotherapists. Psychotherapy must be a covered service in all managed care activities and proposals. The assurance of the highest quality of patient care is directly related to patient freedom of choice of doctoral psychologist psychotherapists. We must be proactive in informing the public, state, national, and local policy makers about the contributions of professional psychologists and the manner in which we use our unique clinical skills in diagnosis and treatment. Division 29 leadership must be aware of and encourage an ever-expanding role for psychologists and psychotherapists in diverse and non-traditional settings.

It is essential that psychotherapists be sensitive to issues of cultural diversity. As a psychotherapist in a state known for its diversity, I have been involved in the promotion of professional psychology by frequent radio, TV, and print media appearances focused on critical societal issues and professional psychology and psychotherapy practice. Psychotherapy as an essential foundational base of practice must be preserved and enhanced. Divisional leadership must be responsive to membership issues and concerns. I encourage the active involvement of all members in asserting the strongest possible role in the development and implementation of member contributed proposals, ideas and visions to achieve the goals of Division 29. This can be optimally accomplished through town hall meetings and direct contact with divisional leaders.

My background and experience in leadership roles includes having been Past President and Charter Fellow in the New Mexico Psychological Association, Past President and Division 39 Representative of the New Mexico Psychoanalytic Society, Past President of the New Mexico Group Psychotherapy Society. I have been an oral examiner for the New Mexico Board of Psychologist Examiners since 1973. I was a founder of and have been chief of the psychology section in the largest hospital complex in New Mexico. I have been a private practitioner specializing in psychotherapy with individuals, couples, families and groups for 35 years. I have been actively involved in Division 29 activities for over 20 years. I have been Mid-Winter Convention Coordinator, and served on the Golden Anniversary Committee for Division 29. I am a charter member of the National Register. I am Professor Emeritus in Counseling Psychology at the University of New Mexico. I have the experience, energy and enthusiasm to provide active, involved leadership for our Division and I respectfully request your vote.

Leon VandeCreek, Ph.D.

It is an honor to have been nominated to run for President Elect of Division 29. Psychotherapy is in the midst of a challenging struggle. On the one hand, psychotherapy offers wonderful opportunities for change for our patients, but on the other hand, the reimbursement systems in society press for ever shorter courses of treatment and fewer options of care. The Division is in a good position to exercise leadership in the training, research, and practice of therapy.

If elected President Elect, I would work for the following goals:

Fiscal Responsibility: For the past many years, the Division has spent money each year that should have been earmarked for the next year. We have modified our accounting practices, and beginning in 2004 the Division should be better able to support initiatives and again develop a reserve fund.

Membership: The average age of our members is among the oldest of any divisions in APA. Not surprising, we are losing members at a faster rate than we are gaining them. We must continue the strong membership drives of the last two years that have increased the numbers of new members, especially student members.

What Do New Members Want? As we attract new and younger members, we need to know how the Division can be of service to them. The needs of our aging membership may not match well the interests of newer and younger members.

Consider a Society of Psychotherapy: Many psychotherapists are not eligible for membership in Division 29. We should explore shifting the Division into a society that would permit a variety of membership categories, including those who are members of other professions, and that would increase and diversify our membership.

Theory, Research, Practice, and Training: We should increase our attention to theory and research, and we need to place much stronger emphasis on training. Some of our members fear that psychotherapy as we know it is losing ground in training programs because of their needs to provide students with broader training for the marketplace.

Sections in Division 29: Sections are permitted by our By-laws to create their own governance structures, levy assessments on their members, hold meetings, develop program proposals, and publish a newsletter. I would ask the Division to explore the development of Sections as a tool to increase membership and to sustain initiatives.

My experience in the Division includes Membership Chair, Board of Directors, and Treasurer. At the state and national levels, I have served as President (Pennsylvania Psychological Association), Financial Affairs Officer (Ohio Psychological Association), Member of the APA Council of Representatives, Associate Member of the APA Ethics Committee, Member of the APA Board of Educational Affairs (chair in 1999), and Member of the APA Insurance Trust (chair in 1997). I have been an author or co-author/editor of more than 90 journal articles, book chapters and books and 70 professional presentations. I served as Dean of the School of Professional Psychology at Wright State University, and I am currently employed there as a Professor.

CANDIDATE STATEMENTS – TREASURER

Jan L. Culbertson, Ph.D.

Jan L. Culbertson is Professor of Pediatrics and Clinical Professor of Psychiatry & Behavioral Sciences at the University of Oklahoma Health Sciences Center (OUHSC), Oklahoma City, OK. She also is Director of Neuropsychology Services at the OUHSC Child Study Center. She received her Ph.D. in psychology from the University of Tennessee (Knoxville), and had a faculty appointment in the Department of Pediatrics at Vanderbilt University School of Medicine prior to moving to Oklahoma in 1982. Her leadership roles in APA include Secretary and President of Division 53 (Clinical Child Psychology) when it was Section 1 of Division 12, Member-at-Large and President of Division 37 (Child, Youth, and Family Services), and Secretary of Division 54 (Society of Pediatric Psychology) when it was Section V of Division 12. She was appointed to the APA Committee on Children, Youth, and Families 1998-2000, and served as Committee Chair in 2000. This was followed by an appointment to the APA Working Group on Children's Mental Health in 2000-01, representing the Board for the Advancement of Psychology in the Public Interest. She was editor of the *Journal of Clinical Child Psychology* (1991-96) and the *Child, Youth, and Family Services Quarterly* (1986-90). She also served as Program Chair of Division 29 in 2001. Her research has focused on neuropsychological functioning of children with complex learning disabilities, attention deficit hyperactivity disorder, and pervasive developmental disorders. She is the author of numerous articles and co-editor of three books, and is an active participant in presenting Division 12 Postdoctoral Institutes and various other training seminars nationally and internationally.

I am pleased to be nominated for treasurer of Division 29. My past involvement with the Division has shown me that there are many important initiatives and projects to be carried out, and having a strong financial base is imperative for realizing these goals. All APA Divisions are struggling at this time to retain their membership, stem the trend toward dwindling revenue, and still maintain an active agenda of professional activities. Division 29 has had strong fiscal leadership in the past and continues to need this strong leadership in the future. I would be honored to help fulfill this role in support of the Board and members of Division 29.

Jeffrey Younggren, Ph.D.

I very much appreciate being nominated to run for Treasurer of Division 29. As a full-time private practitioner in clinical and forensic psychology, I am committed to our profession and to the practice of psychotherapy. I believe I have demonstrated that commitment in the past through my membership on the APA Ethics Committee, having chaired that committee in my final year, and now through my membership on APA's Committee on Accreditation. In addition to my clinical practice, I also work as a consultant to the APA Insurance Trust where I provide workshops throughout the country to our colleagues on risk management and the standards of care. Finally, I am also on the clinical faculty of UCLA's School of Medicine where I supervise residents and provide consultation services. My contributions to our profession have resulted in my receiving fellow status in two divisions of APA.

From a financial perspective, I believe that our Division, and APA, need to be prudent in the management of their finances. The expenditure of the Division's funds needs to be made with foresight such that the programs the divisions chooses to implement are those that are the most cost effective and of the greatest benefit to the most members. In addition, we need to embark on a program to increase membership and revenues in order to make the division more effective in influencing APA policy. It is through membership and revenue growth that we can make sure that the division continues to be a vibrant and effective force within our profession. I believe that I am well qualified to serve as treasurer of Division 29.

Jean Carter, Ph.D.

Although it may sound cliché, my goals as member at large of Division 29 are 1) to enhance the Division's ability to support and enhance psychotherapy — theory, research and practice; 2) to enhance the Division's ability to be responsiveness to needs of members; 3) to return the Division to fiscally sound position that allows better responsiveness to the issues and to members. As member-at-large on the Board I would bring the perspective of a full time independent practitioner of psychotherapy, as well as considerable experience in Division and APA governance.

Issues that the Division faces include 1) the impact of empirically based treatments, which have the potential to control the practice of psychotherapy and stifle creativity; 2) maintaining influence within APA to ensure appropriate attention to the role of psychotherapy and its protection in the healthcare system.

Relevant experience includes service on the Publications Board for Division 29; Vice President for Professional Practice and President (1999-2000) of *Division of Counseling Psychology* (Division 17); Secretary and President (2002) of *Psychologists in Independent Practice* (Division 42). I am in my 2nd term on CAPP (Committee for the Advancement of Professional Practice). I have a history of publication on the psychotherapy relationship and on the integration of science and practice, and I serve as an Adjunct member of the Graduate Faculty in the counseling psychology program at the University of Maryland—College Park.

Susan Corrigan, Ph.D.

Division 29 has so much to offer psychologists. From an excellent journal, local and national presentations to excellence in teaching, research, and practice, we all participate in ensuring the future of psychotherapy. Although we are one of the largest divisions in APA, we must continue to address challenges that could limit our future growth and effectiveness.

- As psychology expands and becomes increasingly specialized, it is critical that we promote the central role of psychotherapy in the field of psychology. In addition, the scope of our practice is changing with new applications in areas such as health care and business. We need to endorse Division 29 as home to all those committed to behavior change practicing in traditional and non-traditional settings.
- The current economic and political climate creates many challenges. The Division has made great efforts to remain solvent, but this continues to be a difficult task.

Although the Division's initiative to attract both psychologists and students has been very successful, tough economic times affect efforts to recruit and retain members. Clearly conveying the value of Division 29 membership to current and new members becomes even more crucial.

I served the Division as the program chair for the 2001 and 2002 APA Conventions. In that role, I witnessed the talent in our division and the appeal that psychotherapy has to so many in psychology. As a supervisor of psychology interns and graduate students as well as a provider at the University of Oklahoma Health Sciences Center, I promote psychotherapy each day. I would welcome the opportunity to embrace these challenges and advocate for our profession and Division 29 as a member-at-large.

Irene Deitch, Ph.D.

I appreciate the opportunity to serve our division. My style is proactive, inclusive and energetic. I work collaboratively to promote psychotherapy. My commitment: achieving diversity, public interest concerns and professional growth

INITIATIVES:
- advance research in psychotherapy
- outreach to academics,researchers, practioners, and graduate students
- share professional and scientific information: bulletins journals
- build and retain membership
- offer continuing education programs
- increased visibility divisional activities
- publicize achievements of membership
- expand opportunities membership involvement
- public education via print &electronic media
- establish liaison with state associations

CANDIDATE BACKGROUND

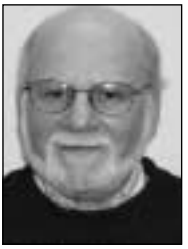
Professor at College of Staten Island, City University of NY; licensed psychologist, psychotherapist, certified in thanatology, (death, dying and bereavement.) producer/ host – making connections (cable tv program featuring-psychological issues) fellow: divisions 29, co-edited: *Counseling the Aging and Their Families;* chapter: *Treating the Changing;* chapter: *Women Therapists Helping Women;* appointed by International Council Ppsychologists NGO delegate– United Nations, (Mental Health Committee)

APA-SERVICE
- active "public education" campaign
- cadre of violence experts
- chair: public information committee
- president: running psychologists
- president: media psychologists
- chair: APA membership committee
- member:committee international relations in psychology
- task force "helping psychologists working with older adults" (publication)

DIVISIONAL SERVICE
- chair: interdivisional task force psychotherapists working with older adults
- chair: interdivisional committee- psychotherapists enhancing quality of life issues
- organized, chaired, presented continuing education
- convention, mid winter programs
- recipient divisional award

Support Irene Deitch — member-at-large demonstrated commitment, service and leadership

Charles J. Gelso, Ph.D.



Throughout my career (doctorate form Ohio State in 1970), I have been immersed in theory, research, practice, and training about and of psychotherapy. Much of my theoretical and research efforts have focused on the therapeutic relationship in both brief and longer-term therapy. Another part of my work has dealt with the question of how to turn professional psychology students on to science and research. In this work, I have sought to understand the factors in the training environment that serve to facilitate or impede students' interest and efficacy around scholarly activity.

Division 29 has been near and dear to me throughout my career. I have been a member and fellow for 30 years and most recently have served as Chair of the Education and Training Committee, which included organizing the Education and Training Corner of the *Bulletin*. I believe we all understand that the field of psychotherapy is at a crossroads. Just as scientific evidence has finally accrued that clearly points to the efficacy of a range of therapies, the specter of managed care has appeared and sought to force treatments into progressively briefer formats that are more and more focused on less and less. To say that this and other forces have created a crisis for the field of psychotherapy and Division 29 (including its role in APA) is an understatement. As member-at-large I would work vigorously to protect and enhance both the field of psychotherapy and its place in APA. My efforts would be aimed at each of the key aspects of psychotherapy that the Division has historically prized—theory, practice, research, and training.

Patricia S. Hannigan-Farley, Ph.D.

NO PHOTO AVAILABLE

It is an honor to be considered for nomination for the position of Member-at-Large for the APA Division of Psychotherapy (29). Division 29 has been my "home" in APA since I was a student. As a student member I was so impressed with the work that the Division conducted on behalf of the theory, research, and practice of psychotherapy. Since that time, I continue to be impressed with the wealth of knowledge and expertise that exists within the Division membership. Because I believed that the Division gave so much to me, I contributed by serving in various capacities within the Division including Chair, Women's Committee, Chair of Hospitality Suite Program; Secretary, and President.

Following my tenure as Past-President of the Division, I took some "time off" from governance in order to pursue family and other professional areas somewhat removed from psychology. Most recently, my attention and energies are turning more and more to the basic important contribution of psychotherapy in the lives of so many.

As a Member-at-large, I would hope to renew my contributions to the Division membership and strive to bring an updated perspective to the activities of the Division.

Thank you for your consideration of my candidacy. And regardless of your choices, please exercise your privilege to vote! Everyone's contribution is very important.

Alice Rubenstein, Ed.D.

In recent times the Division of Psychotherapy, along with so many other organizations, has been forced to respond to these difficult economic times by carefully reexamining our priorities and making cutbacks. We have had to make hard decisions about which projects and initiatives to support and those that must wait. However, in spite of these constraints we have accomplished a great deal. Our student membership has soared, the Brochure Project, which I have directed for many years, has expanded its scope and, beginning this year, will offer CE programs on some of our most popular Brochure Project topics, during the APA convention. This year, you will be able to attend a *free* CE program on ADHD, led by one of our most esteemed members and a national expert on ADHD, Dr. Robert Resnick. Our publications board, on which I have served over the past several years, has been revitalized and is focusing on several new initiatives which will offer members easier access to timely information about psychotherapy education, research and practice, along with tools to help members educate the public about the ways in which psychotherapy can help them. Looking ahead, I propose the introduction of a *member services initiative,* a priority that I believe is long overdue. This *member services initiative* will be aimed at increasing communication between the Board of Directors and the membership, creating opportunities for members to share their expertise with one another, and offering members more tools with which to market their services to the public. To this end I have developed several proposals, including exploring the feasibility of the division sponsoring qualified members to offer CE in their hometowns and states and the introduction of a mentorship-writing project aimed at encouraging and supporting practitioners to publish in journals such as *In Session: The Journal of Clinical Psychology*. This journal, which is published in collaboration with the Division of Psychotherapy, focuses on the challenges facing practitioners by introducing new therapeutic innovations and identifying *treatment methods and relationship stances* that work with different patient populations. These are just a few of the proposals I have developed to better serve you, our members. As an active member of the Division of Psychotherapy for more than twenty-five years I have been honored to serve as your President, Treasurer, and chair of numerous committees and task forces. I ask for your vote so that I might continue to work on your behalf as a Member-at-large.

FEATURE

The Unseen Diagnosis: Addiction Assessment

Marilyn Freimuth, Ph.D.

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 addictions. 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.

Signs of addiction may not be readily apparent in those seeking mental health treatment. Psychotherapy patients rarely exhibit the poor health and pervasive functional impairments of those entering a hospital for detoxification. Level of use may not appear to be an issue for dually diagnosed patients who use less drugs and alcohol relative to the addicted patient with no co-0ccuring psychopathology (Wolford et al., 1999). Further complicating accurate diagnosis is the fact that the consequences of addiction can mimic the symptoms of psychological disorder—especially depression and anxiety.

Given that substance use and abuse is prevalent but not necessarily apparent among those seeking psychological services, one would expect that mental health professionals would routinely do a careful assessment for potential problems. In Part One, I argued how mistaken beliefs about and discomforts with addictions impede accurate assessment. Interviews with clinicians who do not routinely assess for addiction indicate that some feel it is useless to ask about substance use because any one with a real problem will be in denial. While some patients will hide their use, most will answer questions to the best of their knowledge. Even if a given patient is fearful about revealing the full extent of use, there is little danger in asking. However, not all psychotherapists hold this belief. Some are concerned that merely asking about substance use will be met with hostile reactions. This and other beliefs about who is addicted and how an addicted individual presents for therapy hinder accurate recognition. For example, the typical alcoholic does not fit the down and out drunk stereotype but rather, is likely to be married and employed. Finally, some professionals shy away from addressing addictions given the ambiguity around distinguishing recreational use from abuse and dependence. The more like oneself the client is, the harder it seems to be to make these distinctions.

Having argued in Part One for the importance of routinely assessing for addiction, this article examines a variety of formal and informal approaches to addiction assessment. There are a myriad of instruments for such purposes but few are used routinely. In alcohol treatment centers, the clinical interview remains the most frequently used means of assessment (Myerholtz & Rosenberg, 1997). Likewise, for many psychotherapists, information about substance use will evolve out of the clinical dialogue. However, knowing the major instruments and their usefulness in mental health settings gives direction about what is useful to ask. After reviewing a number of standardized screening/assessment tools, this paper will consider some interview-based approaches to addiction assessment.

STRUCTURED SCREENING QUESTIONS

The CAGE is the best known and most often used screening instrument in medical

and health care settings. It consists of four questions directed at the use of alcohol.

1. Have you ever felt you should *cut down* on your drinking?
2. Have people *annoyed* you by criticizing you about your drinking?
3. Have you ever felt *guilty* about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (i.e., *eye opener*)?

A score of two or three is indicative of a substance related disorder. However, in psychiatric populations where even low levels of alcohol use can have adverse consequences (e.g., disrupt the effectiveness of psychotropic medications, lower compliance, exacerbate symptoms), a score of one merits further assessment.

To address the CAGE's limited focus on alcoholism, the CAGE–AID has been developed and validated incorporating reference to drug use into the four questions. Another alternative, the TICS, is a two-item screen for both drugs and alcohol that has been found to have good predictive ability in medical settings (Brown, Leonard, Saunders, & Papasouliotis, 2001). A positive response to either question warrants further investigation.

1. In the last year, have you ever drunk or used drugs more than you meant to?
2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

The CAGE, CAGE-AID, and TICS questions are easily incorporated into a clinical interview or therapy session. They are also easily modified to inquire about behavior-based addictions. Have people annoyed you or criticized you about the way you spend money? Have you felt you wanted or needed to cut down on your use of the Internet in the last year? Although these instruments are not validated for other uses, the answers still provide useful clinical information.

STRUCTURED ASSESSMENT INSTRUMENTS

For clinicians interested in self-administered self-report instruments for alcoholism there is the MAST (Michigan Alcoholism Screening Test) and AUDIT (Alcohol Use Disorder Identification Test). The MAST (Selzer, 1971) is composed of 25 common behaviors and symptoms associated with alcoholism along with the negative consequences of use in the areas of health, work, and social life. A score of 4-10 is considered indicative of possible problematic use while scores greater than 10 indicate alcoholism. Shorter forms of the MAST are available with as few as 10 items. Some sample questions are: Have you ever gotten into trouble at work because of your drinking? Have you ever gone to anyone for help with your drinking? Have you ever attended an AA meeting? This scale is not appropriate for use with adolescents but a similar tool, the PEI (Personal Experience Inventory) by K.C. Winters and G.A. Henley is available through the Western Psychological Association.

The AUDIT (Saunders, Aasland, Babor, De LA Fuente, & Grant, 1993), consists of 10 items asking respondents to indicate their degree of alcohol use such as how often one has a drink (never, monthly, 2-4 times a month, 2-4 times a week, 4 or more times week) and how much is consumed on any one occasion. This instrument also assesses feelings about and reactions to one's drinking. How often have you felt guilt or remorse? Has anyone been injured due to your drinking? Have significant others asked you cut down?

The value of self-report measures has been called into question by the belief that most persons with addiction problems resort to denial. Denial may be less pervasive than generally assumed. In Part One, it was suggested that many with addiction problems fail to link the life problem, for which they seek therapy, to addictive behaviors. When the psychotherapist makes such connections, most patients are open to considering it. Research on the validity of self-report measures within an alcoholism treatment context shows that alcoholics can report accurately on their drinking behavior (Sobell and Sobell, 1990). Whether this accuracy applies to self

reported drug and alcohol use in a mental health context has yet to be determined. For those concerned that denial or a conscious desire to fake will adversely affect assessment, there are several instruments where the questions' intent is less apparent.

For many years the MAC, which consists of 49 MMPI items, has been considered a good measure that avoids the problems associated with high face valid instruments. Like the MMPI, the MAC does not yield a specific diagnosis but rather detects patterns of responding characteristic of alcoholics. However, the MAC needs to be used cautiously in light of recent research showing low predictive validity when used in clinical settings (Myerholtz and Rosenberg, 1997).

Those interested in instruments with low face validity still can turn to the Substance Abuse Subtle Screening Inventory or SASSI (Miller, 1994). The first part consists of a series of questions related to a variety of needs, interests, values, health concerns, social interactions, and emotional states which are considered "subtle" because they do not appear to be asking about substance use. These 62 T-F items have been found to reliably distinguish drug and alcohol dependent persons from others. The second part consists of 26 items asking the usual questions regarding the frequency and amount of drug and alcohol use and the consequences.

The SASSI can take as little as 15 minutes to complete and has good validity in identifying chemically dependent persons even if they wish to conceal their use. A special version of the scale has been developed for use with adolescence, a population most likely to present an inaccurate picture of their drug and alcohol use. The only drawback to the scale is that it must be purchased from the owner.

INFORMAL CLINICAL INTERVIEW APPROACHES

Most psychotherapists, especially those in private practice settings, are not mandated to do a formal screen for addiction. If providers are attuned to addiction issues, they are likely to glean information during the clinical dialogue. Some may ask direct questions about addictive behaviors, others may ask indirect questions about life style and social relationships and still others may not ask any questions until the patient's report suggests that an addictive behavior is likely.

For those comfortable with more direct questioning, it is easy to incorporate CAGE or TICS questions into a clinical interview. These questions elicit information about the consequences of substance use. Or one can ask directly about degree of use. As most know, it is not recommended to ask a "yes" or "no" question such as "Do you drink?" Given that some use is normative, ask, "How much do you drink?" or simply state, "Tell me about your drinking."

Many working in clinic settings are required to ask directly about substance use but regretfully do it in a perfunctory manner without following up on an answer such as, "Oh, just a couple of drinks on the weekend." Clinical wisdom suggests that one never stop the inquiry at this point. For example, a couple of drinks regularly on a weekend may hide a binge drinker. Binge drinking is defined as at least five drinks for men and four for women on a single occasion within a two-week period. The importance of doing a careful inquiry is reflected in one physician's experience with a patient who unexpectedly began to seizure post-operatively. The chart dutifully noted that the patient had two alcoholic drinks a day. However, a follow up with family members revealed that these two daily drinks were of vodka sipped from a beer stein. Given that alcohol dependence is associated with life threatening withdrawal symptoms, any suspicion of addiction should be followed by gathering information about the frequency, amount, and length of use including time between drinking episodes. A thorough inquiry will also collect information about the context of use (alone, with friends, at home, a bar), the experience of use (is it always pleasurable?) and conse-

quences (e.g., legal, health, social or work problems).

Some psychotherapists avoid direct questioning until they hear signs in the clinical material that there may be a problem. Signs that can indicate a more thorough addiction assessment is warranted include a family history of addictive behaviors, a history of trauma, evidence of sociopathy, social isolation or a peer group where substance use is a common part of socializing. Evidence of borderline personality characteristics, anxiety or depression also warrant further investigation given that such characteristics and symptoms can be a consequence of substance dependence. My research interviewing clinicians well versed in addiction treatment indicates that they look and listen very carefully when the topic of substance use comes up. They are sensitive to any changes in behavior such as a brief acknowledgement of use followed by a change of topic, a sudden joking attitude, or an increased level of excitement or enthusiasm when talking about use.

As discussed in Part One, some psychotherapists are uncomfortable asking directly about addictive behaviors out of concern that the patient will experience such questioning as a criticism or insult. For those who are uncomfortable with direct questions, there are a number of less transparent questions that can indicate whether further inquiry into an addictive behavior is warranted. Some possible questions are: What do you do after work? What do you do for pleasure? How do you have a good time/relax? Have you ever behaved in a way that was not consistent with your value system/that you regretted later? Follow a patient's reference to a trauma or stressful situation with the question: How do you cope or deal with that situation?

Over and over again, treatment providers—even those familiar with addictions—can recall a time when they wished they had not taken a patient's casual reference to substance use at face value. One therapist recalled a young man with a sexual addiction who was quite open about his activities. In the process of telling about the previous week's sexual experiences, he would occasionally mention that he had smoked marijuana. No further inquiry was made. When, later in treatment, a referral was made to a psychopharmacologist who did a thorough substance use assessment, this man's degree of use was found to be consistent with a diagnosis of abuse.

Thus, any time a patient makes an explicit reference to some type of substance use, the topic merits further exploration by simply asking the person to say more. Quite often, I find that patients have not thought much about their use and whether it is problematic. Continued questioning can help the two of you decide together if there is a problem. One follow up question I have found very useful is: How much enjoyment/pleasure do you get from the substance? Recently, a man who came to see me for problems achieving his professional goals expressed surprise at how he responded to this question; he had not realized until asked how long it had been since he enjoyed drinking. This led to further explorations into his desire to drink and his increasing lack of control over alcohol. For others, I have found that this question stays with them and they will come back at a later time to report how they no longer enjoy the substance and are conflicted about continued use.

FROM ASSESSMENT TO DIAGNOSIS AND TREATMENT

In a therapy setting, in contrast to an alcoholism treatment center, the initial outcome of an assessment need not be a formal diagnosis. Instead the assessment goal may be to introduce the idea of substance use as a topic for discussion. For others, the intent may to understand the degree to which drinking is enjoyable or not, problematic or not, along with a determination of risk. This material then becomes part of the therapy content. If the therapist believes that the criteria for substance dependence or abuse have been met, s/he will want to share this information with the patient, ensure that substance use is not

endangering others (e.g., driving under the influence) and discuss implications of continuing to use in this way.

In those instances where the patient disagrees or the therapist prefers to avoid the possibility of arguing about the diagnosis, one can help the patient become aware of the negative effects of his/her substance use (Miller and Rollnick, 1991). One can explore if there is any remorse by asking if the person has ever done something or had something happen while under the influence which would not have happened if they were not. Has anyone important in your life ever complained about your use? Have you ever thought of slowing down? Stopping? What would that be like? At what point do you think your drug or alcohol use would be a problem?

Another simple approach that avoids the therapist labeling the patient is to ask: Have you ever worried/thought that you might be an alcoholic? A mere acknowledgement of worry helps bring the issue into the therapy room. Even if the patient says "no", the therapist who is concerned about possible abuse or dependence will remain attuned to negative consequences of the patient's substance use and point these out as they arise in treatment. While some may want to make a referral for specialized addiction treatment, Miller and Brown (1997) strongly argue that psychologists are suited to treat addictions.

SUMMARY

Psychologist may be aware of the frequency with which those seeking mental health services have co-occurring addictive disorders. However, mistaken beliefs and uncomfortable feelings about addictions impede accurate recognition. No matter what approach one takes to addiction assessment—be it formal or informal, direct or indirect questions— it is critical that the topic be addressed and that the assessment not be done in a perfunctory manner.

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Call for Nominations: Editor of *Psychotherapy Bulletin*

The Publication Board of the APA Division of Psychotherapy is seeking applications for the position of Editor of the *Psychotherapy Bulletin*. Candidates should be available to assume the title of Incoming Editor on or before January 1, 2004.

The *Psychotherapy Bulletin* is an official publication of the Division of Psychotherapy. As such, it serves as the primary communication with Division 29 members and publishes archival material and official notices from the Division of Psychotherapy. It is also designed as an outlet for timely information on psychotherapy and professional psychology. Now in its 38th year of publication, the *Bulletin* reaches more than 4,000 psychologists and students with each issue.

Prerequisites:

Be a member or fellow of the APA Division of Psychotherapy
An earned doctoral degree in psychology
Support the mission of the APA Division of Psychotherapy

Responsibilities:

The editor of the *Psychotherapy Bulletin* is responsible for its content and production. The editor maintains regular communication with the Division's Central Office, Board of Directors, and contributing editors. The editor is responsible for managing the page ceiling and for providing reports as required. The editor must be a conscientious manager, determine budgets, and administer funds for his or her office. As an ex officio member of both the Publication Board and the Executive Committee, the editor attends the governance meetings of the Division of Psychotherapy. An editorial term is three years.

Oversight:

The Editor of the *Psychotherapy Bulletin* reports to the Division of Psychotherapy's Board of Directors through the Publication Board.

Search Committee:

Jean Carter, PhD, Lillian Comas-Diaz, PhD, Raymond DiGiuseppe, PhD, John C. Norcross, PhD (chair), Alice Rubinstein, EdD, and George Stricker, PhD.

Nominations:

To be considered for the position, please send a letter of interest and a copy of your curriculum vitae no later than July1, 2003 to: John C. Norcross, PhD, Publication Board, Department of Psychology, University of Scranton, Scranton, PA 18510-4596. Inquiries about the position should be addressed to Dr. John Norcross (570-941-7638; norcross@scranton. edu) and/or to the incumbent editor, Dr. Linda Campbell (706-542-8508; lcampbel@arches.uga.edu).

Free Division of Psychotherapy Continuing Education Workshop at the 2003 APA Convention

Join Robert J. Resnick, Ph.D.
for
An Update on Pharmacological Interventions for ADHD Across the Life Span

Saturday, August 9th, 9:00 AM – 10:50 AM
Metro Toronto Convention Center
Constitution Hall Room 106

You must pre-register in order to receive continuing education credit. All pre-registrants will receive 10 copies each of the Division of Psychotherapy Brochures, "Attention Deficit Hyperactivity Disorder in Children and Adolescents" and "The Hidden Problem: ADD/ADHD in Adults."

Continuing Education Policy: The number of Continuing Education credits is equal to the number of contact hours. **Full attendance is a prerequisite for receiving CE credit**. Partial credit will not be given. Sign-in for each workshop begins 20 minutes before start time and continues 10 minutes after start time. After that, CE cannot be granted. It is the responsibility of the attendee to determine whether these CE credits are valid in his/her state of licensure.

Name _____ Phone (____)_____

Address _____

City _____ State _____ Zip _____

Email _____

FEATURE

Was the Competencies Conference 2002 a Competent Conference?

Jack Wiggins, Ph.D.

Jack Wiggins is a Division 29 Council Representative, a Past-President of Division 29, and the Division's representative to the Competencies Conference.

The Association of Psychology Postdoctoral and Internship Centers (APPIC) held its Competencies Conference 2002: "Future Directions in Education and Credentialing in Professional Psychology" in Scottsdale, Arizona on November 7–9. The ten-person Steering Committee, chaired by Dr. Nadine J. Kaslow, did excellent work in planning and organizing the Conference and making site arrangements for the 130+ attendees' comfort and participation.

Attendees were assigned to one of these ten (10) groups:

- Scientific Foundations and Research
- Ethical, Legal, Public Policy/Advocacy, and Professional Issues
- Supervision
- Psychological Assessment
- Individual and Cultural Diversity
- Intervention
- Consultation and Interdisciplinary Relationships
- Professional Development
- Specialties and Proficiencies
- Assessment of Competence

In addition to the attendees each group had a facilitator, a recorder and a member of the Steering Committee. Division 29 was well represented by officers: Pat Bricklin, President-Elect; and Lee VandeCreek, Treasurer. As a Council Representative for Division 29, I was the official representative for the division as a late substitute for 2002 President Bob Resnick. I was assigned to the Consultation and Interdisciplinary Relationships group. The attendees at the Conference were very able, articulate individually, and collectively represented a broad spectrum of psychological interests.

Each workgroup had a written charge and the facilitators, recorders and member of the Steering Committee were very familiar with this charge. They worked diligently to complete the assigned tasks of the workgroups. Minutes of each workgroup meeting were distributed the following day to all attendees. On Saturday, the final day, facilitators of each workgroup gave oral rather than written summaries of the meetings. These meetings consisted of an integration meeting where one member of the assigned workgroup attended one of the other nine workgroups. I chose last and attended the untaken Scientific Foundations and Research Integration group meeting. After lunch we reassembled back in our assigned workgroup and reported our experiences in the integration groups.

Following this feedback meeting of the workgroups, there was a large group discussion in which group facilitators presented their summaries followed by a question and answer period. It was apparent there was a great deal of overlap in the presentation of the facilitators. There was no attempt to arrive at a consensus of the attendees as whole on any particular point. The overlap among the groups of the consensus reached in each assigned group will apparently be the basis of recommendations coming from the conference. A draft Summary of the Conference is due in December.

The reader will have to make up his/her mind as to the value of the conference based on findings that are to be reported in December. Some attendees were disap-

pointed there was no opportunity to discuss and vote on salient points of the discussions. I have attended both types of conferences where the attendees attempted to reach consensus through voting and through consensus building by the overlap of opinions among the various workgroups. Neither model is completely satisfactory or satisfying to attendees. The model used in this conference tends to have attendees leave "feeling good" though wondering if anything was really accomplished. The conferences where consensus is attempted through voting let attendees know what the conference did or did not do. This latter model also causes many to feel like winners and losers on issues. Attendees leave with hard feelings when their personal positions were not supported by the conference. While there may be a place for both types of conferences, it is my obligation to report on my impressions about the Competencies Conference 2002.

The leaders of the Competencies Conference 2002 acknowledged at the outset there is no consensus about what a "competency" is. It was recognized that the word "competency" is used in a variety of ways in psychological circles; sometimes referring to excellence, sometimes simply meaning a skill set and sometimes meaning that something is "good enough." These meanings are illustrative of the various connotations of the word "competency" and are not intended to be exhaustive. Dr. Kaslow in her opening remarks suggested for purposes of this conference, "competency" would be understood as "good enough." I cannot disagree with such a definition, but it does raise the question of "what is good enough in the education and training of professional psychologists." Dr. Nicholas Cummings was unique in his remarks in the plenary session. He said we must train psychologists to be able to take advantage of new opportunities in the market place and not be limited by traditional training that may have been good enough in the past. Dr. Belar, director of the APA Educational Directorate, alluded to the need to take a fresh look at training competencies but was less explicit in her remarks than was Cummings. Dr. Derald Wing Sue, the discussant of the plenary panel, did not attempt a summary of the panel comments. Instead, he made his own presentation with a plea for cultural competence as a core competency.

Psychology needs to determine training that is "good enough" for specific purposes. It is not clear that this conference addressed that question directly and created some difficulty is reaching consensus in workgroups. Competency comes from the same root words meaning "to compete." Thus, the meaning of competency will shift somewhat according to where the competition is taking place. The marketplace is where practitioners of the discipline of psychology must compete with other professions and other approaches to problem solving. Psychology must compete for students and its training must enhance practitioners' ability to compete in the world marketplace with their psychological skills. As a value-adding discipline, our profession must identify opportunities to compete and we must train our graduates to compete successfully. Through our advocacy, we must create jobs for our graduates to contribute to solving individual and societal problems and be compensated sufficiently to justify their training in psychology. Thus, my position is closer to that of Cummings since the marketplace is the ultimate determiner of competency in psychology.

It is my view that psychology as a profession has continued to be based on an academic economy. There, success is measured by the numbers of students with high SAT/GRE scores that can be attracted; the number of publications of the faculty; the size and number of grants that are accrued; and the success in placement of their graduates on highly esteemed university faculties. These measures have merit in academia but little or no value or cachet in the global marketplace.

It is time for psychology to think more globally and consider a market-based economy for psychology as a discipline. For example, in the integration discussion group dealing with the Scientific Foundations and Research it became apparent that the concept of a market-based economy for psychology had not been considered. One of the principle people of this workgroup let it slip that they had used an Aristotelian dichotomy of "researchers and technicians." In their "future directions" it was proposed to write a book on what a scientifically minded practitioner looks like. I argue that the practitioner of today accurately reflects the scientific training he has experienced. Psychologist practitioners are true professionals and merit this recognition. Practitioners do not merely assume a "scientific technician role" that academicians aspire for them.

Dr. Jane Halonen articulated eight domains of proficiencies from the Psychology Partnerships Project task force including: 1.Descriptive Skills; 2. Conceptualization Skills; 3. Problem Solving; 4. Ethical Reasoning; 5. Scientific Attitudes and Values; Communication Skills; 7. Collaborations Skills; and, 8. Self Assessment Skills.

The Scientific Foundations and Research workgroup recommended these eight domains be tested to see if they make a difference. They also wished to determine ways that practitioners are held accountable for the science they practice. Also, they wished to encourage the continuing education about the scientific practitioner. The participants from other workgroups to this integration group pretty much agreed on the eight domains of skills but questioned the narrow one-way focus of involving research for practice but not considering the feedback of practice to science and training.

This workgroup did recommend a conference that holds training programs accountable. There was a lively discussion of this and the need to make academia more responsive to marketplace issues. The idea of a practice-based research network was brought up. The fact that doctoral level psychologists are required to compete with master's level trained personnel was noted. The economic consequences for both the practitioners and the discipline of psychology of this doctoral/ master's level competition were briefly discussed. The need for the discipline of psychology to be on a market-based economy fell on deaf ears and was not included in the summary remarks of the Scientific Foundations and Research workgroup. Let us hope the critical need for a shift away from an academic-based economy to a market-based economy will appear somewhere in the final text.

I did hear that some were considering teaching "history and systems" of psychology at the undergraduate level for those interested in graduate training in psychology. This could open up opportunities of additional competency training at the graduate level. Perhaps we could also enhance our skill sets in graduate training by reformatting current courses. A marketing course could simultaneously teach marketing skill sets and statistics using the case study approach found in MBA programs. A course in intervention assessment could have similar utility. Training in statistical outcome evaluations is essential for psychologists to become program managers and directors. If the case study method were applied to health field, where 70% of psychologists earn some portion of their incomes, we could find specific examples of how competencies could be determined and implemented in training. Graduate programs could also offer a course in epidemiology for statistical training. Then, Murray and Lopez's Global Burden of Disease epidemiological data could serve as an outline of clinical training for the next 20 years. Depression, Road traffic accidents, Cerebrovascular disease, War and HIV (health conditions with psychological underpinnings) will become five of the 10 leading causes of disability as measured by Disability-Adjusted Life

Years (DALYs). Self inflicted injuries will rise from the 33rd to the 15th cause of DALYs. It is reasonable to ask what competencies (skill sets) will be useful to address these societal needs. This data has been public for six years but we see little evidence that this information has enhanced psychology training programs.

The Scientific Foundations group did recommend that the APA Committee on Accreditation and other regulatory bodies not just "count" courses in evaluating core competencies. Currently, the Committee on Accreditation, lacking measures of needed competencies, uses a "truth in advertising" or "let a thousand flowers bloom" standard for accrediting academic training programs. This allows any academic program to be accredited as long as it trains according to the way the faculty says they are training. Is this good enough?

Without market-based criteria, the Committee on Accreditation lacks defensible standards to evaluate the adequacy of training programs. It was pleasing to see this workgroup endorse a "conference involving regulatory bodies to determine what processes and groupings of core knowledge areas are needed to evaluate core competencies." They asked the right questions but to the wrong group. Again, as in this conference, psychologists are asked to answer market-based questions that are typically addressed by marketing experts. APA has a Division of Consumer Psychology. Perhaps, they could provide some answers from a market-based perspective or direct us how to obtain answers to what jobs need to be done and what skills are necessary. I doubt that another conference will accomplish this desired result. Another, potential resource would be to empower the Association of State and Provincial Psychology Boards (ASPPB) to study where the job opportunities are for psychologists and what training is required to fulfill these job qualifications. Grant money could be obtained to do this since it would be within ASPPB's mission to protect the public. The Council of Credentialing Organizations in Professional Psychology (CCOPP) will publish its evaluative work on competencies in January 2003. Perhaps the CCOPP's report will offer additional guidance and serve as another reference point.

There were many excellent discussions and valuable contributions that were made at the Competencies Conference 2002. Without some means to rank the value added by various competencies (skill sets) suggested at the conference, we will not know how to establish priorities for implementing these skill sets into training programs. My concern is that the excellent discussions that the various workgroups had will become psychocentric rhetoric without some external criterion to judge what is "good enough." "Good enough" can not be based solely on the standards of an academic economy. The marketplace is the final arbiter of the ability to compete as the measure of competence and competencies. Until psychological training programs recognize the marketplace as the measurer of their value-added training, our competency training may feel good but may do less than we desire.

The Competencies Conference 2002 contributions have been outlined and its limitations detailed. Suggestions for market measures for competencies and next steps to taken were addressed. The offensive emailed conference follow-up questionnaire, which permitted only positive answers to the questions asked, was completed. My comments are offered to serve as benchmarks for readers when they review the proceedings of this conference. It is left to the reader of the proceedings to judge whether the Competencies Conference 2002 was a competent conference.

WASHINGTON SCENE

A Range of Interests and Highly Relevant Expertise

Pat DeLeon, Ph.D.

Pat DeLeon is a contributing editor for the Psychotherapy Bulletin in the area of legal and legislative issues. He is a past president of Division 29 and a recipient of the Distinguished Psychologist Award, and 2000 President of APA.

Dedicated Individuals Can Make A Difference: Perhaps the most rewarding aspect of serving as APA President is the opportunity to interact on a face-to-face basis with colleagues across the nation who are genuinely excited about the future and who are personally involved in making society "just a little bit better." And, not surprisingly, experiencing the growing affirmation that the behavioral sciences, including participating in data-based programmatic decision making, truly are the key to successfully addressing many of our country's most pressing public health concerns.

This Spring, although no longer in the APA governance, I was invited by New Mexico Psychological Association President Bob Ericson to attend their dinner in celebration of the "Enactment into Law the Psychologists' Authority to Prescribe." APA's Mike Sullivan, Past-President Jack Wiggins, and I had a wonderful time. In attendance that evening were the bill's House and Senate sponsors, the New Mexico Secretary of State, the psychiatrist who had met twice with the Governor on behalf of the Association, and, of course, our heros Elaine LeVine (accompanied by her son Marshall, appropriately dressed in tux and top hat) and Mario Marquez and his lovely wife, Diana. These dedicated and far-sighted colleagues have truly moved professional psychology into the 21st Century. My sincerest appreciation to APA President-Elect Bob Sternberg and Ray Fowler for making my attendance on behalf of the entire Association possible. It was a very special evening. Mahalo.

It is interesting to reflect upon psychiatry's observations (Clinical Psychiatry News): "'New Mexico should be seen as a sad anomaly, not the start of a perverse trend... There is no reason to believe that the peculiar set of factors that determined the outcome in New Mexico will recur elsewhere...' (The) President of the New Mexico chapter of the American Psychiatric Association, said rural access became the lobbying mantra of psychologists, and legislators readily picked up on it. She and other psychiatrists met with the governor on several occasions, but their testimony did not appear to phase legislators, who had previously granted prescribing privileges to nurse-practitioners, physician assistants, and clinical pharmacists... '(T)he ultimate passage of the bill was not due to any lack of effort on the (ApA's) part...' But the New Mexico lobbying efforts by the (ApA) were deemed too late by some of its own members, who called for a more intense and widespread campaign to prevent the extension of prescribing privileges. 'Those psychiatrists who are in leadership positions, especially those who are leaders in the American Psychiatric Association, are wholly to blame for this disaster...' 'This is a wake-up call...' Psychiatrists need to work with primary care providers, providing consultation and support. Patients do not know the differences between psychologists and psychiatrists, but they do know their primary care providers. The (ApA) has failed to embrace primary care providers as essential caregivers in mental health even though it is well known that

more than 80% of psychotropic medications are prescribed in primary care... (I)f all the states allow psychologists to prescribe, nothing will distinguish them from psychiatrists. 'Thirty years ago, we had psychotherapy to distinguish ourselves; now we don't...' 'This aggression has more to do with guild economics than with real concerns or rationalizations concerning quality or access. It has been particularly exacerbated as the medical model of psychiatric disorders has become dominant, the role of psychological models has become diminished, and managed care has increasingly disenfranchised psychology by reimbursing psychiatrists for medication management and preferred less-costly social workers to provide psychotherapy. Psychology has sought to cloak the motives for this territorial campaign in the self-serving and altruistic-sounding language of greater access for 'clients,' greater economy, equivalent (if not superior) quality, and even, in California, a cynical but transparent concealment within so-called mental health parity legislation...'"

Former New Mexico Psychological Association President Julie Lockwood noted a full page advertisement, taken out by the ApA's Patient Defense Fund, in the Santa Fe New Mexican: "You wouldn't do it to your dog, So why would you do it to your child?... Letting psychologists prescribe is bad medicine — a HIGH RISK our families cannot afford..."

A Broader Public Policy Perspective: An interesting ApA perspective. Nevertheless, as Mike continues to emphasize, the Practice Directorate's Southern-Rural RxP-strategy nicely parallels the findings of the Fordham Institute for Innovation in Social Policy: The Social Health of The States (2001). "As we Americans strive to protect our way of life, we need to pay sustained attention as well to our standard of living. Issues such as health and housing, education and income, need to remain on-going concerns. It is our hope that this document, which assesses and compares the social health of the fifty states on these and similar social conditions, will make a small contribution to that important national dialogue... By using a set of sixteen key social indicators that represent conditions of well-being at critical times of life, from childhood to old age, we have been able to provide an overall picture of America not previously available... This document reveals that, like the nation's geography, there is great variety in the social health of the states. Some states have high levels of performance with exceptional achievement on numerous indicators. Other states are experiencing significant social deterioration, with most indicators pointing to conditions requiring immediate attention..."

The report strongly urges "extensive community participation in evaluating the state's social health performance and developing ways to improve it." It is a tremendous understatement to suggest that Elaine and Mario excelled at community participation. Never during my years of service within the APA governance have I ever experienced such genuine "grass-roots support" for a psychology agenda, the way that it materialized on behalf of the RxP — movement in New Mexico. Vocal public support was expressed by numerous physicians and other health care providers (including clinical pharmacists), the President of the University of New Mexico; representatives of the legal community, including the State Attorney General and various local Bar Association representatives; and even the local chapter of NAMI. Psychology's voice was heard in public legislative testimony; on the radio, television and in the print media; the New Mexico Medical Society endorsed their bill; and perhaps equally impressive, was the nearly unanimous support that surfaced within the New Mexico Psychological Association. There can be no question that this inclusive and collaborate approach made all of the difference in the world. Whereas the Fordham Institute found the top-ranked state (e.g., the healthiest) to be Iowa, the bottom ranked state was New

Mexico. Focusing upon society's real and pressing needs is the key to legislative success. This is a lesson we should take to heart and never forget.

Some of the report's more graphic highlights: the child abuse rate in Montana is more than ten times that of Pennsylvania; teenage suicide in Alaska is nine times that of New Jersey; the percentage of people in New Mexico with no health insurance is nearly four times higher than in Rhode Island; and the homicide rate in Louisiana is seven times that of Iowa. Eight states are considered to be in "social recession", with an overall rank in the bottom ten and poor performance in more than five individual indicators. These include: Arizona, California, Louisiana, Mississippi, Montana, Nevada, New Mexico, and Texas. Those colleagues who have closely followed the maturation of the RxP- agenda will note that six of these states have very active RxP- task forces. Of the bottom overall ranked twenty-five states, psychological leaders in at least 11 are currently aggressively pursuing RxP- action. From a public policy perspective, we would suggest that perhaps New Mexico does not really reflect a "peculiar set of factors," as wished by our medical colleagues.

We were particularly pleased to learn from Steve Tulkin that Elaine may be the keynote speaker for this year's Alliant (CSPP) University's clinical psychopharmacology graduation ceremony. She is an inspirational role model. Undoubtedly, one of her fundamental messages to the graduates will be that in order to truly serve their patients well, they must have faith in themselves and be personally and actively involved in the public policy (i.e., political) process. Her insider view of the now ongoing discussions between New Mexico's Psychology and Medical Boards and their efforts to develop the specifics of the prescribing and supervision protocols will be fascinating, to put it mildly. As the Health Policy Tracking Service (i.e., the literature of state legislators and their staff) reports, Mario and Elaine have revamped the RxP-landscape: "On May 16 or 17, the New Mexico State Medical Board expects to hear a report from a recent meeting in San Diego of the Federation of State Medical Boards, where preliminary discussions concerning prescriptive authority for psychologists were to take place, and to appoint a committee to study the prescription issue. The Board of Psychologist Examiners already has appointed its subcommittee, headed by Tim Strongin. The development of a national examination for 'any mental health provider prescribing psychotropic drugs,' may be a consideration." We can see Mike and Russ Newman smiling. This is a major development for all of professional psychology.

Family Comes First: On a highly personal level, I have always felt it was important to take the time to watch our two children participate in athletic events during their grammar and high school careers, regardless of how pressing work or psychology agendas might appear at the time. Like all involved parents, the sight and sounds accompanying injuries, for example on the soccer field, are never forgotten. Accordingly, I was intrigued by the recent Institute of Medicine (IOM) report—Is Soccer Bad For Children's Heads? And, I was proud to learn that APA colleagues were intimately involved, serving on the IOM Board on Neuroscience and Behavioral Health (e.g., Nancy Adler, Jerome Kagan, Beverly Long, Karen Matthews, and staff Michelle Kipke).

To explore whether soccer playing puts youths at risk for lasting brain damage, the IOM brought together experts in head injury, sports medicine, pediatrics, and bioengineering for a one day workshop. The experts presented the scientific evidence for the possible long-term consequences of head injury from youth sports, possible approaches to reduce the risks, and policy issues raised. "(S)ports concussions are in fact far more serious than most people realize. There are many... examples of former A students struggling to pass high school after experiencing concussions on the soc-

cer or football field. Many student athletes have been forced to abandon both their sports and their career aspirations because they never fully recovered from concussions. These disturbing examples counter the common belief that a concussion is just a bump on the head with no lasting effects. Indeed, recent research reveals that a concussion unleashes a cascade of reactions in the brain that can last for weeks, and make it particularly vulnerable to damage from an additional concussion. There is also evidence that youths who experience concussions may be at more risk for brain damage than adults because their brains are still developing and have unique features that heighten their susceptibility to serious consequences from head injuries. Even though people generally think of soccer as a safer sport than football, soccer players experience concussions about as often as football players... Soccer is probably the most rapidly growing team sport in this country, especially for girls and women. Millions of children and adolescents participate in youth soccer leagues and there are hundreds of thousands of adolescents on high school soccer teams. The growing popularity of soccer among youth... has fostered concern that children who play soccer may not be adequately protected from head injury....

"Although soccer balls can be kicked to speeds as high as 70 miles per hour, even most professional players cannot kick a ball that fast and most soccer players would not attempt to head a ball moving that fast... (Y)ouths rarely have enough force to kick a ball to speeds higher than 40 miles per hour... (C)alculated the impact of a soccer ball on the head of youths of various sizes, based on the likely speed of the ball, and concluded that the force of impact is well below the force that is thought to be necessary to cause a concussion in heading a soccer ball. But.... concussions do occur in soccer when the ball hits an unprepared player in the head... when players accidentally knock their heads into other players while attempting to head the ball, particularly if they are attempting to flick the ball backwards... Compared to other contact sports, head injuries are common in soccer. In neuropsychologist Dr. Jill Brooks' study of high school soccer players, she found that more than one quarter of them had experienced one or more concussions. Neuropsychologist Dr. Ruben Echemendia reported that in his study of college athletes, over 40 percent of the soccer players had at least one concussion prior to attending college. By comparison, only 30 percent of the incoming football players.. had a concussion.. (M)any high school soccer players neglected to report experiencing a concussion, because they didn't think it was serious or wanted to continue playing in the game...

"X-rays and other imaging of the brain often cannot detect signs of a concussion.... (M)any of the symptoms of concussions also occur in people without the condition, and... some of the most widely known symptoms, such as amnesia or loss of consciousness, are frequently lacking in concussed individuals... Loss of consciousness frequently lasts only seconds to minutes, so it is often not even detected because of the delay in stopping a game and assessing the condition of a player following a head collision... Some symptoms do not appear until days to weeks following a concussion.... (S)ubtle signs of a concussion that occur later and appear to be more persistent than the traditional symptoms. Two neuropsychologists, Drs. Barth and Echemendia, reported evidence at the workshop that brain functions are impaired even after the obvious symptoms of concussion disappear... If people are unfortunate enough to experience a second concussion before they have fully recovered from their first, they can experience a life-threatening swelling of the brain, no matter how minor the first or second bang to the head appeared to be...

"The notion that soccer might put youths at risk for brain injury has circulated in the popular media and that has led some to suggest that soccer players wear protective headgear. But.. no protective headgear cur-

rently on the market is designed to protect against concussion. Today's helmets are designed to meet standards for reducing the risk of serious and fatal brain injury and these standards are limited to reducing injury caused by a linear acceleration, or a 'straight on' blow to the head. But a blow that causes concussion typically includes rotational acceleration, in which the brain gets twisted. Current helmets and standards are not designed to take this type of blow into account... 'We talk to trainers, to equipment managers, and they are very surprised when I say that no helmet is designed to prevent concussions'...

"As to federal policies, safety issues in children's sports are often covered by the Consumer Products Safety Commission (CPSC) insofar as sports equipment is involved. In May 2000, the Commission held a workshop to examine the possible use of helmets in youth soccer players, but did not find that the available evidence warranted the mandatory adoption of helmets. The Centers for Disease Control and Prevention (CDC) also monitors childhood injuries and funds research on injury prevention, but has not recommended against heading in youth soccer. Finally, the National Institutes of Health is the major federal supporter of medical research, but currently supports fewer than half a dozen grants related to head injuries in children's sports... (W)ithout definitive data there can be no conclusive resolution about the dangers of heading..."

The First Of Many Appearances: In mid-May, Karen Matthews drove down from the University of Pittsburgh to testify for her first time, along with APA colleague David Abrams of Brown University, before the U. S. Senate Appropriations Committee regarding the "Impact of Stress Management In Reversing Heart Disease." Both were outstanding. Highlights from Karen's testimony: "My own research is on the role of stress in the development of heart disease, with an emphasis on young adults and on women during the menopausal transition. Our Center is dedicated to understanding how stress and other psychological factors translate into risk for diverse diseases, including heart disease.

"Today I would like to make four points: 1. Psychological stress is typically considered to be a process and not a single event. Stress management techniques can intervene in multiple ways in the stress process. 2. Psychological stress can trigger ischemia, heart attack, and premature death. It may also accelerate the rate of atherosclerosis prior to the first heart attack or other clinical event, especially among those who already have high levels of 'subclinical or silent disease.' Thus, effective stress management techniques should theoretically be able to prevent a first or second heart attack. 3. Adequate tests of the impact of stress management interventions in heart disease patients have been few in number, but combining together the data from small clinical trials shows that psychosocial interventions can be a useful adjunct to other therapies. (And), 4. The science of behavior change and practical knowledge of how to conduct clinical trials have advanced sufficiently so that now is an opportune time to conduct high quality studies on the impact of stress reduction on preventing or reversing heart disease....

"We know that the combination of not smoking, having a healthy diet, higher levels of physical activity, moderate alcohol consumption, and not being overweight is associated with very low risk of heart disease in the Nurses' Health Study. Unfortunately, only 3% of the nurses were in this category. Very few people in the United States have adopted life styles that are associated with very low risk for heart disease, in part because of the difficulty in changing well-practiced behaviors later in life and in part because stress may interfere with altering behaviors to more health-promoting forms. We need a better understanding of the role of stress in accelerating disease risk early in life and how stress management interventions might impact early risk trajectories. Stress management combined with promoting healthy life

styles in adolescence and young adulthood may have long term economic and social advantages." During the question-and-answer session, the witnesses stressed the importance of health care reimbursement mechanisms (e.g., health insurance) covering preventive clinical services. Aloha.

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We hope to see you in Newport!

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