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BULLETIN

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Reactions to Segal, Williams & Teasdale's Mindfulness-Based Cognitive Therapy for Depression

Division 29 • 2003 APA Convention Program

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1390 S. Dixie Hwy, Suite 1305
Coral Gables, FL 33145
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whsilvermn@aol.com

***Psychotherapy* Bulletin Editor**
Linda F. Campbell, Ph.D., 2001-2003
University of Georgia
402 Aderhold Hall
Athens, GA 30602-7142
Ofc: 706-542-8508 Fax:770-594-9441
lcampbel@arches.uga.edu

Internet Editor
Abraham W. Wolf, Ph.D., 2002-2004
Metro Health Medical Center
2500 Metro Health Drive
Cleveland, OH 44109-1998
Ofc: 216-778-4637 Fax: 216-778-8412
axw7@po.cwru.edu

DIVISION OF PSYCHOTHERAPY (29)

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

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RESEARCH CORNER

I Sensed You With Me the Other Day: A Review of the Theoretical and Empirical Literature on Clients' Internal Representations of Therapists

Sarah Knox
Marquette University

Sarah Knox, Ph.D., is an Assistant Professor in the Department of Counseling and Educational Psychology at Marquette University. She received her doctorate in Counseling Psychology from the University of Maryland in 1999. Her research focuses on the therapy relationship. Correspondence concerning this article should be sent to Sarah Knox, Ph.D., Department of Counseling and Educational Psychology, School of Education, Marquette University, Milwaukee, WI, 53201. Electronic mail may be sent to sarah.knox@marquette.edu.

"You know, I was spending time with my family the other day, and we were all getting back into our old nasty patterns, but instead of feeling upset and responding bitterly as I usually do, I heard your calming voice and felt you with me, and I was able to get through the situation without getting hurt."

It is not uncommon for therapists to hear such words from clients. Therapists may, in fact, consider such statements an indication that therapy is succeeding and that clients are learning to translate what they experience and learn in therapy to their lives outside the therapist's office. Such statements reflect a phenomenon referred to as an internal representation, defined as clients bringing to awareness the internalized "image" (occurring in visual, auditory, felt presence, or combined forms) of their therapists when not actually with them in sessions, and thereby evoking the living presence of the therapist as a person (Knox, Goldberg, Woodhouse, & Hill, 1999). Through their internalizations, clients continue the work of therapy between, and perhaps more importantly, beyond therapy sessions.

In this short article, I will briefly mention existing theory and research regarding clients' internal representations of their therapists, include some clinical examples to try to bring the phenomenon to life on the written page, and finally offer some thoughts about how these representations may be used in the service of therapy.

Theorists assert that clients' internal representations are critical to the healing processes of therapy, and that clients' improvement may be related to the extent to which they are able to evoke representations of the benignly influential components of the therapy relationship (Rosenzweig, Farber, & Geller, 1996), such as the therapist her-/himself. Some writers further posit that many of the most important experiences that occur in therapy are those that foster the creation of these benevolently influential and enduring representations of the therapist (Dorpat, 1974; Edelson, 1963; Geller, 1984; Horwitz, 1974; Kohut, 1971, Loewald, 1960; Schafer, 1968; Strupp, 1978). Once created, clients' internal representations may function as the unassigned "homework" of therapy, as well as the psychological connective tissue between successive sessions (Orlinsky, Geller, Tarragona, & Farber, 1993), wherein clients continue between sessions to work on what they address in sessions. Just as athletes or musicians may improve by continuing to work on their activities between practices or lessons, so, too, might clients' growth and healing be enhanced by such between-session processes. Clients' internal representations of their therapists may thus serve important functions outside of the therapy office.

Extant empirical research supports these theoretical positions, indicating that internal representations may indeed be helpful to clients. In the Knox et al. (1999) study, for example, the majority of the participants (i.e., 13 adults in individual psychotherapy who were interviewed using a semi-structured qualitative protocol) indicated that they felt positive emotions (i.e., calm, comfort, focus, grounding) when experiencing their internal representations of their therapists. In addition, these respondents reported that their representations largely had salutary effects on the therapy (i.e., the experience of the representations benefited or accelerated therapy and/or the therapy relationship). Furthermore, most of the participants stated that they used their representations for introspection, and also as "between session mini-sessions." Similarly, Wzontek, Geller, & Farber (1995) found that self-perceived improvement in therapy was positively related to the participants' tendency to use their representations to continue the therapeutic dialogue outside of sessions, as well as post-termination. With respect to when internal representations may occur, Geller and Farber (1993) found that clients' representations were most likely to be evoked outside of therapy when painful emotions were experienced (e.g., sadness, anxiety, depression, guilt, fear, stress, self-hate). Calling upon these benign internal representations of the therapist in such circumstances may, then, help clients get through difficult events.

To bring this phenomenon more clearly into focus, what follows are some examples of internal representation experiences that actual clients have reported. Rosen (1982) described two powerful examples of the internal representations experienced by patients of Milton H. Erikson. In the first case, a patient felt too embarrassed to tell Erikson of a problem in a face-to-face encounter. Instead, she drove to his house, parked in his driveway, and evoked his presence with her in the car. This enabled the patient to think her way through her problem. In the second example, a patient wished to take the therapist and zip her up inside of the client's body, certainly a poignant means of holding on to the presence of the therapist. Reflecting the function these representations may serve between sessions, Kantrowitz, Katz, and Paolitto (1990) reported the words of one client as follows: "It [the client's internal representation of the therapist] was like a continuation of the [therapy]. I mean that was part of the way I would think about myself—sort of imagine myself being [in the consultation room], and what would happen there, and how I would think" (p. 643).

As additional examples, Knox et al. (1999) reported a variety of client internal representational experiences. In one example, a client saw her therapist's "penetrating eyes" pulling the client to do what she feared, and saw the therapist's smile when the client succeeded in facing her fears. Another client reported imagining her therapist extending her arms to the client, pleading with her to come for help when the client considered self-mutilation. A third client described his internal representations as more dream-like, as non-literal images of the therapist in which the client experienced his therapist, similar to a Disney cartoon or medieval painting depicting angels and devils, sitting on the client's shoulder. Finally, Knox et al. (1999) reported the case of a client who, when he had what felt like a breakthrough at work with a challenging colleague, immediately found himself, through his internal representation, envisioning himself talking to his therapist to reinforce what had been discussed in therapy.

As these examples demonstrate, clients do find internal representations of their therapists helpful, and use them to continue the processes of therapy outside of sessions. How, then, can therapists attend to clients' internal representations in the service of therapy? One idea is simply for therapists to broach the topic of internal representations with clients. In the Knox et al. (1999) study, several clients indicated during their interviews that although their internal rep-

resentations were ultimately helpful, the clients were nevertheless uncomfortable about having such experiences, fearing that their presence indicated abnormality, dependency, or pathology. As a result, the shame and embarrassment many reported feeling were alleviated simply by recognizing, via their participation in the study, that such experiences are not inherently pathological, but instead are relatively common occurrences in the psychotherapy process. Because the clients themselves were not comfortable discussing their representations with their therapists (few in this study reported having such discussions with their therapists), it may well be the therapists' responsibility to open this up as a topic of discussion. Such discussions may thus normalize the presence of the representations, thereby allaying clients' shame, embarrassment, and fear. Given the strong positive use and impact of their internal representations that clients have reported, even in the presence of some shame or embarrassment, might not even more beneficial effects arise without such fears?

Once clients' qualms about having internal representations of their therapists are reduced, it may also be beneficial to engage in a full discussion of the representations themselves: What form do they take (i.e., auditory, visual, felt presence, combined)? What triggers them? How often they occur and how long do they last? How do clients use them and what effect do they have on clients? What affect is associated with them? How do they change over time? Through such discussions, therapists and clients may come to understand the function the representations hold for clients, functions that may yield clues for enhancing the therapy itself. If, for example, a client's representations are primarily visual, yet traditional talk therapy relies on verbal exchanges of information, therapists may want to think about alternative interventions they may use to better attend to a client's visual way of processing his/her experiences (e.g., visual imagery). If the representations seem to occur only at particular times, or in particular situations, this may give clues as to when clients may be most in distress. Likewise, if the frequency of internal representations suddenly increases or decreases, these changes may signal some alteration in the client's well being and/or in the therapy relationship. Or if the reasons clients invoke their representations change over time, such changes may indicate that clients have resolved some issues but may still be struggling with other, as yet unresolved, issues. These are but a few of the many important questions therapists may wish to ask regarding clients' internal representations of therapists.

It may be that therapists occasionally wish to proceed even further with regard to clients' internal representations. As found in the Knox et al. (1999) study, most therapists took no deliberate role in suggesting to their clients that they use internal representations. It is possible, though, that some circumstances might call for a therapist's more active invocation of such representations. A client in the Knox et al. (1999) study, for instance, expressed a wish that her therapist would provide her with particular statements that she could use to calm herself. One of my colleagues took such an action with a client, with reportedly positive effect: Her client was experiencing significant distress, having difficulty even grounding herself to present reality. The colleague literally wrapped her arms around the client and held her for a few seconds. She then told the client to remember that feeling when the client felt that she was losing her grasp on reality.

Thus, in the same way that a transitional physical object may prove comforting to a client in distress, being able to evoke specific therapist words, images, or presence may likewise be helpful when clients face particularly troubling situations. Imagine, for example, clients who are prone to panic attacks when in crowds. Might it be helpful for the therapist to provide specific words clients could say to calm themselves at such times? Or might clients find it helpful to be invited to recall the therapist's

comforting face when the former faces distressing events? Or as in the case cited above, to recall the therapists' physical presence as a source of grounding and support? Important discussions of clients' internal representations of therapists may, then, have several functions: to normalize the experience of representations, to explore their phenomenology and meaning, and to deliberately invite clients to use such representations in times of need.

There also exist ample opportunities for further research of this phenomenon. As a complement to our present knowledge, for instance, it would be helpful to know therapists' perspectives on clients' internal representations. Secondly, is there any connection between client diagnoses and internal representations? Or between attachment style and internal representations? In addition, tracking the evolution of clients' representations over the course of therapy may yield useful information about change processes: Are such changes, for example, associated with any parallel changes in psychological functioning? These are only a few of the many provocative questions that could be pursued in our efforts to understand, and thus better serve, our clients.

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STUDENT PAPER DIVERSITY AWARD

Twentieth Century Barbarism: Culture, Gender and Acid Violence

Durriya Meir

Durriya received her Doctorate in Psychology from Wright State University, Ohio. Before starting her doctoral program, she worked as a lecturer at North South University where she established the first counseling center in the history of the country. Her clinical work has focused on issues of diversity and violence against women (especially South Asian women), multicultural issues, and providing services to communities of color and international students for which she has won awards. Originally from the state of Gujarat (India), Durriya grew up in Bangladesh and has spent almost 10 years of her life in the USA and Canada. She is fluent in Gujarati, Bengali (Bangla), and Hindi; and speaks French and Urdu as well.

ABSTRACT

Acid violence, in which nitric or sulfuric acid is thrown at the victim at very close range, causes the skin to melt and fuse together, leaving the bones exposed. The scarring and disfigurement are permanent, often resulting in a loss of basic functions, such as vision, hearing, use of limbs, etc. Females are the primary targets, for refusing the advances of a predatory male, family disputes, vengeance, or dowry demands. Acid violence has received wide scale recognition only in the past few years because it has generally been considered to be a "third-world" country problem. Acid attacks against women have been documented in several countries around the world. However, such attacks have seen an alarming rise in Bangladesh over the past few years. One reason for such an increase is the easy availability of acid. A second reason is the corrupt legal, judicial and political systems that allow such violence to go unchecked. Like other forms of violence against women, acid violence cannot be treated as separate from the global context within which violence against women occurs. That there is interplay between gender and violence in most cultures is indisputable and therefore, an understanding of the historical context of a female's status within that culture is critical.

In the traditional, conservative cultures of most South Asian countries (for the purpose of this paper only India, Pakistan and Bangladesh have been considered because of their shared sociopolitical, cultural and religious histories), women today are at best secondary citizens or at worst, non-citizens. This is in contrast to the contention that many historians make about the high status that women occupied in South Asian, specifically Indian, society of ancient times. It is asserted that a multitude of factors, including political upheavals and shifts in religious dominance, eventually led to the decline in the status of the South Asian female to the position that she occupies today. Moreover, the dominance and acceptance of a single religion as a way of life, whether it is Hinduism or Islam, means that many forms of violence may be believed to be condoned by the religion itself. A comprehensive understanding of this form of violence requires that it be examined within the realm of cultural, religious, social, and gender norms. Case studies of survivors of acid attacks in Bangladesh highlight the emotional and psychological consequences on the victim and her family. Lack of adequate medical facilities has resulted in many survivors being sent abroad for treatment, sponsored by international organiza-

tions such as the United Nations. However, once abroad, survivors are faced with adjusting to a new culture with little or no support. Moreover, social isolation due to language barriers and the prospect of prolonged medical treatment in a foreign country intensify the emotional and psychological trauma. Survivors are often faced with a double bind — if they seek political asylum, they risk negatively affecting other survivors' chances of being sent abroad for treatment; on the other hand, if they return, they risk being re-victimized. Moreover, the lack of systematic and well-established psychological services means that there are little or no resources to help survivors readjust to the society. Their only sources of support are their families and informal networks of non-governmental and/or women's organizations. Implications for therapy, which is often considered a necessary part of survivors' psychosocial and emotional rehabilitation, are addressed in light of the lack of awareness about this form of violence, including the social and political context within which they take place. Cultural considerations in treating victims are discussed.

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Roberta L. Nutt, Ph.D.
Division 29 Fellows Chair
Department of Psychology & Philosophy
P. O. Box 425470
Texas Woman's University
Denton, TX 76204-5470
(940) 898-2313
RNutt@twu.edu

FEATURE

Could the Titanic Disaster Have Been Prevented?

The Relevance of Patient Safety to Psychological Practice[1]

Samuel Knapp, Ed.D.
Leon VandeCreek, Ph.D.

On April 14, 1912, 1,503 passengers and crew members on the *HMS Titanic* died in the most publicized maritime disaster of all time. However, on at least four crucial points the disaster could have been averted or at least greatly ameliorated. Three of these four points were characterized by a lack of communication.

First, ships of that era traditionally had several water tight compartments at their bottoms. In the event of a puncture below the water level, one compartment could fill up with water, but the others would be free of water and keep the ship afloat. However, the Harland and Wolff company did not build such traditional water tight compartments in the *Titanic* and when the iceberg punctured the *Titanic* below the waterline its entire bottom filled with water and it sank.

Second, the White Star Line, which owned the *Titanic*, put on life boats for only one-third of the passengers. The owner of the line, J. Bruce Ismay, was so confident of the impregnability of the *Titanic* that he thought lifeboats were unnecessary. The crew was not even trained in the use of the lifeboats that they did have; otherwise routine drills with lifeboats never occurred.

Third, the *Titanic*'s wireless operators had been instructed to give priority to the social messages of its wealthy passengers. Consequently, the wireless operators were so busy sending outgoing social messages that they did not receive all of the incoming telegraph messages warning of iceberg sightings in the vicinity. Unaware of the iceberg danger, Captain Edward Smith ordered the *Titanic* to go full speed through iceberg territory in hopes of breaking the world's record for crossing the Atlantic. If the *Titanic* had been going more slowly, the pilots might have seen the iceberg in time and missed it entirely (as it was, the iceberg barely scraped the *Titanic*, but enough to leave a gash along its side below the water level).

Finally, the USS *California*, which was within only a few miles of the *Titanic* when it struck the iceberg, could have saved everyone if it had responded promptly to the *Titanic*'s distress flares. However, one hour before the *Titanic* struck the iceberg, the *California*'s authoritarian Captain Stanley Lord had ordered his crew to shut down the telegraph post and to not disturb him for any reason. When his sailors saw the flares from the *Titanic*, they chose to interpret them as routine communications between ships and dared not wake Captain Lord to solicit his opinion (Lord, 1955).

Who is to blame for the disaster? Was it the Harland and Wolff Company, J. Bruce Ismay and the White Star Line, Captain Edward Smith and the telegraph operators on the *Titanic*, or Captain Stanley Lord of the *USS California*? In reality each of them shares some portion of the responsibility for the loss of life.

However, it could be asked why systems were not in place to ensure adequate precautions? Why weren't Harland and Wolff required to build their ships appropriately? Why wasn't the White Star Line required to place a sufficient number of life boats on its ships? Why wasn't the crew trained in using them? Why was the *Titanic* allowed to sail in iceberg-infested water without the ability to receive communications through the telegraph? Why was Captain Stanley Lord allowed to give orders that

prevented his crew from notifying him of the distress signals?

A systems perspective has been used to investigate and understand other disasters such as Three Mile Island, Chernobyl, and airplane crashes. Recently this perspective also has been used to evaluate serious errors in the treatment or management of hospital patients, especially in regard to medication errors. This article reviews the basic principles of the systems-based patient-safety movement and identifies its relevance to the practice of psychology, especially in outpatient settings.

Medical Errors

According to the Institute of Medicine (1999), between 44,000 and 98,000 patients die each year because of medical errors, including a substantial number from medication errors. According to some statistics, medical errors are the eighth leading cause of death in the United States. Although some believed that the Institute of Medicine report overestimated the amount of harm done by medical errors, general consensus exists that efforts should be taken to reduce the frequency of those errors.

A medical error is defined as any mistake that substantially harms or creates a realistic threat of harming the safety of a patient. Many medical errors involve medications and include prescribing or delivering the wrong medication or the wrong dose of medication. Other errors include mistakes by laboratories (e.g., the wrong name is submitted with a blood vial), a patient being given an improper diet, surgery conducted on the wrong body part, infant abduction or the discharge of an infant to the wrong family, and failure to provide adequate monitoring to a patient who is suicidal or homicidal.

Some medical errors are the result of intentional acts that involve patient abuse or treatment of a patient by a practitioner who is under the influence of alcohol or another drug. However, most of the errors are related to systematic communication failures. For example, a nurse or pharmacist may misinterpret the medication abbreviation used by the physician; a resident may be afraid to express her doubts or concerns to the attending physician; and patients are not given the opportunity to express their distress or symptoms clearly to their caregivers.

State governments and the JCAHO are taking actions to reduce medical errors. JCAHO has developed the "sentinel" program by which they will require agencies that they accredit to report medical errors. A sentinel event "is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof" (Sentinel Event Policy and Procedures, 2000, p. 1).

States have varied in how they have responded to the problem of medical errors; some states have developed mandated reporting systems for medical errors. The federal Agency for Healthcare Research and Quality (AHRQ) has been awarding research grants directed at studying ways to prevent medical errors. Congress has been considering federal legislation to address the problem of medical errors; however, no legislation has been enacted yet.

Research about medical errors is on-going, but many recommendations have been made, many of them dealing with enhancing the communication that occurs among hospital staff. For example, JCAHO has made several recommendations concerning patient safety such as requiring standardized abbreviations, acronyms, and symbols throughout the organization (including a list of abbreviations, acronyms and symbols not to be used). Organizations that fail to follow these recommendations could be sited for a violation in their accreditation report.

Relevance to Psychology

What relevance does the patient safety literature have for the practice of psychology?

Obviously it applies to psychologists who work in hospitals or other institutions, but the basic principles of patient safety apply to outpatient psychologists as well.

The optimal manner by which to reduce errors is to develop a "culture of safety" in which the welfare of patients becomes everyone's business. According to an editorial in the *Journal of the American Medical Association*, the prevention of medical errors requires a "culture of trust, honesty, integrity and open communications among patients and providers in the health care system" (Lenape et al., 1996, p. 1445). We suggest that psychologists can foster the culture of safety by striving for enhanced communications not only with the patient but with others involved in the welfare of the patient (such as other health care providers or family members), and their office staff, and that they embed themselves in a protective network of trusted colleagues.

Of course, it is essential to develop a trusting relationship with patients (or when clinically indicated, the patients' families) who will share information essential for treatment. However, patient welfare also requires that psychologists work closely and share information with physicians and other health care professionals who are working with the patient. For example, medical errors can occur when physicians do not receive accurate information from psychologists about their mutual patients. Physicians need to know how the patient is responding to medications or if the patient is taking other medications, over-the-counter drugs, or alternative herbal remedies that could compromise the effectiveness of a prescription drug, or otherwise jeopardize patient safety. Unfortunately, many patients do not tell their physicians about their use of alternative medical remedies (Defino, 2000).

Second, psychologists need to keep channels of communications open with members of their office staff and supervisees. Staff members and supervisees need to feel free to bring issues to the attention of their supervisors/psychologists. Busy psychologists can sometimes give a "Captain Stanley Lord" impression that they do not want to be bothered.

Finally, psychologists can embed themselves in a protected network where they receive regular feedback from colleagues and associates concerning their performance. They can receive on-going consultation on cases where knowledgeable associates can give them feedback on their general style of therapy. They can learn about emerging techniques in the field. Sometimes these are called "peer supervision" groups (this is probably a misnomer; peer consultation is a better term). Sometimes they are called journal clubs.

An underlying principle in quality treatment is for psychologists to place themselves in an environment that reinforces desired behaviors that promote patient welfare. "Make your environment work for you, not against you" (Norcross, 2000, p. 711). The environment should provide a consistent feedback loop whereby the outcomes and procedures are consistently being reviewed and modified. The various forms of external feedback include, but are not limited to, consulting with peers, gathering systematic data on patient outcomes or satisfaction, receiving reviews of professional notes, engaging in informal conversations with colleagues, and participating in continuing education programs.

Conclusion

If they could have done it over again, Harland and Wolff would have built the *Titanic* differently, the White Star Line would have had a sufficient number of life boats aboard, the crew would have known how to operate the lifeboats, Captain Edward Smith would have ordered the *Titanic* to slow down and to keep its telegraph post open to receiving iceberg warnings, and Captain Stanley Lord would have sent the *California* to the rescue. Each one of these participants could point the figure of blame at someone else. In reality,

however, each one of them could have prevented or ameliorated the disaster.

Just like the participants in the *Titanic* disaster, all health care professionals have a responsibility to anticipate and prevent tragedies. We need to promote a "culture of safety" characterized by open communication and cooperation with the patient, other health care providers, and members of our staff. We also need to promote a "culture of safety" when we embed ourselves in a protective social network. Patient welfare requires nothing less.

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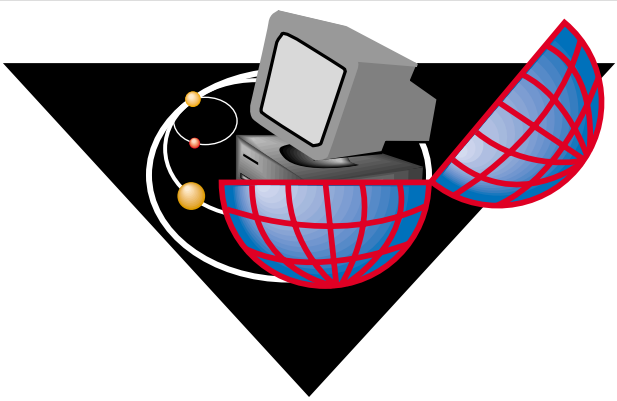
Lord, W. (1955). *A night to remember*. New York: Henry Holt.

Norcross, J. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Theory, Research, and Practice, 31,* 710-713.

[1] A portion of this article has been adapted, with permission of the Pennsylvania Psychological Association, from a previous article published in the *Pennsylvania Psychologist*.



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PRACTITIONER REPORT

Psychological Health Care[1]

Ronald F. Levant, Ed.D., MBA, 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.

From my current vantage point as both a dean of a graduate school of psychology and an officer of the American Psychological Association, I have a unique opportunity to reflect on the evolution of professional psychology. The scope of psychological practice is expanding and diversifying into new areas—areas where the distinction between applied scientist and professional practitioner begins to blur—such as health psychology (and its related aspects such as psychology in primary care, psychoneuroimmunolgy, and applied psychophysiology), neuropsychology, rehabilitation psychology, forensic psychology, child and family psychology, multicultural psychology, geropsychology, business and industry consultation, and psychopharmacology. It cannot be emphasized enough that the future evolution of professional psychology will entail the development of roles that do not now exist—in health care, public sector care, the courts, the correctional system, schools, businesses, etc.—in the numbers that psychologists entered the role of outpatient therapists in the 1970s and 80s.

In this column I want to highlight the new opportunities for expanding the roles of professional psychologists in psychological health care. I will first discuss the redefinition of psychology from specialty mental health care to primary health care and then take up the psychological management of disease and health.

Redefinition: From Specialty Mental Health Care to Primary Health Care

One of the most important aspects of the evolving nature of professional practice: is the redefinition of psychology from specialty mental health care to primary health care. As a specialty profession of mental health care, we deal primarily with the people who self-identify as having psychological problems and who have access to a mental health specialist, which is just a fraction of those who need psychological services. As a primary health care profession we would be able to serve the much larger group of people who do not have access to mental health care or who do not identify their problem as psychological. To grasp this potential, please consider a few facts about health care: (1) The U.S. Department of Health and Human services has pointed out the seven top health risk factors—tobacco use, diet, alcohol, unintentional injuries, suicide, violence, and unsafe sex—are behavioral; (2) Seven out of the nine leading causes of death have significant behavioral components; (3) At least 50% (and maybe as much as 75%) of all visits to primary care medical personnel are for problems with a psychological origin (including those who present with frank mental health problems and those who somaticize) or psychological component (including those with unhealthy

lifestyle habits such as smoking, those with chronic illnesses, and those with medical compliance issues); (4) .Moreover, there is a growing body of empirical evidence supporting the effectiveness of psychological interventions in ameliorating a wide range of physical health problems, including both acute and chronic disease affecting literally every organ system and encompassing pediatric, adult and geriatric populations. In addition to being clinically effective, these interventions are dramatically less expensive than alternative somatic interventions across a wide variety of illnesses and disorders, including cardiovascular disease, diabetes, traumatic brain injury, etc. (5) The vast majority of people receiving mental health treatment are cared for by medical professionals with minimal specific training in mental health.

The Cartesian world view, which separates mental health from physical health, is breaking down, and as a result psychology has a tremendous opportunity to evolve into a premier primary health care profession. At the very least this would put psychologists on the front lines of health care, working collaboratively with physicians and nurses. The more visionary perspective is that health care should be reorganized so that psychologists serve as primary caregivers at the gateway to the health care system, functioning to diagnose and treat the more prevalent psychological problems, and referring to medical physicians when indicated.

Psychological Management of Disease and Health

Over the past several years, it has been a consistently predicted that psychology's potential contribution to the prevention, assessment, treatment, and management of acute and chronic illnesses will play an important role in the future development of the profession. Much of the work in health psychology—and a significant opportunity for the field of psychology in general—focuses on behavioral contributors to health and disease.

Moreover, as noted, psychological interventions are effective and cost-effective in ameliorating a wide range of physical health problems. For example, data regarding the efficacy and cost-effectiveness of psychological interventions for chronic pain are so compelling that the National Institutes of Health (NIH) published a consensus statement calling for wider acceptance and use of behavioral treatments in conjunction with typical medical care (NIH, 1995). In primary care settings, medical utilization can be substantially reduced through the availability of behavioral interventions. Total ambulatory care visits have been shown to decrease an average of 17 percent, with even greater reductions when visits for specific illnesses such as asthma (49 percent) and arthritis (40 percent) are tracked (Sobel, 1994).

All of this suggests a huge potential market for psychological services in health care systems. In order to access these opportunities, however, psychology must define itself as a health profession rather than as a mental health profession. In fact, the APA Board of Professional Affairs Work Group on Expanding the Role of Psychology in the Health Care Delivery System has recently called for a "figure-ground reversal" in professional psychology (APA, 2000). That is, rather than viewing itself as a mental health profession with health psychology representing a subset of its expertise, the group advocated a view of psychology as a health profession, with mental health as a subset of its expertise.

Psychologists' core skills in assessment and treatment can be integrated with roles in supervision, administration, program design, program evaluation, and research. As a consequence, psychologists are uniquely positioned to assume a greater role in the management of both health and disease. Potential functions include coordinating complex interventions, assisting patients to evaluate and select among treatment options, helping people to make necessary lifestyle changes and to comply with complex and difficult treatment regimens, and providing treatment for coexist-

Symposium: Current Perspectives and Future Directions for Treating Personality Disorders

8/07 Thu: 11:00 AM – 12:50 PM
Metro Toronto Convention Centre, Constitution Hall 105

Chair
Jeffrey J. Magnavita, PhD, University of Hartford

Participant/1stAuthor
Judith S. Beck, PhD, University of Pennsylvania
Theodore Millon, PhD, Institute for the Advanced Studies of Personology and Psychopathology, Coral Gables, FL
Francine Shapiro, PhD, Mental Research Institute, Palo Alto, CA
Lorna S. Benjamin, PhD, University of Utah

Conversation Hour: Getting It Right—Legends Albert Ellis (90) and Aaron T. Beck (82) in Conversation With Frank Farley

8/07 Thu: 1:00 PM – 1:50 PM
Metro Toronto Convention Centre, Constitution Hall 105

Chair
Frank Farley, PhD, Temple University

Participant/1stAuthor
Albert Ellis, PhD, Albert Ellis Institute, New York, NY
Aaron T. Beck, MD, University of Pennsylvania

Workshop: Enhancing Psychotherapy Training and Supervision With Computer Technology

8/07 Thu: 1:00 PM – 2:50 PM
Metro Toronto Convention Centre, Meeting Room 203B

Co-chairs
Kenneth L. Miller, PhD, Youngstown State University
Don Martin, PhD, Youngstown State University

Participant/1stAuthor
JoLynn V. Carney, PhD, Youngstown State University
Jan Gill-Wigal, PhD, Youngstown State University
Victoria E. White, PhD, Youngstown State University
Sherry A. Gallagher-Warden, PhD, Youngstown State University
Stephanie J. Ford, PhD, Youngstown State University

Symposium: Role of Emotional Processes in Dysfunctional Behaviors

8/07 Thu: 3:00 PM - 3:50 PM
Metro Toronto Convention Centre, Meeting Room 714A

Chair
Jeanne C. Watson, PhD, University of Toronto, NONE, ON, Canada

Participant/1stAuthor
Goldie M. Millar, PhD, University of Toronto, NONE, ON, Canada
Title: Portrayal of Emotion Within Substance Dependence: Arguing for Change
Fiona Downie, MEd, University of Toronto, NONE, ON, Canada
Title: Disordered Eating and Emotional Expression: Self-Silencing Considered
Lisa A. Berger, MEd, University of Toronto, NONE, ON, Canada
Title: Role of Emotional Processing in Self-Harm Behavior

Symposium: EMDR (1989—2002)—-Update of Sociopolitical, Research, and Clinical Implications

8/08 Fri: 8:00 AM - 9:50 AM
Metro Toronto Convention Centre, Constitution Hall 105

Chair
Byron R. Perkins, PsyD, NONE

Participant/1stAuthor
Byron R. Perkins, PsyD, NONE
Title: EMDR: An Overview

Nancy J. Smyth, PhD, State University of New York at Buffalo
Title: Role of Exposure in EMDR Treatment of PTSD
Susan Rogers, PhD, VA Medical Center, Coatsville, PA
Title: Latest Findings in EMDR Process Research and Component Analysis
John C. Norcross, PhD, University of Scranton
Title: Sociopolitical and Psychohistorical Factors in Acknowledging the Effectiveness of EMDR
Discussant
Francine Shapiro, PhD, Mental Research Institute, Palo Alto, CA
Larry E. Beutler, PhD, Pacific Graduate School of Psychology

Conversation Hour: Albert Ellis at 90—-A Conversation With Frank Farley
8/08 Fri: 2:00 PM - 2:50 PM
Metro Toronto Convention Centre, Constitution Hall 106
Chair
Frank Farley, PhD, Temple University
Participant/1stAuthor
Albert Ellis, PhD, Albert Ellis Institute, New York, NY

Symposium: Dual Perspectives on Dual Relationships—-Critical Incidents in Nonsexual Boundaries
8/08 Fri: 3:00 PM - 4:50 PM
Metro Toronto Convention Centre, Constitution Hall 105
Chair
John C. Norcross, PhD, University of Scranton
Participant/1stAuthor
Arnold A. Lazarus, PhD, Rutgers the State University of New Jersey, Princeton, ZZ
Gerald P. Koocher, PhD, Simmons College
Ofer Zur, PhD, Independent Practice, Sonoma, CA
Eric Harris, EdD, JD, APA Insurance Trust, Lincoln, MD
PLEASE NOTE: THIS SYMPOSIUM HAS BEEN CANCELLED

Social Hour
8/08 Fri: 6:00 PM - 7:50 PM
Crowne Plaza Toronto Centre Hotel, Ontario Room

Symposium: Real Relationship in Psychotherapy—-Theoretical Foundations and Measurement
8/09 Sat: 8:00 AM - 8:50 AM
Metro Toronto Convention Centre, Meeting Room 715A
Chair
Cheri L. Marmarosh, PhD, Catholic University of America
Participant/1stAuthor
Charles J. Gelso, PhD, University of Maryland College Park
Jairo Fuertes, PhD, Fordham University
Title: Measuring the Real Relationship in Psychotherapy: Real Relationship Inventory Therapist Form
Co-Author: Frances A. Kelley, PhD, Georgia State University
Discussant
Bruce E. Wampold, PhD, University of Wisconsin—Madison

Invited Address: Update on Pharmacological Interventions for ADHD Across the Life Span
8/09 Sat: 9:00 AM - 10:50 AM
Metro Toronto Convention Centre, Constitution Hall 106
Chair
Alice K. Rubenstein, EdD, Monroe Psychotherapy Center, Pittsford, NY
Participant/1stAuthor
Robert J. Resnick, PhD, Randolph—Macon College

Symposium: Positive Strategies to Prevent Ethical Problems in Psychotherapy Practice
8/10 Sun: 8:00 AM - 9:50 AM
Metro Toronto Convention Centre, Reception Hall 104C
Chair
Alan C. Tjeltveit, PhD, Muhlenberg College

Participant/1stAuthor
Samuel Knapp, EdD, Pennsylvania Psychological Association, Harrisburg, ZZ
Title: Preventing Ethical Problems: An Overview of Existing and Proposed Strategies
Michael C. Gottlieb, PhD, University of Texas Health Science Center at Dallas
Title: Primary Prevention Approach to Ethical Practice
Melba J.T. Vasquez, PhD, Vasquez & Associates Mental Health Services, Austin, TX
Title: Development of Character, Virtue, and Morality
Caren C. Cooper, PhD, Concordia University at Austin
Title: Ethical Issues in Emerging Areas of Practice

Symposium: Legal and Ethical Challenges in the Supervision of Psychotherapy
8/10 Sun: 10:00 AM - 11:50 AM
Metro Toronto Convention Centre, Meeting Rooms 205A/B
Chair
Janet T. Thomas, PsyD, Independent Practice, St. Paul, MN
Participant/1stAuthor
Thomas F. Nagy, PhD, NONE
Title: Supervision and Ethical Standards
Gary R. Schoener, BA, Walk-In Counseling, Minneapolis, MN
Title: Psychotherapy Supervision: Training in Maintaining Boundaries and Effective Clinical Practices
Linda M. Jorgenson, JD, Spero and Jorgenson, Cambridge, MA
Title: Psychotherapy Supervision: Legal Issues, Risk Management, and Practice Standards
Janet T. Thomas, PsyD, NONE
Title: Supervisees at Various Developmental Stages: Ethical Challenges for Supervisors
Eric Harris, EdD, JD, APA Insurance Trust, Lincoln, MD

Symposium: Using Outcome Measures to Improve Psychotherapy
8/10 Sun: 12:00 PM - 1:50 PM
Metro Toronto Convention Centre, Meeting Room 717A
Chair
David W. Smart, PhD, Brigham Young University
Participant/1stAuthor
Cory Harmon, MS, Brigham Young University
Title: Enhancing Psychotherapy Outcome: Using Client Feedback and Clinical Support Tools
Co-Author: Michael J. Lambert, PhD, Brigham Young University
Co-Author: Eric J. Hawkins, BA, Brigham Young University
Co-Author: Karstin L. Slade, BA, Brigham Young University
Co-Author: Michael Campbell, BA, Brigham Young University
Co-Author: Jeffrey Case, MA, Brigham Young University
Co-Author: John C. Okiishi, PhD, Brigham Young University
Co-Author: David W. Smart, PhD, Brigham Young University
Co-Author: Stevan L. Nielsen, PhD, Brigham Young University
Wade Lueck, MA, Brigham Young University
Title: Differential Response to Treatment as a Function of Diagnostic Classification
Co-Author: Michael J. Lambert, PhD, Brigham Young University
Co-Author: David A. Vermeersch, PhD, Brigham Young University
Stevan L. Nielsen, PhD, Brigham Young University
Title: Continuing Patterns of Treatment Response at Follow-Up
Co-Author: Jacob Hess, BA, Brigham Young University
Co-Author: Melissa Goates, BA, Brigham Young University
Co-Author: Michael Campbell, BA, Brigham Young University
Michael J. Lambert, PhD, NONE

Title: Ethnic Background and Therapy Outcome
Co-Author: Michael Campbell, BA, NONE
Co-Author: Karstin L. Slade, BA, NONE
Co-Author: Eric J. Hawkins, BA, NONE
Richard Isakson, PhD, Brigham Young University
Title: Assessing Couple Therapy as a Treatment for Individual Distress
Co-Author: Eric J. Hawkins, BA, Brigham Young University
Co-Author: Jennifer Martinez, MA, Brigham Young University
Co-Author: Richard Moody, PhD, Brigham Young University
Discussant
Charles J. Gelso, PhD, University of Maryland College Park

Workshop: Cognitive—Behavioral Approaches to Treating Suicidal Behavior
8/10 Sun: 1:00 PM - 2:50 PM
Metro Toronto Convention Centre, Meeting Room 101
Chair
Michele S. Berk, PhD, University of Pennsylvania
Participant/1stAuthor
Michele S. Berk, PhD, NONE
Title: Cognitive Therapy Intervention for Treating Suicide Attempters
Gregg R. Henriques, PhD, University of Pennsylvania
Title: Complex Issues in the Treatment of Suicide Attempters
M. David Rudd, PhD, Baylor University
Title: Cognitive Therapy for Suicidality
Alec L. Miller, PsyD, Montefiore Medical Center, Bronx, NY
Title: Dialectical Behavior Therapy for Suicidal Multiproblem Adolescents

Business Meeting
8/10 Sun: 1:00 PM - 3:50 PM
Fairmont Royal York Hotel, Algonquin Room

JACK D. KRASNER EARLY CAREER AWARD

Congratulations to Craig Shealy, Ph.D., who is the recipient of the Jack D. Krasner Early Career Award. Please join the Division in recognizing Dr. Shealy at the Division 29 Awards Ceremony/Social Hour on Friday, August 8, at 6:00 pm at the Crowne Plaza Toronto Centre Hotel, Ontario Room

ing psychological problems as well as the psychological and emotional reactions of patients, their families, and other health care providers. Further, our strong research background—a unique qualification of psychologists among health care professionals—prepares us to play key roles in the design, implementation, and evaluation of prevention, and intervention programs at the individual, system, and community level.

A serious limitation on psychologists' ability to participate in integrated care has been the absence of payment mechanisms to reimburse psychological services within general health care settings. Psychologists have not been permitted to bill under procedure codes such as evaluation and management of medical disorders, patient education, and preventative services. As a consequence, they were forced to bill under mental health codes, which are often inappropriate, or to make arrangements with systems to bundle their services (e.g., using DRG or per diem methodologies). Moreover, psychologists frequently do not have access to reimbursement for services provided to patients related to non-psychiatric diagnoses, even when these services are well accepted clinically and are strongly supported by the empirical literature. However, the recent approval of the Health and Behavior codes for psychologists will begin to address these problems.

Some of the more specific trends in health care also have implications for psychology. For example, information about genetic factors in a variety of diseases and disorders is rapidly becoming available, largely as a result of the Human Genome Project, and genetic testing is becoming increasingly common. Genetic testing will confront people with profound choices and decisions. Assisting people to evaluate the available information, make appropriate choices, and implement preventative programs are roles that psychologists may fulfill in the future (see Shiloh, 1996). The aging of our society will also present significant opportunities for psychologists to enter health and disease management in the geriatric area (see Haley, Salzberg, & Barrett, 1993; Qualls, 1998; Takamura, 1998). As a part of a large and growing interest in complementary or alternative medicine (see Eisenberg et al., 1998), Americans are increasingly consuming herbal and nutritional remedies for a variety of prevention and treatment purposes. As an aspect of their practice, psychologists can play a key role in helping consumers to evaluate the available empirical data about the effects and the effectiveness of these remedies.

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

Medical School Training, Patient Safety, and Prescriptive Authority for Psychologists

John L. Caccavale, Ph.D., M.S. PsychoPharm

In a previous article I wrote of the added value that I believe derives from training in psychopharmacology. I pointed out that increased patient safety was one important value that one can expect to after completing training in psychopharmacology. Some opponents to prescriptive authority (Hayes & Heigby, 1996; Sechrist, 2002; Bush, 2002) for psychologists argue that medical school training is the only way that psychologists can be trained to safely prescribe medications because of the complexities of the physiological response to psychotropic medications, which they believe are dangerous drugs. Their arguments, however, remain in the realm of opinion because there is no large scale data on psychologists performance prescribing medications. One study, performed by the American College of Neuropsychopharmacology, looking at the performance of military trained psychologists who prescribe medications, does not support the concerns of RxP opponents (ACNP, 1998).

Because there were so few psychologists involved in that study, opponents do not see it as predictive and one that can be generalized to a larger population of psychologists. One possible way to shed some light on the relationship of training to performance is to look at adverse drug events (ADEs), which are preventable errors committed by physicians who presently prescribe the bulk of medications. Also, one can look at a comparison between the injury rates of psychotropics and other classes of medications. Dr. Jack Wiggins and myself have done this and that analysis presently is in review. Some results of our findings may help answer many of the concerns of some that believe patient safety would be jeopardized if psychologists were allowed to prescribe without completing a medical school education and training program.

The Relative Safety of Psychotropic Medications

During the calendar year ending 2001 over three billion prescriptions for medications were written in the United States at a cost well over $132 billion dollars (AHRQ, 2001; Woodcock, J., 2000). Psychotropic comprise about 15% of the total but are the fastest growing drugs of all medication classes. Generally, the risks of ADEs associated with psychotropic medications are less than those of drugs for other disorders (Chakos, M., et al., 2001; Breier, AF, et al., 1999; Khaled, S. & Kaplowitz, N, 1999; Volavka, J., et al., 2002). But, psychotropic medications are also used to treat other than their approved uses for symptoms of psychological disorders. Increasingly, psychotropics are used for conditions that they are not designed or approved for and with populations never intended. Often their use is seen by some as a less costly substitute for psychotherapy. Off label uses can increase ADEs.

Estimates of the annual cost due to increased harm from ADEs ranges from a low of $72 billion to a high of $172 billion dollars (AHRQ, 2000; Classen, D., et al., 1997; Wachter, R., 1997). The fact that the increased harm and costs from medications may actually exceed the total annual cost of the medication themselves begs for further study. Fatalities from adverse drug events (ADE) in the US are estimated to exceed 100,000 people on a yearly basis (IOM, 2000). Non-fatal injuries from ADEs are estimated to be about 650,000, yearly (Gebhart, 2000; IOM, 2000; Schenkle, S., 2001).

The Institute of Medicine of the National Academies of Sciences did a comprehen-

sive investigation of medication errors by physicians and published this landmark study as To Err Is Human (2000). A major findings of that study was that annual fatalities from medication errors surpassed deaths from motor vehicle accidents (43,458), breast cancer (42,297), and AIDS (16,516). Fatalities and injuries from policies in the use of restraints and other non medications procedures in nursing home settings far exceed those associated with psychotropic medications (Bourdel-Marchasson, I., et al., 1997; Castle, NG, Fogel, B & Mor, V, 1997; Evans, LK, et al., 1997; Lackner, TE & Battis, GN, 1995; Mitchell, SL, Kiely, DK, & Lipsitz, LA, 1997). Opiate and cardiac medications contribute the greater share of all ADEs and fatalities (Khaled, S. & Kaplowitz, N, 1999; Love, JN, et al., 2000; Tabboulet, P., et al., 1993; Thomas, EJ & Brennan, TA, 2000). These classes of medications are not being pursued by psychologists seeking RxP.

Yet, even though the incidence rates of injury and fatalities from non-psychotropic drugs vastly exceeds those related to psychotropic medications, there is a misconception by many that psychotropic drugs are more dangerous than other classes of medications. The data, however, does not support this claim. For example, in the year ending 2000, over 16,000 deaths from gastrointestinal complications were attributed to non-steroidal anti-inflammatory drugs (Singh, G., 1998). Further, several thousand more deaths involving cardiovascular complications also were attributed to this same class of medication, which are used to treat common inflammation (Page, H. & Henry, D., 2000).

One cannot find any statistics that mortality from psychotropic medications approach the level of NSAIDS, which now can be obtained over-the-counter. In comparison, since its introduction several years ago, the anti-psychotic medication Clozaril, a drug used to treat schizophrenia in a population of treatment resistant patients, registers about 10-15 fatalities for every 10,000 patient years (Glassman, AH, & Bigger, JT, 2001). This is a very low incidence rate in comparison to fatalities from opiates, cardiac and NSAID medications. Moreover, in general, the causative relationship between Clozaril and fatality have not been clearly established because patients using this medication typically have a very compromised physical state, suffering from a host of non-psychiatric ailments. Most psychopharmacologists, I believe, would agree that Clozaril, despite it being one of the most potentially harmful of all psychotropic medications, represents less potential for harm than the majority of cardiac medications. Thus, any objective analysis shows that prescribing psychotropic medications, which are being pursued by psychologists, are much safer than other classes of medications, which RxP psychologists have no intention to prescribe.

Medical School Training and Prescribing Errors And Proficiency

What types of prescribing errors are made by physicians? Type A ADEs are harms resulting from prescription medication errors and other avoidable errors. Harms can range from a simple rash to death. Type B ADEs are harms not so much related to errors but to the unique response of the patient to the drug, e.g., anaphylactic shock. An undetected hypersensitivity or unknown inherited response to a medication comprise this category of ADE. Most of the studies relating to ADEs show that the errors made by physicians when prescribing are largely due to errors in dosing or ordering the wrong medication (Dean, B., 2001; Kenneth, EB, et al., 2002). They may even give the wrong dose or the wrong medication even when known allergies to a medication exist. Gebhart (2000), in an article published in Drug Topics reported that "overdosing is a major problem. He believes that many ADEs are a result of physicians using higher doses of medications than are needed to treat the problem. Despite the inaccurate claims by the medical profession that physicians are well trained in pharmacology and prescribing, these errors persist.

In testimony before a FDA hearing on ADE's, Dr. Robert Califf, a cardiologist representing the American Heart Association, testified that a major problem in understanding ADE's is that the medical education of physicians is deficient when it comes to training them to prescribe medications . In his testimony, Dr. Califf added: **"Inadequate knowledge is a problem. And I believe here we must point the blame at the academic medical community, my own group. Medical schools....are doing very little to teach practitioners about the system and how it works in terms of where to get information, how the information is actually derived." (*FDA Hearing On Risk Management of Medication Errors. May 22, 2002)***

On the subject of ADEs related to a prolonged QT interval, a serious and potentially fatal event so frequently connected to some medications, Dr. Califf, at that same FDA hearing, testified: "**At the American Heart Association, we're finding that less than 50 percent of physicians can accurately measure a QT interval."** Some psychotropic medications can affect the QT interval, as do other classes of medications, psychologists who have completed training in clinical psychopharmacology receive specific training on these drugs and their relationship to QT prolongation.

A factor to consider in prescribing medications is to have a good assessment of the functioning of a patient's renal system and kidney functioning. If the kidneys are impaired then this will affect the concentration of the drugs in the system after being absorbed and metabolized. In discussing physicians prescribing for elderly patients, Dr. Califf remarked: **"Elderly people by normal physiology have impaired creatinine clearance. As we're now beginning to look at the outpatient clinic, it seems that most doctors just don't remember that you have to adjust the doses of renally excreted drugs for creatinine clearance, and this is a huge national problem that I think really does need to be specifically addressed and soon."** Here, too, clinical psychopharmacology programs differ from medical school programs in that they provide specific training on the differential response to medications by the elderly, polymorphism among different racial and ethnic groups, children and women. When one considers that medications are a routine practice of medicine, Dr. Califf's statements should sound a major alarm.

Yasuda (2002), surveyed a number of medical school programs and found that the majority of medical schools did not offer training to third or fourth-year students in clinical pharmacology or adverse drug reactions. Those schools that did offer such training, only eight percent made it mandatory. Well over 60 percent of the internal medicine residency programs offered only lectures in adverse drug reactions. The authors opined that there is insufficient incentive to include this topic because the subjects is not included as an independent topic in the United States Medical Licensing Examinations.

The Institute of Medicine identified important deficiencies in medical school education and training as a major causative factor in ADEs. The authors of the IOM study made several recommendations focusing on the roles that medical societies and organizations and state medical boards can play in reducing ADEs. Most prominently was that state medical boards should consider periodic physician certification in pharmacology and licensing. My feeling is that anyone advocating for medical school training for psychologists needs to consider that such training appears to be inversely related to learning safe prescribing skills.

Concluding Remarks

The Institute of Medicine identified deficiencies in medical school education and training as a major cause of ADEs. They recommend certification in pharmacology for physicians. Organized Medicine continues to oppose those recommendations. The American Psychological Association's Model Training Program In Psycho-

pharmacology is an example of specialized post doctoral training that would clearly meet the IOM recommendation. The program is built upon specialized education, training, testing, and supervision. While these may not guarantee the competence of any one prescriber, it is far better than anything presently available in general and specialty medicine. Very few psychiatrists have completed proficiency certification in psychopharmacology according to the American Society of Clinical Psychopharmacology. Psychologists are in the unique position of becoming a positive factor in reducing ADEs while at the same time providing mental health services effectively and efficiently. General practitioners and other non-psychiatric physicians are neither mental health specialists or psychopharmacologists. Collaboration between the psychological and medical professions can result in more effective and safer treatment for mental health patients by reducing ADEs. Prescriptive authority for psychologists is expected to promote higher quality mental health care, increase access to services, and promote better efficiency while reducing overall health care costs.(ACNP, 1998; Caccavale, JL., 2002; Norfleet, MA., 2002).

In light of the overwhelming evidence that inappropriately trained physicians are associated with the greatest harm to patients, opponents of prescriptive authority for psychologists need to look inward when insisting that psychologists who want to prescribe go to medical school. Pre-residency medical training is focused on acquiring diagnostic skills. Learning how to prescribe comes much later, if at all. Practicing clinical psychologists already have very good diagnostic skills. Thus asking psychologists to go to medical school may not be in the best interest of patients or the best environment to acquire good prescribing skills. Prescribing is a proficiency and skill that is achieved through training, experience, testing, and practice. Thus, these skills are best acquired as a post doctoral proficiency.

The primary causes of ADEs result from avoidable errors such as writing the wrong dose for a medication or prescribing the wrong medication. Less often, ADEs result from incorrect diagnoses or the interaction of a medication with an underlying medical disorder. The key issue here is avoidable error due to insufficient training or prescribing medications with effects with which the prescriber is unfamiliar. If complex medical knowledge were a significant determinant for the reduction of ADEs then perhaps there would be a correlation with prescribing and medical training. Moreover, although some physicians may not be able to prescribe safely with medical training at an acceptable level of competence, it does not follow that others, such as psychologists, would also prescribe poorly because they are not trained in the manner of physicians. In fact, the converse is apt to be more correct. By providing specialty training in psychopharmacology to psychologists who already have diagnostic and treatment expertise, will insure better outcomes can be expected. Experience shows that one can learn much from the errors of others.

Lastly, psychotropic medications are much safer than other classes of medications. They are typically administered on an outpatient basis. The vast majority of known ADEs occur in hospital settings. When trying to assess safety issues one must look at how mental health patients are presently treated. Most are first seen by a general practitioner who, according to the data, may be the least able to appropriately diagnose and then prescribe an appropriate medication, if needed. If the patient is seen by a psychiatric physician, they may fare better with respect to diagnosis and getting the correct medication. However, they will likely be seen every five to six weeks after an initial consult This is significant because side effects and drug reactions are likely to occur between appointments. This time lag can significantly increase risks. If the patient were being seen by a prescribing psychologist, the scenario is greatly

changed and risks from ambulatory ADEs are significantly reduced because psychologists see patients regularly. Psychologists are not psychiatric physicians and we do not aspire to that treatment model. Thus, all factors considered, psychologists trained in psychopharmacology increase patient safety. Our training programs in clinical psychopharmacology remain the best insurance for our patient's safety.

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DIVISION 29 DISTINGUISHED PSYCHOLOGISTS

Clara Hill, Ph.D.
Charles Gelso, Ph.D.

Congratulations to both Dr. Hill and Dr. Gelso for their outstanding contributions to Division 29 and to the field of psychology.

Please join the Division in recognizing Dr. Hill and Dr. Gelso at the Division 29 Awards Ceremony/Social Hour on Friday, August 8 at 6:00 pm at the Crowne Plaza Toronto Centre Hotel, Ontario Room.

WASHINGTON SCENE

DEJA VU, ALL OVER AGAIN

Pat DeLeon, Ph.D.

One of the rewards of personal involvement in the public policy process is the opportunity to experience, on a first hand basis, concerned citizens laying the foundation for substantive changes in the status quo. When I arrived on Capitol Hill on leave from the State of Hawaii Department of Health, it was the first day of the infamous Watergate hearings. At that time, there were also ongoing (admittedly less visual) discussions regarding the need for the Congress to enact National Health Insurance in order to ensure that all Americans would have access to quality health care. There was a perceived shortage of health care professionals of all disciplines and community health centers, established during the Great Society era of President Johnson, and health maintenance organizations were viewed very positively. Few today realize that the then-Carter White House gave serious consideration to significantly expanding its mental health focus to include insuring access to a broad range of primary care services. That was nearly three decades ago.

The Senate Appropriations Committee, on which Senator Inouye serves, has recently begun a series of public hearings highlighting the related issues of health care access and affordability. Interestingly, this time it is the business community (i.e., the ultimate payers of the bill) that have become particularly concerned. Health insurance premiums are "out of control," having more than doubled for a family with two children from 1999-2003; premiums for employers rose 14.7 percent last year. Some businesses report 30 percent increases in annual premiums; school districts are experiencing premium increases of over 50 percent. Access to quality health care appears to have once again become a major public policy concern.

Our nation currently spends nearly double per person on health care, compared to other countries, with many of them having higher life expectancies and healthier populations. The Commonwealth Fund testified: "It is long past time to simply pay for services rendered without establishing a scientific-basis for effectiveness not just for new drugs but for consultations, procedures, and tests." Today, the lag between the discovery of more efficient forms of treatment and their incorporation into routine patient care is, on average, 17 years. Surveys have shown that an estimated 20 to 50 percent of primary care practitioners are not aware of, or not using, new evidence related to common current practices. This simply is not acceptable.

In my judgment, HPA's impressive foray this past legislative session into the prescriptive authority (RxP-) arena, in conjunction with our State's community health centers, goes directly to the underlying issues of ensuring the highest quality of sychopharmacological care for those citizens who are most in need and delivering services in a cost-effective manner. This is what psychologists, as highly educated professionals, must do. My sincerest appreciation to Don Kopf and his colleagues. Fundamental change in the status quo takes time. However, it is important and it is our societal responsibility to provide proactive vision and effective leadership. Mahalo,

Pat DeLeon, former APA President Hawaii Psychological Association June, 2003

FEATURE

Reactions to Segal, Williams, & Teasdale's Mindfulness-Based Cognitive Therapy for Depression[1]

Adam Leventhal

"I went to University of California Santa Barbara where I received my B.A. in psychology. There I studied the behavioral effects of psychostimulant drug exposure on brain reward circuitry in rats. In the clinical PhD program at the University of Houston, my research interests involve studying hedonic processes in depression and the association between depression, mood, and goal formation."

Mindfulness-Based Cognitive Therapy (MBCT) is a psychosocial treatment program designed to prevent relapse in individuals who have recovered from depression. The therapy capitalizes both on Eastern meditative practices and Western cognitive approaches. Zindel V. Segal, J. Mark G. Williams, and John D. Teasdale, the creators of MBCT, spent much of the 1980s and 1990s researching the link between thought and emotion. Their effort helped lay the groundwork for the development of this treatment. They argue that depression is maintained by the process of rumination, which is defined as the act of trying to reduce discrepancies between actual and desired states through excessive, unproductive thought. To understand and solve their problems ruminators incorporate new thoughts of the same evaluative nature which takes hold of them and only makes matters worse. Segal, Williams, and Teasdale present an interesting hypothesis as why people who have experienced more episodes of depression are at greater risk for future relapse. They believe that those who have recovered from depression tend to use old habits of reacting to negative emotion or negative thoughts in this ruminative style, which only intensifies negative moods. Once a stressful event or painful emotion is present, previous depressive mental patterns are activated which may lead to relapse. MBCT is intended to help clients disengage from ruminative response patterns. The treatment borrows heavily from Jon Kabat-Zinn's mindfulness-based stress reduction program that helps individuals deal with medical conditions, sleep disorders, anxiety, and panic.

During the program, individuals learn to apply a new mode of thought, termed mindfulness, to everyday activities. Thus when a "relapse signature" arises, clients can be mindful of their emotions and thoughts rather than responding with automatic ruminative thought. During states of mindfulness one does not think about the future, past, or any abstract idea but rather focuses on exactly what is occurring in the here and now. Because all attention is directed towards what is occurring, thinking capacity is exhausted leaving no space for rumination. There are two aspects of MBCT that causes change: learning mindfulness and using it. In addition, the authors believe that being mindful not only changes ruminative tendencies but also alters one's whole being. In that they mean that a person can become more perceptive, enjoy the richness of life, and learn to "let go" and accept painful states.

Most of the techniques have never been formally applied to treat depression before. The strategy of the therapist is to teach mindfulness in all situations or better yet to empower clients so that they can become mindful. Mindfulness techniques involve the raisin exercise, the body scan, breathing space, listening to meditative tapes, reading related poems, mindful stretching,

mindful walking, seeing and hearing exercises, and taking a wider view of thoughts (for a description these techniques consult the guidebook). The raisin exercise is the first task introduced in MBCT and is a simple example of mindful thought. In this task, clients spend a few minutes slowly seeing, touching, smelling, and tasting a raisin with strong attention paid to the sensations involved. This exercise introduces the extreme difference between automatic experience and mindful experience. After the exercise some clients will say that they were able to see the raisin with more clarity or that they never noticed how juicy raisins are. These activities are intended to teach clients to pay attention to all things in the present as if watching a movie. Later in the program, a sense of perspective is gained that allows individuals to take a step back and attend to external stimuli, thoughts, feelings, and sensations. During mindful states individuals are not swept away with internal events, but are focused on the present.

The first half of the program is dedicated to teaching mindfulness. This is probably the most challenging part because these sessions require intense concentration and diligence. For example, the sitting meditation exercise that is introduced in session three requires that clients spend up to forty minutes in mindful states, intensely concentrating on their internal sensations and surroundings. Clients who struggle trying to suffocate wandering thoughts are reminded to gently bring back the mind and to be aware of their thoughts and not react to them. It seems that dealing with frustrated client may be one of the most challenging parts of MBCT. The second half of the program teaches clients to apply mindfulness to deal with negative affective states. Once clients can get comfortable with mindfulness practice the program I assume that it becomes much less challenging.

The manual outlines everything session by session. It is an eight week program comprised of one two hour session per week and four follow-up classes in the year following the program. Class size should be around twelve. It is noted that the therapist is more like an instructor in MBCT. Included in the handbook are transcripts of client-therapist interactions, word for word instructions to give clients, and handouts and session agendas that can be copied for use. In addition, the introductory chapters provide fascinating insight as to why the authors decided to pursue mindfulness as a treatment for depression relapse prevention. The manual is useful, but I would recommend that if you wish to disseminate MBCT, you should practice mindfulness yourself before even reading the manual. It's hard to understand mindfulness without having experienced it, which is why the creators insist that therapists should be mindful or have experience with meditation before they can instruct a MBCT group. There is no formal class to teach therapists mindfulness. The authors' best suggestion is to learn it firsthand from someone with experience. To get a better perspective I tried doing some of the exercises and found them very difficult. I can understand why some clients may get discouraged at first because it is challenging to focus your attention so intensely for more than a few minutes. Segal, Williams, and Teasdale emphasize that practicing in and out of therapy six days a week are essential to client and instructor progress. They remind potential disseminators that MBCT is stressful for the client and instructor, but after this new mode of mind is learned and applied, life becomes richer and fuller.

At first there seems to be no resemblance in its techniques, the authors compare mindfulness to traditional cognitive therapy. They state that both involve distancing and treating thoughts just as thoughts and not the truth. Some cognitive-behavioral techniques are brought in towards the tail end of therapy. For example, clients are taught to evaluate mastery and pleasure of situations and to recognize that automatic thoughts are attached to depressed mood

and have no validity in non-depressed states. An important practice is taught towards the end of the program. Clients learn that when a negative thought or feeling occurs, to first be mindful and welcome it, and then if you wish you may act on it by doing something that creates a sense mastery or pleasure.

MBCT's empirical support is in a three site randomized controlled trial was completed with 145 subjects comparing MBCT to treatment as usual in its one-year relapse rate. It was significantly better, but there are many further questions as to its efficacy. For example, the results suggest that the program is more effective for those with three or more past depressive episodes than those with two. The study uses a sample of individuals who have recovered from depression. In the manual it is explicitly stated that MBCT is designed to prevent relapse in recovered individuals. Although the treatment hasn't been applied to acutely depressed populations, the creators believe that intense negative states would prevent them from learning mindfulness in the earlier stages of treatment. In the manual, the client base of MBCT is described as those formerly treated with antidepressants and then pulled off of them before therapy. It would be interesting to see how those treated with cognitive-behavioral therapy respond to mindfulness approaches in preventing relapse. Also, could mindfulness be added to the cognitive therapy package as relapse prevention? We'll have to wait and see as new literature is published on this treatment.

To summarize, MBCT is an interesting new method in the prevention of depression relapse. It is the first American psychosocial program designed explicitly for this purpose. It really is an Eastern approach that incorporates some Western cognitive principles. MBCT may be an appropriate avenue for clinicians who have the time, dedication, and interest to provide a unique empirically supported psychosocial treatment for this population.

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Mark Your Calendars

Don't miss these important Division 29 events at the APA Convention in Toronto, Ontario Canada

Presidential Address
Update on Pharmacological Interventions for ADHD Across the Life Span
Robert Resnick, Ph.D., presenting
Saturday, August 9 9:00-10:50 am
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Social and Awards Hour
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Integrating Self-help into Psychotherapy: A Revolution in Mental Health Practice

Delivered by
John C. Norcross, Ph.D.

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Patricia M. Bricklin, Ph.D., APA Division 29 President

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Dr. Raymond A. Weiss established the Rosalee G. Weiss Lecture Series to honor his wife in 1994. Annual gifts support the series, and a bequest will perpetuate it. Divisions 29 and 42, upon approval by the APA Board of Trustees, select an annual lecturer to speak at the APA Convention. The individual must be an outstanding leader in the arts or sciences whose career is not directly in the spheres encompassed by psychology, or an outstanding leader in any of the special areas within the spheres of psychology.

About John C. Norcross, Ph.D.
John C. Norcross, Ph.D., is professor and former chair of psychology at the University of Scranton, a clinical psychologist in part-time practice, and an internationally recognized authority on behavior change and psychotherapy. Author of more than 150 scholarly publications, Dr. Norcross has co-written or edited 12 books, including *Psychotherapy Relationships that Work* (Oxford University Press), the *Authoritative Guide to Self-Help Resources in Mental Health* (Guilford Press), *Changing for Good* (Avon; with Prochaska and DiClemente), the *Handbook of Psychotherapy Integration* (Basic; with Goldfried), and *Systems of Psychotherapy: A Transtheoretical Analysis* (Brooks/Cole; with Prochaska). He is the past-president of the APA Division of Psychotherapy, president-elect of the International Society of Clinical Psychology, editor of *In Session: Journal of Clinical Psychology,* and has served on the editorial boards of a dozen journals. Dr. Norcross has received many professional awards, such as Pennsylvania Professor of the Year from the Carnegie Foundation, fellowship status in professional organizations, and election to the National Academies of Practice. His work has been featured in hundreds of media interviews, and he has appeared on many national shows, such as the *Today Show*, the *Early Show, CBS This Morning,* and *Good Morning America.* An engaging teacher and clinician, John has conducted workshops and lectures in 20 countries.

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Please return the completed application along with payment of $40 (or $29 for Student membership) by credit card or check (Payable to: APA Division 29) to:

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

Code _____ FD _____

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