Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

BULLETIN

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Do Psychologists Have Supererogatory Obligations?

Overview of the Psychotherapy Outcome Assessment and Monitoring System

Interview With Dr. Charles Gelso, Incoming Editor of Psychotherapy

The Empirically-Validated Treatments Movement: A Practitioner Perspective

VOLUME 38 NO. 3 FALL 2003

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EDITOR'S COLUMN

Salute to Our Division of Psychotherapy Membership

Linda F. Campbell, Ph.D.

This is my last issue of the *Psychotherapy Bulletin* as editor. I am honored to have served you in this capacity and am a privileged spectator of the extraordinary contributions you, our membership have made to the *Bulletin* and to the Division through your participation here. Our Division members are psychologists who are making an impact on the profession and in many different ways. Our mission of promoting, nurturing, and advocating for psychotherapy in training, practice, theory, and research is cross-cutting of the domains, specialties, and proficiencies of the profession. As a result, we are fortunate to include the full spectrum of psychology with the only common thread, but important thread, being psychotherapy. Our membership, through generous submissions to the *Bulletin,* has expanded the focus of topic areas thereby providing a broader base for our readership.

Our new editor, Craig Shealy, is a dynamic, energized, creative, and proactive individual who will embrace the *Bulletin* and its mission with commitment and dedication. I will be interviewing Craig in the Winter, 2004 issue as an introduction of him to you. In the Spring, 2004 issue of the *Bulletin*, Craig and I will have a conversation about the growth of the *Bulletin* over recent years and the function it has served for the membership and the Division. I encourage you to continue sending your articles, manuscripts and ideas to Craig without censoring yourselves. Many of you talked about ideas that you then went back and wrote down but that were not in final form when we discussed them. Craig is a person who will also encourage and support your ideas and interests. This vehicle for publication is not refereed. It is a publication meant to transmit the ideas of the membership to the rest of us.

I am currently the President-Elect of our Division and thereby will become President for the calendar year 2004. Our 2003 President Pat Bricklin, our 2005 President Leon VanderCreek, and myself have embarked on what we think is an important initiative for the Division. Your Board of Directors and Division leadership are an integral part of the project and you will be called upon to participate as you wish in the coming months. We will be talking with you more about it in the coming issues of the *Bulletin.*

Serving as your editor of this most important vehicle for the Division, the *Psychotherapy Bulletin*, has been an honor and privilege. My participation with you, the membership, has been rewarding in many ways. I have become acquainted with members I would not have known otherwise. We have an exceptionally knowledgeable and talented membership that has set the standard of quality and richness of our publication.

I also want to thank the contributing editors without whom the *Bulletin* would not have had the depth and diversity of topics that was accomplished with their contributions: Ron Levant, Pat DeLeon, John Norcross, Leon VanderCreek, Bob Resnick, Jack Wiggins, Clara Hill, Charlie Gelso, Jeffrey Hayes, Marv Goldfried, Sheila Eyberg, Gary Brooks, David Adams, Arthur Wiens, and of course the student editor who is currently Anna McCarthy. These people are each in a league of their own and have enormous wealth of experi-

ence and talent to contribute to our profession and to our Division.

Tracey Martin has been our central office manager for several years and hopefully will remain so for many years to come. She is the true secret behind the success of the *Bulletin* production. Since Tracey began working with us, every element of production has been first class. She is able to work with all of us in an understanding and helpful way. She is also a person who is in a league of her own.

My heart will continue to be with the *Bulletin* every step of the way and I look forward to watching the *Bulletin* bloom even more under the capable eye of Craig Shealy. For now, I salute you, our membership, and look forward to working with you in many other ways.

Call for Award Nominations

The APA Division of Psychotherapy invites nominations for its two annual awards in 2004.

The Distinguished Psychologist Award
recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

The Jack D. Krasner Memorial Award
recognizes promising contributions to psychotherapy, psychology, and the Division of Psychotherapy by a Division 29 member with 10 or fewer years of post-doctoral experience.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 Past-President:

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The applicant's CV would also be helpful.
Self-nominations are welcomed.

Deadline is January 15, 2004.

CONGRATULATIONS TO JOHN C. NORCROSS, PH.D.

Rosalee G. Weiss Lecturer

Dr. John Norcross, Past President of Division 29 and current Chair of the Publications Board, was selected as the prestigious Rosalee G. Weiss Lecturer. Dr. Norcross delivered his lecture, entitled *Integrating Self-help into Psychotherapy: A Revolution in Mental Health Practice,* to a full and enthusiastic audience at the 2003 APA Convention in Toronto, Ontario. Dr. Norcross was introduced by the President of our Divison, Dr. Pat Bricklin.

STUDENT COLUMN

Shooting Towards a Moving Target

Nisha Nayak

Nisha Nayak is a 2nd year graduate student in the Clinical Psychology doctoral program at the University of Houston. Dr. Lynn P. Rehm is her advisor. She graduated from Rice University in 1996 with a B.A. in Sociology and subsequently worked for several years for a small R&D medical technology company. Her current research interests include patterns of autobiographical memory recall in depression and quantitative methods. She is also interested in practical implementation of psychosocial interventions in the community.

You got to be careful if you don't know where you're going, because you might not get there.

– Yogi Berra

Successful progression towards a desired goal requires knowledge of the endpoint. However, students currently undergoing training in psychotherapy are in some important ways 'shooting towards a moving target'. The career path for a young psychologist seeking an academic career still follows a trajectory similar to that of predecessors. However, for students planning to become practitioners, what the future holds is less clear. For example, the work settings and responsibilities of the next generation of practicing psychologists and therapists will very likely be very different from that of previous prototypes, such as the independent therapist who spends most of his or her time seeing patients one-on-one. Such a dedicated client contact role may be particularly unlikely for doctoral-level psychologists. Unfortunately, academic curricula can be painfully slow at responding to changes in the job market. The reasons for this relative immutability are manifold and are not addressed here. Nonetheless, students, interns, and young professionals can benefit greatly from an awareness of the changing landscape of mental health practice. Such awareness can help guide the process of professional development. Furthermore, it will facilitate pursuit and acquisition of requisite knowledge and skills and the acceptance of attitudes compatible with the current systems and realities of practice.

The aim of this article is to provide an overview of relatively recent changes and anticipated trends in the role of behavioral/mental health professionals as discussed in works by Cummings, Pallak, &Cummings (1996) and Cummings, O'Donohue, Hayes, and Follette (2001). The key theme emphasized by the authors/editors is that psychology must relinquish some traditional notions of how and where psychotherapy and/or behavioral health practice should occur. Instead, theories of practice must be developed and adopted based on psychologists' demonstrated and potential contributions to mental and physical health within the contemporary context of managed care.

The laymen's notion of psychotherapy likely takes the form of a patient visiting his or her therapist weekly (e.g. regularly) to discuss life problems and with the goal of curing of some personality problem, mental illness, or neurosis. The contact would typically be one-on-one with little or no involvement of other professionals. The setting would be in office building. The duration may vary, but therapy would typically (or at least ideally) continue until the patient is completely 'cured' so that he/she need never return to therapy. While this depiction is a bit extreme, current perspectives towards therapy may not be terribly different, even among profes-

sionals. For example, while many current training programs may acknowledge that briefer therapy and techniques with demonstrated effectiveness are necessary, the assumptions of the practice model described above often still persist. At the core of these assumptions is what is referred to as the 'dyadic model' of therapy as a relatively long-term, continuous process that emphasizes the central roles of the therapy session and the therapist in achieving a 'cure' (Cummings, Pallak, & Cummings, p. 17-20). Although many of these assumptions regarding the nature of therapy have been questioned in recent years, they have nonetheless propagated the pervasive view that the typical or appropriate format for therapy is individual or group therapy, that reimbursement generally is based on a fee-for-service arrangement, and that all attempts to limit benefits should be resisted. This view of therapy no longer reflects the current reality in terms of consumer needs or job market demand. The solo private practice is declining, and an emphasis on this professional setting inhibits the expansion of psychologists into new roles that are more compatible with the current health care climate. According to Cummings, a more contemporary model of practice involves group practice, acquisition of brief therapy skills, and demonstration that therapy is effective and efficient. Furthermore, he advocates a catalytic model of therapy which is based on brief, intermittent therapy throughout the life span, which depicts the therapy session as a "yeast for growth outside therapy," and which stresses the client's ability to effect change in his/her own life.

Cummings et al. (1996) attribute the "demise of the solo practice" to market forces, namely changes in the reimbursement of services, i.e. the advent of managed care. He terms this process the "industrialization of healthcare." For a period in the 1980's, while the rest of the health care industry experienced the painful adjustment to HMO's, service providers in mental health and chemical dependency fields avoided cost containment owing to the difficulty in classifying patients and establishing clear treatment guidelines. This market opportunity resulted in an abuse of the system by business interests and skyrocketing costs in this sector. This development ultimately brought about a sharp response in the form of managed behavioral health care. Methods of cost reduction included elimination of benefits, limiting services that were covered, and greater use of master's level therapists. Many of these changes adversely affected quality but were not surprising given ownership by those with business interests. In contrast, psychologists might have balanced the demands for quality and cost containment in a more equitable fashion. However, psychologists generally were unable gain the foothold needed in order to exert significant autonomy within the new managed care system. For the most part, managed behavioral healthcare now consists of a few conglomerates that own roughly two-thirds of the market share. The main economic effects of this entire process on psychology are lower private practitioner incomes and fewer viable private practice jobs that can be supported by the market.

The brief historical summary presented above helps provide a sense of where the field has been and the forces that have and continue to affect it. The take-home message is that students who plan to be practitioners likely need to consider options beyond the traditional model of opening up an individual private practice. However, as described in both of the referenced books, an array of potential opportunities with varied work settings and responsibilities are available for those who are willing to forge the path. Master's level practitioners will likely continue to engage in substantial face-to-face contact, although it may be in increasingly structured, brief, and/or directed formats. Psychoeducation, generally in groups, is a particular area that will likely see future

growth. As more junior-level practitioners engage in day-to-day client contact, the demand for qualified and effective supervisors is expected to increase, and doctoral-level psychologists are well-suited to serve in these roles. Ideally, psychologists will have an interactive relationship with other professionals and community resources through consulting work, referral, and ongoing communication. Licensed psychologists will also function in traditional roles of behavioral and functional assessment, treatment planning, and tailoring therapies to address unique individual or cultural issues. Doctoral graduates can also be involved in development of information materials and ready-to-implement clinical protocols based on empirical research findings. Such protocols may deal with prevention, psychoeducation, patient-management therapies, targeted interventions for specific problems, etc., and can be disseminated by junior-level therapists. With increased demand for treatments with proven effectiveness, an important part of the psychologist's role will be outcome research in applied settings. Outcomes of interest may include not only traditional clinical items of interest, such as patient status, but also economic factors, such as costs and health service utilization. Quality assessment and oversight of managed behavioral healthcare systems is yet another area that can benefit from professionals with advanced education in psychology and related clinical fields.

Finally, Cummings et al. (2001) argue that the biggest opportunity for clinically trained psychologists lies in the field of behavioral health. This field involves developing interventions and protocols targeted at negative health behaviors (smoking, alcohol/drug abuse, diet/exercise/drug/medical non-compliance, etc.) as well as addressing the needs of the large segment of patients who present to primary care physicians with nonspecific physical complaints with no identifiable organic cause. The medical service utilization cost associated with these patients is extremely high, and professionals in psychology/behavioral health can develop, identify, and/or implement treatment strategies to serve this class of clients. For these and other reasons, Cummings et al. (2001) propose that the optimal strategy for behavioral health practitioners is to join with primary care physician groups. These groups often operate on a capitation or prospective reimbursement basis. Such an arrangement involves negotiating a fixed reimbursement per insured individual with an insurance company (in exchange for a service agreement) and thereby assuming the financial liability associated with providing services. While such a system requires appropriate business management and is associated with assumption of financial risk, it also affords greater autonomy to professional practitioners, who can then maintain a commitment to quality services. The advantage to psychologists for being on-site practitioners in these networks or groups is that they become part of an integrated health team; somaticizing patients are more apt to abide by physician referrals to psychologist if they just have to go down the hall. The advantage to physicians is the medical cost savings to their practice.

This article was intended to highlight developments over the past decade and predicted trends in the delivery of mental and behavioral health services. Within the confines of current services reimbursed by managed behavioral healthcare systems, there will be a limited number of opportunities for traditional private practice. However, while traditional venues and forms of psychotherapy seem to be on the decline, a wide range of additional opportunities are emerging for the next generation of practitioners. The range of job roles points to the difficulties involved in adequately training psychologists over the coming years. As psychology programs grapple with issues of training and competency, it will fall on the shoulders of the

student to identify gaps in his/her education/training and to attempt to address such deficiencies. Important areas that may often be omitted by academic and professional training programs include formal training in supervision, exposure to issues with managed health care systems, and systems evaluation and development. A basic principle that is driving the new classes of jobs (described above) for psychologists is accountability of the practitioner (e.g. therapist) as a health care service provider. It is important for future psychologists to recognize this responsibility and to become knowledgeable regarding relevant issues. The goal of this process of professional development and education? To bring the 'moving target' a bit more into focus.

References

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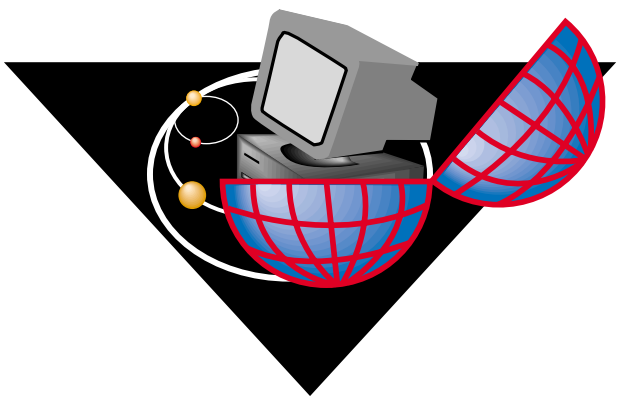
Cummings, Nicholas A., Pallak, Michael S., and Janet L. Cummings (Eds.). *Surviving the demise of solo practice : mental health practitioners prospering in the era of managed care.* Madison, Conn.: Psychosocial Press, 1996.



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DIVISION 29 RECOGNITIONS AND AWARDS

The Division of Psychotherapy Distinguished Psychologist Award

Charles Gelso and Clara Hill, both of the University of Maryland Counseling Psychology program have made significant contributions to the Division. Dr. Gelso has served as Chair of the Education and Training Committee and editor of the Education and Training column in the *Psychotherapy Bulletin.*

Dr. Clara Hill has served as Chair of the Psychotherapy Research Committee and editor of the Research Corner. Both Dr. Gelso and Dr. Hill have made unsurpassed contributions to psychotherapy research and training. They continue to be leaders in the advancement of psychotherapy. Dr. Gelso and Dr. Hill were both presented with the Distinguished Psychologist Award by Division 29 Past President Dr. Robert Resnick.

AMERICAN PSYCHOLOGICAL FOUNDATION

2004 RANDY GERSON MEMORIAL GRANT

The American Psychological Foundation (APF) announces the Randy Gerson Memorial Grant to be given in 2004. For the 2004 cycle of the grant, professional academicians or practitioners engaged in relevant research projects are invited to apply. The grant has been created to advance the systemic understanding of family and/or couple dynamics and/or multi-generational processes. Work that advances theory, assessment, or clinical practice in these areas shall be considered eligible for grants through the fund.

Preference will be given to projects using or contributing to the development of Bowen family systems. Priority also will be given to those projects that serve to advance Dr. Gerson's work.

Eligibility Requirements:
Applicants from a variety of professional or educational settings are encouraged to apply. Awards are given in alternate years to students and professionals. The 2004 grant will go to a professional academician or practitioner. To qualify for the 2004 cycle of the award, all applicants (including co-investigators) must have a doctoral degree (e.g. Ph.D., Psy.D., Ed.D., or M.D.), or an equivalent terminal degree within their field.

Applications must include:

- Statement of the proposed project
- Rationale for how the project meets the goals of the fund
- Budget for the project
- Statement about how the results of the project will be disseminated (published paper, report, monograph, etc.)
- Personal reference material (vita and two letters of recommendation)

Applicants must submit seven (7) copies of their entire application packets. Send application packets by February 1, 2004, to the APF Awards Coordinator (address below). Applicants will be notified on or after April 15, 2002.

Amount of Grant: $5,000.00

Deadline: February 1, 2004

For additional information:

Contact the APF Awards Coordinator/Gerson, 750 First Street, NE, Washington, DC 20002-4242. Telephone: (202) 336-5843. Internet: foundation@apa.org.

COUNCIL REPORT

Highlights of the 2003 Council of Representatives Meeting

John C. Norcross, PhD
Council Representative

The APA Council of Representatives met on Wednesday, August 4 and again on Sunday, August 10 in conjunction with the 111th annual APA convention in Toronto, Canada. The Division of Psychotherapy was ably represented by Drs. Patricia Bricklin (substituting for Jack Wiggins), John Norcross, and Jon Perez (substituting for Alice Chang).

The Council considered, debated, and approved a large number of agenda items. Among the highlights of Council's actions were:

- Renewed recognition of clinical neuropsychology as a specialty.
- Clarified procedures on the creation and promulgation of Standards and Guidelines either by APA as a whole or its divisions. A lengthy process of governance and legal review is required; the new rules are designed to clarify APA policy and to protect practitioners. All standards and guidelines must publish appropriate disclaimer language. Further, all approved standards and guidelines will be sunset in 10 years unless formally renewed.
- Passed a preliminary 2004 budget of $85,800,000 with a modest surplus. The surplus was made possible by refinancing the APA buildings, voluntary staff reductions at APA, and difficult cost-containment decisions.
- Established and funded a new APA electronic database known as *PsycEXTRA*. This database will contain material relevant to psychology that is not currently covered in PsycINFO or PsycARTICLES and will be oriented toward the general public and libraries, as opposed to professionals or scientists.
- Adopted a new edition of *Principles for the Validation and Use of Personnel Selection Procedures* as revised by the APA Society for Industrial and Organizational Psychology (SIOP).
- Approved Guidelines for Psychological Practice with Older Adults, which will soon appear in the *American Psychologist*.
- Received an update on the APA Public Education Campaign, which continues to focus on promoting resilience following trauma, particularly among children.
- Adopted the Final Report of the Presidential Task Force on Governance, which is designed to increase the involvement of the Council of Representatives and streamline its governance process.

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.

PRACTITIONER REPORT

A Social Contact on Health Care?

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 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.

We are living in truly interesting times. The 21st century promises monumental changes in health care, education, communication, and science in general. The technology currently available has provided the tools whereby educated consumers can make critical decisions regarding their own health care and health care providers can call up databases (such as Epocrates ®) to provide up to date information on pharmaceutical agents. Yet despite these promising developments, the status of health care in the U.S. is not good.

Health care costs have once again begun to escalate faster than other segments of the economy, and the number of uninsured is now 43.6 million Americans. In June, 2002, the Secretary of the Department of Health and Human Services (HHS) met with leaders from the National Academies and challenged them to propose bold ideas that might change conventional thinking about the most serious problems facing the health care system today. The Institute of Medicine (IOM) reported: "The American health care system is confronting a crisis…Tens of thousands die from medical errors each year, and many more are injured. Quality problems, including underuse of beneficial services and overuse of medically unnecessary procedures, are widespread. And disturbing racial and ethnic disparities in access to and use of services call into question our fundamental values of equality and justice for all. *The health care delivery system is incapable of meeting the present, let alone the future needs of the American public*." (emphasis added).

A new development in the area of health care reform is emerging from the Wye River Group on Healthcare (WRGH), which held a National Summit Meeting on Health Care in Washington at the prestigious University Club on September 23, 2003. I had the honor of representing APA at this event, along with Russ Newman (who graciously invited me to join him). The Summit Meeting was the culmination of a project initiated in July 2002, titled "Communities Shaping a Vision for America's 21st Century Health and Healthcare."

Quoting from sections of the WRGH report, "This project is fairly unusual in its effort to understand how health care stakeholders and consumers view the values and principles underlying our health care system…. WRGH held a series of Healthcare Leadership Roundtables in 10 diverse communities around the country. During these roundtable discussions, community health care leaders were asked fundamental questions, such as whether there is, or should be, a **social contract for health care in this country**….

"In each community, WRGH assembled a diverse cross-section of public and private

stakeholders with detailed knowledge of health and health care. They included physician leaders, hospital and health system executives, community and public health officials, pharmaceutical and pharmacy representatives, business leaders, consumer representatives, and government officials. WRGH also worked to ensure that important constituencies such as the elderly, the uninsured, minorities, and people with chronic illnesses were well represented….

"After roundtable discussions were held in all 10 communities and the advisory boards wrapped up their work, WRGH hosted a retreat July 9-11, 2003, at the Aspen Institute Wye River Conference Center in Maryland…. To announce the "shared vision" that arose from this project, WRGH organized a national summit designed to showcase the findings of the 10-city tour and launch a national dialogue on health care among the American public, policymakers and health care stakeholders…

"Most community health care leaders agreed that our country has not developed a social contract for health care that is well-articulated and broadly understood. As a result, most Americans do not know what they can and should expect from their health care system. Nor do they understand their responsibility to contribute to the health care system…

"Community health care leaders identified Americans' expectations as a key area that needs to be addressed in a national conversation on health care. There is a general consensus among health care leaders that the public's expectations are often out of line with the reality of what the health care system is able to deliver. There is also recognition that the health care system itself has helped foster these unrealistic expectations, in part by not providing adequate information about the true costs and availability of services…

"According to community health care leaders, most Americans expect high-quality care, on demand, and at little or no cost. Americans don't want to make trade-offs and we don't want to hear about limits. Because of financial constraints on the health care system, this kind of access to inexpensive services may become increasingly unrealistic. Americans need to revisit the discussion about health care as a social contract and also may need to make tough choices about access and availability of health care services...

"There is a need to address the expectations that we have of our health care system by increasing Americans' sense of collective responsibility about their health and health care. Instead of focusing only on whether we, as individuals, have access to high-quality, affordable health care, we need to begin thinking about health care as a collective resource. The choices we make about our health and our use of the health care system have an impact beyond our own quality of life and our own pocketbook; they affect whether there will be more or less resources available for others. We need to start seeing the connections in how our personal decisions affect other people and how we are affected by the choices that others make…

"Americans need to have the information to be empowered to make good choices that will benefit their own health, and they need to be aware of the finite availability of some health care resources. This will require a shift in the way many of us think about our health. Empowering consumers, and giving them the necessary support and access to appropriate health care services will help them to make good health care choices about their health. It could also improve quality of life and reduce unnecessary costs for the health care system…"

It is important to stress the ongoing involvement of the APA in this process. Dr. Sarah Brennen from NM, Sally Cameron from NC, Dr. Dee Yates from TX, Dr. Criss Lott from MS, and Russ Newman all participated in community roundtables. Russ

has been attending other related meetings since January, working to insure that the messages that were being created at the community level were finding their way into the national materials. Also Dr. Nan Klein helped draft a case study of community action in Utah related to passing a mental health parity law in the state which is included in the final report.

Although there are many different aspects to the proposal (of which I have cited only a few), its central thrust seems to be aimed at transforming the role of consumers. The speakers quite appropriately zeroed-in on the facts that seven of the top health risk factors are behavioral (tobacco use, alcohol abuse, poor diet, injuries, suicide, violence and unsafe sex), and that seven of the nine leading causes of death have significant behavioral components. They viewed controlling these "life-style" factors as critical in reducing health care costs. However, the proposed solution was to "make costs more transparent to consumers." What does that mean? My understanding is that people who engage in unhealthy behaviors would pay more for health care. I was a panelist, so at two of my three turns "at bat" I acknowledged that incentives (such as the prospect of lower health care costs) can influence behavior, but pointed out that all behavior, including unhealthy behavior, is motivated. I further suggested that changing motivated behavior may require more than changing the financial incentives for engaging in that behavior. I was able to draw on my clinical experience in helping clients quit smoking, moderate or quit drinking, and lose weight, to highlight the difficulties many have in controlling these unhealthy behaviors. The audience seemed to understand and appreciate this perspective.

It should be noted that among the supporting organizations for the WRGH was the White House Council of Economic Advisors. Further, there were several Bush administration officials in attendance, including Rex Cowdry and Mark Showalter from the Council of Economic Advisors, and FDA commissioner Mark McClellan, who keynoted the meeting. All of this suggests that the project might have the ear of the White House. In addition, the project has attracted bipartisan interest, as Senator Leiberman's staff was present and Senator Wyden was the featured speaker at a "kickoff" press conference. Furthermore, the current phase of the project is attempting to get messages placed and questions raised with as many of the existing presidential hopefuls as possible.

There are many coalitions and processes similar to this one, but this one seems to have more potential than most. To Quote Russ Newman: "Although this project could come up dry given the overwhelming challenges we face in health care today, it seemed to us in the Practice Directorate to be among the more promising projects we've seen. This effort to stimulate grassroots dialogue and community involvement could very well prove to be the missing pieces for successful healthcare reform."

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

DIVISION 29 RECOGNITIONS AND AWARDS

Craig Shealy was selected to receive the Jack D. Krasner Early Career Award. This recognition is given to a psychologist who has made exceptional contributions to the profession within the first ten years of earning a doctoral degree. Dr. Shealy is Director of Clinical Training Combined-Integrated (C-I) Doctoral Program at James Madison University. Dr. Shealy was presented the Krasner Award by Past President Dr. Robert Resnick.

Patricia Hannigan-Farley, Past President of Division 29, received recognition as outgoing Board member from President Pat Bricklin.

FEATURE

Overview of the Psychotherapy Outcome Assessment and Monitoring System

Jenny Lowry, Ph.D.

There are many excellent instruments that we, as clinicians and researchers, may use to understand whether our patients are improving in psychotherapy (e.g., SCL-90-R, BASIS-32, BDI, OQ-45). Although most of us only use them anecdotally to assess how our patients are progressing, reliable and valid models of change exist that allow us to more fully employ outcome instruments to inform our treatment—not only to monitor and track patient progress, but also to predict the course of improvement and increase patient benefit. This ground-breaking line of research began with the discovery of the dose-effect relationship in 1986, by Howard, Kopta, Krause, and Orlinsky.

The Dose-Effect and Phase Models of Psychotherapy

Howard et al.'s (1986) model illustrates the relationship between "doses" of psychotherapy (one dose equal to one session) and patient outcome/improvement (more specifically, the log-linear function of sessions, and normalized probability of improvement). Using meta-analysis methodology, the authors found that approximately 50% of patients showed improvement by session 8, 75% by session 26, and 85% by session 52; In essence, the more psychotherapy, the better, with diminishing returns at higher doses (i.e., numbers of session). Howard et al. also found that patients with different diagnostic syndromes (e.g., borderline personality disorder and depression) required different doses of therapy to achieve similar levels of improvement. Subsequent researchers have found similar, differential dose-effect patterns regarding the responsiveness of acute, chronic, and characterological psychological symptoms and/or syndromes (e.g., Kopta, Howard, Lowry, & Beutler, 1994) and interpersonal problems (e.g., Maling, Gurtman, & Howard, 1995). These exciting discoveries provided a wealth of data to which mental health professionals can compare their own patients' progress. Psychotherapeutic effectiveness was moving closer to being demonstrated as a reliable, scientific treatment.

Another exciting advance in psychotherapy research was the extension of dose-effect methodology to examine the stages of change in psychotherapy. The phase model, discovered by Howard, Lueger, Maling, and Martinovich (1993), demonstrates that change in psychotherapy follows a sequentially dependent, progressive process where the client first experiences an increase in feelings of well-being (remoralization), then symptom distress is reduced (remediation), and finally, after approximately 10 sessions, life functioning (rehabilitation) begins to improve. This model, combined with patient-profiling models (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Leon, Kopta, Howard, & Lutz, 1999; Lutz, Martinovich, & Howard, 1999), completes the picture of how much is enough, as we can now predict how much therapy is needed to achieve the best objectives for our patients in each of the three stages (see Lutz, Lowry, Kopta, Einstein, & Howard, 2001).

The Psychotherapy Outcome Assessment and Monitoring System (POAMS)

Findings from the dosage and phase models inspired me to work with Mark Kopta to develop the Psychotherapy Outcome Assessment and Monitoring System (POAMS®; Kopta & Lowry, 1997)—a comprehensive

method for assessing adult outpatients' progress and outcome in therapy. Much of the aforementioned research on the phase model and patient profiling was conducted using the COMPASS® system (see Sperry, Brill, Howard, & Grissom, 1996)—the POAMS contains the critical variables that made COMPASS a success. Briefer than COMPASS, POAMS assesses the essential dimensions that have been validated to predict and improve treatment outcomes—well-being, symptoms, life functioning, readiness for psychotherapy, and the bond between the therapist and patient. The POAMS was developed as a comprehensive, yet efficient, tool to help clinicians better understand their psychotherapy outpatients' needs, assist in treatment planning, and help clinicians gauge how their clients are responding during the course of psychotherapy. It may also be used with dose-effect, and other methodologies to perform cost-benefit and cost-efficiency analyses.

POAMS Scales

- **Well-being Scale** The four items of the well-being scale were designed to assess a patient's feelings of general distress, satisfaction with life, energy and/or motivation, and emotionality.
- **Symptoms Scale** Twenty-nine items are used to assess 9 symptom clusters, such as depression, anxiety, obsessive-compulsive thoughts/behaviors, mood swings, hostility, somatization, psychotic experiences, drug and/or alcohol problems, and sleep difficulties.
- **Life Functioning Scale** Life functioning is assessed in 9 areas, such as work/school, friendships, intimate relationships, relationships with children, sexual functioning, life enjoyment, physical health, self-management, money management.
- **Global Mental Health** Patient scores on the Well-being, Symptoms, and Life Functioning scales may be used separately to track patient progress through the phase model stages, and/or combined to determine the client's Global Mental Health score, which is an overview, or snapshot, of a client's overall functioning.
- **Psychotherapy Scale** Five items are used at intake to assess a patient's perceived need for treatment, the chronicity of the problems, past treatment experience (if applicable), as well as confidence in overcoming the difficulties that brought the patient to therapy. These types of items have been demonstrated to contribute to successfully predicting patient responses to treatment (see Leon et al., 1999; Lutz et al., 2001).
- **Therapeutic Bond Scale** Six items may be used to assess a patient's perceptions of the therapist on such factors as therapist's interest, understanding, and acceptance of the patient, as well as whether the patient would likely refer a friend with similar problems or needs to the therapist. Research has shown that therapeutic bond is a useful variable for predicting patient progress in therapy (e.g., Saunders, 2000).
- **Outcome Monitoring Scale** The Outcome Monitoring Scale is comprised of 13 items that assess well-being, selected psychological symptoms, and four life functioning areas. The scale also contains a question which asks the patient's perceived benefit from psychotherapy thus far. The Outcome Monitoring Scale was designed to be used at specified session points during treatment to allow for adjusting the psychotherapeutic process. Used alone, or in conjunction with the Therapeutic Bond Scale, information gained at each session may be compared to the intake baseline data to track therapeutic gains/effectiveness, provide data to discuss in treatment (e.g., a particular symptomatic difficulty, bond issue, etc.), and improve outcome and efficiency of treatment.

- **Client Satisfaction Scale** Patients are asked to complete this 12-item scale at discharge. Areas assessed include a patient's overall satisfaction with service, the likelihood of recommending services to a friend, the degree to which he or she felt "helped" with his or her problems, as well as logistical issues, such as ease of making appointments, etc. These types of data may be beneficial to clinicians in terms of identifying strengths and problem areas in order to improve delivery of services.

Psychometric Information
The POAMS scales are patient self-report and efficient to administer. Intake scales typically take 7 minutes for the patient to complete (Psychotherapy, Well-Being, Symptoms, Life Functioning). Therapeutic Bond and Outcome Monitoring Scales, which are optional but recommended, can usually be completed by within 4 minutes. At discharge, patients typically complete the Well-Being, Symptoms, Life Functioning, as well as the Client Satisfaction Scale (usually within 9 minutes).

One unique aspect of the POAMS is the scaling—all scales and items use the same Likert-type continuum of 0 (extreme distress/poor functioning) to 4 (no distress/excellent functioning). Therefore, it is convenient to compare client scores across scales without performing any mathematical conversions. For interpretive purposes, scores of 3 or higher suggest that clients are functioning in the "healthy" range, while clients with scores of less than 2 are symptomatic, or in distress, for that item and/or scale.

The POAMS has demonstrated good internal consistency reliability, as measured by *Cronbach's Alpha* (.75 to .85 for the Well-Being Scale; .91 to .93 for Symptoms Scale; .77 to .87 for the Life Functioning Scale; and .94 to .95 for the Global Mental Health composite—GMH), and strong concurrent validity when compared to instruments measuring similar constructs (e.g., GMH correlates .83 with the OQ-45.2, .86 with Basis-32, and .92 with the SCL-90-R; see Green, Lowry, & Kopta, 2003). Normative data are available for adult outpatient, community adult, college student, and college counseling center populations. In addition, two alternate versions of the instrument are available: the POAMS—Trauma Version, which includes 10 additional psychological symptoms (that assess PTSD, DID, and depersonalization), and one additional life functioning item (abuse susceptibility); and the POAMS—College Counseling Center Version, which assesses life functioning for work and school separately (10 domains total).

Clinicians and researchers are encouraged to choose the POAMS version that will best suit their particular needs. The POAMS is useful as a time- and cost-efficient system not only to assess and monitor therapy progress, but may be combined with dose-effect, patient profiling, and phase model methodologies to increase the efficiency and outcome in outpatient practice (personal practice, college counseling centers, research, etc.). For clinicians and researchers who would like a user-friendly method to quantify patient change, for personal, scholarly, and/or administrative purposes, research suggests that the POAMS is a reliable and valid tool, based on a long, well-validated research history, and may assist them in this process.

There are many possibilities for research and clinical practice with the POAMS. For example, several college counseling centers are currently utilizing the POAMS—College Counseling Center version to help their clinicians gauge progress of individual clients, examine aggregate data of their clientele, better plan for the needs of therapy groups, as well as plan for outreach programs at the college-wide level. My own program of research is beginning to focus on the use of the POAMS—Trauma Version to assess populations who have been

impacted by critical incidents, such as flight attendants after the events of September 11, 2001 (e.g., Lating, Sherman, Everly, Lowry, & Peragine, in press). The POAMS—Trauma Version is well suited to assess people who have experienced critical events, particularly with regard to the three components that comprise mental health according to Howard et al.'s (1993) Phase Model. Moreover, given the recent controversy regarding the efficacy of critical incident stress debriefings (CISD; Mitchell & Everly, 2001), I plan to use the POAMS—Trauma Version to better understand and clarify the process of CISD, as well as the resultant outcome, through the lens of the phase model.

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DIVISION 29 RECOGNITIONS

Linda Campbell received acknowledgement from President Pat Bricklin for her service as editor of the *Psychotherapy Bulletin*. She will be incoming president of the Division in 2004.

Bob Resnick is recognized for his outstanding contribution as past president of Division 29 by President Pat Bricklin.

Leon VandeCreek was acknowledged by President Pat Bricklin for his service as treasurer of Division 29. He is the incoming president-elect for 2004.

2004 NOMINATIONS BALLOT

Dear Division 29 Colleague:

The best talent in the American Psychological Association belongs to the Division of Psychotherapy (29), and we hope to draw from that pool to serve in the governance structure. It is time for us to put our combined talents to work for the advancement of psychotherapy.

NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN THE DIVISION OF PSYCHOTHERAPY. THE OFFICES OPEN FOR ELECTION IN 2004 ARE:

President-elect (1)
Member-at-large (2)
Representatives to APA Council (2)
All persons elected will begin their terms on January 2, 2005.

The Division's eligibility criteria are:

1. Candidates for office must be Members or Fellows of the division.
2. No member many be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for some position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.

Simply return the attached nomination ballot in the mail. The deadline for receipt of all nominations ballots is December 31, 2003. We cannot accept faxed copies. Original signatures must accompany ballot.

EXERCISE YOUR CHOICE NOW!

If you would like to discuss your own interest or any recommendations for identifying talent in our division, please feel free to contact Dr. Leon VandeCreek at The Ellis Institute, 9 N. Edwin G. Moses Blvd., Dayton, OH 45407, Ofc: 937-775-4334, EMail: Leon.Vandecreek@Wright.edu

Sincerely,

Patricia Bricklin, Ph.D. President	*Linda Campbell, Ph.D.* President-elect	*Leon VandeCreek, Ph.D.* Chair, Nominations and Elections Committee

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Indicate your nominees, and mail now! In order for your ballot to be counted, you must put your signature in the upper left hand corner of the reverse side where indicated.

President-elect	**Members-at-large**	**Council Representative**
_____	_____	_____
	_____	_____

Name (Printed)

Signature

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6557 E. Riverdale St.
Mesa, AZ 85215

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WASHINGTON SCENE

Psychological Expertise — Truly A National Investment

Pat DeLeon, Ph.D.
former APA President
Division 29 - October, 2003

I recently had the opportunity to participate in the Arizona Psychological Association's annual convention, Psychology—Surviving & Thriving In Turbulent Times. I was very impressed by their vision in inviting their state legislators to attend a special Saturday morning breakfast, "Creating Positive Political Partnerships." As APA's Mike Sullivan has consistently noted, our nation is currently experiencing a devolution of the public policy process, and it is at the local and state levels that national health policies are being determined. Times will change. However, today our state psychological associations are more than ever absolutely critical to psychology's successful evolution into the 21st Century. Warren Littleford chaired this highly impressive event which was attended by 10 members of the Arizona House and Senate (interestingly, the majority being Republican). At the table where I sat, there were eight colleagues with their own district's State Senator. We were joined briefly by a House member, but she was ushered to a different table which did not have an elected official. Not surprisingly, former APA President Jack Wiggins raised the issue of psychology prescribing (RxP-) and how this would enhance the quality of health care within Arizona. The ensuing discussion sounded most reasonable. The event concluded with each of the legislators (or their psychologist designee) briefly describing to those gathered what topics had been discussed at their table. The wide range of psychology's potential contributions to society were enumerated in various scenarios. The psycho-social and cultural aspects of health care, effectively addressing problems children were having in school, the area's aging population, and the ever escalating costs of health care were noted—not to mention state budget deficits. It was quite evident that both the elected officials and our colleagues learned quite a bit about each other's worlds that morning. My sincerest congratulations to Libby Howell, chair of the convention program committee. This was truly an outstanding weekend.

Children Are Not Merely Little Adults: Psychology has much to offer to society and particularly, to our patients. As one of the "learned professions," we must demonstrate proactive leadership. We can not assume that non-clinicians, and particularly the media and our nation's health policy experts, will appreciate our potential contributions. Collectively, psychology must become more personally involved in the public policy process. Over the years, I have become particularly interested in programs and services that are targeted towards children and adolescents. Those involved in this area are acutely aware of the unique skills and resources (increasingly, including technologies) required. And, that particularly for these populations the dynamic interchange between psychological-social-environmental-cultural-biological and developmental factors is absolutely critical. Interdisciplinary collaboration must be proactively encouraged. Interestingly, the more I reflect, the more I have also come to conclude that the key for ensuring quality care is really not providing additional funding per se, but instead addressing the present scarcity of program and provider accountability and the real need for more active involvement by behavioral experts (i.e., psychologists).

This year the recommendations of the U.S. Senate Appropriations Committee for the Department of Health and Human Services (HHS) included $20 million for emergency medical services for children. HHS had recommended that the program (Pediatric-EMS), which was funded last year at $19.37 million, be moved to the Public Health and Social Services Emergency Fund in the Office of the Secretary. However, the Committee instead continued to provide funding within the Health Resources and Services Administration (HRSA) account, which is also responsible for the Department's various health professions training and service delivery initiatives. The Pediatric-EMS program supports demonstration grants for the delivery of emergency medical services to acutely ill and seriously injured children. The Appropriations Committee noted that it was pleased with the efforts made for the emergency medical services for children and that it would like an update on the program. The ten year Institute of Medicine (IOM) report was found to be extremely helpful and accordingly, the Committee strongly urged a 20 year program study and update to the earlier IOM report. The program has historically included mental health within its jurisdiction and over the years has contracted with various non-physician associations, including APA, to both obtain their professional recommendations and also to assist them in educating their own membership regarding the unique needs of our nation's children.

During the nearly three decades that I have worked on Capitol Hill, I have gradually come to appreciate that national health policies frequently evolve over time and as a direct result of the deliberations of recognized "think tanks" and/or extensive Congressional and Administration public hearings. The public policy process is extraordinarily open to diverse views. The Rand Corporation is one of the most highly respected nonprofit research organizations. It recently announced its October Congressional briefing which was to focus upon mental health services for children. The highlights: 20-50 percent of sixth grade students in the U.S. have been a witness to, or victim of, violence in their community. The Cognitive Behavioral Intervention for Trauma in School (CBITS) program is the first mental health program for children that research has demonstrated to be effective. The CBITS program is an inexpensive, school-based program that both deals with the impact of the violence and gives the children a tool kit to help them deal in the future with stressful or anxious situations, negative thoughts, and other real-life problems. The development and evaluation of this program was funded in part by a grant from the National Child Traumatic Stress Network, created by Congress in 2001. It is provided in schools, and therefore is accessible to many families who face obstacles such as lack of insurance, transportation problems, and time conflicts in bringing their children to more traditional treatment settings. And, today's children are increasingly exposed to violence, ranging from witnessing violent acts to being victims themselves. Unless these children receive help now in coping with violence-related psychological trauma, they are more likely to suffer from emotional and behavioral problems that will follow them into adulthood. We are pleased to note that within the Centers for Disease Control and Prevention (CDC) Rodney Hammond has long been spearheading creative, behavioral science based violence prevention efforts.

This year the Senate Appropriations Committee also provided $98 million for the children's mental health services initiative within the Substance Abuse and Mental Health Services Administration (SAMHSA), which was the same as last year's level. The Administration had requested an increase to $106.6 million. This particular program provides grants and technical assistance to support community-based services for children and

adolescents with serious emotional, behavioral or mental disorders. Grantees must provide matching funds, and services must involve the educational, juvenile justice, and health systems. Acutely aware of the clinical importance of integrating physical and psychological care, the Senate Committee further expressed its strong support for full and timely implementation of the National Children's Study by the National Institute of Child Health and Human Development (NICHD) at the National Institutes of Health (NIH). This study aims to quantify the impacts of environmental influences (including physical, chemical, biological and social influences) on child health and development. The Committee urged the NICHD Director to continue to closely coordinate with the CDC, EPA, other Institutes and agencies and non-Federal partners conducting research on children's environmental health and development, such that this study will be ready for the field by no later than 2005. To that end, in Fiscal Year 2004, the Committee expected the Director of NICHD to increase financial support for study planning, administration, and initial pilots that will provide the information necessary to develop and implement the full national study.

The Senate Committee further noted that between 7 million to 10 million teenagers suffer from a mental health condition which, for many, may lead to serious behavioral problems including dropping out of school, substance abuse, violence, and suicide. The Committee is aware that some school districts, juvenile justice facilities, and community-based clinics have taken advantage of relatively simple screening tools now available to detect depression, the risk of suicide, and other mental disorders in teenagers. The Committee believes that screening should occur with the consent of the adolescent and his or her parents or guardian, and with a commitment by the screener to make counseling and treatment for those found to be at-risk. The Committee strongly urged SAMHSA to make the availability of these screening programs more widely known, and to collaborate with the Department of Education, Department of Justice, CDC, HRSA, and other pertinent agencies to encourage implementation of similar teenage screening programs. The Committee expects a report on steps being taken to promote this effort prior to the Fiscal Year 2005 appropriations hearings.

For those colleagues within the Division who are primarily interested in education and training, one could stress the importance of APA obtaining eligibility for psychology's inclusion under the Children's Hospital Graduate Medical Education program of HRSA. This year the Senate Committee recommended that at least $290 million be allocated, as it was in Fiscal Year 2003. The program provides support for health professions training in children's teaching hospitals that have a separate Medicare provider number ("free-standing" children's hospitals). Children's hospitals are statutorily defined under Medicare as those whose inpatients are predominately under the age of 18. The funds in this program are intended to make the level of Federal Graduate Medical Education support more consistent with other teaching hospitals, including children's hospitals, which share provider numbers with other teaching hospitals. Payments are determined by formula, based on a national per-resident amount. Payments support training of resident physicians as defined by Medicare in both ambulatory and inpatient settings.

The Committee recognized the success of the Children's Hospitals Graduate Medical Education Payment program in providing critical support for training pediatric and other residents in graduate medical education programs in teaching hospitals that do not receive support through the Medicare program. It had come to the Committee's attention that a limited number of

free-standing perinatal hospitals and children's psychiatric hospitals have been excluded from participation in the program despite the fact that these teaching institutions are not eligible for Graduate Medical Education funding under Medicare. Accordingly, the Committee expects HRSA to study and report back to the Committee on this matter by April 1, 2004. The Committee further expects HRSA to explore the appropriateness of including these hospitals in the Children's Hospital Graduate Medical Education program and to offer recommendations that might allow for their inclusion. Under Marilyn Richmond's effective leadership the Practice Directorate has been working closely with the Centers for Medicare and Medicaid Services (CMS) for the past several years to expressly include psychology under the Medicare GME initiative for both internship and post-doctoral training. Once fully operational, the HRSA Children's Hospital GME account might logically become APA's next GME legislative initiative. For it should be evident to all concerned that hospitalized children and their families clearly require the services of a wide range of health care professionals, including psychologists. For this to become a viable APA legislative priority, however, the interest of our Division's pediatric colleagues must first be effectively expressed.

A Time For Reflection: During my tenure as APA President, Surgeon General David Satcher held a special conference on Children's Mental Health: Developing A National Action Agenda. That year, APA Board Member Ron Levant and President-Elect Norine Johnson participated in deliberations at the White House with the Surgeon General and Mrs. Clinton. Highlights of the final report: The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them. It is time that we as a Nation took seriously the task of preventing mental health problems and treating mental illnesses in youth. One of the chief priorities in the Office of the Surgeon General and Assistant Secretary for Health has been to work to ensure that every child has an optimal chance for a healthy start in life. When we think about a healthy start, we often limit our focus to physical health. But mental health is fundamental to overall health and well-being. And that is why we must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well being. Responsibilities for children's mental healthcare are dispersed across multiple systems: schools, primary care, the juvenile justice system, child welfare and substance abuse treatment. But the first system is the family, and this agenda reflects the voices of youth and family. The vision and goals outlined in this agenda represent an unparalleled opportunity to make a difference in the quality of life for America's children.

The Overarching Vision of the conference was that mental health is clearly a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority. Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals. To achieve these goals, the Surgeon General's National Action Agenda for Children's Mental took as its guiding principles a commitment to: 1) Promoting the recognition of mental health as an essential part of child health; 2) Integrating family, child and youth-centered mental health services into all systems that serve children and youth; 3) Engaging families and incorporating the perspectives of children and youth in the development of all mental healthcare planning; and 4)

Developing and enhancing a public-private health infrastructure to support these efforts to the fullest extent possible.

The nation is facing a public crisis in mental healthcare for infants, children and adolescents. Many children have mental health problems that interfere with normal development and functioning. In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment. Yet, in any given year, it is estimated that about one in five of such children receive specialty mental health services. Unmet need for services remains as high now as it was 20 years ago. Concerns about inappropriate diagnosis of children's mental health problems and about the availability of evidence-based (i.e., scientifically proven) treatments and services for children and their families have sparked a national dialogue around these issues. There is broad evidence that the nation lacks a unified infrastructure to help these children, many of whom are falling through the cracks. Too often, children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources. Impressive thoughts. An outstanding vision. However, one must also wonder if collectively psychology will seek to effectively address these pressing issues as we enter the 21st Century.

Personal Involvement IS The Key: Those of us captivated by the extraordinary success in March of 2002 of Elaine LeVine, Mario Marquez, and their New Mexico colleagues in enacting RxP- legislation truly appreciate, above all else, the extent to which they were ultimately successful in galvanizing "grassroots" community support for their initiative. The political (i.e., public policy) process sincerely attempts to be responsive to the needs and expressed wishes of an enlightened constituency. That is what I experienced at the Arizona Psychological Association legislative breakfast this fall. In Louisiana, Jim Quillin and John Bolter have established their LaFact support network, which is essentially a consumer/public citizen "grass roots" organization sympathetic to Louisiana's psychology RxP- agenda. They successfully worked to receive clearance from the APA ethics committee and as of this summer, they had enrolled in excess of 3500 members, surpassing NAMI of Louisiana. Currently colleagues in at least 32 State Psychological Associations have established RxP- task forces. With the number of Americans without health insurance having increased to 43.6 million and with young adults (18-24 years of age) less likely to have coverage than other age groups, it is our societal responsibility to strive to effectively address these pressing needs. For former APA Presidents Ron Fox, Jack Wiggins, and myself, RxP- has always first been about providing quality health care in a highly cost effective fashion.

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FEATURE

Do Psychologists Have Supererogatory Obligations?

Samuel Knapp, Ed.D.
Pennsylvania Psychological Association

Leon VandeCreek, Ph.D.
Wright State University

Consider these vignettes that represent the contributions of three psychologists:

- **Helping Underserved Populations**

  One psychologist donated hundreds of hours to a struggling clinic serving inner city poor who otherwise would not receive mental health services. His efforts kept the clinic afloat and ensured continuity of care until it was eventually taken over by another agency.

- **Addressing an Important Social Need**

  A second psychologist researched and spoke about domestic violence and treated victims of abuse. Her research led to a better understanding of the causes and ways to prevent abuse. Her speaking engagements enlightened many professionals and laypersons. Each year she directly provided or supervised low cost or free services to dozens of abused women. Many would have been severely injured, or even killed, if it were not for these services.

- **Research That Has Saved Many Lives**

  A third psychologist conducted research with inner city youth with, or at risk for contracting, HIV. Her research led to a better understanding of effective STD and HIV prevention programs. Her programs probably saved thousands of lives and gave direction to other researchers and practitioners.

These psychologists engaged in commendable actions. Society is better off and psychology is strengthened as a discipline because of their contributions. These examples may be especially dramatic, but psychologists commonly contribute to others without obvious personal advantage. Other common examples include working to become especially skilled in an area of practice, or donating extra hours a week to patient care without compensation. As commendable as these acts are, are they supererogatory (performing beyond the minimum that is expected by disciplinary codes; doing more than is required) or do all psychologists have similar responsibilities? These questions overlap, but are not identical, with the question as to whether psychologists should be altruistic. Some striving for excellence or work on behalf of apparently disenfranchised groups may, under some circumstances, represents enlightened self-interest as opposed to altruism. However, the motivation for these actions is incidental to the issue of whether they are supererogatory.

The Obligations of Psychologists?

The APA Ethics Code, licensing laws and regulations, standards of malpractice courts, and other laws impose special obligation on psychologists. According to the APA Ethics Code (APA, 2002), psychologists must, among other things, avoid harmful conflicts of interests (Standard 3.06), protect patient confidentiality (4.01), be competent in their duties (2.01), and avoid unfair discrimination (3.04). These and other obligations are further expanded and clarified in the APA Ethics Code. Other psychologists have special obligations to their research participants, organizational clients, students, or supervisees.

In addition, the APA Ethics Code and other regulatory codes place some obligations to the public upon psychologists. For example, psychologists must take reasonable steps to protect the public when they learn of misconduct by a psychologist (Standards 1.06 and 1.07). Also, according to the duty to warn or protect, they must take protective measures when a patient presents an imminent danger of substantial physical harm to an identifiable third party (see for example, VandeCreek & Knapp, 2001).

The disciplinary codes of psychologists and the standards of malpractice courts may subject psychologists to penalties if they deliver services below minimal standards. However, are psychologists obligated to go beyond those minimal standards of behavior? The methodology we will use to answer this question is to consider supererogatory obligations from the standpoint of prima facie or principle-based ethics, which has become very popular in discussions of health care.

Prima Facie or Principle-Based Ethics

According to W. D. Ross' concept of principle-based or prima facie (from the Latin for "first appearance") ethics, ethical theory rests on several and not one moral principle. Ross referred to these principles as prima facie duties, meaning an obligation that holds unless it is overridden by a superior obligation. Ross identified some of these moral duties as fidelity, gratitude, justice, beneficence, self-improvement, and nonmaleficence, but acknowledged that there may be others as well (1930/1998).

However, these moral principles are not absolute and may be over-ridden if they conflict with another moral principle. There is no inherent hierarchy to follow in determining when one moral principle should override another. When a moral principle is overridden, efforts should be made to make the infringement the least possible, commensurate with achieving the primary goal.

From a principle-based perspective we would argue that the principle of beneficence would obligate psychologists to act to their highest level of ability (such as striving for high levels of competence or donating services), subject to the limitations placed on them by other obligations. According to principle-based ethics, supererogatory obligations should: (a) not divert us from our obligation to those with whom we have special relationships (family, friends, current patients); (b) be moderate and not cause us more suffering than they produce relief to others; and (c) be thought out deliberately and done selectively (Beauchamp & Childress, 2001).

According to the first point, Ross might have criticized the actions of Mahatma Gandhi when, in his efforts to ensure justice and well-being for India, he failed to attend to the needs of his family and refused to pay (or allow his friends to pay) for the education of his children (Fischer, 1983). As applied to psychology, psychologists may have obligations to their own family members that require them to restrict their working hours, even though more people would be assisted and the overall good of the community might be improved if they worked more hours.

According to the second point, psychologists ought not to donate time and resources if doing so causes as much suffering to themselves as they would relieve through their giving. Also, giving to others to the point of personal exhaustion would result in the loss of the gift in the first place. Competence as a psychologist requires emotional competence. Effective psychologists need balance in their personal lives and outside sources of social support and strength. They can gain distance from their professional lives and have a breadth of activities and life experiences that enrich their work as psychologists. Those psychologists who fail to care for their personal needs may loose their effectiveness and their ability to perform their minimal professional obligations.

Other Moral Theories

We could conduct similar analyses of supererogatory behaviors from the standpoint of other ethical theories as well. For example, accordingly to Kant's deontological or duty-based ethics, behavior needs to be judged by the categorical imperative, one formulation of which can be paraphrased as "do unto others as you would have them do unto you" (Kant, 1785/1988). Since we would want other professionals to show high levels of concern and competence for us if we were patients, we should show high levels of concern and competence for others, even if that concern exceeds the bare minimum required in the disciplinary codes.

According to utilitarian ethical theory, the rightness of an action is determined by the principle of utility or the greatest amount of good for the greatest number of persons (Ewing, 1953). The standard of producing the greatest good for the greatest number would require actions exceeding the minimum required by legal standards.

According to virtue ethics, the goal of behavior is moral excellence (Ewing, 1953). However, it is hardly moral excellence to be guided only by a desire to avoid sanctions for violating a professional standard of conduct.

Application to the Question of Supererogatory Ethics

The ethical systems reviewed here have standards of conduct higher than the minimum found in the ethics and disciplinary codes of the profession. Consequently, the question that should be asked is not "what is the minimum that the Ethics Code requires me to do?" Instead it should be, "what must I do to fulfill my ethical ideals?" If psychologists strive to become moral maximalists, instead of moral minimalists, they would still follow the disciplinary codes, but only as the beginning of their ethical responsibilities. Ethics would not be concerned exclusively with ways to conform to disciplinary codes, but with ways to conform to personal ethical ideals. This perspective has been called "positive ethics" (Handelsman, Knapp, & Gottlieb, 2001).

Accordingly, ethics education that focuses exclusively on the minimal standards found in the disciplinary codes is incomplete. Ideally ethics education in graduate school courses and continuing education courses also will consider how psychologists can integrate their ethical beliefs into their work and rise above minimal obligations. According to Beauchamp and Childress (2001), the "concentration on minimal obligations has diluted the moral life... If we expect only the moral minimum we have lost an ennobling sense of excellence in character and performance" (p. 44).

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[1] The views expressed do not necessarily represent those of the Pennsylvania Psychological Association.

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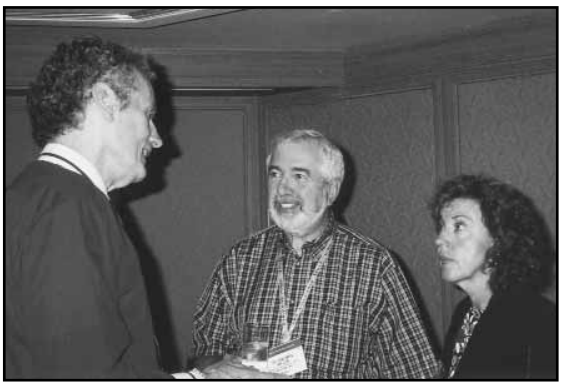

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FEATURE

Interview with Dr. Charles Gelso
Incoming Editor of the journal *Psychotherapy*

Linda Campbell, Ph.D.

Division 29 is pleased to introduce our membership to our new editor of *Psychotherapy: Theory, Research, Practice, and Training*. Dr. Wade Silverman has been our editor since 1992 and Wade is now leaving the role as editor. The Division 29 Publications Board interviewed three very strong candidates for the editorship. The Board determined that Dr. Charles Gelso has the understanding of the spirit and purpose of the Division. Further, he has the publication and editorial abilities, collegial skills, professional vision, and the passion for psychotherapy that will represent a very central contribution to our mission.

By way of introducing Dr. Gelso to you, our membership, I have interviewed Dr. Gelso on his own professional journey and on his goals for the journal.

Campbell: Dr. Gelso, congratulations on your selection as our incoming editor of *Psychotherapy*. I am very pleased that you are taking on the job and I'm sure that our Division will be greatly benefited by your leadership. I would like to ask you several questions about your interest and experience in psychotherapy and then talk a bit about your ideas for the *Journal*.

You have made very important contributions to psychotherapy research and training. How did you first become interested in psychotherapy research?

Gelso: When I took my very first counseling course (it must have been 100 or so years ago), I read an article that presented the results of an outcome study. I remember my amazement and excitement like it was yesterday. The logic and method of the study fascinated me, and I had a clear sense of wanting to do something like that in my career. It was a kind of "love at first sight." The idea that an enormously complex and intriguing process like psychotherapy could be studied and quantified really grabbed me, and it still does.

Campbell: In what way has your interest in psychotherapy either changed or refocused over time?

Gelso: My early interests were pretty diffuse. Studying anything therapy related was fascinating. Then I became more focused on time-limited therapy and how abbreviating therapy affected the process and outcome of treatment. This interest was driven by very practical concerns. At the University of Maryland's counseling center, we had a huge waiting list and a long wait for treatment. Something had to be done. But could shortening therapy result in good outcomes? This practical concern formed the basis for a research program that I and my colleagues carried out for several years. Gradually my interests became more theoretical and clinical. Based on my clinical work and the work of some of my graduate students, I became interested in studying aspects of the therapy relationship. Topics like countertransference, transference, working alliance, and most recently what I term the real relationship in therapy have captured my curiosity for the last 20 years or so. Figuring out how to study some of these constructs can be brain breaking, but it is also very intellectually exciting and clinically meaningful. I think I'll stay with these topics for a while longer.

Campbell: What do you think are the more critical areas for continued study in psychotherapy research today?

Gelso: I really do not think it is helpful, scholarly, or just plain interesting to think

about what topics are the most important and, by implication, the least or perhaps less important. The important thing is that we want to try to understand the process and outcome of diverse forms of therapy, and each scholar/practitioner has his or her own agenda and passion about what specifically is important. I suppose in a general sense I would say that our growing edge may be to move forward in tackling what I refer to as the "who, what, when, and where question", e.g., what treatments offer by which practitioners are most effective (and least effective) with what clients possessing which problems? This of course will involve a generation and more of research and theory.

Campbell: How have the important areas for study changed over the years?

Gelso: Interesting question. When I was a graduate student, the "does it work" question absorbed the field. I believe that question has been answered ***on the whole***, and we are now about the business of addressing more specific questions. Managed care has introduced a whole new level of pragmatism into our field, and pushed us in the direction of figuring out specific treatments that work in the briefest time for specific problems, often framed in terms of disorders. This is a certain version of the "who, what, when, and where" question, and in a way it formed the basis for the empirically-validated treatments movement. However, at least initially it was framed in such a circumscribed and, shall I say, theoretically biased manner that it was not very helpful or enlightening. Beyond this general evolution from does it work to more specific and refined questions, many hot topics have come and gone over the years, and probably each has left its mark. As this has happened, knowledge has very gradually accrued, so that we now actually know a tremendous amount about psychotherapy. And yet, the scientific spirit involves never being satisfied—always feeling that we do not know enough. Of course, we shall never know enough, and when we feel we do, it is probably time to more on to another endeavor.

Campbell: You have made very significant contributions not only to research, but to training and teaching. Is there a way that your expertise in training and teaching can contribute to your role as editor or to influence the direction of the *Journal*?

Gelso: If I may dichotomize the world, you may think of two roles an editor can take: That of gatekeeper and that of educator. The gatekeeper's job is to keep all of the junk and worse (a.k.a, bad research and theory) out of the journal. The educator, on the other hand, seeks to aid authors in producing the best work possible. Naturally the review process is a key part of this, and in this sense, I cannot overestimate the importance of high quality reviews by the editorial board. The editor-educator, however, must also work with these reviews, integrating them and communicating to authors in a way that is helpful, even when the manuscript is not accepted for publication

Campbell: What do you see as your initial goals as editor of the *Journal*?

Gelso: At a very practical level, we need an increase in submissions if we are to maintain the number of pages we are allotted. My initial goals are to do the very best job possible in reviewing and working with the manuscripts that are submitted. I would like to see some excitement about the *Journal*, and have it seen as an outlet that scholars and practitioners are eager to publish there work in.

Campbell: How do you see the role of our journal among other psychotherapy journals?

Gelso: We have historically and currently had a special place in psychology in that we (1) focus exclusively on psychotherapy (2) seek a balance of research, theory, and practice, and (3) are not theoretically biased. Our uniqueness rests in the combination of these three thrusts. The Journal has a history of being highly relevant to practitioners as well as scientists, of being open to all views of psychotherapy, and also of being methodologically open, as well.

Campbell: Our Division mission is to promote training, theory development, research and practice. How do you see the role of the *Journal* in this mission?

Gelso: I think I just addressed that. As editor, I really do want to seek a balance of all of these areas. Any given article of course will not likely be relevant to each of these domains, but it is important to me that the Journal is a place that readers go to in order to find pieces that are highly relevant to practice, highly relevant to science, and of course highly relevant to the integration of the two. Well, I'm probably beginning to sound like a politician, which I am not, so I'll just end by saying that the Journal's role in this mission is to publish a balance of articles on all of the domains you mention.

Campbell: Making the *Journal* a home for psychotherapy research, practice, theory, and training could be a formidable challenge. How will you approach this challenge?

Gelso: Eagerly!

Campbell: What are some topic areas you would like to see more represented in the *Journal?*

Gelso: I plan to have some special issues and special subsections. The first one that I am already seeking manuscript submissions for is the "interplay of therapy techniques and the therapeutic relationship." To me, how the relationship and techniques work together in affecting the therapy process is a vital area of inquiry. Similarly, variations on the "who, what, when, and where question" are vital. I would also like to see continued increases in submissions pertaining to multicultural issues in therapy and training. I haven't thought through other topics, and in fact, I want to be cautious about promoting too many topics. I believe there is a natural evolution of topics and that editors shouldn't promote their own views too much (although some of this is okay). Most basically, I want the Journal to be methodologically open and also be open to all content. It is the quality of the work that matters most, and I am very happy to have the individual scientist and practitioner decide what topics get submitted.

Campbell: Are there emerging issues in psychotherapy research, practice, training, and theory that you might see as special focus area in the *Journal*?

Gelso: Nope. This would be too limiting and, more important, too, should I say, dominating for an editor. Let the field decide what topics become hot and thus get studied and written about. What the Journal can do that is most helpful to the field is concentrate on improving the quality of research and presentation through the review process. If the readers, in fact, have ideas for special sections or issues, I'm all ears.

Campbell: What would you like the Division 29 members to know about your professional direction and purpose in working with the *Journal*?

Gelso: I have always had a great liking for this journal, and have loved its way of presenting a combination of think pieces, clinical papers, and research pieces. My "direction and purpose" is to help this journal become the very best psychotherapy journal it can be, given its mission. One of the features of *Psychotherapy* since its early days that made it very special to me has been its focus on creativity. I think it has placed a premium of creative thinking in psychotherapy more than just about any journal I know. This came through loud and clear in the editorial statements of the early editors and has been maintained to the present day. Some of the articles that I liked best as a reader were pretty theoretically outrageous, i.e., often ahead of their times. One of my goals is to keep this creative focus, while also enhancing methodological and theoretical rigor. A pretty tall order, isn't it.

Campbell: Are there other comments you would like to make that I haven't asked?

Gelso: I think I have been redundant enough for one day! Thanks for the opportunity to share some of my views.

FEATURE

The Empirically-Validated Treatments Movement: A Practitioner Perspective[1]

Ronald F. Levant

Ronald F. Levant, Ed.D., A.B.P.P., is a fellow of Division 29 and 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 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.

I would like to weigh in on the issue of what has been called, sequentially, "empirically-validated treatments" (APA Division of Clinical Psychology, 1995), "empirically-supported treatments" (Kendall, 1998), and now "evidence-based practice" (Institute of Medicine, 2001).

Empirically-validated treatments is a difficult topic for a practitioner to discuss with clinical scientists. In my attempts to discuss this informally, I have found that some clinical scientists immediately assume that I am anti-science, and others emit a guffaw, asking incredulously: "What, are you for empirically unsupported treatments?" McFall (1991, p. 76) reflects this perspective when he divides the world of clinical psychology into "scientific and pseudoscientific clinical psychology," and rhetorically asks "what is the alternative [to scientific clinical psychology]*? Unscientific* clinical psychology." (see also Lilienfeld, Lohr, & Morier, 2001).

There are, thus, some ardent clinical scientists (e.g., McFall and Lilienfeld) who appear to subscribe to scientistic faith, and believe that the superiority of scientific approach is so marked that other approaches should be excluded. Since this is a matter of faith rather than reason, arguments would seem to be pointless. Nonetheless, clinical psychologists have argued over it, a lot, for the last eight years. Punctuating these interactions from the practitioner perspective, the controversy seems to stem from the attempts of some clinical scientists to dominate the discourse on acceptable practice, and impose very narrow views of both science and practice.

Let's start with a brief recapitulation of the events. Division 12, under the leadership of then-President David Barlow, formed a Task Force " to consider methods to educate clinical psychologists, third party payors, and the public about effective psychotherapies" (APA Division of Clinical Psychology, 1995, p. 3). The Task Force came up with lists of "Well-Established Treatments" and "Probably Efficacious Treatments." Not surprisingly, the lists themselves emphasized short term behavioral and cognitive-behavioral approaches, which lend themselves to manualization; longer term, more complex approaches (e.g., psychodynamic, systemic, feminist, and narrative) were not well represented.

The empirically-validated treatments movement has had quite an impact on practitioners. It provided ammunition to managed care and insurance companies to use in their efforts to control costs by restricting the practice of psychological health care (Seligman & Levant, 1998). It has also influenced many local, state and federal funding agencies, who now require the use of empirically-validated treatments. Moreover, this movement could have an even greater impact on practitioners in the future. For example, it could create additional hazards for practitioners in the courtroom if empirically-validated

treatments are held up as the standard of care in our field. Further, adherence to empirical-validated treatments could become a major criterion in accreditation decisions and approval of CE sponsors, as the Task Force urged (APA Division of Clinical Psychology, 1995, p. 3). Some clinical scientists have gone so far as to call for APA and other professional organizations "to impose stiff sanctions, including expulsion if necessary," against practitioners who do not practice empirically-validated assessments and treatments (Lohr, Fowler & Lilienfeld, 2002, p. 8).

Given all of this fallout, it should be no surprise that the Task Force report was soon steeped in controversy. Critics argued first and foremost that the Task Force used a very narrow definition of empirical research. For example, Koocher (personal communication, 7/20/03), observed that "'empirical' is in the eye of the beholder, and sadly many beholders have very narrow lens slits. That is to say, qualitative research [and] case studies… have long been a valuable part of the empirical foundation for psychotherapy, but are demeaned or ignored by many for whom 'empirical validation' equates to 'randomized clinical trial' [RCT]. In addition, a randomized clinical trial demands a treatment manual to assure fidelity and integrity of the intervention; however, the real world of patient care demands that the therapist (outside of the research arena) constantly modify approaches to meet the idiopathic needs of the client…Slavish attention to 'the manual' assures empathic failure and poor outcome for many patients."

Furthermore, Seligman and Levant (1998) argued that, whereas efficacy research programs based on RCT's may have high internal validity, but they lack external or ecological validity. On the other hand effectiveness research, such as the *Consumer Reports* study (Seligman, 1995), has much higher external validity and fidelity to the actual treatment situation as it exists in the community. Additional effectiveness studies are needed, and could be conducted by the Practice-Research Networks that have recently appeared (Borkovec, Echemendia, Ragusea, & Ruiz, 2001). Finally, others have pointed that many treatments have not been studied empirically, and that there is a big difference between a treatment that has not been tested empirically, and one that has not been supported by the empirical evidence.

A few years later, John Norcross, then-President, of Division 29 (Psychotherapy), countered by establishing a Task Force on Empirically Supported Therapy Relationships in 1999, which emphasized the person of the therapist, the therapy relationship and the non-diagnostic characteristics of the patient (Norcross, 2001). Lambert and Barley (2001) summarized this research literature, pointing out that specific techniques (namely those that were the focus of the studies underlying the Division 12 Task Force Report) accounted for no more than 15% of the variance in therapy outcomes. On the other hand, the therapy relationship and factors common to different therapies accounted for 30%, patient qualities and extra therapeutic change accounted for 40%, and expectancy and the placebo effect accounted for the remaining 15%.

Westen and Morrison (2001) reported a multidimensional meta-analysis of treatments for depression, panic disorder, and GAD, in which they found that "the majority of patients were excluded from participating in the average study," due to the presence of comorbid conditions (p. 880). Approximately 2/3 of the patients in the studies they reviewed were excluded, which seems like a high percentage, but is actually a bit lower than national figures for comorbidity. Meichenbaum (2003) noted that fewer than 20% of mental health patients have only one clearly definable Axis I diagnosis. Thus, the vast majority of cases seen by practitioners do not meet the exact diagnostic criteria used in the RCT's that established efficacy for various treatments.

Furthermore, the empirically-validated treatments on these lists have typically

been studied using homogeneous samples of white, middle class clients, and therefore have not often been shown to be efficacious with ethnic minority clients.

So what does this all mean? Suppose we had lists of empirically-validated manualized treatments for all DSM Axis I diagnoses (which we are actually a long ways away from). We would then have treatments for only 20% of the white, middle class, patients who come to our doors, namely those who meet the diagnostic criteria used in studies that validated these treatments. That's bad enough, but that's not all. In order to limit services to only these 20% of the white, middle class, patients who come to us, the average practitioner would have to spend many, many hours, perhaps years, in training to learn these manualized treatments. And if we restricted ourselves to use only these manualized treatments, we would be limiting our role to that of a technician. And, in the end, these treatments would only account for 15% of the variance in therapy outcomes in these patients. One can readily see why few practitioners embraced the empirically-validated treatments movement.

My view is although one of psychology's strengths is its scientific foundation, the present body of scientific evidence is not sufficiently developed to serve as the sole foundation for practice. Practitioners must be prepared to assess and treat those who seek our services. To be sure, we all get referrals of clients that we decide to refer to others because we don't think that we are the best clinician for that case, but those who are in general practice have to work with the clients that come to us. Whether we operate from a single theoretical perspective or are more eclectic, we bring to bear all that we know from the empirical literature, the clinical case studies literature, and prior experience, as well as our clinical skills and attitudes, to help the client that is sitting in front of us. This is what is often referred to as clinical judgement. Some condemn clinical judgement as subjective. To them I say that clinical judgement is simply the sum total of the empirical and clinical knowledge and practical experience and skill which clinicians bring to bear when it is our job to understand and treat a particular and very unique person.

Fox (2003) goes even further, pointing out that in many learned fields science and practice are often separate endeavors, and that practice often has to precede science. Physicians were treating cancer long before they had much of an idea of what it was, and were using pharmaceutical agents like aspirin long before the pharmacodynamics were known. To quote Fox (2003):

The fact of the matter is that if clinicians restrict themselves to applying only narrowly validated or known techniques, they will never be of much value to society. Lest you think that statement is an invitation to charlatanism, remember that clinicians do not have the luxury to start from what is known. They must start with the needs of the people who come to them and then apply all the knowledge, information and skill they have to help resolve those problems.

On the other hand, we do have a problem of accountability in health care, one that will surely affect psychology. For example, the current lag between the discovery of more effective forms of treatment in health care and their incorporation into routine patient care is, on the average, 17 years. DeLeon (2003) predicts that health care in the 21st century, abetted by technology, will be characterized by even greater accountability for practitioners, due to the combined effects of the increasingly well-informed health care consumer, who gathers relevant health care information from the internet, the increasingly well-informed practitioner, who will be able to obtain best practice information from a PDA, and increased monitoring of health care practices, to flush out variation in treatment for specific diagnoses. In this environment we are going to need betters ways to evaluate practice. I would suggest

that we consider using the broad and inclusive definition of evidence-based practice adopted by the Institute of Medicine (2001). This definition consists of three components: *best research evidence, clinical expertise* and *patient values.* The definition does not imply that one component is privileged over another, and provides a broad perspective that allows the integration of the research (including that on empirically-validated treatments and that on empirically supported therapy relationships) with clinical expertise and, finally, brings the topic of patient values into the equation. Such a model that values all three components equally will better advance knowledge related to best treatment, and provide better accountability.

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

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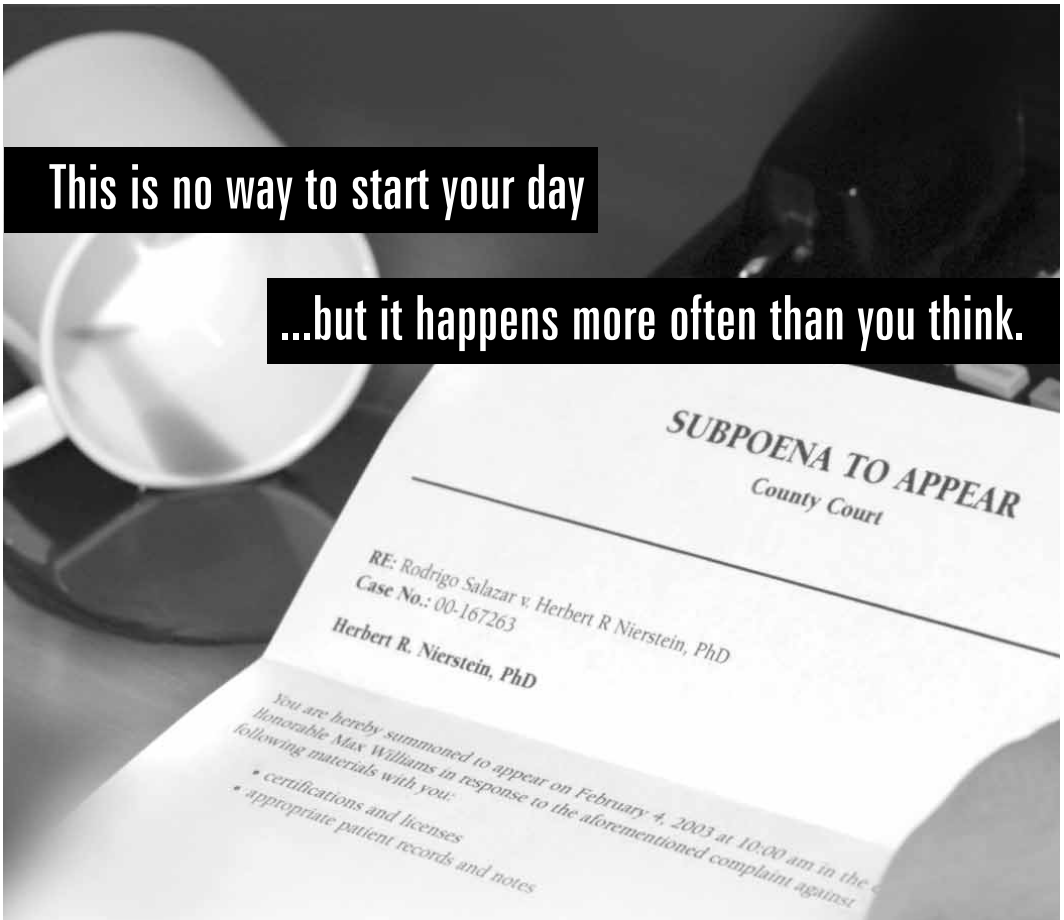
[1] Adapted from Levant, R. (in press). The empirically-validated treatments movement: A practitioner/educator perspective. *Clinical Psychology: Science and Practice.*



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