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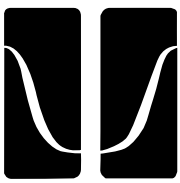
BULLETIN

In This Issue



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CONTENTS

PRESIDENT'S COLUMN

Psychotherapy Advancement and Advocacy

Linda F. Campbell, Ph.D.

Greetings to you, our Division 29 members. Again I am honored to be speaking to you as President of your division. In the first column of this year, I described the very exciting and important initiative that is in process now. The initiative is called the Advancement and Advocacy of Psychotherapy. There are several elements to the initiative that are already in process and we are now embarking on the next phase. Please peruse the first issue of this year for an update on what has already been accomplished. I want to bring you up to speed, in this column, on the continued aspects of the initiative that are still in discussion.

You've heard the expression that sometimes the good news and the bad news is the same news. Such a case has occurred in our division by my standards. I am confessing to you that I was the last person to cross the bridge to the twenty-first century in regard to technology and have reluctantly learned what was required. Even I am accepting the fact that much can be accomplished through technology that would not have been possible otherwise. All of this is to say that the Board of Directors will soon be considering several important decisions that may contribute significantly to the welfare and promotion of the division that is made possible only through technology.

We realized at the last board meeting that much needs to be done in our division in order to accomplish what we want in the next several years and that an efficient means to do so is to have designated online discussions that will enable us to take action on important topics between meetings. There are six topics currently that we will discuss and subsequently vote on for adoption or rejection. I would very much like for you, the membership, to consider these topics and if you are interested in voicing your opinion and weighing in on the topic, you can communicate to Leon VandeCreek or me through e-mail or the Division 29 listserv and we will include you in the process. Technology enables individuals to be part of a process who otherwise would not. I am hoping that our membership will find enthusiasm for the division's initiatives and let us know.

1. The first discussion and decision item is the consideration of developing sections within the division. Several other divisions have sections that represent specific areas of interest within the purview of the division. In our case, the sections would be topics within psychotherapy that may garner more specific interest for some of our members. The board online discussion will take place this summer, after which the board will decide to postpone the topic until the in person board meeting in October or will decide to vote on it online. Dr. Jean Carter has taken the lead on this item and understands the pros and cons.

2. The second item is the consideration of liaisons to other divisions, committees, boards, and governance structures within APA and outside APA. Policies, procedures, and decisions may be made in other entities that affect psychotherapy generally or even our division specifically. Liaisons are individuals who, in our case, would represent the division and would attend meetings of the other entities, then report back. Liaisons are distinguished from monitors in that monitors receive minutes and information from a meeting but do not attend.

3. Dr. Leon VandeCreek is the co-chair of the Task Force on the Advancement and Advocacy of Psychotherapy and is the President-Elect of the Division. Leon has worked tirelessly on the initiatives that are currently in progress. He is an industrious person, however, and has several other initiatives that he would like to introduce and endorsed by the division. Leon will discuss those initiatives with the board and we will go from there. We have adopted an "implementation schedule" in the last couple of years in which we lay the groundwork for presidential initiatives during the president-elect's year and then are ready to hit the ground running when the year of presidency arrives. Leon will likely begin work early on his initiatives once they are presented to the board. Leon's initiative will be discussion the first two weeks of July.

4. The consideration of becoming a "society" has been recommended for exploration. Dr. Jean Carter and Dr. John Norcross have accepted the leadership on this matter and have provided very useful and thorough information on the subject. Several divisions of APA have taken the name of "Society" rather than division. There are several reasons for this (we can maintain the advantages of an APA Division while broadening our appeal and membership).

5. The board will discuss and decide whether or not to accept non-APA psychologists as members of the division. Approximately 85% of the APA Divisions have a professional affiliate category for non-APA members. In this case, we are considering non-APA members, yet the person must be a psychologist rather than a member of a related field. This action could expand our membership, but on the other hand, may have disadvantages that we must consider. The elements of this decision are not completely known but will be available before August of this year. Again, Drs. Norcross and Carter have devoted much time and energy in acquiring sufficient information for our decision making.

As mentioned in the first issue of the *Bulletin*, during June and July, Leon and I are also pursuing further conference communication with our practice focus group, training focus group, and research focus group. We will review the action plans suggested in the first round idea exchange last spring. The group will then have the opportunity to prioritize the action items and delete or add from the original draft.

Further, Leon and I will be conducting conference calls for the focus group of early career psychologists and another focus group for student interns. These are two groups who are vitally important to the future of the division. The early career group will consist of psychologist members of Division 29 who have graduated within the last five years. These are members who can speak to the transition from student to psychologist and identify the concerns as well as the healthy aspects of beginning their careers as psychologists/psychotherapists. Also, Leon and I decided to include student interns in the student focus group because they could speak to the full spectrum of pre-doctoral training, internship, and pursuit of the post-doctoral experience. These calls will be held in June.

Although the voting and decision making on these subjects will be conducted by the voting board, we are very committed to being responsive to you, the membership, and your views on the direction of the division. Please consider your views on these subjects and contact Leon VandeCreek (Leon.Vandecreek@Wright.edu) or me, Linda Campbell (lcampbel@uga.edu).

You, the membership, are the vitality of the division. Please join us in the advancement and advocacy of psychotherapy.

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John Norcross, chair of the Publications Board presents Linda Campbell, outgoing Bulletin editor, with a gift of appreciation from the Publications Board

FEATURE

Focusing on the Person of the Therapist

Edward W.L. Smith, Ph.D., ABPP

Dr. Smith is a Professor of Psychology and Coordinator of Clinical Training at Georgia Southern University. His books include The Growing Edge of Gestalt Therapy *(edited),* The Body in Psychotherapy, Sexual Aliveness: A Reichian Gestalt Perspective, Not Just Pumping Iron: On the Psychology of Lifting Weights, Gestalt Voices *(edited),* Touch in Psychotherapy: Theory, Research, and Practice *(co-edited), and most recently,* The Person of the Therapist. *Currently he is on the editorial board of* Voices. *Edward has offered training workshops in psychotherapy throughout the United States, in Canada, the Caribbean, the Czech Republic, Denmark, England, Germany, Ireland, and Mexico. He is a past Chair of the Training Committee of the American Academy of Psychotherapists and a Fellow of the Georgia Psychological Association, the American Psychological Association (Division of Psychotherapy and Division of Humanistic Psychology), and the American Academy of Clinical Psychology. From time to time he writes poetry.*

"Any sincere therapist should be in continuous therapy for himself during his entire professional life" (Warkentin, 1965, p. 4). Perhaps, shocking to some, and surely surprising to many, these bold words of exhortation were the lead in to John Warkentin's editorial in the premier issue of *Voices*. The idea of further professional training, a refresher course, or an updating of skills was probably seen at that time as something for the minority of practitioners. So, continuous therapy for the therapist was an outrageous suggestion! At the root of Warkentin's provocative statement is the idea that something other than technique, procedure, or method is necessary for good psychotherapy. What is necessary, and some would even argue, what is the necessary and sufficient ingredient in good psychotherapy is the *person.* It is the *personhood* of the therapist that is the most important and most vital contribution of the therapist.

In a rush to oversimplification, therapies are usually dissected and discussed in terms of the techniques that they employ. Often, the focus is on the reflection, the interpretation, the empty-chair dialogue, the confrontation, the cognitive re-framing, the homework assignment, and so forth. It is, in fact, the technique that is most often taken as the hallmark and identifying feature of a therapy. But the technique, method, or procedure is an abstraction, and becomes a lived event only when brought to life through the person of a therapist in collaboration with a person in therapy. That is to say, therapeutic interventions become actual and concrete only in the here-and-now as they are brought to life through the therapist's *person*-al expression (Smith, 2003).

I have suggested that no given technique, regardless of how objectively pure it seems in the abstract, as it is read about or discussed, is ever the same when given life by different persons. Herein, the *person*-al is critical and it is vital. *It is the individual, personally mediated expression of the technique that is real and present for the person in therapy* (Smith, 2003). And what is the ubiquitous and enlivening presence for every technique, every time it manifests as a concrete event? It is the *person of the therapist.*

The major portion of the psychotherapy research reported in the past decade supports the position that psychotherapy, in general, is efficacious and is effective. Compelling evidence for the efficacy of psychotherapy, generated from a large number of studies, has been summarized by Lambert and Bergin (1994). The first major study on psychotherapy effectiveness has been discussed at length by

Seligman (1995). More recently, Lambert and Ogles (2004) reviewed efficacy and effectiveness research, and consistent with the review of a decade earlier, concluded that "providers as well as patients can be assured that a broad range of therapies, when offered by skillful, wise, and stable therapists, are likely to result in appreciable gains for the client" (p. 180).

Moving, then, beyond the broad question of whether psychotherapy works (a question that by now can, I believe, be laid to rest with an affirmative answer), more specific questions beg to be answered. One such question is, of course, the role of the person of the therapist. The importance of this question was highlighted by Lambert and Bergin (1994), with their characteristic regard for evidence when they reported, "despite careful selection, training, monitoring, and supervision, therapists offering the same treatments can have highly divergent results" (p. 174). Lambert and Ogles (2004) further limned the picture, stating that "the individual therapist can play a surprisingly large role in treatment outcome even when treatment is being offered within the stipulations of manual-guided therapy . . . . Wide variations exist among therapists. The therapist factor, as a contributor to outcome, looms large in the assessment of outcomes" (p. 181). Furthermore, based on cogent evidence, a portion of those whom therapy "is intended to help are actually harmed by . . . negative therapist characteristics." (Lambert and Bergin, 1994, p. 182).

Consistent with the above, John Norcross (2000) highlighted the importance of the role of the person of the therapist in the context of the ethical and professional commitment to conduct evidence-based psychotherapy. He noted wryly that although "efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact is that the therapist as a person is a central agent of change" (p. 2-3). Citing the work of Crits-Christoph and colleagues in 1991 and that of Lambert and Okiishi in 1997 to support that claim, Norcross also observed that the "curative power of the person of the therapist is, arguably, as empirically validated as manualized treatments or psychotherapy methods" and that techniques account for "only 12-15% of the variance across therapies" (Norcross, 2000, p. 3) (see also Hubble, Duncan, and Miller, 1999; Lambert, 1992; Orlinsky, Graw, and Parks, 1994).

With the importance of the role of the person of the therapist established, the next question is appropriately the nature of the *person of the therapist*. As central as this question is, it has proven to be extremely hard to answer. Beutler, Machado, and Neufeldt (1994) performed the impressive task of reviewing the relevant research, concentrating on that reported since 1985, including more than 340 references. These authors began their review of therapist variables by establishing this foundation: (1) In statistical analyses, magnitude of benefit is more closely associated with the identity of the therapist than with the type of psychotherapy that the therapist practices; (2) some therapists in all therapeutic approaches produce consistently more positive effects than others; and (3) some therapists produce consistently negative effects" (p. 229).

After acknowledging that the effort to identify the therapist characteristics that account for these general findings has not been very fruitful, they offered the tentative explanation that "therapist characteristics interact in complex ways with characteristics of the client, the situation, and the type of therapy practiced" (p. 229). It is noteworthy that the more recent and equally ambitious review of therapist variables reported by Beutler and his colleagues (2004) added little more to our understanding of these processes. Regrettably, they reported that "over the last two decades, there has been a precipitous decline of interest in researching areas that are not associated with specific effects of treatment and its implementation... Recent research is noticeably sparse, or even absent, on the effect of therapist

personality, well-being, personal values, and religious viewpoints on outcomes" (pp. 289-290).

Considering these research-based conclusions in conjunction with those research-based conclusions mentioned earlier, I derive the following. *Even when therapy is conducted "by the book," through training, supervision, and monitoring, different therapists demonstrate different levels of efficacy.*

CONCLUSION

The person of the therapist is at once ubiquitous and yet elusive, as we have seen. But in spite of its elusiveness-cum-mysteriousness, and because of it's ubiquity-cum-vitality, we must honor it with our attention. With practical concern, Lambert and Bergin (1994) stated their opinion "that training programs should emphasize the *development of the therapist as a person* in parity with the acquisition of therapeutic techniques" (p. 181) (italics mine). Or, recalling John Warkentin's (1965) words, "Any sincere therapist should be in continuous therapy for himself during his entire professional life" (p. 4).

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PRACTITIONER REPORT

21st Century Psychology: Toward a Biopsychosocial Model

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Health Care in the 21st Century

We are living in truly interesting times, as the ancient Chinese curse goes. The 21st century promises monumental changes in health care. The technology currently available has already 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 receive up to date information on pharmaceutical agents. Yet despite these promising technological developments, the status of health care in the U.S. is very troubling.

Serious Problems in the U.S. Health Care System

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. The Secretary of the Department of Health and Human Services (HHS) met with leaders from the National Academies and challenged them to propose bold new ideas that might change conventional thinking about the most serious problems facing the health care system today. In response, the Institute of Medicine (IOM, 2002, p.1) 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).

These problems are clearly so serious that they should compel a complete re-examination of the U.S. health care system from the ground up. One central assumption that requires re-thinking is the idea of the separation of mind from body, the notion pervading our concepts of health and illness that there are some illnesses that are physical and others that are mental, a notion that is enshrined in the current practice in healthcare reimbursement of "carving out," or sub-capitating, mental health benefits. In fact, mind and body are not separate, but rather they are inseparable. By maintaining the fiction that mind and body are separate, and, further, assuming that the only role that the mind plays in health and illness is in mental health and illness, we have developed a healthcare system that is hobbled in its ability to deal with the many varied roles that mind and behavior play in so-called physical illness. This system, further, does not even deal with mental health and illness, per se, effectively.

Magnitude of the Cartesian Error

Mind-Body dualism has an enormous negative impact on our health care system. Because of it, our health care system does

not systematically attend to the many psychological risk factors for both morbidity and mortality, and it virtually ignores the psychosocial pathways that lead to unnecessary utilization of medical and surgical services. Further, our health care system does not fully utilize appropriate tools to tackle the current chronic disease epidemic, such as the numerous disease management programs aimed at treatment adherence and lifestyle improvement developed and validated by psychologists. Nor does it utilize fully the many well-documented psychological interventions for acute illness and management of stressful medical procedures. In addition, the psychological impact of having a medical illness is not well addressed by the health care system, nor is the fact that many people suffering from a physical illness have comorbid psychological illness, nor is prescription drug abuse. Finally, the lion's share of mental health problems are treated, ineffectively, by primary care providers. Let's take a look at some of the evidence.

(1) Seven of the top health risk factors are behavioral (tobacco use, alcohol abuse, poor diet, injuries, suicide, violence and unsafe sex, USDHS, 2002).
(2) Seven of the nine leading causes of death have significant behavioral components (McGinnis & Foege, 1993).
(3) At least 50% (and maybe as much as 75%) of all visits to primary care medical personnel are for problems with a psychological origin (including those who present with frank mental health problems and those who somaticize), or for problems with a psychological component (including those with unhealthy lifestyle habits such as smoking, those with chronic illnesses, and those with medical compliance issues (O'Donahue, Ferguson & Cummings, 2002).
(4) Stated another way, one study found that less than 16% of somatic complaints had an identifiable organic cause (Kroenke & Manglesdorff, 1989).
(5) A large number of studies have demonstrated that providing behavioral health care reduces the utilization of medical and surgical care (Chiles, Lambert, & Hatch, 1999).
(6) The vast majority of people receiving mental health treatment are cared for by medical professionals with minimal specific training in mental health (Glied, 1998).
(7) Moreover, there is a growing body of empirical evidence supporting the effectiveness of psychological interventions in ameliorating a wide range of physical health problems, including both acute and chronic disease affecting literally every organ system and encompassing pediatric, adult and geriatric populations. In addition to being clinically effective, these interventions are dramatically less expensive than alternative somatic interventions across a wide variety of illnesses and disorders, including cardiovascular disease, hypertension, diabetes, neoplasms, and traumatic brain injury (Smith, Kendall, & Keefe, 2002).

Toward a Biopsychosocial Model

Descarte's 17th century philosophy, which separates mind from body, is, quite simply, bankrupt. We, as a nation, need to transform our **biomedical** health care system to one based on the **biopsychosocial** model. This coming transformation will create tremendous opportunities for psychology to play a major role in resolving some of this nation's health care problems with regard to cost, quality, and access.

The recent approval by the Center for Medicaid and Medicare Services of the Health and Behavior codes for psychologists will facilitate these developments. These new codes allow psychologists to see patients for medical diagnoses in their private offices and bill for assessment and intervention (Foxhall, 2000).

In order to rise to this challenge, psychology must define itself as a health profession rather than as a mental health profession. An APA Board of Professional Affairs Work Group recognized this need when it called for a "figure-ground reversal" in professional psychology. The Work Group advocated that, rather than viewing psychology

as a mental health profession with health psychology representing a subset of its expertise, we should view psychology as a health profession, with mental health as a subset of its expertise.

The American Psychological Association took a major stride in this direction, when, in 2001, under the leadership of then-President Norine Johnson, the mission statement was amended to include health as part of its mission, which now reads: "to advance psychology as a science and a profession, and as means of promoting health, education, and human welfare." This bylaw change was approved by one of the largest pluralities ever.

This change in perspective, to viewing psychology as health discipline operating from a biopsychosocial perspective, would, of course, require a dramatic change in our training programs. If psychology truly wishes to rise to the challenge presented by the failures of the US health care system and respond in a fulsome way to the tremendous opportunities in health care, we would have to change not only the doctoral curriculum but also the undergraduate pre-requisites. Both are long on the "psycho" and "social" parts, but short on biology and the related areas of mathematics, physics, and chemistry. So too, training programs are highly variable in the degree to which students gain experience working in interdisciplinary collaboration in the broader health care arena, whether it be primary care, general hospitals, academic medical centers and the like, and this would have to change to ensure significant training in health care.

Undertaking a change of this scope will, of course, not be easy. However, to put this in perspective, consider that psychology now has before it a rare transformational opportunity, on the scale of what took place more than 50 years ago at the end of World War II. Prior to World War II professional psychologists had very limited roles as psychodiagnosticians working under the direction of psychiatrists. The war and its aftermath brought with it a tremendous demand for mental health services, including psychotherapeutic treatment, which helped wrest control of psychotherapy from psychiatry and opened this field up to psychology. This, in turn, led to a tremendous expansion of the scope of practice for professional psychology (Humphries, 1996).

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AN INVITATION TO STUDENTS

Dear Students,

You are cordially invited to participate in Division 29 Student Membership activities. These include:

1. Writing articles for the student column in the Psychotherapy Bulletin.
2. Contributing to the Division 29 Student Listserv.
3. Joining the Student Membership Committee.
4. Becoming a Division 29 spokesperson at your campus.
5. Encouraging other students to join Division 29 (remember: if you renew your membership and get a friend to join at the same time you both receive a $10 discount on your annual fees).
6. Contacting us with ideas and suggestions for Division 29 student activities.

Please send your comments and questions to

Anna McCarthy
Graduate Student Liaison
Division 29

Email: annamuck@hotmail.com

We look forward to hearing from you!!

THE DIVISION 29 BOARD OF DIRECTORS MEETING MID-WINTER 2004

Leon VandeCreek, Bill Stiles, John Norcross, Craig Shealy, Wade Silverman, Jack Wiggins, (Front row, l-r) Matty Canter, Linda Campbell, Alice Rubenstein, Jan Culbertson, Jean Carter, Abe Wolf, Charlie Gelso

Matty Canter,
Alice Rubenstein,
Jeffrey Hayes,
Alex Siegel

Leon VandeCreek,
Jan Culbertson,
Bill Stiles

FEATURE

Louisiana Grants Prescriptive Authority to Psychologists

By Jack G. Wiggins, Ph.D.

Louisiana became the second state and the third jurisdiction to enact legislation granting prescriptive authority to psychologists. Governor Kathleen Blanco signed HB 1426 into law on May 6, 2004. This was the culmination of a multiyear struggle by the Louisiana Academy of Medical Psychologists (LAMP) to expand psychological services to the underserved populations in their state. The bill was endorsed by the Louisiana Psychological Association and introduced by the Speaker of the House Joseph R. Salter. HB1426 passed the House by a 62-31 margin. President of the Senate Donald E. Hines, M.D. guided it through the Senate with a 21-16 majority. The bill survived the great political lobbying for which LA is noted. Norman Anderson and Anita Brown both made presentations to the legislators in addition the lobbyists for LAMP.

This bill gives control of the implementation of law to the State Board of Examiners of Psychologists. There are specified limits on the scope of practice of prescribing and distributing medical drugs. However, the psychologists in Louisiana believe it is workable and will enable them to serve a broader range of the population. It is important to note that this legislation was adopted with significant support from our medical colleagues. Governor Blanco was willing to spend her political capital in signing this bill. Just like Governor Johnson of New Mexico, Governor Blanco showed her courage in signing the legislation when it could have become law without her signature.

Our hearty congratulations to Jim Quillin, John Bolter, Glenn Ally, David Post, Robert Younger, Samuel "Web" Sentell, Michael Berard, Lawrence Klusman and Cathy Castille.

I apologize to those others in Louisiana who have contributed to this legislative achievement that I have not cited here. This was a real team effort on the part of many over a period of years. We will celebrate with you in Hawaii.

Prescriptive authority for psychologists is essential so psychologists can integrate psychotherapy with pharmacotherapy. Psychotropic medication has become a major treatment resource and cost to states and the federal government. We a spending more on psychotropic drugs for children under 19 than for diabetes and asthma, the two leading cost of pediatric medications until now. Many children are being medicated unnecessarily. Currently, 81% of the people receiving mental health care are receiving psychotropic medications, 34% are receiving a combination of psychotherapy and medications, leaving 19% receiving psychotherapy only. Thus, 53% are receiving some psychotherapy when most could benefit from psychotherapy. This legislative action in Louisiana will help to pave the way for other states to adopt this type of legislation integrate psychotherapy and pharmacotherapy. We also applaud the seven other states for their efforts to have prescriptive authority enacted by their legislatures this year. We are expecting up to twelve states to introduce such legislation next year.

FEATURE

Living Up to Your Ethical Ideals: Three Reminders for Psychotherapists*

Samuel Knapp
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Dallas, TX

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Denver, CO

**The views expressed here are those of the authors and do not necessarily represent those of any organizations with which they are affiliated.*

ABSTRACT
Virtually all psychotherapists want to act ethically, yet all have the potential to make ethical errors. The authors present three reminders to help mental health professionals better fulfill their ethical ideals. Psychotherapists can better fulfill their ethical ideals if they remember that (a): ethical behavior involves more than just rules and regulations; (b) all psychotherapists have the potential to make ethical errors; and (c) they can take concrete steps to increase the likelihood that they will live up to their ethical ideals.

Living Up to Your Ethical Ideals: Three Reminders for Psychotherapists
Ethics are at the core of professional competence. Psychotherapists who understand professional ethics are better able to fulfill their obligations to their clients/patients and often excel in their professional lives. However, excellent practice involves more than just avoiding ethical errors, although that is an important goal itself. Practicing ethically also means trying to consider the ethical implications of all professional behaviors.

We present three reminders that can help psychotherapists to fulfill their ethical ideals. First, psychotherapists can better live up to their ethical potential if they remember that ethics involves more than just the standards in disciplinary codes. Second, awareness of the potential for ethical errors can help protect them from those errors. Finally, psychotherapists can take practical steps to increase the extent to which they live up to their ethical ideals.

Reminder One: Ethics is More Than a Code
Ethics is much more than the duties found in the state laws or the disciplinary codes of professional associations or regulatory bodies. These standards represent only the ethical "floor" or the minimal shared duties that psychotherapists assume. The enforceable standards in the ethics codes are designed to address violations of standards, but they cannot address more subtle acts of harm and they do not encourage ethical excellence (Handelsman, Knapp, & Gottlieb, 2002).

We contend that ethical behavior involves more than just refraining from harmful acts—it also involves a proactive morality rooted in the power to act beneficially (Bandura, 2002). An exclusive focus on disciplinary codes fails to sensitize mental health professionals to the needs of their

clients/patients, research subjects, or students in ways that are not explicitly specified in those codes. "Shared duties form the backbone of professional ethics, but a backbone is not a complete anatomy" (Martin, 2000, p. 4). Psychotherapists who rely exclusively on mandatory ethical standards will not be able to achieve the highest moral conduct for themselves. Of course ethics codes or state licensing board regulations have a place in professional practice. These documents contain the consensus of the profession on how to respond to situations commonly faced by psychotherapists. For the most part these codes and regulations are consistent with sound ethical theory, but they are sufficient neither for excellent ethical practice, nor for a solid grounding in ethics.

We believe that a more effective and ethical practice focuses not only on how psychotherapists avoid ethical infractions, but also on how they can improve the sensitivity with which they approach their teaching, research, or treatment of clients/patients. Such a broad view of ethics requires psychotherapists to consider the aspirational goals and the underlying philosophical systems or beliefs that guide their behavior.

Psychotherapists need to understand the philosophical bases of ethics to engage in productive decision-making in those situations where the ethics code does not provide clear direction or when ethical or legal standards conflict. For example, the Ethics Code of the American Psychological Association (APA, 1992) does not, nor could it reasonably be expected to, address all of the ethical complexities that confront psychologists within specialty practices such as working with families (Gottlieb, 1996), forensic psychology (Committee on Ethical Guidelines for Forensic Psychologists, 1991), or consulting (Newman, Gray, & Fuqua, 1996). An emphasis on the helpful aspects of ethics that go beyond rules of disciplinary codes has been called positive ethics (Handelsman et al., 2002). Consider the following example:

> A psychologist began an earnest study of Buddhism and tried to incorporate its teachings into her daily life. She deliberately cultivated a "reverence for life" in all aspects of her conduct, and became more sensitive in how she treated her clients/patients. In this connection, she sought out consultation on various aspects of her clinical style, such as her use of self-disclosure, to determine if she were acting in the best interests of her clients/patients.

In this case the psychologist took the initiative to avoid compartmentalizing her personal morals from her professional life. She sought a moral foundation and tried to apply it consistently in her work and personal life. Nor did she assume that acting on her personal moral values guaranteed ethical professional practice. Most North American psychotherapists have a moral philosophy based upon the Judeo-Christian tradition and can describe, with varying degrees of sophistication, the moral principles derived from it that guide their behavior. But, we are not saying that religious beliefs are the only personal values that can be integrated with professional behavior; rather this is just one example of how such integration may be accomplished.

Reminder Two: All Psychotherapists Can Make Ethical Mistakes

"Good" practitioners can make ethical mistakes. Even psychotherapists who hold doctoral degrees, are licensed, have good intentions, and consistently have good client/patient outcomes can, under some circumstances, commit ethical errors. Although some psychotherapists who are disciplined for ethical misconduct may have personality disorders and/or serious character flaws, it is inaccurate to attribute all, or even most, ethical violations to such factors. Situational problems or temporary lapses can lead competent, moral, and mentally healthy people to commit ethical infractions as well.

We should refuse to adopt an "us v. them" (or "righteous v. sinner") mentality. Behavior is a function of both environmental and contextual variables. In reality, any psychotherapist, given the right circum-

stances, might experience an ethical lapse. Factors that appear to be associated with ethical infractions include inadequate training, professional isolation, and a lapse in judgment during periods of personal distress. Even dedicated and compassionate psychotherapists can never guarantee that their professional work will not suffer, perhaps seriously, from the individual or collective impact of physical illness, family problems, financial pressures, institutional stressors, or fatigue.

The belief that only bad people behave unethically may be strengthened by the "availability heuristic," that if an event easily comes to mind, we assume that it is common (Kahneman & Tversky, 1973). For example, people sometimes overestimate the dangers of airplane travel because the incidents of airplane crashes are more highly publicized than the more frequent (but equally tragic) instances of automobile accidents. Accordingly, a belief that ethical infractions are committed only by seriously disordered or psychopathic psychotherapists may arise because they may have engaged in the more egregious or highly publicized misconduct.

Attribution theory teaches us that people tend to interpret the negative behavior of others as due to dispositional factors, and their own negative behavior as a result of situational factors. Conversely, people tend to interpret the positive behavior of others as a result of situational factors and their own positive behaviors as due to dispositional factors (Heider, 1958). For example, psychotherapists may tend to attribute their positive outcomes to dispositional factors (e.g., their skills, positive work habits, years of experience, etc.) and minimize the situational factors that may contribute to their success (e.g., they largely have a YAVIS [young, attractive, verbal, intelligent, successful] case load where many of their clients/patients are inclined to respond well to therapy).

Accordingly, when accusations of ethical misconduct arise, psychotherapists tend to attribute the problems of others to dispositional factors (e.g., their lack of skills or character) and to minimize situational factors (e.g., they ran into a litigious client/patient, had a temporary lapse of judgment due to unusual stressors, etc.).

These attributional errors can cause psychotherapists to develop blind spots regarding the treatment of their clients/patients and other professional behavior. They may lead psychotherapists to ignore or misinterpret the impact that external pressures could have on their behavior. Indeed, more experienced therapists may be more susceptible to attributional and other errors (Handelsman, 1997, 2001). However, awareness of the potential to make ethical errors should increase the likelihood that we will take adequate precautions to ensure that we live up to our ethical ideals.

Reminder Three: Psychotherapists Can Take Steps to Improve Their Ethical Conduct

Probably all psychotherapists want to do what they know to be right. In reality, they do not always do so. For example, Barnard and Jara (1986) found that, in response to vignettes describing ethically problematic situations, graduate students in psychology often did not intend to act in a way that was consistent with the answers they identified as correct. Psychotherapists often feel pulls from various sources such as agencies, clients/patients, managed care companies or others to do things that they sense or believe are wrong (or fail to do things they believe to be right). How might psychotherapists succumb to these pressures, and how might they become better at resisting them?

We do not know what causes the inconsistency between moral judgment and moral behavior. Bersoff (1999) wrote that the breakdown could occur because of an inability to analyze ethical issues clearly. Although this may be true in some cases, we must also consider the possibility of a lack of moral depth and commitment, which may interact with situational factors to influence the actions of psychotherapists. We consider these possible explana-

tions in detail and recommend positive preventive steps. These explanations may, in many situations, be interactive and not exclusionary.

Analyzing Situations Clearly

Bersoff (1999) noted that unethical acts can occur when self-interest causes people to analyze a situation selectively. That is, they may look for confirming evidence of the moral judgment that favors their interest, and fail to examine critically all aspects of the situation (see also, Pope, 1991). These misconstruals may occur without awareness or intention. Psychotherapists can reduce these dangers if they are taught to "correct for" self-interest and other relevant factors when they apply ethical principles to real-life situations. Such training can expose fallacious justifications as well as other forms of flawed moral reasoning. Bersoff noted that these kinds of trial applications may inoculate individuals against misconstrual errors. For example:

> A psychiatrist was treating a man with dysthymia and the sessions allotted by the managed care company were approaching an end. The patient could not pay for therapy out-of-pocket and was too proud to accept a reduced fee. However, the psychiatrist knew that she could receive authorizations for additional sessions if she changed the diagnosis to major depression with suicidal ideation. The psychiatrist considered upcoding and giving more emphasis to the suicidal ideation that the man had reported in the past.

In this example, the psychiatrist knew that falsification of diagnoses could not be defended. Nevertheless, there was danger that her self-interest, mixed with concern about the welfare of her patient, could have influenced her to act contrary to her ethical mandates. Moreover, the extent to which situational factors influence her thinking may be subtle and outside her full awareness. She may not even consider that others could see her actions as anything but a manifestation of her good intentions. If, however, she routinely "corrects for" self-interest, she can avoid the pressure to act unethically. She can do this in (at least) four ways. First, she can imagine defending her choice in front of an ethics committee—what sounds very reasonable in one's head often becomes much easier to see as faulty when said out loud in front of colleagues. Second, she can consider the situation from the viewpoints of others, such as the insurance company, members of an ethics committee, or her mother. Third, she can "control for" her self-interest by considering what is right if she wasn't the therapist. Finally, she can "control for" her compassion by considering her options under the assumption that all alternatives would lead to equally good treatment outcomes (Handelsman, 1998).

Strengthening Convictions

Another factor influencing our actions may be the degree of conviction concerning the ethical standard in question. Is the rule simply a "hand-me-down" remembered from a graduate school class or a workshop on the discipline's ethics code? That is, do psychotherapists recall the standard but fail to appreciate the moral principles supporting it? If psychotherapists do not appreciate the relationships between the standards of an ethics code and their personal moral beliefs, they may feel alienated from the ethics code and be less prone to adhere to it (Handelsman et al., 2002). If so, psychotherapists may be less likely to follow the standard if it is challenged. On the other hand, if the ethical standard is connected to a deeply held core belief, then psychotherapists will have far less inner turmoil about "doing the right thing" and will be more able and willing to withstand external pressures to act differently.
Consider the following example:

> A psychologist acquired clear and direct knowledge that a colleague was suffering from severe alcoholism, was not receiving treatment, and was delivering professional services below acceptable standards. She knew that, according to the APA Code of Conduct, the right thing to do was for her to confront her colleague and encourage him to seek treatment.

Will the psychologist follow through with what she "knows" to be the right thing to do? Data suggest that fewer than one-half of the psychologists placed in this position would intervene (VandenBos & Duthie, 1986). However, the psychologist may be more willing to act on her convictions if she paid more attention to her professional obligations to (a) the colleague (rather than, for example, to the personal inconvenience or intervention), (b) the clients/patients of the colleague, and (c) the profession. Additionally, if the psychologist knew about the pernicious cycle of addiction, the great harm that can come to clients/patients from seeing an impaired psychologist, or appropriate procedures for confronting an impaired colleague, she might have greater moral strength to act upon her convictions.

Appreciate the Influence of Situational Factors
Human behavior, including ethical conduct, can be viewed as a result of an interaction between personal and situational variables (Bandura, 2002). Psychotherapists can increase the likelihood that they will act in accordance with their values and ethical standards if they identify those factors that might influence them to act more or less ethically. For example, psychotherapists can embed themselves in a professional social life that can create a safety net wherein they receive timely and useful advice concerning their actions or planned actions. Professional colleagues can provide both useful information (e.g., where to find a good continuing education program on a particular topic; who is a good psychiatrist to refer clients/patients to, etc.) and emotional support during difficult times. Colleagues can provide positive feedback when it is warranted and compassionately confront colleagues with their shortcomings when necessary.

On the other hand, isolation makes it easier for psychotherapists to take ethical chances without scrutiny (Handelsman, 2001). Consider the following example of a "good" social worker who almost committed an ethical error.

> A social worker who had been in independent practice for more than 15 years had achieved substantial financial and clinical success. However, his marital break up and its subsequent economic pressures caused him to spend more time at work and to isolate himself both socially and professionally. It was in this context that he found himself attracted to a female patient and was tempted to tell her so.

In this case the social worker immediately caught himself, recalled the moral foundations of his ethics code, and redirected his attention to the client's needs and sought consultation. The sum of this social worker's career had been good and, in certain respects, exemplary. However, his unmet personal needs almost caused a serious lapse in his otherwise good clinical judgment. This vulnerability might have been prevented had the social worker anticipated the impact his divorce could have on his professional conduct, and moved toward his colleagues rather than away from them.

Summary
Our ultimate goal is to improve both our ethical conduct as measured by a reduction of ethical violations and an increase exemplary ethical conduct. We presented three suggestions that can help psychotherapists to fulfill their ethical goals. First, we can focus more attention on ethical development, not just by learning disciplinary codes and risk management principles, but by striving to clarify and live out a belief system that goes beyond what is found in the disciplinary codes. This personal moral system may sensitize us to ethical issues that are not addressed in the disciplinary codes, assist us in our ethical decision making, and help us to identify our supererogatory obligations.

Second, we must acknowledge our vulnerability to ethical lapses. All of us can fail to live up to our ethical obligations under the right circumstances. The recognition of this fact leads us logically to the third reminder in this article, that there are specific steps

DIVISION 29 PROGRAM SUMMARY SHEET

Symposium: ***Finding Your Voice—A Process for Women Patients and Therapist***
7/28 Wed: 8:00 AM - 9:50 AM
Hawaii Convention Center, Meeting Room 310
Chair: Dorothy W. Cantor, PsyD, Independent Practice, Westfield, NJ
Participant/1stAuthor
Dorothy W. Cantor, PsyD
Title: Overview of the Process of Finding Your Voice
Alice Rubenstein, EdD, Monroe Psychotherapy Center, Pittsford, NY
Title: Self-Talk: Helping Women Find Their Own Voice
Carol D. Goodheart, EdD, Independent Practice, Princeton, NJ
Title: Psychologist's Voice in the Era of Evidence-Based Practice

Poster Session: [Poster Session]
7/28 Wed: 10:00 AM - 10:50 AM
Hawaii Convention Center, Kamehameha Exhibit Hall
Participant/1stAuthor
Lorna V. Myers, PhD, Bilingual Neuropsychology Center, New York, NY
Title: Treatment of Psychogenic Nonepileptic Seizures With Psychoeducational Group Therapy
Jane L. Weisbin, PsyD, The Wright Institute
Title: Psychotherapy Effectiveness in a Clinic Following an Integrationist Theory
Michael Basseches, PhD, Suffolk University
Title: Tracking Clients' Development in Psychotherapy: A Common Factors Coding System
Lori S. Katz, PhD, VA Medical Center, Long Beach, CA
Title: Holographic Reprocessing: An Innovative Psychotherapy to Treat Couples
J. Ryan Fuller, MA, St. John's University
Title: Effects of Cognitions and Breathing on Physiological Anger Experience
Thomas F. Locke, PhD, University of California—Los Angeles
Title: Psychosocial Predictors of Suicidal Ideation in Teenage Latinas
Mirela A. Aldea, MA, University of Florida
Title: Providing Test Feedback to Perfectionists
Stacy S. Shaup, PhD, Nova Southeastern University
Title: Treatment Goals Checklist: Usefulness and Impact on Psychotherapy Goal-Setting
Laura C. Reigada, MA, Hofstra University
Title: Clinicians' Attitudes Toward Evidence-Based Treatments and Implications for Dissemination
Adam O. Horvath, EdD, Simon Fraser University, Burnaby, BC, Canada
Title: Clients' Lived Experience of the Therapeutic Relationship: Unique Versus Consensually Observed Perspectives
David L. Duke, MA, Moscati Health Center, Hastings, NE
Title: Does Consultation Change What Psychotherapists Would Do in Ethical Dilemmas?
Sara J. Landes, MA, University of Wisconsin—Milwaukee
Title: Women's Therapist Selection Based on Therapist Sex and Presenting Problem
Adena B. Meyers, PhD, Illinois State University
Title: Increasing Batterers' Readiness to Change via Child-Focused Education Sessions
Michael J. Lambert, PhD, Brigham Young University
Title: Supershrinks and Pseudoshrinks: Therapist Effects in a Managed-Care Setting

Julia C. Ford, MA, Doctors Hospital—Bridges, Springfield, IL
Title: Determinants of Substance-Abuse Counselors' Interventions
Nicole M. Taylor, PhD, University of Indianapolis
Title: Development and Implementation of the Training Module: Bridging the Gap
Pierre Baillargeon, PhD, Université du Québec à Trois-Rivières
Title: Types of the Therapeutic Alliance Between Different Professionals and Suicidal Teenagers
R. Fox Vernon, PhD, Rutgers the State University of New Jersey New B
Title: Philosophical Analysis of Insight in Psychotherapy
L. Shane Blasko, MS, Georgia State University
Title: Stress Management After Trauma: Helping Hypervigilant Clients Relax
David H. Rosen, PhD, MD, Texas A&M University
Title: Innovative Approach to Treating Suicidal Depression
Julie Chapman, MA, University of Saint Thomas
Title: Empirically Supported Treatments and Graduate Training
Christine Truhe, PsyD, Truhe Consulting, Summit, NJ
Title: Career Methods in Therapy Through Collaboration, Referral, or Expanding Skills
Jennifer C. Salib, PsyD, Kaiser Permanente South Sacramento
Title: Factors Associated With Technology Adoption in Private Practice Settings

Symposium: *Mindfulness Meditation—Progressive Behavior Therapy From a Time-Honored Tradition*
7/28 Wed: 11:00 AM - 11:50 AM
Hawaii Convention Center, Meeting Room 311
Cochairs: Katie A. Witkiewitz, MA, University of Washington—Seattle and Alan G. Marlatt, PhD, University of Washington—Seattle
Participant/1stAuthor
Alan G. Marlatt, PhD
Title: Mindfulness-Based Relapse Prevention: A New Treatment Balanced With Eastern Philosophy
Ruth A. Baer, PhD, University of Kentucky
Title: Assessment of Mindfulness: An Essential Component of Mindfulness-Based Treatment Research
Marsha M. Linehan, PhD, University of Washington—Seattle
Title: Mindfulness Meditation: The What and How of Dialectical Behavior Therapy

Symposium: *Applied Research on Forgiveness—-Implications for Therapy*
7/28 Wed: 12:00 PM - 12:50 PM
Hawaii Convention Center, Meeting Room 317B
Chair: Nathaniel G. Wade, PhD, Iowa State University
Participant/1stAuthor
Nathaniel G. Wade, PhD, Iowa State University
Title: Forgiveness in Therapy: Prevalence and Outcome Data
D.E. Glasner, MS, Clay County Family Court, Liberty, MO
Title: Mental Health and the Forgiveness of Self and Others
Kristina C. Gordon, PhD, University of Tennessee
Title: How Can I Forgive You? Let Us Count the Ways
Discussant: Steven J. Sandage, PhD, Bethel Seminary, St. Paul, MN

Conversation Hour: *Good, Bad, and Ugly—The Most Unusual Cases of the Most Prominent Therapists*
7/29 Thu: 8:00 AM - 8:50 AM
Hawaii Convention Center, Meeting Room 313A
Chair: Jon D. Carlson, EdD, Governors State University

Participant/1stAuthor
Jeffrey A. Kottler, PhD, California State University—Fullerton
Jon D. Carlson, EdD

Workshop: *Teaching Psychotherapy—Integrating Research,Theory, and Clinical Practice*
7/29 Thu: 9:00 AM - 9:50 AM
Hawaii Convention Center, Meeting Room 318A
Participant/1stAuthor
Richard R. Kopp, PhD, Alliant International University—Los Angeles

Workshop: *Counter-Response Training—Adult's Reaction to Youth's Behavior*
7/29 Thu: 10:00 AM - 11:50 AM
Hawaii Convention Center, Meeting Room 311
Participant/1stAuthor
Linda R. Paull, PsyD, Allendale Association, Lake Villa, IL
Patricia A. Taglione, PsyD, Allendale Association, Lake Villa, IL

Workshop: *Management of Panic in PTSD*
7/30 Fri: 8:00 AM - 9:50 AM
Hawaii Convention Center, Meeting Room 328
Cochairs: Pamela J. Swales, PhD, National Center for PTSD, Menlo Park, CA and Julia M. Whealin, PhD, National Center for PTSD, Honolulu, HI

Invited Address: *Dual Perspectives on Dual Relationships—Critical Incidents in Nonsexual Boundaries*
7/30 Fri: 12:00 PM - 1:50 PM
Hawaii Convention Center, Meeting Room 311
Chair: John C. Norcross, PhD, University of Scranton
Participant/1stAuthor
Eric A. Harris, EdD, JD, Lincoln, MA
Gerald P. Koocher, PhD, Simmons College
Martin H. Williams, PhD, Independent Practice, Sunnyvale, CA
Ofer Zur, PhD, Independent Practice, Sonoma, CA

Social Hour
7/30 Fri: 6:00 PM - 7:50 PM
Hilton Hawaiian Village Beach Resort and Spa, Tapa Ballroom III

Workshop: *Cognitive—Behavioral Approaches to Treating Suicidal Behavior*
7/31 Sat: 8:00 AM - 9:50 AM
Hawaii Convention Center, Meeting Room 313A
Chair: Michele S. Berk, PhD, University of California—Los Angeles
Participant/1stAuthor
Michele S. Berk, PhD
Title: Cognitive-Therapy Intervention for Treating Suicide Attempters
Jason E. Chapman, PhD, University of Pennsylvania
Title: Treatment Issues With Underserved Urban Suicide Attempters
M. David Rudd, PhD, Baylor University
Title: Cognitive Therapy for Suicidality
Alec L. Miller, PsyD, Albert Einstein College of Medicine of Yeshiva
Title: Dialectical Behavior Therapy for Suicidal Multiproblem Adolescents

Presidential Address: *Psychotherapy Practice and Research—Collaborative Directions and Common Grounds*
7/31 Sat: 12:00 PM - 1:50 PM
Hawaii Convention Center, Meeting Room 310
Chair: Linda F. Campbell, PhD, University of Georgia
Participant/1stAuthor
Alice Rubenstein, EdD, Monroe Psychotherapy Center, Pittsford, NY
Title: Psychotherapy Practice: Status and Direction
William B. Stiles, PhD, Miami University

Title: Psychotherapy Research: Status and Direction
Carol D. Goodheart, EdD, Independent Practice, Princeton, NJ
Title: Focus on Multiple Streams of Evidence in Practice
Louis Castonguay, PhD, Penn State University Park
Title: Psychotherapy Research: Collaboration and Alliances With Practice
Jeffrey A. Hayes, PhD, Penn State University Park
Title: What Psychotherapy Researchers Need From Practitioners
Leon VandeCreek, PhD, Wright State University
Title: What Psychotherapy Practitioners Need From Researchers
Discussant: John C. Norcross, PhD, University of Scranton

Symposium: *Culture-Centered Psychotherapy Interventions—Adapting Strategies From Five Theoretical Approaches*
8/01 Sun: 8:00 AM - 9:50 AM
Hawaii Convention Center, Meeting Room 320
Chair: Jeff E. Brooks-Harris, PhD, University of Hawaii at Manoa
Participant/1stAuthor
Dorje M. Jennette, MA, Indiana University of Pennsylvania
Title: Culture-Centered Adaptations of Cognitive Psychotherapy Interventions
Jill M. Oliveira-Berry, PhD, Na Puuwai Native Hawaiian Health Care S
Title: Culture-Centered Adaptations of Behavioral Psychotherapy Interventions
Kimberly S. Wagner, MA, University of Akron
Title: Culture-Centered Adaptations of Experiential Psychotherapy Interventions
George L. Hanawahine, MEd, University of Oregon
Title: Culture-Centered Adaptations of Interpersonal Psychotherapy Interventions
Cristina Castagnini, MA, University of Southern California
Title: Culture-Centered Adaptations of Systemic Psychotherapy Interventions
Discussant: Allen E. Ivey, EdD, University of Massachusetts

Symposium: *Back to the Future? Consensus Conference and Combined-Integrated (C-I) Model of Doctoral Training in Professional Psychology*
8/01 Sun: 10:00 AM - 11:50 AM
Hawaii Convention Center, Meeting Room 308B
Chair: Craig N. Shealy, PhD, James Madison University
Participant/1stAuthor
Larry E. Beutler, PhD, Pacific Graduate School of Psychology
Title: History of Combined-Integrated Doctoral Training in Professional Psychology
Susan L. Crowley, PhD, Utah State University
Title: Case for Combined-Integrated Doctoral Training in Professional Psychology
Ronald E. Reeve, PhD, University of Virginia
Title: Overlap Among Clinical, Counseling, and School Psychology: Implications for the Profession and Combined-Integrated Training
Jessica Blom-Hoffman, PhD, Northeastern University
Title: Voices of the Five Doctoral Training Councils in Psychology: Seeking Common Ground on Combined-Integrated Doctoral Training in Psychology
Martin A. Volker, PhD, State University of New York at Buffalo
Title: What Do Students Want? Perspectives From the Front Line of

Doctoral Training in Professional and C-I Psychology
Lee G. Sternberger, PhD, James Madison University
Title: Development of a Global Curriculum for Professional Psychology: Implications of the Combined-Integrated Model of Doctoral Training
Gregg R. Henriques, PhD, James Madison University
Title: Unified Professional Psychology

Symposium: *Therapist Self-Differentiation, Working Alliance, Countertransference Reactions, and Psychotherapy Outcome*
8/01 Sun: 12:00 PM - 12:50 PM
Hawaii Convention Center, Meeting Room 301B
Chair: Elizabeth A. Skowron, PhD, Penn State University Park
Participant/1stAuthor
Elizabeth A. Skowron, PhD, Penn State University Park
Title: Therapist Differentiation of Self, Working Alliance, and Client Outcomes
Jeffrey A. Hayes, PhD, Penn State University Park
Title: Therapist Self-Differentiation, Internal Countertransference Reactions, and Outcome
Discussant: Myrna L. Friedlander, PhD, State University of New York at Albany

Business Meeting
8/01 Sun: 12:00 PM - 4:50 PM
Hilton Hawaiian Village Beach Resort and Spa, Sea Pearl Suite IV

we can take to improve our ethical conduct. We can strive to achieve greater congruence between our ethical beliefs and conduct by becoming more aware of the processes of selective attention and how emotional factors can influence our decision-making processes. We can study ethics in more detail and identify stronger connections between our ethical theories and professional standards. Finally, we can embed ourselves in a protective social network that would support our ideals to act in an ethical manner and help us correct risky behavior when others saw it.

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DIVISION 29 GOVERNANCE

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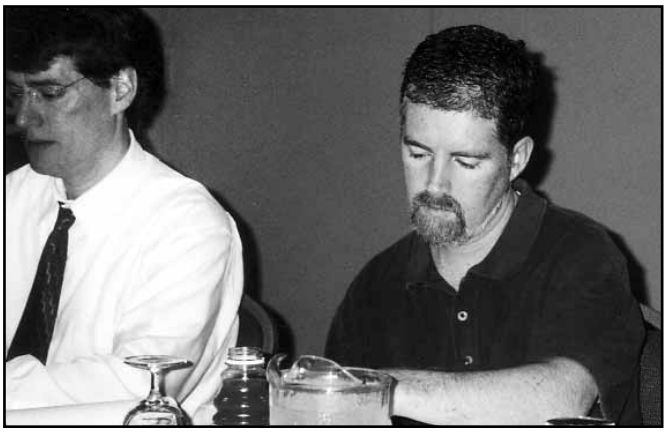

Cultivating Therapist Facilitative Interpersonal Skills

by Timothy Anderson, Ph.D.

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A depressed young woman is in her third session with an advanced doctoral student. He is upbeat and committed. He quickly, almost reflexively, seems to respond with a silver-lining type of response to each of the stormy clouds that she shows him. On this particular day she tells him that she saw something on television about "complexity disorder." She is afraid she might have it. He quickly assures her that he had heard about the disorder and that such disorders are only pop psychology labels that are designed to "make lots of remotely neurotic people do more neurotic things they have been doing their entire lives without realizing it was a problem." He tells her, "Remember, I am not a psychologist." In fact, this much was true because this "therapist" had no formal therapeutic training and his doctoral training was in history and not psychology.

The client made marked improvements over the course of seven sessions, which was evident in her responses to him. For example, after he told her, essentially, that much of pop-psychology was designed to make her feel more neurotic, she said, "But it helps just to talk about it" and that she left sessions "feeling like this huge weight has been lifted off." Psychotherapy researchers recognize these sorts of statements by clients as signs that change processes are active. More formally, her changes were evident on numerous standard assessment measures and an independent assessment interview. So what allowed this pseudo-therapist, and many like him (see below), to be effective?

My hypothesis is that a major component of success in such cases is shared or common among all or most forms of psychotherapy. My approach to researching this hypothesis has been to focus on common interpersonal variables that may underlie the skills of the therapist. The pseudo-therapist in the example displayed many of the positive relational qualities that previous psychotherapy research has identified as important. For example, he was optimistic, hopeful, interpersonally warm, and very persuasive (as seen in the example).

The fact that clients can improve when meeting with paraprofessionals or supportive listeners with no mental health training, has been one of the great enigmas in psychotherapy research. For over a generation, psychotherapy researchers have been reporting that training status does not tend to predict outcome. The landmark study that opened this issue (or "sore"!) was reported by Hans Strupp and Susan Hadley (1979). Similar to the "therapist" described in our study, Strupp and Hadley found that college professors without therapy training achieved outcomes equivalent to those of fully trained psychologists and psychiatrists. Strupp focused on relationship variables (e.g., warmth and friendliness) to explain the results.

Relationship variables, such as the therapeutic alliance, have received increasing attention within psychotherapy research. The therapeutic alliance has been described as accounting for the largest amount of process-outcome variance in psychotherapy outcomes (Martin, Garske, & Davis, 2000) in correlational studies.

Relationship variables are often considered "common," or distributed across all types of therapy, making them difficult to control. That is, it is easier to train therapists to adhere to specific techniques (e.g., increase the number of transference interpretations) than to construct a specific sort of relationship.

An illustration of this vexing problem came from the Vanderbilt II study (Strupp, 1993), in which therapists were meant to follow a manual for how to address interpersonal problems that arose in the treatment. Bein et al. (2000) found that therapists could be trained to use specific interventions that were designed to improve the therapeutic relationship, but that they rarely demonstrated the capacity to intervene in a skillful and competent manner. Henry, Schacht, Strupp, Butler, & Binder (1993) reported that sessions conducted by those therapists who adhered to the treatment manual the most actually were rated lower in therapeutic warmth and other common interpersonal therapy processes.

Facilitative Interpersonal Skills (FIS)

I and my students and colleagues at Ohio University are trying a different approach. Our research focuses on crucial therapist relationship skills. The purpose of the research is not to show that anyone can do therapy but to identify common interpersonal skills so that the effectiveness of psychotherapy training can be improved. In other words, we are hoping to learn from therapists who bring strong relationship skills to therapy and then attempt to apply what is learned so that other therapists and clients might benefit from using these skills too.

The importance of therapist relationship skills has been emphasized by a recently completed APA Division 29 and Division 12 joint task force report on Empirically Supported Relationships (ESRs; see Norcross, 2002). This report points to a relationship-based conception of psychotherapeutic interventions, a rather direct contrast to the technique-based direction of Empirically Supported Treatments (e.g., Nathan & Gorman, 2002; Chambless & Ollendick, 2001).

The ESR task force focused largely on strong correlational results. The variables used in the ESR studies make them difficult to study as fixed, independent variables. Relationship variables like the alliance are often thought of as "non-specific" factors, a label that suggests an elusive quality, portending poorly for research, particularly experimental research, in which variables must be specified and manipulated. However, we suggest that these non-specific relationship variables can be specified and the therapeutic relationship can be studied experimentally.

In a study conducted at Ohio University (Anderson, Crowley, & Wang, 2002), we identified advanced graduate students in clinical psychology and in other, non-psychological fields that didn't involve mental health treatment (such as history) as having high versus low Facilitative Interpersonal Skills (FIS). FIS were defined as including a broad mix of skills such as empathy, sociability, persuasiveness, and collaboration. We measured these skills before collecting any process or outcome data. These graduate students, of whom half had received two or more years of clinical training and half had not had any clinical training (but had similar levels of education), served as therapists in the study. We screened approximately 2,500 undergraduate students with a symptom checklist. Those who scored above 2 standard deviation units above the average were asked to return a week later and were given a diagnostic interview by a clinician. Those deemed to have clinically significant problems were asked if they would be interested in talking to someone about their problems. Those who were interested were then assigned randomly to one of the therapists

Results indicated that therapists with high FIS had much stronger alliances with their clients than did therapists with low FIS, regardless of whether the therapists had received clinical training. Further, thera-

pists with high FIS tended to have better outcomes than therapists with low FIS, though this was not true for all outcome measures. Interestingly, outcome differences between the high and low FIS therapists appeared to be greatest on those outcome measures that specifically emphasized the interpersonal component of symptoms (e.g., "It's hard for me to trust others") compared to those measures that did not include interpersonal symptoms (e.g., "I'm an anxious person").

Perhaps the most interesting finding was that on the interpersonal symptom measure used in the study (the Inventory of Interpersonal Problems; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), therapist FIS statistically interacted with client social skills. The most dramatic changes in interpersonal symptoms were seen for therapists with high FIS when they saw clients who also had high social skills. Perhaps both therapist and client must have moderate to high levels of social and interpersonal skills before certain interpersonal process measures can register any therapeutic effect of brief treatment. Future study could examine the joint role of client and therapist abilities to process interpersonal messages on the formation of therapeutic alliances and the activation and triggering of client change processes.

These findings are being explored further. We are qualitatively investigating individual therapists with distinctively high and low FIS. One noteworthy post-hoc observation is that some of the high-FIS therapists appeared to be highly relaxed, freewheeling, and "creative" in their ability to generate rationales for their suggestions to their clients. One plausible hypothesis for this finding is that the theory and rationale for interventions may be individualized and integral to the therapist's personality. As discussed in a case study (Anderson & Strupp, submitted), the therapist who had the best outcomes in the Vanderbilt II study was so unconventional and freewheeling in how he implemented the techniques from the manual that we had difficulty identifying his theoretical orientation. Or perhaps Jerome Frank (Frank & Frank, 1991) was right when 40 years ago he intimated that therapists must use deeply personal skills, drawing upon their own personal and cherished beliefs, to persuade clients to accept a "believable myth."

These interpretations require further research. Finding that therapist and client FIS may determine treatment outcome could have significant practical implications, not least the potential importance of training future therapists in interpersonal skills. To the extent that such skills are embedded within personality, clinical instruction may require more than basic coursework. I teach a course on clinical skills to a small group of mostly eager graduate students in their first term of study as future clinical psychologists. Every fall the students always ask a basic question: "Can such key clinical skills as empathy and persuasiveness be taught within graduate training or are they possessed before, perhaps long before, students enter clinical training?"

I increasingly have difficulty giving a straightforward answer, but I'd like to believe that the answer is a qualified "yes." Teaching these types of interpersonal skills might require some new approaches to training, including close understanding of relational moments and intensive practice throughout the whole of graduate training.

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WASHINGTON SCENE

MAKING A DIFFERENCE, STEP BY STEP – A MOVING GLACIER

Pat DeLeon, former APA President – Division 29 – May, 2004

Ensuring Quality Care: On May 6, 2004 Democratic Governor Kathleen Blanco signed House Bill 1426 into public law, thereby providing appropriately trained Louisiana psychologists with prescriptive authority (RxP-), cumulating a quest begun in 1995. The Louisiana House of Representatives passed their bill by a vote of 62-31, after defeating four amendments on the floor, with the Speaker of the House being psychology's chief proponent. The Senate subsequently passed their version by a 21-16 vote, with the President of the Senate (a physician) serving as the Louisiana Psychological Association (LPA) champion. The House concurred almost immediately, voting 68-30. Our sincerest congratulations to Jim Quillin, John Bolter, LPA President Cathy Castille, and their very hard working colleagues. Louisiana has now joined New Mexico in enacting a comprehensive psychology RxP- law, where Republican Governor Gary Johnson, after being briefed by psychology and psychiatry, called-up the RxP- bill during a special legislative session. The prime New Mexico Senate sponsor was the Majority Leader. The New Mexico bill (HB 170) was signed into public law on March, 2002.

During both legislative battles, psychology's Department of Defense (DoD) psychopharmacology graduates were extremely impressive in addressing psychiatry's emotional public health hazard allegations. Morgan Sammons met personally with Governor Johnson and several state legislators. Anita Brown (and APA's Norm Anderson) responded to LPA's request for help. APA Council Representative Glenn Ally: "What can I say about our newest Cajun, Dr. Anita Brown. Literally, at a moment's notice, she rearranged her life to be with us and testify before both committees. Her presence was one of professional dignity, expertise, and outstanding communication. She understands the ins and outs of the issue and was able to speak to the issue not only in theory but also from the standpoint of experience. She was simply amazing." A local newspaper: "(A)s things stand now, the bill would apply only to about 50 psychologists who have taken post-doctoral training in psychopharmacology." The article also noted that psychology had distributed nearly $75,000 in political contributions during a 15-month period. Grassroots involvement – Mike Berard collected the signatures of 45 physicians in Lafayette who were in favor of the psychology bill. Having participated in an Alliant University Louisiana psychopharmacology commencement, I would only add that their graduates are extraordinarily amazing in their personal commitment to our profession's future and to addressing society's pressing needs. Now, Guam (December, 1998) and Indiana (March, 1993) must implement their RxP- public laws.

Governor Blanco's statement at the time of signing the Louisiana RxP- bill was very thoughtful. "After much debate and consultation with medical professionals on all sides of this issue, I have signed HB 1426. This bill, under very tight controls, will give medical psychologists prescriptive authority. I do not take the responsibility of this decision lightly. While the opponents of the bill were persuasive, the proponents, including the Speaker of the House and the President of the Senate, have assured me that there are ample safeguards built into the legislation. In addition, (they) have promised that if this law does not work as intended, they will move quickly on legislation to address any unintended problems.

"I signed this bill for a number of reasons: In many areas of the state there is a shortage of mental health care providers. I hope

that this bill will encourage psychologists to extend care to underserved populations. I am committed to extending quality, affordable health care to as many of our citizens as possible. Many physicians currently work in consultation with medical psychologists and tell me they are comfortable prescribing in consultation with medical psychologists.... The bill mandates that this prescriptive authority shall be given only to psychologists who have undergone specialized training in clinical psychopharmacology and who have passed a national proficiency examination in psychopharmacology approved by the Louisiana Board of Examiners of Psychologists and who hold from the board a current certificate of responsibility. I expect that the State Board of Examiners of Psychologists will promulgate tough rules to require documentation of the required consultation by medical psychologists prior to prescribing medications. I expect the Board to enforce the provisions of the law...."

Without question, one key ingredient to our colleagues' impressive successes in New Mexico and Louisiana was the existence of an increasing cadre of local, senior practitioners who were personally invested in utilizing their extensive training in psychopharmacology (their absence in Guam and Indiana perhaps being a prime reason for a slow implementation process). The 21st century will be an era of distance learning. From my public policy perspective, one of the most critical issues facing psychology today is the necessity of being responsive to the unprecedented advances that are evolving within the communications and technology fields. The President of the Sloan Foundation reflecting upon lessons they have learned from internet education initiatives in which 47 schools in a consortium have provided more than 4,000 faculty-semesters of teaching experience and more than 100,000 enrollments:

"In 1989 there was no commercial Internet. It was hard to get people interested in learning over networks or to even understand what learning over networks meant or could mean.... In actual practice the traditional classroom has proven to be quite resilient, which is a quality we should respect.... (W)hat are the elements of higher education, as we know them....? First there is the Professor.... A second element is the course material.... A third element is classmates. They help both in and out of class. They provide an element of shared experience, and they are people with whom both the course content and what the professor meant can be discussed between classes. They also provide important emotional support. Today it is possible to provide some form of these elements electronically, without a campus, without a classroom, and without the necessity for the learner to be at some fixed place or time when a lecture is being given.... It is not obvious that this process can really educate people or that people will want to learn this way. It is a real question – Will people really learn this way?...

"(W) can do more than speculate, there is a real experience base to work from.... (W)e are confident that the students are not only taking courses, they are actually learning. Many comparisons of learning outcomes have been made.... Usually the learning outcomes for the different sections are indistinguishable.... We do know enough today to say that a new technology has arrived on the higher education scene and that it works.... For those who teach... teaching will be different. How different depends.... Interaction with the students is also different.... New technologies usually succeed first in a niche where they have special advantages.... After a while in a new technology industry, especially if there are economies of scope or scale in what is being provided, there is a shakeout... and the industry takes on a more stable form. Entry of a new technology into an industry often brings in new providers.... One effect of this new learning technology is likely to be more competition at a national level.... There is also, and this is important, for the first time, the possibility of more comparable quality.... (W)e cannot predict what will actually emerge, but the scene will change.... And even beyond the quality issue, it is usually

unwise to ignore a new technology that is having an impact in your industry. And I think that in this case understanding is more likely to come from activity rather than study.... Today it is becoming possible to make learning something that can be done at a time and place of your own choosing, it can be done at home, but without the isolation of solitary learning.... By making learning outside of the classroom less heroic, we can make it what it ought to be, an ongoing part of ordinary life."

Today, those interested in RxP- can readily obtain the didactic expertise. Within the past month, for example, Steve Tulkin:

"The California School of Professional Psychology, Alliant International University, announces the start of a new California class in the Postdoctoral Master of Science Program in Clinical Psychopharmacology. The program now provides 450+ hours, including an 18 hour Home Study PEP review [taught by Louisiana's John Bolter]. Classes are taught approximately every third weekend. The new group will begin on September 18 with the first weekend taught by Morgan Sammons. California students can take the classes via live videoconference in Fresno, Irvine, Los Angeles, Sacramento, San Diego, and San Francisco. Classes will also be videoconferenced to Portland, Oregon, and Salt Lake City, Utah. All classes provide academic credit, as well as CE. Students living more than 100 miles from a class site can use our Flex Plan, that requires in-person attendance for 50% of the weekends (9 per year)." Steve also announced that they will begin their third Louisiana class in June, 2004.

Gene Shapiro: "The Center for Psychological Studies at Nova Southeastern University in Ft. Lauderdale, Florida is pleased to announce that in September it will start its fifth class leading to a Postdoctoral MS Degree in Clinical Psychopharmacology. This well respected program meets all of the criteria suggested by APA. The program has a unique Fly-In program, of eleven long weekend sessions over two years, which minimally impacts on one's practice."

And, Stan Berman: "The Massachusetts School of Professional Psychology offers an innovative Master of Science in Clinical Psychopharmacology program. We are now accepting applications on a rolling admissions basis for our entering class in September 2004. This class will be our forth class. We have a wonderful faculty representing the fields of psychology, psychiatry, nursing, pharmacology, neuropharmacology, neuroscience, physiology, biology and endocrinology. Our students have come from Massachusetts, Maine, New Hampshire, Connecticut, and Rhode Island. Our 450 hour classroom course is offered over four academic semesters (two years) on Fridays and Saturdays. We meet 15 weekends an academic year from September to June. We have an online learning component, so distance learners are welcome to apply." The RxP- didactic information is definitely available in a learner-friendly environment for those interested.

The APA Practice Directorate will provide state psychological associations with outstanding technical consultation on how to draft a locally-appropriate RxP- bill. [The four enacted RxP- laws (and relevant federal statutes) are substantively quite different from each other.] At the national level, APA will continue to address the various complex issues surrounding RxP-. The Public Interest Directorate, for example, has established a Working Group on Psychoactive Medications for Children and Adolescents. What remains to be acquired is an appreciation by individual psychologists of how to engage the public policy (i.e., political) process. Almost every one of us is represented in our local state legislature by a specific State Representative and Senator. At the federal level, each of us votes for one Congressperson and two U.S. Senators. Presently, in the 108th Congress there are five psychologists and three nurses who have been elected to the U.S. House of Representatives. Consistently, lawyers and those involved in business have constituted the vast majority of the Congress. It is simply naive to assume that those without a professional background in health care appreciate the nuances of health care delivery or, in particular, the

potential contributions of psychology. Accordingly, it is incumbent upon us, as concerned citizens, to personally visit with each of our elected officials on a regular basis—at both the state and federal level. There are numerous opportunities for such face-to-face interactions. At the Arizona Psychological Association annual meeting last year, Warren Littleford arranged an impressive constituent breakfast during which 75 psychologists met with 10 of their state elected officials. At this year's California Psychological Association annual meeting, Gil Newman facilitated a PAC-dinner. The opportunities are simply endless. From these personal meetings will gradually develop areas of mutual interests and concerns. From these informal discussions, psychology's future legislative agendas will evolve. Awareness of natural legislative allies, such as those in professional nursing and clinical pharmacy, as well as the concerns of those representing potential beneficiaries of quality psychological care will surface. Our colleagues in New Mexico and Louisiana succeeded because they possessed vision, persistence, and had developed over time considerable grassroots community support. The legislative/political process requires all of the above. And, for those readers actively involved in training, we would suggest that this would be an excellent learning experience for our next generations of colleagues.

A Commitment to Relevancy: The Institute of Medicine (IOM) recently released the far reaching report In The Nation's Compelling Interest: Ensuring Diversity In The Health Care Workplace (former APA Congressional Science Fellow Brian Smedley, an editor; former APA President Dick Suinn, a reviewer). This follows on earlier IOM studies finding overwhelming evidence that disparities in the quality of care for minorities exist even when insurance status, income, age and severity of condition are comparable. And, the Department of Health and Human Services report that racial and ethnic groups experience disparities in care differently with respect to different clinical conditions. This is also at a time when according to the Robert Wood Johnson Foundation (only) 54 percent of Americans support legislation allowing for the collection of racial and ethnic data in health care, even when told that the information would be used only for identifying gaps in care and ensuring that all Americans receive the same high-quality health care. Only 40 percent of African Americans supported such action. As this report indicates,

"For almost a decade, several state referenda and federal court decisions have limited the ability of many universities to consider race and ethnicity in admissions processes. With that background, in a real sense, this committee's assignment has been to examine the question of whether we, as a nation, are properly utilizing the pool of applicants to training in the health professions that we already have (or will have in the future). The need and desire of the American people for competent, compassionate health professionals who have the necessary communications skills for an increasingly diverse society already exists and will only rapidly increase. Are we getting all of the qualified students and faculty that we should from the available applicant pool? From its inception, the committee also recognized there is a need to answer the very important, but usually unspoken, question of how does the broader society benefit by having increased diversity among health care professionals, aside from the gratification of doing what is morally right? ...Whether our current institutional processes and policy-level factors are, at times unintentionally creating barriers to providing the nation with the culturally competent caregivers it needs? ...Can some of the assumptions we have made for a great many decades be fairly challenged, as to exactly what is 'the best and the brightest?' Our committee believes they can be so challenged and, in fact, improved upon in light of the 21st century needs of America....

"The Supreme Court further found that the need of the American society for such better-educated future leaders, who are also better accustomed to interacting with a diverse world community, as well as a more diverse American society, is indeed a

'compelling governmental interest.' Logic would suggest the different problem-solving skills found amongst those of diverse ethnic and cultural backgrounds should lead to more creative thinking about clinical, research, patient satisfaction and/or cost problems, which are the bottom lines for health care. Every student and every patient will be advantaged from the achievement of a critical mass of diversity in all health profession education, not just the minority students and minority patients.... The challenge to American society is clear. In the view of the Court, 25 years (or one generation) from now, we as a nation should have reached a place where there is no longer a compelling need for an exception to the 14th Constitutional Amendment.... THE CLOCK IS TICKING."

Focusing specifically upon clinical psychology the IOM notes: "The number of ethnic minority students enrolled in graduate programs in psychology has been increasing steadily over the past two decades.... Because psychology is a field in which ethnic minority psychologists make up only 7.5 percent of full-time faculty in graduate departments of psychology and 6 percent of the total, the profile of the profession is that of relatively more ethnic minority psychologists in training than in the profession or academia, a situation parallel to that in medicine. This growth in minority enrollment has resulted from institutional commitments and recruitment programs started by professional graduate schools and strong support from professional associations. The American Psychological Association (APA) has had a significant track record of attention to multicultural awareness and competence, recruiting of ethnic minority students, and career guidance...." Psychology is a steadily maturing profession. The 21st century will bring exciting opportunities. Our next generation will be up to the challenges.

Tranquil Reflections: "Louisiana's efforts to gain prescriptive authority for psychologists had a modest beginning, as do many movements of this sort in all likelihood. Just a couple of people (two) kicking around the idea some ten years ago. To accomplish the goal, however, a not altogether friendly (read hostile) state association had to be completely changed from the inside out, a comprehensive training program had to be developed from scratch, a university had to be found to provide the training, a new degree had to be developed and approved, a new specialty had to be conceived (medical psychology) and a sister organization to our state association had to be developed to represent that new specialty (Louisiana Academy of Medical Psychologists—LAMP). In addition, two classes of psychologists had to be recruited and educated. A political action committee (LAMP-PAC) had to be formed and registered, and the 50 newly minted medical psychologists had to contribute over $300,000 to it over the course of a few years with no actual guarantee that a law would ever come to pass. An attitude of 'it's sometimes better to ask forgiveness rather than seek permission' had to be assumed and criticisms from naysayers had to be ignored while limitless encouragement from APA and CAPP was gratefully received. Grants had to be written, the world's best lobbyists had to be hired, legislators educated, and legislative strategies developed then refined on the backs of three initial legislative efforts resulting in a total of three health committee victories and two loses. A patient-based grassroots organization had to be conceived (Louisiana Families for Access to Comprehensive Treatment) and an ethical way of getting it up and running approved and established. A way to effectively use this organization (n = 5800) needed to be formulated and both legislative and gubernatorial elections had to be politically influenced. Legislative leadership had to be enlisted to support an all out assault, and a 'you can't kill it if you can't catch it' strategic philosophy had to be adopted and precisely executed so as to leave the powerful opposition stunned and the pundits speechless. A media campaign had to be waged, prayers had to be prayed, and a Governor's signature had to be secured. Altogether, it was an absolute labor of love." Our sincerest appreciation – Aloha

FEATURE

Meditation as Psychotherapy

Lynn C. Waelde, Ph.D.
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Psychologists are becoming increasingly interested in the uses and consequences of meditation. The psychotherapeutic benefits of many types of meditation have been the focus of research for decades. Although there are hundreds of studies about the effects of meditation, many have serious methodological flaws. Psychological inquiry into the uses and effects of meditation could be aided by greater dialogue among meditation practitioners, clinicians, and researchers.

Applications of Meditation in Psychotherapy
Meditation is widely regarded as a useful element of psychotherapy. Recent clinical writing has described the use of meditation in diverse psychotherapies, including psychoanalytic group therapy (Segalla, 2003), constructive psychotherapy (Mahoney, 2003), group therapy for homeless and addicted women (Plasse, 2001), Christian couples therapy (Blanton, 2002), and insight-oriented therapy for American Indian adolescents (Robbins, 2001).

Many different types of meditation techniques are used in psychotherapy, often in combination with mainstream psychotherapeutic techniques. Although meditation is commonly associated with silent, seated practice, some applications of meditation techniques may not use seated meditation at all. Many writers recognize two major traditions in meditation: mindfulness and concentrative meditation. There is considerable overlap in these traditions. Mindfulness is a set of practices drawn from the Buddhist tradition that are designed to cultivate stable, non-reactive, non-judgmental, present-moment awareness and to maintain this awareness over time through regular daily practice (Kabat-Zinn, 1990). Mindfulness, especially the meditation-based stress reduction (MBSR) program developed by Kabat-Zinn and colleagues, has been extensively researched (for review see Baer, 2003). MBSR includes a number of techniques in addition to mindfulness, such as hatha yoga, imagery, concentrative techniques, and breathing exercises (Kabat-Zinn, 1990). Mindfulness-based cognitive therapy combines cognitive therapy for depression with MBSR to reduce the recurrence of major depression (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000). Dialectical behavior therapy (DBT) uses mindfulness skills, but not seated meditation, in the treatment of borderline personality disorder (Linehan, 1993).

Meditation in the Classical Yoga tradition includes a variety of practices, some of which involve focus on an object of meditation, such as a mantra or visualization. Although yogic meditation is often classified as concentrative meditation, the techniques also address and foster present-moment awareness (Waelde, 2004). Yogic meditation techniques have been used psychotherapeutically (for a review see Murphy & Donovan, 1999), usually in combination with other techniques that are part of that tradition, such as hatha yoga and mantra repetition. Transcendental Meditation (TM), a form of meditation that uses mantra repetition, has been found it to be useful for reducing anxiety, depression, and other symptoms of stress (Brooks & Scarano, 1985; Eppley, Abrams, & Shear, 1989; Dillbeck, 1977). A recent pilot study of a hatha yoga, meditation, and mantra program for women who were dementia family caregivers found that there were statistically significant pre/post reductions in depression and anxiety and improvements in perceived self-efficacy (Waelde, Thompson, & Gallagher-Thompson, 2004).

The State of the Art

Despite the fact that there have been hundreds of studies of meditation over the last several decades, many of these have serious methodological weaknesses. For example, most treatment outcome studies have not used control groups and the use of co-interventions (such as cognitive-behavioral therapy and hatha yoga) makes it impossible to isolate the specific effects of meditation (Canter, 2003; Baer, 2003). Although more rigorous design is necessary and would enhance the credibility of meditation research, there are important elements of the Buddhist origins of mindfulness practice that are not easy to operationalize and empirically evaluate (Baer, 2003). Because meditation practices have been secularized for use in treatment, many traditional techniques and teachings are omitted because they are not regarded as pertinent to the goal of symptom reduction in secular context (Waelde, 2004). Although removing teachings from their philosophical and cultural context makes them more broadly acceptable, potentially beneficial aspects of these traditions may be disregarded. For example, both the Buddhist and yoga traditions emphasize the importance of having spiritual, rather than material, goals for practice. In this sense, practicing meditation to achieve a goal, such as stress reduction, may be a very different endeavor than practicing because the aspirant wants to develop spiritually, regardless of whether life is stressful or not. It is possible that goal-oriented practice may tend to limit the beneficial outcomes to the desired ones and that spiritual goals may promote development in ways that the aspirant had not even considered. Thus, it may be that the mechanisms, methods, and outcomes of meditation could be construed more broadly. Along these lines, Shapiro and Walsh (2003) decry the reductionistic, biomedical approach of current meditation research and call for a perspective that includes subjective and transpersonal domains.

How can these diverse perspectives be encompassed? Clearly, the future of meditation research could benefit from an active exchange among researchers, psychotherapists, meditation practitioners and teachers. To facilitate this dialogue, **there will be a meeting of persons interested in meditation and psychology at the APA conference on Friday, July 30, 2004 from 4:00 to 6:00 pm in the Division 12 Hospitality Suite, Hilton Hawaiian Village Hotel**. For more information, or to RSVP, please contact Lynn C. Waelde, Ph.D., Pacific Graduate School of Psychology, 935 East Meadow Drive, Palo Alto, CA 94303, lwaelde@pgsp.edu, telephone 650-843-3505.

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BOOK REVIEW

by Mathilda B. Canter, PhD

Finding Your Voice: A Woman';s Guide to Using Self-Talk for Fulfilling Relationships, Work, and Life by Dorothy Cantor, PsyD, Carol Goodheart, EdD, Sandra Haber, PhD, Ellen McGrath, PhD, Alice Rubenstein, EdD, Lenore Walker, EdD, and Karen Zager, PhD, with Andrea Thompson. Hoboken, New Jersey: John Wiley & Sons, Inc., 2004. 240 pp. ISBN 0471430757

The book arrived just before my next patient was due, and I skimmed through it until she arrived. As we worked through our session, I was struck by how helpful such a book could be for her. But I hadn't really read it yet. What to do? I think that what I did will make my review no surprise: I suggested that she buy the book! And I did so because I know all seven of its authors —some of them *very well*—and all of them well enough to feel confidant that the information provided would be accurate, ethical, and would reflect their collective wisdom, the wisdom of knowledgeable, responsible, effective therapists. Now that I have read the book carefully, I know that my trust has been vindicated, my decision was a good one. (My patient is finding it very helpful, too.)

This is a jewel of a book, which identifies some of the most common sources of difficulty for women as they live their lives out in our culture(s). It offers, in readable, understandable, jargon-less language, ideas and examples of how to identify what your own voice is saying to you, about what expectations you and others have of you, in relation to a variety of life situations, and how to plan and make behavior changes that will reflect your *own* wishes and values. The chapters highlight common expectations about Friendship, Dating, Sex, Marriage, Child-Rearing, Work, Money, Balancing Act, Appearance, and Self-Esteem. In dealing with each of these life issues, the writers begin the chapter with some commentary on cultural attitudes, pertinent data, and a prelude to the actual case vignettes that will be presented, each of them including sections on what they call voice-mapping, reframing, and movement strategies, with the identification of realistic expectations, of course, essential to these processes. Each chapter ends with a brief incisive commentary.

The material is all presented sensitively, in a context of awareness of and respect for the differences between people so that some topics are clearly separated out of the main text, and designated for specific concerns that are not likely to be of interest to all. Actually, one of the book's strengths, to me, is that it makes it very clear throughout that not all of its vignettes or discussions will fit the reader, though they may offer information and insights that can be generalized to other situations. While its primary purpose is to help the reader focus on her own voice, *Finding Your Voice* clearly recognizes the importance of relationships with others as well as with oneself, for fulfillment. Although the focus of the book is on the self, it is definitely *not* on selfishness. It is about self-respectfulness, which benefits everyone, and about the expectation that one keeps learning, and trying, that trial and error, and "back to the drawing board" is a lifetime process, rather than a failure. Finally, I would like to note that reading *Finding Your Voice* will help many women with Losing Their Guilt. And that's a good thing! The book provides, in its final chapter, the framework and questions for setting up groups by women to discuss some of the issues raised here. That's a good thing, too!

My prediction is that when Norcross et al do their next edition of their Authoritative Guide to Self-Help Resources in Mental Health, *Finding Your Voice* will have a five star rating.

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