Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

In This Issue

VOLUME 39 NO. 3 SUMMER 2004

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Linda F. Campbell, Ph.D.
University of Georgia
402 Aderhold Hall
Athens, GA 30602-7142
Ofc: 706-542-8508 Fax: 770-594-9441
E-Mail: lcampbel@uga.edu

President-elect
Leon VandeCreek, Ph.D.
The Ellis Institute
9 N. Edwin G. Moses Blvd.
Dayton, OH 45407
Ofc: 937-775-4334 Fax: 937-775-4323
E-Mail: Leon.Vandecreek@Wright.edu

Secretary
Abraham W. Wolf, Ph.D., 2003-2005
Metro Health Medical Center
2500 Metro Health Drive
Cleveland, OH 44109-1998
Ofc: 216-778-4637 Fax: 216-778-8412
E-Mail: axw7@po.cwru.edu

Treasurer
Jan L. Culbertson, Ph.D., 2004-2006
Child Study Ctr
University of Oklahoma Hlth Sci Ctr
1100 NE 13th St
Oklahoma City, OK 73117
Ofc (405) 271-6824, ext. 45129
Fax: (405) 271-8835
Email: jan-culbertson@ouhsc.edu

Past President
Patricia M. Bricklin, Ph.D.
470 Gen. Washington Road
Wayne, PA 19087
Ofc: 610-499-1212 Fax: 610-499-4625
Email: pmb0001@mail.widener.edu

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Norman Abeles, Ph.D. , 2003-2005
Michigan State University
Dept. of Psychology
E. Lansing, MI 48824-1117
Ofc: 517-355-9564 Fax: 517-353-5437
Email: Norman.Abeles@ssc.msu.edu

Mathilda B. Canter, Ph.D., 2002-2004
4035 E. McDonald Drive
Phoenix, AZ 85018
Ofc/Home: 602-840-2834
Fax: 425-650-2929
Email: drmatcan@cox.net

Jean Carter, Ph.D., 2003-2005
3 Washington Circle, Suite 205
Washington DC 20037
Ofc: 202- 955-6182 Fax: 202-955-5752
Email: jeancarter5@comcast.net

Jon Perez, Ph.D., 2003-2005
IHS, Division of Behavioral Health
12300 Twinbrook Parkway, Ste 605
Rockville, MD 20852
Office: 202-431-9952
Email: jperez@hqe.ihs.gov

Alice Rubenstein, Ed.D., 2004-2006
Monroe Psychotherapy Center
20 Office Park Way
Pittsford, NY 14534
Ofc: 585-586-0410 Fax: 585-586-2029
Email: akr19@aol.com

Sylvia Shellenberger, Ph.D., 2002-2004
3780 Eisenhower Parkway
Macon, GA 31206
Ofc: 478-784-3580 Fax: 478-784-3550
Email: Shellenberger.Sylvia@mccg.org

APA Council Representatives
John C. Norcross, Ph.D., 2002-2004
Department of Psychology
University of Scranton
Scranton, PA 18510-4596
Ofc: 570-941-7638 Fax: 570-941-7899
E-mail: norcross@uofs.edu

Jack Wiggins, Jr., Ph.D., 2002-2004
15817 East Echo Hills Dr.
Fountain Hills, AZ 85268
Ofc: 480-816-4214 Fax: 480-816-4250
Email: drjackwiggins@cox.net

COMMITTEES AND TASK FORCES

COMMITTEES

Fellows
Chair: Roberta Nutt, Ph.D.
Department of Psychology and Philosophy
P. O. Box 425470
Texas Woman's University
Denton, TX 76204-5470
Ofc: 940-898-2313 Fax: 940-898-2301
E-mail: F_Nutt@twu.edu

Membership
Chair: Rhonda S. Karg, Ph.D.
Research Triangle Institute
3040 Cornwallis Road
Research Triangle Park, NC 27709
Ofc: 919.316.3516 Fax: 919.485.5589
E-mail: rkarg@rti.org

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Anna McCarthy, MA
c/o Department of Psychology
126 Heyne Building
University of Houston
Texas 77204-5022

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Counseling Psychology Program
Pennsylvania State University
312 Cedar Building
University Park, PA 16802
Ofc: 814-863-3799
E-mail: jxh34@psu.edu

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Department of Counseling and Human Development
University of Georgia
Athens, GA 30602
Ofc: 706-542-4103 Fax: 706-542-4130
E-mail: gcalhoun@uga.edu

Diversity
Chair: Jennifer F. Kelly, Ph.D.
Atlanta Center for Behavioral Medicine
3280 Howell Mill Road, Suite 100
Atlanta, GA 30327
Ofc: 404-351-6789 Fax: 404-351-2932
E-mail: jfkphd@aol.com

Program
Chair: Alex Siegel, Ph.D., J.D.
915 Montgomery Ave., #300
Narbeth, PA 19072
Ofc: 610-668-4240 Fax: 610-667-9866
E-mail: ams119@aol.com

Psychotherapy Research
Chair: William B. Stiles
Department of Psychology
Miami University
Oxford, OH 45056
Voice: 513-529-2405 Fax: 513-529-2420
Email: stileswb@muohio.edu

TASK FORCES

Interdivisional Task Force on Health Care Policy
Chair: Jeffrey A. Younggren, Ph.D.
Ofc: 310-377-4264

Task Force on Children, Adolescents & Families
Robert J. Resnick, Ph.D
Department of Psychology
Randolph Macon College
Ashland, VA 23005
Ofc: 804-752-3734 Fax: 804-270-6557
Email: rjresnic@hsc.vcu.edu

Task Force on Policies & Procedures
Chair: Mathilda B. Canter, Ph.D.

PUBLICATIONS BOARD

DIVISION OF PSYCHOTHERAPY (29)

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

www.divisionofpsychotherapy.org

DIVISION OF PSYCHOTHERAPY
American Psychological Association
6557 E. Riverdale
Mesa, AZ 85215

www.divisionofpsychotherapy.org

PSYCHOTHERAPY BULLETIN

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DIVISION OF PSYCHOTHERAPY
American Psychological Association

6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

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PSYCHOTHERAPY BULLETIN

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PRESIDENT'S COLUMN

Linda F. Campbell, Ph.D.

Greetings to our membership of Division 29! I enjoyed seeing many of you in Hawaii and particularly appreciated the turnout of members at the awards and social reception. This event continues to be one time during the year when active Division 29 members can count on seeing each other and catching up on activities in our lives between conventions.

We were also very pleased this year to recognize as fellows several members who have contributed significantly to the division. Carol Goodheart, Doug Haldeman and Nadine Kaslow were there to receive their recognition in person. Other recipients who were not able to attend the convention but were recognized in absentia are Jacques Barber, Steven Gold, Jerry Grammer, Scotty Hargrove, Bruce Wampold, Lillian Comas-Diaz, and Brent Hallinckrodt. The Division was also very proud to acknowledge John Norcross and Wade Silverman as our recipients of the Distinguished Psychologist Award. Both of these individuals have made contributions to the division that have advanced psychotherapy in psychology and strengthened the role of the division in the profession. We extend our gratitude and appreciation to them. We are also very pleased to recognize two recipients of the Krasner Early Career Award, Matt Nessetti and Mark Hilsenroth. A President's Recognition Award was given to Jack Wiggins for his dedication and contribution across the years to our division. He has been a vital part of the growth and development of our division and has been greatly responsible for the leading role Division 29 has taken in the profession.

I am very pleased to report to the membership that the Task Force for the Advancement and Advocacy of Psychotherapy has been active and moving toward action plans that will be determined at the board meeting in October. Leon VandeCreek, our President-Elect, and I have held focus groups with practice members of the division, research members of the division, and training members of the division. Further, we have held focus groups with advanced student members of APAGS and an additional focus group of early career members of Division 29. The goal of the discussions remains to (1) identify obstacles to the well being of psychotherapy in each of these domains of psychology and to (2) determine what action Division 29 can take to promote and advance psychotherapy, in these problem areas. We have learned that our membership has the pulse on exactly what is happening in psychotherapy both positive and negative. They are very involved and committed to the preservation of psychotherapy and have given us excellent feedback with specific directions to pursue in the initiative.

We are learning that both researchers and practitioners in the division do not feel antagonistic toward each other on the science-practice issue but rather are very desirous of finding ways to collaborate in joint projects that draw on the strengths of the clinical judgment of practitioners and the abilities of researchers to frame the questions in important ways. We also have learned that trainers and students alike can identify important directions for the training of doctoral students. For example, researchers are talking about ways to mentor students interested in psychotherapy research when they are in programs that primarily teach psychotherapy practice rather than research. Additionally, psychotherapy researchers would like support from the division in expanding ways to get

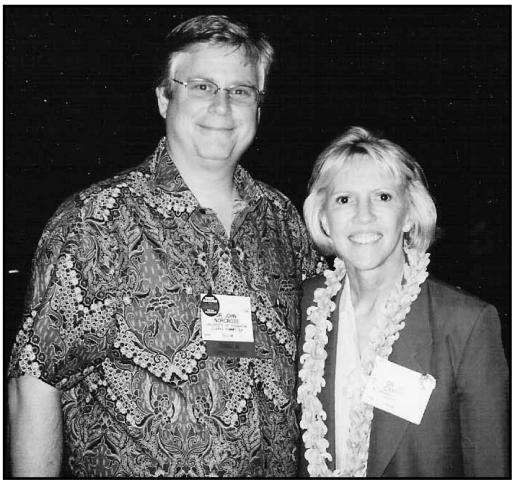
grant and funding support for psychotherapy research by expanding the conventional criteria. And finally, early career psychotherapists are identifying ways the division can be a resource to them through mentoring and access to information as they develop their careers.

As you, the membership, read about these activities, if you are interested in becoming involved in the project, we invite you to contact Leon or me. Our purpose here is to advance and advocate for psychotherapy as we have already said, but additionally, we see this project as a way for members to participate in the division even if they do not hold an office or membership on a committee. This effort is meant to represent the interests of the members of the division who care about the preservation of psychotherapy as a fundamental component of professional psychology.

I look forward to hearing from you and do want to know what your ideas are regarding the health and welfare of our Division of Psychotherapy.

DIVISION 29 AWARDS RECEPTION

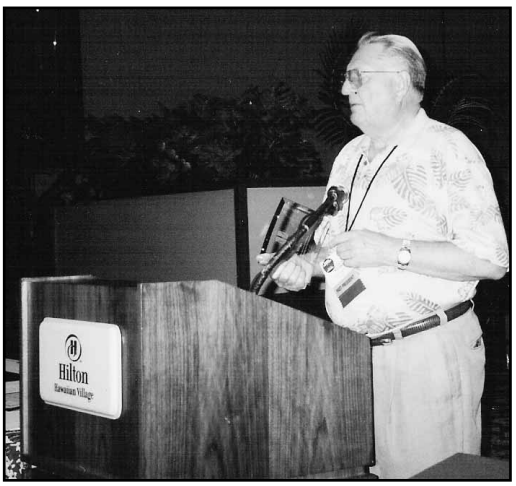
Distinguished Psychologist Award



John Norcross, award recipient, and
Linda Campbell, President

Wade Silverman, recipient, and
his daughter Halley and son Dan

Presidential Award



Jack Wiggins, Presidential Award recipient

Krasner Award

Matt Nessetti, Krasner Early Career Award
recipient and Pat Bricklin, Past President

Polarities and Syntheses

Jeffrey Hayes, Ph.D.

Roberto Assagioli is perhaps the most important therapist that most American therapists have never heard of. Born in Venice in 1888, Assagioli developed a theory and therapeutic method known as psychosynthesis. Among the key aspects of psychosynthesis are an emphasis on the higher reaches of the unconscious, such as scientific and artistic inspiration, transcendence, ethical imperatives, and altruism; a view of the self as multiple, that is, consisting of sub-personalities that are typically not well-integrated; and a set of techniques for developing the will, overcoming obstacles to awareness, and synthesizing the self into a synergistic organism (Assagioli, 1965). Not only do I find Assagioli's theoretical and technical conceptualizations valuable to clinical work, I also believe that his ideas about multiplicity and wholeness are potentially beneficial to the challenges we face within the field of psychotherapy these days.

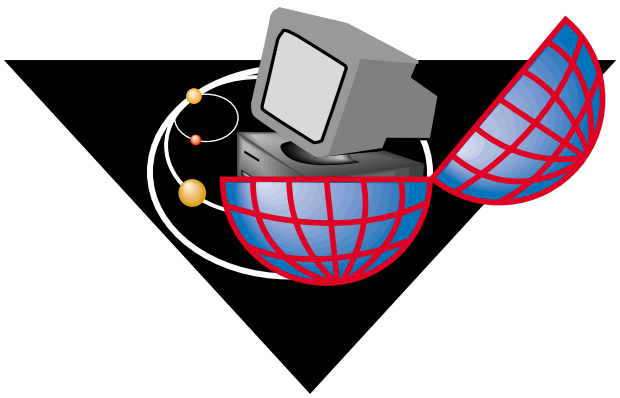
"Polarity," Assagioli once wrote, "is a universal fact." Polarity can be found in the physical world (e.g., positive and negative electrical poles), the emotional domain (e.g., pleasure and pain), and the intellectual realm (e.g., inductive and deductive processes). I would also add that abundant evidence of polarity can be found currently in the field of psychotherapy. There are multiple dimensions along which we are strongly polarized, such as those at either end of the science-practice continuum, advocates vs. opponents of ESTs, and those for and against prescription privileges. Each camp holds passionate beliefs about what is best for the field, and I, for one, don't think that any one group can be characterized by pitchforks, horns, and hooves. The doomsayers among us predict that psychotherapy will ultimately die, aided in no small part by the divisiveness that we are experiencing. Maybe the field will go up in flames, as can occur when positive and negative electrical poles are brought closer together, voltage overcomes resistance, and a spark is generated. Realists, on the other hand, recognize that tensions within a discipline are inevitable and compromises between camps can be achieved, just as positive and negative electrical charges can be fused, resulting in neutralization. Optimists point to the potential for existing schisms to change the field in positive ways. Under the proper conditions, for example, electricity can be transformed into heat, light, and movement. In psychotherapy, analogously, long-standing conflicts between researchers and therapists have led to the development of practice-research networks that hold the potential to generate clinically valuable data and foster professional unification.

It is along the lines of transformation that Assagioli's work has the most to offer the discipline of psychotherapy. For instance, Assagioli recognized that integrative work often is precipitated by crises or powerful conflicts. When addressing such situations, Assagioli prudently cautioned that we must not let emotions overwhelm reason. This requires that individuals (and perhaps groups) dis-identify from emotions so as to better observe and assess them and consciously regulate affect. Intentional and positive transformation requires that we accept, rather than rebel against, existing dualisms and not attach too strongly to any one pole. Operating from a grounded and centered perspective makes the work of integrating polarities easier.

Our future as a profession depends upon our ultimate synthesis. Fortunately, we have in our field a good number of sages and visionaries who are dedicated to the growth of psychotherapy and are not polarized into particular camps. They edit

and publish in our journals; they lead and serve our division. Of course, these individuals are the visible minority. The future of the field may depend more upon the more typical member of the division, the therapist whose daily professional concerns are patients and billing and office expenses and insurance companies. Like sub-personalities, as therapists we may function independently, right into possible oblivion. Or we can devote more of our professional time and energies to fostering synthesis in the field and ensuring our survival.

Assagioli, R. (1965). *Psychosynthesis: A manual of principles and techniques*. New York: Hobbs, Dorman, and Company.



Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

CALL FOR NOMINATIONS: INTERNET EDITOR

The Publications Board is seeking applications for the position of Internet Editor for the APA Division of Psychotherapy. The Internet Editor manages the electronic resources and communications of the Division of Psychotherapy, principally its homepage and listserv. Candidates should be available to assume the title of Internet Editor on March 1, 2005.

PREREQUISITES:

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

QUALIFICATIONS:

The applicant should have experience with the creation and management of Internet resources and electronic publications. The applicant should be familiar with current development in the application of computer technology to the field of mental health.

RESPONSIBILITIES:

The Internet Editor is responsible for content and production of the Division's web site and management of the member listserv. The editor regularly updates information on the website, including information about meetings, changes in governance, new publications, and links to relevant websites. The editor reviews all posts to the listserv, adds new members as required, and responds to requests for assistance. The editor is familiar with APA policies on the use of internet resources and ensures division compliance. The editor maintains regular communication with Division committees, the Division's Central Office, Board of Directors, and Publications Board. As an ex officio member of both the Publication Board and the Board of Directors, the internet editor attends the governance meetings of the Division of Psychotherapy.

TIME COMMITMENT:

Editing the website and managing the listserv requires several hours each month. The home page should be updated on a quarterly basis. An editorial term is three years (2005-2007).

OVERSIGHT:

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

SEARCH COMMITTEE:

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

NOMINATIONS:

To be considered for the position, please send a letter of interest and a copy of your curriculum vitae no later than December 1, 2004 to John C. Norcross, PhD at norcross@scranton.edu. Inquiries about the position should also be addressed to Dr. John Norcross (570-941-7638; norcross@scranton.edu).

PRACTITIONER REPORT

On Being a Medical Patient (II)

Ronald F. Levant, Ed.D., MBA, ABPP
Nova Southeastern University
APA President-Elect

Ronald F. Levant, Ed.D., M.B.A., A.B.P.P., is President-Elect of the American Psychological Association. He was the Chair of the APA Committee for the Advancement of Professional Practice (CAPP) from 1993-95, a member at large of the APA Board of Directors (1995-97), and APA Recording Secretary for two terms (1998-2000, 2000-2003). He is Dean and Professor, Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, FL.

This year I had a significant illness and had to undergo surgery. This was quite a remarkable experience and one that I have been reflecting on from time to time, as the flow of life allows. Colleagues (e.g., D. Linnell, personal communication, 3/10/04) have suggested that I write about my experiences as a medical patient. I had been writing email updates to various groups to keep them apprised of my health. With these as the back bone, in the relatively limited confines of this column, I will continue to experiment with writing about this experience (Levant, in press). As I would like to do more writing in this vein, your feedback will be appreciated (levantr@nova.edu)

I have had a heart rhythm problem for many years, over a decade. It had first been diagnosed as supra-ventricular tachycardia. My heart would start beating rapidly and erratically every few months and this would last a few hours. This was quite scary at first, but the cardiologist back in Boston told me the arrhythmia was "completely benign. Just bash about in your life, and don't worry about it." As it came more frequently over the years he prescribed a beta blocker (Sectral, 200 mg), which seemed to help restore normal rhythm, but I am not really sure it did, or whether it went away naturally, because it always took quite awhile to act.

In the last two years, as my job as dean had become much more demanding and stressful, my arrhythmia came more frequently and lasted longer and was getting to be a royal pain in the you know what. After a series of tests, the new Florida cardiologist determined that I was now suffering from atrial fibrillation, a more serious arrhythmia, which, because blood collects in the fibrillating (quivering) atrium, can thereby clot, and could lead to strokes. He recommended that I see an electro-physiologist (EP), which is a new sub-specialty of cardiology that didn't exist when I first developed this problem. He also suggested I get on a blood thinner, like Coumadin. I put this off for a little while due to the press of daily life, when suddenly the arrhythmia took hold of my throat and demanded that I pay attention to it. I had taken the Sectral and was at home alone when I suddenly felt very short of breath and very lightheaded, so much so that I had to hold on to the kitchen counter to get to the phone. I went to the ER, was told I was in atrial fibrillation (a-fib), and was held there for a few hours. The symptoms (shortness of breath and lightheadedness) dissipated fairly quickly and didn't return that day.

Two weeks later, while at work, the shortness of breath and lightheadedness came back. By this time I was already hooked up with the electrophysiology and heart pacing department at Cleveland Clinic Florida, so I went out there. They put me on a Holter Monitor, which captures heart rhythms over a 24 hour period. The results

were that I was indeed in a-fib, but even more alarming, my heart was now pausing for up to 4 seconds, several times a night. I could actually see the tracings where the heart rate went flat. Very scary, indeed. The EP told me that was quite dangerous. If my heart paused much longer I could black out. The standard procedure was a pacemaker, and I would have to take Coumadin plus an anti-arrhythmia agent, such as Flecainide, for the a-fib. I didn't like this option because I was concerned about the long term use of these drugs, so I asked the doctor what else he could recommend. He suggested a catheter ablation procedure, which was fairly new, actually developed at Cleveland Clinic in Ohio, among other places. As surgery, it was relatively non-invasive, and involved going in through the femoral arteries and using radio frequencies to ablate (remove) neurons which are causing the atrial fibrillation. It had a 60-70% success rate, could be redone if needed, and I could always go the pacemaker and drug route if it didn't work. So I went with it.

With that as background, I'll turn now to the emails which tell the next part of the story.

Email # 1 (2/10).
Hi Folks: I wanted to let you know that I am having surgery tomorrow (2/11). I am having a catheter ablation procedure for treating Atrial Fibrillation, which is complicated by a heart pausing problem that I developed in the last month. Because of the latter, there is urgency about doing this soon. I'll be at the Cleveland Clinic Hospital, Weston, FL, probably until Saturday. I'll let you know how it goes.
Silly me: I was originally thinking that I could attend the Board and Council meetings, but I have now come to my senses and realize that would be foolish. I am sorry because I was really looking forward to seeing you all. I was especially looking forward to thanking my supporters for the presidential race in person.
At any rate, have a great meeting, and I'll catch up with you soon.
Sincerely,
Ron

Email #2. (2/14) (with some details corrected)
Hi Folks: Thank you for all of your calls and emails. I really appreciate hearing from you, and receiving your care and concern! It is difficult for me to spend much time at the computer, hence I will not be able to write individual notes, so please accept this group acknowledgement, thank you, and update. Also I do like to hear from you so please feel free to write, but please don't expect individual replies, at least not right away, OK?

I was released from the hospital yesterday. I have been experiencing atrial fibrillation every day since the surgery on Wednesday (2/11), which is par for the course, due to the post surgical inflammation (for which I am taking prednisone). Pretty much anything I do other than lie in bed sets it off: brushing my teeth, walking around the house, etc. This can continue for up to three months post op (UGH!). The good news is that when I cease the activity and lie down my heart does return to normal sinus rhythm most of the time. Other times I have to take an extra dose of the anti-arrhythmic as well. I will have weekly follow ups, stress tests, Holter monitors, Coumadin (blood thinner) clinic, etc. Hopefully, if I am a good patient and confine myself to bed-rest (which is very hard for me to), I'll see some significant improvement within 2 weeks.

The surgery was quite interesting. For those who don't like these kinds of details, you may want to skip this paragraph. There were three MD's plus a couple nurses and an anesthesiology tech, a team of 6 in all. One of the MD's flew in from Atlanta, as he is a rare radiological expert in intra-cardiac echocardiograms (ICE). They ran catheters up both femoral arteries. The ICE probe went in one artery, and the other contained both the pacing and recording catheter and the radio frequency ablater, which were controlled by the EP. The echo guy acted as navigator telling the EP how to move. I was awake then and could see the echocardiogram (which was just to the left of my head) and hear him

say things like "OK you are near the fossa ovale, rotate ten degrees and hook a right." I thought this was way cool! Just like two guys maneuvering a big truck! Then the third MD came in, the anesthesiologist, and they drugged me out, for which I am glad because the operation took 8 hours, much longer than normal (2-6 hrs). What they did is both ablate (excise) the neurons which act as ectopic excitation sites in both the left and right atria, and then encircle the pulmonary veins in the left atrium. My procedure took so long because my pulmonary veins were "the largest they had ever seen." (I was kind of pleased with that last statement because as you know, for many of us guys, size always matters, no matter what is being measured.)
That's all the news for now. I'll send regular updates.
Warmly,
Ron

Email # 3. Early March
Hi Folks: Good news! I am feeling much better and will be ending my medical leave. I plan to attend an APA meeting on Monday and Tuesday and will be back at work on Wednesday. I will need to take it easy for awhile and cannot do as much as I am used to doing (and it's OK for you to remind me <grin>). My physician indicated that I might continue to experience occasional atrial fibrillation for several months, which, when severe, can cause shortness of breath and dizziness. If that should happen I would simply go to my room and take additional medications until it passes.
Sincerely,
Ron

Email # 4, to Diane Halpern and the APA Board, May 24
Thanks for the heads up, Diane. I hope everything works out for the delivery of your grandson. I need to give you a heads up too. I may have to have the abalation surgery redone. I still have a-fib though it's less severe (slower, more organized) but it is more persistent (I have been in continuous a-fib since 5/3). Today we did an electro cardio conversion and if that holds, I am good to go; If not I'll have the ablation redone, probably first of June, which will mean missing the June Mtg. I'll keep you posted
Best,
Ron
P.S. After typing this, I thought it best to let the Board and EMG know so I am ccing them.

Email # 5. June 20
Hi Folks: Please forgive the cross posting. As you know, in February I had an operation (cardiac catheter ablation) to treat atrial fibrillation. After 4 weeks of recovery with limited activity, I had a good period for about 25 days in April. But then the problem returned, albeit in a less severe (i.e. slower & better organized) but more persistent pattern in May, and I have been in continuous a-fib since 5/3, with HR 80 (whereas before it was 0, when it paused, and went up to 140 if I exerted myself). I had an electro-cardio-conversion on May 24, hoping that once my heart was set back in normal sinus rhythm it might hold, but such was not to be as I went back into a-fib the next day. My EP (electro-physiologist) was planning a second surgery, August probably. The fact that it can be delayed is indicative that there has been some improvement.

But then an extraordinary thing happened. Around 2:30 am Saturday morning I woke up and felt different. No . Can this be? I took my pulse lying in bed and it seemed normal, so I got up and go out my trusty blood pressure monitor (which actually shows the heart beats, so you can see the pacing), and sure enough I was in normal sinus rhythm. I have no idea why this happened, unless it took a bit longer post surgery to see the results; the surgeon said 3 months, and it took 4. It could also be the result of all of my friends and relatives out there praying for me. If it stays like this I will not have to have the second surgery.
With fingers, toes, and eyes crossed, I remain
Sincerely yours,
Ron

Comment, July 5
I have been in and out of a-fib since 6/19. My view is that my heart is still trying to right itself, and it does seem to be getting better in stages. I am certainly improved from before the surgery in that my heart is no longer pausing, and further, the a-fib which I have is now better organized, and I do not have every day. It may turn out that I will need a second ablation but for now I think I will wait and let my heart heal on its own.

Email # 6. August 6
Hi Folks: It was great seeing friends and colleagues in Honolulu. What a terrific convention! I wanted to let you all know I will have a pre-op procedure next Tuesday (August 10) in preparation for admission for surgery the following morning. Since the initial surgery last February I have experienced significant improvement, in that the a-fib is less severe and life-impacting. However, it still persists, which warrants further surgery. My hope is that this procedure will cure it and I will be able to get off the medications. The surgery will not be as extensive as the first time and so my recovery period should be shorter.
I'll keep you posted
Best regards,
Ron

Current Status
I had the second catheter ablation on August 11. The EP reported that the isolation of the pulmonary veins done in February was holding, and that they found a few areas on the bottom of the veins that needed to be done. The procedure was much shorter and the hospital stay was as well. I was released on Thursday August 12. Given the inflammation that comes after surgery, I went into a-fib shortly after discharge, but returned to normal rhythm the next day. Now it's a matter of waiting to see if this will work, which, like the first time, could take up to 90 days.

Reflections
One of my colleagues (D.Linnell, 7/5/04) noted that: "When you talk about the various clinical things happening to your body and the treatment being thrust upon you to deal with it, it comes across like the professor part of your work. How about adding some reality to it?"
OK, Debbie, I will. This experience brought with it an at-times intense fear and also an ongoing sense of vulnerability. I was most afraid the evening I went to the ER unable to breath, and this heightened fear lasted until I understood what was going on and had a plan to deal with it two weeks later. The sense of vulnerability continues to this day, as I am not out of the woods yet. I also had a hard time with the loss of control that comes with being in a hospital. Hospitals simply take your life over. The nurses and techs wake you in the middle of the night to give you sleep medicine, and (actually in my case), lose your blood work and have to do it over. And forget about trying to get even simple questions answered. Either you get no answer or you get crazy answers. This was, by the way, very much in contrast to my experience in the operating and recovery rooms, where the staff was very professional, kind, and helpful.

Lessons Learned (so far)
1) Work stress can be dangerous to your health. Due to political issues at my workplace, I felt ambushed, trapped, hopeless, and unable to make myself heard, while at the same time feeling that the future of my program was on the line, and that, therefore what happened mattered greatly.
2) Traditional masculinity can be hazardous to your health. Despite decades of professional work on the psychology of men and masculinity, as well as my own personal therapy and analysis, I still find that I have some stubborn traditional masculine traits, such as minimizing and ignoring my health needs.
3) Being healthy is now my number one priority. People who know me may wonder about this, because I have always valued health. But they may not know that, due to factors mentioned in item 2 above, I was reluctant to go to physicians when I had a health problem, preferring to wait or "tough it out."
4) Love, support, and care from family, friends, and colleagues is wonderful,

and truly beneficial. As my colleague Jo Johnson noted (personal communication, 7/5/04): "You're an excellent example of the current research on the power of prayer even when one is unaware of being prayed for. There are lots of us out there praying for your physical health and peace of mind."

5) Becoming an educated healthcare consumer is very helpful. It is amazing how easy it is to access medical information on one's condition. I was able to rapidly amass a six inch stack of articles and a book, which I devoured. Being proactive in seeking information and learning about my condition helped enormously in dealing with my sense of vulnerability. It also gave me a conceptual framework and an overview of the various treatment options and their relative efficacies and risks. Finally, it helped me communicate better with my physician.
6) Maintaining a positive attitude is very important. Hard to do, of course, but emotional and cognitive self-management skills really do help
7) Having a good relationship and good communication with your main MD is absolutely key. The first EP I went to had the personality of an onion. He even got into an argument with me in the visit. Needless to say that was also the last visit.
8) Living is not for sissies. In fact, as we age, if we are lucky we will develop an illness. The alternative is much worse.

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FEATURE

Psychology as Psychology

Thomas Greening, Ph.D.

Psychologists seem increasingly reluctant to affirm and practice psychology as a unique science and profession. I am concerned about a trend toward the medicalization of psychology by psychologists who give primacy to biomedical, genetic, neurological, "brain disease," "mental illness" models of deviant, disordered and troubled human behavior and experience. Some employ a medical model in cases where there is insufficient or ambiguous evidence of causal organic pathology. They then advocate chemical, electrical, or surgical "treatment" of these "diseases," sometimes on an involuntary basis.

Psychology has a unique mission and a body of theory and practice that distinguish it from medicine, surgery, pharmacology, endocrinology, criminal justice, law enforcement, etc. I do not deny the powerful effects of genetics and diseases, or the importance of medical treatment of diseases and organic pathologies, or the necessity to control illegal behavior. However, other professions specialize in those areas. Psychologists should maintain close relations with those professions, but not dilute psychology by mimicking them.

This is not an argument against interdisciplinary collaboration. Some psychologists engage in valuable interdisciplinary theory-building, research and interventions involving such diverse fields as neurology, biochemistry, pharmacology, physics, mathematics, political science, social work, law enforcement, religion, philosophy, literature and the arts. Psychology, however, is a distinctive field which addresses, emotional, cognitive, and value-based causes and results in human affairs; in short, *psychological* matters. Psychology has and needs its own theories, training and research programs and professional organizations to support its particular mission and to provide a solid and defined base from which to relate to other professions when appropriate.

Wertz (1998) points out that even Freud, trained as a neurologist, warned against the dangers of training in conventional medicine and science. In fact, Freud insisted on many occasions that training in mathematics, natural sciences, and medicine was not only irrelevant but harmful for psychologists since it directs students away from properly psychological attitudes and subject matter (Freud, 1916, 1926). Instead, he advocated study of the humanities and the arts along with extensive and detailed observations of individual persons' expressive behavior.

At this time in history it seems there is a reluctance by our national organization of psychologists to affirm psychology as psychology. Instead, biomedical and genetic theories seem to be exercising a strong influence on psychology, often in a reductionistic manner. For example, the American Psychological Association and many state psychological associations are campaigning for prescription privileges and support views such as the one promoted by the National Alliance for the Mentally Ill that depression and schizophrenia are brain diseases. Along these lines, Division 29 has issued a pamphlet asserting that ADHD is a diagnosable medical disorder that should be treated with drugs.

This is a long-standing issue in psychology. I am grateful to Amedeo Giorgi for bringing to my attention a relevant chapter published many years ago by Madison Bentley (1930), "A Psychology for Psychologists." Bentley deplores that:

> ...outside concerns and foreign interests have played too great a

> part in shaping and defining our field....Really psychological points of view and interests have been made secondary to evolutionism, the doctrine of heredity, zoological classifications, animal hierarchies, physiological and neurological hypotheses, clinical medicine, psychiatry....Biology has mainly injected physical, physiological, and speculative matters into psychology; medicine has warped it toward the abnormal....Is it possible, now, to restore psychology to a better balance to make it more fundamentally psychological and less accessory to other things?...The equitable partition of work as between biology...and psychology is our first concern. It has been made very difficult by the temporal priority and development of the biological group, which long regarded itself as the totality of the sciences of life....The primary contention of the present article has been that any psychology that is to stand upon the level of the older sciences should squarely face all the relevant facts at hand and should deal with them in a distinctive psychological way and not as merely accessory to other subjects....(pp. 95-114)

Similarly, Philip W. Anderson (1972), a physicist and Nobel laureate, published an essay "More is Different" in Science in which he contends that not only particle physics but all reductionist approaches have only limited ability to explain reality.

> At each stage, entirely new laws, concepts and generalizations are necessary, requiring inspiration and creativity to just as great a degree as in the previous one. Psychology is not applied biology, nor is biology applied chemistry. (p. 108)

Another Nobel laureate, Roger Sperry (1995), writes:

> Countering prior physicalist views, the new principles of causality affirm that subjective human values are today the most strategically powerful driving force governing the course of events in the civilized world—and the key to our global predicament and its solution. (p. 8)

And yet, contemporary clinical psychology seems increasingly enamored with what Sperry calls "physicalist views." What can be done? APA's Division 32 (Humanistic Psychology) might support reviving a non-reductionistic psychology as psychology, but it is a small division that does not include the many psychologists who do not call themselves humanistic but who feel concern about the medicalization of psychology. APA's Division 39 (Psychoanalysis) is a large division that probably includes many members who share these concerns, but does not represent non-psychoanalytic psychologists. The American Association of Applied and Preventative Psychology opposes the seeking of prescription privileges by psychologists as a trend undermining psychology, but attracts mainly academic psychologists and not the many practitioners who share the position expressed here. Division 29 sometimes seems to support biological rather than psychological theories and interventions, as in its pamphlet on ADHD. As the Division explores the future of psychotherapy, will it move beyond a "treatment" approach to "mental illnesses"?

It appears that there is a need for a new organization to support the differentiation and development of psychology as psychology.

Where Does Psychology Belong?

Here is an exercise that can help readers clarify how they view the field of psychology and its relationships with other fields. The College of Letters and Science at UCLA has four academic divisions:

Humanities
Physical Sciences

Social Sciences
Life Sciences

In which of these divisions would you place psychology?

UCLA's definitions of these divisions appear below. I have omitted psychology from the definitions, because the purpose of this questionnaire is to ask you to place it in one of the divisions.

1. Humanities
Study of historical and contemporary perspectives of human traditions through the study of languages, literature, philosophy, culture and the arts.

2. Life Sciences
Study of all living beings and their interactive relationships with their environment. Includes biology, microbiology, kinesiology. Preparation for majors in this area includes course work in biology, chemistry, mathematics and physics.

3. Physical Sciences
Study of the origins, properties and processes of our material world and expanding universe. Preparation for majors in this area includes laboratory and classroom course work in mathematics, physics and chemistry.

4. Social Sciences
Study in this division includes anthropology, sociology, economics, geography, history, urban studies and organizational studies.

Exercise:
Draw four circles representing the four UCLA divisions.
Draw the circles so that they overlap or are separate to whatever degree you believe represents the ways the divisions are related. Then, on the resulting diagram of four circles, place psychology where you believe it should be. It may fall entirely within one circle, or may be within the boundaries of more than one overlapping circle. The resulting diagram will represent how you believe psychology should be related to the other areas of learning.

To my dismay, I found that UCLA places psychology in the Life Sciences along with biology, not in the Social Sciences or Humanities.

What Should Psychologists Study?
Closely related to the question of where psychology belongs in a university is the question of what psychologists should study. Koch (1993) points out that only some aspects of psychology are closely related to the biological sciences, while others need close liaison with the humanities:

> Because of the immense range of the psychological studies, different areas studied will bear affinities to different members of the broad grouping of inquiry as historically conceived. Fields such as sensory, physiological (or broadly neuroscience-oriented) psychology may certainly be seen as solidly within the family of the biological and, in some reaches, natural sciences. But psychologists must finally accept the circumstance that extensive and important regions of psychological study require modes of inquiry (and correlative researcher sensibilities and training backgrounds) rather more like those of the humanities than those of the sciences. (pp. 902-904)

Similarly, Pottharst and Kovacs (1962), summarizing the results of a survey of graduates of the University of Michigan doctoral program, reached a similar conclusion:

> The clinical curriculum should be enriched with larger doses of the humanities and social sciences. Anyone who must work closely with people needs to be steeped in the history and cultures of (hu)mankind as much if not more than he (or she) needs to be steeped in research methodology, mathematics, and the hard sciences. (p. 18)

When I was an undergraduate at Yale, I quickly transferred out of engineering and majored in psychology and literature. I dropped a course called "Contemporary Theories of Psychology" because it was

only about Skinner, Hull, Guthrie, Thorndike, etc. Instead, the course that most inspired me to study other aspects of psychology was on modern French literature taught by Henri Peyre. I am reminded of Mikhail Bakhtin's assertion, "After all, the boundaries between fiction and nonfiction, between literature and nonliterature and so forth are not laid up in heaven." Perhaps this viewpoint is responsible for the fact that I still have the poetry book I stole from my high school English class in 1947, and often turn to it when bored or appalled by psychology.

I became an existential-humanistic psychologist because, much as I valued my psychoanalytic training and personal analysis, and much as I find the methods of behavior therapy practical and effective within limits, I was frustrated by reductionistic aspects of both, and searched for something more. That search led me to existential-humanistic psychology and to James Bugental and Rollo May, and eventually to becoming a faculty member at Saybrook Graduate School, with which they were affiliated.

But even there I ran into the old biases. One day a colleague asserted that students must master quantitative research so they can understand and evaluate "the literature of psychology." What, I asked, is "the literature of psychology," and who gets to define it? Partly to be provocative, but also speaking more seriously than I realized at the time, I proposed that the literature of psychology should also include poetry, and that therefore a psychology doctoral program should require students to be able to write and understand poetry.

I am relieved to find that I am not alone, even within the psychological establishment. Consider this quote from a former president of the American Psychological Association:

> The spiritual side, the poetic side, the giving and forgiving side, the generous and loving side, are humankind's finest features. Hebb defined psychology many years ago as not being poetry. Although Hebb was my scientific hero, I demur from defining psychology without poetry. (Farley, 1994, p. 3)

In supervision sessions with doctoral students learning to do psychotherapy in an APA accredited program, I made references to Faust and Siddhartha to illustrate points I was making about clients' struggles. The students had no idea what I was talking about. Later, during an APA site visit I mentioned this to a member of the accreditation team, and jokingly asked, "Do you feel safe walking the streets at night knowing there are psychologists out there who don't know who Faust and Siddhartha are?" He looked at me, puzzled. In its embrace of quantitative science and biomedical models, has psychology made a Faustian bargain? If the ferryman in Siddhartha applied to a graduate program in psychology, would he have a chance of being admitted?

As psychology struggles to define its own complex and multi-faceted identity, it is important that it simultaneously develop fruitful—but not reductionistic—liaisons with many other fields.

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Comments about this article can be addressed to: Thomas Greening, 1314 Westwood Boulevard, Los Angeles, CA 90024, 310-474-0064
email: tgreening@saybrook.edu

DIVISION 29 AWARD RECEPTION

Congratulations to Division 29 Fellows!

Roberta Nutt, Fellows Chair; Nadine Kaslow, recipient; and Linda Campbell, President

Doug Haldeman, recipient; Roberta Nutt and Linda Campbell

Carol Goodheart, recipient; Roberta Nutt and Linda Campbell

HIGHLIGHTS OF THE 2004 APA COUNCIL MEETING

John C. Norcross, Ph.D.

The APA Council of Representatives met on July 27, 28, and 30th for a total of 12 hours in Honolulu, Hawaii in conjunction with the 2004 APA convention. Dr. Jack Wiggins and I represented the Division of Psychotherapy as your two representatives.

The Council considered, debated, and approved a large number of agenda items. Here are a dozen highlights of Council's actions:

- Eliminated the annoying requirement of placing your signature on APA ballot envelopes.
- Renewed Clinical Health Psychology as a specialty in professional psychology and Biofeedback as a proficiency in professional psychology.
- Joined as a founding partner of the National Foundation for Mental Health – a friends of the NIMH organization.
- Learned that, in 2003, APA had its best financial year ever. We had a 2.4 million surplus, largely due to the performance of the long-term investments.
- Passed a 2005 preliminary budget with a small surplus.
- Approved two pioneering resolutions: Resolution on Sexual Orientation and Marriage, and Resolution on Sexual Orientation, Parents, and Children. (These and all other resolutions are available on the APA website at http://www.apa.org).
- Revised the members due schedule to allow additional steps in the dues step-up program for early career psychologists.
- Funded three leadership training conferences for 2005: State Leadership Conference, Division Leadership Conference, and Education Leadership Conference.
- Established a continuing Committee on Early Career Psychologists.
- Reviewed, in executive session, APA employment contracts and staff compensations packages.
- Celebrated the 30 years of passion and progress of the APA Committee on Women in Psychology (1973-2004). The materials chronicled the 52 resolutions/motions made in Council regarding the status of women in psychology.
- Approved and adopted a resolution on sexual orientation and military service. The document decries discrimination against homosexual behavior and orientation, but reverses the previous ban on military advertisements in APA publications.
- Received a series of reports, including those from the Task Force on Psychology's Agenda for Child and Adolescent Mental Health and another on Bullying Among Children and Youth

The 2004 meeting also served as the farewell meeting of Jack Wiggins, following his distinguished tenure as a Division of Psychotherapy Board Member and Council Representative. He received a special presidential citation at the Division 29 social hour.

At the same time, we take heart in the knowledge that Division 29 has regained its third seat on APA's Council of Representatives, starting in 2005. I will be joined by Dr. Patricia Bricklin and Dr. Norine Johnson as your Division 29 representatives.

As always, please contact me directly (570-941-7638; norcross@scranton.edu) if you would like to speak about the actions and directions of the Council of Representatives.

STUDENT CORNER

Assimilating the Zeitgeist into a Professional Consensus

Gregory S. Chasson

Gregory S. Chasson is currently a second year student in the clinical psychology Ph.D. program at the University of Houston. Prior to graduate school, he graduated from the University of California, Santa Barbara where he investigated social gestures within an evolutionary framework. Gregory's eclectic clinical and research interests include various treatment and diagnostic components of autism, defining a professional standard for child custody evaluations, and treatment effectiveness for children who have been physically and sexually abused. He intends to pursue a career as a researcher and clinician.

Any therapist who deals with depression may have heard about a new technique called Eye Poking Desensitization (EPD). Specifically designed to ameliorate depression, this technique is relatively new, but word of mouth has already spawned a whole cult of followers who are convinced of its efficacy. For a nominal fee, any credentialed therapist can learn to administer the new technique, which involves a strategically placed eye poke at intermittent intervals throughout a silent therapy session. The creators of EPD, who are psychologists at the Spurious Institute of Depression in Iowa, have demonstrated the success of the technique in a series of reputable publications in a top tier journal.

Many people laugh at the fictitious concept of EPD, but unfortunately, there are a select few "professionals" who would adopt such a practice on a whim. The consequences of such a decision extend beyond the prime concern for client welfare. Indeed, the ramifications transcend the mental health arena, even the actions of a single therapist. Once integrated into the mental health community, the consequences reverberate throughout society, including the practice of law. For this reason, the onus is placed on mental health practitioners to make educated decisions regarding the techniques they choose to adopt.

One only has to look as far as Dr. Benjamin Spock to see the resounding effects of a single individual on society. Spock (1946) revolutionized child-rearing practices for decades, and many still adopt his ideas today. In a time when parents were cautioned about providing their children with too much affection, Spock's ideas countered these notions. He encouraged parents to be flexible and affectionate with their children, and he reminded people that they have the inherent ability to be experts at parenting. Spock's ideas are intrinsically satisfying, but at the time of inception, they lacked scientific underpinnings and were based on personal experiences. Spock's beliefs consisted of ingredients that were conducive to rapid and unwarranted proliferation- the makings of a persuasive zeitgeist. The effects of his influence are potentially substantial. Most children from that era were raised with his ideas. Even careful research would have difficulty extricating the myriad of effects of his techniques.

Spock's ideas were probably harmless, if not beneficial, but this example serves to demonstrate an important point. By definition, fads are fundamentally appealing, but without a scientific evidence base, they could have disastrous consequences. If EPD becomes the next fad, and overzealous practitioners implement this technique to thousands of depressed patients, who is at fault when it is discovered posthumously that the technique was harmful? In this case, the proverbial finger is pointed directly at the mental health field as a whole, not just the Spurious Institute of Depression in Iowa. By fervently accepting such a practice prematurely, each professional is jointly responsible for allowing this technique to become a part of professional consensus and practice. The respon-

sibility does not stop at EPD therapists, however, since it is the duty of all mental health practitioners to remain educated consumers of research. The public cannot be held responsible for agreeing to unreasonable practices. It is the practitioner's job to provide the public with honest and competent services.

Even today, some professionals succumb to the faddish nature of certain interventions. Thus, professionals must keep a skeptical eye on the latest techniques. If specifically looking for it, these types of interventions are easy to spot. They are often proclaimed a veritable panacea for a multitude of disorders. Furthermore, serving to perpetuate its burgeoning status, these faddish treatments are also usually marked by clever campaigning, questionable research, and potentially unfalsifiable foundations.

Luckily for the public, most fads are genuinely innocuous or even slightly beneficial; however, some incidences exemplify the very danger associated with negligently adopting the zeitgeist. Hanson and Spratt (2000) critique an approach designed to treat children with Reactive Attachment Disorder (RAD) called holding therapy. Certain forms of holding therapy involve "prolonged restraint for purposes other than protection, prolonged noxious stimulation (e.g., tickling, poking in the ribs), and interfering with bodily functions" (Hanson & Spratt, 2000, p.142). The authors elaborated, "The child may try to resist by screaming, fighting, or crying, but eventually breaks down. When the child reaches the point of surrender, he is then given to his caregiver(s), to whom he reportedly instantly attaches" (Hanson & Spratt, 2000, p.142). This egregious practice seems inherently inhumane. Anyone can terrorize a child into behaving, but to have it recommended under the guise of scientific and professional opinion is detrimental to the reputation of the mental health field. Unfortunately, holding therapy is not just indicated for this particular population of children. It has also been recommended for other populations as well, even children with autism, whose characteristic lack of functional communication further compounds the consequences of this treatment. Thus, it is the duty of the mental health community to filter out these atrocious practices, to maintain standards for evaluating treatments, and to effectively educate the public.

To protect the practitioner from implementing dubious interventions such as holding therapy, a task force from Division 12 of the American Psychological Association (1995) established criteria for assessing the efficacy and effectiveness of psychological treatments. The decisions of the task force served as inspiration for Chambless and Hollon (1998) to elaborate and extend the criteria. They set the standard for labeling an intervention as an Empirically Supported Treatment (EST) (Chambless & Hollon, 1998). It behooves all therapists to become familiar with the concept of EST's, including the benefits and consequences associated with this type of standard (see also Norcross, 2002, for an alternative perspective).

The criteria for EST's provide a sensible guide for a practitioner to assess the nature of a particular treatment. For example, any therapist who wishes to implement EPD should consult the criteria for an EST as a guide for evaluating the humane and effective nature of the treatment. In addition, a thoughtful practitioner should carefully review the literature even for treatments that are considered an EST. As part of scrutinizing relevant literature, the thoughtful clinician should consider methodological confounds, such as the extent to which a research team may have inadvertently demonstrated allegiance to a particular treatment in the study. Similarly, he or she should question potential violations of statistical assumptions and techniques. Finally, and this is probably the most difficult to maintain, one should use common sense when evaluating a treatment, such as judging the extent to which a gimmick adds to the effects of the common elements present in nearly all therapeutic techniques.

The repercussions of assimilating the zeit-

geist into a professional consensus extend into legal contexts as well. Assessment is not only an essential component of psychotherapy, it is also vital to a thorough forensic evaluation, regardless if it is a child custody dispute, personal injury litigation, determination of insanity, etc. *Frye v. United States* (1923) set the earliest precedent for the standard of assessment in legal proceedings. While the details of the case are beyond the scope of this article, *Frye* determined that opinions put forth in court by a professional were considered admissible only if he or she derived the opinions using techniques or methods that were generally accepted in the professional community. *Frye* became the dominant standard until the decision of *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993) helped address certain shortcomings of *Frye* (Sanders, Diamond, & Vidmar, 2002).

Since not all scientific techniques can develop an adequate professional reputation, individuals in the legal arena viewed the *Frye* standard as overly exclusive (Sanders, Diamond, & Vidmar, 2002). As a result, *Daubert* was embraced as a new standard for evaluating scientific evidence in court. While *Daubert* still recognized the standard of professional consensus, it also included the requirements of reliability and validity of the instruments used in court proceedings. Evidence of strong psychometric properties is crucial for meeting the standards of *Daubert*, but professional consensus still plays a powerful role in the court's determination of the admissibility of incriminating or exonerating evidence. Thus, even a single therapist who decides to use a particular assessment, despite a lack of evidence of its reliability and validity, can directly contribute to a professional consensus that condones the use of that questionable instrument. Following from the decisions of *Frye* and *Daubert*, this unjustifiably condoned measure is now potentially admissible in court, facilitating the decisions regarding the welfare of a child in a custody dispute or the fate of a defendant on trial for murder. Therefore, it is imperative that mental health practitioners responsibly elect to use appropriate assessments and techniques in all contexts.

In many respects, psychology is still in its infancy as a science. It is no secret that psychology is still seeking a unifying paradigm to inform research and clinical practice. The state of the field shifts as the metatheories grow or decline in popularity, and this lack of a binding paradigm elicits pseudoscientific ideas and fads. Granted, every field has fads, but the rate at which such fads are accepted is seemingly and alarmingly high in the mental health field. Few individuals would voluntarily ingest an unproven pill that purportedly cures migraines without first determining its safety and effectiveness. Why then should the public engage in psychological treatments that are unproven without first determining their usefulness and safety? From relatively harmless approaches such as Spock's child-rearing advice, to inhumane practices such as certain forms of holding therapy, every decision by a therapist reflects on the field of mental health, and by extension, facets of the law as well. Ultimately, it is the responsibility of the practitioner to remain cognizant of the potential effects of the zeitgeist.

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THE CAROLYN PAYTON EARLY CAREER AWARD

The Carolyn Payton Early Career Award is sponsored by Section One, the Psychology of Black Women, of the American Psychological Association's Society for the Psychology of Women (Division 35). The award recognizes the achievement of a Black woman in the early stages of her career. The applicant must be no more than ten years post doctorate and the submitted work (article, book chapter or book) must be published. Although a submission need not focus exclusively on Black women, the specific concerns of Black women must be a focal point of the submission. Papers may be theoretical or empirically (qualitative or quantitative) based. Each submission will be evaluated on its creativity and must distinguish itself as making a major contribution to the understanding of the role of gender in the lives of Black women. If there are multiple authors, the applicant must be the first author. A $500 prize will be awarded. The award winner will be announced at the Division 35 social hour at the American Psychological Association in August, 2005.

To be considered for the award, please send a cover letter, your vita (please include your email address), three hard copies of your scholarly work, a copy of your paper on a disc formatted for IBM PCs in Word, and two self addressed stamped envelopes to:

Dr. Ruth L. Hall
Department of Psychology
The College of New Jersey
P. O. Box 7718
Ewing, NJ 08628-0718

DEADLINE:
April 1, 2005
Submissions postmarked after 4/1/05 will not be considered for the award.

FEATURE

An Outstanding Return

Patrick DeLeon, Ph.D.

Our recent APA convention in Honolulu was truly outstanding. My sincerest congratulations to President June Ching, Carol Parker, and, of course, former HPA President Tom Glass who successfully maintained the APA Board of Directors' initial enthusiasm for returning to our State. Kathy McNamara and BCA chairs Rodney Hammond and Brian Wilcox were absolutely instrumental in facilitating the visit of over 13,000 colleagues. Our deepest appreciation. Individuals can make a real difference. Since our convention, two proposals promulgated by federal agencies concretely illustrate this policy perspective.

During his APA Presidency, Marty Seligman stressed the importance of Positive Psychology. Accordingly, we were very pleased that the US Department of Education, Office of Special Education and Rehabilitative Services, has now announced a priority under its Special Demonstration Programs, focusing on an area of national need, Positive Psychology. "Positive psychology is the study and practice of counseling techniques based on cognitive-behavioral therapy to assist individuals to develop an increased awareness of their own positive character strengths, emotional processing, and belief systems [citing Marty]. These techniques help consumers to build skills so that they can accurately assess beliefs about themselves that may create barriers to effectively coping with adversities that occur in their lives. These techniques may also expand their ability to challenge these beliefs in order to pursue flexible and appropriate responses to their adversities. Positive psychology techniques empower individuals to take control of their own lives, to increase their capacity for effective decisionmaking, and to persist in pursuing goal-directed activities.

"Research in positive psychology has yielded a variety of approaches to assist individuals to identify their own beliefs and actions that are barriers to their ability to handle effectively life's adversities. These approaches are based on the techniques of cognitive-behavioral skills development and include models developed to change rigid and pessimistic beliefs and cognitive constructs to more flexible and positive ones. Major work in developing positive psychology approaches has been reported.... However, no research literature was identified that applied these principles and techniques to individuals with disabilities in VR [vocational rehabilitation] settings. The overall objective of the positive psychology priority is to develop and demonstrate the validity of counseling tools and techniques based on the principles of positive psychology with individuals with disabilities in the VR system. The priority supports... specifically empowering consumers of VR by implementing techniques that will ncrease the skills of individuals with disabilities, enabling them to achieve high quality employment outcomes. Successful projects under this model demonstration program would address three specific aspects of positive psychology and their application to rehabilitation: learned optimism, strengths and virtues versus talents for employment, and subjective well-being...." Psychology can make a significant difference to the quality of life of our nation's citizenry. Mahalo.

Three members of Hawaii's Congressional delegation served at an earlier point in their careers in our State (or Territorial) legislature. Accordingly, we would rhetorically ask: How many HPA members have personally met with their own State House and Senate member during the past year? How many members or students are currently engaged as volunteers in this year's election process? And, How many truly appreciate the significant impact that one member, in particular, in our delegation

can have upon colleagues employed by the Veterans Administration, due to his senior position on the Senate Committee on Veterans' Affairs?

The Department of Veterans Affairs has proposed to amend its Patients' Rights regulation to bring the provisions regarding medication into conformity with current law and practice. The changes are primarily intended to clarify that it is permissible for VA patients to receive medication prescribed by any health care professional legally authorized to prescribe medication. "When VA promulgated the patients' rights rule in 1982, physicians were generally the only health care providers authorized to prescribe medication.... However, that is no longer the case. Under current law, other health care professionals are legally licensed to prescribe medication and typically do so in health care settings across the Nation. For example, licensed registered nurse practitioners are licensed to independently prescribe medication in virtually every state in the United States.... VA is proposing to eliminate the specific references to physicians... and to substitute references to appropriate health care professionals." A grass roots effort by HPA will definitely make a difference in ensuing that these timely changes are adopted. Aloha,

Pat DeLeon, former APA President
August, 2004 HPA

Division 29 sponsored symposium
Psychotherapy Advocacy:
Training, Research & Practice

Carol Goodheart, John Norcross, Abe Wolf, Linda Campbell, Leon Vandecreek and Jeffrey Hayes

Abe Wolf, Nadine Kaslow, and Alex Siegel

Jeff Younggren, Eric Harris, Garnett Stokes, and Matty Canter

FEATURE

TO CROSS OR NOT TO CROSS:
Do Boundaries in Therapy Protect or Harm?

Ofer Zur, Ph.D.

Ofer Zur, Ph.D. *is a psychologist and forensic consultant practicing in Sonoma, CA. He has been a pioneer in the field of the ethics of dual relationships and a leader in the managed-care-free psychotherapy movement. Most recently, he has co-edited a book with Dr. Arnold A. Lazarus entitled, Dual Relationships and Psychotherapy, published by Springer. His website at www.drzur.com provides extensive online guidelines, articles, home studies, and other resources on boundaries and dual relationships issues in therapy.*

Psychologists have been inundated with unequivocal messages about the depravity of boundary crossings and dual relationships in clinical practice. From graduate courses and texts on ethics, to continuing education workshops on "Risk Management," to attorneys' advice columns, we have been warned never to leave the office with a client, to be very careful about gifts, never to socialize with clients, to avoid bartering and to limit physical contact to a handshake or a pat on the back. We have also been cautioned that boundary crossings are likely to lead us down the slippery slope to exploitive sexual relationships. Boundary crossings and dual relationships have often been labeled unethical and often used synonymously with exploitation and harm.

This article will attempt to shed light on the complexities of boundary crossings and will clarify the relevant ethical and clinical concerns. It will distinguish between harmful boundary violations, beneficial boundary crossings and unavoidable or helpful dual relationships. Most importantly, it will suggest ways to increase clinical effectiveness by appropriately incorporating beneficial boundary crossing interventions into our clinical practices.

Defining Boundaries

Boundary issues mostly refer to the therapist's self-disclosure, touch, exchange of gifts, bartering and fees, length and location of sessions and contact outside the office (Guthiel & Gabbard, 1993). Boundary crossing in psychotherapy is an elusive term and refers to any deviation from traditional analytic and risk management practices, i.e., the strict, 'only in the office,' emotionally distant forms of therapy (Lazarus & Zur, 2002). Dual relationships refer to situations where two or more connections exist between a therapist and a client. Examples of dual relationships are when a client is also a student, friend, employee or business associate of the therapist.

While most analysts, ethicists, attorneys and "experts" may use a broad brush in describing boundary issues, it is important that psychologists differentiate between harmful boundary violations and helpful boundary crossings. A boundary violation occurs when a therapist crosses the line of decency and integrity and misuses his/her power to exploit a client for the therapist's own benefit. Boundary violations usually involve exploitive business or sexual relationships. Boundary violations are always unethical and are likely to be illegal. However, boundary crossings are often part of well-constructed treatment plans and, as such, they can increase therapeutic effectiveness (Lazarus & Zur, 2002). While all dual relationships involve boundary crossing, exploitative dual relationships are boundary violations. Obviously, not all boundary crossings are dual relationships.

Beneficial Boundary Crossings

While from the analytical point of view almost all boundary crossings are detrimental to the transference analysis and the clinical work, behavioral, cognitive-behavioral, Rational-Emotional, humanistic, existential, group, feminist, Ericksonian and family system psychotherapies often endorse many forms of helpful boundary crossings (Lazarus, 1994; Williams, 1997). Additionally, boundary crossing, when executed with the clients' welfare in mind, is likely to enhance therapeutic alliance, the best predictor of therapeutic outcome.

Following are examples of beneficial boundary crossings and, when appropriate, the orientations or settings that support such interventions are included (Note: *None* of the following interventions constitute dual relationships):

- Behavioral therapy endorses walking with an agoraphobic client to an open space outside the office or flying with a fear-of-flying client on an airplane as part of an exposure or in vivo intervention.
- Child psychologists, and other psychologists who work with children, routinely leave the office for walks with them and or perhaps attend school plays in which they are performing. They also regularly touch and hug, provide snacks and drinks, play cards and exchange small gifts and photos with their young clients.
- Albeit for different reasons, cognitive, behavioral, cognitive-behavioral, feminist, group, humanistic, feminist and existential therapies all endorse self-disclosure as a way of modeling, offering an alternative perspective, exemplifying cognitive flexibility, creating authentic connections, increase therapeutic alliance or leveling the playing field.
- Behavioral and family therapy support joining an anorexic or bulimic client for a lunch or for a family dinner.
- Humanistic therapies are apt to frown upon therapists who never self-disclose, touch, hold, or hug their clients.
- Many adolescent psychologists would not hesitate to go for a walk with a resisting, reluctant or irresponsive adolescent in order to break the ice. We have seen how this concept of boundary crossing has already filtered into our entertainment culture. Robin Williams, playing the therapist in the movie, *Good Will Hunting*, had the right attitude regarding boundaries when he decided to effectively break the ice by taking the highly resistive and distrustful young client, played by Matt Damon, to the riverbank for a walk.
- Therapists who work with different cultures inevitably join their Native American clients in some of their sacred rituals, their Latin clients in weddings, their Catholic clients in confirmations, or their Jewish clients for Bar or Bat Mitzvahs. Refusing to do so in certain settings is likely to cause irreparable damage to the therapeutic alliance, nullify trust and render therapy ineffective.
- Psychologists who work in poor, rural communities are often engaged in bartering arrangements, which may be the only way for people there to access mental health services. Bartering with cash-poor and art-rich artists is also a common practice.
- If it is likely to benefit the client, therapists of many non-analytic orientations, will:
  - Go on a home visit to an ailing, bedridden or dying client. Such a visit also gives them a much better firsthand sense of the broader clinical context of their clients.
  - Take a depressed, medically noncompliant client on a vigorous walk.
  - Accompany a fearful client to a medically crucial but dreaded medical procedure.
  - Join a client-architect on a tour of her newest construction, a winery owner on a tour of his beloved winery or a proud sculptor to the opening of an exhibition of her work.
  - Escort a client to visit a gravesite or a place that held special meaning for the client and their deceased loved one in order to facilitate the grief process.
  - Join an addict at a first 12-step meeting.

Dual Relationships
Dual relationships are subtypes of boundary crossing. Psychologists practicing in rural and small communities encounter numerous unavoidable dual relationships in the course of their daily lives. The person who bags groceries in the supermarket, pumps gas, works in a dentist's office or chaperones children on school field trips may often also be the therapist's client. Relationships in such small communities can get even more complex when people choose their therapists *because* they know them and not because they saw their ad in the Yellow Pages. A therapist's fellow congregation member, teammate in a local sports league or car dealer may all choose their psychologist because they have come to know him or her personally and they share values, attitudes, morals and or spiritual values. Like many other boundary crossings, such unavoidable dual relationships are not limited to rural or small communities; they are the norm within numerous small populations in larger metropolitan areas, e.g., gay/lesbian, handicapped, various minorities, religious congregations, and other such distinct small societies. In fact, duality, mutual dependence and prior knowledge of each other are prerequisites for the development of trust and respect in these communities. Non-sexual, non-exploitative dual relationships and familiarity between therapists and clients are not only normal but, in fact, increase trust. This enhances the therapeutic alliance, which is recognized as the best indicator of therapeutic results (Lambert, 1991; Norcross & Goldfried, 1992). Another excellent example is the military where, whether on a ship or in an isolated and remote base on foreign soil, dual relationships are not only unavoidable, but, in fact, mandatory.

It is important to differentiate between boundary crossing and dual relationships. Making a home visit to a bedridden patient or accompanying an acrophobic client to an open space, like many other 'out-of-office' experiences are boundary crossings that do *not* necessarily constitute dual relationships (Zur, 2001). Similarly, exchanging gifts, self-disclosure, bartering of goods (not services) or extending the therapeutic hour when needed are also boundary crossings but not dual relationships.

While dual relationships may be sometimes unavoidable, psychologists must nevertheless pay attention to the harm that can arise from them, especially where there is a conflict of interest. Conflicts of interest are often present in situations where the client is also a student, employee, employer or business partner. Of course, sexual dual relationships are always unethical, counter-clinical and illegal in most states.

The Ethics of Boundaries
Despite the prevalent belief to the contrary, there are no ethics codes or guidelines, which specifically deal with boundary crossings. The APA's and almost all other professional organizations' codes of ethics do not regulate non-sexual touch, gifts, length of sessions or self-disclosure. Of course, they all have a mandate to avoid harm and exploitation and respect clients' integrity and autonomy. The new APA Code of Ethics of 2002 has taken a positive step in regard to boundaries and dual relationships issues. It drops the sentence, "Psychologists ordinarily refrain from bartering", that appeared in the 1992 code and adds the sentence, "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (APA, 2002, section 3.05), to the multiple relationships section. Just as important are clarifications that the new APA code provides in its Introduction and Applicability sections where it finally explains what some of the modifiers that are used in the Code (e.g., *reasonably, appropriate, potentially*) mean. More specifically it states: "As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time" (APA, 2002, Introduction). The importance of this clarification is that hopefully it will stop the experts, courts and ethics committees from using the analytic or urban yard stick to judge non-ana-

lytically oriented psychologists who strategically employ boundary crossing type interventions or work in small or rural communities where boundary crossing and dual relationships are unavoidable.

Boundary Crossings and the Standard of Care

The standard of care is defined as qualities and conditions that prevail or should prevail in a particular mental health service and that a reasonable and prudent practitioner follows. The standard is based on community and professional standards, as well as on state laws, case law, licensing boards' regulations, a consensus of professionals, ethics codes of professional associations and a consensus in the community. The standard of care is not an objective yardstick to be found in any textbook. It is closely tied to a theoretical orientation. The examples of boundary crossings mentioned above clearly fall within the standard of care of behavioral, humanistic, family, and other non-analytic therapies. Regretfully, boards, courts and ethics committees too often confuse the standard of care with the analytic standards or with risk management guidelines (William, 1997). This confusion has caused tremendous injustice and immense suffering to therapists due to many boards' and courts' experts who routinely and mistakenly apply an analytic criterion and pronounce clinically appropriate boundary crossings and dual relationships, such as those mentioned above, to be below the standard of care.

The Slippery Slope Argument

There is a prevalent and unfounded belief in the 'slippery slope' argument, which claims that boundary crossings inevitably lead to boundary violations. It refers to the idea that failure to adhere to rigid boundaries and an emotionally distant form of therapy will ultimately foster exploitive, harmful and sexual dual relationships (Guthiel & Gabbard, 1993, Pope, 1990). This paranoid approach is based on the 'snowball' dynamic that asserts that giving a simple gift is the precursor of an exploitive business relationship; a therapist's self-disclosure inevitably becomes an unhealthy social relationship; and a non-sexual hug will quickly devolve into a harmful sexual relationship. To allege that self-disclosure, a hug, a home visit, or accepting a gift are likely to lead to sex and harm is, in Lazarus' words "an extreme form of syllogistic reasoning" (1994, p. 257).

Sexualizing Boundaries

The rigid attitude toward boundary crossings stems in part from what Dineen (1996) called 'sexualizing boundaries." This is a skewed view that sees all boundary crossings as sexual in nature as illustrated in the slippery slope argument. Simon (1991), for example, decrees that: "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself" (p. 614). Similarly, Pope (1990) states " . . . non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships" (p. 688). These unreasonable beliefs link any deviation from risk management or analytic guidelines to sexual exploitation.

To Cross or Not to Cross

Intentional boundary crossings should be implemented with two things in mind: the welfare of the client and therapeutic effectiveness. Boundary crossing, like any other intervention, should be part of a well-constructed and clearly articulated treatment plan which takes into consideration the client's problem, personality, situation, history, culture, etc. and the therapeutic setting and context. Boundary crossings with certain clients, such as those with Borderline Personality Disorders or those who are acutely paranoid are not usually recommended. Effective therapy with such clients often requires well-defined boundaries of time and space and a clearly structured therapeutic environment. Dual relationships, since they always entail boundary crossing, impose the same criteria on the therapist. Even when such relationships are unplanned and unavoidable, the welfare of the client and clinical effectiveness will always be the paramount concern.

Boundaries are like fences; they are man-made and are designed to separate. Their

function is to "fence in" and "fence out", to include and exclude. Being man-made, they can be constructed or dismantled, heightened or lowered, and made more or less permeable. Psychotherapy boundaries are an inherent part of the therapeutic setting. They have been the focus of psychoanalysts for clinical-transferential reasons. Consumer protection agencies, boards and professional organizations have focused on the boundary issue in order to guard clients from exploitative therapists.

The Concern with Rigid Boundaries

As to whether psychotherapy boundaries serve the protective purpose for which they were erected, I have two major concerns:

Firstly, I am concerned that rigid implementation of such boundaries decreases therapeutic effectiveness. As outlined above, there are numerous proven clinical and evidence-based interventions that fall under the heading of boundary crossings. These theoretically sound interventions are often not utilized due to therapists' fears and their rigid adherence to risk management principles. As a result of this apprehension, many clients receive sub-standard care. Lazarus (1994) underscored that: "One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions" (p. 260). Additionally, outcome research has documented the importance of rapport and warmth for effective therapy, and that rigidity, distance, and coldness are incompatible with healing. Appropriate boundary crossings and dual relationships are likely to increase familiarity, understanding, and connection hence, increasing clinical effectiveness (Lambert, 1991; Lazarus & Zur, 2002, Norcross & Goldfried, 1992).

Secondly, I am concerned that the isolation imposed by rigid boundaries increases the likelihood of exploitation of, and harm to, clients. Exploitation, as a rule, happens in isolation (i.e., child abuse, domestic violence, cults). As with any kind of abuse and exploitation, it is easier for predatory therapists to take advantage of their clients in the 'darkness' of isolation. In fact, many of our clients' early life abuse and neglect was made possible due to the isolation of their families. The boundaries, which are supposed to protect clients from exploitation, also increase the therapists' power and, therefore, increase the chance of a client being exploited (Zur, 2001).

SUMMARY

Boundary crossing in psychotherapy has usually referred to any deviation from traditional analytic and risk management practices, i.e., strict, 'only in the office,' emotionally distant forms of therapy. They refer primarily to issues of self-disclosure, gifts, touch, bartering and home visits. Dual relationships, a sub-type of boundary crossing, refer to situations where multiple connections exist between a therapist and a client. Boundary crossings are different from harmful boundary violations and, appropriately employed, can increase clinical effectiveness and therapeutic outcome. Dual relationships and other forms of boundary crossing are unavoidable in many small and interdependent communities, such as rural, military, minority, church, university campus, and among gays, the deaf, etc. Unlike harmful boundary violations and sexual or exploitative dual relationships, neither boundary crossing nor dual relationships are unethical or below the standard of care. Behavioral, cognitive-behavioral, family, group, and existential therapeutic orientations are the most practiced orientations today. These approaches tend to endorse many types of boundary crossings that are considered clear boundary violations by many psychoanalysts and risk management advocates. In fact, feminist, humanistic, and existential orientations view the tearing down of artificial and rigid boundaries as essential for therapeutic effectiveness and healing. Boundary crossings should be implemented according to the client's unique situation, condition, problems, personality, culture, and history and the setting in which therapy takes place. The rationale of boundary crossing, like any therapeutic intervention, should be articulated (in writing) in the treatment plan and

consultations with experts are advised in complex cases. The unduly restrictive analytic risk-management emphasis on clearly defined, rigid, and inflexible boundaries often interferes with sound clinical judgment, which ought to be flexible and personally tailored to clients' needs rather than to therapists' dogmas or fears.

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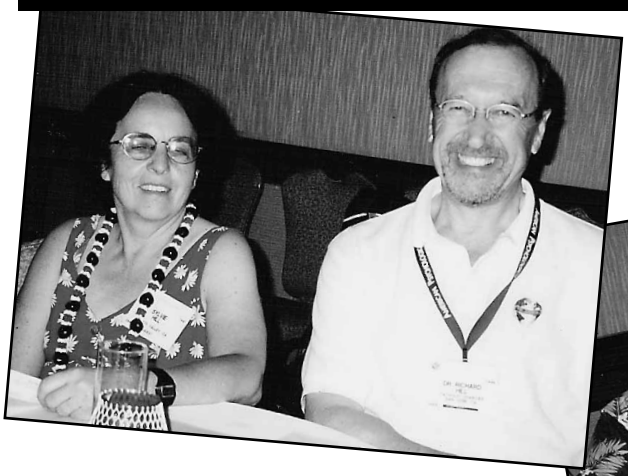
DIVISION 29 MEMBERS RECONNECTING



AMERICAN PSYCHOLOGICAL FOUNDATION
2005 Randy Gerson Memorial Grant

The American Psychological Foundation (APF) announces the Randy Gerson Memorial Grant to be given in 2005. For the 2005 cycle of the grant, graduate students engaged in doctoral studies are invited to apply. The grant has been created to advance the systemic understanding of family and/or couple dynamics and/or multi-generational processes. Work that advances theory, assessment, or clinical practice in these areas shall be considered eligible for grants through the fund.

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

ELIGIBILITY REQUIREMENTS:

Applicants from a variety of educational settings are encouraged to apply. Awards will be given in alternate years to students and professionals. The 2005 grant will go to a graduate student engaged in doctoral studies.

APPLICATIONS MUST INCLUDE:

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

PROCEDURE:

Submit entire application electronically to APF (foundation@apa.org) by February 1, 2005. Applicants will be notified on or after April 15, 2005.

Amount of Grant: $5,000.00

Deadline: February 1, 2005

FOR ADDITIONAL INFORMATION:

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

The APF encourages applications from individuals that represent diversity in race, ethnicity, gender, age, and sexual orientation.

Call for Applications

The American Psychological Foundation (APF) is requesting proposals for the Randy Gerson Memorial Grant. The Gerson Grant provides a $5,000 grant consistent with the goal of advancing the systemic understanding of couple and/or family dynamics and/or multi-generational processes. Work that advances theory, assessment, or clinical practice in these areas shall be considered eligible for grants through the fund. A strong preference will be given to projects using or contributing to the Bowen family systems theory. Priority will also be given to those applicants furthering the work of Dr. Gerson.

Eligibility: Individuals from a variety of educational settings are encouraged to apply. The 2005 award will go to a graduate student engaged in doctoral studies.

Deadline for applications: February 1, 2005

For application procedures and additional information, contact:
APF Awards Coordinator/Gerson • 750 First Street, NE • Washington, D.C. 20002-4242
202-336-5814 • foundation@apa.org

Personal Involvement Makes All the Difference

by Pat DeLeon, former APA President

Children And Youth Are More Than Little Adults – This Spring, the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP) held a hearing entitled "Mental Health in Children and Youth: Issues Throughout the Developmental Process." U.S. Senator Susan Collins noted: "Serious mental illness afflicts millions of our nation's children and adolescents. It is estimated that as many as 20 percent of American children under the age of 17 suffer from a mental, emotional or behavioral illness. What I find most disturbing, however, is the fact that two-thirds of all young people who need mental health treatment are not getting it. Behind each of these statistics is a family that is struggling to do the best it can to help a son or daughter with serious mental health needs to be just like every kid – to develop friendships, to do well in school, and to get along with their siblings and other family members...."

Two APA colleagues testified that morning, providing interesting and yet different psychological perspectives. [Joy Osofsky]: "Despite what we know from science and research, discussions on children's mental health have consistently excluded babies and toddlers, focusing instead on school-age children and adolescents. Although they cannot talk to us about what they are feeling like older children can, babies and toddlers have many ways of communicating, and we have many ways to assess their social and emotional needs. Most babies experience healthy social and emotional development. They smile and coo, cry and recover, and become social beings.... Attachment is one of the most critical developmental tasks of infancy. We know from the science of early childhood development that early relationships and attachments to a primary caregiver are the most consistent and enduring influence on social and emotional development for young children.... Unfortunately, some infant and toddlers experience mental health problems. The early social and emotional development of babies and toddlers is vulnerable to such factors as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as prematurity and low birth weight, and conditions associated with prenatal substance abuse. Without intervention, these risk factors can result in mental health disorders.... Unlike adults, babies and toddlers have fairly limited ways of responding to stress and trauma.... Babies do not exist in isolation. The parent's mental health can also affect the young child.... There are many good reasons to care about early social and emotional development.... Young children who do not achieve early social and emotional milestones perform poorly in early school years, and are at higher risk for school problems and juvenile delinquency later in life...."

[Louise Douce]: "I oversee the provision of a broad range of mental and behavioral health services to nearly 50,000 students each year. I appreciate this opportunity to speak with you today about the growing mental and behavioral health needs of college students.... During the period from 1975 and 1995 colleges and university counseling centers saw a dramatic increase in both the numbers and severity of mental health concerns.... More specifically, a research consortium of 36 counseling centers found increases in anxiety, fear and worries and dysfunctional behavior including eating disorders, alcohol and substance abuse and anger/hostility. They also reported increases in the impact of violence, family dynamics, depression and bipolar disorder.... In the years ahead, I would expect to see the trend of an increasing number of students seeking mental and

behavioral health services to continue – if not grow at a more significant pace. Current research suggests that more students are entering college with prior treatment histories of severe mental illness now controlled with medication, a great thing. However, they may have more difficulty with adjustment to change and are at increased risk of relapse or reoccurrence without appropriate mental health support.... Let me speak to one of the most serious issues in this population, suicide. Suicide is the second leading cause of death among college students. A 2000 survey by the American College Health Association found that within the last year 33% of college students reported feeling hopeless, 22% said they felt so depressed they could barely function, 9% seriously considered suicide; and, 1.5% had actually attempted suicide...." Psychology's scientific and clinical expertise can make a difference in the lives of our nation's families and their loved ones.

An Evolving Awareness – We have been very pleased with the extent to which, over a prolonged period of time, an increasing number of colleagues have made highly tangible and lasting contributions to society. Psychology (i.e., the behavioral sciences) has much to contribute to improving the daily lives of our nation's (and the world's) citizens. Collectively, we are beginning to appreciate that it takes vision, personal commitment, and active participation in the public policy (i.e., political) process to effectively share our expertise with those who ultimately establish the relevant public policies – whether this be in health, education, housing, or any number of other arenas. As highly educated professionals, we can make a real difference on the national, global, and at the extraordinarily important local level. However, to accomplish this objective, we must be personally involved.

At the National Level – Richard McKeon, former APA Congressional Science Fellow, attended the Democratic National Convention in Boston as an elected delegate from the 8th Congressional District in Maryland. Richard was the first Catherine Acuff Fellow in 2001-2003, where he served in the Office of U.S. Senator Paul Wellstone. His Fellowship year on Capitol Hill was marked by momentous events, including September 11th and the anthrax attacks. While with Senator Wellstone, he covered a range of health and mental health policy issues, including bioterrorism, Medicare and Medicaid, domestic violence, medical devices, muscular dystrophy, rural health, and others. At the conclusion of his Fellowship year, Richard stayed on with Senator Wellstone until the Senator's tragic death.

Following his tenure on the U.S. Senate staff, Richard remained involved in both policy and politics. He assisted in vetting Governor Howard Dean's mental health policy and in March ran as a Kerry delegate in the Maryland primary. He received 47,000 votes and was elected as a delegate. In addition to casting his vote at the Boston Convention; participating in policy briefings and forums; and being present for the addresses by former Presidents Clinton and Carter, and by the Presidential and Vice Presidential nominees John Kerry and John Edwards, Richard was particularly proud to have been able to cast his vote in support of the Democratic Party Platform. This was the first time that any political party had included in their party platform an endorsement of mental health parity. The Paul Wellstone Mental Health Equitable Treatment Act was named after the late Senator who for many years was its most vocal Democratic champion.

"The convention was an amazing experience. The energy and excitement was palpable. Each day started with a state delegation breakfast. For the Maryland delegation, that was an opportunity to hear from and talk with the state's U.S. Senators Paul Sarbanes and Barbara Mikulski; from the Maryland Congressional delegation; and guest speakers like Gov. Howard Dean, House Minority Leader Nancy Pelosi, and Gore 2000 Campaign Chair Donna Brazile. The days were filled with policy briefings, receptions, and trainings. An example was

an all day forum on health care at historic Fanueil Hall featuring Senator Ted Kennedy, Gov. Howard Dean, Senator Hillary Clinton, and numerous others. Mental health care was a frequent topic at the forum, with former Surgeon General David Satcher particularly prominent. Especially moving was Iowa Governor Tom Vilsack's passionate plea for the importance of mental health and substance abuse treatment in which he described his own experience as a child of an alcoholic parent, watching his family walking his mother around their home trying to keep her conscious after she took an overdose in a suicide attempt while intoxicated.

"The Convention touched an array of emotions for me. As a young boy who grew up idolizing Robert F. Kennedy, it meant a lot to me to be on the floor to listen to Senator Edward Kennedy; to reflect on the fact that for half a century, Democratic conventions had listened to historic speeches from John, Robert, and Ted Kennedy; and to become part of that tradition. There were moments of great uplift, such as Barack Obama's keynote address, and great sadness, such as hearing once again the voice of Senator Wellstone, as the Convention memorialized those leaders who had died in the past four years. Perhaps stronger than anything else, however, was the powerful sense of a community of people with shared values, united behind a single purpose. It was a privilege to be able to be part of that."

At the International Level – For many years, former APA CEO (and APA President) Ray Fowler has been on the "cutting edge" of psychology's international activities. During my tenure as APA President, Ray provided the Board of Directors with an absolutely invaluable perspective during one of our retreat discussions. He pointed out, for example, that: "We [in the U.S.] are a very small piece of the world's population and only 20 percent of the world's psychologists [100,000 of the estimated 500,000]. Psychology around the world is experiencing the kind of explosive growth we had post-WWII. In another decade or so, there will probably be a million psychologists in the world." Accordingly, it was very nice to see Ray in Honolulu and learn that he and his wife Sandy were soon to be en route to China.

"It was good to see you at the APA convention in your favorite state. The great success of the convention certainly confirmed the wisdom of your strong recommendation seven years ago that it was time to return to Hawaii. From the delightful opening ceremony through the closing, I thought the convention was well planned and very enjoyable. I was no exception in enjoying the convention; I didn't see anyone who didn't. Despite dire warnings that everyone would desert the convention for the pleasures of Oahu, it was particularly good to see the meeting rooms filled and workshops well attended. I am sure it won't be 32 years before APA returns to Hawaii. I heard people suggesting that we start meeting there on a regular basis.

"Immediately after the convention, I left for the International Congress of Psychology (ICP) in Beijing, as did many other APA members, including President Diane Halpern and CEO Norman Anderson. With a few days to spare before the congress began, Sandy and I flew to Shanghai and took an overnight train to Jinan (a memorable experience of roughing it) where the members of the International Council of Psychologists were holding their annual meeting and then flew to Bejing.

"The International Union of Psychological Sciences (IUPsyS) sponsors a major international congress every four years and the International Association of Applied Psychology (IAAP) holds its congress two years later. The two organizations cooperate in many ways, and participate actively in each other's congresses. IUPsyS is sometimes called the United Nations of psychology. Its members are 65 national organizations; most of the nations of the world are represented in its membership. IAAP is an organization of individual members; its membership includes psychologists from 90 countries.

"The Congress in Beijing, sponsored by IUPsyS, was the first major psychological meeting ever held in China. It was scheduled a week after the APA convention to encourage the attendance of APA members. Despite worries that the expense of flying to China might discourage potential attendees, the Congress attracted over 5000 participants and a comparable number of professional papers and symposia. Since psychology has had a difficult time in China, having a successful congress was particularly important, and a success it was, starting with the opening ceremony keynoted by Nobel Laureate and APA member Daniel Kahneman, whose exciting paper was followed by Chinese acrobats doing things one would not believe a human body could do.

"The Chinese Psychological Society and APA were isolated from each other for several decades as a side effect of the cold war between our respective governments, but we have had a warm relationship since relationships were reopened in the 1970s. I had the good fortune of being the first U.S. psychologist to visit the Chinese Institute of Psychology in 1979 after friendly relationships resumed between our countries. I went to represent the APA Board of Directors and extend an invitation to the Chinese Psychological Association to attend the next APA convention. Professor Qicheng Jing, Vice President of the Chinese Psychological Society, attended the 1980 convention in New York and gave a moving address to the Council of Representatives about the troubles experienced by Chinese psychologists during the culture wars of the 1970s. Professor Jing was the President of the Beijing Congress and a major spearhead in its planning and development.

"The election for a new President of the International Union of Psychological Sciences took place during the congress, and APA Board of Directors member Bruce Overmier easily defeated candidates from Mexico and South Africa. Bruce will lead this important organization for four years, concluding his presidency at the 2008 congress in Berlin. For perhaps the first time in the long history of IUPsyS, all four officers are APA members: Canadians Pierre Ritchie (Secretary-General) and Michael Sabourin (Treasurer). Merry Bullock, Deputy Secretary-General, is the associate executive director for science at APA. APA's strong and active international outreach is highly respected by psychologists in other counties, and should certainly be a source of pride to all APA members."

At The All Important Local Level – The 21st century will be an era of interdisciplinary collaboration and psychology's active involvement within our nation's health care arena. Those of us who are supportive of psychology's prescriptive authority agenda (RxP-) see this as a natural expansion of psychological practice. Unprecedented changes and challenges are definitely in the winds. The Veterans Administration (VA) recently promulgated proposed modifications in its Patients' Rights regulations to bring the provisions regarding medication into conformity with current law and practice. The changes are primarily intended to clarify that it is permissible for VA patients to receive medication prescribed by any health care professional legally authorized to prescribe medication. "When VA promulgated the patients' rights rule in 1982, physicians were generally the only health care providers authorized to prescribe medication.... However, that is no longer the case. Under current law, other health care professionals are legally licensed to prescribe medication and typically do so in health care settings across the Nation. For example, licensed registered nurse practitioners are licensed to independently prescribe medication in virtually every state in the United States.... VA is proposing to eliminate the specific references to physicians... and to substitute references to appropriate health care professionals."

Similarly, Morgan Sammons has noted that a recent report from the Center for Mental Health Services (HHS) reflects a similar appreciation for the evolving contributions of non-physician providers: "(A)dvances in psychopharmacology and expansion of the professions able to prescribe medication for the treatment of mental illness are

expected to have major consequences on the ability to effectively treat mental health consumers as well as on the number of active specialty service providers. These advances are most likely to have consequences for the professional groups that now have or can be expected to gain prescription writing privileges as well as those professional groups that the prescription writing professions supervise. Whereas psychiatrists and other physicians now have the right to prescribe medications for the treatment of mental illness, other specialty services providers – for example, Ph.D.-level clinical psychologists and master's-level psychiatric nurses – are gaining the privilege, with proper training, to provide medications for the care of persons with mental illness. When they gain this privilege, their number should increase, particularly in rural and frontier areas, where psychiatrists or child psychiatrists are few in number and primary care physicians may prefer to refer mentally ill persons to specialty providers."

In many ways, the next frontier for psychology's RxP- scope of practice agenda will be at the state and local level, rather than at the federal level. The DoD Psychopharmacology Fellows have proved beyond all reasonable doubt that psychology can learn to competently and cost-effectively prescribe. Professional psychology is well aware of the APA Practice Directorate's impressive legislative successes in New Mexico, Louisiana, and Guam (with some even appreciating Indiana's success back in 1993).

The key to legislative success is developing a credible foundation. Accordingly, we were particularly pleased to learn from Bob McGrath (Director of the Fairleigh Dickinson University RxP- training program) that: "Last Spring, the New Jersey Psychological Association approached the New Jersey Board of Psychological Examiners requesting a formal statement indicating consultation with patients concerning medication falls within the practice of psychology. On July 12, 2004, the New Jersey Board adopted the following statement: 'The Practice of psychology may include the observation and monitoring of the effects and effectiveness of pharmacologic interventions on individual's psychological functioning (e.g., affect, mood, cognition and behavior). The monitoring of pharmacologic effects should be grounded in relevant clinical observation, psychological assessment and/or neuropsychological assessment. Psychologists may engage in consultation with physicians regarding the potential observed effects of medications on psychological conditions; however, psychologists should refer to a physician or appropriate medical provider for the management of medications. Psychologists should be aware of the limitations of their knowledge regarding medication effects (such as medical contra-indications, side effects, drug interactions, or the effects of medications on multiple physiological systems)....' In a letter dated July 16, 2004, the Managing Executive Director of the Board clarified.... 'The issue of such discussions with patients is implicit in the language of the policy' (presumably because consultation with another professional implies prior consultation with the patient)."

In-depth discussions with elected and appointed officials are important and definitely do make a difference. They establish the foundation for mutual understanding and respect over the years. In issuing this RxP- policy statement, the New Jersey Board of Psychological Examiners joined nine other state boards (OK, PA, LA, CA, DC, MA, FL, MO, and NH), with the Ohio Board having modified its regulations. Three of the four members of Hawaii's Congressional delegation served at one point in their careers as members of our Territorial and/or State legislature. I would rhetorically ask: How many of our readers know who are their representatives in their local House and Senate (not to mention at the federal level)? And, How many have actually met with these elected officials within the past year? Personal involvement is the key to having psychology's collective voice heard by those who represent society's interests. Aloha,

Control-Mastery Theory Telephone Case Conferences

Alan Rappoport, Ph.D.

This is to announce openings in two Control-Mastery Theory case conferences being held via telephone. These teleconferences make training in the theory available to anyone, regardless of location. Each conference has a different structure and purpose, and you are invited to participate in either or both of them.

In the *case study* conference, we focus on one case at a time. We follow that case exclusively for several weeks, starting at its inception, to help participants gain experience in building in-depth case formulations. We watch how the psychotherapy process unfolds over time, and see how well our hypotheses about the case are borne out. We also discuss theoretical and practical issues that arise in relation to the case. This conference meets on Mondays at 10:00AM, Pacific Time.

In the second format, the *case consultation* conference, each participant has the opportunity to present his or her own case material. Two or three people may present during each session. In this conference, we use the theory to help participants understand and overcome problems they may have with particular cases. We also attend to countertransference issues and discuss general theoretical matters. This conference meets on Tuesdays at 12:00NOON, Pacific Time.

Each teleconference meets weekly for fifty-five minutes. The fee is $40 per week.

Teleconferences are very time-efficient, since attendance requires no additional time for travel. The fifty-five minute format is designed to fit into clinicians' typical schedules.

Please contact me at arappoport@alanrappoport.com, or at 650-323-7875, for further information. You can also visit my website, www.alanrappoport.com, for more information about me and my work.

AMERICAN PSYCHOLOGICAL FOUNDATION

GOLD MEDAL AWARDS

The American Psychological Foundation (APF) invites nominations for the APF 2005 Gold Medal awards. The awards include a medal, $2,000 (to be donated by APF to the charitable institution of the winner's choice), and an all-expense-paid trip for the award winner and one guest to the 2005 APA convention in Washington, DC, for two nights and three days. (Coach round-trip airfare, and reasonable expenses for accommodations, and meals for two individuals will be reimbursed.) The Gold Medal awards recognize life achievement in and enduring contributions to psychology. Eligibility is limited to psychologists 65 years or older residing in North America. Awards are conferred in four categories:

- Gold Medal Award for Life Achievement in the Science of Psychology recognizes a distinguished career and enduring contribution to advancing psychological science.

- Gold Medal Award for Life Achievement in the Application of Psychology recognizes a distinguished career and enduring contribution to advancing the application of psychology through methods, research, and/or application of psychological techniques to important practical problems.

- Gold Medal Award for Enduring Contribution by a Psychologist in the Public Interest recognizes a distinguished career and enduring contribution to the application of psychology in the public interest.

- Gold Medal Award for Life Achievement in the Practice of Psychology recognizes a distinguished career and enduring contribution to advancing the professional practice of psychology through a demonstrable effect on patterns of service delivery in the profession.

Nomination Process: Gold medal award nominations should indicate the specific award for which the individual is nominated and should include a nomination statement that traces the nominee's cumulative record of enduring contribution to the purpose of the award, as well as the nominee's current vita and bibliography. Letters in support of the nomination are also welcome. All nomination materials should be coordinated and collected by the chief nominator and forwarded together in one package. (Note: There is no nomination form.)

The deadline for receipt of complete nomination materials is **December 1, 2004;** complete nomination packets should be mailed to the Gold Medal Awards Coordinator, American Psychological Foundation, 750 First Street, NE, Washington, DC 20002-4242.

CALL FOR NOMINATIONS • DIVISION 29 FELLOWS

Deadline for nominations: Oct.15, 2004.

Deadline for receipt of all application materials: November 15, 2004

Letters of nomination and requests for application materials should be sent to:

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

The Division offers its congratulations to our 2004 Fellows:

Initial Fellows:
Jacques Barber
Steven Gold

Current Fellows approved for Division 29 Fellow status:

Jerry Grammer
Nadine Kaslow
Scotty Hargrove
Doug Haldeman
Brent Mallinckrodt
Bruce Wampold
Lillian Comas-Diaz

CALL FOR AWARD NOMINATIONS

The APA Division of Psychotherapy invites nominations for its two annual awards in 2004. *The Distinguished Psychologist Award* recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy. *The Jack D. Krasner Memorial Award* recognizes promising contributions to psychotherapy, psychology, and the Division of Psychotherapy by a Division 29 member with 10 or fewer years of post-doctoral experience.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 2005 Awards Chair: Linda Campbell, Ph.D., University of Georgia, 402 Aderhold Hall, Athens, GA 30602-7142, Ofc: 706-542-8508 Fax: 770-594-9441, E-Mail: lcampbel@uga.edu. The applicant's CV would also be helpful. Self-nominations are welcomed. Deadline is January 1, 2005

Call for Nominations • Rosalee G. Weiss Award

The Rosalee G. Weiss Award is a joint award, bestowed by the Divisions of Psychotherapy and Independent Practice in alternate years and administered by the American Psychological Foundation. It was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee. The lecturer receives $800 honorarium

The Awards Committee shall employ the following guidelines for the selection of the recipient of the Rosalee G. Weiss Award:

1. Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology; or,
2. Outstanding leaders in any of the special areas within the spheres of psychology.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 2005 Awards Chair: Linda Campbell, Ph.D., University of Georgia, 402 Aderhold Hall, Athens, GA 30602-7142, Ofc: 706-542-8508 Fax: 770-594-9441, E-Mail: lcampbel@uga.edu. The applicant's CV would also be helpful. Self-nominations are welcomed. Deadline is January 1, 2005

AMERICAN PSYCHOLOGICAL FOUNDATION

Charles L. Brewer Distinguished Teaching of Psychology Award

The American Psychological Foundation (APF) invites nominations for the APF 2005 Charles L. Brewer Distinguished Teaching of Psychology Award.

THE AWARD:
The awardee receives a plaque, a $2,000 check, and a two-night, three-day, all-expenses-paid trip to the American Psychological Association's (APA) 2005 annual convention, in Washington, DC, where the award will be presented.

REQUIREMENTS:
The award recognizes a career contribution to the teaching of psychology. The APF Teaching Subcommittee selects a psychologist for the award who has demonstrated:

- Exemplary performance as a classroom teacher;
- Development of innovative curricula and courses;
- Development of effective teaching methods and/or materials;
- Teaching of advanced research methods and practice in psychology; and/or,
- Administrative facilitation of teaching;
- Research on teaching;
- Training of teachers of psychology;
- Evidence of influence as a teacher of students who become psychologists.

APPLICATION PROCESS:
APF provides nomination forms. Nominations should include the form, a statement that illustrates how the nominee fulfills the guidelines of the award, and the nominee's current vita and bibliography. Letters in support of the nomination are welcome. All materials should be coordinated and collected by the chief nominator and forwarded to APF at the same time.

The deadline for receipt of materials is **December 1, 2004**. Requests for nomination forms and completed nomination packets should be mailed to the APF Charles L. Brewer Teaching Award Coordinator, 750 First Street, NE, Washington, DC, 20002-4242. Requests for nomination forms may also be sent to foundation@apa.org.

DIV 29 CANDIDATES FOR APA PRESIDENT

Gerard Koocher

I am a practitioner

- I am licensed as a psychologist in MA and NH and belong to both SPAs.
- I hold 5 ABPP diplomas (clinical, child and adolescent, family, forensic, and clinical health psychology).
- My practice includes individual psychotherapy with children and adults, family therapy, and child custody evaluations, as well as divorce mediation. I specialize in working with families and individuals confronting chronic and life-threatening illness.

I am a behavioral scientist

- Served as Principal Investigator on competitive research grants worth more than $3.2 million in direct costs from private foundations and federal agencies including the Commonwealth Fund, National Cancer Institute (NCI), National Heart Lung and Blood Institute (NHLBI), National Institute of Mental Health (NIMH), and National Institute of Neurological Disorders and Stroke (NINDS).
- Currently serve as a member of the NIMH Data Safety Monitoring Board for autism studies.
- Published more than 75 peer-reviewed articles in premier psychology and medical journals, and an additional 75 book chapters.
- Served as Editor of four scholarly journals and as a consulting editor to ten.
- Published eleven books, including three widely used textbooks.

I am an experienced educator

- Faculty member at Harvard Medical School, 30 years; Chair of academic department at the nations' premier pediatric teaching hospital.
- In addition to Harvard, taught both undergraduate and graduate students at the University of Missouri, Boston College, Boston University, Northeastern University, and Simmons College.
- Currently, tenured Professor of Psychology and Dean of Health Studies at Simmons College.
- Served as a Trustee of the Massachusetts School of Professional Psychology for 23 years, currently Vice Chair of Board.

I am a public interest advocate

- Served as a public-interest trustee and Chair of the Association for the Advancement of Psychology.
- Served as trustee and President of Community Mental Health Center over two decades
- Received American Psychological Association's Award for Distinguished Professional Contributions to Public Service.
- Served as a member of the National Advisory Board for Ethics and Reproduction.

I have the leadership experience to guide and speak for psychology

- Served as President of Massachusetts and New England Psychological Associations
- Elected a Fellow of twelve APA Divisions (1, 7, 9, 12, 18, 29, 37, 38, 41, 42, 53, and 54)
- Served as President of three APA Divisions: 12 (Clinical), 29 (Psychotherapy), 37 (Child, Youth, and Family), and of the section on Clinical Child Psychology (now Division 53) and Society of Pediatric Psychology (now Division 54).
- Served with distinction in APA governance: Council Representative from Massachusetts (3 terms, 9 years total); Committee on Children Youth and Families (4 years, 2 as Chair); Ethics Committee (3 years); Finance and Investment Committees (13 years total, 10 as Chair); Committee for the Advancement of Professional Practice (10 years); and Publications and Communications Board (10 years); APA Insurance Trust Trustee (10 years); APA Board of Directors (2 terms, 10 years as Treasurer).

Lawrence Ritt

Why am I a candidate? I am very concerned about the negative perceptions held by many members who are not directly involved in APA governance. They complain that "APA is out-of-touch…not very relevant to my professional life…doesn't seem to care what I think." Although perhaps not accurate, such perceptions need to be addressed and corrected because they obviously impact member satisfaction and involvement, retention, and recruitment.

State and provincial associations continuously seek feedback from members and modify their governance, budgetary priorities, conventions, and every other aspect of their organizations based on what members tell them. My book publishing company sends a "*60 Second Critique*" card out with every shipped order….and I make sure all questions and critiques receive a personal response. Yet, in my 30+ years of APA membership, I can never recall anyone at APA asking **"How are we doing?"**, **"What can we do better?"**, or **"What Can APA Do for <u>You</u>?"** If I am elected APA President, I will make APA more responsive to the needs of its members. Among my first initiatives will be:

- The development of a broad-based working group that will use APA's existing research and quick survey capabilities to assess a wide range of member expectation, satisfaction, and quality improvement variables.
- The establishment of mechanisms for disseminating and addressing the findings and recommendations of the working group within all Boards, Committees, Divisions, and State & Provincial Associations.
- Establish **"We are elected and employed to serve our members"** as a guiding principle at APA.
- Encourage members of divisions and state-provincial associations to become involved in APA governance and bring their insights, knowledge and skills to help grow new ideas and behaviors within APA.
- Seek "grassroots" member input into a wide range of governance decisions including choice of convention dates and venues, long term program priorities and goals, etc.
- Establish a cycle of 10-20 year "Sunset Reviews" of all APA Boards and Committees including calls for input from members regarding the continuing need for each committee/board.

Who am I? Doctorate in clinical psychology from an APA-approved program · Independent practice 1974-1998 · President of Professional Resource Press.

APA - 9 years on Council of Representatives · Co-chair of the Finance Committee · Chair of the Caucus of State and Provincial Representatives · Chair of the Public Information Committee · Member of the Continuing Professional Education Committee · Member of the Assembly of Scientist/Practitioner Psychologists, Society of Clinical Psychology, and Divisions of Psychotherapy, Independent Practice, Social Issues, State Affairs, Psychology & Law, Men and Masculinity, and Psychopharmacology.

Florida Psychological Association (FPA) – President · 18 years on Board of Directors · Treasurer · Chair of Political Action Committee (PAC) · FPA awards as "Distinguished Psychologist," "Outstanding Contributions to Professional Psychology," and FPA's Women's Division award for "selfless dedication to the betterment of women within FPA, as well as APA…"

Steering committee and participant in the National Conference on the Scientist-Practitioner Education and Training for the Professional Practice of Psychology ("The Gainesville Conference").

ISN'T THIS WHERE YOU BELONG?

29 - THE DIVISION OF PSYCHOTHERAPY

In challenging times, the core issue for psychotherapists remains **competence**. Without that, even the best marketing plan for being a successful therapist will eventually fail. We are the only APA Division to offer a focus on integrating **research, practice** and **training** in psychotherapy. We are about being competent.

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  Quarterly publication containing the latest news about division activities, helpful articles on education, training, and practice, as well as current book reviews.

➪ **ANNOUNCING A NEW BENEFIT!**

- IN SESSION

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

➪ **REDUCED FEES FOR ALL DIVISION 29 WORKSHOPS**

We offer exceptional workshops at the APA convention featuring leaders in the field of psychotherapy. You have an opportunity to learn from the experts in more personalized settings.

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"Talk to Someone Who Can Help" is a series of brochures developed in collaboration with Division 42 (Independent Practice) to help practitioners expand their practices into new markets. Each order includes a professional skill building bibliography, resources for patients, and marketing tips. The brochures can be ordered with your name, address, and phone number printed on the back.

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Access to the Division 29 Listserv where you can network with other members, make or receive referrals, and hear the latest important information that affects the profession. Imagine being able to converse with colleagues all around the country (and across our borders) about your professional concerns.

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Expand your sphere of influence. Join us in helping to shape the future directions of our chosen field. There are many opportunities to serve on a wide range of Division committees and task forces.

MEMBERSHIP REQUIREMENTS
APA Member (Fellow, Associate, Member), payment of divisional dues; once you are a member, your Division 29 dues will appear on your APA membership dues invoice.

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

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Mesa, AZ 85215

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