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BULLETIN

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PSYCHOTHERAPY BULLETIN

Psychotherapy Bulletin is the official newsletter of Division 29 (Psychotherapy) of the American Psychological Association. Published four times each year (spring, summer, fall, winter), *Psychotherapy Bulletin* is designed to: 1) inform the membership of Division 29 about relevant and upcoming events, awards, and professional opportunities; 2) provide articles and commentary regarding a range of issues that are of interest to psychotherapy theorists, researchers, practitioners, and trainers; 3) establish a forum for students and new members to offer their contributions and perspectives; and, 4) facilitate opportunities for dialogue and collaboration among the diverse members of our association.

Contributors are invited to send articles (up to 4,000 words), interviews, commentaries, letters to the editor, and announcements as well as suggestions or questions regarding the newsletter to Craig N. Shealy, Ph.D., Editor, *Psychotherapy Bulletin*. Please note that *Psychotherapy Bulletin* typically does not publish book reviews (these are published in *Psychotherapy*, the official journal of Division 29). All submissions for *Psychotherapy Bulletin* should be sent electronically to shealycn@jmu.edu; please ensure that any articles conform to APA style. Deadlines for submission are as follows: February 1 (spring); May 1 (summer); August 1 (fall); November 1 (winter). Past issues of *Psychotherapy Bulletin* may be viewed at our website: wwwdivisionofpsychotherapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or Division 29 should be directed to Tracey Martin at the Division 29 Central Office (assnmgmt1@cox.net or 602-363-9211).

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PRESIDENT

Linda F. Campbell, Ph.D.

This is an important and exciting time in the Division of Psychotherapy and there is plenty of room for members who want to work with any segment of the initiative that is underway. In our October Board of Directors meeting, the initiative for the advancement and advocacy of psychotherapy was formalized into the Ad Hoc Committee on Psychotherapy. The task of this committee is to implement the objectives identified by the focus groups on research, training, practice, early career interests in psychotherapy and students. The members of the focus groups were individuals who are members of the division and have made valuable contributions to research, practice, or training, or who have become active as an early career psychologist or student in the division. These individuals worked very diligently over the last year and a half to identify important actions that the division can take in promoting and advocating for psychotherapy in psychology. The Ad Hoc Committee will be pursuing the accomplishments of these action plans over the next three years.

The committee membership is as follows:
Co-chairs—
Linda Campbell and Leon VandeCreek

Practice—
Jean Carter and Alice Rubenstein

Training
Jeffrey Hayes and Craig Shealy

Research—
Bill Stiles

Early Career and Students—
Rhonda Karg

The rest of this column will be a description of the highest priority action plans for each focus area. I want to encourage you as a member of our division to consider your interests in psychotherapy and to consider involvement in any of these priorities that match your professional interests.

RESEARCH

The focus groups in research offered a total of twenty-eight action items that would advance and facilitate psychotherapy research. The contributors are members of Division 29 who are researchers. Also, Leon VandeCreek, Alice Rubenstein and I presented a symposium at the North American Society for Psychotherapy Research and, in the process, received feedback on the status of psychotherapy research and recommendations for advancement of research. The top five priorities chosen by the Board of Directors as the most important, in priority order, are these:

1. Work toward revision of federal grant criteria for inclusion of psychotherapy process and outcome research.
2. Develop a web link on the Division's web page that would list all opportunities for individual studies, participation in practice research networks, and studies directed by research members of the division.
3. Develop a section in the journal *Psychotherapy* that summarizes research studies, specifically (a) what we know, (b) implications of what we know, (c) application to practice.
4. Sponsor readings on line for CE credit that are practice friendly research.
5. Assess the current recognition of psychotherapy in competencies, guidelines, and proficiencies within the profession.

PRACTICE

The focus groups in the area of practice recommended eleven action items. The group

members are leading practitioners in psychotherapy and are longstanding members of the division. The five priority actions recommended are these:

1. Promote multiple evidence strains through collaboratives with researchers.
2. Working with training groups on the role of psychotherapy in training criteria.
3. Develop liaison and representational presence in related committees and boards.
4. Promote process research on patient variables valued by practitioners and researchers, not managed care.
5. Promote the concept of practice as field experiences.

Training

The training focus groups are comprised of individuals who are involved and interested in psychotherapy and who have a presence in graduate education and training. The top five priorities represented are:

1. Develop a task force on psychotherapy training competencies or promote a training conference to (a) identify minimum criteria for psychotherapy training, (b) accomplish the development of competencies for practicum completion, (c) identify criteria for readiness for internship, (d) promote broader training of psychotherapy in programs so that students have wide ranging experiences.
2. Develop a strategy to facilitate competencies for psychotherapy training and practice.
3. Collaborate with APA in advocacy for training grants and funding in psychotherapy research.
4. Conduct an online survey of training directors on the type of training including variables such as settings, supervisors, hours in psychotherapy training, types of theoretical orientation, curriculum faculty, and supervision requirements.
5. a. Develop a series of articles and programs on (a) how to set up a practice and (b) how to develop niches in psychotherapy practice.
   b. Develop a series of articles on training in psychotherapy for practice division journals.

Early Career Psychologists and Students

The Early Career focus group identified fourteen action items and the student focus groups identified five items. The Early Career members were identified from a Division 29 membership list of those who graduated within the last five years. The student group was chosen from a cross referenced list of APAGS students and student membership in the division.

Focus groups were held for both early career psychologists and doctoral students in psychology. These groups identified very similar concerns and solutions. For the purpose of the ad hoc committee progress, both will be considered together. The priorities for the two groups are as follows:

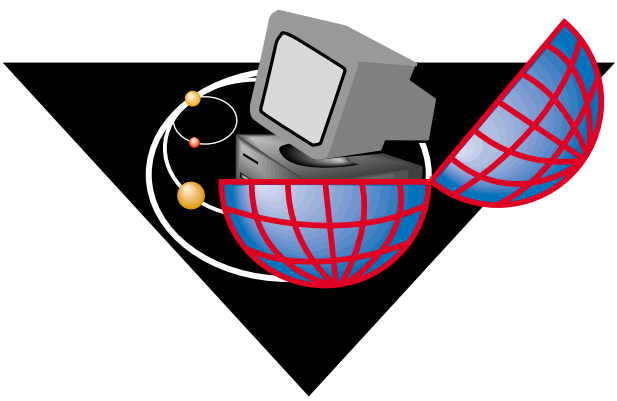
1. Develop a course or workshop on how to set up a practice and how to develop referral sources.
2. Develop a package for how to market oneself for practice.
3. Sponsor workshops or articles on what is effective for realistic practice.
4. Move toward giving CE credits for Division 29 programs at APA.
5. Facilitate addressing problems some students have in training such as not having primary faculty involved in supervision.
6. Early Career Psychologists are concerned that some programs pass along impaired students, and wish to work toward establishing assurance that graduates are functional and competent.
7. Students are concerned that some programs do not offer materials that reflect the quality or content of the curriculum.

We realize that these are ambitious plans. Over our 37 year lifespan, our division has accepted the challenge of ambitious plans many times, and in the process, has helped shape the future of the profession. Our Division of Psychotherapy Board of Directors has assessed the state of psy-

chotherapy in the profession through our focus groups and has carefully and thoroughly identified those actions that would promote growth and wellbeing of psychotherapy within the profession. It is now up to us to follow through. The actual action plans will be adopted by various committees and task forces of Division 29. In the next few weeks the appropriate assignment will be made by the Ad Hoc Committee to the governance structures in the division. As these placements are made, we will announce them to you through a column in the Bulletin. As you read of the action plans above, however, you are invited by Leon and me to contact one of us and let us know of your interest. We can then tell you which committee or task force you might join in order to work on your interests.

This column is my last column as President of the Division of Psychotherapy. I am honored and privileged to have held this position and to represent you. The membership of Division 29 has given generously to APA and to the profession and we have much of which to be proud as we look at the list of our 3,500 person membership and realize the many contributions that you have made to our division and profession. My energy and commitment remains with the division and I will continue working for the promotion and wellbeing of psychotherapy researchers, trainers, and practitioners. I invite you to also join us to whatever extent of time and energy that you might have for this im portant and exciting work. Please contact Leon (Leon.Vandecreek@Wright.edu) or me (lcampbel@uga.edu). We will be happy to facilitate your involvement.

In closing, I salute you, the membership, for the rich and invaluable experience you have given me in allowing me to be your president and for your important role in the future of our division.



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Therapist Know Thyself: Recent Research on Countertransference

Jeffrey Hayes, Ph.D., Pennsylvania State University

Freud introduced the concept of countertransference in 1910 when he wrote, "We have begun to consider the 'counter-transference,' which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this countertransference in himself… we have noticed that every analyst's achievement is limited by what his own complexes and resistances permit" (Freud, 1959, pp. 144-145). Nearly a century later, Norcross (2001) reflected on the plethora of existing definitions of countertransference and wondered, "What is countertransference? Twenty-five years ago we knew what it was: undesirable and contaminated therapist behavior arising from unresolved personal conflicts….In recent years, the term 'countertransference' has been used generically and, at times, indiscriminately… practitioners and students alike are confused" (p. 981). It may be helpful, then, to trace the history of the term countertransference, both to document the multitude of ways in which the word has been used and to lay the foundation for my use of the term later in this article when I discuss recent research findings on countertransference.

Originally, Freud (1959) defined countertransference as the analyst's unconscious, conflict-based reactions to the patient's transference; this has come to be known as the classical definition of countertransference (Kernberg, 1965; Reich, 1951, 1960). From the classical perspective, the patient's transference stimulates the analyst's childhood-based unresolved conflicts, interfering with the analyst's understanding and provoking behavior that meets the therapist's needs rather than the patient's. Thus, from the classical vantage point, countertransference was to be avoided or overcome at all costs.

Subsequent authors began to consider the utility of the therapist's emotional reactions, suggesting that these reactions might hold clues about important client dynamics. All therapist reactions to a client, whether conscious or unconscious, conflict-based or reality-based, in response to transference or some other material, were considered countertransference (Heimann, 1950; Little, 1951). It is unclear why another term was not chosen to refer to a construct that was much broader than what Freud had described. The decision by these authors to retain semantic consistency despite introducing a significant conceptual shift led to years of subsequent professional polarization and debate. In any case, this expanded view became known as the totalistic definition of countertransference. It was developed substantively by Racker (1957, 1968) and has been elaborated by contemporary interpersonal, ego, and object relations theorists (e.g., Aron, 1995; Cashdan, 1988; Tansey, 1994). These more recent theorists have described the ways in which the client evokes therapist reactions, whether by "hooking" the therapist as the client routinely does to others (Kiesler, 1996), through projective identification (Ogden, 1982, 1994), or via role responsiveness (Sandler, 1976). Common to these various conceptions of countertransference is the idea that therapists must understand what clients are eliciting from them and not act impulsively on countertransference feelings. Another mutual point of agreement among theorists, as Gabbard (1995, 2001) has noted, is the idea that both therapist and client contribute to the creation of countertransference. The relative weight attributed to the client's and therapist's contributions, according to Gabbard (2001) "is simply a difference in emphasis rather than in substance" (p. 988). This point is

questionable. On the one hand, it is difficult to argue that the client plays no role whatsoever in stimulating countertransference. On the other hand, the danger with the totalistic definition of countertransference, and its contemporary variations, is that it runs the risk of diverting attention away from the effects of the therapist's personal history on the work. Klein (1946) herself took issue with the totalistic perspective, notes Gabbard (2001), because "she felt it might facilitate the blaming of patients for the analyst's countertransference problems" (pp. 984-985).

A third definition of countertransference, known as the integrative conception (Gelso & Hayes, 2002), emerged from existing dissatisfaction with both the classical and totalistic perspectives. Drawing upon the work of Blanck and Blanck (1979) and Gelso and Carter (1985, 1994), countertransference is defined from this perspective as therapist reactions to clients that are based on the therapist's unresolved conflicts (Gelso & Hayes, 1998; Hayes & Gelso, 2001). This definition is less narrow than Freud's classical perspective in that countertransference may be conscious or unconscious and in response to transference or other phenomena. Nonetheless, unlike the totalistic definition, it clearly locates the source of the therapist's reactions to the client as residing within the therapist. This encourages therapists to take responsibility for their reactions, identify the intrapsychic origins of their reactions, and attempt to understand and manage them.

The emphasis on the therapist's unresolved issues as the origin of countertransference reactions is central to the integrative conception. When a therapist experiences adverse reactions to a client that are heavily influenced by his or her own personal conflicts, the subsequent course of action is necessarily different than if those same reactions were attributable largely to other factors (e.g., projective identification, therapist fatigue from a long work day or a lingering cold, client induced role responsiveness, or therapist inexperience). Rather than disentangling from client dynamics, getting some rest, drinking chicken soup, etc., the therapist whose reactions are countertransference based is faced with the task of deciphering which of his or her personal issues is being stimulated, and how.

The integrative definition of countertransference has been the basis for the predominance of research on countertransference, including my own (Hayes, 2004). By adopting such a definition, I (and others) have run the risk of isolating this research from other scholarly work on countertransference, especially since the totalistic perspective is currently in vogue. Furthermore, because the integrative definition aligns itself more closely with Freud's classical perspective than does the totalistic definition, research that is based upon an integrative stance may be dismissed as "traditional." It is worth noting, therefore, that despite the admittedly psychoanalytic language in which it is dressed, I view countertransference as a transtheoretical construct. That is, all therapists experience countertransference, whether or not they name it as such or devote much consideration to it in their work (see Brown, 2001; Ellis, 2001; Hoyt, 2001; Kaslow, 2001; Mahrer, 2001 for discussions of countertransference in feminist, rational-emotive behavioral, constructivist, family systems, and experiential therapy, respectively). Therapists of all theoretical persuasions, by virtue of their humanity, have personal conflicts; try though we might, no professional credentials or experience shield us from the human condition. Whereas it may be that countertransference exerts less of an effect on therapy that is more technical than relational in nature, this is an empirical question that begs investigation.

How do therapists effectively manage their countertransference?

Regardless of how countertransference is defined, a central question pertains to ther-

apists' ability to manage their countertransference reactions. Research by Robbins and Jolkovski (1987) and Peabody and Gelso (1982) pointed toward three therapist factors that might facilitate countertransference management: empathy, self-insight, and conceptual ability. Peabody and Gelso found that empathy was inversely related to countertransference behavior when male therapists responded to an audiotape of a seductive female client-actress. Robbins and Jolkovski detected an interaction effect between self-insight and conceptual ability such that therapists exhibited the least amount of countertransference behavior when they were self-aware and were able to thoughtfully conceptualize the client, although conceptual skills alone were insufficient in preventing displays of countertransference. This finding was later replicated by Latts and Gelso (1995). In addition to empathy, self-insight, and conceptual ability, the existing literature highlights two other therapist variables that might aid in the management of countertransference. First, in a general sense, a number of sources suggest that therapists who have fewer unresolved conflicts and are more psychologically sound are less likely to experience countertransference difficulties. Thus, therapist self-integration, or the possession of an essentially intact, unified, stable, and differentiated character structure, seems likely to be related to the ability to handle countertransference reactions. Second, anxiety is implicated in both the theoretical and empirical literature as a critical component of countertransference (Cohen, 1952; Hayes & Gelso, 1991; Sullivan, 1954; Yulis & Kiesler, 1968). Thus, therapists' ability to attend to and moderate their anxiety probably facilitates countertransference management.

These five therapist factors—empathy, self-insight, conceptual skills, self-integration, and anxiety management—formed the theoretical basis for the development of an instrument that we named the Countertransference Factors Inventory (CFI; Hayes, Gelso, Van Wagoner, & Diemer, 1991; Van Wagoner, Gelso, Hayes, & Diemer, 1991). We used the CFI in a study to determine whether therapists reputed to be excellent would be rated as better able to manage their countertransference than therapists in general as measured by the factors on the CFI. The CFI was completed by 122 therapists in reference to a therapist whom they considered to be either excellent or ordinary. Scores on all five CFI subscales were found to be higher for the reputedly excellent therapists, and psychodynamic therapists were rated as possessing better conceptual skills than humanistic therapists. No other CFI subscales were found to vary as a function of theoretical orientation (Van Wagoner et al., 1991).

Next we used the CFI to examine the relationship between therapist factors thought to facilitate countertransference management and actual countertransference behavior. In addition, we wanted to test the clinically sensible but empirically unexamined assumption that countertransference behavior adversely affected therapy outcome. Somewhat remarkably, no research had ever been conducted that directly examined the relationship between countertransference and therapy outcome. Consequently, two colleagues and I (Hayes, Riker, & Ingram, 1997) studied 20 cases of brief therapy conducted by 20 advanced doctoral students in counseling psychology. Their former supervisors rated students on the CFI, and their current supervisors observed every therapy session in its entirety and rated every therapist speaking turn for evidence of countertransference behavior. We found that therapists who were judged by their former supervisors to be more empathic and better self-integrated displayed less countertransference behavior. However, countertransference behavior itself was unrelated to outcome in the majority of cases. Only when outcome was poor was countertransference predictive of outcome, and then strongly so. It could be that when the therapist and client have developed a strong

working alliance, as tends to be the case in successful therapy, the relationship can withstand infrequent or minor displays of countertransference so that outcome is not adversely affected (cf. Rosenberger & Hayes, 2002b).

In another field study, Hayes, McCracken, McClanahan, Hill, Harp, and Carazonni (1998) analyzed data from 127 interviews conducted with 8 seasoned therapists immediately following their sessions with 8 clients. Each of the therapists had been identified by peers as an expert clinician. Using a consensual qualitative research strategy (Hill, Thompson, & Williams, 1997), we were able to identify a wide variety of countertransference origins, triggers, and manifestations. Common origins of countertransference included issues related to the therapist's family of origin, narcissism, parenting responsibilities, and role as a romantic partner. Countertransference reactions were frequently triggered by what the client talked about (e.g., death, the client's family of origin), changes in the typical structure of therapy (e.g., sessions starting late or being rescheduled), the client's physical appearance, termination, the progress of therapy, the therapist perceiving the client as dependent, and therapist comparisons between the client and significant others in the therapist's life. We classified therapist manifestations into four common categories: *approach* reactions that drew the client and therapist closer together (e.g., nurturance, compassion, identification with the client); *avoidance* reactions that distanced the therapist from the client (e.g., boredom, blocked understanding, not exploring client material); *negative feelings* that were uncomfortable and could either increase or decrease the distance between therapist and client (e.g., sadness, anger, anxiety); and *treatment planning*, which consisted of therapists' decisions related to the process or course of therapy (e.g., choosing to be less directive, deciding to be more active). In addition to identifying an array of origins, triggers, and manifestations, we also discovered that this group of therapists experienced countertransference reactions in 80% of their sessions. This finding runs counter to the all-too-prevalent myth that good therapists do not experience countertransference.

The data from this study provide a potentially useful framework for clinical reflection. For instance, therapists may find it beneficial to work "backward" through the categories by sequentially thinking about countertransference manifestations, then triggers, and then origins. Beginning at the most surface level, the therapist might question why she or he acted atypically with a client (e.g., giving a lot of advice). The therapist might then try to ascertain what he or she was feeling and thinking in connection with the uncharacteristic behavior (e.g., "I felt very responsible for the client;" "I thought that I needed to be more directive"). After identifying behavioral, affective, and cognitive reactions that could be manifestations of countertransference, the therapist could then turn to exploring possible triggers for these reactions. The therapist might profitably reflect on the content and process of the session, search for similarities between the client and some other important person in the therapist's life, and contemplate whether the typical structure of therapy had changed in any way (e.g., client had missed recent appointments, termination was approaching). Finally, after considering potential countertransference manifestations and their triggers, the therapist ultimately must try to discern the extent to which his or her reactions stem from personal unresolved conflicts. This is an extraordinarily difficult task, for as Thoreau once wrote, it is as difficult to perceive oneself accurately as it is to see behind oneself without turning around.

Rosenberger and Hayes (2002b) conducted a case study that examined the potential effects of countertransference on the working alliance, session depth and smoothness, and therapists' social influence. Contrary to expectation, we found that

when the client talked about topics related to the therapist's unresolved issues, the therapist tended to respond with less avoidance and the working alliance was rated more strongly. The therapist judged sessions to be smoother and shallower and she felt less expert, attractive, and trustworthy the more frequently the client talked about conflict-relevant topics. It seemed that the client and therapist colluded in a positive transference whereby the therapist was idealized (the client gave the therapist maximum ratings on social influence attributes following every session), and the therapist responded to potentially threatening material by approaching rather than avoiding the client. In retrospect, the assumption that the therapist would avoid conflictual client material was influenced by findings from previous studies in which the sample of therapists consisted predominantly or exclusively of men (Hayes & Gelso, 1993; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). It may be that men are more likely than women to exhibit countertransference behavior that assumes the form of avoidance whereas women draw closer to clients when threatened. Finally, in terms of countertransference management, when the therapist thought she did a better job of dealing with her countertransference reactions, the client rated the working alliance as stronger and sessions as deeper. It makes sense that the therapist's ability to manage her defensive or ego-oriented impulses would facilitate deeper clinical work and a stronger relationship with the client.

Conclusion

Most research on countertransference to date has focused on its deleterious effects and how to manage them. While understanding such phenomena is important, especially given the ubiquitous nature of countertransference, it also is time to undertake systematic study of the potential therapeutic benefits of countertransference. That is, how might our experience of personal conflict facilitate our work with clients? Might I better understand a client who is grieving the death of a child if I have experienced, and sufficiently worked through, a similar loss? The ancient notion of the wounded healer comes to bear on such a question. Despite its antiquity and clinical relevance, the concept of the wounded healer has received scant empirical scrutiny. This is yet one more area where research on the person of the therapist can be advanced.

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PRACTITIONER REPORT

Rural Psychology: An Excellent North Dakota Adventure[1]

Ronald F. Levant, Ed.D., MBA, ABPP
Nova Southeastern University
APA President 2005

Ronald F. Levant, Ed.D., M.B.A., A.B.P.P., is the 2005 President 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, Fla.

It is always a pleasure to be invited to address a meeting of one of our State, Provincial and Territorial Psychological Associations (SPTPA). At these meetings I have been given opportunities to put forth my vision for the future of psychology. Moreover, in the discussions, both formal and informal, that occur, I invariably learn many wonderful things about how psychologists who are "on-the-ground," as it were, are advancing psychology's agenda. I only regret that now that I am APA President-Elect my schedule has filled up, so that I cannot accept many of the invitations that have been extended. Hopefully these invitations will still continue to come after I finish my presidential year, when I will have more time.

This particular trip to North Dakota began auspiciously. As the flight from Minneapolis to Fargo was descending, the person sitting behind me tapped me on the shoulder, and said "There are about dozen troops on board coming home from Iraq. Let's stay in our seats to let them get off first to show our respect. Pass it on." "What a wonderful idea," I said, and passed it on as requested. And so when we deplaned, everyone except the soldiers kept their seats and spontaneously applauded these brave men and women, in a truly moving tribute, which the soldiers appreciated.

Upon the kind invitation from APA Council Representative Lee Lipp, Ph.D., and NDPA Executive Director Bonnie Staiger, Paul Craig, Ph.D., a neuropsychologist from Anchorage, AK and member-at large of the APA Board of Directors, and I agreed to do workshops and presentations for the North Dakota Psychological Association in Fargo. In addition, at the gracious invitation of good friend and longtime member of APA governance Justin (Doug) McDonald, Ph.D., Director of the acclaimed Indians into Psychology Program (INPSYCH) at the University of North Dakota (UND), we agreed to present at the UND Northern Lights Conference and cooked up a plan to spend some time with Doug and his companion Tannis Power fishing for Walleye at Devil's Lake.

Fargo is one of the largest metropolitan areas in ND. It has a revitalized art deco style downtown area, containing some very nice restaurants, especially HoDo (short for Hotel Donaldson), where we enjoyed bison steak, intriguing art, and edgy music and one fascinating old book store, where Paul and I browsed and bought some wonderful treasures. Fargoans ask you if you have seen the movie "Fargo," and hasten to point out that "Fargo is not like the movie." I assure

them that I understand, noting that "psychopaths are everywhere."

At the NDPA meeting on Friday, I presented a workshop on my main area of academic interest, the new psychology of men, titled "Men, Emotions and Psychotherapy" in the morning (c.f. Levant, 1998), while Paul presented in the afternoon on the "Neuropsychology of Traumatic Brain Injury: The Alaskan perspective." Paul's presentation was a highly engaging and humorous but tremendously informative talk, in which it became clear very quickly that to fully understand traumatic brain injury (TBI) in Alaska, you need to know a lot about the frontier (or "bush" as it is called locally) in addition to knowing neuropsychology. Just to give you a sample of this, consider that airplane accidents are a leading cause of TBI among men 25-39, and one frequent behavioral pattern for these accidents is a group of men preparing to go hunting in the bush in an overloaded small plane with more than a few belts under their belt, so to speak. In this connection, it was interesting to see how Paul's talk overlapped with mine.

On Friday evening NDPA held a banquet in honor of the association's 50th birthday and the fifteen anniversary of the NDPA Executive Director Bonnie Staiger. I was asked to speak on my planned APA Presidential initiatives. I recognized the leadership of NDPA for creating such a vibrant SPTPA, in particular: Ken Stone, President, Kim LaHaise, President-Elect, Chris Kuchler, Past-President, Lee Lipp, outgoing Council Representative, and George O'Neill incoming Council Representative. In turn, the leadership of NDPA expressed their appreciation to CAPP and the Practice Directorate for making it possible for small SPTPA's like NDPA to exist via the CAPP grants, and to APA Council for making it possible for such small states to be represented on Council.

I gave the same talk on Saturday morning at NDPA and in the afternoon at the Northern Lights conference at UND. This talk is titled: "Psychological Approaches to the Management of Health and Disease: Health Care for the Whole Person" (Levant, 2004) Here is a synopsis:

The 21st century promises monumental changes in health care. The technology currently available has already provided the tools whereby educated consumers can make critical decisions regarding their own health care and health care providers can call up databases to provide up to date health information. Yet despite these promising developments, the status of health care in the U.S. is very worrisome, with dramatically escalating health care costs every year, 45 million Americans now uninsured, tens of thousands dying from medical errors each year, and disturbing racial and ethnic disparities in access to and use of services.

Psychology plays an under-recognized but extremely important role in health and illness. This becomes obvious when one considers the importance of behavioral risk factors for morbidity and mortality, the high costs associated with psychosocial pathways that lead to unnecessary utilization, and the ineffective treatment of the lion's share of mental health problems by primary care providers. Further, as evidenced by the rising prevalence rates of chronic disease, traditional health care providers lack appropriate tools to tackle the behavioral health issues associated with the current chronic disease epidemic, whereas psychologists have developed and validated numerous disease management programs aimed at treatment adherence and lifestyle improvement. In addition, the psychological impact of having a chronic medical condition is not well addressed by conventional medical treatments.

Psychology thus offers a key to saving billions of dollars annually and dramatically improving the U.S. health care system. It is thus imperative that psychologists be more centrally involved in the healthcare system. An integrated biopsychosocial approach to health promotion and disease management in which experts in the fields of medicine and psychology synthesize their knowledge

offers a most promising alternative to the current biomedical health care system, and is likely to become an increasingly significant component of psychology's future. This integrated system will truly offer Health Care for the Whole Person.

Interestingly, at the NDPA conference I asked how many folks were aware of these issues and knew about the Health and Behavior (H & B) codes which allow psychologists to be compensated for their work in the general health care delivery system, and about 75% raised their hands. This is very different from what I typically find, which is less than 10%.

Part of this may be due to the dynamics of a rural state where there are too few providers, but there is more to it than that. George W. O'Neill, Ph.D., Clinical Director of Mental Health for Blue Cross Blue Shield of North Dakota, told me that Blue Cross Blue Shield of North Dakota was probably the first private carrier in the country to cover H&B codes. This illustrates the importance of psychology being at the table locally, where policy decisions are implemented. Dr. O'Neill, being a psychologist and an employee of BCBS was in an excellent position to educate BCBS about the importance of the H & B codes for their subscribers and to reassure them that costs would be reasonable, which indeed turned out to be the case.

Dr. O'Neill noted: "Our rules for H&B claims are few (so far): 1) service must be for a non-psychiatric condition, 2) provider must use a diagnosis established by a physician, 3) provider cannot bill an H&B code and a psychotherapy code on the same day, and, 4) these codes are NOT to be used to cover preventive medicine or risk factor reduction. I recently looked at claims from April 2002 (when our first claim was submitted) through May 2004. During that period 450 H&B claims were submitted, attributable to 240 unique members. Of the 450, 35 occurred in 2002, and 320 in 2003. At the current rate, we estimate that 348 H&B procedures will occur in 2004. However, I have been promoting the use of these codes through various presentations across the state and expect the number to exceed this projection for 2004. Total dollars allowed for H&B codes have approximately 0.1% of all BCBSND mental health expenditures.

"From May '03 to May '04, we have had 112 claims for initial assessment, 168 claims for re-assessment, 74 claims for individual therapy, 47 for group therapy, 29 for family therapy w/ patient present, and 20 for family therapy w/o patient present. Diagnoses involved have been for CNS disorders (e.g. strokes, head injuries) – 45%; musculoskeletal (mostly pain management) – 10%; tobacco cessation in patients with respiratory disorders (e.g. COPD, lung cancer) – 8%; other respiratory disorders (mostly asthma) – 5%; miscellaneous other – 33%."

After the presentations on Saturday, Doug McDonald honored Paul Craig and me by creating an "Inipi," or Indian sweat lodge ceremony. This is a sacred ceremony for purification and also for renewal and for creating a sense of community. All who participated felt that this was an extremely powerful ritual. I could write much more about it, but will save that for another time.

As always, I welcome your thoughts on this column. You can most easily contact me via email: levantr@nova.edu.

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Levant, R. (2004, May 22). Psychological approaches to the management of health and disease: Health care for the whole person. Keynote speech, University of Nevada, Reno, Conference on Psychological Approaches to Disease Management.

[1] Dedicated to the inner adolescent!

FEATURE

The Development of the Unified Theory and the Future of Psychotherapy

Gregg R. Henriques, James Madison University

Questions about the nature of psychotherapy and conflicts between competing paradigms awakened in me a deep intellectual curiosity that ultimately culminated in the development of the "unified theory" (see Henriques, 2003; 2004; in press). I was fortunate in that early in my graduate education I gained a rich exposure to the psychotherapy integration movement. This led me to many important realizations, including: a) many of the "single" schools were defined against one another both conceptually and politically; b) no single school had the depth and breadth in both the humanistic and scientific domains to offer a comprehensive solution; and c) much overlap between the schools becomes apparent as one becomes proficient in their language and concepts. However, despite these problems, there were significant difficulties in achieving a coherent integrative view. First, the competing schools clearly had different (although often implicit) moral emphases. Messer and Winokur's (1980) critique of Wachtel's (1977) work offered perhaps the most eloquent articulation of this point. Second, if one considers, as I do, psychotherapy to be the application of psychological principles in the service of promoting human well-being, then it follows that the disorganization of psychological science seriously hampers, if not completely prevents, the development of a coherent, general approach to psychotherapy (see Henriques & Sternberg, 2004).

Although now obvious with the benefit of hindsight, I essentially backed into this second point. I was looking for basic, core conceptual commonalities that cut across the various perspectives in psychotherapy and started to explore a broad array of literatures. Fortunately, evolutionary psychology was just beginning to make a major impact on the field and in it I found a major piece of the puzzle[1]. All the major perspectives assumed an evolutionary perspective, thus this could provide a shared point of departure from which to view each of the competing paradigms. Moreover, it was in the context of my immersion in biological theory that I realized I needed to make a shift in my thinking from an integrated psychotherapy to an integrated psychological science. As an applied discipline, psychotherapy inevitably involves a moral dimension that basic psychological science does not. Specifically, the descriptions of change offered by the basic science of psychology are a fundamentally different kind of thing than the prescriptions for change offered by the psychotherapeutic community (see Henriques, 2002). I found that clearly disentangling these two domains was crucial in my quest for cumulative knowledge.

The Development of the Justification Hypothesis

It was against this background that I experienced what was for me, my first theoretical breakthrough, in an idea I came to call the Justification Hypothesis (JH; Henriques, 2003). Although it would a take a number of years to develop into a formal proposal, the proverbial "flash" of insight came on a drive home after completing a psychological evaluation on a woman hospitalized following a suicide attempt. In her late thirties, she was diagnosed with a double depression and an avoidant personality disorder. A woman with an above average intellect, she had graduated from high school, worked as a teacher's aide and lived in almost complete isolation on

the brink of poverty. In a reasonably familiar story line, her father was an authoritarian, verbally abusive alcoholic who dominated her timid, submissive mother. He would also be physically and violently abusive to her older brother, who was much more defiant of his power. She distinctly remembered several episodes of her father beating her brother, while yelling at him that he needed to be more like his obedient sister. Perhaps the most salient feature of this patient's[2] character structure was her complete sense of inadequacy. She viewed herself as totally incompetent in almost every conceivable way and expressed an extreme dependency on the guidance of others. In presenting the case to my supervisor and classmates, I argued that the network of self-deprecating beliefs served an obvious function, given her developmental history. Namely, the beliefs she had about herself had justified submission and deference in a context where any form of defiance was severely punished.

It was when I was driving home that the broad generalization dawned on me—this patient wasn't the only individual whose "justification system" for why she was the way she was could be understood as arising out of her developmental history and social context. No, the process of justification (and thus the development of justification systems) is ubiquitous in human affairs. Arguments, debates, moral dictates, rationalizations, and excuses, as well as many of the more core beliefs about the self, all involve the process of explaining why one's claims, thoughts or actions are warranted. In virtually every form of social exchange, from warfare to politics to family struggles to science, humans are constantly justifying their behaviors to themselves and others.

Yet, it was not only that one sees the process of justification everywhere one looks in human affairs that made the idea so intriguing. (Consider, for example, this essay can readily be considered an "act of justification). It also became clear upon reflection that the process is a uniquely human phenomenon. And a crucial aspect of the JH is that it allows for a much clearer view of the relationship between the human mind and the minds of other animals (Henriques, 2004).

Ultimately, I came to organize the JH around three basic claims. The first claim is that Freud's fundamental observation was that the self-consciousness system (SCS) functions as a "justification filter" that inhibits unjustifiable behavioral investments and provides socially acceptable justifications for behaviors that are expressed. The second claim is that the evolution of language created a new and unique adaptive problem for our hominid ancestors, namely the problem of justification. The essence of the problem of justification is that humans became the first animal in evolutionary history that had to justify why they did what they did. This problem arose because the evolution of language allowed other humans much more direct access to one's thought processes. The third claim is that the JH provides the basic framework for understanding cultural levels of analyses because the concept of large-scale justification systems providing the rules and patterns for acceptable behaviors is consonant with modern conceptions of culture (e.g., Cronk, 1999) and social constructionist viewpoints.

The JH became an obsession for me because the idea seemed to cut across many different areas of thought. It was obviously congruent with basic insights from a psychodynamic perspective. It was also clearly consistent with many of the foremost concerns of the humanists. For example, Roger's argument that much psychopathology can be understood as a split between the social self and the true self could be easily understood through the lens of the JH. Consider how a judgmental, powerful other might force particular justi-

fications in a manner that produces intrapsychic rifts between how a person "really" feels and how they must say they feel. The JH is also directly consistent with cognitive psychotherapy, which can be readily interpreted as a systematic approach to identifying and testing one's justification system.

But the idea also pulled in basic psychological science. Cognitive dissonance, the self-serving bias, human reasoning biases, and the "interpreter function" of the left hemisphere all were readily accountable by the formulation of the JH (see Henriques, 2003 for a summary). The JH also seemed to incorporate insights from those who emphasize cultural levels of analysis. Recently, the innovative and useful nature of the JH has been demonstrated by writers articulating its application in clinical and developmental psychology (e.g., Shealy, in press), sociology and social psychology (e.g., Shaffer, in press), and social constructionism (e.g., Quackenbush, in press).

The Tree of Knowledge System: Five Essences Linked By Four Joint Points

By clearly delineating the dimension of human behavior from the behavior of other animals, a fascinating new formulation began to emerge. Reality, in the deepest sense of the word, could now be thought of and clearly depicted as a set of hierarchically arranged levels of complexity. This concept ultimately evolved into a novel scientific philosophy, called the Tree of Knowledge (ToK) System. The ToK System offers a vision of knowledge as consisting of one level of pure information (Energy) and four levels or dimensions of complexity (Matter, Life, Mind, and Culture) that correspond to the behavior of four classes of objects (material objects, organisms, animals, and humans), and four classes of science (physical, biological, psychological, and social). A variety of different representations of the ToK System have been developed and a parsimonious depiction of the system is offered in Figure 1 (see http://psychweb.cisat.jmu.edu/ToKSystem/ for additional diagrams). The formal representation of the system is given in Henriques (2003, p. 154).

A key element of the system, highlighted in the figure, is that each of the four dimensions is associated with a theoretical joint point that provides the causal explanatory framework for its emergence. Accordingly, there are four formal theoretical joint points: (1) Quantum Gravity (theory of Matter; see Hawking 1998; Smolin, 2001); (2) the Modern Synthesis (theory of Life); (3) Behavioral Investment Theory (theory of Mind); and (4) the Justification Hypothesis (theory of Culture).

The ToK System is constructed in the spirit of consilience, but it offers a considerable advance of Wilson's (1998) formulation through the introduction of the novel visuospatial representation and the description of the joint points linking the different levels. The significant advantage offered by the system is that it simultaneous defines extremely broad concepts (e.g., life, mind) and defines how they exist in relationship to one another in a single, coherent knowledge system. The system of interlocking definitions ultimately provides the potential framework for a universally shared conceptual foundation and definitional system from which all psychologists can work. Said differently, the ToK System can be thought of as a new map of the subject matter that can function to provide a base of shared general understanding.

Implications for the Science of Psychology and the Practice of Psychotherapy

As evidenced by the two recent special issues of the Journal of Clinical Psychology [Vol. 60(12) and 61(1)], the unified theory carries with it substantial implications for the science of psychology. With the new map of the sciences offered by the ToK System, I believe psychologists of the future will be able to define crisply the subject matter of psychology, see how psychology exists in relationship to the other sciences, and sys-

tematically integrate the key insights from the major perspectives in a manner that results in cumulative knowledge.

The implications for psychotherapy are also substantial. One of the biggest obstacles to psychotherapy integration has been the absence of a common language and theoretical framework for psychologists (Norcross & Newman, 1992). In combination, the two large concepts of behavioral investments and justifications have the potential to organize much extant psychological research and provide a framework for understanding everyday psychological phenomena. Consider, for example, the construct of depression. The unified theory allows one to easily move between behavioral, cognitive, and psychodynamic perspectives when conceptualizing depression. From a behavioral perspective, consider what happens if the behavioral shutdown associated with depression results in increasingly greater loss. If the shutdown creates greater loss, then a vicious cycle ensues in which the behavioral reaction results in the additional loss, resulting in greater shutdown and so on. The individual can also justify behavioral investments and events in a problematic fashion and overly negative or pessimistic interpretations can also result in vicious depressive cycles. This is essentially the cognitive formulation (e.g., Beck, 1976). Or, from a more psychodynamic perspective, consider how self-criticisms so prominent in depressed individuals might sometimes function to justify submission and the inhibition of aggressive impulses. The unified approach allows one to consider depression from each of these perspectives under the same general framework of understanding. The approach also integrates a biopsychiatric perspective and clarifies the difference between mental disorder and disease (Henriques, 2002).

A Scientific Humanistic Philosophy as a Guiding Frame for a Unified Psychotherapy

Although a common language for psychotherapy does begin to emerge through the application of the unified theory, not all the problems that confront the practice of psychotherapy are of a scientific nature. As mentioned in the beginning of this essay and as is being recognized with increasing regularity in the literature (e.g., Downing, 2004; Shealy, 2004), the practice of psychotherapy is an inherently prescriptive and thus moral enterprise. In offering our services to facilitate change in a particular direction, we inevitably (be it implicitly or explicitly) adopt a moral stance about the way things should be. Yet as a group, we psychotherapists have been timid in acknowledging this fact. For example, many cringed when Szasz argued we were secular priests. And too often we use the justification of empirical support to mask the underlying moral value structure that is motivating the change process (Quackenbush, in press). We have, in short, been either unable or unwilling to stand up and be counted as offering a moral vision of what constitutes psychological health and the contexts that promote it.

I believe the time for reticence and caution in pronouncing our moral values in this way has passed. In the concluding article of the JCP special series, I described the ToK System as a scientific humanistic philosophy that explicitly recognizes Knowledge as an interaction of Knower and Known. The two components, the scientific and the humanistic, reflect two different valuations of the knower. In attempting to construct general laws that objectively describe complexity and change, the scientist works to de-value the influence of the specific knower in the knower-known interaction. In other words, the task of the basic scientist is to describe "reality" in as knower-independent terms as possible. Scientific methodology can be thought of as the tools by which this knower-independent knowledge is acquired, and, in accordance with the analysis offered by Wilson (1998), I believe that the quest for objective truth (defined as accurate models of complexity and change)

should remain the idealized goal of the institution of science.

But science is not the only way of knowing, and describing change is not the only thing humans want to do. As discussed previously, psychotherapists work to facilitate change and thus must construct notions of what kind of change is desired. Basic science can not answer this question and this is where a need for the humanistic side of the philosophy becomes clear. In this system, the humanist values the knower and all of the idiosyncratic subjective elements that contribute to the uniqueness of her knower-known interactions. In the process of valuing the uniqueness of the knower, humanism defines humans as the most valued of subjective objects and, thus, unlike the "cold" formulations of basic science, the humanist side of the equation functions as a prescriptive value system. The value placed on humanity in general forms the base out of which more specific prescriptions about what are the aspects of human life that are most valuable and desirable emerge. I believe this scientific humanistic philosophy provides a framework to construct a general moral vision, one that includes the inevitable pluralism inherent in moral questions.

To conclude, as a new unified theory the ToK System affords us a way to more readily disentangle (although never completely separate) the moral dimension from the scientific one. In doing so, the moral responsibility that accompanies the charge of professional psychology becomes clear. It is to generate a vision of the "good life" and an evidenced based fund of knowledge and technologies that allow human beings to move toward it.

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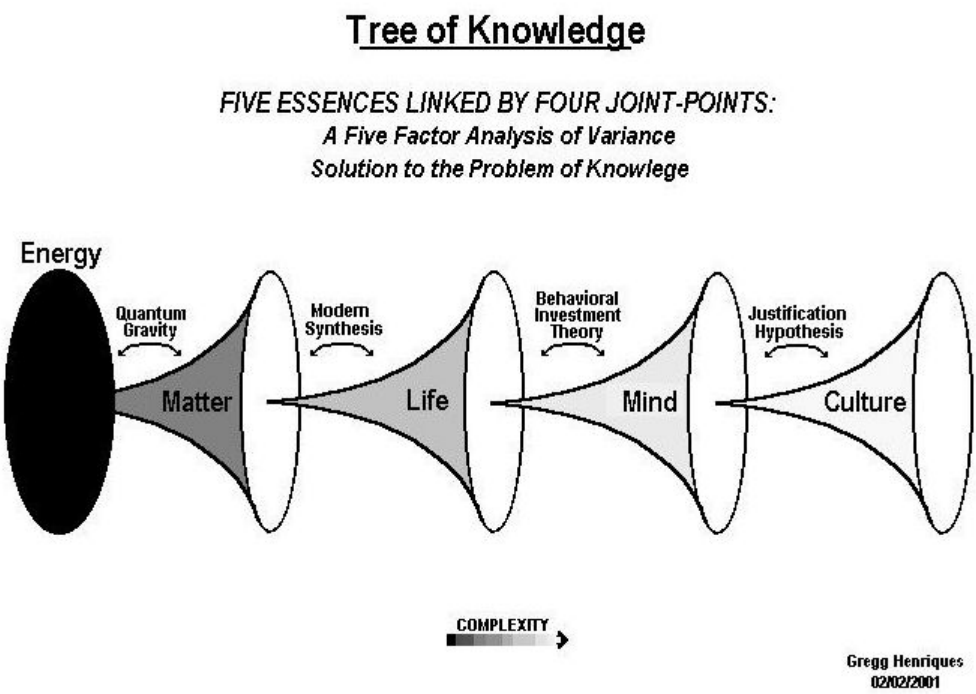

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Footnotes

1. Although there was much about evolutionary psychology I found to be extremely appealing, I eventually came to see it as yet another school in psychological science, rather than a truly integrative framework that many of its founders hoped it would become.
2. I realize that the term "patient" is less popular than client or consumer for individuals receiving mental health services. My rationale for using the term is that I believe it is appropriate to think of people receiving services for psychological ailments to be thought of in terms of the "sick role," which is defined in this context a diminished capacity to function adaptively and the need for assistance from a caretaker. This does not mean, however, that I adopt a "medical model" approach to psychotherapy (see Henriques, 2002 for a full discussion of these issues).

DIVISION 29 BOARD MEETING

Leon VandeCreek and
Linda Campbell

John Norcross, Jan Culbertson,
Tracey Martin and Leon VandeCreek

Pat Bricklin receiving recognition of her
presidency from Linda Campbell

Tracey Martin, George Stricker, Craig
Shealy, Alice Rubenstein, John Norcross

Craig Shealy, John Norcross,
and Leon VandeCreek

APA DIVISION 29 STUDENT MEMBERS
2004–2005 INFORMATION FORM

1. Why did you decide to join Division 29? What is the appeal?

_____

_____

_____

2. Please indicate how helpful/interesting you find the following Division 29 services (1 = the *least* helpful/interesting; 4 = the *most* helpful/interesting):

___ Student Webpage
___ Student Listserv
___ Journal (*Psychotherapy: Theory, Research, Practice, Training*)
___ Newsletter (*Psychotherapy Bulletin*)
___ Annual convention activities

3. Would you recommend joining Division 29 to other students? Why (or why not)? *(Remember that if you renew your membership and get a friend to join at the same time you both receive a $10 discount on your annual fees).*

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4. Would you be interested in becoming more involved in Division 29 activities? If so, please rank the student activities in terms of their appeal to you (1 = the *least* appealing. 5 = the *most* appealing):

___ Writing articles for the *Psychotherapy Bulletin*
___ Joining a Division 29 committee as a student member
___ Joining the Division 29 Student Membership/Development Committee
___ Becoming a Division 29 spokesperson at your campus
___ Joining the Division 29 Student Listserv? If you would like your name to be added to the listserv please provide us with your email address:
_____@_____.

5. What could Division 29 do to make itself more appealing to students?

_____

_____

_____

6. Division 29 is developing a diversity mentoring project. Are you an ethnic minority student? (❑ YES or ❑ NO). If yes, are you interested in having a Division 29 professional member who is also an ethnic minority as a mentor? (❑ YES or ❑ NO).

Please send this completed questionnaire to: Ms. Tracey Martin, Division of Psychotherapy, Central Office, 6557 East Riverdale, Mesa, AZ 85215. FAX: (480) 854 8966. EMAIL: Assnmgmt1@cox.net.

A WORLD OF PSYCHOTHERAPY

International Travel Reduces Professional Myopia: Reflections on what we can teach students about professional psychology and psychotherapy if we take them abroad

Howard Kassinove, PhD, ABPP, Hofstra University

I never realized how narrow my perspective on assessment and psychotherapy was until I began to deliver invited lectures and conduct research abroad. In this paper, I share an eye-opening journey that I hope has cured my personal myopia, has expanded the vision of our doctoral students, and has improved the quality of our student training.

As of 2004, our students and faculty members had made 17 trips to all parts of the former Soviet Union. In addition, we have made five visits to various parts of India, including not only the major cities of Mumbai and Delhi, but also rural areas of the south (Kerala) and the far eastern states of Assam, Meghalaya, and war torn Nagaland. In all probability, many readers have never heard of these Indian states. In addition, with graduate students, we have lectured in Argentina, Italy, Denmark, Poland, and Spain. More than 100 Hofstra University doctoral candidates have experienced these countries, have met with their foreign student-peers, and have learned to *not* see professional psychology and psychotherapy from an exclusively American perspective. They have learned about their own narrow vision *not* by reading books, but by meeting with students and professionals in their home, foreign countries.

Before our international journeys began, I thought I was a well educated professional psychologist. My teachers were of high caliber (e.g., Gordon Derner, Albert Ellis, George Stricker, Julia Vane, and Joseph Wolpe) and my training spanned the areas of clinical and school psychology. I was in charge of our colloquium series for many years and I had invited some major figures to Hofstra. We were enlightened about assessment and psychotherapy by Ann Anastasi, Jerry Deffenbacher, Steve Hayes, Michel Hersen, Bob Kolenberg, Don Meichenbaum, Neal Miller, Ray Novaco, Dick Suinn, David Wechsler, and many others. With regularity, I attended annual meetings of the APA and AABT and by the early 1990's I had more than 75 presentations and 50 publications to my credit. I had worked in areas such at rational emotive psychotherapy therapy, assertion training, compliance in psychotherapy, anger disorders, etc. Surely, I knew what was happening in professional psychology and psychotherapy.

Prior to 1990, what was "right" seemed to be well-known. After all, behavior was a simple function of biology and our learning history. Sure, "culture" was coming on the scene but it was a minor league player. The DSM prescribed how to place patients in pigeon holes and the APA Code of Ethics told us what behaviors in psychotherapy were acceptable. The APA Committee on Accreditation told us there were four practice areas—Clinical, Counseling, School and Combined Psychology. All was in order.

Psychology and Psychotherapy in Russia

Well, it turns out that in many ways I knew much less than I thought. My myopia began to be cured in 1991 during my first trip to Leningrad. The USSR was still in existence and I had been conditioned to "know" that it was an evil empire with the primary goal of putting us out of existence. As a child in the Bronx, we were trained to

hide under a wooden schoolroom desk in case of a nuclear attack. How silly that seems now, especially when I learned that Russian children were being taught to hide under *their* wooden desks to protect themselves from an American attack.

Of course, the work of Nobel Laureate Ivan Pavlov was well-known. He was a hero of behaviorism and behavior therapy. Thus, it seemed likely that everyone in the USSR was practicing high quality behavior therapy in their offices, based on behavioral assessment and other well standardized tests. That, of course, was not true at all.

In December of 1990, a group of psychologists and psychiatrists from Leningrad State University came to New York. They contacted me, to learn a bit about cognitive-behavior psychotherapy in America. With some trepidation, I invited them for dinner. Aside from language difficulties, the dinner went well and we obviously had much in common. At the end, one of them said, "Why don't you come to Russia in April? You can lecture on Rational-Emotive Psychotherapy at the Bekhterev Psychoneurological Institute." Well, I was shocked. Russia. The evil empire. Lack of freedom. Another language. Repression of thinking. What?

The words led to a fear reaction, with many thoughts of avoidance. It's too far! I'm too old! It's too expensive! Nevertheless, the possibility was intriguing. So, I did what any self-respecting graduate professor might do—I told my research assistant that he *had* to go with me. What my assistant really thought is unknown to this day, but the situation was certainly unusual? Could we lecture about psychotherapy in a foreign language? Would we be detained? Was I using my social power as a professor inappropriately to "encourage" him to go? Would we have to share a room and was that ethical? What was psychotherapy like in the Soviet Union? Did I have anything to offer to these great behaviorists in the land of Pavlov?

Our learning began when we went through customs in the Leningrad airport. A Russian social psychologist, returning from New York, was on line in front of us. He was searched and they found a copy of a newly published American book on the *KGB*. It was immediately confiscated and my anxiety increased. But, luckily, we had no troubles.

Our psychotherapy lectures at the Bekhterev Institute went very well. However, at the end one psychotherapist said, "Could you talk about Neurolinguistic Programming? We understand that NLP is the *most common* form of psychotherapy practiced in America." Well, that taught me something about the information gap. They knew very little about American psychotherapy practices and we knew very little about Russian practices. In fact, we were surprised to discover that Pavlov was *not* held in high regard in terms of his contributions to psychotherapy. In fact, he was regarded as an enemy of Soviet psychology and psychotherapy since his teachings were used to show that the study of physiology was the only legitimate way to understand behavior. Russian psychologists whose theoretical orientation was evolving and who seemed to be eclectic, with a strong humanistic overtone, did not perceive Pavlov to be much of a contributor to the field.

On the personal side, we were treated quite well. We lived in a hotel for Young Communists that did not approach Western standards. But, we did have comfortable and separate rooms and that satisfied my American based ethical concerns.

The trip was a great success and in July of 1991 we returned to Russia with 15 Hofstra PhD students for a conference on Political Psychology. I had never heard this term and the presentations would surely be labeled as belonging to Political Science in the United States. However, the Russians labeled themselves "psychologists" who were studying and trying to influence voting behavior, political message transmission,

power, decision making, rule governed behavior, etc. They did not refer to collecting data, random assignment, reliability and validity of measurement, etc. However, in their curriculum, experimental psychology courses were central, and they were well informed about data analysis. They were *professional* psychologists in Russia. OK, that was more learning for us. Our students bonded with the Russians and, as an outgrowth, they came to Hofstra in August of that same year. We even accepted one Russian man (Denis Sukhodolsky) into our PhD program. After teaching us much about Russian psychotherapy during his five years at Hofstra, Dr. Sukhodolsky is now a Research Scientist as Yale University.

During these years, we also learned about the Russian system of education. St. Petersburg State University has an independent "faculty" of psychology that is broken down into 12 departments. Many are labeled in familiar ways such as the departments of clinical, educational, and social psychology. Others are unusual, such as the "Department of Developmental Psychology & Acmeology" (the science of developmental maturity—between the adolescence and the elderly). Graduate degrees include study for a PhD (Kandidat Nyauk) and then, possibly, a Doctor of Science that requires a development of a theoretical model and publication of at least one book.

Our trips have taken us to Arkhangelsk, Gorky, Moscow, Novgorod, St. Petersburg, Tyumen, Krasnoyarsk, Irkutsk, Lake Baikal, etc. With more than 100 doctoral students, we have participated in conferences at the Pavlov Medical University, St. Petersburg State University, the Institute for Sociology of the Russian Academy of Sciences, and the V.M. Bekhterev Psychoneurological Institute. We also traveled to Siberia, for the First Congress of the Russian Psychotherapy Federation. It was very cold! But very "cool!"

Our students have visited schools for gifted children and a Top Security Hospital for mentally ill criminals, where they were able to interview patients about their problems and treatment. At one point, in the top security mental hospital, two of us were left alone in a small workshop with an inmate who had a very sharp woodworking tool in his possession. No guards were in the vicinity. That was also a moment of learning (and, fear).

For history buffs, and behavior therapists, the most exciting experiences have been our visits to Pavlov's apartment in St. Petersburg and to his actual laboratory in Koltooshi. Our students have sat at Pavlov's desk and played his piano. We have also sat at Bekhterev's desk, the arch rival of Pavlov, and examined his books and notes close up. In America, of course, there would be ropes about such objects preventing a visitor from getting too close to them.

These have been many eye opening experiences regarding assessment and psychotherapy. We learned that many American psychological tests have been translated and used in Russia without being restandardized. They simply assumed, for example, that translated items of the MMPI were culturally appropriate and reliable, and they used American norms. We learned about the diagnosis of "Sluggish Schizophrenia," which was used for people who developed *dangerous ideas* such as, "It's possible that communism is not the best political system." Not being in the DSM, it seemed quite strange and, at first, reinforced our items about the evil empire. Of course, similar peculiar diagnoses have existed in other countries, including the United States where at one point we had a diagnosis of *trappidomania* (a "pathological craving" for freedom in black slaves). We learned that to this day psychotherapy in Russian state hospitals and research centers can be practiced only by medical doc-

tors. In recent years, some private psychotherapy centers have opened in big cities and these can, and are, staffed by psychologists. But, who is a psychologist in Russia? Education for practitioner psychologists consists of a five year program (our B.A and M.A. combined), in a department of clinical psychology. However, as there is little formal supervised experience in psychotherapy, students may then take additional training in an institute and receive a certificate. In general, regarding psychotherapy, there are no laws, no licensing, no state oversight, and no insurance reimbursement. It is not a medical expense, as in the U.S., and fees cannot even be used as an income tax deduction. There are no national data regarding the cost of psychotherapy, the length of sessions, the kind of cases seen, or the techniques of practice.

We also learned about the emphasis that has been placed on methods of group psychotherapy. This was due to the work of Myasischchev (1960), who emphasized the importance of interpersonal attitude disturbances in the development of mental disorders. And, we learned that Bekhterev Psychoneurological Institute closes up totally during the summer months. Patients are either released to the community or sent to other hospitals. This, at first, seemed dissimilar to American practices and was considered by us to be unethical and outrageous. However, the reader may recall that in the late 1980s, 10,000 psychiatric patients were released almost at once in New York and most of them became homeless. Not so different!

It has certainly been interesting to learn about Russian scholars whose contributions to psychotherapy have been enormous and, yet, who are relatively unknown in the West. In addition to Myasischev (1960), these include Pavlov's predecessor Sechenov (1952; similar to Skinner, he argued that private mental events are caused by external stimuli), Grot (1883; he suggested that focus be placed on what a person actually does—i.e., motor behavior), and Bekhterev (1918; he applied the reflex theory of stimulus and response to treat *human* psychopathology). We learned that Freudian psychoanalysis was very popular in Russia in 1920s and that his early works were translated into Russian. Evidently, Trotsky was very much interested in the unconscious and was a patient of Adler. However, "Trotskyism" was defeated by Stalin in a political struggle and psychoanalysis was then stigmatized. Psychoanalytic journals and associations closed and some psychoanalysts even changed fields (e.g., Alexander Luria became a neuropsychologist).

At this point, after the fall of communism, psychoanalysis is in a period of revival. The once forbidden fruit is again being embraced. Nevertheless, in 1994 I attended the first meeting of the All Russian Psychotherapy Association and there was clear interest in learning about behavioral techniques such as systematic desensitization. Russian psychotherapists are open to learning, although the language barrier is significant. Readers who are interested in the rise and fall, and rise, of behavior therapy in Russia will find Sukhodolsky, Tsytsarev and Kassinove (1995) to be of interest. Many "developments" in Russia were, of course, the result not of scholarly effort but of political struggle. Based on our meetings with Russian psychologists and psychiatrists, one major difference in our approaches has seemed to emerge. Americans appear to be more interested in psychotherapy and behavior change while our Russian colleagues seem to be more interested in developing theories and understanding "personality."

In addition, North Americans (that's me) are used to the quick dissemination of peer refereed knowledge about psychotherapy. It unifies our thinking. Russia is different – very different. The country spans 11 time zones and, because of this, I have come to

question the generalizabilty of findings even from my own cross cultural research (e.g., Kassinove, Sukhodolsky, Tsytsarev, & Solovyova, 1997). The few psychological associations that exist are local and there is little knowledge about psychotherapy practices outside of the major cites. Learning about psychotherapy is generally a result of learning by expert testimony.

A Code of Ethics was written and adopted by the Russian Psychological Association in 2003. Although it was modeled on the APA code, it no doubt has had limited distribution as it is a St. Petersburg based organization. Some journals have emerged, but their distribution is also limited and there is no way of knowing how many will read published articles (e.g., Kassinove, in press). Many American books about psychotherapy have been translated and can be purchased in Moscow, St. Petersburg, etc. However, there are locations from Vladivostok in the east to Arkangelst in the west where the distribution of journals and training seminars are very limited. PhD level psychologists are researchers. Master's level (or lower) practitioners, particularly in non-urban smaller cities, obtain knowledge on a hit-or-miss basis. Thus, the state of Russian psychotherapy is probably best characterized as highly variable. Our students, who have been brought up to see psychology as unified, have grown from this understanding of practice in Russia.

Learning from Travel to India

As a balance to the cold and formerly communist Russia, we have made five trips to the heat of India, the largest democracy on the planet. Training in psychology and psychotherapy in India is different from ours for many reasons including the limitations caused by poverty. Their contributions to scholarly thought about psychotherapy are far fewer than we discovered in Russia. Indeed, much of their teaching seems related to religious thought—a contrast to the Russian perspective where atheism was the state religion. For students and professors in India there is little access to journals and books. Psychologists in India are always eager for a copy of one of my books (Kassinove, 1995; Kassinove & Tafrate, 2002) or articles related to psychotherapy. They quite often ask for these items as gifts. Students typically don't own text books; rather they go to the library and copy by hand what is needed. In many parts of India, focus on food, shelter and sanitation must naturally take precedence of focus on higher, more abstract, intellectual pursuits.

As in Russia, although there is some specialization in their Master's programs, PhD training is almost purely research oriented with few formal classes. A PhD can be earned in psychology, but it is not in culture bound, APA approved areas. A PsyD is unknown in India (and Russia).

There was much local interest when Hofstra psychologist Joseph Scardapane and I gave a two-day workshop on REBT at the University of Pune in 1999. And, as always, our PhD students joined the trip to learn about India and Indian psychology. The department Head, Dr. Usha Ram, has been very helpful in shaping our thinking. Her 1998 work on "Suffering and Stress Management" has clarified similarities and differences in our approaches to the causes of psychopathology and methods of psychotherapy. In contrast to learning about anger (my area of interest) from research studies, as I do, she takes much of her knowledge from the Bagadvadgita – an Indian book of wisdom. Nevertheless, as our students have learned, our thinking and conclusions about anger seem to be remarkably similar.

Dr. Ram arranged for a visit to the counseling center at the University of Mumbai and helped one of our students collect data for his dissertation in India. He was so thrilled with the Indian culture that he returned there for three months. Then, Indian PhD candidate Neelanjan Konwar took us to

Assam and Nagaland, to give lectures on psychotherapy and to interact with Indian colleagues. Insurgent activity is frequent in Nagaland. To arrive there, we had to cross many gates and bridges that were protected by armed guards. Again, Hofstra Ph.D. students were there to learn and much of the learning was informal and occurred in people's homes.

On two occasions my students and I visited a *face reader* in India, who professed to be able to tell our future by simply looking at us. His office was very busy, with many Indians waiting for his wisdom. Yet, he wanted no payment. It was simply suggested that we offer a candy bar for his services. Interestingly, this gentleman was also a professor of anthropology at the university. For the record, and not unexpectedly, his prophesies were either vague or just plain wrong. Nevertheless, our students learned much from these interactions.

As in Russia, there is little training in psychotherapy per se in India. Given the deep poverty of the country, and the limited opportunity to seek higher education and learn a living as a psychotherapist, some practitioner-trained PhD psychologists have found work in corporate settings. Professional work in such settings is fundamentally related to using psychological skills to enhance human functioning, and sell products, rather than reduce distress through psychotherapy. Recently, however, we discovered that one of the primary government approved training centers for psychotherapy is located in the city of Vellore, in the state of Tamil Nadu. Although this state is mostly Hindu, it is known as the *Christian Counseling Center* and offers courses and seminars on topics in psychopathology and methods of psychotherapy. The Director, B.J. Prashantham, has invited us to travel to Vellore in January of 2006 to give lectures on psychotherapy. No doubt, students will join us and, no doubt, we will learn as much from them as we will teach to them. India is so large, varied, and complex that it has often seemed like we traveled to different countries—all named India.

Concluding thoughts

It would be unwise to profess a full understanding of India or Russia. Both are incredibly large with major variations across their vast bounds. Thus, if the reader has been offended by misstated facts or opinions, apologies are offered. Our knowledge is, of course, developing. The purpose of this paper has been simply to show that practices in other parts of the world are very different and that students (and professors) can learn to be more flexible in their thinking by experiencing these variations.

Some of what we have seen on these trips has been difficult. The alcoholism and aggression that seem to be part of the Russian culture, and the poverty and food shortages in India, have presented personal challenges. Bathroom facilities in both countries have often left much to be desired. The treatment of women in some families in India, and the anger and family violence in Russia, have been problematic. However, each trip has led to increased openness about the practice of psychotherapy and about the skills and tools needed to study human behavior in an ever smaller world. Not surprisingly, much learning has come from personal experience in different settings.

St. Petersburg (Leningrad) State University has produced six Nobel Prize Winners. Not bad! And, certainly, out of my league. My contributions, I hope, have been to help students learn something about the practice of psychology and psychotherapy around the world and to cure their myopic thinking.

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FEATURE

INTERVIEW WITH WADE SILVERMAN, PH.D.
Past President of Division 29, outgoing editor of *Psychotherapy: Theory, Research, Practice, and Training* and former editor of *Psychotherapy Bulletin*

Adam Leventhal, B.A.

Wade Silverman, Ph.D.

Leventhal: Dr. Silverman can you give a short professional biography starting with where you went to graduate school and ending with what you're doing today?

Silverman: I went to graduate school at Kent State University and finished right before the riots. Then, I did a post-doc at the University of Illinois Medical School in Chicago. I became very involved in community mental health and psychology through organizing neighborhoods, working with gangs, and helping poor people get access to the best mental health care in the city. Then, I became involved in a training program teaching principles of community mental health. After that, I went on to Emory where I was chief of psychology and head of the medical psychology program. I then came to Miami to become chairman of the psychology department of Barry University for three years. I'm currently in a clinical and forensic private practice and am consulting for local universities and businesses.

Leventhal: You've spent much of your career both in university settings and working directly with communities. What were those experiences like?

Silverman: Working in medical schools was both exciting and uncomfortable at the same time. Being a psychologist, you're marginalized by psychiatrists. In one respect, this was beneficial because I ended up working in a hospital that got all the unusual cases from all over the state. There, I got an opportunity to see everything there was to see clinically. At the same time, psychiatrists universally treated you like a second-class citizen, which was discomforting.

Leventhal: What advice would you give to psychologists, social workers, and other mental health professionals who plan to or are presently working in medical school settings, where they may encounter marginalization by medical staff?

Silverman: Specifically, it is most difficult working with psychiatrists. I've found working with the general physicians was a very positive experience because there tends to be mutual respect. Because psychiatry is a dying profession, there is a tremendous amount of institutional lack of self-esteem. I would really watch out for that in a department of psychiatry, whereas in family medicine, a pain clinic, or oncology, I would think that psychologists are much more respected.

Leventhal: Can you tell me about your leadership roles in the Division?

Silverman: I was very active in the Division of Community Psychology in the 1970s until they became they became too politically correct for me, stressing that all scientific papers should have direct application to the community. I disengaged

myself from them and found a home in Division 29 because the members were very friendly and accepting. There was no differential treatment of academic and applied members in the Division and, thankfully, this remains the case today.

I then took on some major responsibilities. I first became editor of the *Bulletin* and then served as editor of *Psychotherapy: Theory, Research, Practice, and Training*, which I'll be giving up shortly. This was the single most satisfying academic experience that I've had. It gave me an opportunity to shape the field in a modest way, to be current with cutting edge knowledge, and to work with some fine people in the field.

Later, I accepted a nomination to run for president and began that term during a difficult time. Because of financial issues and moving central offices, I really did not get a chance to work on many of the initiatives I wanted to put into play. Unfortunately, most of the membership was unable to notice a lot of my work because it involved overcoming these obstacles. We pushed through that, and I was able to pass on to John Norcross, the president after me, a safe and secure Division, which was very satisfying.

Leventhal: What were you most proud of during your presidency?

Silverman: I was most proud of hiring Tracey Martin…She is still our central office administrator and is doing a fine job.

Leventhal: You were editor of both the *Journal* and the *Bulletin*. What types of issues do you think should be addressed in these two publications in the future?

Silverman: I like to refer to the *Bulletin* as the "heart of the Division" and the *Journal* as the "soul of the Division." The *Bulletin* should be a method for membership to communicate with each other on a regular basis, exchange ideas, and enjoy each other's successes. In my opinion, the last thing that should be cut in any future financial crisis should be the *Bulletin*.

The *Journal* is what the division should be most proud of. As editor, I carried on the tradition of integrating scholarship and research in the field of psychotherapy and disseminating it all over the world is special, as I'm sure the new editor, Charlie Gelso, will do so as well. This is the best journal of its kind. What was unique to my editorship was the journal's shift from a psychoanalytic focus to a broader coverage of other areas, including humanistic, cognitive-behavioral, and research in natural settings.

Leventhal: What do you think are some reasonable goals for the Division's student section for the 2005 year?

Silverman: For the Division to sponsor a student-only poster session during the APA convention. I also think we should have a mentoring program session both at the midwinter conference and at APA convention. Here, students could consult with Division 29 members about either research or practice interests to help further their careers.

Leventhal: That is a wonderful idea! The other student committee members and I will hopefully get this organized for this upcoming convention and future meetings. What advice would you give to student and young professional members of the Division, such as myself?

Silverman: Stay active! There are a lot of potential benefits in becoming involved as a leader in the Division.

Leventhal: Where would you like to see the Division go in the future?

Silverman: That's a tough one. I can better tell you where I would like us not to go. Don't get involved in the managed care controversy. Professionals should be allowed to do what they want to do; especially young people who are trying to

get their practices up off the ground.

Other than that, the Division is healthy in its broad, inclusive outlook of psychotherapy. I feel optimistic about that.

Leventhal: It sounds like you've had a very successful career, including your many contributions to the Division. What are you planning to do next?

Silverman: I'm not planning to retire. I plan to stay actively involved in Division 29 and the Florida Psychological Association to continue to promote the practice of psychotherapy at national and local levels. I will continue to write and will remain involved in private practice.

Leventhal: Thank you Dr. Silverman.

Silverman: My pleasure.

DIVISION 29 2004 AWARDS AND SOCIAL HOUR HONOLULU, HAWAII

Phyllis Koch-Sheras, Nadine Johnson and Mary Murphy

Jack Wiggins receiving the President's Award from Linda Campbell

Janet DeMaio and Tom DeMaio, Peter Sheras and Phyllis Koch-Sheras

John Norcross and Jan Culbertson

WASHINGTON SCENE

The Closing Hours Of The 108th Congress – A Glimpse Into The Future

by Pat DeLeon, former APA President

The 108th Congress (2003-2004) will soon adjourn sine die and the elections of November 2nd once again have provided the Republican party with the majority in both Houses of the Congress and the White House. Our five psychologist members of the U.S. House of Representatives were re-elected, with Congressman Ted Strickland running unopposed in winning his sixth term. APA's Mike Sullivan reports that there are now 11 state legislator psychologists with California electing four, Massachusetts and Ohio two each, and Ontario with a member of its provincial parliament holding two Cabinet posts. Historically, two legislator psychologists have had the experience of serving as State Psychological Association Presidents, in Utah and New Hampshire. As Mike has frequently pointed out at the extraordinarily impressive Practice Directorate State Leadership Conferences, the majority party controls the legislative agenda. Accordingly, this is a good time to reflect upon some of the federal policy proposals that were enacted, or seriously considered, during the past Congress. For the past is often prologue for the future, especially in the legislative arena.

The Fiscal Year 2005 Omnibus Appropriations bill, which will soon be sent to the President for his consideration, suggests a very bright future for an expanded vision of health psychology. The conference report accompanying the Office of the Secretary of the Department of Health and Human Services (HHS) states: "The conferees are concerned about the absence of mechanisms to ensure the delivery of necessary psychosocial care to individuals with cancer and their family members. The conference agreement provides $1,000,000 for the Secretary, working in collaboration with the Institute of Medicine and relevant governmental agencies and non-profit entities, to study the delivery of psychosocial services to cancer patients and their families in the community setting. Specifically, the report should include an analysis of: (1) the capacity of the current mental health and oncology provider system to deliver such care and the anticipated resources required nationwide; (2) available training programs for professionals providing psychosocial and mental health services; and (3) existing barriers of access to such care. The Secretary is encouraged to issue recommendations to address these issues." Over the years, our APA President-Elect Ron Levant and CEO Norm Anderson have consistently called for psychology's systematic expansion into the generic healthcare arena, pointing out that society's definition of "quality care" must include recognition of the all important psychosocial-cultural-economic gradient of care.

Those involved with training psychology's next generation should be particularly pleased that the Omnibus conferees also directed HHS (specifically, the Health Resources and Services Administration [HRSA]) to continue funding, at last year's level, the graduate psychology education and geropsychology training initiatives. The University of Alaska will receive targeted funding to continue its Alaska Natives in Psychology (ANPSYCH) program. Our sincerest congratulations to the APA staff and governance, and particularly to those colleagues who during the past year personally participated in the public policy (i.e., political) process on behalf of these important programmatic initiatives. We have long ago come to appreciate that both substantive relevance and personal

(and persistent) involvement in the public policy process are absolutely critical to legislative success. For as Mike has also noted, in the 108th Congress the dominant professions of the elected officials continued to be law and business, with 59 Senators possessing law degrees. These disciplines look at health and mental health care entirely differently than do clinicians. They rely heavily upon personal experiences, public testimony, and the media for policy recommendations. Psychology's voice must be heard.

In June, 2004 the House Committee on Ways and Means, Subcommittee on Health held a hearing on Health Care Information Technology. Former APA Congressional Science Fellow (presently, House staff member) Neil Kirschner: "The effort to expand the role of information technology (IT), in the forms of electronic health records (EHR) and e-prescribing, throughout the nation's healthcare system is one of the few truly bipartisan agendas in today's Congress. There is general agreement that IT adoption will increase clinical quality, patient safety and healthcare efficiency. This cooperative effort was demonstrated in this Committee hearing where both the Chairwoman, Rep. Nancy Johnson of Connecticut and the Ranking member, Rep. Pete Stark of California engaged the witnesses in an open discussion on how the federal government can facilitate the establishment of nationally recognized standards to promote the interoperability of these health information systems and how the government can best use limited taxpayer financial resources (e.g., in the form of grants, differential payments based on IT adoption, loan programs, tax incentives, etc.) to promote the adoption of IT throughout private healthcare institutions and other provider settings.

"Among the witnesses were: 1) The President's recently appointed Information Technology Czar, David Brailer, who emphasized the Administration's goal of establishing an EHR infrastructure to be available to all Americans at the appropriate time and place of care within 10 years. He also outlined current efforts to promote this goal including provisions in the recently passed Medicare Modernization Act that provide incentives for providers to adopt IT systems and creates a Commission to develop a comprehensive strategy for the adoption and implementation of health care information standards. He also outlined additional efforts of HHS and its Agency for Healthcare Quality and Research (AHQR) to promote IT adoption through incentives and demonstration project grants. 2) Robert Kolodner of the U.S. Department of Veterans Affairs (VA), who wowed the Committee and the large audience with a demonstration of the VistA system - an integrated health information program that encompasses the VA's 1,300 sites of care throughout the country. The patient records, with appropriate privacy protections, of the five million Veterans treated by the VA each year are readily available to the treating clinicians. VistA also includes e-prescribing, bar code medication administration, decision support tools and the ability to provide the clinician with actual radiological images that were produced in previously requested diagnostic testing. It was truly impressive, and the VA is offering a freely available version of this system to the public. And, 3) Andrew Wisenthal, Associate Executive Director, Kaiser Permanente, described their company's impressive 10 year, $3 billion commitment to implement a comprehensive healthcare system. It is notable that a recent survey of nationwide hospital budgeted expenditures for the coming year indicates an increased private sector investment in IT."

The 21st Century will be an era of increased applicability of the advances occurring within the technology and communications fields to the health care arena. We would rhetorically ask: Are our practitioners, educators, and the future generations of psychologists being prepared for the unprecedented changes (i.e., challenges) that are undoubtedly before us?

Excerpts from the testimony of the National Health Information Technology Coordinator: "I thank you for inviting me here today.... As you know this is a high priority for the President and Secretary Thompson. The priority has been further accelerated by the President's call to make electronic health records (EHR) available to most Americans in the next 10 years and by the creation of my position to achieve this goal. Your thoughtful leadership and that of your subcommittee towards achieving this goal has been widely recognized and demonstrated through the e-prescribing and other health information technology (HIT) related provisions in Medicare Prescription Drug, Improvement and Modernization Act of 2003. As a result of the President and the Secretary's strong commitment to this issue, the Office of the National Coordinator for Health Information Technology has been established to meet the goals of the Executive Order announced earlier this Spring. In my new role as National Coordinator for Health Information Technology, I will be working with the Administration, Congress and the private sector to bring together the resources and talent to drive the adoption of HIT in the health care system. There is unprecedented enthusiasm and commitment for changing the day-to-day world of health care with HIT from leadership across sectors, and my goal in the next year is to focus this into a well-developed plan and a set of coordinated actions to accelerate the widespread adoption of electronic health records and e-prescribing.

"The Administration has already made significant progress in this area. Specifically, last year, we licensed SNOMED (Systematized Nomenclature of Medicine, a comprehensive set of clinical terminologies) to make it available without charge to everyone in the United States. As part of the Federal Health Architecture, we adopted clinical terminology standards across federal agencies through the Consolidated Health Informatics (CHI) initiative. The Department of Health and Human Services (HHS), Department of Defense (DoD), Department of Veterans Affairs (VA), and other Executive Branch agencies have endorsed 20 sets of standards, such as standards for medications, labs, and immunizations. These standards will make it easier for information to be shared across agencies and could serve as a model for the private sector. The Secretary created the Council on the Application of Health Information Technology (CAHIT), which has been the coordinating and internal advisory body for HHS. CAHIT has served as the primary forum for identifying and evaluating activities and investments that promote and/or complement evolving private sector initiatives and strategies.

"The Executive Order of April 27th not only created my position within the new Office, but it also required the Departments and agencies of the Executive Branch of the federal government to work together to develop and align policies and programs that will achieve our common goal of using HIT to improve the safety, quality and efficiency of health care in every area of this country. I have also been given the responsibility to direct the HHS HIT programs, and to coordinate these with those of other Executive Branch Departments and agencies. Specifically, HHS will coordinate with other Executive Branch Departments and agencies to develop and implement a strategic plan for and to use resources to accelerate HIT adoption in the private sector. Both the DoD and VA have surpassed the private sector in successfully incorporating HIT into the delivery of health care, and will play a central role in adoption efforts. The Office of Personnel Management (OPM), as the purchaser of healthcare for federal employees, has a unique role and the ability to encourage the use of electronic health records through the Federal Employee Health Benefits Program. It can join other purchasers who are developing programs that support adoption of HIT by physicians and hospitals, and its use in improving and rewarding quality. In addition to collaboration

with federal agencies and Departments, I will also coordinate outreach and consultation by the federal government with interested public and private organizations, groups, and companies. We will coordinate with the National Committee on Vital and Health Statistics and other advisory committees to do this, and will enhance relationships with public-private collaboratives that are advancing HIT adoption.

"The President's vision is to develop a nationwide HIT infrastructure that ensures appropriate information is available at the time and place of care, resulting in improved health care quality, fewer medical errors and may even reduce health care costs. This new infrastructure will help to connect physicians, hospitals and consumers in every location of our country. This would give consumers and clinicians secure and controlled access to all the important information they need to make informed decisions about their health and health care, while ensuring individually identifiable information is confidential and protected. Designed and implemented correctly, health information exchange organizations could promote a more efficient health care delivery system. They will also help to improve coordination of care through the secure exchange of information among hospitals, labs, physician offices, and other health care providers....

"The purpose of this information exchange would be to personalize care in such a way that each patient could be diagnosed and treated as an individual rather than a disease type. For example, the national availability of patient health information could allow a Medicare beneficiary with multiple chronic conditions to receive the same high quality health care at home or while traveling, without needing to carry their information or fear that new findings or treatments may not be known to all possible health care providers. Many patients take multiple drugs or have histories of drug reactions, but decentralized paper records often do not reveal this fully. Regardless of where a beneficiary is receiving care, health information exchange networks would allow for information about medication history and potentially serious drug interactions to be available in real-time, along with out of pocket costs and therapeutic alternatives, before the physician transmits a prescription to a pharmacy....

"This year, the Agency for Healthcare Research and Quality (AHRQ) will spend $50 million on health information technology research and demonstration projects aimed at improving the safety, quality, efficiency and effectiveness of care. Using a portion of these resources, AHRQ will establish a Health Information Technology Resource Center, a much-needed resource that will provide technical assistance, expert health information technology support, educational services and other services to HHS grantees to support the implementation of HIT into clinical practice. President Bush's fiscal year 2005 budget request includes an additional $50 million to expand health information technology demonstration projects, particularly targeted to health data exchange by providers. This request would double federal investments in this area....

"We are aware that every day, Americans are dying of medical errors and are not always getting the best treatments. We need results that will change care delivery and that will last. The Secretary and the President are firmly committed to improving the safety and efficacy of health care by increasing the use of information technology throughout the health care industry. The Administration has already made significant progress in this area, and we will continue to work diligently to meet the President's goal for most Americans to have electronic health records within 10 years...."

We especially concur with Neil's concluding thoughts: "The effort to expand the role of information technology (IT) throughout the nation's healthcare system is one of the

few truly bipartisan agendas in today's Congress. There is general agreement that IT adoption will increase clinical quality, patient safety and healthcare efficiency. Over the next decade, federal and state governments, as well as the private sector, will be pouring significant funds towards this effort—and psychology has a major opportunity to contribute to and benefit from this expansion. Effective IT systems will require substantial compatibility between the needs and capabilities of provider and patient users and the system design. This area of ergonomics is one in which psychology has historically played a major role. Similarly, the field of behavioral health provides unique challenges regarding issues of privacy and decisions regarding the definition of relevant data. Again, our discipline has much to offer here. From my perspective on the Hill, it appears that physicians are taking the lead in this IT effort. It would be good to see the tide change!" More non-physicians must provide leadership in this exciting arena.

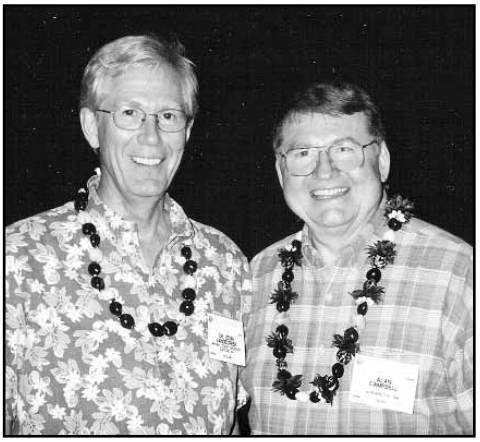
Why is it that so many colleagues seem satisfied allowing medicine to control psychology's professional destiny? In November, the Congress sent to the President for his consideration H.R. 3936, the Veterans Health Programs Improvement Act of 2004. Included in this bill was Section 503 - Under Secretary For Health. "Current law: Section 305(A)(2) of Title 38, United States Code, requires that the Under Secretary for Health be a 'doctor of medicine.' House bill: Section 7 of H.R. 4231 would repeal the requirement that VA's Under Secretary for Health be a medical doctor. Senate bill: The Senate Bills contain no comparable provision. Compromise agreement: Section 503 of the Compromise Agreement follows the House language." When signed into public law, psychology (and other health care disciplines) will be eligible for appointment to the highest ranking "health care" positions within each of the federal Departments; i.e., serving as the Surgeons General of the U.S. Public Health Service, Army, Navy, Air Force, and now the VA. We need to have senior non-physician colleagues considered for these high level policy making positions.

During my tenure as APA President, I heard from colleagues across the nation that they were experiencing unexpected difficulties in becoming licensed in their "new state of residence" during their semi-retirement years. Licensure mobility was also becoming increasingly significant for new graduates. Questions regarding mobility rank among the highest that come into the Practice Directorate's Department of Legal and Regulatory Affairs. The advent of technology (and specifically telehealth) highlights the timeliness of our profession addressing licensure mobility. The enactment of the Health Care Safety Net Amendments of 2002 (admittedly, in a previous Congress) raised this issue to the national level. "It is the sense of Congress that... States should develop reciprocity agreements so that a provider of services... who is a licensed or otherwise authorized health care provider under the law of 1 or more States, and who, through telehealth technology, consults with a licensed or otherwise authorized health care provider in another State, is exempt, with respect to such consultation, from any State law of the other State that prohibits such consultation on the basis that the first health care provider is not a licensed or authorized health care provider under the law of that State." HHS received the authority to: "make grants to State professional licensing boards to carry out programs under which such licensing boards of various States cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine." The Omnibus Appropriations bill includes Senate language for the Office of Telehealth: "Physician licensure is frequently identified as one of the most critical barriers to the increased use of telemedicine. There is a need to stimulate cooperation and communication among licensing authorities to address these

issues and to facilitate multi-State practice, ensure public safety and create an environment for advancing telehealth services. The Committee has provided $1,000,000 above the fiscal year 2004 level to support incentive grants that would be used as authorized in the Health Care Safety Net Act of 2002 to develop and implement policies to reduce barriers to telehealth services."

It should not be difficult to appreciate that the advances occurring in information technology (IT) will have a very direct impact upon psychological practice and the underlying public policy question: Is it in the public interest to have differing licensing standards across state boundaries, especially when it is becoming increasingly possible to obtain provider-specific quality of care data, across patients over time? And, for those who are just beginning to explore the ramifications of HIPAA (the Health Insurance Portability and Accountability Act of 1996), we would suggest that it is only a matter of time before every practitioner must become HIPAA compliant. The winds of change are definitely here. Aloha.

DIVISION 29 2004 AWARDS AND SOCIAL HOUR HONOLULU, HAWAII



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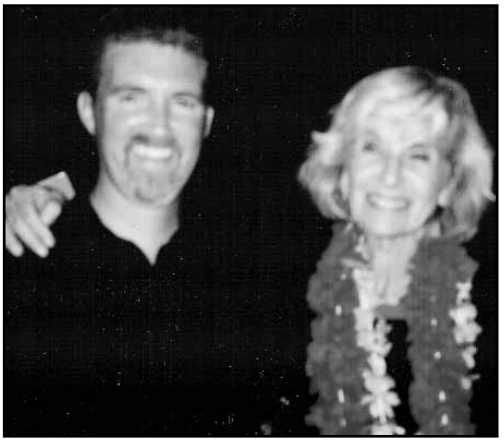

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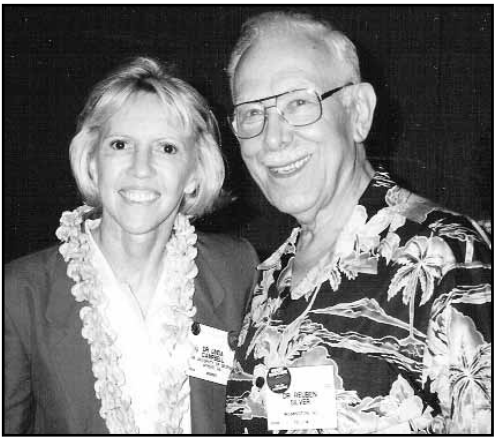

Linda Campbell and Past President Reuben Silver

FEATURE

Adventures of a Psychotherapist: Community Building with a Therapeutic Agenda

Bruce M. Gilberg, Ph.D., M.P.A.

Take twenty five years of clinical and community practice and mix with a mid-career excursion into the study of government. Learn a new vocabulary to understand that caucuses are meetings, sentiment is the preferred reference to emotion, human potential translates more or less into social capital and leadership symbolizes the courage to get something done. In 2001 I attended Harvard's Kennedy School of Government and brought home a master of public education and a civic engagement and child advocacy initiative (i.e. community psychology project with political goals) called the Cross-Generation Emotional Literacy Project or CGEL. The purpose of the CGEL Project was to create a program for the effective use of psychological knowledge in government. CGEL therefore integrated some of the best practices of psychology and strategies for volunteer community service.

The CGEL project began in Rochester, New York during 2001. We looked for a new name to reduce confusion with all sorts of medicinal advertisements and reading programs. The name was changed in the fall, 2004 to The Generation Two Initiative: Caring Adults Advocating for Children (G2). The initiative adheres to a positive psychology model (Seligman & Csikeszentmihalyi, 2000). According to Csikeszentmihalyi (Seligman et al.,2000), the positive effects of insight, love, play and education for individuals and groups deserve further study and applications. The Generation Two Initiative is an "applied side" project. The initiative strives to strengthen children's emotional and social development and their communities. Generation Two dynamically links the recruitment of senior citizen and young adult volunteers (civic engagement), with the psychological knowledge gained by the volunteers during yearlong friendship building meetings with children (intergeneration relationships) with direct communications to public policy officials (child advocacy) about children's education and health needs.

Generation Two has two goals. To reach the first goal requires that impartial adults successfully forge intergeneration friendships with children. Based on the establishment of empathic relationships, volunteers can emotionally and socially compliment the efforts of parents and teachers. The second goal gives attention to the community in which children and their families live. Generation Two believes grassroots child advocacy can grow from emotional mentoring. When volunteers who listen to children also communicate with public policy makers, stronger and more positive community relations are possible. Volunteers may develop a unique and practical message for public officials whose work often is at great emotional and social distance from their constituents.

Civic Engagement

Generation Two recruits senior citizens (our most experienced voters) and college students (the youngest voters). These segments of the population are selected because they are often prone to disengagement due to age. Robert Putnam's (2001) research depicts how uninvolved citizens remain underused capital or untapped human resources that should be available for community building. Both the wisdom of the seniors and idealism of the college students support Putnam's (2003) optimism about the good use of social capital

to bring communities together. The identification and effective use of social capital relies on building partnerships with senior citizen groups, religious organizations, local colleges and social service clubs. The volunteer recruitment process involves visits to the local organizations for information meetings. We discuss the value of bringing people with different abilities and knowledge together, a potent blend of innocence and wisdom. The selection process involves individual interviews with the candidates at the school sites, security checks and in-service training. Qualified volunteers typically live in the urban or suburban school district where they participate.

Intergeneration Relationships

Children in the first grade are chosen because they face the challenges of more work than play for the first time in their school career. During this critical learning phase they are away from home more than ever. It is beneficial that the children receive specialized emotionally–based experiences that support the relaxation and alertness necessary for social and academic learning at school. The friendships are meant to strengthen and advance the emotional and social skills that children need (emotional literacy) to prosper inside and outside the school environment. Cohen's (2004) work suggests this type social support may have positive effects on children's physical health as well. Furthermore, our youngest and senior generations are often strangers to each other. Generation Two helps bridge this relationship gap. Cohen (2004) reports that a broad range of social relationship (social networks) may buffer both the children and adult friends from the negative effects of stress.

Generation Two friendships evolve from the application of basic play psychotherapy and communication techniques. Since it has been made clear that the purpose of the relationships is not to treat mental illness the rules for engagement are quite different than the traditional clinical model. For example, Generation Two adheres to a transparent and inclusive process. Instead of a consulting room, all meetings with children are held in a public space at the schools. There is no need for confidentiality. Parents, teachers and other visitors pass through the cafeteria or library or hallway and quietly observe. The Generation Two program does not use screening instruments that target at risk children. This is a universal program where all children in a classroom receive parent permission to participate. There are no stigmas attached to leaving the classroom. The children are invited to weekly play and conversation meetings. The volunteer friends meet with the same three or four children throughout the year and form relaxing and supportive relationships. Children choose or initiate the direction and themes of the transactions. An assortment of play activities and toys are available in small suitcases on wheels. The volunteers empathically nurture the children's attempts to identify and communicate their thoughts and feelings through encouragement, praise and suggestion. Small group academic activities are scheduled for the children who remain in the classroom. Teachers often invite the volunteers into the classroom during special events, particularly holiday celebrations and plays.

Volunteer Training

There is evidence that non-professional adults can effectively learn basic child-centered psychotherapy skills that result in emotionally supportive relationships with children (Cowen, Trost, & Izzo, 1976). The Generation Two program strictly adheres to a child-centered rather than curriculum-based approach. The program teaches specific therapeutic techniques that adhere to Carl Roger's client-centered (1951) communication approach as well as Virginia Axline's (1947) reliable play therapy techniques. Mental health professionals present in-service programs about the uses of empathy, acceptance, listening, open questions, play and self-disclosure. Often the senior volunteers consider these methods

the outgrowth of common sense. An in-service program entitled: *The Art of Friendship Building Across Generations* is presented prior to meetings with the children. In-service training and support continues throughout the year. There are once per month programs. The topics include: the meaning and uses of play (Schaefer, 1979; Gilberg, 1999), Erikson's (1979) psycho-social stages of development, how children think (Piaget, 1962) and a workshop regarding how to say good-bye at the end of the year. There are 30 minute supervision groups every week and the volunteers keep journals that describe the evolving friendships. The in-service programs also include twice per year "parent-volunteer dialogues" that provide opportunities for parents to discuss their observation and ask questions. Parents and teachers are invited to all in-service programs and they can read the journals.

Child Advocacy

Generation Two child advocacy work requires that volunteers speak to policy makers through direct democratic means. It is not unusual that adults who work closely with children or who are raising them find education public policy incomprehensible or interfering. For example, *The Leave No Child Behind* mandates often place unnecessary burdens on local school district budgets. The reliance on "high stakes" standardized testing may distort the learning process for children as young as fourth grade. A Generation Two child advocacy committee researches how the implementation of national policy effects local education. The advocacy committee informs the volunteers about policy issues on a regular basis. Our volunteer friends consider what they learn from the children and their advocacy committee. They choose when and where to speak out. They may engage in letter writing campaigns, petition drives, public speaking engagements and voting in order to communicate about education policies that hinder or benefit children and their families. The goal is to create a good fit between local need and state or national policies, a systems level mutually empathic relationship. The volunteers work themselves and mobilize their peers to form an advocacy network that reflects the best use of social capital on behalf of children.

Community Building with a Therapeutic Agenda

My experience as a psychologist, student of government, and community organizer tells me that many people from different walks-of-life share aspirations and goals that may improve the lives of their fellow citizens. Unfortunately they do not have the time or inclination to create bridges across professional expertise, religious persuasion or economic class. Each group's territory appears embedded in and protected by a language of specialization that is difficult to decipher. Misunderstanding may alienate one group from another. Our own American Psychological Association learned how the United States Congress could misinterpret and harshly react to research regarding the limited longitudinal effects of sexual abuse on an individual's development by Rind, Tromovitch, and Bauserman (1998). When our national legislators identified the data as immoral support for adult- child sexual relations, APA significantly bolstered its efforts to proactively bring scientific knowledge to policy makers. George Albee (2002) wrote about the difficulties of working in the three worlds of politics, the media and academics. He stated that there should be distinct boundaries and identities for these disciplines, yet communication must be improved. In the same American Psychologist Special Issue about psychology and government, Bennet Bertenthal (2002) called for continued community outreach that educates the public and communicates to government.

The Generation Two Initiative responds to Berenthal's (2002) "Challenges and Opportunities in Psychological Science." Psychology practice and community service run along an advocacy continuum.

The child's psychotherapist always advocates for the mental health of the client. The therapist turned consultant, regularly relies on empirically based principles of therapy when visiting schools to improve the classroom environment for an emotionally vulnerable child. When volunteers learn about this therapeutic sequence of events they develop a coherent perspective for effective advocacy work. Volunteers convert knowledge gained from implementing basic principles of child psychotherapy into wide ranging advocacy activities that inform the public, both the volunteers and public officials, about children's emotional and learning needs. Volunteers advocate by moving from a child-centered or "bottom up" perspective rather than from the "top down" in the political system. Perhaps the therapeutic process is inherently a breeding ground for understanding principles of children's rights.

Results: Intergeneration Friendship Building

The most unpredictable aspect of the initiative proved to be the recruitment component. The relationship building process is occasionally destabilized by personal illness, illness of a family member or travel commitments. Research during the first two years included pre- and post-year questionnaires to assess the value of the initiative. The data suggested that children and volunteers prospered from the weekly experiences. Children in both the urban and suburban school sites regularly exhibited relaxed, cooperative and joyful behavior during their meetings. The observations of teachers, volunteers and school administrators were consistent about the children's enthusiasm. A commonplace anecdotal result was that the children talked about their "friends" throughout the week. Furthermore, while 30 of 36 parents gave their permission during the first year, 120 out of 130 kindergarten families from the pilot school requested that their child participate the next year. A documentary (in production) will provide additional qualitative data about the process of friendship building across demographics. Empirical evaluations began in the fall, 2004 in order to assess whether the emotional and social mentoring would positively affect classroom behavior and achievement. Many participants question whether Generation Two needs to have a direct impact on academic achievement.

Results: Child Advocacy

Most volunteers participate in child advocacy efforts. During the first year volunteers went on a petition drive to support their suburban superintendent of schools. Senior citizens collected signatures on petitions that advocated for responsible financing for the children's schools. The chancellor of the New York Education Department had threatened to fire the superintendent and school board for not submitting a budget on time. Generation Two supported the superintendent's refusal since the New York State Legislature could not pass a state budget. Last year the child advocates protested the closing of a vital neighborhood city school through a letter writing campaign and pubic speaking at a school board meeting. This year there is work to bring the suburban and urban volunteers together who will oppose the closing of several city schools. The central administration rational includes financial problems and a declining student population. Generation Two volunteers take the position that a decreasing population marks a window of opportunity for the creation of smaller schools within multiple use facilities. Advocacy has begun through a December 2004 Generation Two conference, contact with the city school administration and submission of an op-ed article to the local newspaper.

Anecdotal reports from the discussion group leaders suggest that when the volunteers learn more about the children their interest and concern about each child's classroom and home life increases. During the recent Friends and Volunteer Conference the volunteers expressed appreciation for their personal gains. The

discussion focused on how positive relationships superceded racial prejudice, religious difference, and economic class.

Conclusion

Generation Two volunteers advocate for the first grade child's emotional and social competence. The initiative borrows from the most reliable child psychotherapy communication skills to support intergenerational friendships.An outgrowth of the friendships is child advocacy. Generation Two empowers the youngest generation through an advocacy network across demographics. Next year Generation Two will move to a rural community where high school students volunteer as the children's friends and advocates. The implementation of the Generation Two Initiative will have completed its first therapeutic journey across demographics.

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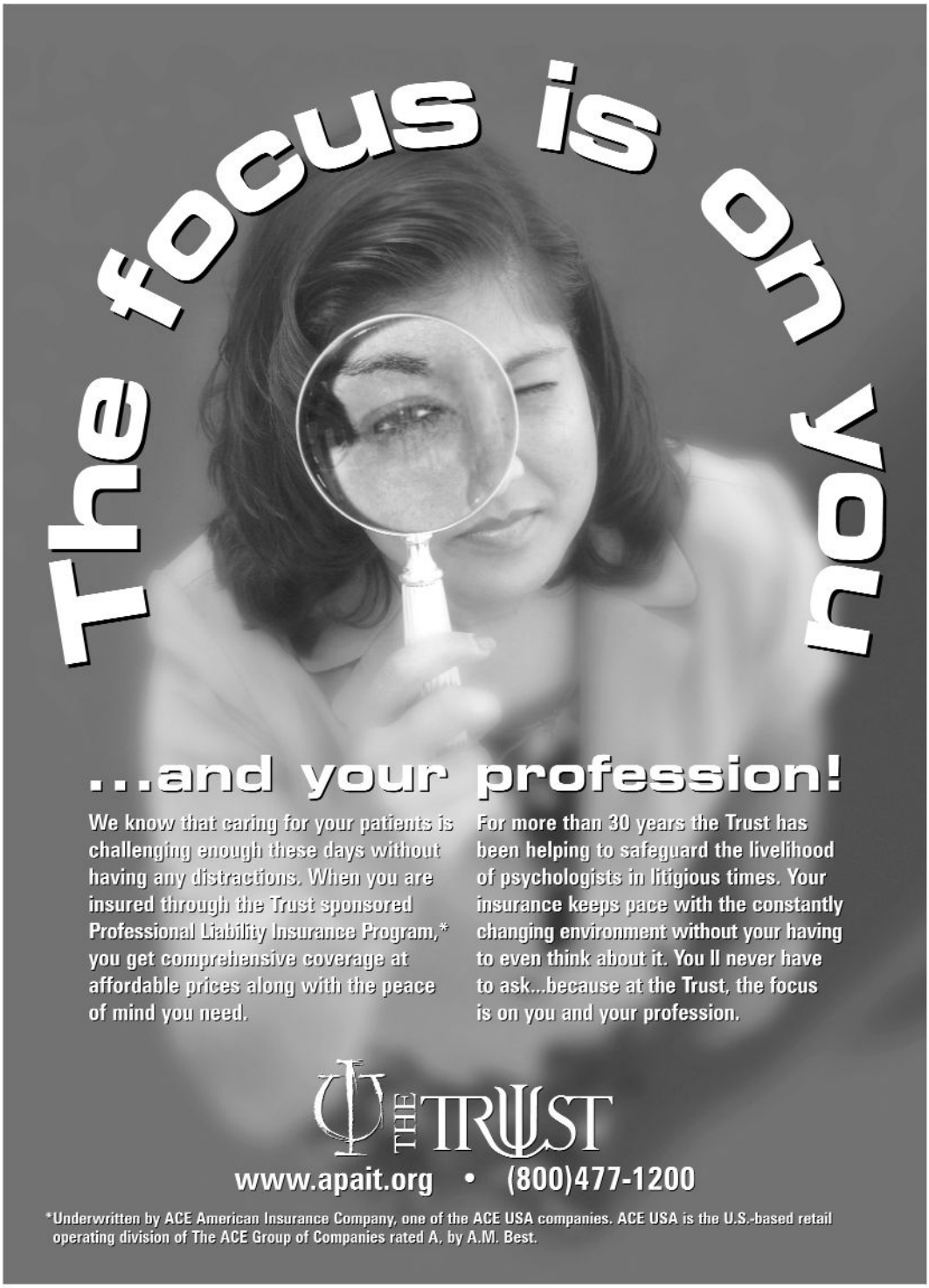
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Sincerely,
Anna McCarthy
Graduate Student Liaison
Division 29, APA
annamuck@hotmail.com

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