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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 events, awards, and professional opportunities; 2) provide articles and commentary regarding the 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, 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 to Craig N. Shealy, Ph.D., Editor, *Psychotherapy Bulletin*. Please note that *Psychotherapy Bulletin* 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 articles conform to APA style. Deadlines for submission are as follows: February 1 (spring); May 1 (summer); August 1; November 1 (winter). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.divisionofpsychotherapy.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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PSYCHOTHERAPY BULLETIN

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CONTENTS

PRESIDENT'S COLUMN

Leon VandeCreek, Ph.D.

One of the exciting and challenging aspects of serving as president of Division 29 is that I get to participate in many of the cutting edge issues of the committees of the Division. You would be pleased to know that many psychologists are actively working on initiatives for psychotherapy. I will highlight a few of them here, and others have described them elsewhere in this issue.

Linda Campbell, past-president, and I have continued to consult on a regular basis about the initiatives that were begun last year. She and I have hosted conference calls with members of the Research Committee (Bill Stiles is the committee chair) and with members of the Professional Practice Committee (Jean Carter and Alice Rubinstein are co-chairs). We have found these conference calls to be a very efficient and effective way to keep informed about committee work and to keep enthusiasm high. Some of these initiatives are described by Linda Campbell in this issue. We expect to have similar calls in the next month with both the Membership Committee and the Training Committee.

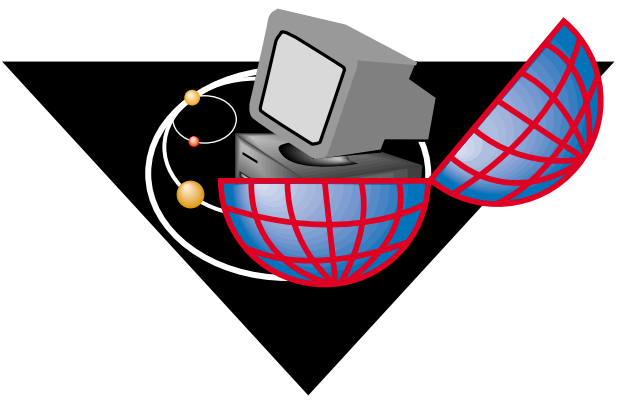
One of the exciting developments has been the continued expansion of the division's web page. Bryan Kim has added several new features. It will soon be possible to apply for membership online (including payment) without needing to download or mail the application form. Please encourage your colleagues to join; it is easy and inexpensive. Another new feature of the web page is the Research Clearinghouse which provides an opportunity for researchers to list their research projects and to invite participation. All of us probably receive periodic requests from researchers to serve as subjects or participants, but we hope that our Research Clearinghouse will encourage researchers to invite others in the division to participate in projects in a variety of ways. For example, researchers could invite practitioners to participate by collecting client data, or researchers could invite practitioners and trainers and other researchers to play a role in the design of a project. We hope the Clearinghouse will be attractive to many members of the division.

One of APA President Ron Levant's initiatives is to gain some consensus on evidence-based practice in psychology (EBPP). He established a task force that developed a draft policy statement. The members of the Ad Hoc Committee on Psychotherapy: Commitment to the Scientist-Practitioner Collaboration discussed this statement and made recommendations that I submitted to the task force. Our recommendation was to include the phrase "psychologically-based psychotherapy" in the definition of EBPP and we referenced a definition of psychotherapy that was adopted by the division in 2002. That definition reads as follows: "Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions which the participants deem desirable." Our recommendation to insert the phrase "psychologically-based psychotherapy" was consistent with our on-going effort to increase the presence of the word "psychotherapy" in clinical literature and policy statements. As Linda Campbell noted last year in one of her presidential columns, this

word has disappeared from many policy documents and has been replaced by broader phrases, such as "methods of intervention" which includes procedures that are not psychotherapy. The upshot of this shifting terminology is that training programs and accreditation bodies do not require that students receive training in psychotherapy, but rather in methods of intervention. We want to keep the word psychotherapy front and center for the profession.

Our discussion about the policy statement on evidence-based practice led to another exciting idea, namely that we are poorly informed about the role of clinical judgment and expertise of psychotherapists in providing care to our clients. Some researchers contend that practitioners should only use empirically supported treatments which usually refers to those treatments that have found research support in rigidly controlled studies. The role of the clinician's judgment in tailoring treatments to match the unique needs of each client is usually excluded from this line of research. Yet, the experiences of practitioners tell us that few clients match the inclusion criteria of the research studies and most of our clients are too complex for us to be bound by laboratory criteria. We really need to know more about the role of clinical judgment in selecting and implementing treatment. In response to our discussion, the Practice Committee has suggested to our journal editor that a special section of the journal be devoted to clinical judgment and he has enthusiastically agreed.

A lot is happening in the division and we are always interested in hearing from you. I am easy to contact at leon.vandecreek@wright.edu.



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STUDENT FEATURE

Fostering Self-Awareness: Moving in the Direction of Empirically-Based Training

Scott D. McDonald
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Abstract
Self-awareness is regarded as an essential characteristic of the competent, well-functioning therapist. However, it is unclear whether general didactics and supervision practices are effective at fostering self-awareness. Recent findings suggest that an evidence-based training approach, using self-reflection, improves self-awareness and subsequently clinical skills. This article asserts that self-reflection, particularly when paired with self-practice, is a technique that can be used to enrich personal awareness, clarify the mechanisms of change, and deepen the understanding of the therapeutic process.

Fostering Self-Awareness: Moving in the Direction of Empirically-Based Training
Fellow therapist trainees: Let me begin by asking a few questions about your most recent intake session. In your best estimation: 1. How would the client rate the quality of the therapeutic bond? 2. Did you and the client have a common perception of his or her goals for therapy? 3. Did you and the client have a common perception of what tasks would be important in therapy? And lastly, 4. Do you think the client will return for another session?

Now, let me ask two more questions. How much confidence do you have in your answers? Do you feel that your estimate of quality of the therapeutic alliance and likelihood of client return would correspond to your client's experience? If you are like many trainees, you probably rationalized that, regardless of how good or bad, your ratings were fairly accurate. But according to a recent study described in *Professional Psychology: Research and Practice*, the therapist trainee is a poor judge of the client's experience in the intake session. In fact, although client and observer quality ratings of the therapeutic working alliance and likelihood of return were comparable, therapist trainee ratings on analogous measures bore little resemblance to client ratings, even after a year of supervised clinical practice.

For the abovementioned study, O'Donovan, Bain and Dyck (2005) recruited 61 therapist trainees from clinical psychology programs and clinical apprenticeships (both approaches can lead to licensure in Australia). At the beginning of therapist training and one year later, trainees conducted intake interviews with researcher confederates who assumed standardized patient profiles. The researchers found that although the client and observer were in strong concord on ratings of rapport, agreement on therapeutic goals and tasks, and ratings of likelihood of returning for future sessions, ratings by trainees did not match those of the clients.

What could account for the inaccuracy?
O'Donovan and colleagues (2005) suggested that although the trainees in their study may have properly followed protocol and techniques appropriate for conducting an intake session (i.e., building rapport, identifying the problem, and setting goals), they had not yet developed a depth of awareness that would allow them to discern the experience from the client's perspective. However, lack of experience alone may not have been to blame. In fact, therapists with substantially more experience than O'Donovan's trainees appear to suffer the same inclination to misread clients' dispositions. An earlier study by Hill and colleagues (1993) asked therapists

with an average of ten years postgraduate clinical practice to anticipate what thoughts or feelings their clients experienced but did not relay during therapy sessions. Results indicated that although clients reported hiding negative thoughts and feelings during the session, the therapists were seldom aware of their clients' reactions.

In clinical psychology, a tenet of professional competence is the possession of a self-awareness of biases, stereotypes, and self-schemas that can interfere with treatment (American Psychological Association, 2002). Along those lines, several sources have emphasized that building a student's self-awareness is critical in training (e.g., Sue et al., 1998). In fact, the Council of Chairs of Training Councils (CCTC)—the umbrella system of doctoral, internship, and postdoctoral training councils in professional psychology—recently developed a document designed, in part, to notify students and trainees that their academic performance will be evaluated across a wide spectrum of competency areas, including but not limited to sufficient self awareness (see http://gradpsych.apags.org/jun04/competence.cfm). Moreover, surveys of both practicing licensed psychologists and heads of doctoral clinical, counseling, and school psychology programs agreed that self-awareness was the leading contributor to whether a psychologist is able to function in an unimpaired manner (Schwebel & Goster, 1998). Furthermore, in a more recent study, interviews with highly-regarded therapists revealed that awareness of their own issues and the understanding that personal issues had the potential to impact the therapy session was a primary ethical value (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005).

How can therapists improve their self-awareness?

In light of their findings with trainees summarized above, O'Donovan and colleagues (2005) recommended that experiential aspects of therapist training programs, in addition to didactic seminars, should include the formal practice of self-reflection to improve the burgeoning professional's ability to accurately judge their therapeutic work (see also http://gradpsych.apags.org/jun04/competence.cfm). The recommendation that self-reflection be included as part of clinical training was not derived in a vacuum, however. A quick search of the literature reveals several examples of how self-reflection has been identified as a valuable component of professional training programs in medicine (Niemi, 1997), nursing (Marita, Leena, & Tarja, 1999), marriage and family therapy (Naden, Johns, Ostman, & Mahan, 2004), and music therapy (Camilleri, 2001).

Self-reflection, which refers to a "metacognitive skill that encompasses observation, interpretation and evaluation of one's own thoughts, emotions, feelings, and actions" (Bennet-Levy et al., 2001) is thought to be a key element in the learning of new skills (Schön, 1987). Practicing self-reflection can foster a deeper understanding of technical-rational knowledge (i.e., textbook learning and lecture) and the mechanisms through which particular techniques work. Although didactics lay the foundation for professional development, self-reflection helps the trainee mature a sense of "professional artistry," an important component of professional competence that involves self-awareness and versatility in practice. In his seminal work, *The Reflective Practitioner,* Schön (1983) described the process of self-reflection:

> When a practitioner reflects in and on his practice, the possible objects of his reflection are as varied as the kinds of phenomena before him and the systems of knowing-in-practice which he brings to them. He may reflect on the tacit norms and appreciations which underlie a judgment, or on the strategies and theories implicit in a pattern of behavior. He may reflect on the feeling for a situation which has led him to adopt a particular course of action, on the way in which he has framed the problem he is trying to solve, or on the role he has constructed for himself within a larger institutional context.

Can clinical training improve self-awareness? Certainly, as this author's Director of Clinical Training recently pointed out, self-awareness takes the guise of various "general" factors in clinical competence such as supervisablity, maturity, and motivation to improve. Unfortunately, it is unclear from the literature whether standard didactics and supervised experience alone leads to the trainee developing self-awareness. In fact, as the results of O'Donovan et al. (2005) indicate, a full year of supervised clinical training did not improve trainee's ability to accurately judge their therapeutic work.

On the other hand, there is some evidence that programs implementing specific protocols utilizing self-reflection have been successful in improving clinical skills (Bennett-Levy, et al., 2001; Marita et al., 1999). For example, Bennett-Levy and colleagues (2001) performed a qualitative study of a course in cognitive therapy that included self-reflection paired with self-practice, such as completing thoughts records, setting personal goals, and conducting behavioral experiments. At the end of the course, participants reported a deeper understanding of the therapeutic process which was useful as a therapist but also in their personal lives. Specifically, they reported an enhanced understanding of the therapist role, cognitive theory, and the mechanisms by which change occurred. As one participant conveyed,

> Although I already knew that emotions are a result of our interpretation of events, this situation gave me a good example of that from my own experience. So rather than just "knowing" about this phenomenon I "realized" it – the difference between understanding the concept at a head level and gaining an unquestionable, full-bodied experience of understanding (p. 211).

Many participants also reported enriched personal awareness:

> The whole process has taught me things about myself, the way I think, and the way I unconsciously sabotage the positive. I am now aware of Little Miss Nasty, who rears her ugly head whenever something positive happens (p. 213).

Results also suggested participants experienced an enrichment of therapist skills and developed stronger self-concepts as therapists. In the words of one trainee,

> What it has truly given me is a belief, a belief that cognitive therapy works, that I am capable of doing cognitive therapy and that I can help clients do cognitive therapy. Empirical and scientific grounding helped me to believe in the efficacy of cognitive therapy. Practice and reflection demonstrated I could do it. Reflection and my own experience of cognitive therapy techniques gave me confidence that I had what it took to help my clients use cognitive therapy (p. 214).

How does one practice self-reflection? There are several avenues to increasing self-awareness through the use of self-reflection. One approach is for the trainee to enter therapy as a client (Ramos-Sanchez et al., 2002). However, despite the requirement of analysis for the practitioner of psychoanalysis (Prochaska & Norcross, 1999) and limited evidence that personal therapy improves skills and attitudes used in practice (Macran, Stiles, & Smith, 1999), it is unclear whether experience as a client has an impact on a therapists clinical effectiveness (Macaskill, 1988; Macran & Shapiro, 1998).

Perhaps a better option is for the trainee to practice self-reflection techniques during supervised practica, such as watching tapes of therapy sessions, keeping a "learning log" of clinical experiences (Niemi, 1997), writing periodic reflection papers (Nadan et al., 2004), and role-playing from a client's viewpoint with colleagues (Beck, Rush, Shaw, & Emery, 1979). In addition, there is a growing emphasis, particularly in cognitive therapy, for therapists to practice techniques on themselves and reflect on the experience (Bennett-Levy et al., 2001). As Padesky (1996) succinctly declared, "to fully understand the process of the therapy,

there is no substitute for using cognitive therapy methods on oneself." (p. 288). The Bennett-Levy et al. (2001) study reviewed above illustrated an exemplar of self-practice and self-reflection, utilizing group meetings, weekly diaries, and Grenberger and Padesky's (1995) *Mind over Mood* which included thought records and self-guided behavioral experiments. Furthermore, interested therapists may benefit from taking advantage of other learning opportunities such as workshops on schema identification (Padesky, 1996), practica experiences in group therapy with an interpersonal focus (Yalom, 1995), and becoming familiar with the relevant literature (e.g., Schön, 1983, 1987; Von Wright, 1992).

In summary, self-awareness is regarded as an essential characteristic of the competent, well-functioning therapist. Furthermore, therapists who are highly regarded by their peers report self-awareness as one of their core ethical values. However, it is unclear whether general didactics and supervision practices are effective at fostering self-awareness. Recently, the practice of self-reflection, particularly when paired with self-practice, has gained support as a technique to enrich personal awareness, clarify the mechanisms of change, and deepen the understanding of the therapeutic process (e.g., see http://www.apa.org/ed/graduate/cctcevaluation.pdf). Despite the apparent agreement of the APA, clinical training directors, and practicing clinicians that self-awareness is a critical attribute of the competent therapist, the paucity of research that can inform training in this area is perplexing. Furthermore, a review of the four example student evaluation forms in the *Manual for Directors of Clinical Training* prepared by the Council of University Directors of Clinical Psychology (CUDCP, 2005) revealed that only two had items that directly dealt with self-awareness (e.g., "shows a sensitivity to his/her own strengths and weaknesses"; "understands clients impact on self."). Clearly, a more focused definition of "self-awareness" is needed if clinical researchers are to work towards developing a useful research-based training agenda. Perhaps the recent and above noted efforts by professional organizations such as the Council of Chairs of Training Councils—combined with increased interest in empirically supported therapeutic relationships (e.g., Norcross, 2002)—will draw more eyes toward this issue.

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AD HOC COMMITTEE ON PSYCHOTHERAPY

Commitment to Scientist-Practitioner Collaboration

Linda Campbell, Ph.D., Co-Chair

The Ad Hoc Committee on Psychotherapy was developed to advance the role of psychotherapy in practice, training, and research. This mission was the presidential initiative of Pat Bricklin, Linda Campbell, and the current president, Leon VandeCreek. This column in each issue of the Bulletin will inform the membership of the progress being made toward the fifteen goals set as priority actions by the board of directors.

Several activities have occurred since the last Bulletin briefing and several of these are addressed in the President's Column. Two major components of our priority actions are continuing education opportunities and collaboration with federal grantors on psychotherapy research.

In a conference call with the practice representatives on our committee, Jean Carter and Alice Rubenstein, the need for additional vehicles for scientist-practitioner collaboration was discussed. Our research and our practice membership are very interested in working together to advance clinically based psychotherapy research and to be in the forefront of the evidence based movement on clinical judgment and clinical expertise. The ideas that our focus groups and our leadership offer as an initial collaboration model include several variations.

Practitioners are very involved in applied research that focuses on the psychotherapeutic process. Conventionally, when practitioners participate with researchers, the researchers benefit by advancing their research project, but the practitioners may not be able to benefit other than altruistically (when we acknowledge it as an important motive). The practice and research focus groups suggest that continuing education credit for types of participation could be valuable. Further, a clearinghouse function for practitioners and scientists to match up for various levels of collaboration would also be valuable. These ideas take the form of the following recommendations:

1. Practitioners who want to learn more about clinically relevant psychotherapy research could read articles in this specific focus area, answer questions provided by the author, and gain continuing education credit for the activity. This activity could also be expanded to include a time designated chat room or a web feature that allows practitioners to discuss the article with the author. This option allows participation at the CE learner level but does not require active participation in projects.

2. Practitioners may volunteer to participate as subjects in clinically based research. This option could include research geared to therapist variables, client variables, relationship variables, or outcome. The type and level of participation would depend on the subject of the research. This option could be implemented by researchers presenting their ideas through a clearinghouse function on our web site. Practitioners could select those that most appeal to them.

3. A type of actual collaboration was suggested in which researchers could present their research questions and

proposed methodology to our practitioner participants in order to gain recommendations for practicality, implementation, pitfalls, and additional complicating factors not considered. Also, practitioners could identify the strengths in the research questions and other factors that enhance the project.

4. The clearinghouse function would also make possible the equal collaboration for practitioners and researchers to work on a project from the beginning together. There isn't a mechanism currently within our division, nor elsewhere as we know it, that promotes the matching of practitioners who have specific clinically based research interests with psychotherapy researchers of the same interest areas. As these dialogues begin and our membership becomes more accustomed to this activity within the division, a clearinghouse function through the web would offer a vehicle for practitioners and researchers to begin their collaborations.

5. As Carol Goodheart and Jean Carter so eloquently put it, "clinicians are canaries in the coal mines." The coal miners carried canaries in cages with them down those several miles into the mines and knew when the canary could not breathe, that only a short time later, they too would not be able to breathe the deadly, but odorless, gases. Our Division of Psychotherapy is proud to have among our membership, many master psychotherapists who have made and continue to make invaluable contribution to the field and whose influence has shaped the landscape of clinical work immeasurably. These are clinical experts who identify previously unknown themes, patterns, patient/client reactions, relationship variables, client variables and their relationship to other factors, and many other perceptions that are unlikely to be known by researchers before they are noted by practitioners.

Jean Carter and Alice Rubenstein suggested that practitioners could suggest research questions to be considered for adoption by psychotherapy researchers. These questions would emanate from observations made by practitioners but which are not pursued by researchers in the field. This possibility opens up a very exciting potential for collaboration and for early detection of ideas that have not been formulated heretofore.

These practitioner-researcher collaboration ideas are very exciting to those participating and we would very much appreciate hearing from you, our membership, on your ideas or simply your thoughts on these ideas.

Additionally, as reported in the last Bulletin issue, our research members have noted that psychotherapy research that focuses on process variables, client or therapist variables, and other worthy variables for investigation are often not noted in the criteria for federal funding of mental health research. Our research members are diligently composing a document that described their issues and concerns regarding consideration for federal grant money. When the position paper is completed, the Ad Hoc Committee representatives will work within APA to determine how to proceed with the initiative. The 2005 Presidential Task Force on Evidence-Based Practice has issued a draft for comment (see President's Column). This position paper, if advanced through APA, further documents the importance of clinical evidence and expertise. The Ad Hoc Committee is encouraged that the current climate supports inclusiveness of clinical variables in practice and therefore sets the stage for our pursuit of these variables being extended into psychotherapy research criteria.

Please let us hear from you as you have comments or ideas that contribute to our mission of advancing psychotherapy. This is an important pursuit and we need you,

the membership, to make this initiative successful.

If any of our members are interested in involvement in any activities described here, please contact Linda Campbell (lcampbel@uga.edu) or Leon VandeCreek (Leon.VandeCreek@Wright.edu) and we can steer you to the person conducting the activity. We will be highlighting an area of the Ad Hoc Committee focus in each *Bulletin.* In the next issue we will update you on the activities going on in practice. Please stay tuned and stay connected to these important initiatives for psychotherapy.

INTERVIEW

INTERVIEW WITH PATRICIA BRICKLIN, PH.D.
Past President of Division 29

Amber Paukert, B.S.
University of Houston

Patricia Bricklin, Ph.D.

Paukert: Dr. Bricklin, can you give me a summary of your professional history starting with where you went to graduate school and ending with what you are doing today?

Dr. Bricklin: Actually, my professional career began a little bit before I went to graduate school. I majored in English and journalism in college and I wanted to be a writer. One summer while I was still in college, I got a job at a small private residential school for children. They were 3 to 12 years old and they had moderate to severe special needs. I fell in love with the children and I was intrigued by all of the issues surrounding them. I decided to go to graduate school mostly to learn a little bit about these children and what contributed to their problems. I decided to apply to graduate school at Johns Hopkins University because I had heard good things about their psychology program. It was there that I experienced discrimination; they let me take courses, but when I applied for the doctoral program, I was turned down, specifically because I was a woman. I will never forget the words of the professor who interviewed me: "If we thought that you were never going to get married and you were never going to have children, we would let you into the program. Your grades are great, everything is fine. But, you would take the place of a man." So, I didn't go to Johns Hopkins University for graduate school. I went to Temple University in Philadelphia, and received my doctorate in clinical psychology with a focus on children with language, learning, and emotional disorders. In graduate school I met my husband, Barry, also a clinical psychologist-to-be. We married and along with completing our dissertations we had two sons. In addition to my role as wife and mother I was on the faculty at Temple for a while and I worked with children and their families in two private schools that were very much like the one in which I began my career.

To my surprise, I got a phone call one day asking me to be a guest on a popular daily radio show. Out of that guest appearance, I was invited to do a continuous daily radio and later, a television show with my husband. Although there were few psychologists in the media at that time, the two of us accepted the challenge and began what became a very important part of our professional career for fifteen years. One thing I observed about myself was that I never seemed to leave one job for another, but just kept adding them. During the last twenty years I added doctoral training at Hahnemann University and Widener University and developed a special interest in the Psy.D model. Additionally I focused on the legal, ethical and regulatory aspects of psychology as a profession through my work on and with licensing boards.

Paukert: Wow, you've done a lot. I'm interested in how you have integrated your professional and personal life through all of this.

Dr. Bricklin: Radio and television were the first place, although it doesn't seem like a likely spot. It was during that time that our family grew and we had four children, two boys and two girls. The part of the show that most interested our listeners was not so much the psychology we talked about, but our own relationship with each other and the children. On a day to day basis I worked out my role as a professional and a wife and a mother with an audience of over a million people. We talked about most of the stresses and joys of daily life. My husband was a very assertive person and I was very shy. People used to write letters telling him to not talk so much and to let me talk more. We really worked out our relationship on the radio and I also used our children as examples of some of the things I was struggling with as a mother of young children. I used them to discuss issues like bed time, adjusting to school, helping children with homework and what you do in the supermarket when your child is throwing a tantrum and everyone is looking at you. Over the years, some sad things happened in our family and some happy things and all of them happened while we were on the air and they became things we could develop as examples and issues for problem solving.

In those days, if you wanted to be an ethical psychologist, you couldn't give advice on the air if somebody asked a question. You weren't ethically allowed to advise them. You could only talk about the issue and give them examples in a very general way. We struggled with maintaining the integrity of psychology, the integrity of our family, and providing people with something that kept them listening and that they could learn and profit from. It was truly a challenge and very rewarding. We still meet both fathers and mothers who say "I raised my children listening and watching you."

Paukert: How do you think radio and television psychologists are different now, and what do you think of these differences?

Dr. Bricklin: I think the biggest difference is that today is the day of the sound bite and people want a quick fix. Unless you can say what you're going to say quickly and catch people immediately, they're not going to stay with you. That makes it harder for the psychologist or the professionally trained person to do their job; there is no real time to build a relationship with an audience. Although I think there are some very qualified people on the air right now, it is difficult for the consumer to know who is qualified and who is not. Almost anyone can do a psychology type show and there are fewer boundaries.

Paukert: Stemming from the ethical dilemmas of television and radio psychologists, how do you think ethics have changed over the course of your career?

Dr. Bricklin: Oh, I think they've changed quite a bit. Psychology has become a regulated profession. Ethics are both guiding principles and regulatory codes of conduct. We've become a much more litigious world. Because ethics have become part of the regulatory world, I think there's a lot more concern and even fear. The psychologist's concern is about risk management of their practice, and certain areas of psychology are more risky than others. This has affected the way people look at ethics. I think in one sense, people have become much more conscious of what is ethical and what is not. On the other hand, I think people used to think that ethics were in many ways absolute and that is just not the case. However, people want yes or no answers and basically a lot of the answers are not yes or no answers. Students for some reason, really want a yes or no answer, they want to know what they need to do, to do things correctly, but a lot of the issues you confront in practice, in research, and in teaching, are not cut and dry and it's a little hard to live in that kind of a world. I think most of us have come to understand that besides some very basic ethical truths, a lot about ethics is dynamic and almost

never absolute. Many of the problems that people confront today are ethical dilemmas where there are really no absolute wrong or right answers. Ethical decision making and critical thinking, problem solving models are most useful.

Paukert: How has licensing changed over the years?

Dr. Bricklin: Licensing has changed over the years in the sense that the first activity of licensing boards was to get qualified people licensed. As time goes on, we are still concerned with what should be the qualifications of somebody who is licensed, but the disciplinary part of licensing has increased and the focus of licensing boards now is not only to act as sort of a filter to make sure only qualified people are licensed, but also act to in a disciplinary way to make sure consumers are protected from psychologists who don't pay attention to what they're supposed to do, and I think that's a change. The practice of psychology is an evolving process and the licensing process must keep pace. Issues of interdisciplinary practice, mobility, increased scope of practice (like prescribing) are all issues that must be considered.

Paukert: Switching topics somewhat, you mentioned that you experienced some adversity entering the field as a woman; do you think that women still experience adversity entering the field?

Dr. Bricklin: Yes, I think that women experience it differently depending on the part of psychology that they're interested in pursuing. I don't think that women experience adversity particularly in getting into doctoral programs. There are still, from what I understand, in some academic programs, issues of promotion and tenure that are sometimes problematic. Discrimination is more subtle today. I don't think the areas of discriminations are as easy to identify as they were.

Paukert: Can you tell me a little bit about your involvement in Division 29 and APA in general?

Dr. Bricklin: I had always been an advocate for children and their families and did a lot of public relations kind of work and talked and raised money and made sure laws got passed in my state that had to do with children and their families, but I never really thought about being an advocate for professional issues in psychology until I got involved in the state psychological association. I did a lot of work with them all the way up to being president of the association and of course the next step to that was becoming a council rep to APA from the state. For the first ten years or so, most of my APA activity was done as a representative of Pennsylvania to various parts of APA. Then, I served on a number of APA boards and committees. Most recently, I was chair of the APA Committee for the Advancement of Professional Practice.

Division 29 was one of my favorite divisions. I went to their midwinter meetings all the time. I read the journals. I was active as a member and a fellow in the division's work, but I had never held an office in the division. Bob Resnick, who was then president of division 29, called me and asked me if I would run for president of Division 29. I said, "Look, I've been very active in the division as a member and a fellow, but I have never held office, I don't think I'm prepared" and he, along with several other people, talked me into doing it and that got me right smack in the middle of the governance of Division 29. I loved and valued it. I find I like Division 29 particularly because of the integration that 29 has of practice, science, and academics. The active members of the division are a combined group; they are either people who do a little bit of all of those things or else they're scientists, researchers, academics, or practitioners. All of them coalesce around the area of psychotherapy in its broadest sense and I find this a really powerful group and love to be part of it.

Paukert: What do you think were your most important contributions to Division 29 during your presidency?

Dr. Bricklin: There are two things that occur to me. The year that I was president, Division 29 was in a temporary financial situation, in which many divisions find themselves, and I thought, "Well, this is not the time for a presidential initiative or any costly activities. I think one of the things that would be most helpful to the division would be to focus on an active year but not spend any more money than we need to, and not put us any further into debt." It turns out that that year happened to be a critical year for us getting back on keel. In addition, I had the opportunity to work with Linda Campbell and Leon VandeCreek, to plan a long term initiative that would look at the field of psychotherapy from the standpoint of research, training and, practice. The purpose would be to articulate the state of the art in each of those three areas to determine what's needed and where some of the difficulties may be. That initiative has taken off and it seems the results may make a very big contribution to the field of psychotherapy. It was during my presidency that we had the time to talk about such an initiative and plan it carefully. I'm really delighted to see Linda, Leon, along with others, moving it forward. I am currently pleased to be serving Division 29 as Council representative and hope to make a contribution there to both Div. 29 and APA.

Paukert: My last question is, what advice would you give students entering the field today?

Dr. Bricklin: Be optimistic and be fully engaged in the field. I would suggest that people look at the field very carefully, look at the many parts of it, pick the program that you want to go to carefully in terms of its focus. Be aware that psychology is a constantly evolving field and that's the most exciting part about it. If you ask anybody that is more than 20 years out of a doctoral program, the psychologists they are today are not exactly what they were trained to do. The field of psychology that you're learning about today is evolving and you have to look at it as, "I'm learning this as the information that will help me to develop the field." Keep an open mind, recognizing that what you're learning, you're not learning as something that's going to stand still. Love what you do, and be an active part of the field as it moves forward.

FEATURE

Recent Trends in Internship Training

Joyce Illfelder-Kaye, Ph.D.
Pennsylvania State University

Joyce Illfelder-Kaye is the Associate Director of Training at the Center for Counseling and Psychological Services at the Pennsylvania State University. She is also the Vice Chair of the Board of APPIC (The Association of Postdoctoral and Psychology Internship Centers).

The internship experience continues to be one of the capstone experiences in the training of doctoral students in clinical, counseling and school psychology. Depending on when the reader completed the internship experience, some of the changes in the experience of seeking an internship and completing an internship might be surprising. Technological changes have helped to substantially improve the internship selection process. At the same time some recent trends in the field have intensified the anxiety students are experiencing about the internship process. Since most clinical, counseling and school psychologists in training are expected to complete an internship as a final requirement before receiving their degree, data collected at the internship juncture can also provide a snapshot for trends and changes in the profession. This column is designed to provide an update on the recent technological changes in the application and selection process and to highlight some recent trends in graduate training.

Technological Changes
Intern applicants of today have grown up in a technological era. Recent technological changes in the internship application and selection process represent an effort to keep pace with the technological developments in society at large. These changes are outlined below and include the APPIC Directory on Line, the APPIC Application for Psychology Internships, and the APPIC Computer Match.

APPIC Directory on Line: Intern applicants have always needed to collect information about potential sites prior to submitting applications for internship. The APPIC Directory has long been the initial resource for obtaining information about internship sites. Applicants at a minimum would collect addresses from the directory and send post-cards to sites requesting their brochures. Any student seeking an internship or post-doc can now access the APPIC Directory on Line (DoL) through the APPIC website at www.appic.org, in addition to the printed directory. This format has provided APPIC member internship and post-doc sites with an opportunity to include more information about their sites, in addition to electronic links to their own institutional program website, and the e-mail addresses of the training director. Students can search the DoL according to specified criteria, including geography related search options, time-related search option (application due dates), program-related search options (accreditation status of internship or post-doc, agency type, type of program from which applicants are accepted), position-related search options (full-time versus part-time, stipend amounts, and number of interns). Finally applicants can search on training opportunities provided (populations, treatment modalities, and specialty areas).

APPIC Application for Psychology Internships
Students applying for internships now complete a universal application form, rather than different applications for each site. The APPIC Application for Psychology Internships, known in short as the AAPI, has mostly replaced the individ-

ually designed applications used by each training site. It is available on line on the APPIC website as a word document, and students are asked to complete it and to submit it individually to each site in which they are interested. It is a long document, and it does take students a while to complete, however, it is no doubt a shorter process than in the past when students completed 15 different applications for 15 different sites. APPIC member programs have been strongly encouraged to use the AAPI, and when we last inquired all but 13 sites were using the AAPI. Exploration continues into the possibility of a truly online AAPI that could be electronically submitted via a website to a specified list of programs, but exploration into other professional fields that are using such models has not yet yielded a highly compelling option. Our training sites still vary in terms of their own technological resources and capabilities for receiving electronic applications. It should be noted that there is not a universal application for APPIC post-doctoral programs at this time.

APPIC Computer Match

The APPIC Computer Match which is run in conjunction with National Matching Service (NMS) has replaced the old internship call day. Applicants for psychology internship must now register with NMS during the fall of the year that they are applying for internships. Sites must also register with NMS. Applicants submit their applications to individual sites, and interview with those who invite them to do so, as they always did. In early February by a date that is specified each year, applicants and sites must submit their rank order list to NMS. There are also special provisions for applicants to submit their rank order list as couples if they are in a relationship and want to seek internships in similar locations. NMS takes approximately two weeks to run the match. On the Friday before Match Day applicants are informed whether or not they matched; sites are not provided with this information. This was a relatively recent change in order to provide applicants who did not match with time to prepare for entering the Clearinghouse on Monday. On the Monday of Match Day both sites and applicants are informed of their match for the coming year. The computer match in combination with clearly stated Match guidelines has helped to eliminate much of the pre-internship courting rituals, as sites and applicants are not allowed to request or provide any rank related information. Those applicants and sites that do not fill through the match may participate in the Clearinghouse that begins on Match Day. There is not currently a match for APPIC member post-doctoral programs.

Recent Trends

Our profession is facing a number of challenges and opportunities at present. Some of the challenges that directly are impacting the internship process include internship supply and demand issues and funding issues. In addition the internship match and follow-up survey allow us to make some observations regarding changing demographics in our field.

Internship Supply and Demand Issues

While the number of internship positions available to applicants has shown a modest increase in recent years, the number of applicants applying for internships has continued to grow at a faster rate. In the most recent match 617 sites participated in the match, offering 2,757 internship positions. This represented an increase of 25 positions from the previous year. The match successfully matched 2,448 applicants, but 669 applicants were not matched and 309 positions remained unfilled. If the clearinghouse successfully filled the unfilled positions, there were still 360 more applicants than positions in the match. This represents an increase of 131 more applicants in the match in 2005 than in 2004. As a result of this ongoing and increasing discrepancy, students are increasingly anxious about the internship match process.

Financial Pressures on Internship Sites
The difference in the number of internship positions and applicants would suggest that more internship positions could provide one solution to the internship supply and demand problem. At the same time, sites are facing a number of concerns that make the creation of more internship positions difficult. Medical centers are all under financial pressure to produce revenue. Internships and training continue to be evaluated and reviewed regarding their contribution to the financial health of the medical center. If the internship training is not contributing to the research mission by supporting the implementation and success of external grants and/or to the clinical revenue stream, they are most likely vulnerable to reduction or closure. Recently, government GPE (Graduate Psychology Education) funds and GME (Graduate Medical Education) funds became available. However, there are too few of these to have made much impact on the supply and demand issues in psychology.

In addition recent changes in regulations in the Fair Labor Standards Act (FLSA) have increased the minimum annual salary for full-time employees in this country who are not eligible for overtime pay to $23,660. Depending on the way that internship positions are created at different sites, the legislation may or may not apply to internship positions. One of the determining factors seems to be whether interns are considered employees with benefits, or whether the interns simply receive a training stipend. Since the median intern stipend across all settings in 2004-2005 was $19,400 (APPIC Directory data) one can see that the FLSA legislation creates issues for many sites. Some sites have needed to cut internship positions, others are paying overtime pay, while others have been able to increase their stipend.

Demographics of Internship Applicants: This year for the first time, APPIC asked applicants who completed the post-match survey to provide demographic information. This is information that has not been requested at the time of the match, due to concerns about the potential appearance of discrimination. Results of the survey conducted post-match suggest that at the present time approximately 78% of internship applicants are female, 22% of applicants were male. Approximately 39 % are coming from Psy.D. programs, while 61% are coming from Ph.D. programs. Approximately 59% of intern applicants were under the age of 30, 31% of applicants were in their 30's, while 10% of internship applicants were over age 40. Seventy eight percent of intern applicants were white, while 22% represented other racial or ethnic identifications.

Conclusion
As the demands and challenges of our work change over time, we strive to meet new demands and take advantage of new technology. This is an ever changing landscape, and yet at the core internship training continues to provide a pivotal training experience in the development of clinical, counseling and school psychologists, much as it always has.

DIVISION 29 EXECUTIVE COMMITTEE MEETING

Miami, Florida • January 14, 2005

(Clockwise) Armand Cerbone, Craig Shealy, Abe Wolf, Leon VandeCreek, Linda Campbell, Jan Culbertson, John Norcross, and Tracey Martin.

WASHINGTON SCENE

A Few Dedicated Visionaries

by Pat DeLeon, former APA President

This is the time of year for commencement activities, and I was able to attend two that were particularly notable. At American University, **U.S. Senator Daniel K. Inouye** provided an historical perspective upon the issues underlying today's intense Senate debate on the filibuster and the so called "nuclear option" proposed by the Majority Leader. "As I speak to you, a great debate is raging in the United States Senate. It involves a parliamentary action that is commonly referred to as the 'filibuster.' On the first Tuesday of January 1963, I took my oath of office as a Senator from the State of Hawaii. Four weeks later I found myself involved in what was later looked upon as a historic debate on civil rights. The main issue was the filibuster. Many insisted that the filibuster was the stumbling block that prevented passage of decent laws to protect the rights and privileges of all citizens, regardless of race, color, or religion.

"On January 31, 1963, I said: 'I have heard so often in the past few weeks, eloquent and good men plead for the chance to let the majority rule. That is, they say, the essence of democracy. I disagree, for to me it is equally clear that democracy does not necessarily result from majority rule, but rather from the forged compromise of the majority with the minority. The philosophy of the Constitution, and the Bill of Rights is not simply to grant the majority the power to rule, but is also to set out limitation after limitation upon that power. Freedom of speech, freedom of the press, freedom of religion; what are these but the recognition that at times when the majority of men would willingly destroy him, a dissenting man may have no friend but the law. This power given to the minority is the most sophisticated and the most vital power bestowed by the Constitution....

"The majority leadership of the Senate has insisted that these matters [federal judicial confirmations] should be resolved with a simple majority vote. To accomplish this end, they would do away with the right of the minority to filibuster. To those who would advocate this position, I say to them as I did 42 years ago: 'You sow the wind, for minorities change and the time will surely come when you will feel the hot breath of a righteous majority at the back of your own neck. Only then perhaps will you realize what you have destroyed.'"

The Senator made these remarks within the context of a very personal experience: "When I entered high school in 1939, I noted that my parents, in filling out a school form, had provided information that was surprising and stunning. I noted that my father had indicated that he was not a United States citizen. That was understandable because he was born in Japan, and came to Hawaii as a young child of three. I noted, however, that my mother had also noted that she was not a citizen. I was certain she was born in Hawaii, and, therefore, a citizen of the U.S. I took the form to her and said, 'I think you made a mistake in filling out the form,' pointing to the citizenship question. She looked at me with sad eyes and told me that she had not made a mistake. 'According to the law,' she said, 'an American who marries a Japanese loses his or her U.S. citizenship, and, therefore, I really don't know what I am.'... I was horrified to learn of this law, but this horror was magnified when soon after December 7, 1941... an Executive Order authorized and established 10 concentration camps in desolate areas in our nation....

"In 1988, an official apology to those who were placed in the internment camps was

issued, and a token amount of redress payment was provided to surviving internees. I cite this because it was a proud moment for me to know that my country was strong enough to admit her past errors and apologize. I cannot think of any other country that has come forth to make such an admission of wrong and officially apologize....

"I could not help but conclude that history is an ever-changing scenario, and that our democracy was an ever-evolving concept. For example, the minority opinion in the Supreme Court may in later years become the majority view. Slavery and segregation are some of the numerous examples. Laws may be repealed or amended.... Democracy is an imperfect concept slowly seeking perfection."

Personally, having attended an anti-war candlelight service (at which Mary, of Peter, Paul, and Mary heritage performed) the night before the bombing, I was deeply moved by the Senator's observation that: "However, I note that we Americans have been quite impatient with people of other lands who have not embraced our democracy. In some cases, we have officially condemned these nations in very harsh terms, and, in some, we have even used military force. The question we Americans have debated over the decades is simple but profound: 'Should we impose our will upon other lands? Or should we adopt a more peaceful path in convincing others of the goodness of our system and philosophy?' I suppose this matter will be debated for as long as we exist." As one might imagine, these words elicited a very engaged response from the audience—from both ends of the spectrum. On a personal note, I suspect that those protestors who stormed out, subsequently re-entered via the back door to see their loved ones graduate later on in the program.

The second commencement exercise was at Simon's Rock College of Bard, located in the hills of Great Barrington, Massachusetts, known to many of our colleagues, and particularly by those who attended the APA Opening Ceremony during my Presidential year, as the home of Alice's Restaurant of Pete Seeger and Arlo Guthrie fame. In the 1920s, when the land upon which the college now stands was mostly pasture and cultivated fields, a local landmark—Simon's Rock—was plainly visible. And from the rock there were extended views of the surrounding Berkshire hills and the valley below. Today, the rock—now surrounded by trees—still sits on the mountainside between the main and upper campuses. When **Elizabeth Blodgett Hall** decided to found an early college, she named it after the rock and explained its significance by describing what it meant to her when she was an adolescent:

"Simon's Rock is a glacial erratic on a Berkshire hillside. The small band of neighborhood children who built a cabin there in the early twenties did not know this until they grew up. At twelve and thirteen, their interest centered on the rock for other reasons. It was a good place to get away to. The adult world in the valley below could be viewed from on high. Grown men and women, teams of horses, and Model T Fords all dwindled to a size where one could imagine oneself competent to direct and control them. Yet the valley remained to return to when one wearied of freedom, wet feet, and raw bacon burned at one end.

"And each time they returned they knew a little more about a lot of things: that dry wood and a proper draft make a big difference in a fire; that much snow makes little water; that umbrellas opened at the top of the rock will not suffice as parachutes for a quick descent; that killing a squirrel with a .22 is not much of a victory; that adults may be more like oneself than one thought." Today's Simon's Rock college, like its namesake, still offers a place for young people to learn and gain perspective, a haven where they can explore, exchange confidences, grow and dream like the builders of that first cabin.

This year's commencement speaker was **Eli Pariser**, a Simon's Rock alumnus. As the program said: "Known to millions of Americans through his political leadership, particularly through the Internet, the 24-year old Pariser is executive director of MoveOn.org—a grassroots organization dedicated to empowering ordinary Americans to be catalysts for political change. Pariser became a groundbreaker in the movement to use the Internet for political organizing when, 24 hours after the events of September 11, 2001, he launched a website calling for alternatives to a military response to the terrorist attacks.... (He) has directed MoveOn's campaign against the Iraq war – in the process tripling the organization's member base, which now stands at 2.9 million. He also raised more than $30 million from over 350,000 small donors to support the efforts of MoveOn." Eli Pariser matriculated at Simon's Rock at the age of 15, graduating in 2000, summa cum laude. An impressive resume.

The underlying, take-home message of Eli's address was: "There ain't nobody here but us chickens." Or, stated another way, "It is up to us as individuals and concerned citizens to accept responsibility for our own future." There are no grand plans for the future or infallible leaders. Living in a democracy means there is only us.

Eli got me thinking about our profession of psychology. Who are our visionary leaders? Who is making a difference in our daily lives? The individuals who quickly came to mind during that rainy, and yet sunny, afternoon were APA President **Ron Levant** and Practice Directorate executive director **Russ Newman**. Both have long appreciated (as did former APA President **Norine Johnson**) the importance of psychology becoming one of the *healthcare* professions and obtaining prescriptive authority (RxP). For, the prescriptive authority agenda has always been about revolutionizing society's definition of "quality" care and ensuring that the all important psychosocial-economic-cultural gradient of care is granted appropriate priority by society and our nation's healthcare policy experts. RxP is all about bringing psychology into the 21st century. Nothing more; nothing less.

In New Mexico, **Elaine LeVine** and **Mario Marquez** have clearly made a difference, as has Guam's **Mamie Balajadia** and Indiana's **Mike Murphy**. Each of these visionaries has been instrumental in having RxP legislation enacted by their legislatures. Elaine recently reported: "I have been prescribing for about a month now. I have had a number of positive experiences already. Given the grueling efforts needed to pass a prescribing psychologist law, my short life as a prescribing psychologist highlights why it is worth psychologists pursing this path.... Now that I have a license/certificate to prescribe, the physicians have been quite willing to defer to my judgment regarding the specific medication. Their input regarding the medical management of the patient has been very helpful. There are new issues every day in this new territory. For example: Who should take my call when I am unavailable?—The best person would be a prescribing psychologist because no one else is prepared to deal with both the psychological and the medication issues, but so far there are only two of us in the State! There are issues regarding getting a DEA license; the government has not figured out there are prescribing psychologists yet. Pharmacists wonder how to code us. Pharmaceutical companies wonder if they can sample us. All this commotion is actually kind of fun. It doesn't have the same vicious underpinnings as our legislative battles. Out here in the primary care, everyone seems to have the same goal of getting care to the patients, in an underserved and overburdened medical arena. The question is how to get through and over all the hurdles."

In response to Elaine's queries APA Presidential citation recipient **John Bolter** noted: "I got my DEA number about a

month ago. I think I was the first psychologist to get a DEA number. I don't think any of the [DoD] PDP people have actually obtained a DEA number. Anyway, just thought I would let you know the DEA has resolved the issue of providing a DEA number for medical psychologists (prescribing psychologists)." Earlier this year, **Glenn Ally** reported: "On February 18, 2005, the first prescription was written by a civilian 'medical psychologist' in Baton Rouge, Louisiana under the new RxP law signed by Governor Blanco. Dr. John Bolter wrote the first prescription—a prescription for Remeron (for the trivia folks). This was an historic moment for the Louisiana Academy of Medical Psychology, for the citizens of Louisiana, and for psychology as a profession." Our special thanks to **John** and **Jim Quillin**—Louisiana is truly on the cutting edge of change.

Recently, under **Mike Sullivan's** tutorage, **Lance Laurence** and his Tennessee colleagues have taken on the good fight. **Keith Hulse**: "Well, we have some good news and some bad news to report. The bad news is that we were unable to pass our prescriptive authority bill out of the Senate General Welfare committee today. We have concluded that it will not be possible to do so during this legislative session. While we are disappointed, we are not discouraged, and we are determined to prevail in the long run. Passing this piece of legislation is the hardest thing that TPA has ever tried to do. In Louisiana, it took 10 years of work to pass a similar bill. This is our second year. We have made remarkable progress compared to where we started just two years ago in advancing our 'case' for the bill. In fact, the 'case' itself was not disputed this year to any significant degree, even by our opposition. If not for 'larger' political forces outside our control, we might well have been writing you a very different letter today. A year ago, we were unable to move the bill out of any committee. This year, we successfully moved the bill out of the House Professional Occupations subcommittee despite there being an MD on the committee, and we also passed the bill untouched out of the House Governmental Occupations subcommittee. Unfortunately for our efforts, the majority in the legislature shifted towards Republican, on the coat-tails of the last Presidential election, and the legislature this year has been divided along party lines to an unusual and unfortunate degree. Our bill became caught up in that partisan battle. As a result of this shift in the composition of the legislature, in the Senate General Welfare committee this year, we had two definite 'yes' votes unexpectedly thrown off the committee and replaced with Republicans, one of which was yet another Republican MD. The vote today would have been along straight party lines (had we allowed it to go forward). We needed five of nine votes to pass out of committee, but all five Republican members of the committee, in the end, signaled that they intended to vote against our bill.

"The good news: there is much good that has come out of this legislative effort, despite our not passing the bill this year. TPA's 'status' in the legislature has never been higher. We have earned an unprecedented overall presence and level of respect. This status will outlast the outcome of any given bill, RxP or otherwise. Not a single bill adversarial to TPA was dropped this year, which is unusual. Increasingly, TPA is being looked to by the legislature as THE expert in the area of mental health. In the process of pursuing the RxP effort, we have continued to build strong relationships with many members of the legislature, and those will also endure far beyond this one bill. The size of TCPA (TPA's PAC), thanks to you all, has increased over 400 percent in the past two years(!). APA has given TPA substantial grant support in the past two years, and has also included Tennessee in its pilot project utilizing their CAP Wizard website, which has allowed literally thousands of e-

mails to be sent to the state legislators during this session. And you all, our grassroots network, have responded unbelievably well to our calls. APA tells us that Tennessee's use of the CAP Wizard website is an order of magnitude greater than any other state's. Your utilization of their website has been greater than that of every other state combined! That is totally to the credit of you, the TPA membership. TPA's grassroots network has been phenomenal and is the envy of every other state. Our PowerPoint presentation and 'white paper' supporting the RxP agenda are both being utilized nationwide to advance the case for RxP. And rest assured, we have already started today laying the groundwork for passing our RxP bill next year.

"To quote Jim Quillin: 'If we don't quit, we win.' And to quote Margaret Meade: 'Never doubt that a small group of thoughtful committed people can change the world; indeed it's the only thing that ever has.' We hope that all of you will all continue to be members of our now-not-so-small group of thoughtful committed people. Thank you for all your hard work this year. Please seriously consider signing up for RxP training. We are going to be asking for your help very shortly in the 'off season' to begin to prepare for next year's legislative session."

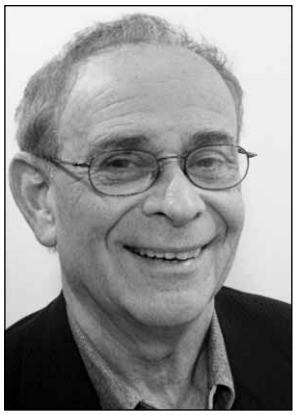
And finally in Hawaii, one can feel the flow tide for psychology where two colleagues who work within our state's *community health centers*, **Jill Oliveira-Berry** and **Robin Miyamoto**, have taken the lead on behalf of HPA's RxP legislative efforts. Jill is a Native Hawaiian and member of the APA Committee on Rural Health. After extensive public hearings focusing upon the critical issue of access—and with the enthusiastic support of the Hawaii's Primary Care Association and its centers' medical directors—two Senate Committees recommended the enactment of legislation allowing appropriately trained psychologists to prescribe within federally qualified health centers. HPA was one vote short on the Senate floor. However, subsequently House Concurrent Resolution #255 passed both bodies, "Establishing An Interim Task Force On The Accessibility Of Mental Health Care To Consider The Feasibility Of The State Authorizing Trained And Supervised Psychologists To Safely Prescribe Psychotropic Medications For The Treatment Of Mental Illness." Jill: "The resolution basically seeks to form a task force that will consist of the chairs from the House and Senate Health Committees, along with two appointees from HPA and the Hawaii Psychiatric Medical Association." These two legislators know the issues well and it is anticipated that implementing legislation will be introduced next session.

Aloha,

Pat DeLeon, former APA President
Division 29 – May, 2005

2005 ROSALEE G. WEISS LECTURER

Dr. Marvin R. Goldfried



The American Psychological Foundation (APF) and APA Division 29 (Psychotherapy) are pleased to announce Marvin R. Goldfried, Ph.D., Distinguished Professor of Psychology at Stony Brook University, as the speaker for the 2005 Rosalee G. Weiss Lecture. The Rosalee G. Weiss Lecture was established in 1994 by Raymond A. Weiss, Ph.D., in honor of his wife, Rosalee Greenfield Weiss, Ph.D. The lecturer, who is an outstanding leader in psychology, or a leader in the arts or sciences whose work and activities has had an effect on psychology, presents at the annual APA Convention.

Goldfried is a diplomate in clinical psychology and is the recipient of numerous awards including the APA Distinguished Psychologist Award for Contributions to Knowledge, Distinguished Psychologist awards from the clinical psychology; general psychology; psychotherapy; and gay, lesbian, and bisexual divisions of APA, and the Award for Clinical Contributions from the Association for the Advancement of Behavior Therapy. He is Past President of the Society for Psychotherapy Research, founder of the journal *In Session: Psychotherapy in Practice* and author of several books. Dr. Goldfried is cofounder of the Society for the Exploration of Psychotherapy Integration (SEPI), and founder of AFFIRM: Psychologist Affirming Their Gay, Lesbian, and Bisexual Family. Dr. Goldfried will present *The role of relationship and technique in therapeutic change* on Saturday, August 20, 2005 from 3:00 p.m. – 3:50 p.m. in the Washington Convention Center, Meeting Room 143C.

RESEARCH

Therapeutic Work and Professional Development:

Main Findings and Practical Implications of a Long-Term International Study

Michael Helge Rønnestad & David E. Orlinsky

How do psychotherapists experience their work with patients? What impacts do therapists' work experiences have on their professional development? How does the therapist's level and state of development, in turn, influence their therapeutic work? These are the central questions explored, empirically and theoretically, in a new book titled *How Psychotherapists Develop* (Orlinsky & Rønnestad, 2005) that we summarize selectively and briefly here, emphasizing the main findings and some of their practical implications.

Background

In 1989, a group of international colleagues in Society for Psychotherapy Research (SPR) began a cooperative, self-supporting study of psychotherapists' experiences of therapeutic work and professional development. This group, the SPR Collaborative Research Network,1 consisted of clinical researchers who also were well-experienced practicing therapists. We conceived of our project as a study of, by, and for psychotherapists, aiming to study the processes of therapeutic work and professional development from the psychotherapist's own perspective.

Toward this end, we designed the *Development of Psychotherapists Common Core Questionnaire* (DPCCQ) to survey various professional and personal experiences in the spirit of a wide-ranging interview among colleagues. To date, our group has gathered extensive information from more than 7,000 therapists of diverse professions, theoretical orientations, and career levels. These therapists represent two dozen countries, with the largest groups thus far from the United States (many of whom were Division 29 members), Norway, Germany, the United Kingdom, and South Korea. The results reported in our book are based on approximately 5,000 of these therapists, analysts, and counselors, who were engaged in various forms of individual, couple, family and group psychotherapy.

Therapeutic Work and Practice Patterns

Two broad dimensions of therapeutic work experience were identified inductively by factor analyses of many specific facets of work, such as therapists' clinical skills, difficulties in practice, coping strategies, modes of relating to patients, and in-session feelings. One broad dimension clearly described an experience of *Healing Involvement*. This consisted of current skillfulness, minimal difficulties, constructive coping strategies, genuine personal investment in affirmative, receptive relationships with patients, in-session experience of flow (Csikszentmihalyi, 1990), and an overall sense of therapeutic efficacy. The other broad dimension clearly reflected a parallel but contrasting experience of *Stressful Involvement*. Therapists in this case frequently reported multiple difficulties in practice accompanied by defensive, therapeutically unconstructive coping strategies as well as in-session feelings of anxiety and boredom.

These two dimensions are statistically independent, and both are descriptive, in varying degrees, of all our therapists' experiences with their patients. The variables that most strongly predicted experiences of Healing Involvement with

patients were the therapist's theoretical breadth, work setting support and satisfaction, and the breadth and depth of case experience across different treatment modalities—as well as their positive work morale (about which more later). Relatively few therapist characteristics predicted Stressful Involvement, suggesting that this aspect of experience is more responsive to current caseload and practice characteristics, but work stress was greater for therapists who felt little support or satisfaction in their main work setting, who had no private practice—and who were caught in a process of demoralization.

Since Healing Involvement and Stressful Involvement were statistically independent, we were able to characterize therapists' overall practice experience by distinguishing between those who reported much (or not much) Healing Involvement and little (or more than a little) Stressful Involvement. These distinctions allowed us to see four broad patterns of current therapeutic work experience, as follows. Approximately 50% of our therapists experienced an *Effective Practice*, featuring much Healing Involvement and little Stressful Involvement. Another 23% were in what might be called a *Challenging Practice*, in which there was much Healing Involvement but also more than a little Stressful Involvement. The "good news" is that nearly three-fourths of those we surveyed were actually experiencing much Healing Involvement in their therapeutic work.

By contrast, 17% of our therapists reported a personally neutral but apparently unproductive pattern of *Disengaged Practice*, featuring little Stressful Involvement but not much Healing Involvement. Even worse, about 10% of our therapists were involved in a basically *Distressing Practice*, where they experienced not much Healing Involvement and more than a little Stressful Involvement.

The incidence of Effective Practice increased markedly in successively more experienced therapist cohorts, from 40% among novices to 60% among seniors, with a total reporting of all those having much Healing Involvement rising from 60% among novices to 80% among seniors. A parallel decline was noted in the incidence of Distressing Practice, which typified 20% of the novices but only 6-7% of established, seasoned, and senior therapists. Some of these differences may be due to departure from clinical work by the most distressed therapists, but much is also likely due to therapists' improvement over time. What these figures demonstrate dramatically is the relative vulnerability of novice therapists, and their need for effective supervisory guidance and support.

Professional Development

Development was defined and assessed in three ways. First, comparisons were made among cohorts of therapists at different career levels, as mentioned above. Six levels were distinguished based on clinical and statistical considerations: *novices* (less than 1.5 years of work with patients); *apprentices* (1.5 to 3.5 years); *graduates* (3.5 to 7 years); *established* therapists (7 to 15 years); *seasoned* therapists (15 to 25 years); and *senior* therapists (with 25 to 50 years of clinical practice). These cross-sectional analyses were supplemented by measures of the therapists' experiences of their current or ongoing development, and by various measures of their cumulative career development.

Analyses of ongoing development yielded two independent dimensions, *Currently Experienced Growth* and *Currently Experienced Depletion*. Currently Experienced Growth included a sense of active change and improvement, a deepening understanding of therapeutic process, enhanced skillfulness, enthusiasm for practice, and a sense of overcoming past limitations as a therapist. A major portion of this can be interpreted as a continuing renewal of the therapists' work morale (Orlinsky, Rønnestad, Ambühl et al., 1999), which derives in large part from their

experience of Healing Involvement, and enables them to continue engaging productively with patients despite the stresses of professional practice.

By contrast, Currently Experienced Depletion included a sense of deteriorating skills, loss of empathic responsiveness to patients, routinization of practice, and growing doubt concerning the effectiveness of therapy. This can be interpreted as a process of demoralization resulting in large part from the experience of therapeutic work as a Stressful Involvement, which tends to further undermine the therapist's ability to engage positively with patients, producing a spiral of negative effects that can lead to therapist burnout and potential harm to patients.

Growth and depletion both are experienced by therapists in response to their practice experience, although in varying degrees. Where Currently Experienced Growth predominates, the therapist's overall sense is one of *Progress*. By contrast, where Currently Experienced Depletion is predominant, the therapist's overall sense is one of *Regress*. Where both are clearly present, the overall experience is a confusing one of *Flux*, with improvement felt in some areas and deterioration in others. Therapists who experience little depletion but not much growth can be described as in *Stasis*, of which the positive side is stability but the negative is stagnation.

Therapists' experiences of *Cumulative Career Development* were reflected in a single second-order dimension that included separate factor-analytically defined dimensions of retrospective perceived development, change from initial to current levels of clinical skill, and level of attained therapeutic mastery. Cumulative Career Development was only modestly correlated with years in clinical practice, and in fact was more strongly related to the breadth and depth of the therapist's case experience across diverse treatment modalities—indicating that what one does and learns has more to do with career development than mere length of service.

Higher levels of Cumulative Career Development were positively related to Currently Experienced Growth, as expected, and were inversely related to Currently Experienced Depletion. This means that the harmful effect of experiencing clinical work as a Stressful Involvement is attenuated or buffered by advanced development, but that, by the same token, relatively inexperienced therapists are most vulnerable.

Our book presents a detailed, empirically-grounded theoretical model of the reciprocal impacts of professional development and therapeutic work experience, as well as many other relevant findings, which we hope interested readers will want to examine there. Here, in this brief article, we conclude by summarizing some of the practical implications explored in the book based on our findings. These include recommendations with respect to professional training, clinical supervision, and therapeutic practice.

Professional Training

The most important recommendation for training is to ensure, as far as possible, that novice and apprentice therapists experience Healing Involvement in their initial work with patients, and that Stressful Involvements be kept to a minimum. Beginners are especially vulnerable to the demoralizing impact of a Distressing Practice, and may sustain personal harm as well as fail to help their patients.

These recommendations require careful case selection to match the skill level of beginning therapists, as well as practical education to provide them with relevant skills and ample supervisory and peer support. Given appropriate training and supervision, early exposure to clinical work is also recommended as therapists of all orientations and career levels consistently focus on practice as their major source of learning. Moreover, we further

recommend that this early practice include meaningful participation in diverse treatment modalities—that is, in couple and family and group psychotherapy with more experienced co-therapists, in addition to standard one-on-one individual therapy.

Clinical Supervision

The significance of supervision for therapists is reflected in its consistent ranking by practitioners at all career levels as the second or third most important positive influence on their development, following learning from work with patient—and was ranked as the most important influence by novice therapists. The value of supervision is expressed by the simple but convincing fact that 56% of established therapists (7-15 years in practice) and 42% of seasoned therapists (15-25 years in practice) reported they were currently in supervision for some of their cases. Thus many therapists seek supervision well beyond what is formally required to attain licensure.

Despite its positive importance, our study also highlights a negative potential of supervision, particularly when it involves evaluation of the student or candidate. This circumstance exaggerates the power differential between participants and compromises the supportive part of the relationship. Recent empirical contributions on non-optimal supervision have focused on conflicts in supervision (Moskowitz & Rupert, 1983), distorted and restricted communication (Yourman & Farber, 1996); supervisee non-disclosure (Ladany, Hill, Corbett & Nutt, 1996) counter-productive events (Gray, Ladany, Walker & Ancis, 2001), impasses (Nigam, Cameron & Leverette (1997), and factors that contribute adversely to supervision (Reichelt & Skjerve, 2002). These negative aspects of supervision erode the trainees' self-confidence, engender self-doubt about their ability to become effective therapists, evoke self-criticism as well as negative personal reactions to the supervisor and negative countertransference reactions to patients. Reactions such as these in supervision when combined with the experience of therapy as a Stressful Involvement can be very detrimental to the development of inexperienced therapists. The concept of *double traumatization* introduced in our book refers to the process in which the candidate is simultaneously stressfully involved in work and also experiencing conflict with a supervisor—a circumstance in which Stressful Involvement is exacerbated by negative supervision, and a negative supervisory process is augmented by Stressful Involvement. Supervisors should be particularly aware of the potential for double traumatization when supervisees are experiencing Stressful Involvement with clients, and be sensitive not only to the quality of the supervisory alliance but also the need to supportively confront and repair alliance ruptures.

Therapeutic Practice

Probably the most important finding of our study for practicing therapists, at all career levels, is the reciprocal influence between the clinician's work morale and their experience of therapeutic work. Positive morale (in the guise of Currently Experienced Growth) appears both as a consequence and a major contributor to Healing Involvement. Incipient demoralization (in the guise of Currently Experienced Depletion) similarly is attendant upon and a forerunner to Stressful Involvement. Although therapist self-awareness is deeply embedded in the psychotherapy culture, it is all too easy to discount one's sense of improvement or depletion as a purely personal reaction, rather than as an indicator of the freshness, vitality, and optimism—or else the possibly "technically correct" but unenthusiastic and indifferent manner—that one brings to work with patients. The cyclical relationship between currently experienced development and therapeutic practice is an argument for all therapists to continually monitor their own sense of development as well as quality of their work involvement. To assist therapists in this,

we selected the most relevant items from the DPCCQ to construct two brief self-rating forms for monitoring work involvement (the *Therapeutic Work Involvement Scale*) and professional growth and depletion (the *Current and Career Development Scale*). These are included as appendices in our book, along with data enabling practitioners to match themselves with comparable therapists.

Other recommendations to practitioners are addressed specifically to the small but significant minorities who are experiencing *Stasis* (not much growth and little depletion) or Regress (not much growth and more than a little depletion). To the one-in-five we estimate are in Stasis, we propose that they take steps to diversify their therapeutic work (e.g., by doing couple, family, or group therapy as well as individual therapy), and we encourage them to explore diverse theoretical approaches. The key to both recommendations is breadth: breadth and depth of case experience across modalities, as a stimulus to cumulative career development; and theoretical breadth, as a facilitator of Healing Involvement. This empirically based advice converges with the recommendation of Norcross (2000) to "Diversify, diversify, diversify" as a principle of therapist self-care. Another source of stimulation that therapists in Stasis should consider is voluntary, non-evaluative supervision, either in an individual or peer group format—with the latter of particular value for therapists who practice independently.

To the one-in-ten therapists who may be caught in a state of professional *Regress*, we strongly urge that they take steps to protect themselves as well as their patients from potential harm. Over 60% of novices and nearly 60% of apprentices in *Regress* are also in a Distressing Practice, where they are experiencing more than a little Stressful Involvement and not much Healing Involvement. For them especially (but also for all except the most senior therapists) we recommend a change in composition of caseload, where that is possible, to obtain a better match between their current skills and the challenges presented by patients. Attempting to treat too many difficult patients at the same time may result in treating some not very well, in addition to possible adverse effects for the therapist.

A disproportionate number of those who practice *only* in institutional settings (especially inpatient institutions) were also found prone to professional *Regress*. The source of this negative influence according to our therapists appears to be the institutional conditions of practice rather than the challenge presented by treating severely disturbed patients, and therapists should not be reluctant to treat such clients. The addition of some private practice to the therapist's work pattern seems to insulate the clinician from professional *Regress*, but in extreme circumstances change in employment and work role are alternatives to consider.

Finally, our study indicates that two leading sources of professional growth for all therapists are supervision (Orlinsky, Botermans & Rønnestad, 2001) and personal psychotherapy (Geller, Norcross & Orlinsky, 2005). These are important as sources of motivational support and stimulation to professional and personal growth. They also support the process of continuous professional reflection that Rønnestad and Skovholt (2003) found to be an essential factor in therapist development. To facilitate this, therapists can help themselves by using aids such as the self-monitoring measures assessing therapeutic work involvement and professional development included in *How Psychotherapists Develop*.

Authors' note
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Notes

[1]This article is a highly condensed summary of the major findings reported in *How Psychotherapists Develop*, published by the American Psychological Association in 2005

[2]David Orlinsky has served as the group's coordinator for North America and elsewhere in collaboration, successively, with Paul Gerin, Hansreudi Ambühl, and Michael Helge Rønnestad, who served as European coordinators for the project. The group initially included (in alphabetical order): Nicoletta Aapro (Switzerland), Hansruedi Ambühl (Switzerland), Wouter Backx (Netherlands), Jean-François Botermans (Belgium), Christine Davidson (USA), John Davis (England), Marcia Davis (England), Alice Dazord (France), Paul Gerin (France), Jean-François Iahns (France), David Orlinsky (USA), Thomas Schröder (England), Ulrike Willutzki (Germany). They were soon joined by Peter Buchheim (Germany), Manfred Cierpka (Germany), Michael Helge Rønnestad (Norway), and Hadas Wiseman (Israel), while some also left (e.g., Backx, Davidson, Iahns). The present international steering committee consists of Botermans, Orlinsky, Rønnestad, Schröder, Willutzki, and Wiseman.

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2005 RECIPIENT OF THE APA DISTINGUISHED CONTRIBUTIONS TO EDUCATION AND TRAINING

John C. Norcross, Ph.D., ABPP

The APA Division of Psychotherapy is pleased to recognize that Dr. John C. Norcross has been selected as a 2005 recipient of the APA/APF Distinguished Contributions to Education and Training Award. Dr. Norcross is a Council Representative from the Division of Psychotherapy and is also a Past-President of the Division.

Dr. Norcross is being acknowledged for the continuing impact of his work on education and training in psychology. The award criteria include positive influence in the teaching of students, engagement in educational and training research, development of instructional materials that influence the direction of training, professional governance, and promotion of continuing education.

Dr. Norcross's scholarly productivity and his educational impact are of the highest quality. His ongoing work in chronicling the course of psychotherapy in psychology has been invaluable to the work of the Division of Psychotherapy. His governance and policy contributions are singular in their value to the profession.

Dr. Norcross will be delivering his award address at the APA convention in Washington, DC. We look forward to your joining us to celebrate this distinguished recognition.

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APA Membership Number _____

APA Status:
____ Member ____ Associate ____ Fellow

MC / VISA # _____
EXPIRATION DATE _____

_____
Signature

CLINICAL AND RESEARCH INTERESTS:

_____

_____

_____

_____

REASONS FOR JOINING DIVISION 29:

_____

_____

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_____

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

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

Code__FD__

ACT NOW FOR

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