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BULLETIN

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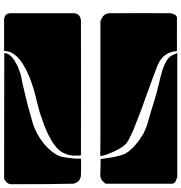
Student Abstract: Consensus on Ratings of Therapist Competence

Student Abstract: A Meta-Review of the Empirical Suport for Ethnic Matching Between Therapist and Patient Psychotherapy

Student Abstract: Problem Solving Treatment for Suicidal Behavior in Young Adults: Also Effective for Alcohol Abuse



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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 (fall); 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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PRESIDENT'S COLUMN

Leon VandeCreek, Ph.D., ABPP

Congratulations to elected officers of the Division—

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The Division is in very good hands for the next several years.

This issue of the *Bulletin* presents the division's APA convention programming. I think you will agree that we have an exciting and comprehensive set of programs that cover research, practice, and training. Several of the programs will offer CE credits by APA.

During the past few months members of the Division have cast their ballots on five issues. The results are now in. With one exception, the membership approved each of the questions. More specifically, the membership did not support (majority but not the required two-thirds) the proposal to change the name from Division of Psychotherapy to The Society for Psychotherapy: Division 29 of the American Psychological Association. On the other hand, several other proposals were approved by the required two-thirds vote. For example, a new membership category is formed for psychologists who are not APA members. The new category is called "Psychologist Affiliate" and includes psychologists who hold the doctoral degree in psychology but who are not members of APA. These members will receive the division's publications but will not be eligible to hold office or vote. They are eligible to serve on committees and task forces. We will begin a membership campaign for this category immediately with the state of Ohio serving as a trial run. We will contact all licensed psychologists in Ohio who are not already members of Division 29 and invite them to join. Depending on the response rate, we may then send invitations to non-APA members in other states.

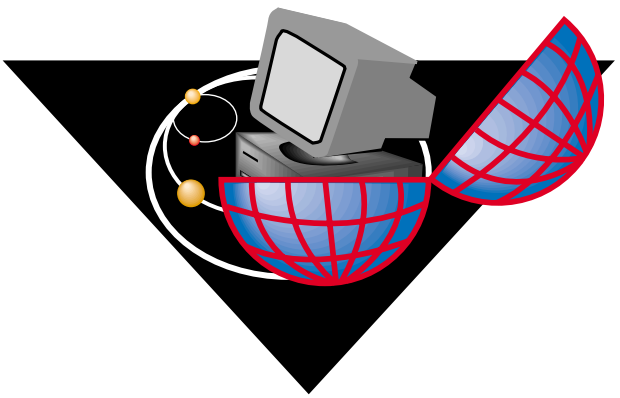
Other changes to the bylaws were designed to bring them into compliance with current practices. For example, one section of the old bylaws requires the Membership Committee to review each application for membership. In reality, it is not feasible for the Membership Committee to complete a thorough review of each application; rather, our Central Office processes the applications. Another change to the bylaws makes it easier for members who have resigned from the Division to rejoin at a later time just by reapplying (it is no longer necessary to pay past dues). The revised bylaws will soon appear on the division's webpage.

Since my last column, Linda Campbell (Past President) and I have conducted conference calls with some of our committee chairs. Most recently, we "met" with Rhonda Karg, chair of the Committee on Early Career Psychologists. Among the tasks of this committee is an initiative to pull together a series of brief articles for the *Bulletin* that will provide suggestions for new psychologists who have an interest in setting up a private practice. Hopefully, the first article in this series will appear in the next issue of the *Bulletin*. When Linda and I surveyed early career psychologists and graduate students last year about their interests and concerns, this theme emerged consistently: Doctoral programs do not provide sufficient training on the "how to"

of getting started. Graduates felt sufficiently confident of their clinical skills, but they were not prepared for the nuts and bolts of running a small business. This series of articles will help to fill that gap.

As always, I welcome comments and reactions from the membership.

Leon VandeCreek



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AD HOC COMMITTEE ON PSYCHOTHERAPY

Initiatives: Training and Early Career Advancements in Division 29

Linda Campbell, Ph.D., Co-Chair

Over the course of the last several issues of the *Bulletin*, President Leon VandeCreek and I have reported to you the extraordinary progress that the division is making in accomplishing initiatives developed last year for the advancement of psychotherapy. These focused on practice and research initiatives. We have more recently witnessed progress by the Training Committee group led by Jeffrey Hayes and the Early Career and Student Committee group led by Rhonda Karg.

The objectives for training advancement in psychotherapy include (a) promotion of competencies for clinical training in psychotherapy, (b) facilitation of training grants for psychotherapy research, and (c) development of a survey for training directors and for students on required experiences and required supervision in psychotherapy training. In response to these objectives, the Training Committee is currently conducting the following activities:

1. The Division has submitted specific recommendations for the inclusion of psychotherapy training evaluation in the upcoming Practicum Competencies developed by the Council of Chairs of Training Councils.
2. The Division submitted a recommended inclusion of "psychologically based psychotherapy" in the APA Task Force Evidence Based Practice Document.
3. Division 29's Research Committee, under the direction of Bill Stiles, in concert with the Society of Psychotherapy Research is developing a position paper and set of recommendations for submission to national health institutes. These recommendations respond to the obstacles experienced by psychotherapy researchers in their attempts to acquire funding for process research in psychotherapy.

The Early Career and Student Initiatives include: (a) development of a course or workshop on how to set up a practice, and (b) development of a package on how to market oneself for practice. The committee is currently involved in the following activities:

1. Dr. Linda Forrest and Dr. Nancy Elman will be writing a series of articles for the *Bulletin* on student impairment.
2. The Division will be pursuing a collaboration with APAGS on a survey for training directors and for students in evaluating the experience of psychotherapy training in doctoral programs.
3. A marketing series for early career psychologists doing psychotherapy will be initiated in the *Bulletin*.
4. The Division will initiate an on-line workshop for early career psychologists in four areas: (a) finding a job, (b) licensure, (c) balancing career and personal life, and (d) collaboration with peers in practice.

These activities represent the commitment of all of those involved in the division to the promotion of the advancement of psychotherapy. If you are interested in participating in any way, please contact Leon VandeCreek or myself. We would very much like for you to be on board.

FEATURE

Wrestling with vulnerability: Countertransference disclosure and the training therapist

Elizabeth A. Manning

Abstract
While some psychotherapists claim countertransference disclosure obscures the patient's transference and diverts attention away from the patient's intrapsychic conflict, the growing popularity of relational theory has made it a widely accepted tool of psychodynamic therapists. Countertransference disclosure can confirm a patient's sense of reality, strengthen the therapeutic alliance, humanize the therapist, promote empathy, and encourage collaboration. Despite the potential value of countertransference disclosure, however, a number of studies have shown that inexperience in dealing with countertransference may lead to negative patient outcomes. Due to their lack of sophistication, therapist trainees are especially vulnerable to the temptation to employ or avoid self-disclosure. This paper explores the challenges therapist trainees must often face when learning to disclose countertransference and makes recommendations on how to address these challenges.

Introduction
The use of countertransference disclosure has been a contentious topic within the psychoanalytic community for almost as long as psychoanalysis has been in existence. While most classically trained analysts claim countertransference disclosure obscures the patient's transference and diverts attention away from the patient's intrapsychic conflict (Aron, 1996; Burke & Tansey, 1991), the growing popularity of relational theory has made countertransference disclosure a widely accepted tool of psychodynamic therapists. In fact, in a recent survey of therapists from a variety of orientations, 94% reported they self disclosed (Hill & Knox, 2002).

There are currently three accepted definitions of countertransference (Gelso & Hayes, 2002). *Classical countertransference* is the therapist's unconscious, conflict-laden reaction to a patient's transference; *totalistic countertransference* is all of the therapist's emotional reactions; and *complementary countertransference* is a counterpart to the patient's transference—every negative transference elicits negative countertransference and every positive transference is met with positive countertransference (Burke & Tansey, 1991; Gabbard, 2001; Gelso & Hayes, 2002). Regardless of the definition, according to its devotees, the disclosure of countertransference is an essential part of treatment (Bridges, 2001). It can confirm a patient's sense of reality (Aron, 1991, 1996), help to strengthen the therapeutic alliance (Aron, 1991; Peterson, 2002), encourage intersubjectivity (Aron, 1991), facilitate the patient's understanding of what has transpired during the analysis (Renik, 1995), promote the patient's own disclosure (Greenberg, 1995), help the patient to understand how his or her behaviors affect others (Aron, 1996), give the patient an opportunity to empathize with another human being (Ulman, 2001), establish an atmosphere of authenticity (Renik, 1995; Peterson, 2002), humanize the therapist (Aron, 1996; Ehrenberg, 1995), and encourage the patient's collaboration (Ehrenberg, 1995).

This is not to say, however, that all therapists encourage the comprehensive use of countertransference disclosure. Most therapists maintain that it is necessary to consider the individual context of each analysis—the participants in the therapeutic dyad and the course of treatment—before engaging in countertransference disclosure

(Davis, 2002; Ehrenberg, 1995; Peterson, 2002). In a survey by Hill and Knox (2002), therapists reported they avoided self-disclosure when it would fulfill their own needs, move the focus from the client to therapist, interfere with the client's flow of material, burden or confuse the client, blur boundaries between the client and therapist, overstimulate the client, or contaminate the transference. Even its staunchest supporters acknowledge that the disclosure of countertransference is a complicated maneuver requiring self-awareness, self-integration, empathy, ability to regulate anxiety, and ability to conceptualize (Davis, 2002; Ehrenberg, 1995; Gelso & Hayes, 2001; Peterson, 2002).

If the decision to disclose countertransference is difficult for experienced therapists, I would propose it is even more difficult for therapist trainees. Davis (2002) describes the trainee's disclosure dilemma as the "countertransference temptation." He proposes that, due to a lack of experience in working with transference and countertransference, therapist trainees are especially susceptible to the temptation to employ or avoid self-disclosure in order to shut down—rather than analyze—a patient's intense transference feelings.

According to the literature, this lack of experience in dealing with countertransference can have a negative effect on the therapeutic relationship. A number of studies have linked inexperience with negative patient outcomes. Fauth and Hayes (2001) found that therapists who felt more threatened and less effective were more hesitant in verbal responses to patients; Gelso and Hayes (2002) discovered that therapists with greater anxiety were more likely to avoid the patient's affect, inaccurately recall the patient's material, and ignore the patient's feelings regarding the therapist; and Rosenberger and Hayes (2001) demonstrated that avoidant behavior linked to a therapist's countertransference was associated with lower therapist ratings of overall alliance. In this context, I will explore the challenges that therapist trainees often face when learning how to disclose countertransference and offer recommendations on how to address these challenges.

Challenges for the new therapist

The first mistake trainees often make is relying too heavily on theory. For example, it is common for some therapist trainees to begin their careers believing they should avoid self-disclosures because of classical psychoanalysis' longstanding advocacy of analyst anonymity and neutrality. Some supervisors perpetuate the classical psychoanalytic stance by advising their trainees to err on the side of nondisclosure so as to keep things simple. The problem with this advice is that it prevents training therapists from being spontaneous and authentic in therapy (Davis, 2002). While theory may provide an excellent foundation for trainees, it prevents them from using their own intuition (Charles, 2004). As Greenberg (1995) puts it, "The theory of technique comes to our aid when it teaches a mode of discourse; when it prescribes what we must do across the board it can only stultify our efforts to work effectively for our clients" (pp. 204-205).

Trainees may also avoid disclosing countertransference because it opens them up to vulnerability. When disclosing personal information they may feel they are allowing the patient to see and know them entirely, which may be very threatening (Bridges, 2001). Nevertheless, as Aron (1991) and others (Ehrenberg, 1995; Renik, 1995) point out, self-exposure of some kind is inevitable in therapy. It is impossible for therapists not to reveal their feelings, whether it's by the way they dress or decorate their office, the way they shift uncomfortably in their seats when faced with a patient's troubling material, or by the silence they maintain in response to a patient's questions (Ehrenberg, 1995).

Like many trainees, I had to learn this lesson the hard way. At the beginning of a group therapy session, one of the patients

who had earlier expressed his reluctance to attend asked me what I thought he would get out of group. Caught off guard, I responded, "Uh, well, what do you think you'll get?" He rolled his eyes and said, "You're just like the rest of them—always answering a question with a question! Do you people know anything?" I had avoided his question to prevent myself from being vulnerable – I did not want to admit that I really did not know what he would gain from coming to group. Despite my best efforts, my avoidance of his question revealed to the patient how inexperienced I was.

Another difficulty that young therapists face in the early years of their training is the paucity of "right" answers. Having completed undergraduate or graduate programs where they excelled in their classes, it can be alarming for trainees to discover that all the studying in the world cannot prepare them for the challenges that arise in therapy. New therapists may feel inadequate and unprepared to hold someone else's life in their hands. They may want to give their patient a simple answer in order to avoid the discomfort of guilt, helplessness, and the oppressive weight of the patient's dependence and longing (Davis, 2002). Davis (2002) describes a therapy session early on in his career when his patient, a young college student, expressed anxiety regarding his poor performance in an algebra class required for his degree. Davis, discomfited by the depth of his patient's distress, disclosed a trivial detail about himself (he had never learned to play the guitar) in order to escape from his own feelings of distress and helplessness.

Alternately, trainees may find themselves growing defensive in response to the patient's material or emotions, which, in turn, "can block the openness of the mind necessary for perceiving the emotional truth that emerges in the session" (Safran, 1999, p. 5). In these instances, they may disclose their countertransference through some kind of enactment. During a psychoeducation group therapy session I asked the patients to define what "mental illness" meant to them. I was proud of having chosen this somewhat provocative intervention, and when one of the patients refused to participate in the exercise because it was "stupid," I heard myself respond defensively, "Well, you don't have to be so rude about it!" At that moment, my mind was clouded by anger and humiliation and I lost the ability to regulate my own emotions, let alone the patient's.

One of the more frightening experiences for a new therapist is the disintegration of the boundary between self and patient, whether it is due to the patient's transference, projective identification, or the therapist's own powerful countertransference. Feeling exposed in this way can disrupt the therapist's coherent sense of self (Ulman, 2001). Suddenly, there is nothing to distinguish the therapist from the patient. As Benjamin (2004) describes it, the event is often "signaled by the feeling expressed in the question, 'Am I crazy or is it you?'" (p. 31). Faced with this danger, young therapists may use self-disclosure in a desperate attempt to restore reality to the therapeutic setting or they may avoid self-disclosure to hide under the cloak of anonymity. Trainees have to learn to be open to patient's transference toward them and work non-defensively with these feelings (Davis, 2002).

Finally, age difference can have a powerful effect on the therapeutic dyad. Most beginning therapists are younger than their clients and desperately want to appear competent. Disclosure of countertransference allows the older, more experienced patient to see a potential chink in the therapist's armor and may threaten the therapist's authority.

Learning to use countertransference disclosure

Learning to recognize countertransference reactions and reflect on them is a critical part of a trainee's development. The litera-

ture shows that awareness of countertransference feelings is related to less countertransference behaviors (Latts & Gelso, 1995; Robbins & Jolkovski, 1987) and effective management of countertransference positively affects outcomes (Gelso & Hayes, 2001). However, countertransference reactions can sometimes happen before it's even possible to become aware of them. In some cases, they can only truly be understood *after* they've occurred—in supervision (Davis, 2002). Supervisors can help trainees to prepare for the disclosure dilemma by encouraging them to think about the possibility of countertransference reactions in advance. Trainees can engage in role playing exercises where they "try on" various scenarios of exposure, thereby learning how to anticipate how they and their patients might react (Ulman, 2001), determine the right contexts in which to disclose countertransference, and practice different ways of communicating their countertransference to their patients.

The research literature on countertransference indicates that patient factors alone do not trigger a therapist's countertransference. Instead, countertransference is more likely to originate in the interaction between the patient's material and the therapist's personal, unresolved conflicts (Gelso & Hayes, 2002). For this reason, it is wise for therapists to engage in their own personal therapy to gain insight into personal issues that might be triggered by an exchange with a patient. In gaining awareness of these issues, the therapist becomes more capable of being able to reflect instead of react. In reflecting, one gains enough distance to ask, "What and why am I disclosing now? Am I sharing my feelings to open up a dialogue with the patient or am I offering a simple answer to avoid confronting the patient's distress?" Reflecting on the therapeutic process can provide the therapist with a great deal of information about the therapeutic relationship. In fact, Greenberg (1995) proposes that "how we arrive at our decisions is often more interesting than the conclusions that we reach" (p. 197).

The therapist trainee must also learn to be comfortable with the unknown—to accept that there are no real answers or absolute truths. The therapist must learn how to tolerate feelings of inadequacy and ineffectiveness (Safran, 1999). Accepting the unknown—letting go of memory and desire (Bion, 1967)—allows the therapist a tremendous sense of freedom. Instead of having to concentrate on finding the "real" answers, the therapist is free to be a participant observer – to focus on simply understanding what both the patient and therapist are experiencing in the moment (Charles, 2004). I find it ironic that, in a sense, it can take years of training to reach the conclusion that one truly knows nothing.

Basic guidelines for countertransference disclosure

I am not alone when I express how difficult it is for trainees to translate theory from the classroom into digestible bits of information they can use in vivo. I know how much I appreciate authors who supplement their theoretical discussions with practical advice and, for this reason, I've included five guidelines for disclosing countertransference, mined from in the literature, that I found particularly illuminating:

1) Remain patient focused. Bridges (2001) advises against frequent therapist disclosures, as it deflects attention away from the patient's concerns to the analyst's (Aron, 1996). Cooper (1998) finds it useful to learn as much about the patient's perspective as possible before disclosing. This, he believes, prevents the patient from feeling as though the therapist's attention has shifted to an exploration of the therapist's experience.
2) Consider patient resources. There are certain client traits that one should consider before disclosing countertransference. For example, patients with severe psychopathology have significantly less resources to call upon when faced with emotionally arousing material. It is

probably best to refrain from disclosing countertransference to patients with poor boundaries, patients with poor reality testing, and impulsive patients. Neurotic patients are more likely to tolerate countertransference disclosure, but there are some patients for whom it may be disconcerting. Countertransference disclosure should probably be avoided with patients who tend to focus on the needs of others instead of their own, at least until they have developed a more established sense of self worth. Patients who fear closeness with others and those wanting to avoid strong emotions will most likely need to form a trusting alliance with their therapist before they feel comfortable with the therapist's countertransference disclosure. Self absorbed patients may feel threatened if they are not the center of attention, and for this reason, countertransference disclosure should be used sparingly, if at all, until their narcissism is somewhat tempered (Peterson, 2002).

3) Model emotional honesty. In disclosing countertransference, therapists are portraying themselves as trustworthy, which strengthens the therapeutic alliance (Aron, 1991; Hoffman, 1983; Peterson, 2002) and encourages intersubjectivity – the ability to see another person as an individual with a subjective experience of the world (Aron, 1991). Countertransference disclosure also allows the patient to feel comfortable in making his or her own self-disclosures (Knox, 1997; Peterson, 2002).
4) Keep it in the moment. In the relational model, psychopathology is measured by the degree of flexibility a person has during his or her interactions with other people (Burke & Tansey, 1991). What takes place during therapy is another kind of interaction – one that provides valuable information regarding a patient's relational patterns. For this reason, the patient's psychic reality should remain embedded within the matrix of therapeutic relationship (Cooper, 1998).
5) Be willing to explore the multiple meanings of the disclosure to both the therapist and the patient. Countertransference disclosure should always be offered tentatively, so as to accommodate the feelings and perceptions of the patient (Cooper, 1998). There are times when the therapist may assert his or her own subjectivity upon the patient, thereby reducing a two-person therapy into a one-person therapy (Aron, 1991). Moreover, due to the asymmetry of the therapeutic relationship, the patient may interpret the analyst's experience as the absolute truth (Cooper, 1998). Both of these activities should be discouraged, if possible. The therapist/patient relationship may be asymmetrical, but it is also mutual and requires the collaboration of both parties to succeed (Cooper, 1998). In addition, the therapist should be aware that patients might react in different ways to countertransference disclosures. One can never know how the patient will respond or how he or she will use the information in the future, so the therapist should be very cautious in disclosing sensitive personal material (Bridges, 2001).

Conclusion

The training therapist should take comfort in the fact that knowledge and self-confidence come with time and experience. Marilyn Charles emphasizes this in her recently published text for beginning therapists: "… 'learning from experience' became a kind of mantra for me as I took deep breaths and tried, in spite of my terror, to trust what seemed to me to be true. This terror was a function of the tension between my ideas regarding how therapy is 'supposed to be' and my own sensibilities in the moment" (p. 61). Research shows that, with practice, therapists can learn to effectively manage their countertransference disclosures. Gelso & Hayes (2002) found that experienced therapists were more likely to be aware of countertransference, more likely to prevent themselves from enacting countertransference, and more capable of preventing counter-

transference from influencing their behavior than inexperienced therapists.

In one of his hallmark papers, *Observations on Transference-Love*, (1915) Freud wrote that, "Every beginner in psycho-analysis probably feels alarmed at first at the difficulties in store for him…When the time comes, however, he soon learns to look upon these difficulties as insignificant" (p. 37). Countertransference disclosure is just one of the many alarming difficulties lying in store for therapist trainees. At some point, however, in order to fulfill their potential, training therapists must learn to accept the insignificance of their anxieties and let them go.

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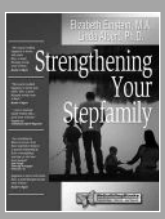
Client Resources for Therapists



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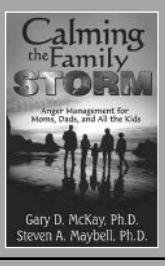

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INTERVIEW

Observations from my interview with Dr. Donald Freedheim

Andrea Current
Wright State University

You may know Dr. Freedheim's name from a variety of sources: you might be a current or past student of his at Case Western Reserve University where he is currently a Professor Emeritus; maybe you are a candidate for — or recipient of — the Division 29 student paper award in his name; perhaps you simply remember him fondly as a past president of Division 29. No matter why Dr. Freedheim is familiar to you, it is certain that his work for the Division and our profession has impacted your career.

Although editing has been a large part of Dr. Freedheim's career, he admits that it was not an option that he had truly considered until the opportunity was offered to him. He believes that this is often the case in our field, which is unique in its ability to produce a variety of worthwhile endeavors. As he observed, "maybe an opportunity comes up, and it is something you haven't considered, or maybe you weren't trained for it, but if it seems interesting, run with it and see what you can do with it."

It is that spirit and initiative which first led Dr. Freedheim to editorial work. As a budding professor, he was first approached to assist in editing a Division 12 newsletter. From there, he became the third editor of the journal *Psychotherapy*, where he continued the tradition of special issues on specific topics. He greatly enjoyed the challenge of developing a publication which promotes advancements in psychotherapy, research, and education while educating the field on current areas of interest and furthering the education of the writers who submitted papers. Perhaps the greatest down side to the position was that he "turned down many more authors than I ever accepted."

While editing the journal in the late 1980s, Dr. Freedheim proposed a special issue of the journal which covered the history of psychotherapy in honor of the upcoming 100th anniversary of APA. As he began the task, it became clear that there was more material than could be properly covered in a journal issue. The special issue then switched topics to the future of psychotherapy, and the information compiled on the history of psychotherapy became a book published by APA. Although the book is nearly 15 years old, it is still selling well. All of the royalties from its sale go directly to Division 29, and to date the book has generated over $30,000 in royalties.

As a result of the success of this publication, Dr. Freedheim was also asked to edit a Wiley publication titled *History of Psychology*. He is quick to note the chain of progression from one duty to the next. As each opportunity came to a close, a new, different, and interesting opportunity emerged. All of these later editorial duties were "directly linked to my involvement in APA and Division 29."

For student members of the division, Dr. Freedheim promotes getting involved early, not only in Division 29 roles, but also in APAGS. "APAGS is well-respected in the APA community, so it's a great opportunity." He advises students to be active in both your specialized area of interest and in the governance at large; in this way, students are able to discover new areas of interest that they may have otherwise missed. Specializing in one area of interest

is a positive thing, but Dr. Freedheim also notes that it is important not to neglect the field as a whole. As he observed, one of the biggest challenges and goals Division 29 will face is grappling with the issue of increased specialization. Dr. Freedheim believes that "Division 29 has a responsibility to preserve psychotherapy as a general approach" which includes all specialized areas, including cognitive therapy, psychodynamic therapy, and psychopharmacology. From his perspective, it is very important for the field as a whole to resist the temptation to splinter. All of the different branches benefit by keeping in contact with, and learning from, each other. These opportunities for professional dialogue and encounters are one of the major purposes of Division 29, and a goal that Dr. Freedheim hopes will be affirmed over time. As he noted, "Psychology is an interesting field," precisely because it is constantly adapting, creating new roles, new avenues for research, and new adventures for us all.

Finally, through his many years of service to APA and to Division 29 in particular, Dr. Freedheim also emphasized the wide array of experiences he has had as well as the many lasting friendships and partnerships along the way. He credits much of his career development to his active involvement in Division 29, and urges student to become involved for the same reasons.

Among many other reactions, the overarching sense that emerged from my stimulating conversation with Dr. Freedheim is how broad the horizons of our field really are. For all of us who dream of making a difference, Dr. Freedheim's perspectives and accomplishments provide a timely and inspirational model for how a career in psychology can become a rich and rewarding life-long journey.

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DIVISION 29 – PSYCHOTHERAPY
2005 APA ANNUAL CONVENTION PROGRAM

DIVISION 29 PROGRAM SUMMARY SHEET

THURSDAY, AUGUST 18

10:00 AM – 10:50 AM • Renaissance Washington DC Hotel /Ballroom West B
Symposium (N):
TOP—A Core Battery to Assess Psychotherapy Outcome
Chair: Abraham W. Wolf, PhD

11:00 AM – 11:50 AM • Washington Convention Center / Halls D & E
Poster Session (S):

12:00 PM – 1:50 PM • Washington Convention Center / Meeting Room 146C
Symposium (S): *What Do You Do When You Hate Your Patient?*
Chair: Abraham W. Wolf, PhD

2:00 PM – 3:50 PM • Washington Convention Center / Meeting Room 146A
Symposium (S): *Dream Work—-How Does It Work?*
Chair: Clara E. Hill, PhD

7:00 PM – 7:50 PM • Washington Convention Center / Meeting Room 146B
Symposium (S): *Expanding Internship Models—*
Half-Time, Captive, Consortia, and Others
Chair: Lorraine Mangione, PhD

8:00 PM – 8:50 PM • Washington Convention Center / Meeting Room 146B
Symposium (S): *Unification of Psychotherapy—Challenges for Theory, Research, Practice, and Training*
Co-chairs: Jeffrey J. Magnavita, PhD and Jack C. Anchin, PhD

FRIDAY, AUGUST 19

8:00 AM – 9:50 AM • Washington Convention Center / Meeting Room 146B
Symposium (S): *Using Effectiveness Research to Understand Psychotherapy*
Chair: David W. Smart, PhD

2:00 PM – 3:50 PM • Washington Convention Center / Ballroom B
Symposium (S): *What Is the Proper Focus of Evidence-Based Practice in Psychotherapy? Five Contenders*
Chair: Leon VandeCreek, PhD

4:00 PM – 4:50 PM • Washington Convention Center / Meeting Room 146A
Conversation Hour (N): *Aaron T. Beck, MD, in Conversation With Frank Farley, PhD*
Chair: Frank Farley, PhD

FRIDAY, CONTINUED

4:00 PM – 5:50 PM • Washington Convention Center / Meeting Room 145B
Symposium (S): *Practice-Based Research Networks in Mental Health*
Chair: Abraham W. Wolf, PhD

6:00 PM – 7:50 PM • Grand Hyatt Washington Hotel / Constitution Ballroom A

Social Hour

SATURDAY, AUGUST 20

8:00 AM – 9:50 AM • Washington Convention Center / Meeting Room 206
Symposium (S): *Evidence From Real Practice—Effectiveness Research and Clinical Implications*
Chair: Bruce E. Wampold, PhD

10:00 AM – 11:50 AM • Washington Convention Center / Meeting Room 150A

Symposium (S): *How Can We Do a Better Job of Training Novice Therapists?*
Chair: Jeffrey A. Hayes, PhD

12:00 PM – 1:50 PM • Washington Convention Center / Ballroom B

Symposium (S): *Distinguished Elders Appraise the Field of Psychotherapy—Perils and Possibilities*
Chair: Alvin R. Mahrer, PhD

SUNDAY, AUGUST 21

8:00 AM – 8:50 AM • Washington Convention Center / Meeting Room 151B

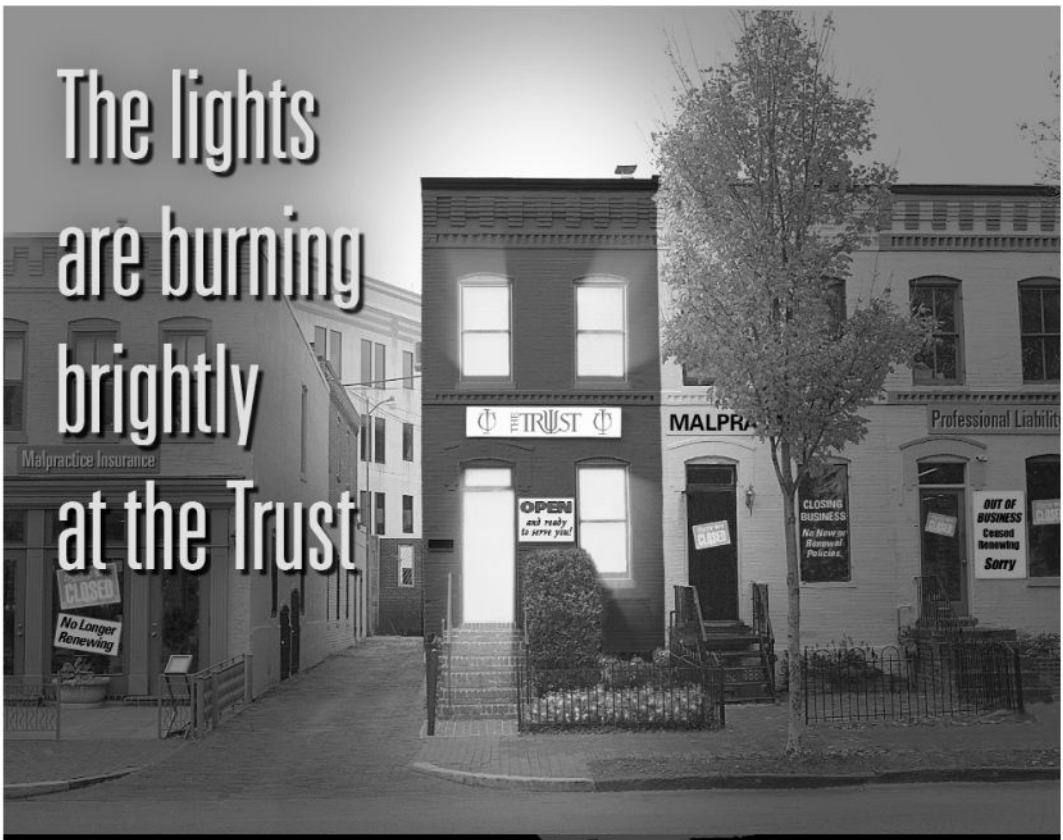
Symposium (S): *Understanding and Treating Traumatic Grief*
Chair: Donna S. Davenport, PhD

9:00 AM – 9:50 AM • Washington Convention Center / Meeting Room 146B

Symposium (S): *Therapists' Apologies in Psychotherapy—Possible Benefits, Potential Perils, Empirical Findings*
Chair: Randolph B. Pipes, PhD

10:00 AM – 11:50 AM • Washington Convention Center / Meeting Room 103B

Symposium (S): *Surviving the Storm—Treatment Innovations for Borderline Personality Disorder Patients*
Chair: Joan M. Farrell, PhD



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WASHINGTON SCENE

Interesting Perspectives, Especially from Afar

by Pat DeLeon, Ph.D., ABPP, former APA President

Without question, one of the most rewarding aspects of working within the public policy (i.e., political) process is the opportunity to experience (often seemingly from afar) evolving changes in the status quo. Within the health care arena, for example, one can definitely feel increasing concern within the leadership of both political parties (not to mention among business, labor, and average citizens) regarding the ever-escalating cost of health care in our nation. As Harvard Law Professor **Elizabeth Warren** commented to the media, "Nobody's safe. That's the warning from the first large-scale study of medical bankruptcy. Health insurance? That didn't protect 1 million Americans who were financially ruined by illness or medical bills last year. A comfortable middle-class lifestyle? Good education? Decent job? No safeguards there. Most of the medically bankrupt were middle-class homeowners who had been to college and had responsible jobs until illness struck. As part of a research study at Harvard University, our researchers interviewed 1,771 Americans in bankruptcy courts across the country. To our surprise, half said that illness or medical bills drove them to bankruptcy. So each year, 2 million Americans those who file and their dependents face the double disaster of illness and bankruptcy. But the bigger surprise was that three-quarters of the medically bankrupt had health insurance... The link between jobs and health insurance is strained beyond the breaking point... Every 30 seconds in the United States, someone files for bankruptcy in the aftermath of a serious health problem. Time is running out. A broken health care system is bankrupting families across the country."

Although the ultimate solution may not be evident at this point, it is clear that increasing concern is definitely present.

Our colleague **Neil Kirschner** served as an APA Congressional Science Fellow on the staff of Congressman Pete Stark (D-Ca) and then moved to the private sector as Senior Associate for Regulatory and Insurer Affairs, at the American College of Physicians. As he observed, "The fact that healthcare costs continue to increase each year at a pace that far exceeds inflation is not unnoticed by either the public or private sector. One response to this trend is the call for 'pay-for-performance' (P4P) or 'value purchasing' to use the buzz words of Capitol Hill. This approach challenges the current system of paying all similarly credentialed providers the same amount for the same procedure. Under P4P, providers who meet specific performance goals will receive more than those who don't. My concern is that the behavioral health field (e.g., psychology) remains silent in this arena and by doing so places its future in the hands of others.

"The Medicare Payment Advisory Commission (MedPAC) has recently recommended P4P under Medicare in such areas as physician fees and hospital payments. Word from the Hill is that there is bipartisan, bicameral support for this recommendation: such cooperation is exceedingly rare for any issue in Congress these days. Furthermore, there are over 100 private sector P4P initiatives already taking place throughout the country implemented by such entities as Bridges to Excellence, Leapfrog, Blue Cross/Blue Shield, UnitedHealth and Aetna. As part of this movement, a consortium of the American College of Physicians (ACP), the American Association of Family Practitioners (AAFP), the American Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ)

recently released a 'starter set' of reliable and valid performance measures agreed upon by a panel of healthcare stakeholders (e.g., providers, health plans, insurers, employers, consumers).

"The healthcare world is in the midst of a radical change, and I am concerned that our profession is doing too little to adjust and remain viable. My belief is that if we don't work towards defining quality and value, others will and we may not like the results. By taking a 'place at the table,' psychology and the other behavioral health fields can help shape the performance measures that underlie this P4P approach so that they primarily reflect quality rather than efficiency or costs. Furthermore, I believe this effort cannot be done in isolation. The behavioral health field needs to join with relevant payers and consumers to ensure recognition and adoption of the fruits of this endeavor."

In my judgment, we are collectively making significant progress; however, institutional change takes much longer than those with vision may wish. For practitioners, the qualitatively different roles for psychology (and psychotherapy) can be unsettling. How will those with established practices (or those just entering the employment market place) flourish/survive in this new healthcare environment? No one knows for sure.

During the Presidency of **Norine Johnson** in 2001, the APA membership voted overwhelmingly to expressly include "health" within the association's underlying mission statement which now reads to: "advance psychology as a science and profession and as a means of promoting health, education and human welfare." Likewise, our current President **Ron Levant,** has noted that "The historical separation of physical from mental throughout our healthcare system is precisely the problem that my 'Health Care for the Whole Person' Presidential initiative was designed to solve. By collaborating with a broad range of health care organizations on a public statement on the role of psychology in health care, I hope to promote the integration of physical and psychological health care in a reformed health care system in which health care professionals team up to treat the whole person."

This spring, Senators **Hillary Clinton** and **Susan Collins** introduced legislation to amend the Older Americans Act of 1965 to provide for mental health screening and treatment services and to provide for the integration of this care (S. 1116). Senator Clinton introduced this legislation as follows: "Mr. President, today, Senator Collins and I, and in the House of Representatives Congressman Kennedy and Congressman Ros-Lehtinen, are reintroducing the Positive Aging Act, in an effort to improve the accessibility and quality of mental health services for our rapidly growing population of older Americans. We are pleased to be reintroducing this important legislation during Mental Health and Aging Week.

"I want to acknowledge and thank our partners from the mental health and aging community who have collaborated with us and have been working diligently on these issues for many years, including the American Association for Geriatric Psychiatry, the American Psychological Association, the National Association of Social Workers, the American Nurses Association. Today, advances in medical science are helping us to live longer than ever before. In New York State alone, there are two million citizens aged 65 or older. And this population will only continue to grow as the first wave of Baby Boomers turns 65 in less than 10 years. As we look forward to this increased longevity, we must also acknowledge the challenges that we face related to the quality of life as we age. Chief among these are mental and behavioral health concerns.

"Although most older adults enjoy good mental health it is estimated that nearly 20 percent of Americans age 55 or older experience a mental disorder. It is anticipated

that the number of seniors with mental and behavioral health problems will almost quadruple, from 4 million in 1970 to 15 million in 2030.... Among the most prevalent mental health concerns older adults encounter are anxiety, depression, cognitive impairment, and substance abuse. These disorders, if left untreated, can have severe physical and psychological implications. In fact, older adults have the highest rates of suicide in our country and depression is the foremost risk factor.

"The physical consequences of mental health disorders can be both expensive and debilitating. Depression has a powerful negative impact on ability to function, resulting in high rates of disability. The World Health Organization projects that by the year 2020, depression will remain a leading cause of disability, second only to cardiovascular disease. Even mild depression lowers immunity and may compromise a person's ability to fight infections and cancers. Research indicates that 50-70 percent of all primary care medical visits are related to psychological factors such as anxiety, depression, and stress. Mental disorders do not have to be a part of the aging process because we have effective treatments for these conditions. But in far too many instances our seniors go undiagnosed and untreated because of the current divide in our country between health care and mental health care.

"Too often physicians and other health professionals fail to recognize the signs and symptoms of mental health problems. Even more troubling, knowledge about treatment is simply not accessible to many primary care practitioners. As a whole, we have failed to fully integrate mental health screening and treatment into our health service systems. These missed opportunities to diagnose and treat mental health disorders are taking a tremendous toll on seniors and increasing the burden on their families and our health care system...."

One of the most innovative provisions of the bill would authorize demonstration projects to integrate mental health services in primary care settings. According to Senator Clinton, "The Secretary, acting through the Director of the Center for Mental Health Services, shall award grants to public and private nonprofit entities for projects to demonstrate ways of integrating mental health services for older patients into primary care settings, such as health centers receiving a grant under section 330 (or determined by the Secretary to meet the requirements for receiving such a grant), other Federally qualified health centers, primary care clinics, and private practice sites... (T)he project... shall provide for collaborative care within a primary care setting, involving psychiatrists, psychologists, and other licensed mental health professionals (such as social workers and advanced practice nurses) with appropriate training and expertise in the treatment of older adults, in which screening, assessment, and intervention services are combined into an integrated service delivery model..." Not surprisingly, pursuant to Neil's perspective, the legislation also included language calling for: "using evidence-based intervention and treatment protocols to the extent such protocols are available."

I was recently invited to participate in the Global Health Summit, organized by the U.S. Public Health Service Commissioned Officers Foundation for the Advancement of Public Health. In attendance among the 400+ officers were the Surgeon General, **Richard Carmona**, who shared the platform with then Past-President **Phil Zimbardo** at our Toronto convention as well as a delegation from the People's Republic of China and the Afghanistan National Army Surgeon General. Later on that week, APA's ethics officer **Stephen Behnke** and DoD prescribing psychologist **Morgan Sammons** addressed members of the psychology corps. My responsibility was to read from an article in the *The Philadelphia Concord*, entitled: "Global Health Improves Lives, Reduces the Spread of Disease and Contributes to World Stability. This June 5th, 2005 article

was based upon the Global Health Summit, Philadelphia Pennsylvania (the birthplace of America and the United States Public Health Service).

"We the participants in the Global Health Summit meeting in the historic city of Philadelphia recognize that: The Institute of Medicine (IOM), part of the U.S. Academy of Science, has defined global health as referring to 'health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions.' Therefore, global health is the health of all populations of humanity at large. It is our shared responsibility as citizens of the world, neighbors to all. This is substantiated repeatedly, particularly during times of crisis, such as natural and humanitarian disasters like the recent flood in Haiti and the Tsunami affecting Southeast Asia. In this current age of rapid travel, international trade, commerce, and the ease of global communication, it is clear that artificial borders and geographic distances cannot isolate the health and safety problems and concerns of people in one community from those in another. Thus, health is global in nature.

"Global health is of fundamental moral, practical, and strategic importance to the United States and all other nations, for peace, prosperity, and well-being. Through private contributions, government assistance, and other forms of technical cooperation significant improvements in health and development have occurred across the globe. These improvements include clean water supply and community environmental sanitation systems, access to basic immunizations and medications, and developing educational processes and related activities which support national health systems in need or in crisis. Working together nations of the world have demonstrated capacity for improving the health and well-being of millions of people, thus bringing the opportunity for social stability, prosperity and peace, and the strengthening of democracy.

"We are conscious of the challenge to understand that this new century has brought about numerous challenges and opportunities in global health. Vaccines, antibiotics, clean and available water, proper environmental sanitation, and other breakthroughs in scientific and health research and technology are among the many contributions to improved health. However, current challenges include: new emerging diseases like the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Severe Acute Respiratory Syndrome (SARS), Avian Flu; increases in chronic diseases; and the unprecedented flows of people and goods throughout the world. [Thus we must] deal with the contributing factors such as poverty and health disparities which contribute to those numerous challenges to global public health; react to the realities of globalization which require greater collaboration and understanding among nations with respect to public health matters; [and strive for] success in improving health status and prevention of new disease outbreaks, which require health workers and the general public to adopt a global view of health. We must think beyond our borders. What happens across the globe affects us, and what we do affects our neighbors across the globe. [We must] develop a proactive global health agenda to meet these new challenges and opportunities, which means renewing the commitment to improve global health among: national governments, non-governmental organizations, faith-based organizations, and advocacy groups; public and private funders of health programs; multilateral organizations dedicated to health and environmental enhancement; health professional societies and associations; general educational systems of all nations; the media; and in particular the general public of the United States. [We must] encourage and support health as an integral component of international development; leader-

ship coalitions and participation in global partnerships to address pressing disease and environmental challenges that are global in nature; [and conduct]…biomedical research and health services systems research related to these global health issues, taking into consideration the cultural, ethnic, religious values and principles of nations and applying the results by putting them into practice; the consideration of global health topics at all levels of education and training from early childhood to the graduate studies level; health literacy or an understanding of health matters by all citizens, including the values of health promotion, and disease prevention; promotion of volunteering in global health activities by individuals and organizations; the forging of international projects that encourage scientific collaboration on global health issues between investigators in all nations; the reduction of health disparities among vulnerable populations, including women, children and the disadvantaged; an ongoing dialogue among community leaders and their beneficiaries about the importance of global health; health system infrastructure enhancement, including addressing shortages of human resources and promoting greater access to needed health care; [and again, recalling Neil's perspective], the use of proven best practices, including lessons learned from other nations, as well as information-sharing about best-practices in community health; health diplomacy as a tool to bring nations together to improve global health."

This was a most impressive Summit. I only wish that those Public Health Service psychologists who attended the presentations by Stephen and Morgan had been present for their Surgeon General's presentation.

Aloha,
Pat DeLeon, former APA President

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.

CONGRATULATIONS TO THE 2005 DIVISION 29 DISTINGUISHED PSYCHOLOGIST

Gerald P. Koocher, Ph.D.

Congratulations to Dr. Koocher for his outstanding contributions to Division 29 and to the field of psychology.

CONGRATULATIONS TO THE 2005 DIVISION 29 STUDENT PAPER AWARD WINNERS!

Donald K. Freedheim Student Development Award

LaRicka R. Wingate of Florida State University

"Problem solving treatment for suicidal behavior in young adults: Also effective for alcohol abuse?"

Mathilda B. Canter Education and Training Award

Jay L. Cohen of Wayne State University

"Consensus on ratings of therapist competence: A generalizability analysis"

Diversity Award

Roger Karlsson of University of California, Berkeley

"A meta-review of the empirical support for ethnic matching between therapist and patient in psychotherapy"

Please join us in honoring all these winners at the Division's Awards and Social Hour
Friday, August 19th – 6:00 pm – 7:50 pm
Grand Hyatt Washington Constitution Ballroom A

STUDENT ABSTRACT

Consensus on Ratings of Therapist Competence: A Generalizability Analysis

Study Summary for Mathilda B. Center Education and Training Award

Jay L. Cohen
Wayne State University

A science of psychotherapy presumes that consensus exists about which behaviors in which contexts are viewed by experts as competent. Institutions that train and evaluate therapists assume that (a) experts can recognize and evaluate competent therapist behavior and (b) people can be trained toward achieving a required level of competence. This study addressed the following questions: (1) To what extent is there consensus among students and faculty regarding the relative competence of expert therapists? (2) Does consensus increase as a function of training? (3) To the extent that consensus is suboptimal, what can be done to ensure that evaluations of competence are reliable?

Thirty-three individuals representing four levels of training (junior- and senior-level graduate students, program alumni, and faculty) at an APA-approved doctoral program in clinical psychology rated video clips of three master therapists engaged in therapy demonstrations. A *generalizability* study evaluated the contribution of both consensus as well as idiosyncratic judgment on ratings of therapist competence. Two specific forms of idiosyncratic judgment are *rater* and *dyadic* variance. Rater variance reflects mean differences between raters in how they perceive therapists. To the extent that rater variance is large, some raters perceive all targets in a favorable light while other raters perceive all targets in a negative light. Dyadic variance represents systematic differences among raters in their rank ordering of targets; it can be conceptualized as rater preference for specific therapist interventions. Formulas provided by generalizability theory were used to calculate effect sizes. Overall, there was a small degree of consensus (mean ù2 = .11). Rater bias was responsible for 15% of the variance in competence ratings, while dyadic variance accounted for an additional 24% of the variance. Limiting the group of raters to those with similar levels of training did not substantially increase consensus about the relative competence of therapists. While consensus was significant for all four levels of training, the magnitude of the effect sizes were small (range: ù2 = .03 - .16).

Although a low degree of consensus may suggest lack of a coherent paradigm of competence in conducting psychotherapy, low consensus does not necessarily undermine the reliable use of such judgments for training or credentialing psychologists. A decision study was conducted in which the results of the generalizability study were used to estimate the number of raters and items needed for reliable judgments. Results of the decision study indicated the reliability of ratings of therapist competence using five raters and eight items was ö =.52. While increasing raters provided a larger "bang," those with limited resources could achieve acceptable levels of reliability by adding several items or clinical situations.

This study demonstrated the potential benefits of using a generalizability framework to increase our understanding of the state of a shared paradigm of psychotherapy competence among a group of psychologists and their trainees. While there was limited consensus in the current study, the decision study showed that, while not

desirable, limited consensus does not necessarily impair the reliability of competency judgments. Therefore, the low consensus should not cause distress to those who train and evaluate future psychologists. However, it raises the questions of whether a shared paradigm exists for competent therapist behavior, and how this influences scientific progress in the field of psychotherapy.

The author may be contacted via e-mail at jay.cohen@wayne.edu.

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.

Invited Address

The Psychotherapist's Own Psychotherapy: Educating and Developing Psychologists

Friday, August 19, 2005
10:00-10:50
Meeting Room 204C
Washington Convention Center

STUDENT ABSTRACT

A meta-review of the empirical support for ethnic matching between therapist and patient in psychotherapy

Study Summary for Student Paper Diversity Award Winner

Roger Karlsson
University of California, Berkeley

The assumptions regarding the benefits of ethnic matching between therapist and patient have become accepted to the point where such matching is commonplace in psychotherapy and case management services today. This article reviews the actual empirical support for ethnic matching. The research has three sources: analogue studies, archival studies of number of attended sessions and dropout rates, and process/outcome studies of psychotherapy. Analogue studies have produced inconsistent findings and suffer from low external validity because of the difficulty to produce a valid fictional script of psychotherapy and the methodological limitations in asking participants to imagine a problem or imagine meeting a therapist. Archival studies have higher external validity than analogue studies but much lower internal validity, which might confound the results. For example, considering that the clients are not randomly assigned to treatment conditions, there is a possibility that self-selection affects the results. Also, such studies have an enormous sample size, which perhaps results in significant results but with a very weak effect size. Findings from studies of actual psychotherapy process and outcome suggest that ethnic matching is not related to outcome of psychotherapy. However, psychotherapy studies suffers from a paucity of studies, small sample sizes, no randomization of patients to treatment conditions, no control groups, and seldom incorporation of psychotherapists representing both European American and ethnic minorities.

In conclusion, the empirical support for ethnic matching suffers from low validity and is inconclusive, with few studies of actual psychotherapy. The research is also hampered by poor conceptualization of key concepts, difficulties in forming ethnically homogenous groups for comparisons, and an abundance of uncontrolled within group variables. For example, researchers might define a group as "Hispanic" because all participants speak Spanish, while in fact the variability in such a group might be enormous, including men and women of different ages from countries in Europe, North, Latin, and Central America. Additionally, therapist variables, e.g., cultural-sensitivity, are rarely investigated.

In fact, there is a notable absence of naturalistic studies and clinical trials where within group variables and therapist variables are systematically investigated. In the absence of such studies it is still unclear how mental health professionals should optimally serve ethnic minorities in a most advantageous fashion. Such types of studies would require very large sample sizes to allow testing of various combinations of populations and within group variables with various types of psychotherapist variables. Nevertheless, the undertaking of such an endeavor would be worthwhile, considering the accumulation of knowledge that such research could provide regarding how to provide psychotherapy under the most advantageous conditions for underserved populations.

Considering the results from this review, it is surprising that the necessity of ethnic matching in treatment planning has

received so much credit among clinicians without any convincing empirical support. However, the lack of support does, of course, not mean that ethnic matching is irrelevant in treatment. Instead it can be argued, based on this review, that the impact of ethnic matching on psychotherapy is still at large despite over 25 years of research.

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FEATURE

Problem Solving Treatment for Suicidal Behavior in Young Adults: Also Effective for Alcohol Abuse?

Study Summary for Donald K. Freedheim Student Development Award

LaRicka R. Wingate, Thomas E. Joiner, Jr., Maureen Lyons Reardon, Alan R. Lang, Ainhoa Otamendi, Daniel L. Hollar, & M. David Rudd

Studies of treatment outcome, which focus on treating one disorder while tracking co-occurring disorders, contribute to evidence of whether the existence of co-occurring disorders consistently requires treatment of both disorders. More research is needed in order to provide more information about how alcohol abuse as a co-occurring disorder can benefit from treatments not specifically designed for alcohol abuse. The aims of this study were to examine the effectiveness of problem-solving therapy (PST) on problematic alcohol abuse in a sample of patients with clinically significant suicidality. Of note, both alcohol abuse treatment and problem-solving treatment for suicidal behavior share key features as intervention targets. For this specific reason, and because both disorders often co-occur, we speculated that problem-solving treatment for suicidal behaviors also would be effective in treating alcohol abuse in those individuals who are suffering from both disorders concurrently.

Following Room's (1998) and Haw et al.'s (2001) call for work on the response of alcohol problems to treatments not specifically targeting alcohol abuse, the present paper measures therapeutic cross-over effects of problem-solving treatment for suicidal behavior on alcohol abuse in a sample of military young adults. It was hypothesized that the problem solving treatment for suicidal behavior would also be effective at reducing alcohol abuse. Moreover, based on Rudd et al.'s (1996) findings, it was expected that problem-solving treatment would be more effective than would treatment-as-usual at reducing alcohol abuse.

Participants were 114 individuals who had recently attempted suicide or ideated about suicide to the degree that they came to clinical attention. They were randomly assigned to either the "experimental" treatment (i.e., the problem-solving treatment) or "control" treatment (i.e., treatment-as-usual for suicidal behavior; often a combination of crisis management, inpatient hospitalization, and antidepressant medications).

It was expected that the treatment assigned at the beginning of the experiment would be predictive of changes in alcohol abuse from baseline to follow-up (controlling for baseline levels of self-reported alcohol abuse, as well as for IQ as measured by the Shipley Institute of Living Scale, and suicidal symptoms as measured by the MSSI at follow-up). We conducted hierarchical multiple regression equations to test our hypotheses. Problem-solving treatment performed better than treatment-as-usual in producing decreases in alcohol abuse at 12-month follow-up ($\underline{pr} = -.27$, $\underline{F}\,[59] = 4.63$, $\underline{p} < .05$). Results supported our hypotheses, indicating that problem solving treatment performed significantly better at reducing alcohol abuse than did treatment-as-usual.

In conclusion, it appears that our understanding of the nature and treatment of the dually-diagnosed indeed may be advanced by evaluating change in alcohol disorder symptoms with treatment for a co-occurring condition (Room, 1998). This study provides some interesting new data in this regard, in that among those who remained in our study, problem-solving treatment for suicidal behavior was better than treatment-as-usual for reducing harmful use of alcohol.

LaRicka R. Wingate is at the Department of Psychology, Florida State University, Tallahassee, Florida. Contact the author at: LaRicka@aol.com.

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