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BULLETIN

In This Issue

2005 VOLUME 40 NO. 4

Division of Psychotherapy ■ 2005 Governance Structure

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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

This is my final column as President of Division 29. Time really flies. It has been an honor to serve the Division of Psychotherapy in this and several other capacities over many years. As I describe some of our ongoing initiatives, I hope you get a sense of the excitement and energy that is present in the Division today.

One of our important ongoing initiatives is the development of a position paper that addresses federal funding of psychotherapy research. The Division is alarmed that psychotherapy research is endangered by current funding polices and guidelines. Specifically, many categories of psychotherapy research fail to fit into the current federal funding guidelines. For example, process research, naturalistic studies, qualitative and single case designs, among others, are less and less likely to be funded, while preference is given to randomized clinical trials research on manualized treatments of patients who fit neatly into diagnostic categories. In response, our Research Committee, under the leadership of Bill Stiles, and with input from many of our top psychotherapy researchers, is writing a position paper that will lay out the arguments for federal funders to be more inclusive in their funding criteria. Linda Campbell and others have drafted a brief executive summary that will be shared with the leadership of APA and other groups to assist in advocacy efforts. These documents should be in final form by the end of this year.

The Division will begin to send liaisons to the Board of Educational Affairs, the Board of Scientific Affairs, and the Board of Professional Affairs. Dr. George Striker has agreed to serve as our liaison with BSA; as of this writing, we are still finalizing our appointments for the other two positions. The Board is convinced that the affairs of our Division can be significantly enhanced by having our voice heard in several venues. As an example, the Board approved a policy statement that expresses serious concern about the use of generic terms to describe the health-care activities of psychologists. Generic terms such as "therapist" are often used in psychology literature and contribute to the confusion of psychology with other professions. The policy asks that the Division, APA, and other groups representing psychology avoid the use of generic terms such as "clinician," "intervention," and "assessment" when referring to psychologists and instead use terms such as "psychotherapy," "psychological assessment," and "psychological treatment."

At its recent meeting, the Board generated considerable enthusiasm for both membership recruitment and membership development activities. This fall we will begin our first large scale membership recruitment campaign for psychologists who are not APA members. In the first step, all licensed psychologists in Ohio, including those who are not APA members, will receive an invitation to join the Division. While bringing new members into the Division is important, we also know that we lose members every year and we need to do more to keep current members attracted to us. Jean Carter has expressed an interest in spearheading a membership development initiative and you should be hearing more about that in the coming months.

We also know that new career psycholo-

gists are eager for information that will assist them in establishing their careers. Rhonda Karg is developing a resource document for new psychologists in practice careers and Libby Williams, a new board member, will assist in creating or collecting resources for new psychologists with interests in careers in teaching, training, and research.

Finally, with our Division now in stronger financial shape than it has been in several years, the Finance Committee (Jan Culbertson is chair) will be expanding to include members who have expertise in long-range financial planning. Steve Sobelman and Larry Ritt have agreed to join the committee and we are still looking for one or two others who have strong financial planning expertise.

I am pleased to say the Division is doing very well. The members of the Board have a high level of energy and enthusiasm and we continue to bring in new faces in leadership positions who generate fresh ideas.

The Division will be in very good hands in 2006 under the leadership of Abe Wolf and then in the next year with Jean Carter. Abe has been working on his initiatives for the past year and will assume the presidency in full stride. He has described some of his initiatives in other pieces in the *Bulletin*.

STUDENT COLUMN

How Should Mental Health Professionals Respond to a Large-Scale Disaster?

By Amber L. Paukert, University of Houston

After the recent hurricane sent thousands of displaced Louisianans to Houston, licensed psychologists in Houston were asked to report to the shelters to volunteer their services. In these post-disaster situations, should mental health professionals utilize the same basic skills used in the treatment of post-traumatic stress disorder (PTSD), even though when treating PTSD the event generally is weeks, months, or years in the past? After examining some of the recent reviews of the field of early crisis intervention, it appears that there is no consensus about what treatment is best for disaster relief, suggesting that much more research is needed in this area. However, there are some psychologists who vehemently oppose what was in the past the standard for counselors who are involved in crisis intervention: psychological debriefing or Critical Incident Stress Debriefing (CISD). This paper reviews the nature of CISD, evidence contraindicating and supporting its use, the response of CISD proponents to evidence contraindicating its use, and how opponents to CISD recommend mental-health practitioners provide disaster relief.

PTSD can be a debilitating disorder; estimates of its prevalence among those exposed to traumas have large ranges depending on the type of traumatic event and the degree of exposure to the event, but these estimates can be as high as 58% (Yehuda, Marshall, Penkower, & Wong, 2002). This high risk of developing PTSD as a consequence of being exposed to a life-threatening event makes it clear why there is such a strong desire in the psychological community to somehow reduce this risk through some form of crisis intervention. This is why CISD was developed. However, this estimate also indicates that many individuals recover naturally from exposure to a traumatic event (at least 42%). This means that crisis intervention actually has the potential to do harm if it causes those who would have otherwise recovered to develop PTSD (McNally, Bryant, & Ehlers, 2003).

There appears to be some confusion in the field regarding the terms used for different types of crisis intervention. Mitchell, a former firefighter and paramedic, developed CISD as a system comprised of 7 steps, which are designed to help those who have been exposed to a traumatic event (Mitchell, 2005). Psychological debriefing, however, is a generic term for crisis intervention that is usually delivered within several days of a traumatic event (McNally, Bryant, & Ehlers, 2003). The most important fundamentals of psychological debriefing include discussing thoughts, feelings, and reactions with a mental health professional who, in turn, provides psychoeducation about traumatic stress responses and attempts to normalize these reactions (Bisson, McFarlane, & Rose, 2005). Some authors state that Mitchell's CISD form of psychological debriefing is generally recognized as the most widely used in the world (McNally, Bryant, & Ehlers, 2003). Although originally recommended for either individuals or groups, CISD is now recommended only for groups (McNally, Bryant, & Ehlers, 2003; Mitchell, 2005). A CISD session lasts between 3 and 4 hours and is typically conducted between 2 and 10 days after a trauma (McNally, Bryant, & Ehlers, 2003). A debriefing session normally includes the following elements: an explanation of the procedure, each participant describing what happened, their thoughts about and their emotional reactions during the trau-

ma, each participant describing their physical or psychological symptoms as a result of the trauma, normalization of stress reactions, and a summary by the facilitator. Proponents of this type of intervention now stress that it should never be provided outside of an integrated package of interventions within a Critical Incident Stress Management (CISM) program (Mitchell, 2005). CISM is not really a technique, but more like a set of procedures that includes the following: educating individuals in high-risk occupations about the kinds of stressors they may encounter, common stress reactions, stress-management techniques, providing food, rest, and information to disaster personnel, psychological debriefing, encouraging family support, and providing referrals for further help after the immediate crisis period is over (McNally, Bryant, & Ehlers, 2003).

Several meta-analyses have found that CISD does not have any beneficial effects, and some studies have even found that it may impede the natural recovery process, resulting in fewer reductions in PTSD symptoms (for a review of these studies, see McNally, Bryant, & Ehlers, 2003). It is important to note that all of the randomly controlled trials finding that CISD may be harmful have used individual debriefing as they believe that it is the most commonly practiced form of psychological debriefing (McNally, Bryant, & Ehlers, 2003). Bisson, McFarlane, and Rose (2005) state that although there are some negative outcome studies existing, most find that the impact of early psychological debriefing is neutral.

A recent paper on the cognitive model of PTSD (Ehlers & Clark, 2000) theorizes that PTSD develops because a heightened sense of threat is maintained after the actual threat is no longer present. According to the cognitive model, this heightened sense of threat occurs because individuals have excessively negative appraisals of the trauma or its effects and the memories of the trauma are poorly contextualized, such that the events are not stored in the context of emotions and other memories. If only the second part of this model is focused on, it seems that psychological debriefing should theoretically be effective in preventing PTSD, as it would help individuals to fully elaborate and contextualize the memories of the event just after they have occurred. This process then should prevent the memory from being cued in unwanted times. That attempts to avoid thinking about the traumatic experience are associated with persistent PTSD symptoms (McNally, Bryant, & Ehlers, 2003) gives further weight to the theory that CISD should be an effective intervention, as this avoidance is prevented immediately after the trauma. However, there are a few hypotheses regarding the purported ineffectiveness of CISD. First, CISD does not address the excessively negative appraisals of the event. The presence of excessively negative appraisals can effectively discriminate individuals with PTSD from individuals without PTSD (McNally, Bryant, & Ehlers, 2003), indicating that these thoughts are particularly important in the development of a disorder. Second, thinking and talking about the event (such as during CISD) often takes the form of rumination about the event rather than going over what actually happened, which can worsen PTSD symptoms (McNally, Bryant, & Ehlers, 2003). Third, the one-time nature of CISD and the immediacy of it may prevent it from being an effective intervention technique. In fact, cognitive interventions have been shown to be efficacious in the treatment of PTSD, but they do not seem to be efficacious if administered within a few weeks of the traumatic event (McNally, Bryant, & Ehlers, 2003). People appear to alternate between periods of avoidance and processing when recovering from a traumatic event. Thus, it may actually be counterproductive to encourage individuals who are using avoidance as an adaptive, protective function to discuss the trauma early in the recovery process (McNally, Bryant, & Ehlers, 2003). Perhaps avoidance and excessively negative appraisals should only be addressed by systematic exposure to the trauma memories and cognitive therapy when they become maladaptive in

the extended time period after the trauma.

In response to the evidence indicating that CISD is not effective and may actually be detrimental to those exposed to traumatic events, Mitchell (2005) states that fatal flaws in the negative studies render them uninterpretable. First, Mitchell states that the International Critical Incident Stress Foundation did not properly train the treatment providers in the studies that suggest the ineffectiveness of CISD. In contrast, the International Critical Incident Stress Foundation trained 79.5% of those researchers who found positive results for CISD. Mitchell also emphasizes that CISD must only be performed in the group format. However, CISD was used in a one-on-one setting in all studies, contraindicating its use. Lastly, Mitchell states that CISD should not be used without the entire CISM program. Consumers of CISD often state that they enjoy the intervention, and these data are often used to support its effectiveness, but other researchers argue that this may just be a reflection of polite expressions of gratitude (McNally, Bryant, & Ehlers, 2003).

In general, there is very little evidence that early psychological debriefing prevents PTSD and some evidence that it may actually inhibit the natural recovery process (Bisson, McFarlane, & Rose, 2005). Research contraindicating the use of CISD often does not incorporate the entire CISM package and it seems, that when used properly in the CISM package, CISD may have some value (McNally, Bryant, & Ehlers, 2003; Mitchell, 2005). Thus, the question remains about whether to promote the use of an intervention technique that may have promise, but when used improperly may actually cause harm. Recent recommendations in the literature do not encourage the use of CISD but do encourage the use of parts of it and of CISM (McNally, Bryant, & Ehlers, 2003). The literature suggests that individuals providing crisis intervention offer support and information about the trauma and its consequences as necessary without forcing survivors to disclose their personal thoughts and feelings about the event (McNally, Bryant, & Ehlers, 2003). Mental health professionals should concede the importance of the trauma and reassure survivors that it is normal to have symptoms of PTSD after a traumatic event. As is emphasized in CISM, recommendations are also made to facilitate social support. Essentially, "psychological first-aid" is recommended, which includes the following: consoling, protecting from further threat or distress, providing physical necessities, providing goal orientation and support for specific reality-based tasks, facilitating meeting with social supports, facilitating some telling of the traumatic memories as desired by the individual while professionals actively listen but do not press for details or emotional responses, and providing referrals for ongoing services (McNally, Bryant, & Ehlers, 2003). Thus, it may be that supportive and noninterventionist interventions are indicated in the aftermath of a traumatic event rather than any specific form of psychological debriefing.

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McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Does early psychological intervention promote recovery from posttraumatic stress? *Psychological Science in the Public Interest, 4(2).*

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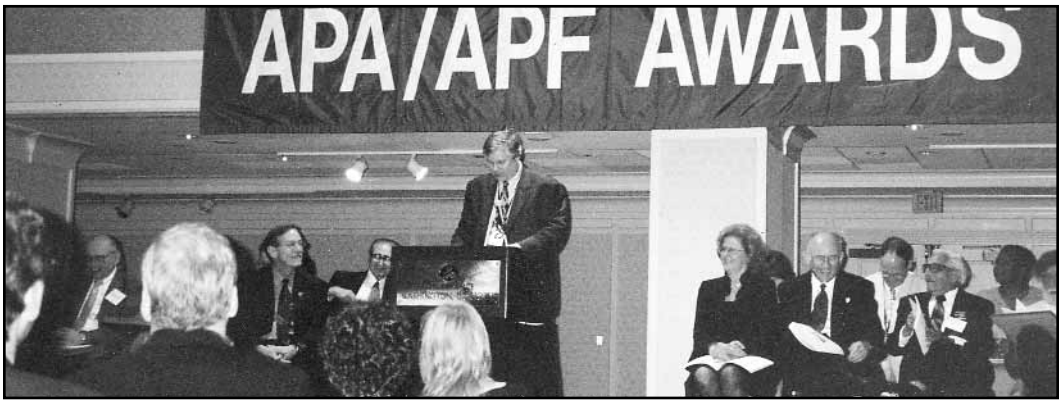
DIVISION 29 AWARDS AND RECOGNITIONS

2005 APA Convention

John C. Norcross, Ph.D., ABPP

Recipient of the 2005 APA Award for Distinguished Contributions to Education and Training



Dr. Norcross was acknowledged at the awards ceremony for his positive influence in the teaching of students, engagement in education and training research, development of instructional materials that influence the direction of training, professional governance, and promotion of continuing education.

Dr. Diane Willis introduced Dr. Norcross for his award presentation, entitled "The Psychotherapist's Own Psychotherapy: Educating and Developing Psychologists."

FEATURE

Perspectives on Psychotherapy Integration

By George Stricker, Ph.D.
Argosy University/Washington DC

This is the first in what will be a regular series providing perspectives on psychotherapy integration. Although organized by the Society for the Exploration of Psychotherapy Integration (SEPI), contributions for this series are welcome from members and non-members of SEPI, and may also be submitted directly to *Psychotherapy Bulletin*. We are very grateful to the editor, Craig Shealy, for introducing a series that will provide insights from what may be the cutting edge of developments in psychotherapy. For readers who wish to learn more about psychotherapy integration, SEPI maintains a website (www.cyberpsych.org/sepi) that contains several articles, information about the next conference, an application for membership, and other materials of interest. For readers who may wish to have articles considered for inclusion in this column, please send them to me at geostricker@comcast.net. This first column presents an introduction to psychotherapy integration, and draws heavily on material I prepared previously for inclusion in The Gale Encyclopedia of Mental Disorders.

Psychotherapy integration is defined as an approach to psychotherapy that includes a variety of attempts to look beyond the confines of single-school approaches in order to see what can be learned from other perspectives. It is characterized by an openness to various ways of integrating diverse theories and techniques. Psychotherapy integration can be differentiated from an eclectic approach in that an eclectic approach is one in which a therapist chooses interventions because they work without looking for a theoretical basis for using the technique, but relies solely on supposed efficacy. The rationale of efficacy is reasonable, but too often it is based on imprecise memories of past experience without any reference to theory or research data. In contrast, psychotherapy integration differs from eclecticism in that it attends to the relationship between theory and technique.

The term psychotherapy integration has been used in several different ways (Stricker & Gold, 2003). The term has been applied to a Common Factors approach to understanding psychotherapy, to Assimilative Integration, to Technical Integration, and to Theoretical Integration.

Common Factors

Common Factors refers to aspects of psychotherapy that are present in most, if not all, approaches to therapy. These techniques cut across all theoretical lines and are present in all psychotherapeutic activities (Grencavage & Norcross, 1990). Because the techniques are common to all approaches to psychotherapy, the name Common Factors has been given to this variety of psychotherapy integration. There is no standard list of common factors, but if a list were to be constructed, it surely would include: a therapeutic alliance established between the patient and the therapist; exposure of the patient to prior difficulties, either in imagination or in reality; a new corrective emotional experience that allows the patient to experience past problems in new and more benign ways; expectations by both the therapist and the patient that positive change will result from the treatment; therapist qualities, such as attention, empathy, and positive regard, that are facilitative of change in treatment; and the provision by the therapist to the patient of a reason for

the problems that are being experienced.

No matter what kind of therapy is practiced, each of these common factors is present. It is difficult to imagine a treatment that does not begin with the establishment of a constructive and positive therapeutic alliance. This relationship has been found to be integral to any change that occurs in treatment (Norcross, 2002). The therapist and the patient agree to work together and they both feel committed to a process of change occurring in the patient. Within every approach to treatment, the second of the common factors, the exposure of the patient to prior difficulties, is present. In some instances the exposure is in vivo, and the patient will be asked directly to confront the source of the difficulties. In many cases, the exposure is verbal and in imagination. However, in every case, the patient must express those difficulties in some manner and, by doing so, re-experiences those difficulties through this exposure. In successful treatment, the exposure usually is followed by a new corrective emotional experience (Alexander & French, 1946). The corrective emotional experience refers to a situation in which an old difficulty is re-experienced in a new and more positive way. As the patient re-experiences the problem in a new way, that problem can be mastered and the patient can move on to a more successful adjustment.

Having established a therapeutic alliance, and being exposed to the problem in a new and more positive context, both the therapist and the patient always expect positive change to occur. This faith and hope is a common factor that is an integral part of successful therapy. Without this hope and expectation of change, it is unlikely that the therapist can do anything that will be useful, and if the patient does not expect to change, it is unlikely that he or she will experience any positive benefit from the treatment. The therapist must possess some essential qualities, such as paying attention to the patient, being empathic with the patient, and making his positive regard for the patient clear in the relationship. Finally, the patient must be provided with a credible reason for the problems that he or she is undergoing. This reason is based in the therapist's theory of personality and change. The same patient going to different therapists may be given different reasons for the same problem. It is interesting to speculate as to whether the reason must be an accurate one or whether it is sufficient that it be credible to the patient and not remarkably at variance with reality. As long as the reason is credible and the patient has a way of understanding what previously had been incomprehensible, that may be sufficient for change to occur. This discussion of common factors combines the early and important work of Goldfried (1982), that of Weinberger (1995), and especially the seminal work of Frank (1973).

Assimilative Integration

The second major approach to psychotherapy integration is Assimilative Integration (Messer, 1992). Assimilative Integration is an approach in which the therapist has a commitment to one theoretical approach but also is willing to use techniques from other therapeutic approaches.

As an example, a therapist may try to understand patients in terms of psychodynamic theory, because he or she finds this most helpful in understanding what is going on in the course of the treatment. However, the therapist may also recognize that there are techniques that are not suggested by psychodynamic theory that work very well, and these may then be used in the treatment plan. The psychodynamic therapist can occasionally use cognitive-behavioral techniques such as homework, and may occasionally use humanistic approaches, such as a two-chair technique, but always retains a consistent psychodynamic understanding (for an example, see Gold & Stricker, 2001). The treatment can take place in a way that is beneficial to the patient and is not bound by the restrictions of the therapist's favorite way of intervening. The patient may not be aware that integration is taking place, for

he or she feels that a consistent approach is being maintained. Most patients are not familiar with theory, don't realize that different techniques are generated by different theoretical understandings, and only are concerned with whether or not the treatment is helpful. Inherent in any attempt to achieve assimilative integration is the challenge of accommodation, an understanding of how the home theory must be altered in order to embrace the value of the technique that was not suggested by that approach.

Inherent in psychotherapy integration is the conviction that there is no one approach to therapy that is suitable to every patient. Both in single-school approaches and in psychotherapy integration, the treatment must be suitable for the individual patient. In making the treatment suitable for the individual patient, the therapist must understand the patient, and that establishes a place for theory. Assimilative Integration is particularly useful in that theory helps in the understanding of the needs of the patient, but then several different approaches to technique can help to design a treatment that fits that particular understanding. The treatment plan then must undergo continuous revision as the understanding of the patient gets fuller and deeper over the course of the treatment.

Technical Eclecticism

Technical eclecticism is a variation of Assimilative Integration and is most common among those practitioners who refer to themselves as eclectic. In Technical Eclecticism, the same diversity of techniques is displayed as in Assimilative Integration, but there is no unifying theoretical understanding that underlies the approach. Rather, the therapist relies on previous experience and on knowledge of the theoretical and research literature to choose interventions that are appropriate for the patient.

The obvious similarity between Assimilative Integration and Technical Eclecticism is that both rely on a wide variety of therapeutic techniques, focusing on the welfare of the patient rather than on allegiance to any particular school of psychotherapy. The major difference between the two is that Assimilative Integration is bound by a unifying theoretical understanding whereas Technical Eclecticism is free of theory and relies on the experience of the therapist to determine the appropriate interventions. There are some excellent examples of technical eclecticism, although these are so well worked out and systematic that they may belong in another category (Beutler, Consoli, & Lane, 2005; Lazarus, 2005). For Beutler, the unifying principle is treatment matching based on well-developed research findings. For Lazarus, there is a core adherence to social learning theory, girded by a systematic rubric (BASIC-ID) for understanding the breadth of the patient's difficulty.

Theoretical Integration

The fourth approach to psychotherapy integration is called Theoretical Integration. This is the most difficult level at which to achieve integration because it requires integrating theoretical concepts from different approaches, and these approaches may differ in their fundamental philosophy about human behavior. Whereas Assimilative Integration begins with a single theory and brings together techniques from different approaches, Theoretical Integration tries to bring together those theoretical approaches themselves and then to develop what in physics is referred to as a "Grand Unified Theory." Neither psychotherapists nor physicists have been successful to date in producing a Grand Unified Theory. It is difficult for me to imagine a theory that really can combine an approach that has one philosophical understanding with a different approach that has a different philosophical understanding (Messer & Winokur, 1984). For example, a psychodynamic approach believes that an early difficulty leads to a pattern of behavior that is repetitive, destructive, and nearly impossible to resolve. In contrast, behavior therapy

sees problems as much more amenable to change. This difference may represent a basic incompatibility between the two theories. Therefore, theoretical integration would be faced with the task of integrating a theory about the stability of behavior with a theory about the ready changeability of behavior, and unless this obstacle can be overcome, Theoretical Integration will not be achieved.

Nonetheless, there have been many attempts to develop such high level integrative approaches, and some of these are imaginative and highly influential. The first and perhaps still the most important of these (Wachtel, 1997) combined psychodynamic and behavioral approaches. Even if the grand vision of a unified theory is not accomplished, much of value can be done when the most valuable aspects of different theoretical efforts can be joined in a synergistic way.

In any case, the general point in three of these approaches, Common Factors, Assimilative Integration, and Theoretical Integration, is that there is a clear value to the role of theory in psychotherapy integration, whether the theory deals with the way integration works (Theoretical Integration), the framework that governs the choice of interventions (Assimilative Integration), or the organizing principle for understanding the Common Factors that are present in all psychotherapy. The fourth approach, Technical Eclecticism, is not concerned with theory, but does view the benefit of the patient to be of more significance than the adherence to any single theory.

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DIVISION 29 AWARDS

2005 APA Annual Convention

Dr. Gerald P. Koocher, Ph.D., ABPP

2005 Distinguished Psychologist Award

Dr. Gerry Koocher was presented the Distinguished Psychologist Award by Dr. Linda Campbell, past president of the division. Dr. Koocher has served as President of Division 29, Treasurer of APA and is currently President-elect of APA. He has been elected Fellow of twelve divisions of APA and has served as president of two divisions in addition to Division 29.

Dr. Koocher continues to make important contributions to our profession through his work in pediatric psychology and as Dean of the School for Health Studies at Seminar College in Boston.

Integrating Research Findings on Therapeutic Alliance Into Your Practice

By Mark J. Hilsenroth Ph.D., Adelphi University

Contemporary psychotherapy research has underlined the importance of the technical and relational aspects of therapeutic alliance. Decades of research have consistently found a significant relationship of alliance with therapy process and outcome (Horvath, 2001; Martin, Garske, & Davis, 2000; Norcross, 2002). These research findings may help therapists who have a range of experience and practice various forms of psychotherapy develop stronger therapeutic connections with their patients. Yet, how does one translate these research findings on therapeutic alliance into applied clinical practice?

Interventions Associated with Alliance Strength and Weakness

Two reviews by Ackerman and Hilsenroth (2001, 2003) have integrated information from several empirical studies in a way that helps clarify the relation between a therapist's specific in-session interventions and therapeutic alliance. The studies covered in these reviews suggest that therapists' use of techniques drawn from a range of psychotherapy orientations (cognitive-behavioral, experiential, interpersonal, family therapy, psychodynamic, etc.) may influence the therapeutic alliance in both positive and negative ways. Table 1 summarizes therapist techniques identified in these reviews that were reported to be important in the development and maintenance of a strong alliance or, conversely, related to lower levels of, or even to deterioration in, the alliance.

Therapist techniques found to contribute positively to the alliance could generally be categorized as: Supportive, Exploratory, Affective, or Engaged. Research indicated therapists' techniques that specifically convey support, understanding, affirmation, and noting adaptive changes across the treatment process were significantly related to higher alliance. In addition, higher alliance was related to therapist techniques that increased a patient's understanding of the problems that brought them to treatment through greater exploration and in-depth (i.e. full, special, powerful) discussion of these topics as well as accurate interpretations (high quality and case-specific interpretations, not simply a larger quantity). Techniques that closely attended to and maintained focus on the patient's in-session subjective experience (i.e. reflection) and affect, or that facilitated the expression of these emotions, were also related to higher alliance. Finally, it seems that a more active, involved, and engaged stance by the therapist was important in a positive therapeutic relationship.

Therapist interventions that were found to have negative effects on the alliance seemed to be at extreme ends of particular technical continua. For instance, the over-structuring and managing of the therapy in an inflexible manner as well as a failure to structure the treatment in any organized or coherent manner were both negatively related to alliance. Also, the therapist talking either "too much" concerning superficial information not related to key treatment issues or self-disclosure of the therapist's own emotional conflicts (as opposed to "self-involving" exploration of therapist's in-session process, see Teyber & McClure, 2000) as well the therapist talking "too little" through the misuse of extended silence or withdrawal from the in-session process were detrimental to alliance. The use of transference interpretations in a sustained and unremitting manner can be detrimental to the therapeutic alliance, particularly for patients with Axis II disorders

(see Ogrodniczuk & Piper, 1999). However, it is important to note that a therapist's continued focus on the transference relationship (i.e. linking patient, therapist, and past others from a closed, single person, theoretical perspective or system) is not necessarily the same as exploring the in-session process, including thoughts and feelings of the treatment relationship (i.e. exploring patient-therapist interactions without linking to a past other from an open, two-person, theoretical perspective or system; Greenson, 1967; Summers, 1994; Wachtel, 1993). This is an important distinction that I will return to in the discussion of alliance ruptures. Finally, of little surprise, communication of hostility, disrespect, or belittling by the therapist toward the patient was found to be significantly related to lower alliance.

Rupture and Repair of the Alliance

It is interesting to note that the research identifying a therapist's significant contributions to the alliance are similar to features salient in the rupture and repair of the alliance. Research on alliance ruptures support the notion that such ruptures are an expected and normal part of the treatment process (Safran & Muran, 2000, 2005). Ruptures in the alliance are most likely to occur when a patient experiences negative feelings toward the therapist or therapeutic process. Not surprisingly then, therapist interventions found to be related to the development or exacerbation of ruptures were similar to the techniques reported as contributing negatively to the alliance generally. Attention to these interventions is important as unresolved ruptures can lead to treatment failures and, more importantly, the continuation of maladaptive relational patterns in the patient's life. However, alliance ruptures are also fertile ground for positive patient change and present an opportunity for deepening the therapeutic relationship (Safran, 1993; Safran & Muran, 2000, 2005; Wachtel, 1993). Thus, resolution of alliance ruptures can lead to deeper exploration of relational patterns and help patients develop the skills necessary to understand as well as resolve similar patterns in other relationships. Resolution of alliance ruptures often entails therapist techniques and processes similar to the interventions positively impacting the alliance described above. To successfully manage the resolution of ruptures in the alliance, Safran and Muran (2000, 2005) recommend that the therapist acknowledge and explore his/her contribution to the rupture experience, convey an affirming and understanding stance as well as validate the patient through exploration of their experience to gain a greater understanding. Additionally, the therapist examining in-session affect, experience, and process is a crucial element to the successful resolution of an alliance rupture. These recommendations converge with previous findings that therapist exploration, depth, interest, affirming, understanding, and the discussion of in-session process contribute to the development of a stronger alliance.

Finally, several studies have found that therapeutic alliance established very early in psychotherapy (i.e. by approximately the 3rd session) is often related to later process and outcome (Horvath, 2001; Martin, Garske, & Davis, 2000). Recent studies have begun to extend this research and examine therapeutic alliance developed during the initial interview, consultation or psychological assessment (Hilsenroth, Peters, & Ackerman, 2004; Huber, Henrich & Brandl, 2005; Rumpold et al., 2005; Sexton, Littauer, Sexton & Tommeras, 2005). Each of these studies has demonstrated that these initial patient-therapist interactions have a significant impact on subsequent treatment process and outcome. These findings suggest that careful awareness of the therapeutic relationship *as early as possible in treatment (i.e. initial interview or psychological assessment)* may provide patients with a secure foundation for therapeutic progress.

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Table 1

Summary of Therapist's Techniques Found to be Significantly Related to Therapeutic Alliance

Techniques Positively Related to Alliance	Techniques Negatively Related to Alliance
Supportive	Over structuring the therapy
Understanding	Managing
Affirming	Failure to structure the therapy
Noting past therapy success	
Exploration	Superficial interventions
Depth	Inappropriate self-disclosure
Accurate interpretation	Inappropriate use of silence
Attend to patient's experience	Unyielding transference interpretations
Reflection	
Facilitate expression of affect	
Active	Belittling

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AD HOC COMMITTEE ON PSYCHOTHERAPY

Advancement of Psychotherapy Training

Linda Campbell, Ph.D., Past-President and Co-Chair

The Presidential Column written by Dr. Leon VandeCreek reflects the many accomplishments of his administration, but is modest regarding his central role in the advancement of our division over the last three years. Leon has continued to focus his energy and attention on the training, research, and practice goals set two years ago. He has also inspired and encouraged the governance of the division to hold steadfast in our mission to promote and enhance the presence of psychotherapy in the profession. I urge you to read Leon's column to learn the exciting and important advances being made by our division.

Leon described one of our important initiatives of this past year, led by Bill Stiles our Research Committee Chair. In collaboration with psychotherapy researchers who are members of our division, Bill has written a seminal article on the state of psychotherapy research. A synthesis of that article is being developed, as Leon noted, that will serve as a position paper for the division in continued advocacy for the funding of psychotherapy research.

As this very significant achievement is culminating, we will additionally focus on training goals that the division identified as priorities. During recent years, efforts have been made by several entities within APA to develop competencies in several areas of training. Under the guidance of Dr. Robert Hatcher and Dr. Kim Lassiter, The Association of Directors of Psychology Training Clinics, developed a draft of Practicum Competencies that identify skills, values, attitudes, and core knowledge that should be accomplished in the doctoral practicum experience. The APA Accreditation Guidelines also highlights criteria that must be met for practicum training within the doctoral program. This document was reviewed and endorsed by the Council of Chairs of Training Councils.

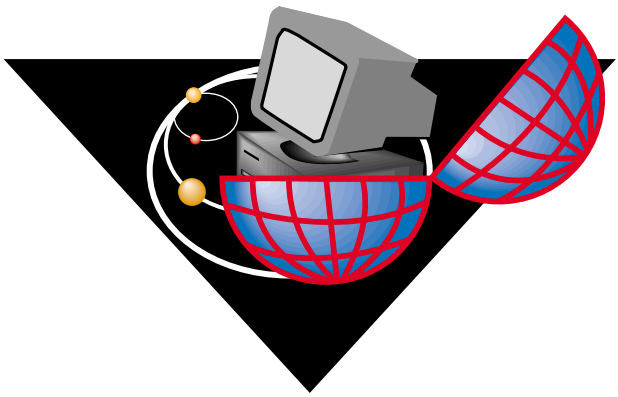
The Division of Psychotherapy notes that competence training specifically in psychotherapy has not been identified. The practice and training dimensions of our profession are moving ahead admirably in promoting criteria and advancing knowledge that contributes to standards in the practice of professional activities. Certainly, the recent product of the APA Task Force on Evidenced Based Practice is an important example of our continued commitment to quality practice. The Division of Psychotherapy Ad Hoc Committee and the Education and Training Committee are most interested in exploring the status of psychotherapy competency training and informing our membership and ourselves of the existing need for development of standards.

In 2004, Leon and I held many focus groups of Division 29 members regarding their perspectives on the state of psychotherapy. The student focus groups we held reflected several themes. One prominent observation and concern by students was that their practicum experiences did not meet a uniform standard and that, in fact, students were facing instability in site location, quality and quantity of supervision, access to clients, and several other logistical and training problems. Neither Division 29 nor the students interviewed have taken the position that all programs should meet the same standard of psychotherapy training. Our interest, however, is

(a) in assisting students in identifying those programs that do have quality training in psychotherapy and (b) in developing a means by which students and psychologists involved in training can work with similar expectations regarding the quality and presence of psychotherapy in their training.

As always, Leon and I are very interested in the involvement of our membership in these initiatives. We encourage you to let us know of your interests in any aspect of these activities. Please contact Leon at Leon.Vandecreek@Wright.edu or me at lcampbel@uga.edu.

As Leon mentioned in his column, Dr. Abe Wolf will become our president in January, followed in the next year by Dr. Jean Carter. Both of these individuals are extremely dedicated to the division and they both have very exciting and significant goals planned for our future. We urge you to get on board and participate in the very rewarding activities and the important mission that your leadership has developed.



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INTERVIEW

A Discussion with Dr. Marvin Goldfried

by Rachel Hamilton, Miami University of Ohio

Dr. Marvin Goldfried is a psychologist who believes that when traditionally distinct groups, approaches, or ideas are brought into dialogue, all may be positively transformed. His career has included considerable work in the field of psychotherapy integration, addressing issues such as the integration of research with practice, of past with current findings, and of techniques, terminology, and theories across theoretical orientations. Dr. Goldfried was co-founder of the Society for the Exploration of Psychotherapy Integration (SEPI), the founding editor of *In Session: Psychotherapy in Practice*, and a past president of the Society for Psychotherapy Research. While he is currently involved with research examining commonalities across theoretical orientations at the State University of New York at Stony Brook, Dr. Goldfried's research for the past several years has focused on integrating gay, lesbian, bisexual and transgender (GLBT) issues within mainstream psychology. As a proud father of a gay son, he is committed both to enhancing the lives of GLBT individuals through psychology and to enhancing psychology through the incorporation of GLBT individuals and their experiences.

Dr. Goldfried observes that GLBT issues have not been made a priority by mainstream psychology. While there is a discipline-wide movement toward multicultural sensitivity, sexual orientation has received little attention within this movement compared to other minority statuses. Dr. Goldfried attributes this oversight to several factors, including existing cultural attitudes about homosexuality and historical biases against GLBT populations within the mental health field. Furthermore, Dr. Goldfried notes that GLBT status is a 'concealable stigma'—since sexual orientation is not apparent, those who are GLBT are often assumed to be heterosexual. Such social invisibility masks the true prevalence and diversity of GLBT people, as well as the unique issues they face. Commenting on the recent changes in public awareness and presence of GLBT people, Dr. Goldfried wonders, "How can society and the media be so aware of gay issues and the profession be so ignorant?"

This lack of awareness is particularly problematic for clinicians. GLBT people are more likely than heterosexuals to seek psychological services, and therefore clinicians are likely to encounter GLBT clients. Unfortunately, most clinicians have received little if any clinical training in GLBT-specific treatment issues, and there is a relative lack of GLBT-focused research due to stigma still surrounding this topic. Without adequate knowledge of specific treatment and life issues for GLBT clients, clinicians may attempt to show acceptance of their GLBT clients by treating them identically to heterosexual clients. While well-intentioned, Dr. Goldfried stresses that this strategy can "deny significant issues of difference and miss the boat clinically." To promote competence in treating GLBT clients, Dr. Goldfried suggests that clinicians read, learn from their GLBT clients and younger generations who may be more aware of GLBT issues, and advocate for greater GLBT-focused research and training opportunities within the field.

Dr. Goldfried notes that one of the crucial issues for GLBT people is family support for their GLBT identity. It has been observed that when a family member comes out, families frequently "go into the closet" about their GLBT relative's sexual identity. While families may come private-

ly to accept a family member as GLBT, they often fail to acknowledge publicly their relative's GLBT identity due to internalized stigma and a fear of social discrimination. This may communicate to GLBT individuals the presence of shame and absence of support within the family. He points out that GLBT people often refer to their close friends and lovers as their "chosen family," which speaks to the meaningfulness to GLBT individuals of having a family who can accept them in their entirety.

The importance of family support is part of why Dr. Goldfried is a strong proponent of Parents, Families and Friends of Lesbians And Gays (PFLAG), a support and advocacy group for GLBT people and their loved ones (http://www.pflag.org). He views PFLAG as a powerful organization for creating a shift in consciousness. Through the exchange of dialogue between both GLBT and non-GLBT people at different stages of acceptance, PFLAG transforms anger at GLBT people and loved ones into empathy for their perspectives. By facilitating personal contact with GLBT individuals, PFLAG fosters cognitive dissonance with negative and simplistic social stereotypes. Finally, PFLAG presents an alternative to mainstream attitudes about GLBT people through group modeling of GLBT-positive norms. Due to these aspects of PFLAG, Dr. Goldfried views it as potentially more powerful than individual therapy in helping family members adjust to and embrace a relative's GLBT identity. Witnessing the influence of PFLAG was part of what motivated Dr. Goldfried to start AFFIRM (short for Psychologists Affirming their Lesbian, Gay, Bisexual and Transgender Family) in 2000.

AFFIRM is a network of psychologists with GLBT family members (see also the recent article on AFFIRM in the October APA Monitor, http://www.apa.org/monitor/oct05/affirming.html). The primary purpose of AFFIRM is to demonstrate a public presence of psychologists who are proud to come out in support of their GLBT family member(s). AFFIRM operates through an Internet-based listserve to share GLBT-relevant information and resources, post events and research of interest, and advocate for GLBT issues in psychology education, research, and clinical work. Dr. Goldfried is pleased to note that AFFIRM is currently moving from its member recruitment phase to a more proactive phase focusing on raising consciousness of GLBT issues within the field. His dream for AFFIRM is to extend its concepts to other professions, particularly those that deeply affect GLBT individuals such as teaching, medicine, social work, and law. If such networks were established across professions, social change could occur through the sheer number of people publicly promoting acceptance and resisting stigmatization of their GLBT family members.

Currently, AFFIRM has over 600 members. Given the approximately 80,000 membership of the American Psychological Association, the existing membership in AFFIRM is considerably lower than its estimated potential. Dr. Goldfried acknowledges that many family members of GLBT individuals do not see themselves as having a personal interest in GLBT issues. Nevertheless, he considers relatives of GLBT individuals to be those with the greatest stake in improving the social climate for their GLBT family members. He therefore views organizations made up of GLBT family members—such as PFLAG and AFFIRM—as powerful agents of advocacy.

Dr. Goldfried firmly believes that coming out, both as GLBT and as family and friends of GLBT people, is a key to changing negative social attitudes and stereotypes. The more people come out in public support of GLBT individuals, the greater the pressure will be on society to recognize that GLBT people and those who love them truly "are everywhere," and that they will not accept social stigmatization or invisibility. Dr. Goldfried urges psychologists who wish to join AFFIRM to visit the website at www.sunysb.edu/affirm Any non-psychologists who have interest in starting an AFFIRM-like network within their own profession are also highly encouraged to contact AFFIRM.

The Steady Evolution of Psychology into the 21st Century

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

A Glimpse Into The Future—Earlier this year, the Hawaii Psychological Association (HPA) was successful in having two committees of the Hawaii State Senate recommend the enactment of legislation (SB 1239) which would have allowed properly trained psychologists, working within community health centers, to prescribe psychotropic medications. During the process, **Jill Oliveira-Berry** and **Robin Miyamoto** were successful in obtaining the support of each of the health center medical directors, the Hawaii Primary Care Association, and a number of other "interested parties" (including the Native Hawaiian healthcare organization, Papa Ola Lokahi), pursuant to the recommendations of our colleagues in New Mexico regarding the importance of developing visual grassroots support. In March, the bill failed to pass Third Reading by the full Hawaii Senate, on a vote of 12-12-1. However, the legislature eventually enacted House Concurrent Resolution 255 which established a six person 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 and Ray Folen** represent HPA on the task force. Ray's report on their first meeting this October:

"The first meeting of the legislatively mandated RxP Task Force started with a parking lot encounter with the anti-RxP psychiatrist assigned by organized psychiatry to represent them during the discussions. He greeted me with an obvious dig – 'So what do you guys do? Testing, right?' I didn't offer him the courtesy of a reply as we walked to the State Capital for our meeting with the legislators chairing the task force. One thing was clear, though: he was feeling threatened. My colleagues and I knew he confided in others that it was only a matter of time before psychologists had prescriptive authority. His job was to stave off the inevitable as long as possible. I might have felt some sympathy for his situation, were it not for the fact that he had little to offer in the face of the desperate need for mental health services in our state. We, like most areas of the country, have a critical shortage of psychiatrists, particularly in rural and underserved areas and we have a desperate need for pediatric psychiatrists in particular. Inpatient adolescent units have had to close due to a lack of psychiatrists.

"Is there any chance they will be able to improve this situation in the future? The answer is a resounding 'No.' Psychiatry residencies have to pull 40% of their residents from foreign countries due to a lack of U.S. applicants. Only three percent of psychiatry graduates have plans to work in rural or underserved areas. Hawaii psychologists, on the other hand, can be found in almost all areas of the state. A large percentage are providing psychological services to children. Psychologists are found in most of the federally-designated community health centers (CHCs), whose charter is to provide services in underserved areas. The CHC psychologists work collaboratively with the primary care physicians to provide their patients with appropriate therapy and adjunctive pharmacological interventions when needed.

"Prescriptive authority is only meaningful in appropriate context, and the primary care psychology model is one that makes the most sense to us. Primary care psychologists work in a primary care clinic. They provide traditional behavioral health services (e.g., treatment of depression, anxiety, substance abuse), as well as more specialized

behavioral medicine services (e.g., treatment of obesity, high blood pressure, diabetes, headache). In our experience, family practitioners welcome psychologists in their clinics. These psychologists not only provide an opportunity for the immediate referral of the distressed patient, but also provide truly comprehensive treatment in the primary care environment. The patients welcome the seamless continuity of their overall health care and appreciate the lack of stigma that has been historically associated with behavioral health care. Additionally, insurance companies are beginning to realize that services provided in this manner are leading to a reduction in overall healthcare costs.

"Many primary care psychologists (almost all of those in Hawaii) have received additional training in psychopharmacology. This is particularly valuable as psychologists are often the sole behavioral health provider in our rural clinics. Over the last several years, the primary care providers, with an average of six weeks of mental health training and limited formalized psychopharmacologic education, have come to rely on our expertise in this area. It is noteworthy that the CHC medical directors wrote a letter to the state legislature endorsing prescriptive authority for psychologists last legislative session.

"This scenario could be repeated in other places. Federally-qualified CHCs can be found in every state. Primary care psychologists have clearly demonstrated their proficiency in this venue and it is imperative that we continue to do so. As more psychopharmacology-trained psychologists provide services in the primary care environment, it will offer an increasingly convincing argument for the value this expertise provides to our patients and our communities alike. Unlike some of our psychiatric colleagues, we have begun to respond to the behavioral health care crisis by 'walking the walk, not simply talking the talk.'"

To place this legislative accomplishment in perspective, the HPA quest began back in 1984-1985. **Jim Quillin**, President of the Louisiana Psychological Association, recently noted that:

"Louisiana's Medical Psychology statute was signed into law on May 6, 2004, and the rules governing this landmark statute were finalized on January 20th of this year clearing the way for the certification of medical psychologists (MPs) under state law. This represented the culmination of a decade of hard work by a small group of extremely dedicated psychologists who believed in themselves and in their ability to effect progressive health care change through the political process." Under President **Tanya Schwartz's** leadership, HPA has now established a political action committee (PAC). Hopefully, Hawaii's time has finally arrived.

A Look To The Past

One of the rewards of being a former APA President is that from time to time, one gets invited to address psychology's next generation. This fall, **David Baker**, Director of the Archives of the History of American Psychology, invited me to present a public lecture on "Psychologists and Prescription Privileges" at the University of Akron. Not only is the Midwest beautiful at this time of year, I also had the opportunity of meeting with a number of APA President **Ron Levant's** new colleagues. Long time friend and colleague **Ludy Benjamin** has often spoken eloquently of the importance of psychology reflecting upon its past. He is so correct. David's report:

"The Archives of the History of American Psychology, located on the campus of the University of Akron, is the largest archival collection of its kind in the world. Established in 1965, the Archives' mission is to promote research in the history of psychology by collecting, cataloging, and preserving the historical record of psychology. In the early 1960s, a small group of psychologists, led by **John A. Popplestone** and **Marion White McPherson**, recognized that materials critical to understanding the development of psychology in America were being lost because there was no

nationwide effort to preserve them. These concerns led to the founding of the Archives of the History of American psychology at the University of Akron. Central to its mission is the preservation of personal papers, artifacts, and media that tell the story of psychology in America. In archival terms, 'papers' refers to one of a kind (unique) items. Papers can include such things as correspondence (both personal and professional), lecture notes, diaries, and lab journals. The term 'American' is used to refer to all range of psychologists, artifacts, and objects that bear on the history of psychology as it is expressed in American culture and society. Recently named a Smithsonian Affiliate, the Archives of the History of American Psychology houses more than 1,000 objects and artifacts that offer unique insights into the science and practice of psychology. Instruments from the brass and glass era of the late 19th century share space alongside such significant objects as the simulated shock generator used by **Stanley Milgram** in his famous studies of obedience and conformity, the flags of the Eagles and Rattlers of the Robbers Cave experiment by **Muzafir and Carolyn Sherif**, and the props that supported Professor **Phil Zimbardo's** well-known Stanford prison studies.

"From small beginnings in the 1960s, the Archives in Akron have grown to house the largest collection of historical materials on psychology in the world. It contains the personal papers of over 700 psychologists. There are papers of those representing professional (**David Shakow, Edgar Doll, Leta Hollingworth, Herbert Freudenberger** [one of the founders of the Division], **Sidney Pressey, Joseph Zubin, Erika Fromm, Jack Bardon, Robert Waldrop, Marie Crissey, and Morris Viteles**), and experimental (**James McConnell, Leo and Dorothea Hurvich, Kenneth Spence, Ward Halstead, Mary Ainsworth, Frank Beach, Knight Dunlap, Dorothy Rethlingshafer, and Hans Lukas-Tuber**) psychology, to name but a few. Also included are the records of more than 50 psychological organizations including the American Group Psychotherapy Association, the Association for Women in Psychology, Psi Chi, Psi Beta, the Association for Humanistic Psychology, the International Council of Psychologists, and the Psychonomic Society. State and regional association records that can be found at the Archives include the Midwestern Psychological Association, the Ohio Psychological Association, and the Western Psychological Association. The test collection includes more than 8,000 tests and records. There are more than 15,000 photographs, and 6,000 reels of film including home movies of Freud [which I must say were absolutely fascinating], footage of Pavlov's research institute, and research film from **Arnold Gessell** and the Yale Child Study Center.

"Without question the APA is well represented in the holdings of the Archives. Over the last 38 years, 16 APA Divisions (2, 6, 9, 12, 14, 16, 17, 18, 22, 24, 25, 26, 27, 32, 33, and 36) have deposited records that are maintained at the Archives. Consider that the papers of 12 APA Presidents are housed at Akron (**Raymond Dodge, Knight Dunlap, Harry Hollingworth, Walter Miles, John Dashiell, Gardner Murphy, Jack Hilgard, Abraham Maslow, Anne Anastasi, Leona Tyler, Brewster Smith, and Jack Wiggins**). Twenty-five recipients of APA's Awards for Distinguished Scientific Contributions are found at Akron, as are three winners of the Award for Distinguished Contributions to the Public Interest, and four awardees of the Distinguished Career Contributions to Education and Training.

"As Director of the Archives, I have a strong personal commitment to ensuring that the historical record of psychology be as complete as it can be. One manifestation of this was the convening in 2000 of a national conference at the Archives to honor **Robert V. Guthrie**, a psychologist and historian, and the first psychologist of color to be included in the Archive's manuscript collection. The presence of tradi-

tionally underrepresented groups in the historical record is a priority for the Archives of the History of American Psychology.

"The materials in the Archives form a database that is crucial to understanding our past, present and future. The size of the collection is now more than 5,000 linear shelf feet (placed end to end, the collection would stretch for a mile) and it grows daily. Scholars and researchers from around the world travel to Akron to work in the collection. Over a period of three decades, the results of that work can be seen in the publication of hundreds of books and journal articles, as well as several conferences, exhibits, and displays. The Archives represents the science and practice of psychology with permanent displays on view at the Ellis Island Museum (psychological testing) and the National Zoo (primate learning). In 2003, the APA Science Directorate made a gift of the APA Traveling Exhibit to the Archives and it is now on display along with more than 100 artifacts at the National Inventors Hall of Fame.

"The Archives at Akron represents the national archives of psychology. It is the national database for psychology in the United States. Its mission is very different from the APA Archives, which exists to house the records of the Association and its constituent members. The Archives of the History of American Psychology and the APA Archives share an excellent working relationship."

I was especially pleased to learn that although during my approximately 25 years of service within the APA governance there was very little discussion regarding the importance of "remembering our past" (and the Archives in particular), that today the Council of Representatives has rectified this by directing APA to provide some (albeit limited) financial support to preserve our history. It was impressive to learn from David that under his leadership in April of this year, Roadway Express donated a 70,000 square foot facility to the University of Akron to allow the Archives to expand its offerings and to create the Center for the History of Psychology. This Center will include a museum, archive, educational center, library, and facility space for visiting scholars. **Ron Levant**, as the new Dean for Akron University under whom the Archives is located, is undoubtedly entering a most exciting next phase of his professional career. The extraordinary advances occurring within the technology and communications fields (i.e., distance learning, virtual realities, etc.) will ultimately allow world-wide audiences to personally experience psychology's rich history. **Ludy Benjamin** was indeed correct and is a true visionary. If one ever wonders whether the past points the way to the future, I would only note that after returning from my Akron visit, I received an e-mail from David indicating that the University's School of Nursing had agreed to allow counseling psychology graduate students to take their nursing psychopharmacology course during the Spring semester—a possibility raised during my public lecture. Psychology's prescriptive authority quest is very nicely on track and definitely maturing.

The Importance of Possessing That Bigger Picture

When one is personally involved in the public policy (i.e., political) process, one soon develops an appreciation for the critical importance of conceptualizing one's personal agenda (i.e., issue) within the larger societal context that is evolving. From this frame of reference, the prescriptive authority agenda is all about access, consumer choice, and ensuring the highest possible quality of care. It is about bringing the all important cultural-psychosocial-economic gradient of health care to society's definition of "quality" care. It has been our experience, however, that our colleagues in psychology are often overly concerned with the minute details of what they want in the immediate future, rather than stepping back, reflecting, and looking at the larger context which might be evolving around them. It is as if we do not understand the

2006 NOMINATIONS BALLOT

Dear Division 29 Colleague:

The best talent in the American Psychological Association belongs to the Division of Psychotherapy (29), and we hope to draw from that pool to serve in the governance structure. It is time for us to put our combined talents to work for the advancement of psychotherapy.

NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN THE DIVISION OF PSYCHOTHERAPY. THE OFFICES OPEN FOR ELECTION IN 2006 ARE:

President-elect (1) Member-at-large (2) Treasurer (1)

All persons elected will begin their terms on January 2, 2007.

The Division's eligibility criteria are:

1. Candidates for office must be Members or Fellows of the division.
2. No member many be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for some position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.

Simply return the attached nomination ballot in the mail. The deadline for receipt of all nominations ballots is December 31, 2005. We cannot accept faxed copies. Original signatures must accompany ballot.

EXERCISE YOUR CHOICE NOW!

If you would like to discuss your own interest or any recommendations for identifying talent in our division, please feel free to contact Dr. Jean Carter , 5225 Wisconsin Ave., N.W. #513, Washington DC 20015, Ofc: 202– 244-3505, Email: jcarterphd@aol.com

Sincerely,

Leon VandeCreek, Ph.D.
President

Abe Wolf, Ph.D.
President-elect

Jean Carter, Ph.D.
Chair, Nominations and Elections Committee

NOMINATION BALLOT

President-elect	Members-at-large	Treasurer
_____	_____	_____
	_____	

Indicate your nominees, and mail now! In order for your ballot to be counted, you must put your signature in the upper left hand corner of the reverse side where indicated.

Name (Printed) _____

Signature _____

FOLD THIS FLAP IN.

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Division29
Central Office
6557 E. Riverdale St.
Mesa, AZ 85215

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importance of the media, for example, in shaping our nation's priorities.

During my APA Presidential year, I came to appreciate how we really are all one large family, with many diverse strengths and interests. Psychology has so much to offer society. And yet, as I was filling out my APA membership renewal form this year, I began to think that perhaps too many of us do not understand this simple, yet fundamental concept. We all seem to want our own way, rather than working together and sharing resources. What crystallized this notion was the realization that my division dues payments had become significantly greater than the APA dues. I simply could no longer justify this expenditure to my wife. When I was President of Division 29, our newly elected Treasurer **Stanley Graham** was able to recommend a reduction in the division's annual dues. We had a vibrant and visionary Executive Committee with smaller expenditures. We were productive and satisfied. This year, with great sadness, I decided to resign from two other divisions (thereby saving over $100.00). I had been a founding member of one, from which I had been elected to the Council of Representatives; I had served as President of the other. I am a Fellow in both. I deeply believe in their mission, but I have come to the conclusion that APA cannot serve us well, if we collectively use our limited resources to splinter our focus. Wouldn't these funds be better utilized if they were instead made available to either the Practice or Education Directorates? Perhaps I am merely a single voice in the wilderness; however, I sincerely believe that the time is rapidly approaching when we will have to rethink our APA divisional structure. Aloha,

Pat DeLeon, former APA President

DIVISION 29 SOCIAL HOUR AND AWARDS

2005 APA Annual Convention

Jay Cohn is presented the Matty B. Canter Education and Training Student Paper Award by President Leon VandeCreek

Dr. John Norcross, Publications Board Chair and outgoing Internet Editor Dr. Abe Wolf

Dr. John Norcross acknowledges outgoing Publications Board member Dr. Jean Carter

Past and current presidents of Division 29 and Education Directorate Director Dr. Cynthia Belan recognize Dr. John Norcross for his APA Award

Psychotherapy for Poorly Performing Trainees: Are There Limits to Confidentiality?

By Linda Forrest, Ph.D, University of Oregon and Nancy S. Elman, Ph.D., University of Pittsburgh

Note: Correspondence concerning this article should be addressed to Linda Forrest, Counseling Psychology Program, College of Education, University of Oregon, Eugene, OR 97405. Email: forrestl@uoregon.edu.

During annual trainee evaluations by faculty, student A's practicum supervisor raised concerns about her developing clinical skills, citing an inability to engage clients at deeper levels, and to hold clients across sessions. Other faculty mentioned A's interpersonal skills, noting a hesitancy to engage in more complex or challenging issues with peers during classroom discussions. The student's advisor agreed to talk with the student about the benefits of personal therapy that might help her understand herself and her hesitancies. The faculty was hopeful that A would address these issues without a formal remediation.

During the same faculty review, faculty reviewed student B's efforts to address serious concerns identified during her previous annual evaluation. The supervisor's report included continued concerns about client welfare due to B's hostility and anger, an unabated defensive and argumentative style, and continued rationalizations for her behavior. Faculty wondered whether she had been attending and making progress in the personal psychotherapy recommended during the previous review. Some faculty wished they had required the therapy, but were concerned that both B and her therapist might perceive this as intrusive to the therapeutic relationship. Faculty members were frustrated and there were differences of opinion, especially about the personal therapy.

In this article, we want to focus on (a) the role of psychotherapists who treat psychology trainees, particularly those who are performing poorly during training, and (b) treating psychotherapists' relationship to training programs. For the great majority of trainees who seek psychotherapy as part of training, there is no need for faculty or program intrusion into confidentiality of psychotherapy. Yet, in those exceptional cases in which serious personal difficulties and problematic functioning interfere with the trainee's capacity to attain appropriate competence, the role of personal therapy as remediation intersects with a training program's ethical and legal responsibilities to graduate competent professionals. In these cases, the nature of confidentiality in a trainee's psychotherapy and treating therapist's relationship with training programs requires further examination. In these more serious cases, we suggest that maintaining confidentiality in all aspects of the psychotherapy is not an "all or nothing" decision, but a more nuanced decision that protects trainees' privacy, yet creates options for the training programs and treating psychotherapist to determine whether the psychological issues that affect professional competence are being adequately addressed. Confidentiality need not be an inviolate and unquestioned assumption. Challenges to our traditional beliefs about confidentiality need careful thought and much dialogue among training programs, trainees, and treating therapists, so that a balance is attained between the student's right to privacy and due process and the program's need for accountability to the profession and the public.

Background

A majority of psychologists report having received personal psychotherapy at some time, many during graduate training, suggesting that a great many psychologists in practice are providing treatment to trainees

or other professionals (Geller, Norcross & Orlinsky, 2005; Guy, Stark, & Poelstra, 1988; Pope & Tabachnick, 1994). For the most part psychologists report that psychotherapy has been important for their growth and development as professionals. They comment that the experience of being "on the other side" of the role for which they are training, and the ability to reduce distress and manage personal problems make psychotherapy a beneficial experience (Wise, Lowery, & Silverglade, 1989). The empirical literature on whether psychotherapy affects later outcomes as a psychologist is inconclusive (Clark, 1986; Greenberg & Staller, 1981; Macaskill, 1988; Macran, Stiles, & Smith, 1999), possibly because there has been no effort to distinguish between (a) those who seek therapy for professional development and personal growth, and (b) those who seek therapy because serious psychological problems interfere with the capacity to become competent psychologists.

The challenges to behave ethically with regard to trainee and psychologist competence, combined with the high use of personal psychotherapy in the training of psychologists and the lack of clarity about its role, particularly with trainees who have psychological problems, has fostered our interest in writing about the role of treating psychotherapists and their relationships to training programs. As the two case examples above indicate, the range of motivations and psychological problems that bring trainees to psychotherapy have implications for the trainee/client, the therapeutic intervention, and the trainee's progress in the program. The second case suggests great challenges for all parties involved.

We will argue herein that we need a dialogue among treating psychotherapists and training programs that identifies systemic gaps in our current practices and creates the framework for possible new and ethical models of collaboration among trainees, treating therapists, and training programs. A fuller understanding of appropriate collaborations will assist us in accomplishing the goals of (a) providing psychotherapy for trainees who are struggling, and (b) meeting programs' ethical and legal responsibilities to maintain quality assurance in the services provided by trainees and program graduates. To do so we believe, requires faculty, treating psychotherapists, and trainees to rethink the boundaries of confidentiality in trainees' personal psychotherapy when professional competence is threatened.

Although not a new problem, there has been an increased number of publications in the last 10 years focused on the topic of inadequate, diminished or unethical professional functioning by trainees (Elman, Forrest, Vacha-Haase, & Gizara, 1999; Elman & Forrest, 2004; Forrest, Elman, Gizara, & Vacha-Haase, 1999; Gaubetz & Vera, 2002; Gizara & Forrest, 2004, Huprich & Rudd, 2004; Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004; Rosenberg, Getzelman, Arcinue, & Oren, in press; Vacha-Haase, Davenport & Kerewsky, 2004). Similarly, several national training and professional organizations have focused on this topic with invited addresses at their annual meetings (Elman, 2001a, 2001b; Forrest, 1998, 2001, 2005; Kaslow, Mitnick, & Baker, 2002; Thorn, Rudd, & Bernstein, 2003). The 2002 National Competencies Conference on Future Directions in Education and Credentialing in Professional Psychology (Kaslow et al., 2004) focused on issues of identifying, training, and assessing core competencies in psychology. Many of the work groups on core competencies mentioned the importance of determining minimum acceptable levels of professional competence. Also, the Council of Chairs of Training Councils (CCTC) established a Student Competence Taskforce. This 17 member Taskforce representing the various training councils developed a model policy statement that describes the comprehensive evaluation of student-trainee competence in professional psychology training programs. Based on recommendations made in the national presentations and

publications cited above, this document attempts to disclose and make evaluation expectations explicit for trainees prior to entry and at the outset of their education and training. The model policy also makes explicit training programs commitment to not advancing, recommending or graduating students or trainees with demonstrable problems that interfere with professional competence (Student Competence Taskforce of CCTC, 2004). This model policy has been approved by CCTC and the majority of the training councils. On the practice side, the Advisory Committee on Colleague Assistance (ACCA) of APA's Board of Professional Affairs (BPA) has been working for several years to increase the capacity of state and territorial psychological associations (SPTAs) and licensing boards, via the Association of State and Provincial Psychology Boards (ASPPB), to address more effectively issues of impairment or incompetence by creating collaborations and developing models for intervention from self-care and early identification, to remediation interventions that both assist the psychologist and protect the public (ACCA, 2005; Allen & Elman, 2004a, 2004b; Johnson & Campbell, 2002; Johnson, Porter, Campbell, & Kupko, in press; Forrest, 2005; Yarrow, 2004). Other professions (notably medicine and law) have long held that when professional competence is in question, authorizing the release of reports on attendance and progress in psychotherapy is expected, tracked and utilized in decision-making by licensing boards or professional associations.

The Code of Ethics of APA (2002a) mandates practicing within our competence (Section 2.03) and addressing issues with other professionals who do not appear to be meeting this standard (Sections 1.04 and 1.05), a standard some research suggests is not often met (Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Wilkins, McGuire, Abbott, & Blau, 1990). Specifically relevant to graduate trainees are two new sections in the Standard on Education and Training that specify conditions under which student disclosure of personal information may be required (Section 7.04) and personal psychotherapy may be mandated (Section 7.05) (these two sections are not found in earlier versions of the Code of Ethics). Faculty may now require disclosure of personal information and personal psychotherapy if appropriate, so long as due process concerning issues of privacy and confidentiality are addressed in advance. Similarly, the recognition of the importance of students' due process rights is well articulated in the Guidelines and Principles of the Committee on Accreditation (APA, 2002b). Two threads run through the current writings on psychologist and trainee impairment and incompetence: (a) a systemic rather than an individual focus and (b) terminology and definitional problems.

Toward a Systemic Focus

Historically, we have treated the trainee or psychologist as though problematic behavior or impairment existed in isolation – as an individual intrapsychic problem. It has become clear, however, that the problem is a systemic one. The individual psychologist or trainee is influenced by and influences peers (fellow students or professionals), faculty and supervisors, administrators, professional associations, and regulatory boards (Elman et al., 1999; Schoener, 1999; Vasquez, 1999). A systemic focus also encourages a deeper understanding of how individual, group, and institutional diversity issues intersect with professional competence evaluations (see Forrest et al., 1999 and Vasquez, 1999)

Our research and anecdotal reports of others suggest that a more developmental and organizationally seamless approach to problems of incompetent functioning will improve identification, assessment and intervention. Such an approach will encourage a developmental focus over the life course of the therapist from novice trainee to career-long practitioner as well as across organizational systems from training programs to internship through licensing boards and SPTAs, organizations that effect and regulate practice.

Terminology and Definitions

There is a lack of clarity about the definition of *impairment* that contributes to the difficulty in adequately addressing problems in professional functioning. The use of the term *impairment* is problematic in several ways. First, it is often used to describe diminished professional functioning, which implies a previously attained level of competence, despite the fact that in training situations, competence may never have been acquired. Second, the term is a global one and may refer to any number of specific challenges (for example, *impairment* does not differentiate among lack of knowledge or experience, personal characteristics, or professional functioning). Third, impairment as currently used does not differentiate between causes and the behavior itself (e.g., alcohol abuse). Fourth, and perhaps the most serious challenge to use of the term *impairment* is that the same term is used in the Americans with Disabilities Act (ADA, 1990). The ADA uses the term *impairment* interchangeably with the term *disability* and requires educational and employment accommodations for individuals with disabilities so that they can perform the essential functions of the job. ADA language, alone, makes it essential that we find another term to describe the circumstances under which programs identify, assess and place trainees on remediation. Thus, in the reminder of this article we avoid using the term *impairment*.

Psychotherapy as Remediation

When psychology training programs decide to intervene with a student due to problem behaviors or performance, the most common recommendation is personal psychotherapy, whether as part of a gentle suggestion, a recommendation, or a formal remediation plan. At least six studies (Burgess, 1994; Huprich & Rudd, 2004; Kaczmarek & Connor, 1998; Olkin & Gaughen, 1991; Procidano, Busch-Rossnagel, Reznikoff, & Geisinger, 1995; Vacha-Haase, 1995) confirm that personal therapy is the most common remediation strategy. The majority of remediations are established to address personal and interpersonal psychological problems (Huprich & Rudd, 2004; Procidano et al., 1995; Vacha-Haase, 1995), which probably directly relates to why personal psychotherapy is the most common form of intervention. Yet, little is known about how faculty make decisions to use personal psychotherapy as part of a remediation plan. In fact, the limited empirical or conceptual writing on the topic of personal psychotherapy as remediation leaves training programs without guidance about: (a) the types of professional behavior or performance problems that personal therapy can address successfully; (b) the appropriate balance between trainee confidentiality in personal therapy and the training program's accountability for graduating competent professionals; (c) the type and quality of disclosures (e.g., about what, level of detail, by whom, to whom, with whose consent) about personal therapy to the training program; and (d) the roles, responsibilities, and expertise of the treating therapist.

Training Directors' Views of Psychotherapy as Remediation

To address this lack of knowledge, we conducted exploratory interviews with 14 graduate program training directors (TDs) about how faculty handle the complex dilemmas associated with recommending or requiring personal therapy for trainees whose personal problems interfere with their ability to function at an acceptable level of professional performance (Elman & Forrest, 2004). We used semi-structured interviews to gather information about the issues identified in the previous paragraph.

The interview data revealed that faculty struggle to find a balance among the trainee's need for privacy, the profession's long standing commitment to confidentiality as an important aspect of the success of personal therapy, and the training program's responsibility to assure the quality of the psychological services provided by its trainees and graduates. Thirteen of the 14 TDs described an implicit "hands-off" approach to the trainee's therapy, recommending, but not requiring therapy.

"Hands-Off" Approach

When reporting psychotherapy as being recommended rather than required, due to concerns about trainee's confidentiality, TDs described both low-risk and developmentally focused cases as well as high-risk, serious concerns (e.g., personality disorders, substance abuse) that resulted in serious interference with professional functioning and clear concerns about client safety. Several TDs described ambivalence about requiring therapy and cited concerns about the power differential between students and faculty and the risk of coercion, which might undermine the therapeutic relationship and ultimately the psychotherapy outcomes.

The TDs describing hands-off approaches had no information about whether or not the trainee was attending therapy, the identity of the treating therapist, or information about the therapist's qualifications and expertise, unless the trainee volunteered that information. Yet, TDs described a belief that treating therapists needed to have special expertise to address the unique issues that arise when treating trainees (see Kaslow & Friedman, 1984) and some TDs were concerned about treating therapists' expertise, especially for trainees with more serious problems that interfere with professional functioning.

Although TDs described desirable characteristics and qualifications of treating psychotherapists, no programs with hands-off practices initiated a collaboration between the psychotherapist and program to assure that treatment goals were relevant to the trainee's specific performance problems. Several kept a referral list of psychologists in the community who were familiar with the program, perhaps were even graduates of the program, and had previously been known to treat program trainees. These TDs who described "hands-off" practices emphasized the trainee's privacy and confidentiality rather than the program's responsibilities for accountability and quality assurance.

Active Involvement Approach

Five TDs described seven cases that included more active involvement by faculty with the treating therapist; four TDs reported a decision to shift to more active involvement in the trainee's psychotherapy because the trainee's behavior did not improve or became progressively more problematic. These TDs differentiated between low-risk cases in which therapy could be recommended for developmental and professional growth and high-risk cases that required more active involvement and decision making by the faculty. These TDs also articulated greater concern about client welfare as well as protection of the profession, and wanted greater treating psychotherapist involvement including updates on attendance and progress.

Of these five TDs, one TD from the onset of developing a remediation plan described active program involvement with treating psychotherapists. This program required (a) the trainee to select a therapist from a program-approved list of psychologists, (b) meeting with the treating therapist and trainee to establish goals of therapy specific to the professional functioning concerns identified by faculty, and (c) establishing up-front an agreement with trainee and treating therapist that both attendance and progress in therapy would be reported to the training program. This TD spoke directly to the need for information from the treating therapist to determine the success of the remediation. This TD also described a more balanced approach between trainee confidentiality and program responsibility for quality assurance in their interactions with trainees and treating therapists, thus addressing the issue of potential harm to future clients of the trainee and the risk of not being able to attest to competence when knowledge of the remediation is unavailable.

Our conclusion after analyzing these interviews with TDs was that personal therapy as remediation during training may require a more nuanced and sensitive model of trainee privacy and confidentiality. Such a

model would distinguish between information revealed in therapy that should always remain private and protected (e.g., dreams, fears, personal histories) and information pertinent to trainees' professional competence and efforts to ameliorate difficulties that interfere with professional performance (e.g., boundary problems, excessive anger or anxiety, substance abuse). We further concluded that the hands-off approach does not facilitate communication between training programs and treating psychotherapists nor does it allow faculty, trainees, and treating therapists to explore boundaries that might more adequately addresses both concerns for trainees' privacy and program responsibilities for graduating competent professionals. Also hands-off practice does not provide faculty with opportunities to model professional yet effective boundary management in complex professional situations. In fact from student perspectives, faculty hands-off approaches may model behavior for trainees that reinforces future "hands-off" approaches and this, in turn, may explain why practicing psychologists often do not apply known ethical mandates when colleagues are believed to be harming their clients (Bernard & Jara, 1986; Bernard et al., 1987).

Encouraging Dialogue between Treating Therapists and Training Programs

Because the above research focused on psychology training programs, most of the recommendations were directed to academic and internship training programs. Yet the lessons learned seem equally important to treating psychotherapists. Recognizing that many members of Division 29 in all likelihood are treating clients who are currently trainees in psychology graduate programs, we want to take this opportunity to open a dialogue. Conversations with treating therapists would be helpful in examining current practices, their strengths and limitations, as well as new and innovative possibilities for addressing the ethical conundrums that rest at the intersection of trainees in personal therapy remediations, their psychotherapists and training programs.

Some questions for consideration are: Do current practices of little or no interaction between training programs and treating therapists increase the likelihood of splitting on the trainee's part? Would meetings among the parties (faculty, trainee, and treating therapist) early in the process of developing remediation plans, with the goal of creating more openness and clarity, work to everyone's benefit? Might explicit triangulation among trainee, treating therapists and training programs create clearer expectations about each party's roles and responsibilities? Might such arrangements create a larger and safer holding environment for trainees to address psychological issues that interfere with their ability to be successful in their training program?

Questions we have for treating psychotherapists include: When treating a client/trainee, do you wonder about his/her ability to develop into a competent therapist? Do you wonder what the program faculty is doing to address the potential issues of professional competence that you observe based on your therapeutic relationship with the client? Do you sometimes wish there was an ethical way to identify to the program your concerns about a trainee/client's capacity to function as a psychologist? When trainee/clients indicate they are struggling with faculty, do you wonder what part of the problem is the client's, what part is attributable to the natural stressful demands of graduate training, and what part has to do with faculty and/or larger programmatic or systemic problems? When a trainee/client describes a remediation plan, do you ask to see the plan? Might it be helpful to have contact with training programs when you are seeing a trainee/client who is on a remediation plan? When you see practicing therapists and trainees in your caseload, have you developed special skills for understanding how to work more effectively with them? Do you think that there is special expertise or additional responsibilities you hold when treating trainees or practicing psychologists? If you have treated practicing psychologists or other professionals mandated to treatment by a licensing board, what from this

experience is pertinent to treating trainee/clients? Has your interaction with licensing boards helped you think through how you interact with training programs when seeing trainee/clients on remediation plans? Might you be able to provide training programs with some guidance based on your experience?

We hope that these questions pique your interest in further communications with trainee/clients who are on remediation plans, graduate training program faculty in your area, and other treating psychotherapists about the ethical dilemmas at the nexus of these questions. We believe meetings among program faculty and treating psychotherapists to discuss these ethical dilemmas will be productive in identifying what is and is not currently working from different perspectives. Recent surveys of students in training programs suggest that students are deeply concerned about peers who are not performing competently (Mearns & Allen, 1995; Oliver et al., 2004; Rosenberg et al., in press; Swann, 2003); their perspectives might further our understanding of the systemic interactions surrounding psychotherapy as remediation.

More forthright descriptions of the dilemmas from different perspectives may provide (a) a larger understanding of each party's experiences, (b) help develop a more refined consideration of confidentiality that honors the profession's commitment to quality assurance standards, and (c) create an opportunity to develop new standards for communication among program faculty, trainees and their treating psychotherapists when trainee/client problem severity warrants it. The treating psychotherapists and faculty are in relationships with respect to trainee/clients that have been described as a "black hole." Open dialogue and testing out new strategies might create a more tenable position for all parties and provide opportunities to develop and study different models of intervention. Ultimately, psychology as a profession could create guidelines for addressing confidentiality issues and appropriate roles and responsibilities for trainees, treating therapists and training programs in instances when psychotherapy is used as a remediation strategy.

Conclusions

In conclusion, research on psychology trainees with problems of professional functioning has moved beyond a focus on the individual trainee or professional towards larger systemic perspectives (ACCA, 2005; Elman et al., 1999). New models for psychotherapy as remediation need to be developed that better balance the trainee's need for privacy with the program and the profession's need for accountability. Challenges to confidentiality deserve more careful scrutiny suggesting action toward (a) building interconnecting relationships between practicing psychotherapists and training programs, (b) further examining the systemic nature and impact of our interactions on each other, and (c) opening up the possibility of more integrated and effective systems of communication. We welcome comments from readers of *Psychotherapy Bulletin* as we continue research on these questions.

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DIVISION 29 AWARDS AND RECOGNITIONS

Dr. Marvin Goldfried, Ph.D., ABPP

2005 Rosalee G. Weiss Award for Outstanding Leaders in Psychology

Dr. Marvin Goldfried received recognition from the Division 29 past president, Linda Campbell, for his outstanding contribution to the advancement of psychology.

Dr. Goldfried is also a past recipient of the APA Distinguished Psychologist Award for Contributions to Knowledge and the Distinguished Psychologist Award from the Divisions of Psychotherapy, Clinical Psychology, General Psychology, and Gay, Lesbian and Bisexual Concerns. He is also past president of the Society for Psychotherapy Research.

PRACTICE RESEARCH NETWORKS IN PSYCHOTHERAPY

By Abraham W. Wolf, Ph.D.
Departments of Psychology and Psychiatry
MetroHealth Medical Center
Case Western Reserve University

P*resentation at the 112th American Psychological Association Annual Convention, Honolulu, Hawaii, July 31, 2004, Presidential Symposium: Psychotherapy Practice and Research—Collaborative Directions and Common Grounds.*

During the recent practice focus group conference calls, the theme of bridging the gap between researchers and practitioners was raised again and again. How to disseminate research findings in such a way that practitioners will implement these findings? How to get practitioners to participate in collecting data for these studies? Ron Fox, as he always does, reduced the issue to its basic parts: How are you going to get practitioners to "buy-in" to research both as consumers and producers?

This is not a problem unique to psychotherapy. Evidence-based medicine represents a major shift in how all health care providers conceptualize the clinical decision making process. One solution to the problems of getting practitioners to "buy-in," is provider-based research networks, or practice research network. The following is a brief discussion of what they are, why they are important, how they have been used both in primary care and mental health, and some ideas about how they have been and can be implemented in psychotherapy research.

Dissemination/implementation Gap—technology transfer/translational blocks

This year's NIH budget is in excess of $25 billion. Nevertheless, the U.S. ranked 72nd in the world for disability adjusted life expectancy by World Health Organization. The problem of implementing research findings has become so critical that Congress enacted legislation to make sure that the federal investment in research translates into practical application. This gap between research and practice is called technology transfer and less, frequently, translational bock.

The Cochrane Collection, a clearinghouse of meta-analyses and systematic reviews for all areas of health care, summarize the literature on best practices to encourage implementation of research-based recommendations and to ensure changes in practice. These reviews indicate that the passive dissemination of information through journals was generally ineffective in altering practices no matter how important the issue or how valid the methods. The use of computerized decision support and, especially, educational outreach visits resulted in practice changes. The drug companies know this; that's the reason drug reps persistently knock on physicians' doors.

The practice research network—A strategy for bridging the gap

In 1999, Congress enacted legislation encouraging the Agency for Healthcare Research and Quality (AHRQ) to develop initiatives that expand our understanding of translating research to practice, especially the use of practice research networks in primary care and to address issues of disparities in health care quality, outcomes, cost and access.

Practice research networks are groups of practicing clinicians who cooperate to collect data and conduct research studies. These networks use the practice setting both as a laboratory and as a vehicle to implement research findings. Initially established in Europe and the United

States in the late 1960's in primary care and family practice settings, they vary considerably in terms of their mission, funding, and the types of data they collect.

The advantage of these networks is that they provide systematic, patient-level clinical data that document treatment process and outcome across a broad range of practice settings. As a research methodology in basic clinical services, network generated data are useful to both clinicians and policy makers working to ensure that clinical as well as economic issues are considered when making health policy decisions. Because network members are practicing clinicians who participate directly in the selection, development, and implementation of studies, these networks succeed in facilitating the transfer of research into practice.

Since 2002, AHRQ provided support to 36 practice research networks comprised of over 10,000 primary care clinicians with practices in 50 states, serving almost 10 million primary care patients.

PRACTICE RESEARCH NETWORKS IN MENTAL HEALTH

American Psychiatric Association
In 1993, the American Psychiatric Association, formed a network of psychiatrists in clinical practice to study their practice patterns and patient characteristics. It was funded by the ApA as well as the federal Center for Mental Health Services and private sources. Membership in the network included both a randomly selected group of practitioners in order to increase generalizability but also a "volunteer" group for more intensive long-term studies. Data were collected through mailed paper-and-pencil questionnaires.

Since 1993 there have been about 20 publications from this project. The *American Journal of Psychiatry* recently published a study examining the relationship between utilization management techniques and psychiatrists' modification of treatment plans. In a sample of 1,800 patients treated by 600 psychiatrists, they found that psychiatrists in independent practice with non-salaried income were more likely to modify treatment decisions for patients under utilization management. When compared to evidence-based treatment recommendations, these changes seem likely to result in less than optimal care.

American Psychological Association
Our own APA has a practice research network. Since 2001, PracticeNet has done five studies using an Internet based methodology. Developed by the Practice Directorate with grant support from the Center for Substance Abuse Treatment, PracticeNet uses real time behavior sampling to capture specific moments of practitioner activity. Participants include licensed psychologists as well as APAGS members, interns, and postdocs.

These volunteer samples participated in surveys on reactions to 9/11, on the effects of war and terrorism, clinical practice patterns and two substance abuse surveys. Sample sizes varied between 200 and 300. One interesting finding from the practice patterns survey was that 24% of patients with private insurance do not use that benefit, presumably because of privacy concerns. Slide presentation of survey results are available at www.apapracticenet.net.

Hampstead Index
An example of a practice research network in a training setting comes from a source not usually associated with evidence-based methods—child psychoanalysis. Since the mid-1950's the Hampstead Child Therapy Clinic—the Anna Freud Center—has collected and organized case material using the Hampstead Index.

It was developed as follows: Child therapists documented daily analytic sessions that were summarized weekly and every two months. In order to retrieve that material for teaching and research purposes, an index of reference terms was constructed. The goal was to provide a comprehensive system of classification for clinical material. Trainees would consult with supervisors to

breakdown their notes for indexing. Data were organized as general case material, that is, demographic data, and psychoanalytic material. The result of indexing a case was a set of typed cards each containing a "unit of observation" and a set of cross-references using the indexing system. Examples of index terms are object relations, defenses, superego, transference, and so forth. Joseph Sandler's work on the representational world and work by Peter Fonagy utilize this data base to assess outcome.

The Pennsylvania Psychological Association PRN

In 1994 the Pennsylvania Psychological Association formed a task force for empirical documentation of psychotherapy effectiveness through increased collaboration between researchers and practitioners. The goal was to create a practice research network—a functional integration of practitioner and scientist roles. With funding from the APA Practice Directorate and the Pennsylvania Psychological Association, committees were formed to create a Core Battery assessment tool and to investigate ethical issues involved in such a network.

Phase I of the project started in 1996. 205 volunteers responded to a call for participants and of these, 77 returned therapist variable forms; 57 of those therapists obtained initial assessments on 220 patients. Data on 75 of these patients were available at mid-assessment (7-8 weeks) and these indicated significant improvement on all symptom measures and global indices. The termination data on 42 patients indicated significant decreases in problems in all functioning areas. These were some interesting findings, such as a less improvement on some patient outcome measures among therapists with heavier caseloads.

In Phase II , practicing clinicians in Central Pennsylvania are collaborating with clinical scientists to investigate, on a session-by-session basis, the most significant events that occur in therapy from both the therapist's and the patient's perspective. An additional experimental manipulation embedded in this therapy process study involves random assignment of consecutive patients to conditions in which they do or do not complete the ratings and content forms after each session in an effort to test whether explicit focus on significant session events and feedback from the patient to the therapist about such events impact on therapist behavior and on ultimate patient outcome. 100 patients from 18 therapists were followed for 18 months. The group hopes to present their findings this year.

National Training Clinics Practice Research Network

The dream of the founders of the Pennsylvania network is the creation of collaborative practice research networks in all graduate training program clinics and internships. They hope that cohorts of new Ph.D.'s raised in such a system enter the work force where they recreate the collaborative networks in which they were trained. This will lead to the creation of a National Practice Research Network where large numbers of practicing clinicians and clinical scientists can do rigorous research in a naturalistic setting. The clinical psychology program at the Penn State has already begun efforts to establish such a research infrastructure.

A PROPOSAL

Louis Castonguay, an organizer of the Pennsylvania network recently wrote, "It became clear to me that simply asking clinicians to provide data within the context of an already developed research protocol would preclude the establishment of a long and productive relationship. This amounts to what I now call 'empirical imperialism'." The data from the American Psychiatric Association, the American Psychological Association, and Pennsylvania all point to the same problem: recruitment and retention of participants in a practice research network. There are 6000 licensed psychologists in Pennsylvania; less than 5% responded to the call for participation in the network. Of these, only 38% submitted therapist variable forms, 20% obtained initial assessments, and 9%

submitted termination assessments.

Some of the major lessons learned from the Pennsylvania project are that clinicians need an incentive to participate in these networks. Not just continuing education credit but 1) reimbursement for time, 2) minimal time needed for the project, 3) clinically useful material for patients, and, 4) practitioners having an equal voice in determining research questions.

This gets back to Ron Fox's question? "How do we get practitioners to 'buy-in' to such a project?"

I think that computer technology may help here. Increasingly, major medical centers and individuals are relying on computerized medical records. A collection of practitioners sharing the same computer program to store and retrieve patient information is a network. A collection of practitioners sharing the same computer program and who use the same assessment battery and outcome measures is a practice research network.

What I envision is a computer program that can be utilized to store patient information at different levels. At its most basic, this program can be used for scheduling. At this level, information about frequency of visits and cancellations could be retrieved. Additional components could include structured initial assessments that include basic demographic information and clinical parameters. The pay-off for the practitioner is the creation of an intake note; the payoff for the network is a patient profile. This part is not fantasy. Vendors at this conference already offer this program - most with billing software.

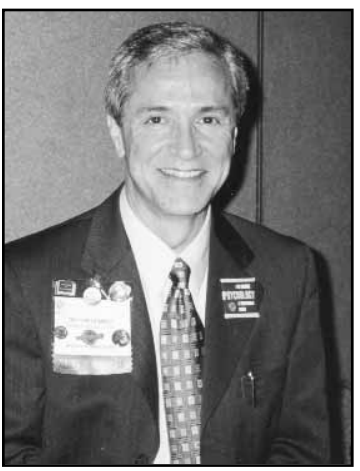
Such a computer program can be integrated with a curriculum of continuing education courses that can be completed online. In order to participate in specific studies, practitioners would be required to complete such courses. They don't have to— they just won't participate in that study on process and outcome. Courses could be offered on how to do a detailed case study, an area of research with a long history that is again becoming popular. Completing the course would allow one to use specific programs for completing the study.

Many, perhaps most, psychotherapy researchers and most practitioners are increasingly disillusioned with a model of clinical research and practice that idealizes the randomized clinical trial. That does not make us real scientists or real doctors. What does, is taking a hard look at what we in fact do and what is best for our patients.

DIVISION 29 SOCIAL HOUR AND AWARDS RECEPTION

Dr. Leon VandeCreek acknowledging outgoing Past President Dr. Pat Bricklin

Drs. Gerry Koocher and Linda Campbell welcome students Alicia Jackson, James Lee and Tanette Robinson



Dr. Tom DeMaio, APA Board of Directors

CALL FOR AWARD NOMINATIONS

The APA Division of Psychotherapy invites nominations for its two annual awards in 2006

The Distinguished Psychologist Award recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

The Jack D. Krasner Memorial Award recognizes promising contributions to psychotherapy, psychology, and the Division of Psychotherapy by a Division 29 member with 10 or fewer years of post-doctoral experience.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 2006 Awards Chair: Leon VandeCreek, School of Professional Psychology, Wright State University, 117 Health Sciences Bldg., Dayton, OH 45435, Ofc: 937-775-4334; Fax: 937-775-4323; E-Mail: leon.vandecreek@wright.edu.

The applicant's CV would also be helpful.
Self-nominations are welcomed.

DEADLINE IS JANUARY 1, 2006

GLOBAL REALITIES: INTERSECTIONS & TRANSITIONS

February 2, 2006

Through his "focus on family" platform, APA President-Elect Dr. Gerry Koocher plans to spotlight three areas that span all of psychology's constituencies, one of which is: Diversity in Psychology: "Our society is becoming diverse in ways that couldn't have been imagined 20 years ago," says Koocher, noting that not only are minority populations growing, but so are transracial marriages and international adoptions. "Psychology has the potential to help to move America in greater acceptance of multiculturalism."

Registration: *available beginning 9/1/05 at* ***www.Reisman-White.com***
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Confirmed Plenary Speakers:
Dr. Mary Pipher: Clinical psychologist and an adjunct clinical professor at the University of Nebraska; *NY Times* bestselling author of *Reviving Ophelia* and *In the Middle of Everywhere* in which she "unites refugees, people who have fled some of the most repressive regimes in the world, with all of us..."

Dr. Donald J. Hernandez: Professor in the Department of Sociology at the University at Albany (SUNY); had overall responsibility for the National Research Council report titled From Generation to Generation: The Health and Well-Being of Children in Immigrant Families and Children of Immigrants: Health, Adjustment, and Public Assistance

Dr. Carola Suarez-Orozco: Co-Director of Immigration Studies at NYU and co-author of *Children of Immigration* and *Transformations: Migration, Family Life, and Achievement Motivation Among Latino Adolescents*. She is also a co-editor of the award-winning six volume series entitled *Interdisciplinary Perspectives on the New Immigration.*

A call for Conference Poster presentations is forthcoming through participating Divisions (*Div 12 Section VI, Divisions 12, 16, 17, 29, 35, 37, 39, 42, 43, 45, 48, 51, 52, 53, 54)*. Check your newsletters for more information.

Location: *St. Anthony- A Wyndham Historic Hotel, 300 East Travis, San Antonio, TX, 78202 (*210) 227-4392. **Room Rate:** $139.00 (single/double) before January 9, 2006

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Summit Co-Chairs:
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Cynthia de las Fuentes, PhD, President of Div 35

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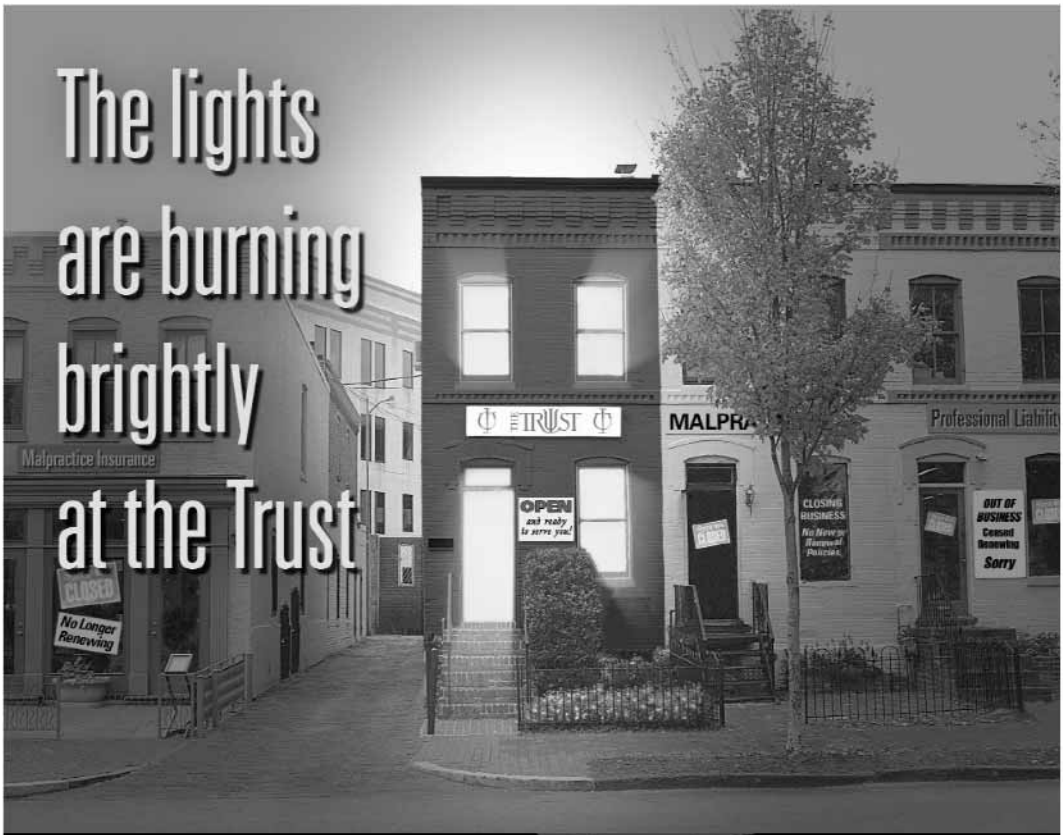

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➨ **ANNOUNCING A NEW BENEFIT!**

- IN SESSION

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

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

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

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

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