Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

In This Issue

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Training for Novice Therapists

Psychotherapy Around the World

Bylaws Approved by Board for Change
Don't forget to vote—see ballot inside!

2006 VOLUME 41 NO. 1

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PRESIDENT'S COLUMN

Abe Wolf, Ph.D.

The Glass Half Empty – The Glass Half Full

It's hard to be a psychologist doing psychotherapy.

If it's not reimbursement problems, it's evidence-based guidelines flaunted as the only scientific and even ethical way of treating patients. Psychotherapy is increasingly seen as a second tier treatment, chosen when medication is not as effective as hoped. Psychologists struggle to maintain a distinct identity, competing with other professionals who all practice psychotherapy.

GLASS HALF EMPTY

As the new president of the Division of Psychotherapy, I was pleased to see psychotherapy make the front page of New York Times Tuesday Science section. In "On The Road To …Where?" Benedict Carey (December 27, 2005) reported on The Fifth Evolution of Psychotherapy Conference that was held in Anaheim, California earlier that month. The tone of the article was alarming. It spoke of the graying of psychotherapy. "As psychotherapy struggles to define itself for an age of podcasts and terror alerts, it will need ideas, thinkers, leaders. Yet the luminaries here, many of whom rose to prominence three decades ago, were making their way off the stage. And it was not clear who, or what, would take their place." Our field has a great past, but where are the voices of the future?

In that same month, Pat DeLeon, a former president of both Division 29 and APA, wrote a column for the National Psychologist, "Division Dues: A Time For A Reassessment?" He admitted to resigning from two APA divisions that he been very active in. (Pat reassured me that Division 29 was not one of them.) His reasons were not just to save $100 a year on APA dues. He had questions about the duplication of efforts of the different practice divisions, the need for multiple division boards of directors, and the compartmentalization of professional psychology. "Each of the divisions seems to perceive their special interest as being central to professional psychology, rather than viewing themselves as but one small component of the larger whole of the family of psychology." Pat writes that he gets very little organization support for his ideas to consolidate practice divisions, but privately his colleagues are telling him that they are also resigning from divisions.

The leaders of Division 29 are well aware of the messages in both the pieces cited above. While our members may not always vote for the election of board members or on the apportionment ballot for Council of Representatives, they do vote with their feet. Our membership dropped from 6500 in 1996 to 3200 in 2005, a loss of over 50%. The average age of of Division 29 member is 61 years; 20% are over 70 while 10% are under 50. This is not unique to Division 29. Other practice divisions tell the same story. There is no reason to suspect that this trend is going to change.

GLASS HALF FULL

The Division 29 Board of Directors just finished our midwinter meeting in San Antonio, held in connection with the APA Expert Summit on Immigration. We have been busy. We have an exciting program planned for the APA convention in New Orleans. We are at the forefront in developing online continuing education programs. We are advocating policies to avoid the use of generic language when referring to psychologists and for increased funding of psychotherapy research. We are identifying the priorities for psychotherapy in the areas of practice, training, early career, and research.

Our Program Chair, Jeff Magnavita, organized an exciting program for the APA convention. Here are some of the sessions: "Current Developments in the Cognitive Neuroscience of Psychotherapy," "What Do You Do When You Hate Your Patient," and "Empirically Supported Treatment for Personality Disorders" to name just a few. Join us in New Orleans.

In her January *Monitor on Psychology* column, Cynthia Belar discussed how distance learning is affecting the teaching of psychology at the high school, undergraduate, graduate, and postgraduate level. APA continuing education offerings already include independent study programs based on books in addition to multimedia courses through the new APA Online Academy. Division 29 is working closely with APA to develop a model for offering online continuing education based on material produced by our members. Two special issues of our journal on *Empirically Supported Psychotherapy Relationships* and *The Technology of Psychotherapy* will be summarized and offered through the APA website. Keep an eye on our web page *(www.divisionofpsychotherapy.org)* to find out when these courses will be available.

Division 29 has become increasingly concerned over the past few years about the use of generic terms to describe health-care activities of psychologists. The identity of psychology as a profession is being confused with other mental health professions such as "therapists" and "counselors." Generic terms such as "therapy," "assessment," "clinician," and "intervention," among others, are used when referring to "psychotherapy," "psychological assessment," and "psychologist." This erodes the uniqueness of psychological services and does a serious disservice to psychological health service providers and to the general public. Norine Johnson and John Norcross, the Division 29 Council Representatives, drafted a policy statement that was approved at the last Board of Directors meeting that addressed this issue for our own journal and Internet editors. The policy statement also authorized our members to advocate for this policy in APA communications and products. Norine and John will place this issue on APA Council of Representatives agenda. See our web site for a copy of this policy.

We have been working hard over the past few years to set an agenda for our division. Under the leadership of Linda Campbell and Leon VandeCreek, the Ad Hoc Committee on Psychotherapy held a series of focus groups to determine the state of psychotherapy. The committee interviewed researchers, educators, practitioners, students, and new career professionals to create lists of initiatives that were given to committee chairs as mission statements. These efforts have already bore fruit. Bill Stiles, Chair of the Research Committee, organized a task force of Society for Psychotherapy Research and Division 29 leaders that drafted a document advocating for changes in funding practices for psychotherapy research. We look forward to similar efforts from other division committees. If you want to find out where the voices of the future of psychotherapy are, one place to look is in the research literature.

A PERSPECTIVE

So, when was it ever easy to be a psychologist doing psychotherapy? It is important to look at the whole picture. Our field is not what it was nor is our division what it was. There is reason for concern but not for despair. I encourage you to make your voice heard by personally contacting me. My mailing address, phone number, and e-mail address are listed at the front of this newsletter. Write to me. Talk to me. You—the membership—are our division and our field.

STUDENT COLUMN

The Good News from a Graduate Student in the Bastion of Psychoanalysis: Sigmund Freud and the Unconscious Are Alive and Well

Michael Stuart Garfinkle, Adelphi University

Michael Stuart Garfinkle is currently a doctoral candidate (Ph.D.) in clinical psychology at Adelphi University's Gordon F. Derner Institute of Advanced Psychological Studies. A graduate of Toronto, Canada's York University, Michael moved to Manhattan in 2004 to effect a thorough immersion in things psychoanalytic. In addition to his work at Adelphi, Michael is also an extern at the New York Psychoanalytic Institute. After graduating, Michael intends to pursue a career as a clinician and professor. Michael is also the chair-elect of the Division's Student Development Committee.

The New York psychoanalytic community, as I understand it, seems to be under constant criticism from the rest of the country. In my wanderings outside of the New York area, I've observed that no consensus exists about the status of psychoanalytic theory, or even the concept of an unconscious (I've been told that using the word "implicit" draws fewer stares). In my program at Adelphi, visiting lecturers warn psychodynamic graduate students that the outside world does not share our assertions and unless we brush up on cognitive-behavioral treatments and generally adopt a behaviorist stance, we don't stand a chance. While I don't doubt the veracity of those claims, my supervisors and many of my professors have provided me with a simple solution: never leave New York.

On his only visit to America in 1909, Freud expressed little excitement for what he found here, summarizing his visit in a complaint regarding the absence of bathrooms, writing: "They escort you along miles of corridors and ultimately you are taken to the very basement where a marble palace awaits you, only just in time" (Jones, 1956, p.60). His visit and the subsequent emigration from continental Europe through the course of the Second World War infused this country with psychoanalytically minded children of the Enlightenment.

America of the 1940s was fascinated by Hull's *Principles of Behavior* and B. F. Skinner's "Baby in a Box," and fundamental psychoanalytic concepts did not mesh with the prevailing climate of behaviorism. While psychoanalysis did not enjoy the psychological spotlight, the discipline began growing slowly through the first-half of the twentieth century. By 1936, the New York Psychoanalytic Society had 68 members and by 1952, nearly 500 of the 762 members of the International Psycho-analytical Association were located in the United States (Kurzweil, 1998). As America became more affluent, psychoanalysis became more popular surging in the late-1970s and 1980s until the advent of managed care.

The differences in orientations between behaviorism and psychodynamic psychology are not limited to psychotherapeutic practice. While not required at Adelphi, students are strongly encouraged to be patients in some form of psychotherapy over the course of their training, and most of my classmates are in treatments ranging from once-per-week insight-oriented psychotherapy to five-times-per-week psychoanalysis. The argument for this is that therapists who believe in an unconscious, working with their own unconscious is cru-

cial for a therapist to practice competently. Regular supervision encourages responsible, effective practice but further ensures that the budding therapist is aware of her own emotional factors that interact with and affect interactions with the patient in treatment. In my own experience, in addition to my personal psychotherapy, I have upward of six hours a week of supervision for everything I do as a clinical psychology student, from psychotherapy to psychological testing. To translate this time commitment differently, I spend one hour in supervision for every patient I see in a 45-minute session. The result is a rich multiplicity of approaches, opinions, and ideas for every moment of therapy.

When I speak to friends in clinical psychology programs elsewhere, they react with surprise when I tell them that we "still" read Freud and consider his works relevant and interesting. They're further awestruck when I tell them that classical analysis and cognitive neuroscience are being integrated and dyed-in-the-wool scientists are reading Freud too. Bornstein (2001) suggests that there are tough times ahead for all insight-oriented practitioners. Indeed, in their analysis of trends in psychology. Robins, Gosling, and Craik found fewer than 1.3% of "flagship" articles in psychology to be reflective of a psychoanalytic orientation and fewer than 0.5% of doctoral dissertations published from this school of thought (1999). Plant yourself at the intersection of West End Avenue and 72nd Street in Manhattan's Upper West Side, walk up and down the avenue and ring a few buzzers at random, and you will get a very different impression. With more than 40 psychoanalytic institutes in the area, each with multiple training programs and affiliated research sections, the eleven months of the analytic year (August is the vacation month for New York analysts, perhaps an artifact of European origins) are filled with meetings, symposia, and conferences.

In an early article in psychiatry, Saul Rosenzweig argued against claims of significant differences between schools of thought, quoting Alice In Wonderland: "At last the Dodo said, '*Everybody* has won and *all* must have prizes'" (1936, p. 412). While this assertion has been challenged by many, the general idea that each approach offers something to the field is above reproach. While my objective here is not to argue for psychoanalysis above other approaches, I would like to make something clear: psychoanalysis is alive and well and living in New York and I feel privileged to be around to see it.

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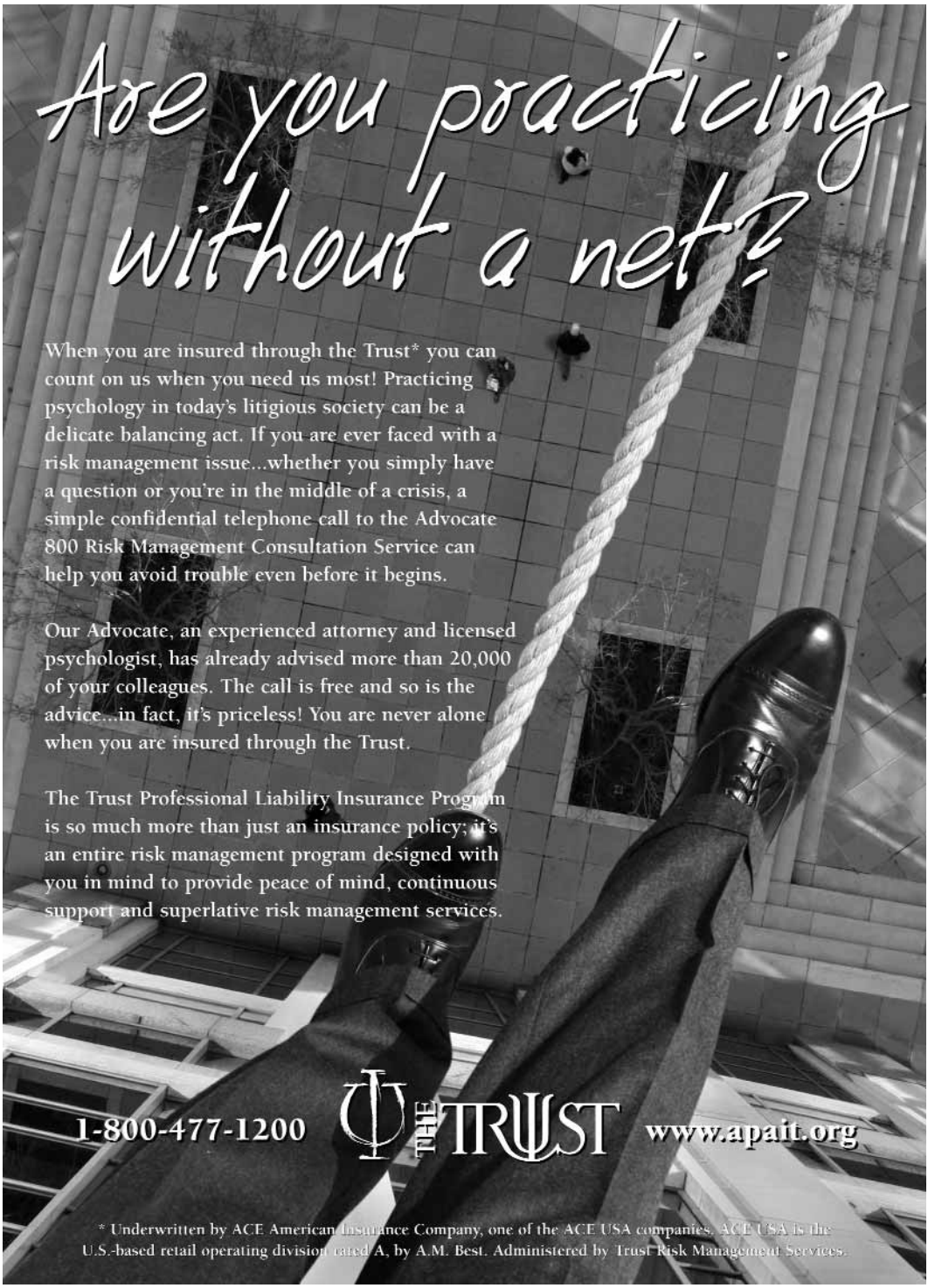
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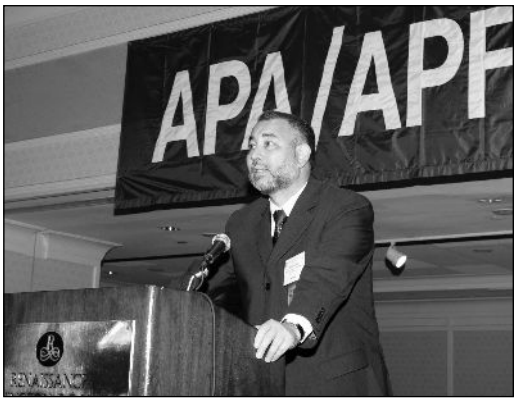
DIVISION 29 MEMBER RECEIVES AWARD

APA Award Citation 2005 for Distinguished Contributions to Independent Practice in the Private Sector or Public Sector: Edward A. Wise, Ph.D.

For his passionate examples as a true scientist practitioner, a role at the heart of psychology's identity and values, but one that is rarely fully realized. Through his practice and his research, Edward A. Wise has developed, refined and integrated assessment and treatment strategies for more than 20 years. As a practitioner, he has compassionately treated patients in multiple outpatient and inpatient settings, among other accomplishments developing an innovative and cost effective intensive outpatient treatment program. As a scientist, he has published more than 25 peer-reviewed articles with the incentives provided by a traditional academic career. As an advocate, he has advanced public acceptance of psychology. As a mentor, he has guided many fledgling psychologists. As a humanitarian, he has served the indigent and incarcerated. As a friend, he has enriched the lives of those who know him.



Edward A. Wise, Ph.D.

Dr. Wise received his B.S., cum laude, from Washington University, St. Louis, MO in 1975. He received his Ph.D. from the University of Wyoming and completed his internship at the University of Tennessee Center for the Health Sciences at Memphis in 1980. He was employed at a mental health center before establishing a multidisciplinary group practice, where he serves as the Executive Director. He was instrumental in the founding of the Division of Psychology at Methodist Hospital, Memphis, one of the largest medical-surgical hospitals in the country, where he provided individual and group therapy and performed psychological evaluations for patients with eating disorders, substance abuse, personality, and medical disorders. In addition to traditional mental health services, Dr. Wise has provided forensic evaluations for indigent offenders and contracted with state and national organizations to provide mental health services to inmates in correctional settings. He has also developed, implemented and empirically validated an Intensive Outpatient Program which operates as a hospital diversion program within his practice. He has authored over 25 peer-reviewed publications in the areas of personality assessment, psychotherapy outcomes and program evaluation. He was recently nominated for the Health Care Hero Award by the Memphis Business Journal for collaborative work with the health care and business communities. Dr. Wise is a Fellow of the Society for Personality Assessment and has served as an ad hoc reviewer for numerous journals. He currently serves on the Editorial Board of the Journal for Personality Assessment.

Congratulations from Divison 29!

RESEARCH

Improving the Quality of Care Through Practitioner Research Networks

Samuel Knapp, Ed.D., Pennsylvania Psychological Association and
Peter Keller, Ph.D., Mansfield University

One of the important demands of being a psychologist is the need to stay abreast of changing developments in the field. Although the licensing laws are designed to ensure minimal competence when psychologists enter practice, the relevant knowledge base quickly becomes obsolete. Without continuing exploration of relevant literature, consultation with colleagues, and continuing education, psychologists may rapidly fall behind. However, psychologists often lack ready access to the latest scientific findings to inform their treatment decisions.

This problem is pervasive across all health care professions. For example, medicine is continually struggling with the "translation block"—the issue of how to get physicians to learn and apply the latest research findings in their practices (Barclay, 2003). Within psychology, many commentators have noted the problem of the "practitioner-scientist split." That is, practitioner psychologists, like their practitioner physician colleagues, do not always understand and apply the latest in scientific advances in their practices.

Simple finger pointing—"if only practitioners would read the current research literature," or "if only the researchers would learn to communicate their findings in an intelligible manner"—is counterproductive. Although there may be some elements of truth to each of the accusations, mutual finger pointing ignores the complexity of the problems and does little toward generating solutions. Furthermore, finger pointing ignores the underlying fact that both psychologist practitioners and psychologist researchers implicitly share the goal of developing and implementing treatments that produce the best results for their patients.

What approaches might help address the research-practice gap? The first step is to acknowledge and clarify the problem. Practitioner psychologist Paul Kettlewell (2002) has described the obligations of practitioner psychologists to use the latest scientific findings, and also acknowledged the challenges inherent in doing so. Alternatively, some authors have called upon psychology researchers to attend more carefully to the identified needs and observations of professional psychologists (Newman et al., 1999).

We believe that the optimal solution is to promote on-going dialogue and cooperation between practitioners and researchers. Practitioners can inform researchers of the issues that are most salient to them and help formulate research questions that address practical challenges. Researchers can inform practitioners of the latest scientific evidence. One example of such cooperation and collaboration is already occurring through the Practice-Research Network (PRN) sponsored by the Pennsylvania Psychological Association (PPA). About 15 practitioner psychologists are working with researchers Thomas Borkovec and Louis Castonguay from the Pennsylvania State University in developing and implementing a research project. Through their treating psychologists, about 150 patients have participated in the study, and data analysis will begin shortly. When the project is completed, the focus and findings of this research will be described elsewhere.

The project avoids "empirical imperialism," which requires practitioners to apply protocols established by outside researchers (Castonguay, cited in Lampropoulos, et al, 2002). Instead, practitioners have been involved in every step of the process, from selecting the issue to be studied to choosing the design. The partnering scientists/advisors have relied on their research expertise to inform the practitioners of the advantages or disadvantages of these decisions. It is intended that every practitioner involved in the study will be one of the authors in the reports that emerge from the study. It is true that mere data gathering does not typically represent a sufficient enough contribution for a psychologist to be listed as an author of an article. However, these practitioner psychologists did not just collect data; they created the project, made essential design decisions, and will be involved in drafting the final report(s).

Practitioner psychologist Dr. Stephen A. Ragusea, who chaired the PRN Steering Committee and helped gather data for the project, feels great enthusiasm for this kind of collaborative research. According to Dr. Ragusea, "this is unconventional research and it presents challenges to both practitioners and researchers." Nonetheless, Dr. Ragusea states that it helps practitioners become better at delivering services and it helps researchers improve the usefulness of their research programs.

Participants also received continuing education credit for many of the planning meetings. I (SJK) have been fortunate enough to attend several of these meeting, and they are among the best continuing education programs I ever attended because I learned so much in the give and take dialogue concerning the status of outcome research.

This type of study falls under the general description of effectiveness research, as opposed to more highly controlled efficacy studies. PPA's PRN had supported a previous effectiveness study (see Borkovec, Echemendia, Ragusea, and Ruiz, 2001), and we recognize that such research has limitations. For example, these types of studies may not screen out patients with comorbid disorders or serious complications, randomly assign patients to control groups, or systematically modify the treatments offered. In this sense these studies compromise internal validity, or the extent to which one can infer that the treatments were responsible for the outcomes obtained.

Nonetheless, efficacy studies that screen patients carefully, randomly assign them to treatment groups, and carefully monitor and vary the treatments offered, may have limited external validity. That is, the extent to which the findings generalize to the real-life populations that often present complex treatment challenges may not be clear. Consequently, efficacy studies may not provide all of the information needed to make decisions about the treatment for patients with complicated needs or mixed diagnoses. From this perspective, effectiveness research conducted in the real-world clinical office is not inferior to efficacy research; it is just different.

We are convinced that effectiveness research projects have the potential to gather additional data to guide the practice of psychology. Furthermore we believe that this approach can help inform practitioner psychologists of the latest developments in scientific research. Consider what might happen if practitioner-science projects were integrated with new approaches to continuing professional education. Current models of continuing education are increasingly focused on learning by doing or participatory learning (Mazmanian & Davis, 2002). Instead of just listening to a 6 or 3-hour presentation on the status of psychotherapy outcomes, the PRN psychologists learned about the status of psychotherapy outcome studies by building upon the existing knowledge base, designing, and implementing a research program that they believed would

assist them in improving the quality of their services. Promoting collaboration between psychologist practitioners and researchers holds the potential to improve both profession learning and service delivery in powerful ways, and we encourage additional projects of this type.

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Training for Novice Therapists: Skills Plus

Clara E. Hill, Ph.D. and Robert W. Lent, Ph.D.

Training students to become therapists is at the core of our graduate programs in counseling and clinical psychology. Many programs begin by teaching helping skills, and then move on to provide individualized supervision through practica, externship, and internship. Our focus in this paper is on the initial training in helping skills, given that it sets the foundation for later experiences.

Helping skills training typically involves teaching students attending skills (e.g., listening, eye contact) and verbal skills (e.g., reflection of feelings, interpretation). These skills are designed to be taught in a systematic manner, such that instructors provide instruction about each individual skill, model appropriate implementation of the skill, allow trainees to practice using the skill in role-plays, and then provide feedback about the trainee's performance using the skill. It is assumed that teaching these skills allows trainees to examine their communication at a micro level, allowing them to learn or hone their ability to use helpful skills and at the same time eliminate problematic behaviors (e.g., interruptions, excessive talking, inappropriate self-disclosure or advice-giving). By learning helping skills and having a chance to practice during role-plays with classmates prior to seeing clients, trainees are able to focus on strengthening their own skills prior to being required to "help" a client.

Historically, helping skills training was initiated about 40 years ago by innovators such as Carkhuff (1969), Ivey (1971), and Kagan (1984), who built on Rogers' (1957) conceptualization of therapy process. Baker, Daniels, and Greeley (1990), in their meta-analysis, provided considerable support for the helping skills programs developed by both Carkhuff and Ivey, with less support for the program developed by Kagan. A number of serious methodological problems, however, limit the conclusions that we can draw from this literature (see Hill & Lent, in press). Furthermore, training has evolved since the time of the previous reviews, with trainers integrating the previous models and adding new elements. But these new programs have received minimal empirical attention.

At this point, it is a good time to step back and take a look at helping skills training to examine what is good about it and what needs improving. C. H. Patterson (personal communication, July 5, 2004) made a provocative statement that "Skill training has set back - or delayed - progress in the education of counselors and psychotherapists by more than 20 years." Our contention is that skills training as it was initially taught was quite mechanistic, in that skills were taught in isolation and outside the context of the therapeutic relationship. Researchers have suggested that the therapeutic relationship is more predictive of outcome than is skill use (e.g., Asay & Lambert, 1999, estimated that the therapeutic relationship accounted for 30% of the variance in outcome whereas techniques accounted for only 15%). Hence, we need to incorporate aspects of the therapeutic relationship into our helping skills training. More specifically, we need to teach not only skills but how to develop a therapeutic relationship and communicate the facilitative conditions (empathy, unconditional positive regard, genuineness).

Furthermore, we believe that past training and research on helping skills did not attend sufficiently to the complexity of clinical practice. For example, the idea that

reflection of feelings could be taught to introductory psychology students in less than an hour using very structured methods, as was typical in past research on the training components (see Hill & Lent, in press), greatly downplays the complexity of teaching skills in the context of the facilitative conditions.

Our goal in this paper is to present some of our ideas about helping skills training in the hope of stimulating better practice and renewed research. Our hope is to incorporate more soul, art, and compassion into helping skills training so that it is not a mechanistic enterprise but a humanistic imparting of how to relate to other people in a therapeutic manner.

Additional Components of Helping Skills Training

In conjunction with teaching the skills, there are a number of other important components of training that have not been emphasized adequately in the previous helping skills programs. Specifically, we believe that students need to learn about the following things in conjunction with helping skills: a theoretical framework, self-awareness, a facilitative attitude, responsiveness to clients, case conceptualization skills, case management skills, professionalism, and ethics. In practice, these targets are often blended together but, theoretically, it helps to describe them separately. Without these other foci of training, skills training could become mechanistic. These other components are needed to ensure that trainees become empathic, responsible, and flexible in their roles. Our sense is that these additional elements are dealt with implicitly and non-systematically in training by good trainers. Our intent here is to raise the awareness that these are key and necessary components of the training process and to encourage more systematic inclusion of them in training and in research.

Theoretical Framework

Based on our reading of the literature and our training experiences, we believe that training works best when trainees possess a credible theoretical framework or cognitive map of how the helping skills fit into the therapeutic process. For example, the three-stage model of helping (Hill, 2004) provides trainees with a very general map of how helping works (e.g., trainees learn that exploration leads to insight and action, and that the role of helpers is to facilitate clients' ability to solve their own problems). This knowledge provides a framework that helps trainees organize what they learn about the helping process and is analogous to the role of theory in psychotherapy. Similarly, Frank and Frank (1991) and Wampold (2001) proposed that one of the effective components of psychotherapy is the provision of a theoretical rationale, which allows therapists and clients to understand how the therapy process operates. To the extent that trainees agree with and value the theoretical framework they are being taught, they are probably more likely to invest themselves in learning and practicing the helping skills. We would stress, however, that the theoretical model should probably be very flexible and inclusive rather than too formalized and narrow (such as a treatment manual for a particular therapeutic approach).

Self-Awareness

We teach trainees that they are the "instruments" of the helping process. In other words, we encourage them to be aware of (a) how they react to clients (so that they know how their clients may affect other people), and (b) how their own issues might facilitate or hinder the therapeutic process (Nutt-Williams, Hurley, O'Brien, & DeGregorio, 2003; Williams, Judge, Hill, & Hoffman, 1997). Positive self-awareness relates to being aware of what is going on in the session and how one is coming across. Hindering self-awareness, on the other hand, refers to situations in which trainees become immobilized by debilitating awareness of their anxiety, self-doubt, and self-criticism. At the extreme, trainees have told us that they were not "present" in the room because they were so focused

on their own feelings. Once trainees are aware of their hindering preoccupations, they can learn to manage them in sessions through strategies such as deep breathing, positive self-talk, and refocusing on the client. During training, we strongly recommend that trainees seek personal therapy, where necessary, to increase their positive self-awareness and reduce their hindering self-awareness.

A Facilitative Attitude

In teaching all of the helping skills, trainers are not only teaching the specific skills, they are teaching trainees to respond with a facilitative attitude. Hence, they encourage trainees to respond to clients with empathy, unconditional positive regard, and genuineness, all of which are related to psychotherapy outcome (see Norcross, 2002). For example, it is not enough to give a reflection of feelings that is technically accurate in its reference to verbal content (e.g., "You feel angry because she didn't show up") but lacking in affective tone; rather, it is important to be empathic, nonjudgmental, and genuine in the delivery of the reflection.

It is difficult to describe exactly how these facilitative attitudes are communicated and even more difficult to know exactly how an attitude is "taught." Our experience has been that a facilitative attitude may be encouraged by asking trainees to try to feel what the client is feeling (perhaps via role-reversal role plays), to experience what they feel in response to the client, to ponder what might have caused the client to get to where he or she is, and to reflect upon what the client might like from a helper in the moment. In effect, we encourage trainees to empathize with their clients by searching inwardly and experiencing their own affects and then thinking about how to communicate most effectively with their clients based on these experiences.

Responsiveness to Clients

Although we can teach some general principles about helping skills (e.g., reflections of feelings are generally good to help clients get in touch with their feelings), the truth is that helping skills work differently with different clients (e.g., reflections of feelings work with some clients but not others). Essentially, we need to teach trainees to be responsive to clients' needs and preferences (Stiles, Honos-Webb, & Surko, 1998) and to be flexible and innovative (Binder, 2004) so that they can know when and how to use specific skills with different clients.

One way we think this might be taught is by encouraging trainees to look below the surface of the helping interaction. We ask them to think about their intentions for each intervention so that they can become planful and strategic in their interventions (see Hill & O'Grady, 1985). Being intentional differs from positive self-awareness in that it is focused solely on the rationale for using interventions rather than on awareness of oneself. Often, becoming aware of one's intentions requires slowing down the role-played session by watching session videotapes and thinking about why each intervention was used.

Similarly, we can teach trainees to pay close attention to client reactions (Hill, Helms, Spiegel, & Tichenor, 1988). We emphasize that clients are the ultimate arbiters of what works; hence, even though trainers tend to assume that open questions are generally helpful, they may not be for a particular client. Trainees need to observe the client carefully to see what works and what does not for each individual client. Replaying tapes of sessions can also help trainees identify client reactions.

Case Conceptualization Skills

To be responsive to clients, trainees need to understand client dynamics. As we teach the skills and have trainees practice them, we also encourage trainees to make hypotheses about client dynamics (Caspar, 1997). Hopefully, trainees have had courses that cover theories of personality, hygiology, and psychopathology and that can help

them to think about how clients developed the issues that they bring into therapy (e.g., client problems may be linked to an insecure attachment style, faulty learning about relationships, early abuse, and so forth). Thinking about case dynamics often enables trainees to be more empathic, understanding, and curious rather than blaming or judgmental. Programs, such as the one reported in Caspar, Berger, and Hautle (2004), might also be helpful in teaching case conceptualization skills.

Case Management Skills

We propose that in addition to learning the helping skills, trainees need to learn how to apply these skills in specific situations, such as beginning sessions, developing a focus, summarizing, ending sessions, referring, and terminating. The attending and verbal skills may be generally useful in all these situations, but trainees need to learn how to adapt and modify the skills to fit particular scenarios or stages in counseling.

Similarly, trainees need to learn how to manage difficult clinical situations. For example, trainees need to learn how to deal with clients who become angry with them, reluctant or resistant, seductive, manipulative, suicidal, silent, and too talkative. In such situations, trainees often "forget" their helping skills and revert to familiar extra-therapy ways of behaving. We suggest that structured training could be used to expose trainees to such client scenarios. For example, vignettes could be created in which trainees are encouraged to respond to clients expressing intense emotions or difficult dynamics (e.g., Hess, Knox, & Hill, in press). Responding to such vignettes would allow trainees an opportunity to think through their countertransference reactions, see various models of effective interactions with clients, and practice more adaptive responding.

Professionalism

Becoming a therapist is a major role shift for trainees and requires that they think about themselves and present themselves in a different way than they have previously. Rather than viewing themselves as friends who casually listen and help, they have to recognize that they are in an authority role and are ascribed power based on their position. In effect, they learn to take on the demeanor of therapists in terms of their clothing (e.g., no short shorts, bare midriff), behavior (e.g., not as much self-disclosure, less talk, focus on client rather than an equal focus, as in friendships), and boundaries (e.g., keeping to the allotted time, following standard practices for starting and stopping sessions, having limited contact with clients outside the session). These guidelines are generally taught when the trainees begin seeing volunteer or actual clients.

Ethics

Finally, we believe it is important to teach students not only which skills to use in different situations, but also to teach them to use the skills in an ethical manner. Hill (2004) discussed several ethical issues that are relevant to beginning students: confidentiality, recognizing limits, educating clients about the helping process, focusing on the needs of the client, avoiding harmful dual relationships (including dealing with sexual attraction issues), being aware of values and culture, acting in a virtuous manner, and taking care of oneself to provide better care for others.

Conclusions

We conclude that effective helping skills training invariably includes a host of issues – in addition to the skills themselves – that students need to grasp as part of the art of therapy. We believe that adding these additional variables into training helps to teach the art and preserves the humanity of the therapeutic process (see also McWilliams, 2005).

Some students have told us that it is really important to practice the skills initially, but that the skills eventually tend to recede

into the background as students become more adept at focusing on these other issues (e.g., case conceptualization). In retrospect, the skills training seems valuable to them for giving them confidence in what to do in sessions and giving them a structure and way to think about their interactions but, once the skills are mastered, they typically become second nature.

It may be that some of these additional skill or attitudinal variables may be more challenging to teach than other ones or than the more fundamental helping skills. For example, imparting an empathic attitude may be more difficult than teaching a more intellectually-oriented theoretical framework. It also seems important to continue to teach these additional skills and attitudinal variables throughout training (and as appropriate at different levels of therapist development)—rather than just at the beginning of training.

In fact, we view helping skills training as just the first step along the path toward a life-long journey of becoming a therapist. Following helping skills training, trainees go into practicum training, externships, pre-doctoral internships, and post-doctoral placements, all of which require extensive supervision. Furthermore, once students earn their terminal degrees, they "practice"— a wonderful term that indicates that perfection is never reached.

Finally, we would be remiss if we did not acknowledge the need for more and better research on helping skills training (see Hill & Lent, in press). We need to know what works in training and why (e.g., What are the best methods for training? Which methods work best for teaching different skills?). We also need to know whether the additional targets that we have proposed for training do indeed make a difference. Such research could not only improve current training practices but, more fundamentally, provide an all-important empirical basis for such practices, rather than basing them merely on tradition or authoritative fiat.

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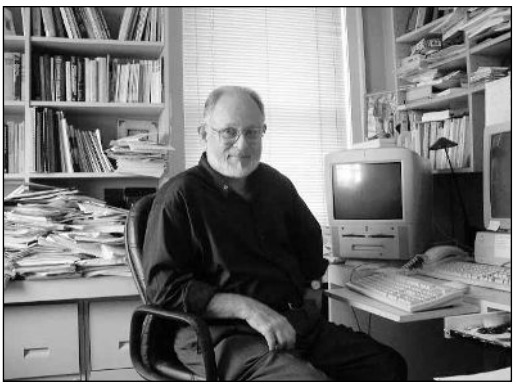
INTERVIEW

A Talk with Dr. David Orlinsky

By James Mosher, Miami University, Oxford, OH



A Brief Biography and Introduction
David Orlinsky was born in Brooklyn, N. Y. in 1936, the first child of his generation in a large extended family, and received his early education in public schools there and in Queens. At the age of 16, he followed his interests in chemistry, astronomy, and poetry to attend College at the University of Chicago, where he hoped to wed his love of poetry and science to understand human experience by pursuing a medical degree with a specialty in psychiatry. However, once at Chicago, exposure to the "great books" of writers and philosophers such as Plato, Aristotle, Dostoyevsky, Kierkegaard, and Joyce, as well as psychologists such as Freud and Piaget, turned his interest to the "psychology of creativity" (Orlinsky, 2005, p. 1003), and ultimately to a graduate degree in psychology.

Dr. Orlinsky received his Ph.D. in clinical psychology from the University of Chicago in 1962, interned at various V.A. facilities in the Chicago area, and has spent the rest of his adult life in Chicago where he commenced a remarkably distinguished and productive career. He has taught at the University of Chicago since 1960, beginning as an instructor in the College and reaching his present position as a professor in the Department of Comparative Human Development. From 1965 on he also maintained a part-time psychotherapy practice.

As a teacher, Dr. Orlinsky received the University of Chicago's Quantrell Award for Excellence in Undergraduate Teaching in 1966. As a researcher, Dr. Orlinsky mainly studied patients' and therapists' experiences in psychotherapy, publishing many articles and the book *Varieties of Psychotherapeutic Experience* with his lifelong friend and colleague, the late Dr. Kenneth Howard (Orlinsky & Howard, 1975). He also co-founded the Society for Psychotherapy Research (SPR) with Dr. Howard in 1968-69, was its first president-elect and then succeeded Dr. Howard, as its second president (Orlinsky, 1995). Dr. Orlinsky and Dr. Howard also initiated a series of often-cited reviews of research on the relation of psychotherapeutic process to outcome for the 1978 and 1986 editions of the authoritative *Handbook of Psychotherapy and Behavior Change*, which Dr. Orlinsky continued to do in the 1994 and 2004 editions as well. In 1993, Dr. Orlinsky was awarded the Distinguished Research Career Award of the Society for Psychotherapy Research, and in 1998 he was presented with the Distinguished Psychologist Award of the American Psychological Association Division of Psychotherapy in recognition of his many contributions to the field of psychotherapy research.

Dr. Orlinsky's most recent research has been done as part of the SPR Collaborative Research Network which he co-founded and has served as coordinator since 1990. This group has conducted a large-scale international study of the development of psychotherapists, and to date has collected data on approximately 8,500 therapists of

various professions, theoretical orientations and career levels in more 25 countries. This work was reported recently in two books, *How Psychotherapists Develop* (Orlinsky & Rønnestad, 2005) and *The Psychotherapist's Own Psychotherapy* (Geller, Norcross & Orlinsky, 2005).

Dr. Orlinsky is married, has two children, six grandchildren, and one great-grandchild. He lives in Chicago where still teaches and chairs the undergraduate program in Human Development at the University of Chicago, and from where he continues to write and collaborate with colleagues around the world as part of the SPR Collaborative Research Network.

Preface to a Conversation

Before recounting my conversation with Dr. Orlinsky, I would like first to step briefly out of my role as interviewer and budding journalist in order to describe my experience in doing so. I think I may communicate *who* Dr. Orlinsky is better in this than through any specific question I may have asked, or any particular answer he may have provided.

In preparing for the task of interviewing such an estimable name in psychotherapy research and psychology in general, I was filled with a mixture of awe and anxiety. As a second year graduate student in clinical psychology and one who sees himself as a still-wet-behind-the-ears tyro, who was *I* to interview this great name (several times cited in my thesis proposal)? How could my questions even begin to tap his voluminous body of research? These reflections capture but some of the tension I held as I picked up the phone to call him. However, the good-humor, kindness, and warmth that Dr. Orlinsky exuded were immediate and obvious, and the instant rapport we established disarmed any worries I may have held. It is apparent that Dr. Orlinsky is not just a great name in psychology. My feeling was that he is also a great *person*.

My Conversation with David Orlinsky

I began by asking Dr. Orlinsky to describe the Society for Psychotherapy Research (SPR), and to talk about his involvement with it. He said the idea for SPR grew out of conversations with Ken Howard, with whom he started to do research largely as a way to see one another and have fun together after finishing graduate school, where they had met and become close friends. Later Dr. Orlinsky (1995) wrote about their experiences in founding SPR, which he said seems always to have attracted extraordinarily nice people who form a supportive community, many of whom he feels fortunate to count as personal friends. Thus, SPR seems to be an organization that has been incredibly rewarding for him in many ways, and he likened it to an extended family. Dr. Orlinsky acknowledged the importance of creatively merging the personal and professional aspects of his life, noting that sometimes the best ideas emerge from good dinner and conversation with friends. He said "Doing research is like playing in a sand pile," and nothing is better than to "grab a pail and a shovel and get some friends to play with."

I then asked Dr. Orlinsky to talk about his biggest and perhaps most ambitious project to date—the development and administration of the *Development of Psychotherapists Common Core Questionnaire* (DPCCQ). Many findings were published in the recent book *How Psychotherapists Develop: A Study of Therapeutic Work and Professional Growth*, coauthored with Dr. Michael H. Ronnestad, and further studies of the DPCCQ data are currently underway. The project has been conducted by many colleagues working together in the SPR Collaborative Research Network (CRN), which is essentially a consortium of psychotherapists and researchers working that functions like a "research co-op." Dr. Orlinsky indicated the truly collaborative nature of this network, saying that those interested in the study of psychotherapists and psychotherapies around the world would be welcome to contribute their efforts and would be encouraged to draw

on the project in turn for their own studies. He said that interested colleagues and students could contact him at d-orlinsky@uchicago.edu.

Dr. Orlinsky mentioned that a recent focus of the CRN project has been to expand the sample to include more non-Western countries, in Asia (China, Korea, India, Malaysia, Japan) and the Middle East (Turkey, Egypt, Israel, Lebanon). He related how working with colleagues in these countries helped him recognize a Western cultural bias in the DPCCQ, despite (or because of) its having been carefully designed by collaborators from Europe and the U.S. for therapists of all theoretical orientations. He joked "just when we were congratulating ourselves on how well we had done" to bridge the different therapeutic subcultures, comments of Asian colleagues pointed out the decidedly individualistic tilt in certain parts of the DPCCQ. Consequently, a good deal of effort has been made to adapt both the language and the items of the survey to reflect the cultural context of the countries in which it is administered. This has included, he said, expanding concepts of therapists' treatment goals and psychotherapeutic practice to reflect the ideals of both Western and non-Western cultures.

This commitment to expanding contemporary definitions of psychotherapy and helping practices beyond the traditional U.S./European paradigm is being furthered by a recent petition Dr. Orlinsky has submitted to the SPR Executive Council to establish a special interest section on Culture and Psychotherapy. Dr. Orlinsky said he feels very optimistic about gaining approval for the petition and excited by the prospect of adding ethnographic and sociological questions, concepts, and methods to the resources on which psychotherapy research can call. He noted that psychotherapy research has been based largely on a biomedical/clinical psychological model that tends to view persons as essentially separate individual organisms rather than as participants living within and shaped by their communities and cultures.

I asked what he thought some of the issues surrounding culture and psychotherapy were, and one example he cited was the radical distinction between body and mind that became a foundation of modern Western thought after the 17th century philosopher Descartes. Because of this cultural assumption we routinely separate the spheres of physical health and mental health, and do not think, as many other cultures do, that "a person is a psychosomatic continuum." Instead "we are constantly surprised by findings that there are physiological correlates of psychological conditions," and "given our culture's materialist bias, we also tend to view those correlations in reductionist terms."

Dr. Orlinsky continued by commenting on multiculturalism within the United States. He said that colleagues in Latin America are more vividly aware of the mental health needs of underserved poor and impoverished classes, whereas in the United States modes of psychotherapy are based largely on middle class values and make assumptions about the education of clients and their capacities for reflection, introspection, and "psychological-mindedness." Thus, a disconnect between treatment modes and patient needs can sometimes leave marginalized populations without much needed services. He illustrated this by relating an anecdote of a colleague who commented that while psychotherapists often assume that "the unexamined life is not worth living," sometimes people can find that it feels like "an examined life is not worth living either."

When I noted his obvious commitment to multiculturalism and diversity in psychotherapy and its research, Dr. Orlinsky credited his affiliation at the University of Chicago, which is not in the psychology department but rather in the University's interdisciplinary department of Comparative Human Development. There, he

said, developmental, biological, and clinical psychologists work together with anthropologists, sociologists, and linguists. He said that the interdisciplinary climate of his department makes his own strong cultural emphasis seem very natural.

When asked about future CRN research, Dr. Orlinsky said that beyond expanding it culturally, he also hoped to adapt the DPCCQ to investigate psychotherapist's development in individual cases rather than the therapist's current caseload. CRN colleagues such as his coauthor Dr. Rønnestad in Oslo plan to modify the DPCCQ for use by therapy supervisors and their supervisees, adapting it to study the psychotherapist's development within the supervisor-supervisee relationship.

As our conversation concluded, Dr. Orlinsky reflected on his life and career. With his 70th birthday approaching, he said he now finds himself faced with the task of determining what goals are most important for him to accomplish in however much time remains. He noted that, "when you are young, the horizon seems far away, but now I have a sense that the horizon is very close." These musings, however, belie the aspirations of a still ambitious man who remains young-at-heart and hopes to write "one or two more books" – for some, the work of an entire career. However, Dr. Orlinsky captured these sentiments best, perhaps, when he left me with these lines from the poem "To his Coy Mistress," by 17th century poet Andrew Marvell:

Had we but world enough, and time,
This coyness, lady, were no crime.
We would sit down and think which way
To walk, and pass our long love's day.
…
But at my back I always hear
Time's winged chariot hurrying near:
And yonder all before us lie
Deserts of vast eternity.

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James K. Mosher completed his undergraduate work at Michigan State University in 2004, and is currently in his second year in the clinical psychology program at Miami University of Ohio. Jim's research interests include: harmony and discord between the psychological theories of the client and clinician in the psychotherapy of psychotherapists, the role of the therapist in clients' assimilation of problematic experiences, and clients' internalization and assimilation of the psychotherapeutic experience. Jim has been a member of the Division's Student Development Committee since the fall of 2004.

WASHINGTON SCENE

A Maturing Profession Enters The 21st Century

Pat DeLeon, Ph.D., former APA President

The Prescriptive Authority Agenda Matures: In our last column we reported on the progress of the Hawaii Psychological Association (HPA) in seeking prescriptive authority (RxP) for their colleagues working within federally qualified community health centers. During the previous session of the Hawaii legislature, HPA was successful in having the legislature enact 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. Native Hawaiian psychologist **Jill Oliveira-Berry** and former HPA President **Ray Folen** represented psychology on the task force. "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." Jill and another community health center colleague, **Robin Miyamoto**, have taken the lead legislatively, with the enthusiastic support of every one of the health center medical directors. "The Hawaii RxP bill has now been introduced for the 2006 legislative session. We have just been informed that our first hearing in the House is set for Wednesday, February 8th. This year looks particularly promising with the amount of support we have in the House. We have seven signatures as introducers and co-introducers on the bill which is another first in our RxP history. Our prime supporter in the House is a practicing primary care physician with considerable community health center experience, not to mention having served as a volunteer physician in South Africa during the AIDS and malaria epidemic of the '90s."

"House Concurrent Resolution 255 was enacted as a result of collaborative efforts by HPA, the Hawaii Primary Care Association, community health centers (CHCs), Native Hawaiian Health Systems, and other groups that supported increased access to health care for the underserved and unserved peoples of Hawaii. The mandated Task Force, comprised of two legislators, two psychologists, and two psychiatrists, met four times over the last three months of 2005. Key objectives included: 1) An exploration of access to mental healthcare in Hawaii, particularly in rural areas of the islands; and 2) Proposed models from both the Hawaii Psychiatric Medical Association and HPA to enhance services, especially for the identified areas and patient populations that experience significant barriers to mental healthcare access (i.e., primary care patient populations, the uninsured, rural communities, etc.).

"It was clear from the outset that the mental health needs of Hawaii's rural, poor, and underserved areas are severe and that the last two decades have not seen an appreciable change in this condition. Consensus was reached that there are not enough licensed mental health care providers who can prescribe to fill the need that exists. It was also evident that despite promises made over the last 20 years, psychiatry has been unable to meet the need for psychoactive medications, which all recognized is at times a critical component in mental health care.

"Psychiatry offered their ideas for models to enhance service delivery. They promised to expand their residency training program. Sadly, they barely have enough applicants to fill current positions; in fact, about 40% of all U.S. psychiatry residency positions are filled by foreign applicants. They also proposed 'soon to be established' telepsychiatry consultations with primary care docs in rural locations. The primary care physicians quickly rejected that option, though, as they barely have time to see the multitude of patients lined up in their waiting rooms, let alone take time to dial up a psychiatrist for an extended mental health consultation. The final option psychiatry proposed was to increase the number of J-1 visa (foreign) psychiatry residents. Unfortunately, the cultural and language problems associated with these foreign doctors in Hawaii's rural areas are perceived as potentially significant impediments to effective treatment.

"An examination of the promises made by psychiatry to serve the rural and medically-underutilized areas over the last 20 years was particularly illuminating. We found that the number of psychiatrists serving Hawaii CHCs has not changed in decades. In 2004, there were psychiatrists serving three of the CHCs despite the overwhelming need for behavioral health services in all 13 centers. By contrast, in the four years that Hawaii psychologists have been involved in this primary care initiative, psychologists are now employed and/or contracted to provide behavioral health services in nine of the 13 CHCs on O'ahu, Kaua'i, Moloka'i, Maui, and the Big Island. All of these psychologists have been trained to provide culturally-appropriate psychological services as well as psychopharmacological consultation.

"At the third meeting of the task force, the psychiatrists offered an alternative to their decades-old argument that: 'we have to go to medical school' to prescribe. That alternative was medical training equivalent to that received by nurses or optometrists. Interestingly, the psychiatrists' willingness to discuss this alternative deteriorated almost from the minute it was proposed and, by the start of the fourth and last meeting, they had retreated back to their original 'medical school only' position.

"The task force psychologists offered an alternative. In addition to the 7-8 years of training required to receive the doctoral degree, we proposed that primary care psychologists meet the psychopharmacology certification requirements by completing: * 500 hours of didactic training in clinical psychopharmacology and related courses; this significantly exceeds psychiatry's 50 lecture (yes, only 50 one-hour lectures!) Model Psychopharmacology Curriculum for Psychiatric Residency Programs recommended by the American Society of Clinical Psychopharmacology; * a year-long, 100 patient practicum, 100% supervised by a physician; * a two-year conditional prescribing period during which the psychologist must have concurrence by a supervising physician for every prescription written; And, * passage of the APA National Psychopharmacology Examination for Psychologists.

"Given that: * CHCs and other primary care settings serve as a 'de facto' mental

BYLAWS APPROVED BY BOARD FOR CHANGE

The two bylaws the Board approved for change are listed below with the approved changes.

ARTICLE V: OFFICERS

F. The Treasurer shall be a Member or Fellow of the Divisions, elected for a term of three (3) years. During that term, the Treasurer shall be a member of the Board of Directors with right to vote; shall oversee custody of all funds and property of the Division; shall direct disbursements as provided under the terms of these Bylaws; shall oversee the preparation of an annual budget for consideration and adoption by the President and the Board of Directors; shall make an annual financial report to and in general shall perform the usual and customary duties of a Treasurer. The Treasurer shall serve as ~~chair~~ ex officio member of the Finance Committee.

ARTICLE XI: COMMITTEES

G. Standing Committees of the Division for Psychotherapy shall be:

1. The Finance Committee, which shall consist of a minimum of three (3) members of the Division, plus the Treasurer who shall serve as ~~chair~~ ex officio member. The Finance Committee shall oversee the fiscal practices and planning of the Division, monitor its financial records, cause a final yearly audit of its annual financial activities, and aid the Treasurer in the preparation of the annual budget to be submitted for the approval of the Board of the Division.

Please indicate your acceptance or rejection of the proposed bylaws changes

Article V, Section F

❑ Accept ❑ Reject

Article XI, Section G

❑ Accept ❑ Reject

Name (Printed) _____

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health care system, non-psychiatric physicians prescribe 85% of the psychotropic medications despite their lack of training in this complex area; * CHC medical directors have observed first hand the work of psychologists working in their primary care settings and have endorsed legislative proposals for prescriptive authority for psychologists; * RxP for psychologists is a **no-cost solution** for the State of Hawaii as: a) the costs of additional training are borne by the psychologist; b) the costs to employ prescribing psychologists in the CHCs are more than covered by the Federal support under Section 330(e) of the U.S. Public Health Service Act; and c) CHC-employed psychologists are deemed 'federal employees' for the purpose of medical malpractice protection, the psychologists on the task force recommended that the legislature authorize appropriately trained psychologists, who have a professional affiliation with a Federally Qualified Community Health Center, to prescribe psychoactive medications. We also advised the legislature that we were open to any reasonable compromise."

I recently had the opportunity of participating in a most impressive HPA Primary Care Institute, which was co-sponsored by the Hawaii Primary Care Association. Former HPA President **Kate Brown** did a truly outstanding job of crystalizing for the audience the importance of psychology being actively engaged in providing primary healthcare as we collectively address the challenges (and opportunities) of the 21st century. Exciting workshops were presented by **Dan Egli** and **Susan McDaniel**. Ray and his Department of Defense colleague **Larry James** stressed the importance of integrating psychological services and of actively collaborating with a wide range of professional disciplines. Enthusiastic "calls for action" were issued by a community health center medical director who had testified on behalf of psychology during the last session of the legislature, as well as by HPA's legislative champions in the Senate and House. At one point, Dan Egli (who served on the original APA RxP task force back in the early 1990s) turned and commented that he had never seen state elected officials who understood the underlying issues so well during all his travels across the nation. I was impressed by the new faces that were in the audience; especially those of LCDR **Julie Miller** and LCDR **Erick Bacho**, U.S. Navy post-doctoral Fellows assigned to Hawaii for their Health Psychology training. Psychology's prescriptive authority quest **is** steadily advancing. And, in my judgment, it has become increasingly difficult for those who oppose this natural evolution to turn back the clock. Over the next several months, Jill and Robin fully expect that the voices of our prescribing colleagues in New Mexico, Louisiana, and the federal sector will have a demonstrably positive impact upon the Hawaii State Legislature. Psychology has unequivocally demonstrated that possessing RxP authority improves the quality of care available for our nation's citizens.

An Important Societal Consideration: One of the most rewarding aspects of working within the public policy process is the opportunity to learn from visionary colleagues, from a wide range of disciplines and professional settings. The Institute of Medicine (IOM) epitomizes this experience. In the future, our State Associations and professional journals will routinely educate their membership on the latest IOM findings and its implications for practice, research, and education. APAGS members (i.e., the next generation) will eagerly view the IOM website for updates and announcements of public hearings in their geographical area. Our senior colleagues will be elected to IOM membership; thus ensuring that psychological expertise will become an integral component of its deliberations. The unprecedented advancements

of the 21st century in the technological and communication fields make this vision possible, if not highly probable. Our nation's healthcare arena is becoming increasingly data-driven, as demanded by educated consumers and those who ultimately pay the bill. Professional accountability will become the norm. The behavioral-psychosocial-economic-cultural gradient of healthcare will be deemed to be an integral component of "quality care." Accordingly, we have been very pleased with the APA Monitor's increasing coverage of IOM deliberations, as well as the numerous references APA Past President **Ron Levant** made to their findings during his tenure in governance. It is vitally important to educate our membership regarding the dramatic changes occurring within the healthcare environment and how these will impact upon their personal and professional lives. As one of the nation's bona fide health professions, psychology has a societal responsibility to provide visionary and proactive leadership. For every profession, ready access to the most up-to-date knowledge is the key to fulfilling this special responsibility; not to mention, for the survival of its practitioners and the necessary expansion of its clinical practice.

The IOM recently released its report "From Cancer Patient To Cancer Survivor: Lost In Transition." Today there are more than 10 million cancer survivors who can be found in the places where we live, work, and play. And yet, they remain largely understudied and lost to follow-up by our scientific research and health services delivery communities. Although the concept of survivorship is not new, there are times when trends in medical science, health services research, and public health awareness converge to forge a new realization. Such may be happening with respect to survivorship research and cancer care. For many, cancer has become a chronic condition as a new generation of cancer survivors is living longer following improved access to effective screening, diagnosis, and treatments. With a risk of more than one in three of getting cancer over a lifetime, each of us is likely to experience cancer, or know someone who has survived cancer. Although some survivors recover with a renewed sense of life and purpose, what has often not been recognized is the toll taken by both cancer and its treatment – on health, functioning, sense of security, and well-being. Long-lasting effects of treatment may be apparent shortly after its completion or arise years later. Personal relationships change and adaptations to routines and work may be needed. Importantly, the survivor's health care is forever altered.

For all of us who have ever been diagnosed with cancer, for all of us who know someone with cancer, for all of us who have lost someone to cancer, for all of us who will be diagnosed with cancer in our lifetime, and the millions who will survive this diagnosis, we hope this report will forge a new era of cancer survivorship by raising awareness of the many concerns facing cancer survivors. Most importantly, the IOM wants to persuade the policy makers of the imperative to assume the large tasks ahead and ultimately to improve the care and quality of life of individuals with a history of cancer.

APA should be especially pleased with this particular IOM report, given its revolutionary vision for the integration of psychology into the generic healthcare arena. Ron's "Health Care for the Whole Person" Presidential initiative could not been more timely. "To ensure the best possible outcomes for cancer survivors, the committee aims in this report to: 1. Raise awareness of the medical, functional, and psychosocial consequences of cancer and its treatment. 2. Define quality health care for cancer survivors and identify strategies to achieve it. 3.

Improve the quality of life of cancer survivors through policies to ensure their access to psychosocial services, fair employment practices, and health insurance." Similarly, the heroic work of his Presidential initiative on the importance of Evidence-Based Practice was also enthusiastically affirmed: Health care providers should use systematically developed evidence-based clinical practice guidelines, assessment tools, and screening instruments to help identify and manage late effects of cancer and its treatment. Existing guidelines should be refined and new evidence-based guidelines should be developed through public- and private-sector efforts. The importance of psychological expertise to developing effective anti-smoking campaigns should be evident to all, as should be the potential for psychology to address the all to common symptoms of fatigue and sexual dysfunction. We should be particularly pleased with the IOM view that of particular concern for cancer survivors are the psychological effects. There may be cancer specific concerns, such as fear of recurrence, to more generalized symptoms of worry, fear of the future, fear of death, trouble sleeping, fatigue, and trouble concentrating. The pervasive uncertainty associated with cancer survival has been labeled the "Damocles syndrome." Thus, routinely assessing cancer survivors for psychosocial distress is warranted because it often exists and effective interventions are available. From a public policy perspective, it is especially nice when there is a genuine convergence of a learned profession's interests and those of the nation.

During President Bush's State of the Union address, he described an exciting future for those psychologists with vision. "Tonight the state of our union is strong, and together we will make it stronger. In this decisive year, you and I will make choices that determine both the future and the character of our country.... Keeping America competitive requires affordable health care.... We will make wider use of electronic records and other health information technology to help control costs and reduce dangerous medical errors.... (T)o keep America competitive, one commitment is necessary above all: We must continue to lead the world in human talent and creativity. Our greatest advantage in the world has always been our educated, hardworking, ambitious people, and we are going to keep that edge...." For psychology, the President's challenge is to ensure that the all important behavioral-psychosocial-economic-cultural gradient of health care becomes an integral component of society's definition of "quality care." Our former APA Presidents **Joe Matarazzo**, **Charlie Spielberger**, **Norine Johnson**, and most recently **Ron Levant** have established an important foundation. We must work together to fulfill Ron's vision of: "A day in the not too distant future when people will make appointments for psychological check-ups. At these check-ups they may address such matters as their stress level and their psychological well being, auditing their work/family life balance, their relationships, how they are caring for their children and/or aging parents, and health basics like diet, nutrition, sleep and exercise." Our active involvement in the prescriptive authority evolution and with cancer survivors and their families represents the maturation of our profession.
Aloha,

Pat DeLeon, former APA President –
Division 29 – February, 2006

PRACTITIONER REORT

Update On Health

Ron Levant, Ph.D.

Hi Folks. I had been sending periodic postings about my medical odyssey with Atrial Fibrillation (A-fib) for almost two years now, but I had not posted on this topic for awhile. I had been waiting to see what the results of my last surgery would turn out to be. I would now like to bring you up to date.

I had my third surgery on June 27th. Like the others it was a catheter ablation procedure (which is minimally invasive). It was done at the Cleveland Clinic in Oho, reputed to be the best in the US for such procedures.

The electrophysiologist (EP) was not encouraging when I met with him for a consultation in April. He had read the reports of my first two procedures and concluded that I must have "atypical A-Fib". He told me that 80% of the time A-fib arises in two areas, and those areas had been ablated in my two prior procedures. Unless the neurons in these areas had grown back (which he thought unlikely) the A-fib was originating from some other area, which could be anywhere in the atrium. The only way he'd be able to find that area was if the A-fib spontaneously started up when he was in my heart with his instruments. He left me with the impression that that was about as likely as winning the state lottery.

There was an electrical storm on Friday 6/24, the day on which my surgery was originally scheduled, and as a result there was a power outage which delayed everything for many hours. I waited around for a long while to be prepped, until the afternoon, when the nurse made me an offer I could not refuse. She told me that the EP was running way late, due to the outage plus a complicated procedure on another patient, and would likely not be able to start my procedure until after 6 p.m. on a stormy Friday evening, at the end of a very long week. Or, I could wait till Monday morning and have a fresh surgeon, and the Cleveland Clinic would pay all of our expenses for the weekend. So naturally we chose the latter option and enjoyed a nice weekend in Cleveland, my wife Carol, brother- in-law Steve, and I, going to the Rock and Roll Hall of fame and eating great dinners.

About midway through the surgery, during which I was awake, I heard the EP scream. Now this has got to be the second most frightening thing to hear when you are in surgery, the first being the surgeon saying "Oh sh.t." The nurse, sensing my concern, told me not to worry. The surgeon was very excitable and he just found the area from which my A-fib originated. Yes! It had started up spontaneously while he had his instruments in my heart, and he found the area. He spent the next hour or so making sure he got every one of those errant neurons before he finished the procedure.

Unlike the prior two procedures I had no A-fib symptoms after the operation, whereas it is expected that there will be at least some, because the heart has been irritated during the procedure.

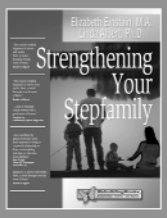
My three-month follow up was originally scheduled for September 27, but was pushed back to November 9th. For three months I transmitted EKG's telephonically and never once was in A-fib

(though I did have some periods of premature beats). The EKG, CT-scan and The Holter monitor were all good, so the EP took me of all medications and pronounced me cured.

I couldn't be more delighted! I had had A-fib for 20 months and at long last have my health and life back. This is such a terrific feeling! I could not imagine how much I would come to treasure my health before I had lost it, thankfully temporarily. I want to thank all of you for your steadfast support and prayers during this difficult period in my life.

Warmly,
Ron

Client Resources for Therapists



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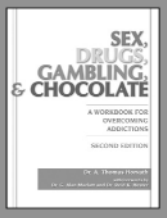

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An Integrative Perspective on the Anxiety Disorders

Barry E. Wolfe, Ph.D.

The guiding premise of SEPI and of psychotherapy integration, more generally, is that the complexities of clinical practice seem to demand an integrative approach to the treatment of many, if not most, emotional and behavioral disorders. Since the formation of SEPI in 1983, literally hundreds of books and thousands of articles have been published on the topic of psychotherapy integration (e.g., Norcross & Goldfried, 2005).

Most work in the field of psychotherapy integration has not focused on the application of an integrative psychotherapy to a specific class of disorders. Instead, the work has centered primarily on generic issues in psychotherapy integration. Consequently, several integrative models of psychotherapy have been developed that appear to be generally applicable to psychotherapy patients (e.g., Lazarus, 2005; Wachtel, Kruk, & McKinney, 2005).

More recently, however, a number of models of integrative psychotherapy have been developed for specific mental disorders (McCullough, 2005; Wolfe, 2005a). For the past two decades, I have been developing an integrative perspective on the anxiety disorders. These disorders are quite amenable to an integrative approach for the following reasons. All anxiety disorders possess a number of symptoms that are clearly observable to the therapist. These symptoms typically compel an initial focus of treatment and yet, in most cases, they are connected to tacit issues that go to the core of the patient's being. These tacit issues typically require different kinds of therapeutic interventions than those required for symptom management.

In a recently published book, (Wolfe, 2005b), I have presented an integrative perspective on anxiety disorders. By perspective, I mean two separate but interrelated models, an integrative conception of the etiology of anxiety disorders and an integrative psychotherapy. Both of these models were developed on the basis of my clinical experience, a review of the research literature, and a review and synthesis of psychoanalytic, behavioral, cognitive and experiential therapy orientations on the etiology and treatment of anxiety disorders.

The Integrative Etiological Model
This model attempts to describe the nature, development, and maintenance of anxiety disorders.

The Nature of an Anxiety Disorder
From my review of the various etiological theories of anxiety, I concluded that there is a growing theoretical convergence on the "self" as the final core locus of psychopathology. My clinical experience had taught me that every anxiety disorder is experienced as one's self in mortal danger. Each patient possesses morbidly feared unconscious catastrophes that are embedded in unacceptably painful emotions. This expectation of catastrophe to the self I call self-endangerment. Self-endangerment is consciously experienced as a sense of losing control, lacking safety, and feeling powerless. When one becomes anxious, one's attention automatically shifts away from one's immediate experience of anxiety to a more perceptually distant focus on the self as anxious. This self-focused attention (Ingram, 1990) is accompanied by self-preoccupied cogitation about the implications of being

anxious. The experience of self-endangerment, therefore, involves both the immediate experience of anxiety and cogitation about its implications.

Because of this automatic shift of attention to cogitating, the individual cannot discover the implicit or pre-conscious meaning of the anxiety. The implicit meaning of self-endangerment is that one anticipates a confrontation with an excruciatingly painful view of the self. I call these unbearably painful self-perceptions self-wounds. Self-wounds are organized tacit structures of painful self-related experiences or generalizations of such experiences stored in memory. They may be experienced directly in terms of self-diminishing feelings or conceptually in terms of negative self-beliefs. They are mostly outside the person's focal awareness but are often close to the surface. These self-wounds heavily influence an individual's decisions, choices, feelings, and actions. These painful self-views may be specific memories of traumatic, painful, or humiliating encounters a person has experienced with a significant other or they may represent a generalized view of self constructed out of a series of such painful experiences. The individual fears both the meanings of these painful self-views and the accompanying emotions such as humiliation, rage, or despair. Thus, an anxiety disorder appears to possess three nodal points: (a) the immediate experience of anxiety, (b) cogitating its catastrophic implications, and (c) the implicit meaning of anxiety or panic.

The Development of an Anxiety Disorder

While many patients may have a genetically transmitted predisposition for an anxiety disorder, this model highlights the damaging life experiences that the patient has suffered, the self-wounds that those experiences have engendered, and the ineffective "protective strategies" that are employed to prevent one from facing these wounds head-on. These damaging experiences include trauma, shaming or toxic ideas, betrayals by significant others, emotional miseducation, and ineffective responses to the realities of ordinary living.

The Maintenance of an Anxiety Disorder

An anxiety disorder appears to be maintained by a number of self-defeating cognitive, behavioral and emotional processes that automatically spring into action to protect the self-wound from exposure. These include: (a) avoidance, (b) cogitation, and (c) negative cycles of interpersonal behavior. Avoidance may be behavioral, cognitive, or affective. Cogitation prevents the individual from confronting, accepting, and healing the underlying self-wounds. Negative cycles of interpersonal behavior are interpersonal strategies that inevitably reinforce the validity of the individual's negative self-beliefs (i.e. self-fulfilling prophecies).

Applicability to Specific Anxiety Disorders

This integrative etiological model appears to be applicable to all of the anxiety disorders. The need for brevity limits my description of the model's applicability to one anxiety disorder, social phobia. Social phobias develop in a matrix of destructive, shaming hypercriticism from primary caregivers. When individuals are severely criticized for revealing a vulnerability or weakness, they are likely to internalize toxic opinions of the self. Typically these opinions suggest that individuals are defective or inferior. They produce self-wounds, which are characterized by feared self-appraisals that they are socially inadequate, unlovable, or unworthy. As a result, self-endangerment is experienced in social and public speaking situations. The associated anxiety protects the individual from painful feelings of inadequacy. The extreme humiliation is unbearable and is thus avoided by experiencing the panic/anxiety instead. The anxiety or

panic leads to an automatic shift of attention to a preoccupation with one's social limitations and with the imagined rejection from a hostile or disdaining audience. This self-preoccupation degrades social performance, and the vicious circle is then completed when the degraded social performance reinforces the feared negative self-appraisals.

The disorder is basically maintained by four separate processes: (1) the self-diminishing opinions (i.e., self-wounds), (2) avoidance of social occasions or public speaking engagements, (3) cogitating about the audience's reactions or one's flawed performance and (4) impression management, which involves behaving in ways that patients believe will bring them approbation from others. The difficulty with impression management strategies is that the behavior feels inauthentic. Typically social phobics fear several interrelated catastrophes, including being exposed as a fraud or imposter, being unacceptable or, being rejected, and losing status. Social phobics also fear the associated emotions of shame and humiliation (Wolfe, 2005b).

The Integrative Psychotherapy

The point of departure for the integrative treatment model is the evidence-based treatments for anxiety disorders. Various forms of cognitive-behavior therapy have obtained empirical support with anxiety disorders (Barlow, 2001). However, the positive benefits of these treatments are mostly confined to the management, reduction, and, rarely, the elimination of anxiety symptoms. The integrative model postulates that it is necessary to treat both the symptoms and the underlying determinants of anxiety disorders. What these studies have shown is that it is possible to achieve significant symptom relief and even the elimination of panic attacks without comprehensively treating an anxiety disorder.

The integrative psychotherapy presented here conceptualizes the treatment process in terms of four phases: (a) establishing the therapeutic alliance, (b) cognitive-behavior therapy for anxiety symptoms, (c) eliciting the tacit self-wounds, and (d) healing the self-wounds.

Phase I: Establishing the Therapeutic Alliance

Therapy with anxious patients is often characterized by a difficult beginning because of their self-protecting interpersonal style. The life histories of anxiety disorder patients are replete with experiences of betrayal, empathic failures, mistreatment, and difficulties with attachment. Thus, the negotiation of trust is typically the first task of therapy. From the first session onward, the therapist will typically encounter fears of trusting, humiliation, and of being known. The process of repairing the wounded self begins here by attempting to enhance the client's ability to trust both the therapist and him or herself, and with desensitizing the client's fear of being known. The patient's increasing ability to acknowledge and accept the therapist's trustworthiness is a major task of this first phase of therapy.

The direct experiencing of the therapist's trustworthiness indirectly contributes to the rebuilding of the patient's sense of self-efficacy. With the therapist as ally, the patient feels more confident of his or her ability to face the anxiety-inducing objects or situations, and to endure the automatically occurring anxiety. The provision of a safe relationship that is empathic, genuine, and nonjudgmental serves as a therapeutic bulwark against which the patient leans as he or she negotiates the specific therapy tasks.

Phase II: Treating the Symptoms of an Anxiety Disorder

The goals of what I call the symptom-focused treatment are to reduce the somatic symptoms of anxiety and directly

modify the catastrophic interpretations of anxiety symptoms (i.e., modifying the process of cogitating). This phase of therapy is designed to help patients achieve some control over the anxiety symptoms. Such cognitive-behavior interventions as relaxation strategies, exposure to fear stimuli, and the cognitive restructuring of conscious catastrophic thoughts serve as the primary interventions during this phase of therapy.

It is extremely important to monitor the state of the therapeutic alliance as the patient begins to carry out the phase II interventions. The introduction and implementation of these therapy techniques possess meaning for the patient in terms of his or her feelings toward the therapist. If they are presented in an authoritarian manner, for example, the patient may rebel either directly or implicitly, and may refuse to carry out the treatment or terminate it prematurely. The patient may resist the treatment because its nature or manner of presentation activates unconscious conflicts regarding authority.

Phase III: Eliciting the Tacit Self-Wounds
Once an anxiety patient achieves some measure of control over his or her anxiety symptoms, the therapy is at a decision-point. For some patients, the therapy is complete. They have received what they came for and are ready to terminate the therapy. Many other patients, however, wish to explore the roots of their anxiety and are willing to undergo a shift in therapeutic focus and technique. The therapeutic goal of Phase III is to elicit the tacit self-wounds and the feared catastrophes and emotions associated with them. The major technique employed during phase III is Wolfe's Focusing Technique, a form of imaginal exposure (Wolfe & Sigl, 1998).

The patient is first told to relax and to engage in the previously taught diaphragmatic breathing for about two minutes. During this induction process, the patient is primed to allow him or her to be open to whatever thoughts or feelings may arise during the exercise. The patient is subsequently instructed to focus all of his or her attention on the anxiety-inducing cue and simply to notice whatever thoughts, feelings, or images appear. In the case of phobias, the patient is asked to imagine the phobic object or situation. In the case of panic disorder, the patient is asked to identify the most prominent bodily sites of anxiety and to maintain a strict attentional focus on these sites. OCD patients, focus their attention on the anxiety-inducing obsessive thought. Typically, within one or two sessions, this procedure results in the appearance of several thematically related and emotionally laden images. It usually takes longer with panic-disorder patients because they have great difficulty contacting emotion-laden imagery. Despite this, however, the procedure is almost uniformly successful in eliciting the catastrophic imagery reflecting a specific self-wound.

The imagery is imbued with themes of conflict and catastrophe that the patient is helpless to prevent or terminate. These memories of self-endangerment reflect specific self-wounds. For example, memories of parental betrayal may shape a painful view of oneself as unwanted, unlovable, or unworthy, which in turn produces fears of abandonment. These memories are usually accompanied by powerful and painful emotions, which also become fear stimuli. This technique often segues into a guided-imagery procedure that allows us to explore the network of interconnected ideas, feelings, and associations that constitute the implicit meaning of anxiety.

Though focusing and guided imagery are the major techniques for eliciting self-wounds, they also may be elicited on occasion through interpretive insight-

oriented techniques. The downward arrow technique (Beck, 1995) has also being successful, on occasion, in pursuing a fear to its ultimate catastrophic end, which will reveal the specific self-wound in question. Whether one initially employs imagery, interpretation, or other cognitive techniques depends on what is determined to be the most acceptable or congenial access point for the patient. Some patients are most comfortable beginning with behavioral techniques; others prefer more cognitive interventions to start with; still others prefer insight-oriented initial work. In rare instances, patients begin with experiential or imagery-based interventions.

Phase IV: Healing the Self-Wounds

The healing of the activated self-wounds involves a variety of interventions, focused on a number of separate but interrelated goals. For self-wounds to heal, a number of processes must be set in motion, including: (a) identifying and modifying the patient's defensive interruption of his or her organismic experiencing, (b) enhancing the patient's self-efficacy or sense of agency, (c) resolving discrepancies between self-beliefs and immediate self-experiencing, (d) increasing tolerance for—and ownership of—negative affects, (e) resolution of conflicts that prevent the patient from a complete commitment to a particular self-focus, (f) the emotional processing of painful realities, (g) restructuring toxic views of the self, and (h) increasing the patient's willingness to engage in authentic relationships.

Often, this phase of therapy begins with the identification of the patient's defenses against emotional and visceral experience. This is often done in conjunction with the application of Wolfe's Focusing technique. Occasionally patients are unable to carry out this technique and the immediate therapeutic task is to understand why. Typically, one finds variations of the same theme, an intense fear of feelings. These fears are desensitized gradually, which then allows the patient to engage in the imagery techniques previously described.

The enhancement of the patient's self-efficacy actually begins with phase II, the symptomatic treatment phase. By achieving some control over their anxiety symptoms, patients begin to feel more confident and hopeful not only about "beating their disorder," but also about solving the basic difficulties of their lives. Self-efficacy increases as they begin to allow themselves to experience and accept their tacit fears and disavowed emotions.

Often, the imagery work will uncover tacit catastrophic conflicts to be resolved. Conflict resolution essentially involves the creation of a synthesis between incompatible aims. The steps involved in solving the conflict include (a) identifying the poles of the conflict, (b) employing the two-chair technique in order to heighten the experience of each pole, (c) beginning a dialogue between the two poles in an effort to create a synthesis, and (d) making a provisional decision to take specified steps toward change. Once a decision has been made regarding specific behavioral changes, the next step is to take action and allow one's immediate experience to inform patients of the results of the change steps taken. Successful outcomes from these self-fashioned choices increase the likelihood of a change in dysfunctional self-representations. As patients try to change, they will encounter the specific ways in which organismic experience is defensively interrupted, and additional work will be necessary to limit the impact of these defenses and increase patients' ability to accept their immediate in-the-moment emotions (Wolfe, 2005a).

Because this model has yet to be empirically tested, I view it as research

informed rather than evidence based (Wolfe, 2005b). The difficulties of empirically testing an integrative psychotherapy are compounded by the fact that I am in no position to mount an empirical study of the model's efficacy. One of my future goals is to stimulate interest in psychotherapy researchers who might be willing to undertake such a study. The time is overdue for evaluating integrative models of psychotherapy, including this one, to see if one of the original predictions of the psychotherapy integration movement is valid—that an integrated psychotherapy will produce more comprehensive and more durable benefits than a so-called pure-form psychotherapy (Wolfe & Goldfried, 1988).

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PSYCHOTHERAPY AROUND THE WORLD: PART I

Norman Abeles, Ph.D., Michigan State University

Before reviewing psychotherapy practices around the world in the next issue of Psychotherapy Bulletin, I would first like to highlight a number of international organizations that may be of interest to members of Division 29.

International Psychotherapy Organizations

Where can one find information about developments concerning psychotherapy from an international perspective? In addition to occasional articles on this topic in Psychotherapy, the official journal of Division 29, you can look at research articles published by the Society for Psychotherapy Research (SPR) in their journal titled Psychotherapy Research. This journal caters to an international interdisciplinary audience and encourages submissions from a range of theoretical orientations, treatment modalities and research paradigms. The website for the Society for Psychotherapy Research is www.psychotherapyresearch.org; see www.ptr.oupjournals.org for information about this journal. A list of current psychotherapy research can be accessed for free at www.3oup.co.uk/jnls/toc-mail. The Society for Psychotherapy Research also publishes a newsletter for members living in the UK. This newsletter can be accessed on the web at www.psyctc.org.

In 1991, the American Psychological Association also published an "International Review of Programmatic Studies on Psychotherapy Research" (Beutler andCrago 1991), which considered several large scale research programs in North America and Europe (i.e., Switzerland, Germany, The Netherlands, United Kingdom and Sweden). The publication also considered small scale and developing programs in France, Germany and the United States. The overarching conclusion of this review was that psychotherapy is effective; however, there was dispute about the relative efficacy of specific psychotherapy models as well as how psychotherapy was delivered (e.g., group, family and individual).

In June of 2005, the International Congress of Cognitive Psychotherapy met in Goteborg, Sweden. This congress featured Aaron T. Beck, the founder of cognitive psychology, and is supported by the International Association of Cognitive Psychotherapy (IACP). The World Congress of Psychotherapy met in Buenos Aires, Argentina in August 2005.

Originated by the European Association for Psychotherapy, the World Congress of Psychotherapy is sponsored by the World Council for Psychotherapy, which seeks to encourage debate about psychotherapy and hopes to unite psychotherapists and psychotherapy organizations. The Council was founded in 1995 and has organized three prior congresses that met in Vienna, Austria. Board members include individuals from India, Japan, China, South Africa, Cameroon, Morocco, Argentina, Australia and New Zealand as well as Europe, Latin America, and the United States.

The International Institute for the Advanced Studies of Psychotherapy and Applied Mental Health was co-founded with the Albert Ellis Institute, and is affiliated with Babes Bolyai University in Romania; the Institute provides postdoctoral training and research opportunities. From another perspective, the International Psychoanalytical Association

seeks to form new psychoanalytic groups; at present, this organization has 11,000 members in 33 countries and organizes a biennial congress. The 44th such Congress met in Rio de Janeiro, Brazil in July 2005.

Also in Brazil, the International Council of Psychologists held its annual conference from July 16-20 in 2005 in Foz do Iquacu (near the borders of Paraguay and Argentina, where the falls are more spectacular than those of Niagara Falls). On the subject of Brazil, it should be noted that Brazil has more psychologists than any country other than the United States. More information about the International Council of Psychologists can be accessed at http://icpsych.tripod.com.

For those interested in integrative perspectives and approaches, there is the International Integrative Psychotherapy Association, which was formed in April 2001. This non-profit organization facilitates international communication among therapists who utilize integrative psychotherapy approaches. The organization also helps to develop cross-disciplinary thinking and supports the professional development of integrative psychotherapists. Integrative psychotherapy takes into account a variety of approaches including psychodynamic, psychoanalytic, object relations and self-psychology. In addition it also includes cognitive, gestalt and other approaches and is based on "research-validated knowledge of normal developmental processes and theories describing self-protective defenses used when there are interruptions in normal development" (International Integrative Psychotherapy Association, 2005).

The International Society for Interpersonal Psychotherapy is based on the work of Klerman and others (Klerman & Weissman, 1993). This society aims to provide accurate information on the application of interpersonal psychotherapy for the treatment of mental health disorders.

For those interested in group therapy, there is the International Association for Group Psychotherapy (IAGP), which was founded in 1973. This worldwide organization is made up of special interest sections devoted to diverse areas that include group analysis, psychodrama, and transcultural issues. Members of this organization receive information through an annual publication called the Forum, which presents scientific and professional articles. The organization may be contacted at office@iagp.com

In 2006, the International Congress of Psychotherapy will be held in Japan, in conjunction with the Third International Conference on the Asian Federation for Psychotherapy (from August 28 to September 1 in Tokyo). You can contact the secretariat by e mail: icptj2006@the-convention.co.jp. One of the most comprehensive sites for international meetings is the APA website's International Affairs Calendar. Just click on www.apa.org/international This website also tells you about the 26th International Congress of Applied Psychology which is scheduled for Athens, Greece in July of 2006. You can also check on the International Family Therapy Association. Their World Congress will meet in Reykjavic, Iceland In October 2006. If you are interested in Forensic Psychotherapy, access the website for the International Association for forensic Psychotherapy at info@forensicpsychotherapy.com. Although there are more sites that could be referenced, the above listings give you some sampling of international meetings that focus in psychotherapy. Good hunting, and good traveling.

Jeffrey E. Barnett, Psy.D., ABPP

It's a great honor for me to be nominated to run for President-Elect of Division 29. As President I would dedicate my energies to helping make Division 29 more relevant to the needs of all psychotherapists, helping it to be the essential APA Division for psychotherapists. I will focus on the development of tangible benefits that meet the needs of our members. I will build on the work of current and past leaders to energize members and will work collaboratively with colleagues to build alliances that meet members' needs. I will focus on diversity, inclusiveness, and student/early career psychotherapist issues and needs. I will work to lead us forward through active advocacy on issues that impact psychotherapists to include evidence based practice, licensure and training issues, continuing education, insurance and managed care, ethics, and other professional practice issues. And, I will actively seek your input to guide me in these and other important areas.

My relevant experience includes being a licensed psychologist in independent practice, Board Certified in Clinical Psychology through ABPP, a Distinguished Practitioner in Psychology of the National Academies of Practice, past president of two APA Divisions and my state psychological association, and an active leader in APA governance. I am also a Professor on the Affiliate Faculty at Loyola College in Maryland. Further, I am an Associate Editor of the APA journal Professional Psychology: Research and Practice.

I hope to have the opportunity to serve you and our profession as President of the Division of Psychotherapy.

Kristin Hancock, PhD

It is an honor to be nominated for President-elect of Division 29. Psychotherapy has been a major focus of my career in several ways: (1) having been a psychotherapist in independent practice for over 20 years; (2) as a co-author of professional practice guidelines for psychotherapy; and (3) as a full-time professor of psychology devoted to the education and training of professional psychologists.

I do have leadership experience at a number of levels in the American Psychological Association. I was the first full-term President of Division 44. I have chaired three APA committees (the Committee on Lesbian, Gay, and Bisexual Concerns, the Committee on Women in Psychology, and the Committee on Professional Practice and Standards) and am the 2006 chair of the Board of Professional Affairs. In addition, I am serving my second term as a Council Representative (Division 44).

These are challenging and exciting times for psychotherapy service provision, research, and education and training. The nature and face of psychotherapy is evolving and I believe this division has a great deal to offer. We can provide effective leadership in the dissemination of information regarding the effective assessment and treatment of diverse populations, help psychotherapy practitioners better understand the significance of evidence-based practice in their work, and mentor early career psychotherapists. I would look forward to serving this division in these endeavors and working with its leaders to ensure the growth and prosperity of Division 29.

CANDIDATE STATEMENTS — Treasurer

Steve Sobelman, Ph.D.

Thank you for the opportunity to continue to serve Division 29. I am currently the Division 29 CE Chair and on the Finance Committee.

My professional life is split between two worlds—psychology and corporate America.

I have spent many years teaching, practicing, and advocating for psychology through various leadership positions. I am Past-President of Division 49 (Group Psychology and Group Psychotherapy) and Maryland Psychological Association, regularly attend the State Leadership Conference as Maryland's Federal Advocacy Coordinator, and serve on the Legislative Working Group in Maryland. I maintain a small private psychotherapy practice and was a fulltime faculty member and director of graduate programs in psychology at Loyola College in Maryland. Additionally, I was founder and clinical director of a large private mental health facility in the Baltimore Metropolitan area.

And for my other professional world….. I am the CEO of a mid-sized and growing IT company, where we specialize in software development, data warehousing, web hosting, and web design. Through my business ventures, I've had significant experience with investor relations and venture capital exploration and have learned fiscal responsibility by growing the company ceiling while being mindful of the company floor.

If elected as your Treasurer, I will bring vigilant and progressive approach to fiscal responsibility. Specifically, I believe our Division needs a prudent and realistic fiscal overhaul through the following initiatives: 1) create a working finance committee; 2) provide approaches for increasing non-dues revenue, e.g., online CE workshops; 3) provide communication with the membership through the listserv, website, and Newsletter; and 4) provide incentives for increasing membership.

I strongly believe that "if you want to get something done, give it to a busy person." I'm a busy person and will "get it done" for you. Again, thank you for your consideration and I welcome your vote.

We do not have a second candidate at press time.
Write-ins will be accepted.

CANDIDATE STATEMENTS Member-at-Large / Diversity

Jennifer F. Kelly, Ph.D.

I am honored to be considered to serve on the Board of Division 29. I believe I possess qualities and skills that make me an excellent candidate for the Board. I have been involved in various activities within APA and the Georgia Psychological Association, including current Chair of the Committee of State Leaders, Board of Professional Affairs, Council Representative from Georgia, and Federal Advocacy and Grassroots Coordinator for Georgia. Through these positions I have developed leadership skills that can be utilized in the position of member-at-large of Division 29. I currently serve as Diversity Chair of the Division and represented the division at the 2005 Education Leadership Conference, which focused on diversity. I believe the division has done an excellent job in fostering collegial relations between psychologists interested in psychotherapy, stimulating the exchange of information about psychotherapy, encouraging the evaluation and development of the practice of psychotherapy, and educating the public regarding the service of psychologists who are psychotherapists. Although I believe the division has many issues to address, it is clear that racial/ethnic diversity in membership and leadership is one key to our success and survival, in addition to other factors such as financial viability. If elected to the position, I will look at creative ways of addressing this, such as having inclusion from early career psychologists from ethnically diverse backgrounds and partnering with other groups, such as the Committee of Ethnic Minority Affairs.

Thank you for your kind consideration.

Lisa Porché-Burke, PhD

It is an honor and a pleasure to be asked to serve as member-at-large for Division 29. In many ways, Division 29 feels like home. I started my involvement in APA through the Division of Psychotherapy as a student and then became the Chair of the Ethnic Minority Affairs Committee. Having served on a number of committees within the APA governance structure including on the Council of Representatives, I am keenly aware of the myriad of issues confronting psychology in general and practitioners more specifically. We are facing hard and challenging times as a profession, and it is critical that we all come together as a discipline to develop strategies and solutions to ensure that the entire field of psychology continues to grow and prosper. Having been involved in the training and education of practicing psychologists for over twenty years, I am also keenly aware of the impact that the changes in insurance reimbursement as a result of managed care have had not only on the independent practitioner but also on our ability as a discipline to attract people to the field. I am also aware of the many challenges practitioners face as they attempt to develop interventions and treatment strategies that can be evaluated for their efficacy with a diverse population of people. If elected, I will do my best to advocate for these and other issues that affect the practice of psychology and work hard to ensure that our collective voices are heard.

Jeffrey J. Magnavita

I am pleased to be nominated to serve on the Board of Directors for Division 29. I have been actively involved in Division 29 for many years. Currently, I am the Program Chair and am eager to continue to serve on the Board. My primary professional activity for the past 23 years has been clinical practice. I have authored and edited five volumes on psychotherapy, as well as numerous professional publications. I believe in the power of psychotherapy to transform and alleviate emotional suffering; left untreated, it often adversely effects the next generation. We are currently witnessing a resurgence of interest in psychotherapy, stimulated in part by findings from neuroscience and related fields demonstrating efficacy. It is urgent that we continue to actively educate the public and inform policy makers about the benefits of psychotherapy. We are poised at a very important juncture for the future of psychotherapy. If we take advantage of the impressive advances made over the past century, we can build on the accumulated science and wisdom of our profession and work toward the provision of effective psychotherapy for those with psychological disorders. The practice of psychotherapy requires the mastery of multiple psychological domains and should not be practiced by technicians. Division 29's mission is to assure that the science and practice of psychotherapy continues to be a viable choice. I will work toward representing the members of Division 29 if I am elected, and on advancing the field of psychotherapy as an art and a science.

Michael Murphy

I would be honored and pleased to serve on the Division of Psychotherapy Board as member at large. In serving I would offer my background and experience in as an officer in other practice divisions and will bring broad perspectives on psychotherapy from my professional experience.

In service to other divisions I have worked collaboratively in governance to foster increases in membership, establish consensus on strategic goals and objectives, marshal and manage resources to both ensure a strong foundation for the organization and to accomplish its objectives. I have also learned the importance of and strategies for pursuing the difficult task of communicating with and involving members in the division's work.

I believe that I bring multiple perspectives to on psychotherapy in working with other members of governance based on my professional background. I serve as director of clinical training, teach and supervise psychotherapists in training, conduct research on factors that affect the careers and well being of psychotherapists, and work in independent practice as a psychotherapist. I have learned about the range of perspectives and the common threads that link these roles. In the process I have learned to balance what research and personal experience of the therapeutic relation contribute to our understanding.

I would value the opportunity to apply my experience in governance and multiple perspectives I have gleaned from professional roles to advance the work of our Division.

REPORT OF FEBRUARY 2006 COUNCIL

The Council of Representatives, APA's governing body, met February 17 - 19 in Washington, DC. The APA Division of Psychotherapy was represented by Drs. Norine G. Johnson and John C. Norcross.

Following are 10 highlights of Council's actions, beginning with the most significant development.

• Approved a policy statement that affirms that admission to licensure as a psychologist requires sequential, organized, supervised professional experience equivalent to two years of full-time training. One of those years should include a predoctoral internship, but in an important change, the other year of supervised experience can be completed either prior to or subsequent to the granting of the degree. In other words, APA policy no longer requires a postdoctoral year of supervised experience for licensure. Of course, each jurisdiction controls its own licensure requirement, but this policy change encourages state boards to petition for removal of a postdoctoral year of supervised practice. Graduate students and early career psychologists had advocated for the passage of this policy, and your Council Reps were strongly supportive of the change.

Here is the specific language of the new policy: *The American Psychological Association affirms the doctorate as the minimum educational requirement for entry into professional practice as a psychologist. The American Psychological Association recommends that for admission to licensure applicants demonstrate that they have completed a sequential, organized, supervised professional experience equivalent to two years of full-time training that can be completed prior or subsequent to the granting of the doctoral degree. For applicants prepared for practice in the health services domain of psychology, one of those two years of supervised professional experience shall be a predoctoral internship. The American Psychological Association affirms that postdoctoral education and training remains an important part of the continuing professional development and credentialing process for professional psychologists.*

• Supported, in adopting these policy statements, development of competency goals in the professional education of psychologists. That is, the profession needs to better define and ensure quality in practicum training.

• Received a report from Chief Executive Officer Norman Anderson regarding plans for the 2006 annual convention in New Orleans. He emphasized the adequacy of facilities, safety, and medical services and noted that holding the convention in New Orleans allows psychologists to contribute to its rebuilding.

• Heard APA President Gerry Koocher outline the three foci of his presidential year and his programming for the APA convention, including scheduled presentations by Bill Crosby, Ed.D., and Phil McGraw, Ph.D.

• Participated in breakout sessions designed to enhance multicultural sensitivity in APA governance and to develop skills to address racist comments.

• Voted to accept a $101 million 2006 budget, with an anticipated surplus. This follows a very successful 2005 financial year featuring a $5.5 million surplus. (Not raising dues in 2007 was raised by your Council reps)

• Approved the establishment of a new Division of Trauma Psychology, but rejected the establishment of a Society for Human-Animal Studies.

• Funded a series of conferences and task forces: National Conference on Training in Professional Geropsychology; Task Force on Training Issues for Graduate Students with Disabilities in Testing & Assessment; Task Force on Guidelines for Assessment & Treatment of Persons with Disabilities; Task Force on the Sexualization of Girls; Task Force for Increasing the Number of Quantitative Psychologists; Task Force on Gender Identity, Gender Variance, and Intersex Conditions; and Task Force on Mental Health and Abortion.

• Adopted several resolutions as APA policy, notably the Resolution on Prejudice, Stereotypes and Discrimination, and the Resolution on Drug Abuse Treatment to Prevent HIV among Injecting Drug Users.

• Invited members of four ethnic minority psychological organizations to serve as formal observers of Council.

In addition, we submitted a new business item entitled Reclaiming Recognition of Psychology, which follows our recently approved Division 29 policy on the topic. We are increasingly concerned that generic terms are being used to describe the health-care activities of psychologists. As a consequence, the profession of *psychology* is losing its distinctive connotation, being confused with subdoctoral mental health professions, and being indiscriminately lumped together with services of unknown effectiveness performed by generic "therapists."

Our motion is that authors of APA communications and publications should be strongly encouraged to use the terms "psychology," "psychological," and "psychologists" when referring to the activities of psychologists. Specifically:

1) Avoid use of generic terms (e.g., clinician, intervention, therapy, assessment) in professional communications when referring to psychologists and psychological activities.
2) Use generic terms only as necessary in public information publications to introduce concepts to consumers. Use "psychological" terms in subsequent references as often as possible.
3) Employ generic terms in only those situations referring to the activities of members of multiple mental health professions.
4) Adopt brand recognition of psychology; for example, "psychotherapy" in place of "therapy," "psychological disorder" in place of "disorder," "psychological assessment" or "neuropsychological assessment" (as appropriate) in place of "assessment," "psychological treatment" in place of "treatment," and "psychological counseling" in place of "counseling."
5) Use the legally protected terms of "psychology" and "psychologists" when so indicated.

The aim of our motion is to reclaim the distinctiveness of the term *psychology*, not to be divisive with fellow health-care professions. Of course, in other contexts outside of APA, such as clinical work, psychologists may well use generic terms.

Thank you for your support in our representation of the Division of Psychotherapy in APA governance. As always, please keep us informed of matters that you want Council to address.

John C. Norcross, Ph.D. (norcross@scranton.edu) & Norine G. Johnson, Ph.D. (norinej@aol.com)

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