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BULLETIN

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Division of Psychotherapy ■ 2006 Governance Structure

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Abraham W. Wolf, Ph.D.
MetroHealth Medical Center
2500 Metro Health Drive
Cleveland, OH 44109-1998
Ofc: 216-778-4637 Fax: 216-778-8412
E-Mail: axw7@cwru.edu

President-elect
Jean Carter, Ph.D.
5225 Wisconsin Ave., N.W. #513
Washington, DC 20015
Ofc: 202-244-3505
E-Mail: jcarterphd@aol.com

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3625 North Paulina
Chicago, IL 60613
Ofc: 773-755-0833 Fax: 773-755-0834
E-Mail: arcerbone@aol.com

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Jan L. Culbertson, Ph.D., 2004-2006
Child Study Center
University of Oklahoma Health Sciences Center
1100 NE 13th St
Oklahoma City, OK 73117
Ofc: 405-271-6824, ext 45129
Fax: 405-271-8835
E-Mail: jan-culbertson@ouhsc.edu

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Leon VandeCreek, Ph.D.
117 Health Sciences Bldg.
School of Professional Psychology
Wright State University
Dayton, OH 45435
Ofc: 937-775-4334 Fax: 937-775-4323
E-Mail: Leon.Vandecreek@Wright.edu

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6444 East Hampden Ave., Ste D
Denver, CO 80401
Ofc: 303-753-9258,or 303-526-1101 Fax: 303-753-6498
E-Mail: JGBENEDICT@aol.com

James Bray, Ph.D., 2005-2007
Dept of Family & Community Med
Baylor College of Med
3701 Kirby Dr, 6th Fl
Houston, TX 77098
Ofc: 713-798-7751 Fax: 713-798-7789
E-Mail: jbray@bcm.tmc.edu

Irene Deitch, Ph.D., 2006-2008
Ocean View-14B
31 Hylan Blvd
Staten Island, NY 10305-2079
Ofc: 718-273-1441
E-Mail: ProfID@AOL.COM

Charles Gelso, Ph.D., 2005-2006
University of Maryland
Dept of Psychology
Biology-Psychology Building
College Park, MD 20742-4411
Ofc: 301-405-5909 Fax: 301-314-9566
E-Mail: Gelso@psyc.umd.edu

Alice Rubenstein, Ed.D., 2004-2006
The Park at Allens Creek
160 Allens Creek Road
Rochester, NY 14618
Ofc: 585-271-5940 Fax: 585-271-3045
E-Mail: akr19@aol.com

Libby Nutt Williams, Ph.D., 2005-2007
St. Mary's College of Maryland
18952 E. Fisher Rd.
St. Mary's City, MD 20686
Ofc: 240-895-4467 Fax: 240-895-4436
E-Mail: enwilliams@smcm.edu

APA Council Representatives
Norine G. Johnson, Ph.D., 2005-2007
13 Ashfield St.
Roslindale, MA 02131
Ofc: 617-471-2268 Fax: 617-325-0225
E-Mail: NorineJ@aol.com

John C. Norcross, Ph.D., 2005-2007
Department of Psychology
University of Scranton
Scranton, PA 18510-4596
Ofc: 570-941-7638 Fax: 570-941-7899
E-Mail: norcross@uofs.edu

COMMITTEES AND TASK FORCES

COMMITTEES

Fellows
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Phillips Graduate Institute
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Encino, CA 91316-1509
Ofc: 818-86-5600 Fax: 818-386-5695
E-Mail: lpburke@pgi.edu

Membership
Chair: Rhonda S. Karg, Ph.D.
Research Triangle Institute
3040 Cornwallis Road
Research Triangle Park, NC 27709
Ofc: 919-316-3516 Fax: 919-485-5589
E-Mail: rkarg@rti.org

Student Development Chair
Adam Leventhal, 2006
Department of Psychology
University of Houston
Houston, TX 77204-5022
Voice: 713-743-8600 Fax: 713-743-8588
E-Mail: aleventhal@uh.edu

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Education & Training
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Georgia School of Professional Psychology at Argosy University/Atlanta
980 Hammond Drive, Ste. 100
Atlanta, GA 30328
Ofc: 770-407-1018 Fax 770-671-0476
E-Mail: jbinder@argosyu.edu

Continuing Education
Chair: Steve Sobelman, Ph.D.
Department of Psychology
Loyola College in Maryland
Baltimore, MD 21210
Ofc: 410-617-2461
E-Mail: sobelman@loyola.edu

Diversity
Chair: Jennifer F. Kelly, Ph.D.
Atlanta Center for Behavioral Medicine
3280 Howell Mill Rd. Suite 100
Atlanta, GA 30327
Ofc: 404-351-6789 Fax: 404-351-2932
E-mail: jfkphd@aol.com

Program
Chair: Jeffrey J Magnavita, Ph.D.
Glastonbury Psychological Associates
300 Hebron Ave., Ste. 215
Glastonbury, CT 06033
Ofc: 860-659-1202 Fax: 860-657-1535
E-Mail: magnapsych@aol.com

Psychotherapy Research
Chair: William B. Stiles, Ph.D.
Department of Psychology
Miami University
Oxford, OH 45056
Voice: 513-529-2405 Fax: 513-529-2420
E-Mail: stileswb@muohio.edu

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John C. Norcross, Ph.D., 2002-2007
Department of Psychology
University of Scranton
Scranton, PA 18510-4596
Ofc: 570-941-7638 Fax: 570-941-7899
E-mail: norcross@scranton.edu

Lillian Comas-Diaz, Ph.D., 2002-2007
Transcultural Mental Health Institute
908 New Hampshire Ave. N.W., #700
Washington, D.C. 20037
cultura@erols.com

Raymond A. DiGiuseppe, Ph.D., 2003-2008
Psychology Department
St John's University
8000 Utopia Pkwy
Jamaica , NY 11439
Ofc: 718-990-1955
DiGiuser@STJOHNS.edu

Nadine Kaslow, Ph.D., 2006-2011
Grady Hospital
Emory Dept. of Psychiatry
80 Jesse Hill Jr. Dr.
Atlanta, GA 30303
Ofc: 404-616-4757 Fax: 404-616-2898
Email: nkaslow@emory.edu

Alice Rubenstein, Ed.D., 2000-2006
Monroe Psychotherapy Center
20 Office Park Way
Pittsford, NY 14534
Ofc: 585-586-0410 Fax 585-586-2029
akr19@aol.com

George Stricker, Ph.D., 2003-2008
Institute for Advanced Psychol Studies
Adelphi University
Garden City, NY 11530
Ofc: 516-877-4803 Fax: 516-877-4805
stricker@adelphi.edu

Psychotherapy Journal Editor
Charles Gelso, Ph.D., 2005-209
University of Maryland
Dept of Psychology
Biology-Psychology Building
College Park, MD 20742-4411
Ofc: 301-405-5909 Fax: 301-314-9566
Gelso@psyc.umd.edu

Psychotherapy Bulletin Editor
Craig N. Shealy, Ph.D., 2004-2006
Department of Graduate Psychology
James Madison University
Harrisonburg, VA 22807-7401
Ofc: 540-568-6835 Fax: 540-568-3322
shealycn@jmu.edu

Internet Editor
Bryan S. K. Kim, Ph.D., 2005-2007
Counseling, Clinical, and School Psychology Program
Department of Education
University of California
Santa Barbara, CA 93106-9490
Ofc & Fax: 805-893-4018
bkim@education.ucsb.edu

Student Website Coordinator
Nisha Nayak
University of Houston
Dept of Psychology (MS 5022)
126 Heyne Building
Houston, TX 77204-5022
Ofc: 713-743-8600 or -8611 Fax: 713-743-8633
nnayak@uh.edu

PSYCHOTHERAPY BULLETIN

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

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

DIVISION OF PSYCHOTHERAPY (29)

Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net

www.divisionofpsychotherapy.org

DIVISION OF PSYCHOTHERAPY
American Psychological Association
6557 E. Riverdale
Mesa, AZ 85215

www.divisionofpsychotherapy.org

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6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

EDITOR
Craig N. Shealy, Ph.D.

CONTRIBUTING EDITORS

Washington Scene
Patrick DeLeon, Ph.D.

Practitioner Report
Ronald F. Levant, Ed.D.

Education and Training
Jeff Binder, Ph.D.

Psychotherapy Research
William Stiles, Ph.D.

Student Feature
Adam Leventhal

STAFF

Central Office Administrator
Tracey Martin

Website

www.divisionofpsychotherapy.org

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PRESIDENT'S COLUMN

Abe Wolf, Ph.D.

Psychotherapy as Clinical Science

Working in the Department of Psychiatry of a large county hospital for over 25 years has broadened my perspective on how research affects practice. The questions psychotherapists struggle with do not differ that much from those of our colleagues in primary care. How do we translate research into practice? What is the role and value of the treatment relationship versus specific interventions? How much can we rely on our own clinical experience in making treatment decisions versus evidence-based guidelines? How do we train students as competent and knowledgeable professionals and caring healers?

The distinction used in medicine between basic versus clinical science is very useful. Basic science pursues knowledge about diagnosis and treatment by studying fundamental biomedical processes, primarily through laboratory work. Clinical science seeks to understand diagnosis and treatment through studies of people in clinical settings. Clinical science assumes that there is a hierarchy of evidence ranging from systematic literature reviews to randomized clinical trials to case studies. The *New England Journal of Medicine* routinely uses case studies as teaching tools. Letters to the editor of medical journals are full of clinicians challenging studies by citing their own clinical experience. While there is a serious lag in translating clinical research into medical practice, there is usually no active resistance to research informing practice.

The relationship between psychotherapy researchers and practitioners has been more adversarial. While the Boulder model advocates the ideal of the scientist-practitioner, the tension between science and practice is just too difficult for most psychotherapists to contain. Many psychotherapy researchers are deeply entrenched in a methodology that relies on a model of randomized clinical trials as the only standard to prove that psychotherapy works. In contrast, practitioners with many years of practice doing both short -and long-term psychotherapy rely on the hard won knowledge gained from personal therapy, careful listening to patients, and working through their own countertransference issues. They are indignant and alarmed that research findings are summarized in systematic reviews that glibly prescribed practice guidelines.

There are those that see psychotherapy as a clinical science. Recent books edited by Division 29 members advocate for a wide range of clinical evidence in evaluating the effectiveness of psychotherapy and for the use of evidence-based principles rather than evidence-based techniques. These books are:

John Norcross, Larry Beutler, and Ron Levant—*Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*

Louis Castonguay and Larry Beutler—*Principles of Therapeutic Change that Work*

Carol D. Goodheart, Alan Kazdin, and Robert Sternberg—*Evidence-Based Psychotherapy: Where Practice And Research Meet*

At a time when psychotherapy researchers and practitioners live on a fault line with periodic shake-ups and rumblings, these works by our members seek to foster a stabile environment for constructive work.

A major function of the Division of Psychotherapy is to contain the conflicting and contradictory views in psychotherapy.

The program organized by Jeff Magnavita, our Program Chair for the 2006 annual APA convention, strives for this "holding environment." The following list gives you some idea of the range of topics that will be addressed this summer in New Orleans:

- Current Developments in the Cognitive Neuroscience of Psychotherapy
- Empirically Supported Treatment for Personality Disorders
- Research on Anger Treatments
- Insight in Psychotherapy
- What do you do when you hate your patient?

We hope that you will add your voice to the ongoing conversation on the theory, research, and practice of psychotherapy that defines and distinguishes Division 29 by attending these programs.

The field of psychotherapy faces challenges from without and within. The leaders of Division 29 are working hard to create an organization that contains the wide range of voices of all psychotherapists and that can move into effective action to meet the challenges of a health-care economy in disrepair. We look forward to your continued support and active participation in our division.

DELAY IN JOURNAL DISTRIBUTION

The Publication and Communications Office of the American Psychological Association regrets any inconvenience to the members of the Division of Psychotherapy due to the delay in the distribution of the Winter 2005 and Spring 2006 issues of *Psychotherapy: Theory, Research, Practice, Training*. Although the journal editor sent the contents of the issues to the APA office in a timely manner, the implementation of a new production process caused unacceptably long delays within our office. These problems have been corrected, and the overdue issues have been distributed. Thank you for your patience and continued support of Division 29.

Gary R. VandenBos, Ph.D.
Executive Director of Publications and Communications
American Psychological Association

A WORLD OF PSYCHOTHERAPY

Part II—Psychotherapy Around the World: A Sampler

Norman Abeles, Ph.D., Michigan State University

Editor's Note: This article is the second of two regarding psychotherapy practices around the world (for the first article, see Psychotherapy Bulletin, 2006, Vol. 41, No. 1). In the current article, Dr. Abeles highlights psychotherapy practices, policies, research, and conferences in a sample of countries around the world, and provides context and references for further information and reading.

Psychotherapy in Africa

Statistics from South Africa indicate that about 25% of patients going to a general medical practitioner suffer from mental health problems; 20% of high school students think about harming themselves; between 1-3% of the population in South Africa has emotional problems that are severe enough to require hospitalization (Mental health in South Africa, 2005). Partly in response to data like these, the World Health Organization (WHO) is working on a "Global Mental Health Policy Project," which is designed to strengthen mental health and substance abuse policies within a number of African countries. The WHO cites mental health in Uganda as a challenge for research, and suggests that this country could be a test case since conditions in Uganda could easily generalize to other countries in Africa. The aim of this pilot project will include three phases. The first phase will include data collection concerning mental health (psychiatric) needs, with particular focus on services to the rural poor, including women, children, and orphans. The second phase will include self-guided training and classroom training with technology assisted "e-learning". There will be focus on training primary care providers that will diagnose and treat mental disorders in primary care settings. The third phase will include an evaluation of the data related to Ugandan mental health needs and there will be an effort to see if the Ugandan findings will be generalizable to other sub-Saharan countries. With regard to institutions and personnel for this project, there are plans for a consortium that will work with the Africa Telehealth group to study mental health needs. Personnel will include professional staff that have been trained in all aspects of health services research (African Mental Health project, 2005).

There is a strong presence of psychoanalysis in Africa, which is described in an article in the *Journal of Psychology in Africa* (Peltzer & Reichmayr, 1999). While psychoanalysis in Africa may sound counterintuitive, the authors of this journal article point out that psychoanalysis is alive in South Africa, Senegal and some North African countries. The presence of psychoanalysis in South Africa is frequently attributed to an influx of German speaking immigrants who moved there to escape fascism in Europe. There have been plans to form a psychoanalytic group in South Africa, which was the residence of French psychoanalyst, Marie Bonaparte. Fritz Perls, the founder of Gestalt therapy, was trained in psychoanalysis and also lived in South Africa from 1933 to 1946. The time of apartheid in South Africa deterred further development of psychoanalysis until a psychoanalytic study group was founded in 1979 (Peltzer & Reichmayer, 1999). It should also be noted that Mary Ainsworth wrote on attachment theories while in Uganda; some professionals were also trained in Kenya in the 1980's. In the 1990's there were a number of clinical psychologists and psychiatrists who practiced psychotherapy in Africa and some of them utilized psychoanalysis. There are psychotherapy societies in Nigeria and there is

an African Chapter of the World Council for Psychotherapy.

Psychotherapy in Latin America

There is a strong presence of psychotherapy in Latin America. The World Congress for Psychotherapy which met in Buenos Aires in August 2005 is one of many Latin American psychotherapy organizations. Osvaldo Filidoro warned about converting psychotherapy into psychology or psychiatry at the meeting of the Latin American Federation of Psychotherapy in Quito, Ecuador in 2001. He views psychotherapy as an art or ability formulated as a science determined by an empirical field of observation (p 3). Filidoro regards language as an obstacle and wonders how we can even attempt to obtain uniform criteria for a definition of psychotherapy when there are countries that have more than twenty-three languages which "cohabitate under the roof of the Spanish language" (p 6). He notes that the instability of political regimes causes a source of existential insecurity for Latin American societies and individuals. He insists that psychotherapy in Latin America is not tied to any dominant school of therapy. The Pan American Health Organization (PAHO) estimates that by the year 2010, 35 million Latin Americans will suffer from depression and 5.5 million will suffer from schizophrenia. PAHO recognizes that there is a need to do away with large mental hospitals and shift treatment to the communities but there is recognition of the gap between what is known and what is being done (International Development Bank, 2005).

Psychotherapy is alive and well in Brazil. A recent article (DeMello, Myczcowisk, & Menezes, 2001) reports on a random controlled trial concerning the efficacy of interpersonal therapy plus medication compared to routine clinical management plus medication (moclobemide) for 35 dysthymic patients. The 7th International Congress on body psychotherapy took place in Sao Paolo, Brazil in October 2005. Body Psychotherapy goes back to the work of William Reich and involves a range of techniques including touch, movement and breathing. Gestalt therapy, transactional therapy, psychoanalytic therapy, psychodynamic therapy, and cognitive therapies are also frequently used by practitioners in Brazil. In an article on psychotherapy in Brazil written by Stubbe (1980), he notes that there are a variety of Brazilian psychotherapy methods that range from Indian medicine to spiritualism to scientific founded psychotherapy. I suspect if we search thoroughly enough we can also find comparable non-empirically supported therapies in the United States.

Psychotherapy in Australia and New Zealand

1987 saw the founding of the Australia and New Zealand Association of Psychotherapy (ANZAP). This association was an outgrowth of the psychotherapy program at the University of Sydney's psychotherapy unit at Westmead Hospital in Sydney, Australia. The ANZAP publishes a bulletin, provides a course in adult psychotherapy, and provides post-graduate supervisor-training programs (ANZAP, 2005). In 1998, the Psychotherapy and Counseling Federation of Australia was established. This organization serves as an umbrella association for a number of professional groups in Australia. There is also an active Australian Counseling Association (ACA) that deals with standards and helps to provide recognition for counselors. Currently there are about 2500 members in the ACA. This organization has worked to develop a register of counselors, therapists, and psychologists who are willing to provide therapy for victims of the recent tsunami. Volunteers will need to carry their own liability insurance, and are sought to provide both crisis and long-term counseling to victims.

There are numerous other associations that represent various disciplines in Australia. The Association of Cognitive and Behavior Therapy held its 28th Annual conference in 2005. The Victoria Association of Psychoanalytic Psychotherapists recently presented an introduction to analytically oriented

group therapy. Another seminar by this group dealt with forensic psychotherapy and an understanding of the criminal mind. In addition to these groups are the Australian and New Zealand Psychodrama Association, Australian and New Zealand Society of Jungian Analysts, and Gestalt Australia and New Zealand organization.

The association that regulates therapy in New Zealand is the New Zealand Association of Psychotherapists. Australia has psychologist registration boards in the various states and territories that set requirements concerning issues like the use of the term "psychologist." In general, four years of academic study in psychology and two years of additional postgraduate training or two years of supervised experience are the prerequisites for becoming a psychologist. The New Zealand Association of Psychotherapists sets standards and provides expectations for the practice of psychotherapy in New Zealand. Admission to membership requires a structured training program in therapy or counseling plus the equivalent of two years full-time practice.

Previously psychotherapy health care coverage (including psychoanalysis) provided by psychiatrists was unlimited in Australia while limits existed in New Zealand (Gabbard & Lazar, 1997). This was cited to demonstrate that unlimited psychotherapy care in Australia actually cost 44% less than it did in New Zealand because of their reliance on inpatient psychiatric hospitalization. I do not have current statistics on this topic, and I doubt if unlimited outpatient mental health care is available anywhere in the world. However, please contact me if our readers know of a place where unlimited psychotherapy costs are reimbursed.

With regard to scope of practice, clinical psychologists in New Zealand require a master's degree or its equivalent plus an approved practicum or internship which lasts 1500 hours or more. In Australia there is a six year training program leading to an accredited professional psychology degree; additional internship activities are also included. Much of the professional training in Australia and in New Zealand occurs doing the first four years of college. This is contrasted by the United States, where professional training does not occur until after a bachelor's degree has been earned.

Psychotherapy in Asia—Japan and Singapore

The third International Conference of the Asian Federation for Psychotherapy takes place from August 28 to September 2006 in Tokyo, Japan. This conference will be held in conjunction with the International Congress of Psychotherapy. The conference will be under the auspices of the Japanese Psychological Association, Japanese Society of Psychiatry, Association of Japanese Clinical Psychology, and Komazawa University. Twenty-four academic societies will have international symposia and/or workshops. Concurrent meetings of six psychotherapy societies will include the Japanese Society of Transactional Analysis, and the societies of hypnosis, autogenic therapy, transpersonal psychology/psychiatry, rational therapy, and existential therapy.

A less familiar practice called Morita Therapy, which was developed by the Japanese psychiatrist Shoma Morita in the early 1900's is also practiced in Japan. Originally designed for anxiety problems in Japan, it is now practiced in the United States and workshops have been given in Germany and France. The aims of Morita Therapy include the following: being able to accept less desirable feelings and traits as part of one self, being able to interact effectively with the world outside and pursuing ones goals even with symptoms (Morita Therapy, 2005). Advocates of Morita Therapy believe that the total elimination of symptoms may be undesirable and probably not realistic because to do so would eliminate our humanity and individuality. Proponents of this believe that people need to live with painful symptoms. Morita Therapy focuses on the here and now, openness to sensory experience,

the ability to cope with reality, and the need to accept ourselves. Dr Morita expressed the viewpoint that living life fully requires the development of a balance between concern for self-preservation and self-development.

Methods of Morita Therapy can include periods of bed rest and isolation before counseling begins. This is possible in Japan because patients can obtain inpatient treatment. In the United States, many view Morita Therapy as occurring on an outpatient basis where the focus is on providing educational means for overcoming self-imposed limitations. Morita Therapy advocates have claimed that this approach has successfully treated individuals who suffered from depression, severe illnesses, eating disorders, obsessive-compulsive disorders, and psychosomatic problems.

The *British Psychiatric Bulletin* (Kang, 2001) discussed the history of psychotherapy training in Singapore and noted that a small number of psychiatrists provided psychotherapy training in the 1980's in 1990's. These psychiatrists were trained in behavioral or psychodynamic methods. In 1997, psychologists and psychiatrists formed the Association of Group and Individual Psychotherapy. This coincided with the development of the Psychotherapy Training Program by the Department of Psychological Medicine at the National University Hospital. In 1998, external visitors from the United Kingdom provided training for mental health personnel. These developments resulted in a move to provide a graduate diploma in psychotherapy that included both medical and non-medical professionals as trainees and supervisors. Not surprisingly there were more applicants for this program than had been accepted. The article points out that many Asian societies still view psychotherapy as a "Western invention" (p 3) and it is noted that in Korea there were attempts to relate psychoanalysis to Confucian philosophy.

Singapore has an active psychological society and the recent meeting of the International Association of Applied Psychology (IAAP) testifies to this. The society recognizes international criteria for the use of titles like clinical psychologist, counseling psychologist, educational psychologist, occupational psychologist, and industrial/ organizational psychologist. The Singapore Psychological Society regards licensed members or our APA as meeting their title requirements. Additionally, qualified members of the Australian, British, and Hong Kong Psychological Societies are also recognized and can practice in Singapore. Full members of the Singapore Psychological Society who do not meet the international criteria can be assumed to have sufficient professional skills if they have relevant academic and supervised experience.

Final Comments

In this article, I have tried to provide the readers of our bulletin with an introduction to psychotherapy in an international context by discussing various groups and organizations relevant to psychotherapeutic practice. I also provided a sampling of somewhat less known (as far as psychotherapy is concerned) places in the world and briefly discussed issues relevant to the practice of psychotherapy. Note that I provided a subtitle, "a Sampler," to indicate the selective nature of this discussion. I chose material that particularly interested me and acknowledge that it might not be readily familiar to some of my colleagues. Should there be sufficient interest, I will follow up with discussions of psychotherapy relevant to other areas of the world. Feel free to contact me at abeles@msu.edu.

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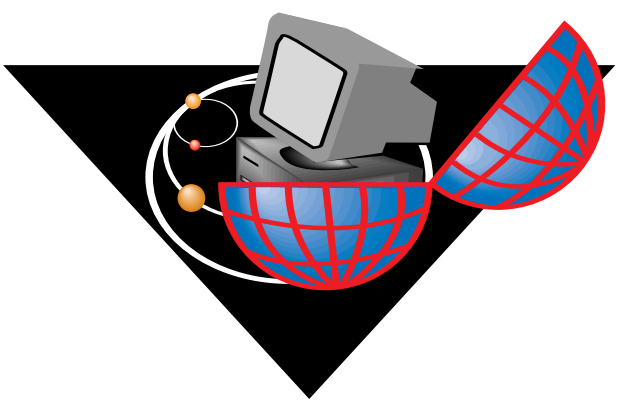

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POSITION PAPER

Funding for Psychotherapy Research

Approved March 7, 2006

The Ad Hoc Committee on Psychotherapy is a set of focus groups established during the Division 29 presidencies of Pat Bricklin, Linda Campbell, and Leon VandeCreek to set an agenda of priorities for the field of psychotherapy. One of the priorities established by the research focus group was to address the lack of government funding for psychotherapy research. Under the leadership of William Stiles, chair of the Division 29 Research Committee, a task force of prominent psychotherapy researchers associated with the Society for Psychotherapy Research wrote a white paper addressing this lack of funding. John Norcross, Chair of the Publication Board, collaborated with Linda and Leon in revising that document to the following position paper. The Division 29 Board of Directors voted to endorse this document.

The APA Division of Psychotherapy is committed to advancing psychotherapy training, research, and practice within the profession of psychology. At this time, programmatic psychotherapy research is confronted with obstacles that endanger its continued contribution to the health and welfare of the populace. Psychotherapy researchers are increasingly alarmed by sociopolitical policies and funding priorities.

Background

Over 5,000 empirical studies and 300 meta-analyses have established the clinical and cost effectiveness of psychotherapy in reducing symptoms, restoring work performance, and improving quality of life for the vast majority of those who seek treatment. The research demonstrates that 75% of people who enter psychotherapy evidence meaningful improvement. Moreover, research consistently indicates that psychotherapy produces favorable results when compared to psychoactive medications and when assessed for cost effectiveness.

Three Problems and Recommended Solutions

Problem 1: The limited funds available for psychotherapy research are largely devoted to randomized clinical trials (RCTs). While RCTs are valuable designs for establishing the causal effectiveness of treatments, they are incomplete in explicating the reasons for such effectiveness and in translating science into service.

Recommended Solutions: Fund an array of methodological designs for psychotherapy research. These include:

a. *Process research* is a primary method of conducting basic research and understanding the mechanisms of change.
b. *Qualitative and single-case designs* are necessary to study important aspects of process research, such as participant moment-by moment responsiveness and the therapist-patient relationship.
c. *Effectiveness research* examines psychotherapy as it is commonly practiced and such critical parameters as patients at risk for negative outcomes, and the generalization of treatments validated in the laboratory to routine clinical practice.
d. *Practice-based research networks* enhance collaboration between researchers and clinicians and facilitate technology transfer.

Problem 2: The limited funds available for psychotherapy research are largely allocated to investigating the efficacy of manualized treatments. These are valuable studies but incomplete as the research repeatedly demonstrates that the therapeutic relationship, patient contributions, and therapist effects account for as much, if not more, of patient success than particular treatments.

Recommended Solutions: Fund psychotherapy research that investigates more than manualized treatments. These include:

a. *Adaptation of treatments to patient characteristics* (e.g., stages of change, preferences for treatments, ethnic diversity) is necessary for predicting outcome and customizing the most effective treatment for individual patients.
b. *Sub-threshold disorders and comorbid disorders* are more common than in medicine and are frequently excluded from funding consideration because they fail to meet diagnostic criteria for randomized clinical trials.
c. *Long-term treatment studies* can determine which treatments are most clinically and cost effective.
d. *Research on psychotherapy with marginalized clients*, such as members of ethnic/racial minorities and the physically disabled.
e. *Couples and family therapy* are treatments of choice for many relationship problems with public health implications. Yet, psychotherapy research on couples and family processes is rarely identified or funded.
f. *Therapist-focused research* investigates the impact of therapists' personal characteristics, relational style, and training on their effectiveness and are critical to understanding why some therapists are more effective than others.
g. *Application of psychological research to physician-patient relationships* contributes to health-care outcomes given the increasing attention in the medical literature to the treatment relationship.

Problem 3: The criteria for evaluating grant proposals in psychotherapy research are frequently inadequate and the reviewers are expert in only efficacy designs.

RECOMMENDED SOLUTIONS:

a. *The criteria for evaluating research proposals* should be appropriate for the area of investigation, stage of inquiry, and state of knowledge. When recommending criteria revision, psychotherapy researchers are often referred to the NIMH R34 program, a standing program for many of the types of studies requested. These are "early" studies proposing new models or developing new treatment approaches.
b. *Reviewers* should be peers of the applicants and knowledgeable about the relevant areas of psychotherapy research. Panels should be composed of established psychotherapy researchers with experience in the kinds of research questions being reviewed and the methodologies being employed.
c. *Federal grant office staff* should included individuals with experience in psychotherapy research in order to provide adequate consultation to grant applicants and to initiate conferences addressing relevant research issues.
d. *Membership on special task forces* is essential for psychotherapy researchers in that these working groups produce documents that set priorities for future funding.

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RESEARCH

Good Enough Science: The CORE-OM as a Bridge Between Research and Practice in the Psychological Therapies

Michael Barkham, Psychological Therapies Research Centre, University of Leeds

I recall a story told to me many years ago about a colleague who was discussing different forms of science with a very eminent head of a major scientific funding body. After several moments, having been presented with an array of differing scientific approaches, the latter turned and said "There are only two types of science: good science and bad science." Today, terms such as *precision* and *specificity* are often used as hallmarks of good science. So raising the spectre of a *good enough* science might seem strange and open to misunderstanding. However, it could provide a window through which to consider slightly differing ways of engaging practitioners and researchers in the common task of improving the quality of client care. To this end, I will set out how the phenomenon of good enough science has become a thread of our current research program in bridging the scientist-practitioner gap. The program is based in the Psychological Therapies Research Centre (PTRC) at the University of Leeds, England, which was set up by David Shapiro following our move there from the University of Sheffield on completion of the Sheffield Psychotherapy Projects.

A CORE APPROACH TO PRACTICE-BASED EVIDENCE

Developing a family of CORE measures

Irene Waskow's (1975) call for a core outcome battery has been the pivotal component in our program of work. The appeal of implementing a common outcome measure or group of measures seemed so obvious that it was difficult to understand why this notion had not progressed as far as it might. So starting in the mid 1990s, our focus was on devising just such a core outcome measure, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), which is now widely adopted in the United Kingdom (Barkham et al., 1998, 2001, 2005; Evans et al., 2002). Two driving principles in the development of CORE-OM were (a) that it was informed by practitioners' views as to what they felt was important to measure, and (b) that the psychometric properties of the measure were good enough in the view of both researchers and practitioners. Hence, the primary drivers were not theory or fidelity, but rather practitioner ownership and utility. It was also free.

Since then, we have built up a family of derivative measures drawing on the pool of 34 CORE-OM items, each being designed for a specific purpose (e.g., initial screening, session-by-session monitoring) or population (e.g., young people). The premise is that one version cannot fulfill all requirements and our approach has been to be responsive to the needs of practitioners and the requirements of policy calls. Importantly, outcomes occur in a broader context and the development of the fuller CORE System has been crucial in providing contextual data within which to interpret the outcome data (Mellor-Clark & Barkham, 2006). Again, this was devised by collaboration between practitioners and researchers. Having established a good enough psychometric status for the CORE-OM, we have recently been identifying and implementing ways of making the scoring of the CORE-OM, and the meaning the scores, easier for practitioners to handle and use (Barkham, Mellor-Clark et al., in press).

REWIRING EFFICACY STUDIES FOR PRACTICAL RELEVANCE

A key component in our program has been establishing the empirical relationship

between the CORE-OM and other commonly used outcome measures. Where practitioners have a preference for another outcome measure, we want to enable them to make comparisons with the CORE-OM. Hence, we have addressed how the CORE-OM compares with other measures (Cahill et al., in press)—for example, the Beck Depression Inventory (BDI; Beck et al., 1961) and the Hamilton Rating Scale for Depression (Hamilton, 1967). More specifically, we have developed transformation rules for converting individual BDI scores into CORE-OM scores and *vice versa* (Leach et al., in press). The yield of this work is that we can now transform BDI scores (and logically also BDI-II scores) from archived efficacy trials into CORE-OM scores using simple transformation rules. Hence, results from older studies using the BDI can be made more relevant to practitioners who use the CORE-OM in routine practice (Barkham, Rees et al., 2005).

Towards chiasmus

The development of the CORE-OM and CORE System provided us with the tools for investigating the psychological therapies as delivered within routine service settings and it has become the central component in our espousing a paradigm of *practice-based evidence* (Barkham & Mellor-Clark, 2000; Margison et al., 2000). This is the chiastic counterpart to *evidence based practice* which itself has, over the past 20 years, established randomized controlled trials and meta-analytic studies as the gold standards upon which governments base decisions about health care policy. However, it leaves open issues of transportability to everyday practice. Rather than simply carrying out effectiveness studies as a logical extension to RCTs, there is a need for a research paradigm that not only fulfills this function but also that is sufficiently robust to initiate research from practice settings that might then lead to more specific investigation via RCTs. In this way, evidence-based practice and practice-based evidence are complementary to each other (Barkham & Mellor-Clark, 2003). Moreover, both paradigms are necessary to build a robust knowledge base for the psychological therapies. Hence, rather than focusing solely on either approach alone, we need to adopt the position of chiasmus, namely *evidence-based practice and practice-based evidence.* The combination of a good enough tool (i.e., CORE-OM) and a research approach rooted in practice have enabled us to build just such a complementary evidence-base (see Barkham, Mellor-Clark et al., in press).

Utilising large (and larger) practice-based data sets

Building large practice-based datasets

Since our developmental work on CORE, we have accrued datasets that comprise increasingly larger numbers of clients, practitioners, and services. These datasets will yield results that are robust and will permit statistical analyses on subgroups that would previously not have been feasible (e.g., ethnic minorities, reliable treatment deteriorations). A CORE National Research Database has now been established (see Mellor-Clark et al., in press) and a first stage of analyses has been carried out on a sample of >30,000 clients drawn from within the United Kingdom's National Health Service.

Practice-based evidence: Informing research

To date, our large data sets have enabled us to develop new methods of predicting treatment response (see Lutz et al., 2005), and to investigate the phenomenon of sudden gains in routine mental health settings (Stiles et al., 2003). We have established the broad equivalence of outcomes between, for example, cognitive-behavioural, psychodynamic-interpersonal, and client-centred therapies (Stiles et al., in press). Interestingly, when each of these orientations was delivered with an additional approach, each was, if anything, slightly more effective. In other words, greater purity of these therapies did not yield greater effectiveness in routine settings.

We also found that the mean level of out-

come tended to be broadly similar regardless of the number of sessions clients received. We interpreted this seemingly paradoxical finding as being that clients exited therapy when they had reached a point they deemed was good enough. This empirical observation was wholly consistent with responsiveness theory. Hence, we argued that treatment duration is largely responsive to client need – that is, it is self-regulated (Barkham, Connell, et al., in press). In a climate where fixed duration is the currency, then such a finding has practical implications for service planning and delivery.

Practice-based evidence: Informing services

Data from such large scale naturalistic settings has enabled us to focus on more service-oriented questions raised by practitioners, service managers, and commissioners of services. We have previously established benchmarks for a range of service variables on a smaller data set (Evans et al., 2003) and have now provided a range of benchmarks using the CORE National Research Database for service parameters in primary care settings comprising, for example, waiting times, perceptions of risk, and importantly the key area of outcomes (see Mullin et al., in press). However, establishing benchmarks at a service level is not an exact science. For example, confidence intervals can be large at the service level and, when considering benchmarks for practitioner performance, the crucial issue of case-mix adjustment needs to be addressed. The complexity of some procedures for taking account of case-mix reduces the feasibility of their being used – and owned – by practitioners in routine services and makes this a key area for developing a science that is good enough.

Towards a good enough science

The golden thread in our research program has been the CORE-OM—a simple outcome measure which has provided the foundation for research rooted in routine practice. Work using the CORE-OM is planned in many areas ranging from methods of providing patient feedback to deriving indicators from the CORE-OM that could be used in health economics. Far from being just another outcome measure, our program has tried to redress the balance in which trials methodology has traditionally been valued by policy makers. But in order for this to succeed, there is a need to readjust our view of science and shift to what might be called a *good enough* level of science – a practice-based science – that can be owned by practitioners, driven by clinical and service utility, and yet accepted by academics and policy makers alike as a legitimate complement to trials methodology.

In balancing these complementary approaches, there might be mileage in considering the notion of the *expected value of perfect (or near perfect) information*. This concept attempts to gauge what we are prepared to pay for acquiring perfect, or near perfect, information about a certain phenomenon. It is a process that is often used in decision making and health economics and is crucial in terms of allocating research funding. But, even if information could be (near) perfect, there is then the parallel issue of perfect, or near perfect, implementation of such information within routine practice. In this context, our large data sets – and those of others – have great appeal in that they enable us not only to profile routine practice (i.e., realistic implementation) but also to mimic trials methodology by designing studies that select sub sets of data which meet specific criteria in order to answer specific questions (i.e., valuable but certainly not perfect information).

In sum, considerable effort has been directed towards reshaping practice via trials methodology in order to fit our own constructions of what might be seen by many as a somewhat rigid model of science. Mindful of the concepts of the value of information and implementation, we need to build a more rugged but good enough science that is designed to deal with the naturally occurring and unpredictable terrain of routine clinical practice.

Footnote

The work reported in this article reflects an ongoing research program variously funded by the Mental Health Foundation, NHS Priorities and Needs Research & Development Levy via Leeds Mental Health & Teaching NHS Trust, the Counselling in Primary Care Trust, and the Artemis Trust. Collaborations involve the CORE System Group, Psychological Therapies Research Network (North), and international collaborators from the US and continental Europe.

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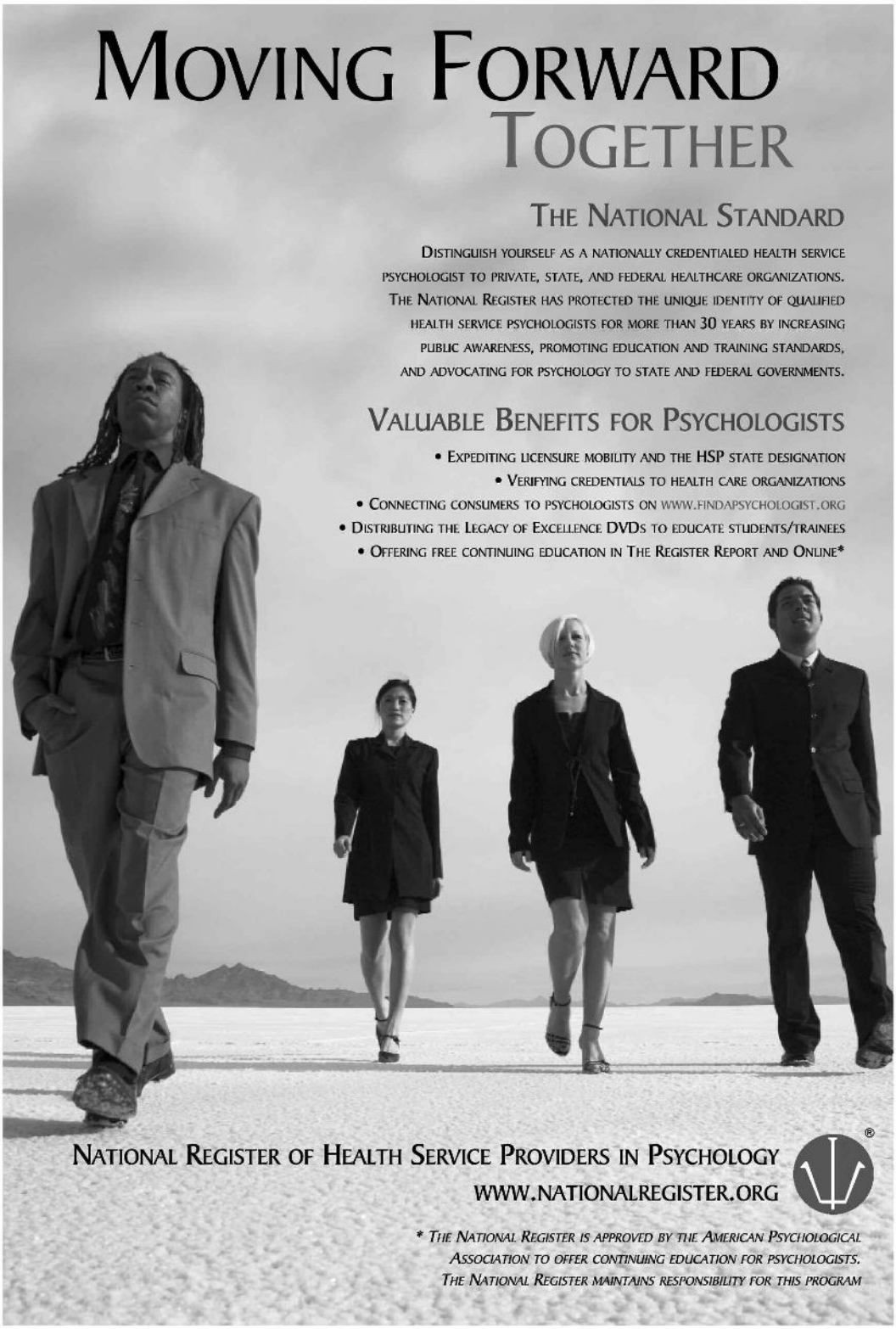
Michael Barkham is Professor of Clinical & Counselling Psychology and Director of the Psychological Therapies Research Centre at the University of Leeds, UK. He has an abiding interest in bridging the scientist-practitioner gap.

ADDRESS FOR CORRESPONDENCE:

Psychological Therapies Research Centre
17 Blenheim Terrace
University of Leeds
Leeds LS2 9JT UK
Email: m.barkham@leeds.ac.uk
Tel: +44(0)113-343-5699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INTERVIEW

Interview with Dr. Nadine Kaslow

By Theodore Nnaji, M.A.

Nadine Kaslow, Ph.D., ABPP

Nnaji: Dr Kaslow can you give a brief professional biography starting with where you went to school and ending with what you are doing today?

Dr. Kaslow:
I attended the University of Pennsylvania for my undergraduate degree, where I was mentored by Martin Seligman, Ph.D. and Lyn Abramson, Ph.D. I got my Ph.D in clinical psychology from the University of Huston with Lynn Rehm, Ph.D. as my primary mentor. My internship and post-doctoral training were at the University of Wisconsin—Madison in the Department of Psychiatry. I was on the faculty of Yale University School of Medicine from 1984-1990 and in 1990 moved to Emory University School of medicine, where I am currently a professor and the chief psychologist. At Emory I am deeply involved in the training the next generation of psychologists. Due to my passion of training future psychology, I became the Chair of the Association of Psychology Postdoctoral and Internship Centers (APPIC) from 1998-2002. Within the local community I am actively involved both in clinical practice with adolescents, and adults as well as being involved in research especially in the assessment and treatment of abused, suicidal and low income African American women. Another focus is the impact of intimate partner violence on low- income African American children and treatment of suicidal behavior in African American women.

Nnaji: You have spent much of your career working in the university setting, medical schools, as a researcher and in direct service to individuals and communities. What were those experiences like for you?

Dr. Kaslow: Working in medical school has been a wonderful experience as I love the interdisciplinary approach, as well as the clinical work, education and research involved in the setting. I really cherish the opportunity to train future psychologists, particularly during their internships and postdoctoral fellowships. This passion led to involvement with APPIC where I was the chair for four years, an experience that has been fruitful and rewarding to me. I enjoy doing clinically relevant research. I also enjoy taking care of patients and I am based in part at Grady hospital, a university affiliated inner-city hospital that predominantly serves low-income children and adults of color. At Grady, I really value the chance to provide services to people with serious and persistent mental and medical illness. I also have a private practice through the Emory Clinic where I work with adolescents, adults, couples, and families. I do a lot of administration as a chief psychologist and I am very active in the medical school, Atlanta community, and committees in the university. I feel it is important and personally meaningful to be active in one's university, local, and larger professional community. Participation in these activities has provided me with countless enriching experiences and has afforded me the opportunity to interact with a diverse group of fascinating individuals.

Nnaji: Having worked in the medical schools, what advice would you give to psychologists, social workers, and other mental health professionals who plan to, or are presently working in medial school setting where they may encounter marginalization from the medical staff?

Dr. Kaslow: It is really important to hold to and be proud of your own professional identity and I also think you need to learn how to fit into another culture. One needs to be bi-culturally competent; that is, one needs to be competent as a psychologist and also have the skill to function effectively in another cultural environment, such as the medical culture. Also you need to be respectful of that culture. The ability to be successful in any environment depends in large part to the nature of the relationships that we form with our interdisciplinary cadre of colleagues and peers, students, patients/clients, and superiors. If relationships are respectful and positive, we can minimize most of the historical tensions that exist between disciplines or professionals.

Nnaji: Can you tell me about some of your leadership roles?

Kaslow: As I mentioned earlier, I am the Chief Psychologist and the Director of Postdoctoral Fellowship Training. We have approximately 14 fellows each year, and it is so much fun to help them as they make the transition to their first job. We have a wonderful job mentorship program, designed to assist fellows with securing employment. Within the medical school, I am the chair of the board that disburses research funds and the past chair of the Committee on the Status of Women in Medicine. At the University, I am the President-Elect of the President's Commission on the Status of Women. I am also on the University Senate and will be President of the Senate from 2007-2008. At the state level, I am on both Mrs. Rosalynn Carter's mental health advisory board, and the Mayor of Atlanta's advisory board on women. At the national level I am the President of the American Board of Clinical Psychology and also the secretary for American Board of Professional Psychology Board of Trustees. I am Past Chair and Board Member Emeritus of APPIC and currently a board member where I handle informal complaints of pre and post- doctoral interns. Through this role, I assisted displaced interns and post-doctoral fellows in the gulf coast states following the tragedy of Hurricane Katrina, and for these outreach efforts, I was recently honored with a Presidential Citation from the American Psychological Association (APA). I am also the President-Elect of the Family Process Institute Board and currently the associate editor of three journals: *Journals of Family Psychology*, *Journal of Clinical Psychology in Medical Settings*, and *Professional Psychology: Research and Practice*. I am on the Council of Representative for Division 12 (Society of Clinical Psychology) within the APA and I am a Past President of Divisions 12 (Society of Clinical Psychology) and 43 (Division of Family Psychology).

Nnaji: You have been involved in numerous leadership positions not only at the University but also at local, state and national levels. What were you most proud of during your tenure in these leadership roles.

Dr. Kaslow: One thing I am most proud of is reaching out to multiple constituencies when I was APPIC Chair and now as the person who handles informal problem resolution processes, including graduate students, interns, and postdoctoral fellows, as well as faculty and staff in graduate school, internship, and postdoctoral settings. I am delighted that I have been able to communicate and respond to people's needs and make them feel that they belong, that they have a voice. Through these efforts, I strive to be particularly sensitive to individual and cultural diversity and am enormously committed to making people's lives better. A second accomplishment in which I take particular pride was my role as Chair of the Steering Committee for the very successful, mutli-national Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology. It was quite an honor to receive the 2004 APA Distinguished Contributions to Education and Training for my investment in advancing our profession with regards to the competency-movement. One of the most special aspects

of receiving the award was having the opportunity to express my sincere and heartfelt gratitude to my family, friends, colleagues, faculty, mentees, and patients who have so influenced my life.

Nnaji: You are associate editor to these journals: *Journals of Family Psychology, Journal of Clinical Psychology in Medical Setting and Professional Psychology: Research and Practice.* What type of issues should be addressed in these publications?

Dr. Kaslow: It is important to address topics that are relevant to practitioners, scientists, educators, and policy-makers alike. There is a need to reduce the separation in our profession between quality research and practice. Researchers need to be better informed by practitioners, while practitioners need to be informed by researchers; the flow of information need to go in both directions. We also need to think about the public policy implications of what we are publishing. How we need to train students and ourselves are also important issues to be considered, especially how to integrate information in the journals. It is also imperative that our publications be timely and attend to current challenges facing our society. From my vantage point, all of our scholarly endeavors should highlight all aspects of individual and cultural diversity, including but not limited to, race and ethnicity, age, gender, and disability/ability status.

Nnaji: What advice will you give to students and young professionals like myself?

Dr. Kaslow: Figure out what you want to do and go for it. You need to figure out who you are and your strengths. Capitalize on your personal strengths. Find your passion in our profession and pursue it, and if you do that in a thoughtful way and allow other people to mentor and support you, you can be successful in your chosen path. It is essential to recognize that your career path isn't going to be a straight line; there are always twists and turns that you don't expect, which invariably will enrich your career and life. Find a mentor to guide you, as I firmly believe that people can really help you to be successful. Networking is crucial. Spend time networking. It is also important to take your learning and growing seriously because the more competent you are in a broad range of domains, the better you will be. And finally, don't forget to maintain your integrity. Self-respect is invaluable.

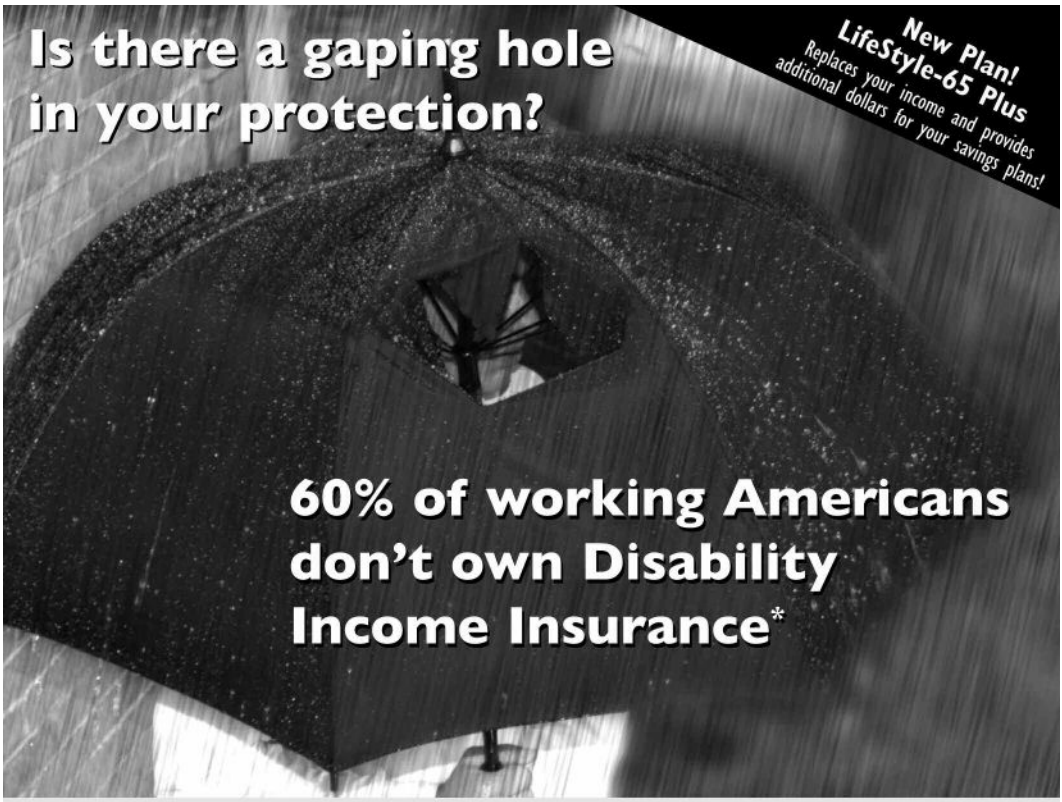
Nnaji: It is evident that you have had a successful career, including your many contributions to the field of psychology. What are you planning to do next?

Dr. Kaslow: I don't know. Just like a new professional, I am trying to figure out the next stage in my life and career. However, I really like what I am doing now, which is a wonderful, albeit very busy blend, of clinical practice, clinically-relevant research, teaching and supervising, mentoring, administration, and policy work and advocacy. Therefore I plan to continue most of these activities. Yet, part of me is also thinking of pursing different kinds of opportunities, so stay tuned. I am confident that the knowledge, skills, and attitudes that I have embraced as a psychologist will serve me well in whatever direction that I go. In the meantime, I love what I do. In addition, I am really enjoying having ballet be a vital part of my life again. Ever since dancing seriously as a child and adolescent, ballet has had a special place in my heart. Dancing actively again gets my body in shape and alive, just as psychology keeps my mind agile and enlivened.

Nnaji: Thank you Dr. Kaslow

Dr. Kaslow: My pleasure.

Theodore Nnaji is originally from Nigeria. He graduated with a B.A. (Hons.) in Philosophy from St. Joseph Major Seminary in Ikot Ekpene, Nigeria. He also received his M.A. in Psychology from City College of New York. Currently, he is a second year graduate student in the Psy.D. program at School of Professional Psychology at Wright State University in Dayton, Ohio. His research interests focus on health psychology, cross cultural psychology, mental health, and psychotherapy.



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An Exciting Future for the Flexible and Creative

Pat DeLeon, Ph.D., former APA President

When I was growing up, we used to spend the summers at the beach. Almost every day the challenge was to see how long that small pile of nickels my parents provided would last. Could I win enough pinball machine games to justify having a hot dog for lunch? If not, it was time to swim, sail, or build forts in the sand. Saturday evening there might be a trip to the amusement park with its rides and skee-ball alleys. Games were special those days; never to be forgotten. Today, there is no question in my mind that the 21st century will be an era of educated consumers utilizing the most up-to-date technology to ensure that they and their loved ones will have timely access to the highest possible quality of healthcare. Yet, one must wonder: Where will the unprecedented advances occurring within the communications and computer fields actually take us? Will society come to appreciate what psychology's expertise can bring to their overall quality of life? Will professional psychology help shape the future or merely react?

This spring I attended an interesting Congressional reception sponsored by the Robert Wood Johnson Foundation (RWJ), entitled Games for Health. According to RWJ, games are the world's fastest growing media form. In North America, 54 percent of all households purchased at least one video game in 2004. Internationally, 150 million computer-based game consoles have been sold. Computer games are now portable, with sales of over 170 million handheld systems like Game Boy or multiplayer games such as Dark Ages of Camelot generating millions of dollars in subscriptions monthly. The audience share of some games is arguably larger than some major cable television programs. I was back on the beach.

Games for Health, funded by RWJ, was produced by The Serious Game Initiative, an effort led by the Woodrow Wilson International Center for Scholars and Digitalmill which seek to apply games and game technologies to a range of public and private policy, leadership, and management issues. By promoting research and the dissemination of "best practices," their objective is to build a community of experts who will explore how innovative computer and video game design and development methodologies can improve health and health care services. Specifically, Games for Health seeks to build on the enthusiasm for this technology and to capitalize on its potential to: reduce patients' pain and the burden of illness; strengthen health care providers' and leaders' knowledge and skills; and inform the general public about maintaining and improving their health, while supporting their efforts to engage in healthy behaviors. Interestingly, psychotherapy and addressing post traumatic stress disorder are two of their identified interests.

At the reception we were invited to take a turn at a variety of simulation, virtual reality, and other innovative interactive video games that were specifically designed to improve health and health care. Examples: Pulse!!—a lifelike virtual environment for civilian and military health care professionals to practice clinical skills in response to catastrophes. Yourself! Fitness—the first mass-market PC and console-based videogame workout system. Sweat it out with your own virtual personal trainer, Maya. Ben's Game – designed by a nine-year-old in remission from Leukemia and a LucasArts game professional; children with cancer fight back to relieve the pain and stress of treatment. And, Dance Dance Revolution—this best-selling videogame

features dynamic dance workouts proven to burn calories and hit cardio target levels. Watching the considerable enthusiasm demonstrated by those Senate staff participating, it was evident that many of us have never really grown up. It was also evident that basic psychological research and attention to the psychosocial-cultural-economic gradient of health care was actively employed in the design of the various exhibit modules.

Highlights: Brain Age: Train Your Brain in Minutes a Day, developed for Nintendo DS, is designed to push people to exercise their mental muscles. Inspired by a prominent Japanese neuroscientist, it draws upon studies that evaluate the impact of certain reading and mathematical exercises on brain stimulation. Project activities include quickly solving simple math problems, counting people going in and out of a house simultaneously, drawing pictures on the Touch Screen, and reading classic literature out loud. DanceDanceRevolution (DDR): This videogame challenges players to follow dance steps and music cues using a special, interactive dance mat. Hugely popular among kids, adolescents, and Senate staff, school officials in West Virginia—a state with one of the highest obesity rates in the nation—recently partnered with Konami to add DDR to the physical activity curriculum in all public schools throughout the state. "Teachers found that kids who didn't like sports got into the game and were more likely to get moving." Immune Attack combines 3D depiction of biological structure and function with advanced educational technologies to provide an introduction to basic concepts in immunology for high school and college students. It is intended to be as fun and compelling as the computer games currently played by many adolescents and young adults. Students are motivated with a series of progressively more difficult challenges in a compelling gaming environment in which success depends on increasingly sophisticated grasp of concepts in immunology. The goal is to help young adults to choose better lifestyle behaviors to protect themselves from infection by experiencing first-hand how difficult it is for the immune system to defend against many viruses and bacteria. Second Life is a Web-based multiplayer world which allows its users, or citizens, to construct their own virtual worlds within it. This has spawned a number of amazing health-related efforts. For instance, Dartmouth University researchers are looking at using it to create virtual scenarios that help train first responders to react to biohazard attacks. Other researchers have "built" a house that approximates the visual experiences described by patients suffering from schizophrenia, in an effort to better understand and treat that condition. Scientists devoted to studying and helping people with various neurological disorders also see significant potential for this modality to help individuals struggling with Asperger's syndrome. Their game has been used to create "Brigadoon Island," a space where people with Asperger's and their caregivers can interact and help patients develop the socialization and coping skills needed to minimize the effect of their disease. And, without question, my personal favorite: FreeDive, an immersive experience that transports the user to a virtual sea floor. This engaging virtual reality environment for critically ill children seeks to reduce anxiety and pain associated with certain medical procedures and to foster a more positive outlook for children and their families. Once there, visitors can explore a coral reef system, check out diverse sea life and search for sunken treasure. Researchers are looking at how exposure to this serene and interesting environment might help children to better tolerate pain associated with chemotherapy treatment. The results of Phase I, which tested how long subjects could endure immersing their hand in ice water while interacting with the game, found that the group of 60 children dramatically increased their pain tolerance from a baseline average of 28 seconds of immersion to 78 seconds. This suggests that procedures lasting approximately a minute, like IV and port insertions, may be administered with much less pain and anxiety for the child.

As one contemplates the changes within healthcare that will undoubtedly occur during the 21st century, it is of particular interest that the RWJ presenters noted: "As telemedicine expands, health care providers will need to work more and more with their colleagues and their patients over vast distances and in virtual environments. Collaboration and networking are also critical aspects of modern-day online multiplayer games; information sharing tools (e.g., blogs and wikis), online instant communications (e.g., instant messaging), and virtual space manipulation (allowing players to construct or interact within an online world) are skills and tools being pioneered in computer gaming that are likely to become commonplace in health and health care." How, we wonder, will our profession respond to these changes in their daily practices?

It should be quite evident that the gaming industry is developing the technology – using physics systems, facial animation technologies, and artificial intelligence algorithms—to create "virtual humans," software-based visuals combined with artificial intelligence and modeling that create believable and lifelike human characters. This technology, when combined with the virtual patient technologies being developed for medical uses, will result in lifelike and accessible simulations of patients' conditions. Research agendas that quickly come to mind: Will games truly help get health information to hard-to-reach audiences, or will they primarily be used by those already motivated to seek ways to improve their health? Will the impact of games be short-term, or will the use of health promotion games affect behavior in a sustained way? Are games as effective, or in some cases even more effective, at promoting and improving health and health care than other methods of training and communication? This is what health psychology is really all about. RWJ expects to make a difference in our lifetime. Will psychology rise to the challenge?

Former Pennsylvania Psychological Association President **Steve Ragusea** and I frequently discuss when private practitioners will personally experience society's growing interest in data-driven, "gold standard" treatment protocols in their daily lives. The Institute of Medicine (IOM) reports that the time lag between the discovery of more efficacious forms of treatment and their incorporation into routine patient care is unnecessarily long, in the range of about 15 to 20 years and even then, many medical technologies are being used inappropriately. Further, 46 percent of American adults (60 million people) are functionally illiterate in dealing with health. Health literacy reflects having the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. This is a very important aspect of public health, and although as profound as any new infectious or chronic disease, it is rarely discussed by patients, policy makers, and the public. Nevertheless, 100+ million Americans utilize the Internet to retrieve health-related information. Psychology must be proactive in insuring that psychological expertise becomes a "Household Expectation," as proposed by Past President **Ron Levant** and further, that as one of our nation's bona fide healthcare professions, we accept our societal responsibility to help educate consumers in developing their expectations.

Hawaii's Prescriptive Authority Quest – A Proactive Agenda for the Future: During last year's session of the Hawaii legislature, the Hawaii Psychological Association (HPA), under the leadership of **Jill Oliveira-Berry** and **Robin Miyamoto**, was successful in having the legislature establish an Interim Task Force to explore the feasibility of psychologists prescribing. HPA's two legislative champions co-chaired the group. This year, the Hawaii House of Representatives passed HR 2589, which would allow appropriately trained psychologists practicing within federally qualified community health centers and in medically underserved areas to prescribe. The legislation was supported by each of

the 13 community health center medical directors; HMSA, the Blue Cross/Blue Shield plan of Hawaii; and the Hawai'i Nurses' Association. HPA's quest became the topic of radio debates and newspaper articles (including on the editorial page), where it received the enthusiastic endorsement of the Hawai'i Primary Care Association. The Senate Health Committee recommended the adoption of the House proposal and ultimately both legislative bodies agreed upon a compromise under which the State's Legislative Reference Bureau was directed to study the issue and report back their findings to the legislature for consideration in the 2007 legislative session. Included in this report is to be a review of the Department of Defense RxP experiences. In my judgment, HPA made considerable progress, particularly in educating the broader community regarding the clinical expertise of our profession, as well as truly engaging their membership in determining their own destiny. An insider's view of the process – **Ray Folen**:

"Having previously passed through the House Health Committee, this prescriptive authority bill was recognized as having some 'legs' on it. It is an access to care bill for the underserved and uninsured people of our State seeking care in community health centers (CHCs). Psychologists, well represented in these areas, are in most cases unable to get the psychiatric support needed. Working collaboratively with primary care physicians has proven to be a successful alternative. They trust the medical psychologist's psychopharmacology skills and want them to operate more independently.

"Psychology was well represented at the hearing. Robin and Jill, co-chairs of the HPA RxP Task Force, delivered exceptionally persuasive testimony, as did other HPA board members, doctoral-level psychology trainees, CHC staff, CHC medical directors, the APA Practice Directorate, the Louisiana Academy of Medical Psychologists, DoD prescribing psychologists, social workers, and community-based organizations such as the Hawai'i Primary Care Association. A number of psychologists working in CHCs testified and made compelling statements, but clearly the most powerful message they communicated to the legislature was their very presence in the rural and underserved communities.

"Organized psychiatry, also realizing that the RxP bill had 'legs,' was particularly unkind at the hearing. It's amazing that some of our legislators still find their self-serving arguments persuasive. Does it matter that so few of them provide care to the underserved? Does it matter that they have not initiated any meaningful efforts to address the mental health problems of this population? Thankfully, some of our legislators continue to champion our efforts to increase access to care, despite the opposition.

"Psychiatry fervently brought out the same tired arguments. They reported that the number of Hawaii psychiatrists per capita is greater than in most other states, but failed to mention that very few psychiatrists will treat Medicaid, welfare or uninsured patients. Indeed, even in rural Honolulu, it is near impossible for a welfare patient to get an appointment with a psychiatrist. Psychiatry did their best to scare the legislature by conjuring up visions of psychologists killing patients and, of course, failed to mention evidence from the DoD reports, the GAO reports and the Louisiana psychologists that suggested a far more positive reality. Thankfully, several psychologists who testified late in the session had the opportunity to correct these distortions.

"More egregious were the outright lies and misrepresentations. A state psychiatrist, attempting to minimize the severe lack of psychiatric services, testified that 'every square mile of the State is covered by psychiatrists in the Adult Mental Health Division,' but forgot to mention that the Division provides services only to the SMI population. After Robin spoke eloquently and in detail about the additional training

prescribing psychologists receive, a psychiatrist told the legislators it was an '11 week training program.' After Robin provided a map showing where psychologists were providing services in Medically Underserved Areas, a psychiatrist testified that psychologists don't work in underserved areas. We were also amused by the creativity of the testimony: one psychiatrist said we don't read medical journals and therefore shouldn't prescribe; another psychiatrist showed a graph with two years of RxP training presented as two hours. When pressed by the legislators to define the minimum training necessary to prescribe, the psychiatrists reluctantly suggested the training required for licensure as an APRN. When asked what that training entailed, they didn't have a clue! A Professor of Psychiatry called both psychology and the legislature 'immoral' for promoting the bill.

"One of the more disturbing moments at the hearing was when a noticeably medicated patient read testimony that had been prepared for her in opposition to RxP. The patient stumbled over words she could not pronounce and obviously had not seen before, parroting arguments that she didn't appear to understand.

"Over the past two decades we have placed many psychologists in underserved areas of the State; psychologists are in 80% of all CHCs and the goal is to have 100% by the end of 2006. We have articulated a financial model that will allow CHCs to easily recoup the costs of hiring medical psychologists. We have a school (Argosy University/Honolulu) with a primary mission of training psychologists to work with diverse and marginalized populations. We have a post-doctoral psychopharmacology training program in place. On the other hand, psychiatry is placing only 3% of its graduates in underserved areas. It can't fill psychiatry residency positions without recruiting 40% from foreign countries. Psychiatry's goal at the hearing was to install fear and confusion in the legislature. In the past, this strategy was effective. It appears, however, that the reasoned word is gaining ascendancy." And, we would add, that HPA's membership is fully engaged. Aloha

The Nature of Unified Clinical Science: Implications for Psychotherapeutic Theory, Practice, Training, and Research

Jack C. Anchin, Ph.D., University at Buffalo, The State University of New York

Jeffrey J. Magnavita, Ph.D., ABPP, University of Hartford and The Connecticut Center for Short-Term Dynamic Psychotherapy

THE NATURE OF UNIFIED CLINICAL SCIENCE

A convergence of findings from a variety of disciplines is dramatically advancing our insight into the multilevel complexities of such fundamental realms of human experience as the nature of consciousness and the relational-interpersonal origins of the self (Damasio, 1999; Kandel, 2005; Shore, 2003; Siegel, 1999; Wilber, 2000) and in the process significantly reshaping the way in which we conceptualize personality theory, psychopathology, and psychotherapy. These latter three interrelated fields of psychology and their increasingly multidimensional frameworks offer valuable lenses into the nature and complexities of human function and dysfunction, processes of development, and mechanisms of change. More broadly, these three fields form the foundations of unified clinical science, defined as follows:

Unified clinical science is a theoretical, clinical, and research movement, which attempts to identify the structures, processes and mechanisms that interconnect the major domains of human functioning. Included within the domain of unified clinical science are personality theory, developmental psychopathology, and psychotherapy, which include the processes and mechanisms of change that are initiated in relationship with a professsional therapist. (Magnavita, in press, ms. p. 3)

In our view, the field of psychotherapy is a subdiscipline of unified clinical science, and it provides a distinctly important and valuable point of convergence for many of the multidisciplinary findings emerging from contemporary clinical science.

UNIFIED PSYCHOTHERAPY

Our field's quest for the "holy grail"— the most potent therapeutic approach with applicability to the widest array of psychological disorders and forms of human suffering—has fueled incredible discoveries over the past century of modern psychotherapy. Whereas a century ago there were few treatments for mental disorders, contemporary psychologists have a plethora of methodologies from which to select and to offer those experiencing emotional and psychological pain. Numerous approaches to psychotherapy have been developed, some have evolved, and some have dropped by the wayside. Unified psychotherapy emerges from the scientific advances and treasure trove of clinical evidence accruing from these multiparadigmatic developments over the past century, and from intimately related interest in developing a holistic model that can account for the main domains of human functioning while offering ever more potent guidelines and principles for instigating healthy change processes.

Placed in this dynamic historical context, we perceive unified psychotherapy to be the next emerging wave in the evolution of psychotherapy, preceded by three previous developmental stages over the past century. The first wave was characterized by the appearance of *single school models*, beginning with Freud's psychoanalysis and fol-

lowed, during overlapping periods, by behavior therapy, humanistic psychology, family systems, cognitive, and biomedical approaches. Each such approach tended to emphasize a particular domain or dimension of human personality and functioning, and by virtue of the parochial attitudes of developers and followers of these models, contentiousness among adherents of different models was not unusual. The second wave was one of *rapprochement* as clinical theorists and practitioners, amid development of branches within each of the dominant models, undertook forays into other schools of thought in an effort to understand these alternative approaches. At times these cross-theoretical understandings were achieved through interpreting and retranslating them into the familiar terms of one's favored theoretical system, well exemplified by Dollard and Miller's (1950) significant book *Personality and Psychotherapy*. The third developmental wave has been *psychotherapy integration.* Given major impetus by Wachtel's (1977) seminal volume *Psychoanalysis and Behavior Therapy* and propelled by still additional factors (see Gold and Stricker, 2006), the highly productive integrative movement has moved psychotherapy significantly beyond rapprochement, placing emphasis on identifying and harnessing key common therapeutic factors and on systematically integrating theoretical concepts and technical procedures associated with diverse approaches to create new therapeutic amalgams more encompassing, versatile, and effective than any single approach taken alone.

Even as the integrative movement continues to make highly valuable contributions to the field's advancement, several noteworthy developments convergently point to unification as a building dynamism in psychotherapy's evolution. One such development has been increasing theoretical and empirical work seeking to understand complex interrelationships among *clusters* of domains constituting human structure, process, and functioning (e.g., neurobiology, human attachment, self-other schemas, motives, affect, interpersonal processes, culture), their interconnective dynamics in psychopathological and healthy states, and implications for therapeutic intervention (e.g., Andersen & Saribay, 2005; Fosha, 2000; Reis, Collins, & Berscheid, 2000; Siegel, 1999). This development is concordant with Kendler's (2005) call for psychiatry "to move from a prescientific 'battle of paradigms' toward a more mature approach that embraces complexity along with empirically rigorous and pluralistic explanatory models" (p. 433). The unificationist trend is also evident in the growing appearance of different systems of psychotherapy founded on distinctly unified conceptions of personality, psychopathology, and psychotherapy (e.g., Allen, 2006; Mahoney, 2003; Marquis & Wilber, in press; Millon, 1999; Pinsoff, 1995; Singer, 2005). Each of these therapeutic systems offers a cartography of the major domains of human structure and function and their interconnectedness, and uses its all-encompassing metamodel as a basis for comprehensive clinical assessment and formulation of specific therapeutic strategies and interventions. A third and broader development, incorporating but going beyond psychotherapy, is the highly substantive body of proposals calling for the theoretical and methodological unification of the discipline of psychology as a whole (e.g., Henriques, 2003, 2004; Staats, 1983, 1991; Sternberg and Grigorenko, 2001). And as perhaps the most ambitious contemporary expressions of the unificationist Zeitgeist, Wilson (1998) and Henriques (in press) have offered provocative metatheories designed to bring about nothing less than the transdisciplinary integration of all knowledge residing in the natural sciences, social sciences, and humanities.

Set against the backdrop of this variegated unificationist wave, we define unified psychotherapy as a metatheoretical framework—a metaframe—on human adaptation, disorder, and psychotherapy that encompasses all the major, presently identifiable component domain systems of human personality and functioning and their complex interconnections.

Accordingly, unified psychotherapy takes into account the entire ecosystem contextualizing and determinatively relevant to adaptive and maladaptive human functioning and experience, ranging the spectrum from macrolevel to microlevel structures, processes and their interrelational dynamics. Dynamic system processes are as vital as structures and functions, and part-whole relationships are central, standing in dialectical contradistinction to reductionistic levels of analysis. Unified therapy is by definition applicable to the entire spectrum of psychopathological adaptations seen in human systems, from microsystemic to macrosystemic forms of dysfunction. This unifying framework is also capable of organizing the vast assortment of empirically supported and clinically useful strategies and methods now utilized in fostering therapeutic change. Unification does not reject the usefulness or validity of different approaches, such as cognitive-behavioral, psychodynamic, interpersonal, experiential, and neurobiological, but rather views the respective modes of action posited by each of these paradigms to be integral aspects of the domains and subsystems of a coherent unity.

As a context for further delineation of implications embedded in this unificationist perspective, we next offer one conception of a metatheoretical framework that can serve as a guide for unified approaches to psychotherapy. Fundamentally, this framework entails a biopsychosocial systems model grounded in the relational world.

A MULTICOMPONENT, BIOPSYCHOSOCIAL SYSTEMS MODEL OF PERSONALITY AND PSYCHOPATHOLOGY

A *component systems model* of unified psychotherapy, presented in detail in Magnavita (2005; cf. Magnavita, 2004b), was developed and in its evolution is based on classic theoretical and empirical findings, as well as on new and pertinent findings from clinical science. Any system guided by principles of unification is necessarily an evolving one, and by its very metatheoretical nature is equipped with both the scope and continuing capacity to incorporate new findings from clinical science. The component system model is based on the melding of a number of important advances in clinical science, including the primacy of the biopsychosocial model of health and illness, its capacity to incorporate the major subsystem domains identified by clinical scientists as integral to lifelong development and functioning of human systems, the particular centrality of relational matrices in the development and evolution of personality functioning and dysfunction, and the explanatory power of systemic concepts and principles for understanding how this enormous complexity functions as a singular, unified being.

We underscore that this is by no means a purely mechanistic conception, a doctrine of fundamental determinism disguised in sophisticated conceptual clothing. Processes of motivation and agency, complex issues of human purpose and meaning, and the extensive impact of these animating processes and issues on the vital realm of subjective experience are integral to this model. Magnusson (1995) emphasizes similar points in his "integrated, holistic model for individual functioning and development" (p. 24). From his perspective, models for understanding the "dynamic, complex processes" (p. 25) focused on by the natural sciences are also applicable for theory and research on the functioning and development of the human being. Importantly, however, alongside similarities in structures and processes studied in the natural sciences and psychological research, "there are also essential differences, particularly when the interest is in the functioning of the total organism. At that level, fundamental characteristics and guiding elements in the dynamic, complex process of individual functioning are intentionality, linked to emotions and values, and lessons learned from experience" (p. 26).

Organizing the Various Component Domains and Subsystems

There are various ways to parse and organize the vast sea of structures and processes that interactively constitute, influence, and color human functioning and experience over time, but by definition any unified model must take account of structures and processes at every level of the human ecosystem. No vital domain can be ignored, or we risk failing to consider the nature and weighting of its contribution to maintaining a system in a state of dysfunction and pain. The component systems model presents a framework for coherently organizing and holographically representing this complex human ecosystem—the total ecology of the human personality system at its various levels. A holograph can be pictured as a three dimensional map of a complex system that visually organizes an array of data culled through different lenses.

The development of this model has been strongly influenced by the work of Bronfennbrenner (1979), who describes the interconnected domains of human ecology as "a set of nested structures, each inside the next, like a set of Russian dolls" (p. 3). Building on his and others' work, the component system model divides the total ecology of the human personality system into four nested levels that move from the most microscopic to increasingly macroscopic levels. Each of the four levels is represented as a triangular configuration, and each triangle encompasses the interplay among critical subsystems and associated factors identified over the course of a century of empirical and clinical investigation.

At the most microscopic level—the microsystem—is the *intrapsychic-biological triangle*, which concentrates on dynamic interrelationships among affective/emotional, cognitive, and defensive systems and processes, a matrix reciprocally linked to the neurobiological system. The next level is the *interpersonal-dyadic triangle*, one component of the macrosystem and focused on interpersonal processes in present-day dyadic relationships. It emphasizes the interplay among the human attachment system, issues of closeness and intimacy, internalized relational schemas, interpersonal expectancies, verbal and nonverbal communication processes, and the still-influential role of earlier attachment experiences in shaping these key relational arenas. The third level, another component of the macrosystem, is represented by the *relational-triadic triangle* and includes among its emphases the structure, functions, and processes that transpire when an unstable dyad—one experiencing more conflict and anxiety than it can manage—seeks to stabilize itself through engaging a third individual. The fourth and widest perspective on the human personality system—the mesosystem—is offered by the *sociocultural-familial triangle*, encompassing complex interactions among the individual personality system, the family system, and the sociocultural matrix; the later includes the significant yet often underattended to impact of cultural, economic, and political systems on the functioning and dysfunction of individuals, couples, and families.

Principal Dimensions of the Biopsychosocial System

Because of their assumptive importance, here we briefly highlight several principal dimensions that radiate throughout this unified multicomponent biopsychosocial framework. An overarching postulate is that the human biopsychosocial system functions as a nonlinear dynamic system (Anchin, 2003, 2005, in press; Magnavita, 2005a, 2005b, in press), which encompasses several key implications:

1. *The interconnective, dialectical dimension.* A living system functions holistically as a consequence of the complex networks of interdependence that in self-organizing fashion bind together its component domains and subsystems into "an authentic substantive unity" (Millon, 2000, p. 41). Thus, we can beneficially dissect a living system into the plurality of domains and subsystems of which it is composed, as in

the multicomponent system model presented above, but there is the tacit understanding that this diverse array of subsystems is united into a singular whole form through complex interconnective processes. It follows that a significant epistemological dimension of systems thinking is its dialectical nature, in that "thorough understanding of any particular constituent part [of a system] is achievable only insofar as that understanding grasps the nature of that part's reciprocal, dynamic interrelationships with other parts that constitute the whole" (Anchin, 2002, p. 303).

2. *The dynamic dimension*. This dimension captures the centrality of *process*, of continuous movement, change, and activity over time. The vast networks of interrelationships that permeate the biopsychosocial matrix unfold, in real time, as fluid, changing processes of multivariate interactions. Fay (1996) offers a valuable recommendation that captures this essential dimension of systemic thinking: "*Think processurally, not substantively (that is, think in terms of verbs, not nouns). Include time as a fundamental element in all social entities. See movement—transformation, evolution, change—everywhere*" (p. 242, emphasis in original).

3. *The nonlinear dimension*. Nonlinearity provides a more fine-grained picture of the interwovenness of biological, psychological, and sociocultural processes. In contrast to the unidirectional, linear metapsychology that dominated 20th century psychology, nonlinearity highlights the multidirectional and circuitous pathways of influence that radiate throughout the human biopsychosocial system by directing attention to reciprocal interactions, mutual effects, feedback loops, circles, networks, and cycles (Anchin, in press; Goerner, 1995; Lasser & Bathroy, 1997). Nonlinearity also holds that there can be a disproportionate relationship between the magnitude of an input and the size of its effect; a small increase in parental praise can dramatically improve a child's self-worth.

The Potency of Chaos Theory for Explaining Biopsychosocial Processes

A major branch of contemporary systems thinking exploding across the scientific landscape over the past two decades (e.g., Gleick, 1987; Capra, 1996; Chamberlain & Butz, 1998), chaos theory offers a powerful explanatory foundation for accelerating our understanding of the complex dynamics of nonlinear systems and so the vast intricacies of the human biopsychosocial system (Anchin, in press; Magnavita, 2005). Chaos theory concentrates especially on how nonlinear dynamic systems self-organize, develop and evolve over time and space (Miller, 1999). Taking as its starting point "the delicate balance between the forces of stability and the forces of instability" (Gleick, 1987, p. 309) that pervade living systems, it articulates multivariate systemic processes that unfold when endogenous and/or exogenous factors disrupt these "dynamic tensions" (Mahoney, 1991, p. 419) between order and disorder—a balance embodied in the continuous organismic dance between structural stability and continuous process in biological, psychological, and social systems (Fredrickson and Losada, 2005; Mahoney, 2003). Under certain conditions, disruption of these dynamic tensions may trigger the system's transition into the highly disequilibrial phase denoted by the concept of chaos. A nonlinear system in a chaotic phase undergoes turbulence, confusion, and disorder, yet this upheaval also opens the door for significant structural change (Perna and Masterpasqua, 1997). Nonlinear systems transition out of chaos through self-organizing processes, but the trajectory of that movement can be in any number of directions. For the human biopsychosocial system, this can range from personal growth and development spawned by self-restructuring processes that create a more differentiated, complex, and resilient biopsychosocial structure, to sustaining structural impairments that result in compromised levels of functioning, negatively-toned experiential concomitants, and more chronic sequelea (Mahoney, 1991). In this

light, psychotherapy entails the timely and planful introduction into a high level of individual biopsychosocial "disorder and disequilibrium" (Mahoney and Moes, 1997, p. 186) salutary processes that promote, enhance, and accelerate in healthy directions the individual's intrinsic self-organizing and reconfiguring capacities.

PSYCHOTHERAPEUTIC IMPLICATIONS

It is important to delineate what differentiates the unification of psychotherapy from psychotherapy integration and to specify the numerous implications for the psychotherapist and clinical theorist, a task undertaken in detail in Anchin and Magnavita (in press). The most essential differentiating factor is that psychotherapy integration characteristically starts at the level of theory and then expands to the blending of therapeutic techniques, while the foundational starting point for unified psychotherapy is the view that "integration inheres in the person, not in our theories or the modalities we prefer" (Millon, 2000, p. 49). As such, from the outset unified psychotherapy emphasizes organismic holism and is multiparadigmatic within a unifying systemic framework. The focus of our interventions is thus based on an understanding of the multilayered system. Here we briefly distill core clinical implications deriving from this general perspective.

Assessment Implications of Unified Psychotherapy

The provision of effective psychotherapy depends significantly on the vitality and capacity of clinical assessments and their implications for treatment. Most experienced clinicians would agree that an assessment geared towards establishing a DSM diagnosis offers only limited guidance about an optimal treatment package, which encompasses therapeutic approach, modalities, time frame, format and setting. From the perspective of a unified model, the progressively microscopic to macroscopic levels that constitute the human personality system necessitate a holonic, multidimensional assessment, which seeks to understand the patient's dysfunctionality and distress in terms of not only essential processes at play within each component domain, but crucially, how all of these domains are interwoven, including how the system has encoded at multiple levels of analysis the core disturbance, and the function of symptom constellations throughout the total ecological system. Thus attuned to manifestations and processes of functionality—dysfunctionality and adaptation—maladaptation across all levels of the patient's personality system, the therapist is better positioned to locate fulcrum points of change— that is, particular subsystem processes where well targeted intervention yields maximum therapeutic benefit. Such focal intervention can create a "tipping point" (Gladwell, 2000) at which the entire system reconfigures and attains a higher level of functioning.

Unified Psychotherapy: Central Elements of Therapeutic Strategy and Intervention

It is our strongly held belief that a unified model of psychotherapy should be able to incorporate and organize the vast body of therapeutic methods and techniques that have been clinically and empirically demonstrated to be effective across the entire spectrum of psychological disorders and relational dysfunctions. The present unified approach does so by dividing therapeutic procedures into four categories of restructuring based on the systemic domain level it is designed to target and in which its primary mutative action occurs. Specifically, coordinate with the four domain levels of the biopsychosocial system, these entail techniques and methods for achieving (a) intrapsychic restructuring, (b) dyadic restructuring (c) triadic restructuring, and (d) mesosystemic restructuring. By the same token, a unified model maintains that, by virtue of nonlinear interconnections throughout the biopsychosocial system, effective restructuring at a given level is likely to have reverberating, constructive effects on processes at other systemic levels. In selecting from the wealth of therapeutic inter-

ventions falling within these four categories, decisions must be made on the basis of the multisystem assessment and case formulation about such matters as whether multiple levels of the biopsychosocial matrix need to be targeted, which systemic level to intervene in at any given time, whether multiple therapeutic modalities are needed and if so concurrently or sequentially, and the optimal fulcrum point(s) within a given systemic level. It is also desirable that the therapist be able to flexibly navigate the microsystem to the mesosystem in her or his intervention strategies and, as continuous data are gathered and clinical understanding increases, that she or he tailor to the patient the specific restructuring methods to be used.

The treatment process is also informed by the view that for a system to evolve and grow it must be able to increasingly *differentiate* and *integrate* its functions and processes. A system unable to differentiate as the need for more complex adaptation is demanded is increasingly likely to falter and malfunction. To illustrate at the relational-triadic level, a family low in self-differentiation may not be able to tolerate the heightened oscillations in self-identify and its relational expressions as children proceed through adolescence, causing the family system to become pathogenically stuck in this developmental transition. Virtually all modalities and techniques of psychotherapy advance differentiation and integration within and among the various component domains of the biopsychosocial system, thereby enhancing growth and adaptive capacity.

TRAINING IMPLICATIONS

Implications of the field's movement toward unification for the training of psychotherapists are complex and can only briefly be highlighted here. A unified model places an enormous burden on graduate programs and students to master or at least be conversant with findings from all of the domain levels and subsystems composing the biopsychosocial system. We believe that it is vital for training institutions to provide a solid grounding in *personality systemics* (Magnavita, 2004a), which "emphasizes the study of personality systems in their various forms and associated processes" (p. 19), so that the tremendous complexity of human systems can be appreciated and understood. It is essential, as well, that psychotherapists in training develop knowledge of the broad spectrum of therapeutic processes and techniques associated with multiple paradigms, and that they begin to develop skills in implementing selected interventions associated with each of the four categories of restructuring. It is also highly desirable that training programs cultivate skills in dialectical thinking vis-a-vis the multifaceted data of clinical science and practice, for example learning to move back and forth between thinking *analytically and reductionistically* (e.g., keying into and assessing different subsystems constituting the patient) and thinking *synthetically and holistically* (e.g., examining how these different subsystems mutually influence one another and discerning resultant, potent implications for intervention).

RESEARCH IMPLICATIONS

The research implications of unified clinical science are crucial to creating a unified psychotherapy that is vital and multiply informed. Essential to such research are nonlinear research methodologies, which empirically study and in some cases present in illuminatingly visual fashion processes and patterns transpiring within and between different domain levels of the biopsychosocial matrix in both healthy and unhealthy states. These methods are well illustrated by the sequential analysis techniques and nonlinear dynamic modeling used by Gottman (Gottman and Roy, 1990; Gottman et al., 2002), Reidbord and Redington (1995), and Fredrickson and Losada (2005). However, in a unified clinical science nonlinear systemic methodologies do not obviate the value of more traditional reductionistic linear approaches to scientific investigation; rather, "the various method-

ologies, both linear and nonlinear, are mutually compatible, not contradictory. They can be used to study different aspects of a system, depending on which is most appropriate for addressing the specific question at hand" (Barton, 1994, pp. 12-13). Based directly on the critical work of Norcross (2002) and colleagues, deciphering the complex webs of interconnection that exist between the psychotherapy relationship and therapeutic outcomes provides a compelling illustrative arena for integrating linear and nonlinear methodologies. Qualitative-hermeneutic modes of inquiry also have distinct value in a unified armamentarium of methods for studying the human ecological system, capturing the phenomenological emergence—that is, subjective experiences and meanings—that characterize complex biopsychosocial interrelationships as unified, lived phenomena.

We thus view methodological pluralism (e.g., Polkinghorne, 1983; Yancher & Slife, 1997; Sternberg & Grigorenko, 2001) to be vital to unified clinical science. We suggest, as well, that methodological pluralism is likely to be embraced to the extent that researchers and practitioners are willing to adopt the underlying philosophical position of *epistemological* pluralism, which endorses as meaningful and legitimate multiple kinds of knowledge and multiple ways of knowing (e.g., Downing, 2004). Grounded in this epistemic position, the diverse kinds of knowledge yielded by quantitative-empirical linear and nonlinear methods and qualitative-hermeneutic approaches can thereby be fully accommodated and integrated, fundamental to developing "truly comprehensive and unified explanations and understandings of the complex biopsychosocial composition, dynamics, and experience of psychological health, disorder, and the transitional processes that connect them" (Anchin, in press).

CONCLUSION

The fourth wave in the evolution of psychotherapy is swelling, carrying compelling implications for enriching conceptualizations of personality and psychopathology, heightening therapeutic potency and efficacy, broadening the scope of clinical training, and substantively expanding and integrating the foci and methodologies of contemporary clinical science. Like any complex dynamic system in motion, the trajectory of the multiply constituted unificationist wave is by no means entirely predictable, but if the present article has succeeded in piquing the reader's interest in exploring and experimenting with any of its numerous heuristic elements, its purposes have been effectively served.

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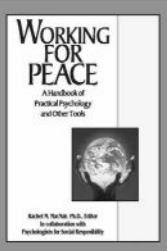
Client Resources for Therapists



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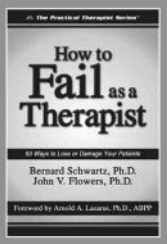

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FEATURE: INFORMED CONSENT IN PRACTICE

Informed Consent and the Psychotherapy Process

Tiffany A. Snyder, B.S. Loyola College of Maryland
Jeffrey E. Barnett, Psy.D., ABPP, independent practice, Arnold, Maryland

Informed consent is an essential aspect of the psychotherapy process just as it is for research, teaching, consultation, and all other services psychologists provide. As a general concept, it seems well ingrained in the minds of psychotherapists but its specifics may be less clear. Just what informed consent is, why it is so important for the psychotherapy relationship, what elements it must include, what form it should take, when it should occur, and the factors that impact its relevance are addressed in this article. Recommendations for the appropriate and ethical use of the informed consent process are also provided.

What is Informed Consent?

Informed consent has been defined as "the process of sharing information with patients that is essential to their ability to make rational choices among multiple options" (Beahrs & Gutheil, 2001, p. 4). It is intended to protect the welfare of clients by offering them the opportunity to make free and informed choices (Corrigan, 2003). Therefore, consent necessitates that clients and potential clients are provided with the information needed for them to make an informed decision about whether or not to participate in a professional relationship with a psychotherapist. In providing this information, informed consent serves as a means of sharing decision-making power in the therapist-client relationship (Meisel, Roth & Lidz, 1977). Additional functions of informed consent include promoting client autonomy and self-determination, minimizing the risk of exploitation and harm, fostering rational decision making, and enhancing the therapeutic alliance. These factors clearly impact the therapeutic process and the quality of the psychotherapy relationship.

The APA Ethics Code

The APA Ethics Code has developed through its various revisions over time to address the issue of informed consent with increasing specificity. The Ethical Principles of Psychologists and Code of Conduct (APA, 2002) clearly states that all psychologists intending to "conduct research or provide assessment, therapy, counseling or consulting services" must obtain the informed consent of that individual (p. 1065).

With regard to psychotherapy, the APA Ethics Code states that when obtaining informed consent, psychologists must "inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers" (p. 1072). When utilizing treatments for which generally recognized techniques have not been established, psychologists must inform their clients of the potential risks, uncertainties and alternatives to such treatments. Clients must also be made aware of the fact that their participation is voluntary in nature. Further, when a trainee offers treatment the client must be informed that the psychotherapist is a trainee under supervision and be given the name of the supervisor as part of the informed consent process (Standard 10.01, Informed Consent to Therapy).

While informed consent strives to uphold multiple ethical virtues as stated in the General Principles of the APA Ethics Code—including beneficence, helping others, nonmaleficence, not doing harm, and fidelity, our obligation to clients—autonomy, or respect for a client's independence, is said to be the foundation (Kitchener, 1984; Bremer & VandeCreek, 1991). According to the APA Ethics Code, psychologists offering psychotherapeutic

services are explicitly required to structure the professional relationship to ensure that the client has the right to make informed, autonomous decisions regarding treatment (Fisher & Younggren, 1997).

Autonomy upholds the notion that individuals have the right to live independently, meaning one can think and act in any way they choose, so long as they are not harming others (Bremer & VandeCreek, 1991). When applied to informed consent, the principle asserts that a person has the right to act as a free agent and make decisions freely. Thus, the assumption underlying the implementation of informed consent is that doing so will protect the rights and welfare of individuals by offering them the opportunity to make free and informed choices (Corrigan, 2003). In order to make an informed choice, a client needs information that is relevant to his or her decision (Somberg, Stone, & Clairborn, 1993). Once a client has such information, he or she can then weigh the positives and negatives of treatment and decide whether or not to enter into psychotherapy (Gustafson, McNamara, & Jensen, 1994). It is then and only then that a client has the ability to make a free and informed choice. Therefore, informed consent maintains a client's autonomy by providing the client with adequate information to make rational decisions, allowing the client to be the ultimate authority regarding their health.

Consent can also be said to increases a client's autonomy by making him or her less dependent on the therapist for information (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud, 1986). This in turn increases client responsibility and decreases the likelihood of the client being exploited (Handelsman et al). In addition to promoting autonomy, the act of obtaining informed consent by means of a collaborative process should also help lay the groundwork for and promote the therapeutic process and relationship.

What Constitutes a Valid Decision?

Informed consent must uphold three basic elements in order to be valid. The person consenting to treatment must be competent to do so, the consent must be voluntary, and the person must understand that to which he or she is agreeing. With respect to competence, clients are presumed to have the capacity to comprehend information unless it has been shown otherwise (Lyden & Peters, 2004). Voluntariness asserts that the client's decision is made in an environment free from coercion (Meisel et al., 1977), while understanding ensures that a client is provided with adequate information and comprehends his or her current situation and the proposed intervention (Lynn, 1983). For informed consent to take place, these three forces are expected to work together to manifest a truly informed, educated decision. It is assumed that information given to a competent, free individual will result in understanding and that this understanding will yield what is considered to be a valid decision (Meisel et al). But, ensuring a client's understanding of the information presented is no simple matter. We must do more than just have a client sign an informed consent agreement or just ask if the client has any questions. We must actively ensure each client's understanding by reviewing written materials verbally and asking questions to assess their understanding.

Verbal and Written Consent

It is generally agreed that informed consent information should be provided to clients both verbally and in writing. Having information regarding the therapeutic process written down and at a client's disposal may allow clients to learn better, remember information longer, and avoid misunderstandings (Handelsman & Galvin, 1988). Such forms may also increase clients' autonomy by helping them to be less dependent on the psychotherapist for information (Handelsman et al., 1986). In addition, by anticipating potential pitfalls, consent forms begin a dialogue between client and psychotherapist. This exchange of information may help the dyad avoid surprises, disappointments and false expectations that would distract from the therapeutic work

(Hare-Mustin, Maracek, Kaplan, & Liss-Levinson, 1979).

Yet, the use of written informed consent agreements presents special challenges for psychotherapists. While a written record of an agreement is important for client and psychotherapist alike, just how this is done is a matter of great importance. The typical informed consent agreement is written in a manner not easily comprehended by the average consumer. An interesting recent study on the readability of Notice of Privacy forms highlights this issue:

0 Percentage of patient privacy forms that were shown to be as easy to read as comics.

1 Percentage as easy to read as J.K. Rowling's "Harry Potter and the Sorcerer's Stone."

8 Percentage as easy to read as H.G. Wells' "The War of the Worlds."

91 Percentage as easy to read as professional medical literature or legal contracts. (The Numbers Game, 2005, p. F3)

It is recommended that informed consent documents be written at the fifth to eighth grade reading level to ensure readability by our clients, although this may be modified up or down depending on the population with which one works. The reading level of all documents may be assessed in Microsoft Word using the Flesch-Kincaid Scale, which rates a document's reading difficulty from grade 0 to 12. It is interesting to note that in one recent study of 114 informed consent documents used for participation in research studies in medical schools, the average readability level was 10.6, 2.8 grade levels above that which was required by those institutions' Institutional Review Boards (Paasche-Orlow, Taylor, & Brancati, 2003).

Several sample informed consent agreements are available for psychotherapists' use and many individuals also choose to create their own documents. One document available for our use and modification is provided on the website of the APA Insurance Trust at www.apait.org. Handelsman and Galvin (1988) have also created an outline of questions regarding the nature of treatment, financial arrangements, confidentiality and therapist credentials. By providing a client with a list of questions, the outline proposes all the potentially necessary content areas, while allowing the psychotherapist to elaborate upon the information that is relevant to that particular client and omit unnecessary information. More recently, Pomerantz and Handelsman (2004) updated this outline to include questions on insurance and managed care, use of therapy manuals or guidelines, psychopharmacology, other approaches to therapy, HIPPA requirements, and credentials. It is intended to be used to improve the effectiveness of whatever written information therapists give their clients or ask them to read and sign. The use of such questions for discussion will also assist in ensuring clients' understanding of that to which they are agreeing (one of the requirements for a valid consent process).

Informed Consent and the Psychotherapy Process

It has already been reviewed that informed consent is a collaborative process that helps to establish and enhance the psychotherapy relationship. The use of an active informed consent process helps the client to be more invested in treatment and to participate more actively in treatment decisions. It also works to minimize misunderstandings that could jeopardize the psychotherapy relationship and process.

Most would agree that informed consent should be provided prior to providing services. But, informed consent should be viewed as a process, not a singular event. It should be an ongoing dialogue between psychotherapist and client in which both parties exchange information, ask questions, and together, reach agreements about the course of treatment over time (Packman, Cabot, & Bongar, 1994). Thus, the consent process should be initiated as early as is feasible in the treatment relationship and then updated on an ongo-

ing basis as additional treatment decisions need to be made. Rather than being seen solely as a legal and ethics requirement, informed consent should be viewed as an integral aspect of the psychotherapy process that is essential for its success. In fact, the open and honest discussion that occurs facilitates the growth and development of the therapeutic alliance and lays the groundwork for a relationship based on empowerment through information sharing (Pomerantz & Handelsman, 2004). This discussion also helps the psychotherapist to more fully understand the client's goals and concerns regarding psychotherapy (Fisher & Younggren, 1997). Engaging in the process of informed consent, as has been described, also implies a certain level of respect for clients and their ability to utilize the information shared, make good decisions based on it, and to participate as partners in their treatment. This hopefully helps set the tone for the psychotherapy process and relationship to come.

What Clients Want to Know

While the APA Ethics Code and relevant state laws will dictate much of what must be included in the informed consent process, knowledge of clients' preferences may impact how we implement the consent process and which issues we emphasize. In one study, Braaten and Handelsman (1997) found that current and former clients rated information about inappropriate therapeutic techniques, confidentiality, and the risks of alternative treatments as most important. Yet, clients wanted to be informed first about how much therapy would cost, whether the psychotherapist had the appropriate credentials, and how sessions were scheduled despite rating other factors as most important.

Further, Pomerantz and Grice (2001) found that many potential clients and mental health professionals were not in agreement on the ethicality of a range of behaviors by mental health professionals. The psychotherapy relationship will be well served if psychotherapists ensure that clients understand the psychotherapy process and have realistic expectations regarding it. This is further highlighted in a study of clients and potential clients in which 69% expressed the view that everything shared in treatment is confidential, 74% believed that there should be no exception to this rule, and 96% stated that they wish to be informed about confidentiality and any limits that exist prior to entering the psychotherapy relationship (Miller & Thelen, 1986). These data are of special significance in that unanticipated breaches of confidentiality are likely to result in significant breaches in the psychotherapy relationship.

Additional Issues and Recommendations

While a detailed discussion of the following issues is beyond the scope of this brief article, psychotherapists should consider the informed consent process with various populations and settings and when utilizing a wide range of therapeutic media and formats. For example, we must be aware of additional clinical, legal and ethics requirements regarding informed consent with minors, the elderly, when providing treatment to couples, families, and groups, in situations involving various custody arrangements, in the managed care environment, and when engaging in telehealth and using various electronic media to provide services. Care and attention should also be given in other situations where informed consent may not be truly possible such as with prison inmates, inpatients, and with court ordered treatment.

Current studies suggest that not all mental health professionals share the same view of the informed consent process. It appears to be applied in a wide range of ways and many may not follow professional standards regarding informed consent. In one recent study (Croarkin, 2003), only 51% of the mental health professionals surveyed reported conducting and documenting an informed consent process for psychotherapy in their practices. Further, only 25% of those surveyed acknowledged utilizing a written informed consent agreement with their clients.

Additional study is needed to better understand the role, value, and benefit of the informed consent process and how it should best be implemented. Any possible limitations or drawbacks to the informed consent process should be understood and their implications addressed. It is also important to better understand just how psychotherapists implement informed consent and how the decisions they make impact this. It will also be of value to better understand the actual impact of the informed consent process on the course of psychotherapy, including just which aspects of informed consent promote a productive psychotherapy relationship and enhance psychotherapy outcomes.

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Introducing the Division 29 Suite Program at APA in New Orleans—2006

Division 29 is pleased to announce our *Suite Program* which will be launched at APA this summer in New Orleans. We are planning to offer a number of exciting opportunities to interact informally and explore your interests with some of the leading figures in psychotherapy. We will host hour long conversations on a variety of topics such as how to get started publishing, advice for incorporating research in your clinical practice, innovations in psychotherapy practice, and others. You will have the opportunity to meet some of the leading pioneers in the field, and we will also be raffling books for students who join our division. We are encouraging our members to bring in others who might be interested in joining our division and partaking of the advantages of membership. We will be offering a limited number of Division 29 hats for those who sign up during the convention. We will update you in the next issue of the Bulletin and on the website at www.divisionofpsychotherapy.org as to our schedule of events. We look forward to seeing old friends, students, and new faces at our suite program in New Orleans.

Jeffrey J. Magnavita, Ph.D.
Program Chair

Cultural Considerations of Informed Consent When Conducting Mental Health Research

Tina Kaljevic and Leon VandeCreek, Wright State University, School of Professional Psychology

Informed consent is the process by which research participants are informed of the potential risks and benefits of taking part in a research study (National Institute of Mental Health [NIMH], 2005). Other basic elements of informed consent involve addressing the purpose and goals of the research, assuring participants that data will be kept confidential, and informing participants that they may stop participation at any time without penalty (United States Department of Health and Human Services, 2005, section 46.116). These steps are usually completed in part by having participants sign consent forms, indicating their voluntary participation in the study (United States Department of Health and Human Services, 2005, section 46.117). The basis for such systematic procedures lies in preserving the autonomy of participants (Koocher & Keith-Spiegel, 1998), but the informed consent process may be hindered if researchers overlook cultural factors of potential participants, especially those with language and reading limitations, high regard for collectivism, great respect for or mistrust of authority, and severe limitations of financial means. We discuss these potential challenges to obtaining informed consent and offer suggestions.

Linguistic/Readability Issues

Many researchers agree that facility with language influences the informed consent process because it relates to participants' comprehension of the research process as described in the informed consent materials (Brugge, Kole, Lu, & Must, 2005; Cooper et al., 2004; Marshall, Koenig, Grifhorst, & Van Ewijk, 1998; Quill, 2002). Cooper et al. (2004) have described language barriers that arose when working with migrant farmworkers, most of whom were Latinos and had limited proficiency in English. In addition, these migrant farmworkers were often functionally illiterate in their native language, so providing just a written consent form in their native language would not have been sufficient. In order to accommodate the needs of this population, the researchers invited bilingual community members to participate in developing questions for the research survey, translated all instruments and forms into Spanish, and provided bilingual interviewers. While these researchers provided instruments in the preferred language of the participants, others (e.g., Fisher et al., 2002) have pointed out that some instruments, especially standardized instruments, may not be appropriate for use with some groups if they have not been represented in the test development process.

Using the MMPI-2, Lucio and Reyes-Lagunes (1994) pointed out a related issue of using translations. The researchers utilized transliteration, which proposes that the psychological meaning of the concept in relation to the category is more important than a strict translation. They suggest that it is important for researchers to consider that an exact translation is not always preferable because it may not enhance participants' comprehension of the concept being assessed.

Brugge, Kole, Lu, and Must (2005) worked primarily with an Asian population and in order to resolve language obstacles, they provided participants with surveys translated into Cantonese. While most of the participants completed the surveys themselves, translators were available to read the surveys and transcribe responses for participants who were unable to read.

While Marshall, Koenig, Grifhorst, and Van Ewijk (1998) acknowledged that translators decrease some of the barriers created by language limitations, they also described some of the potential problems associated with the use of translators. One potential drawback is that because jargon does not readily lend itself to precise translations, participants may not comprehend translated terminology or the nuances of the research task. Yet another potential problem is that translators may not always be objective about the content of what they are translating, especially when the translator is a member of the community or culture itself. Translators' values and beliefs may influence how communications among the translator, participant, and researcher take place. In this case, the translator retains the power of deciding which information to relay and how to relay it to the others involved, which in turn influences the level of comprehension that takes place.

Another language issue influencing informed consent is that of the readability of the consent forms provided to participants. Hochhauser (1999) reviewed several studies that have examined this issue and found that many consent forms were written at reading levels far higher (e.g., at a 12th grade reading level or higher) than was appropriate for participants and concluded that informed consent was not likely obtained.

As a way to remedy these issues, researchers can make concerted efforts to create readable consent forms by having individuals with similar reading/educational levels as participants ensure readability of forms, explain information provided in the consent forms, ask participants to explain the content of the forms in their own words, and provide participants with ample time to read the consent forms.

Influence of Authority Figures

Another factor that may influence the informed consent process is that of how participants perceive the researchers, especially as this relates to the power dynamics within the relationship (Alvidrez & Arean, 2002; Brugge, Kole, Lu, & Must, 2005; Chan, Haynes, O'Donnell, Bachino, & Vernon, 2003). Cultural characteristics such as respect for authority may influence individuals' decision to participate in research. For example, Brugge, Kole, Lu, and Must (2005) examined how respect for authority influenced elderly Asian immigrants' decision to be involved in a research study. The researchers presented the participants with written scenarios that assessed their willingness to participate in research if their family members, their landlord, and their physician asked them to participate. Participants were more likely to participate if authority figures such as landlords and physicians asked them to participate, than if they were recruited through advertisements or monetary enticements. Implications of the findings include whether or not Asian populations may be more susceptible to taking part in research studies due to their respect for authority and not necessarily due to their own willingness to be a part of the study. This in turn may affect participants' willingness to ask questions or refuse to participate due to their high level of respect for the researchers. Some racial and cultural groups mistrust researchers (Alvidrez & Arean, 2002; Darou, Hum, & Kurtness, 1993; Twenty Years After, 1992). For example, because of the Tuskegee Syphilis Study (Twenty Years After, 1992), there is an historical context for the mistrust of researchers by African Americans. That study examined the effects of syphilis on groups of African American males who were not told of the risks/effects and were denied treatment for the disease. This is an extreme example of how participants' rights were grossly violated, with immensely negative consequences. Chan, Haynes, O'Donnell, Bachino, and Vernon (2003) illustrated how the Tuskegee study can have long-standing effects on how participants view research. They conducted focus groups to determine the type of information that couples of various racial groups desired with regard to prostrate cancer screenings. The researchers discov-

ered that African Americans wanted information regarding the risks of the procedures specific to them as a racial group, which the researchers hypothesized is likely due to past research abuses. So, researchers must be aware of how history plays an important role in how some cultural groups view research.

American Indian and Alaska Native groups also have unique reasons to be suspicious of participating in health related research. Norton and Manson (1996) discussed how research results were reportedly manipulated by the media, leading to headlines linking the groups to alcoholism and likely negative perceptions by society. It should not come as a surprise, therefore, that Native groups have shown a mistrust and dislike of researchers wanting to study their culture, with researchers sometimes being denied permission to conduct such research. In the event that these groups consent to being part of a research study, however, historical factors may have an impact on how participants view researchers and how engaged they are during the informed consent process. Alvidrez and Arean (2002) have suggested providing educational materials and referrals as a way for researchers to maintain a presence and develop trust in the community for potential recruitment in future studies.

Collectivism

Collectivism refers to the degree to which members of a community or culture identify as a single unit, with decisions being made by the community as a whole rather than individually (Brugge, Kole, Lu, & Must, 2005; Cooper et al., 2004; Darou, Hum, & Kurtness, 1993; Marshall, Koenig, Grifhorst, & Van Ewijk, 1998; Norton & Manson, 1996; Quill, 2002). This can have vast implications for researchers who approach participants as individuals, without viewing them as members of their community and family.

Darou, Hum, and Kurtness (1993) explained how the idea of collectivism influenced how Native groups in Canada responded to researchers studying their culture. Researchers were expected to address the Crees as a community, as opposed to asking specific individuals for permission to conduct the study. Researchers were viewed by community members as creating conflict if they deviated from this request. In addition, researchers had to make clear the potential benefits of the study for the group as a whole in order for the group to give consent. Finally, Norton and Manson (1996) explained that some American Indian and Alaskan communities prefer to have any monetary compensation given to the community as a whole rather than to specific individuals.

Financial/Economic Concerns

When monetary compensation is provided to participants involved in research studies, researchers need to be cognizant of how this may influence the informed consent process for culturally diverse participants. Norton and Manson (1996) briefly explored this idea with respect to the American Indian and Alaska Native groups, as these communities sometimes had high rates of poverty. The authors questioned whether compensation could be perceived as coercive in light of the economic situations of the groups. It might be argued that high levels of compensation obstruct the informed consent process, with participants experiencing economic hardships because of the perception that the financial benefits outweigh any potential risks, even if this is not necessarily true. In addition, members of groups that are struggling economically may find it burdensome to miss work or pay for child care in order to be involved in a research study (Fisher et al., 2002).

Summary

Linguistic and readability issues, high regard for collectivism, mistrust of authority, and financial issues are among a few of the factors that influence informed consent when conducting mental health research

with culturally diverse groups. These factors influence various aspects of research including recruitment of participants, the participant-researcher relationship, and perceptions of psychological research. An awareness of these factors may assist researchers in creating an atmosphere whereby an open dialogue regarding informed consent can take place. This open dialogue creates a sense of trust between researchers and participants and may allow the opportunity for participants to ask more questions and gain a better understanding of the risks and benefits. This in turn may increase the likelihood that the decisions that participants make with regard to research participation will truly be theirs.

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FEATURE

Expanding Your Psychotherapy Practice into Primary Care

James H. Bray, Ph.D.

Changes in medical practice due to managed care have put tremendous pressure on primary care physicians (PCPs) to diagnosis and treat a broad spectrum of biomedical and psychosocial problems. PCPs treat over 60% of all mental health problems in the United States, without assistance from psychologists or other mental health providers. While psychologists are trained to provide the needed services, they are often NOT trained in working in primary care or collaborating with PCPs. Working in primary care provides great opportunities and challenges for psychologists. This paper will provide a brief introduction to working in primary care and how to develop referrals from PCPs. For more extensive information please see the references at the end of this article.

Psychologists can provide important diagnostic services and information about psychological treatments. PCPs are often unfamiliar with various mental disorders and psychological treatments. Successful collaboration with PCPs needs to be a win-win business relationship for both providers. PCPs want psychologists' help in solving patient care problems, being given feedback and information about their patients' status and progress, and receiving referrals back from psychologists. This type of help reduces the PCP's hassle with patient care. Psychologists can provide important diagnostic information about the patient, recommend additional psychological treatment options, provide information about the progress of psychotropic medications and help increase patient compliance with medical treatments. All of these often improve patient satisfaction (Bray & Rogers, 1995).

PCPs are "over marketed" by pharmaceutical companies, medical supply companies, and other specialists. Thus, a variety of contacts will need to be made to establish and maintain an ongoing relationship with the PCP. As we found in our research, "once is not enough," and the psychologist needs to arrange for regular contact with the PCP (Bray & Rogers, 1995). Many PCPs welcome psychologists to practice in their offices either part-time or full-time. Patients usually prefer this arrangement, since they can go to one place for their health care, they may feel less stigma about obtaining treatment for their psychological problem, and appreciate the collaboration between PCP and psychologist.

Physicians usually have a different practice style than psychologists. It is important to make arrangements to get through the doctor's staff to the physician or for the PCP to be able to rapidly contact the psychologist. Most PCPs take phone calls during sessions, while most psychologists do not. Establish ways to have regular meetings with the PCP to discuss patients (regularly scheduled breakfast, lunch, consultation time). There are a variety of other opportunities for seeing PCPs. These include joining the hospital staff at medical/surgical hospitals, joining hospital staff committees, providing continuing medical education seminars to local medical societies and provide patient education and prevention services. Be sure to market your services to the entire medical community, which includes physician assistants, nurse practitioners, nurses, and medical staff and clerks.

PCPs develop long-term relationships with their patients and provide continuity of care that includes comprehensive, continuous services in sickness and in health (Rakel, 2002). Feedback on patient progress is essential to the PCP. Most PCPs only want a brief note (1 to 3 paragraphs, no

longer than one page) about your work with the patient. They want a diagnosis, a brief explanation of your treatment plan, and any recommendations you may have to improve patient care. It is also important to help the patient return to his/her PCP for follow-up visits. Arranging for follow-up visits is a way of continuing to market your services to the PCP. Working with PCPs is a great way to expand your practice.

Further information about working with PCPs can be found in:

Bray, J. H., & Rogers, J. C. (1995). Linking psychologists and family physicians for collaborative practice. Professional Psychology: Research and Practice, 26, 132-138.

Bray, J. H. & Rogers, J. C. (1997). The linkages project: Training behavioral health professionals for collaborative practice with primary care physicians. Families, Systems, & Health, 15, 55-63.

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James H. Bray, Ph.D. is a candidate for President of the American Psychological Association. He is Director, Family Counseling Clinic and Associate Professor in the Department of Family and Community Medicine, Baylor College of Medicine, 3701 Kirby Drive, Houston, TX 77098, (713) 798-7752, jbray@bcm.edu. He maintains an active clinical practice focusing on children and families and behavioral health.

FEATURE

Licensure Mobility for Credentialed Psychologists in the US and Canada

Judy E. Hall, Ph.D. and Andrew P. Boucher
National Register of Health Service Providers in Psychology

ABSTRACT

Psychology is rapidly becoming a mobile profession. Credentialed psychologists have unprecedented access to expedited licensure mobility as a growing number of regulatory boards in the United States and Canada are incorporating provisions to expedite licensure applications. Psychologists who hold nationally recognized credentials can now apply for licensure by endorsement of credentials and bypass the time consuming and often frustrating document collection process that is traditionally associated with licensure applications. Expedited access to licensure accelerates public access to psychologists, brings psychology in step with other health care professions solution to mobility, and provides regulatory boards with more time to consider other agenda items such as emerging practice areas that require adoption of rules and regulations, such as psychopharmacology and telehealth. This article presents a summary of mobility progress to date, data on psychologists' movement, and addresses some of the concerns about licensure mobility.

The more the workforces feels mobile...the more it will be willing and able to jump into the new industries and new job niches spawned by the flat world and to move from dying companies to thriving companies (Friedman, 2005, p 285).

As adapted from Hall & Lunt (2005), there are four key components to achieving mobility for psychologists:

- Consensus by the profession on recognition standards
- Demand by psychologists for mobility
- Advocacy efforts by psychology organizations to promote multiple pathways
- Cooperation among states/provincial regulatory boards

COMPONENT 1: CONSENSUS ON RECOGNITION STANDARDS

In the US and Canada, the definition of a psychologist is at the doctoral level. Regulations and statutes typically mandate that the doctoral program either qualify as American Psychological Association (APA)/ Canadian Psychological Association (CPA) accredited or as meeting the Association of State and Provincial Psychology Boards (ASPPB)/National Register of Health Service Providers in Psychology (National Register) "Criteria for 'Defining a Doctoral Program in Psychology'" (http://www.nationalregister.org/designate.htm). Although there is slight deviation to enter practice in five states (AR, AZ, KY, WV, VT) and six provinces (AB, NB, NL, PEI, SK, QC) at the master's level, there is consensus that the doctoral level should be the admission standard for practice. The doctoral internship and the year of postdoctoral experience have been adopted by most of the jurisdictions in the US and Canada as a requirement for licensure. The same applies to the national examination for psychologists, the Examination for Professional Practice in Psychology (EPPP). So it appears that at least at the present time in the US and Canada, the profession agrees on recognition standards. That is critical to facilitating the concept of mobility, since jurisdictions must have assurances that their neighboring states or provinces are applying essentially the same requirements for licensure as they are.

COMPONENT 2: DEMAND BY PSYCHOLOGISTS FOR MOBILITY

In the 1990's psychologists and psychological organizations began advocating for a means to expedite re-licensure for currently licensed professionals who meet the

national standard for education, supervised experience, and examination performance. There were two primary reasons for this movement.

Expanding Practice Opportunities: Psychologists who seek opportunities across state/provincial lines can benefit from expedited access to licensure whether they provide services face-to-face or virtually via telehealth. For example, a Virginia licensed psychologist treats an adolescent for a year. The family moves to Colorado due to a divorce, but both parents want the psychologist to continue treating the adolescent. The psychologist could do this from a distance, but only if the psychologist is licensed in Colorado. Expedited access to a Colorado license could ensure treatment continuity. In contrast, a traditional licensure process could take months, primarily because psychology licensing boards require primary source documentation of education and training. In most cases, this means tracking down and obtaining signed verification forms from internship and postdoctoral supervisors from years past who may be difficult or impossible to locate. To compete in the healthcare marketplace and make these opportunities logistically and economically feasible, psychology needed an expediting mechanism to ease re-licensure.

Frustration and Redundancy: The evolution of the information age, spurred by the Internet, rapid data exchange, increased consumer access to information, and globalization, further added to the exasperation over traditional application processes. As psychologists sought re-licensure to pursue emerging opportunities, many asked a fundamental question: If I have met the licensure requirements for licensure in at least one state, and I have met the credentialing requirements for a post-licensure nationally recognized organization through primary source documentation, and I have not had any disciplinary action taken against any license, why must I go through the entire process anew in another jurisdiction?

Survey Data on Demonstrates Demand for Licensure Mobility

In a survey of National Register credentialed psychologists in 2004 as reported in *The Register Report* (Fall, 2004), 57% of the 3665 respondents indicated that licensure mobility was "very important" to them. This survey was sent to the ~8,000 National Register credentialed psychologists with email addresses on file. There was a 46% response rate to the survey. This outcome was no surprise to the National Register as a concerted effort to address the mobility problem had been initiated by the National Register in the late nineties based upon repeated requests by Registrants. Separate surveys of graduate students and early career psychologists in 2005 produced similar results. Of the 3835 responses to the 2005 National Register Graduate Student Survey, 62% described licensure mobility as a "very important" credentialing benefit. Of the 1819 responses (as of 5/1/2006) to the 2005 National Register Early Career Psychologist Survey, 57% described licensure mobility as a "very important" credentialing benefit. Therefore, the conclusion can be drawn that mobility is an important issue to doctoral students, early career psychologists, and more established practitioners.

Component 3: Advocacy efforts by psychology organizations to promote multiple pathways

The National Register, established in 1974, is the largest and most successful credentialing organization in psychology in terms of numbers credentialed (Wise, Hall, Ritchie & Turner, in press). For thirty years the National Register has promoted licensed psychologists who are qualified by education, training and experience in health service provision to be included in health care plans. However, psychologists want more than simply the distinction of being credentialed by the National Register.

Taking the initiative, Missouri was the first state to include a mechanism for mobility when it endorsed the National Register

credential for that purpose. According to Carl Willis, (Boucher, 2001), this 1989 legislation, "grew out of a state-wide planning conference that addressed the future of psychology and what laws were needed for the public as well as the profession" (p. 16). Unfortunately, many years passed before other states followed Missouri's lead. In 1999, Virginia adopted the National Register, followed by the District of Columbia and Maryland in 2000. Based upon the leadership shown by these states and a very positive Registrant response to the value of this benefit, National Register representatives began meeting with representatives of licensing boards and psychological associations across the US and Canada to discuss licensure mobility. ASPPB representatives engaged in a similar and successful effort.

Licensing boards first needed to understand the concept of endorsement of individual credentials as a mechanism to facilitate licensure. Slowly, the boards began to realize that by allowing a non-profit national credentialing organization acting as a credentials repository to verify primary source documentation directly to a licensing body, both the psychologist and the board benefited, saved time and money, and the consumer gained by the expedited access to services.

Deemed Equivalence

The concept of using established mechanisms to facilitate licensure for already licensed psychologists is based upon the licensing board reviewing the credentialing organization's requirements for credentialing and at the same time that the organizations relies on primary source documentation, and determining that the criteria are deemed to be equivalent to those required for licensure. Deemed equivalence means that a jurisdiction might require 1600 hours on internship for an initial applicant but still be able to accept either the National Register or the CPQ, both of which require a minimum of 1500 hours. The difference is that these credentialed psychologists are already licensed in one jurisdiction, have met national standards for education and training, and have no disciplinary actions on their record.

Current Success

These efforts over the past seven years to reason with licensure boards have resulted in dynamic growth in the number of jurisdictions in which psychologists can expedite licensure and health service provider (HSP) recognition. As of this writing, 41 jurisdictions in the United States and Canada have voted to approve the National Register Health Service Provider in Psychology credential to expedite licensure. More are considering endorsement of the National Register for this purpose.

How Does the National Register Mobility Program Help?

Licensure by endorsement does not constitute a right to practice in other jurisdictions, or the right to become automatically licensed. The endorsement candidate must complete a general information form, pass any required oral or jurisprudence exams, and be approved by the regulatory board. This process simply assists licensure boards in their function to review candidates for licensure.

In most cases, the National Register verification exempts the psychologist from ordering transcripts, locating past supervisors to document the internship and postdoctoral experience, and submitting EPPP scores to the licensing board. (A few boards require the EPPP scores to be sent directly to the board office.) There is no fee charged to the Registrant or paid by the licensing board for the credentials verification.

The features of the expedited licensure process vary by jurisdiction. For ease of understanding exactly what is waived based upon credentials verification by the National Register, see table 1 on page 52.

Table 1: Jurisdictions that currently recognize or are currently in process (IP) of modifying regulations to accept the National Register Health Service in Provider in Psychology credential to expedite licensure mobility

Waive Documentation of Doctoral Degree, Internship and Postdoctoral Year, and EPPP Score

Alberta
Arkansas
British Columbia
California
Colorado
District of Columbia
Delaware (IP)
Hawaii
Indiana (IP)
Manitoba
Massachusetts (IP)
Missouri
Montana
New Brunswick*
Nebraska
Nevada
Newfoundland/Labrador
North Carolina (IP)
North Dakota (IP)
Northwest Territories*
Nova Scotia*
Ontario*
Oregon
Quebec
Pennsylvania
Prince Edward Island
Rhode Island
Saskatchewan
Tennessee
Texas
Utah (IP)
Virginia
Washington
West Virginia
Wyoming (IP)

Waive Documentation of Doctoral Degree, Internship and Postdoctoral Year, and EPPP Score

Arizona
Iowa
Maryland
Minnesota (IP)
New Mexico

Board Accepts Primary Source Documentation from the National Register as part of the Application Process

South Carolina

* May only apply to Canadian Licensees

Other Organizations Promote Mobility

Other credentialing organizations promote mobility. The ASPPB Certificate of Professional Qualification (CPQ) and the American Board of Professional Psychology (ABPP) specialty certification facilitate mobility and function in much the same way that the National Register credential does, as individual endorsement mechanisms. Currently, approximately 3700 psychologists hold the CPQ (ASPPB, n.d.), and 2600 hold the ABPP certification (Finch, 2006). Both of these organizations have sought recognition by state licensing boards and been successful. In fact, in the U.S. with its 50 different jurisdictions enacting slightly differing laws and regulations, endorsement of an individual credential is the most successful mechanism for expediting licensure. The other three mechanisms (reciprocity agreements, senior psychologist provisions and endorsement of other jurisdictions' license) have not been adopted by many jurisdictions and apply to fewer psychologists.

Psychologists Movement

In 2004, the National Register began tracking credentials verification letters sent on

behalf of Registrants to licensure boards to expedite mobility. As of April 2006, there were 421 known verifications, with each year's total increasing over the previous year. However, this number is an underestimate. It does not include the verifications that occur by state boards using the National Register Find Psychologist Database. (For example, the Missouri licensing board verifies the National Register credential holder online.) In addition, while the number taking advantage of licensure mobility may not be large in comparison to the total number of National Register credentialed psychologists (~13,000), we know from survey data and Registrants that the availability of this benefit is very important to them. It is there when they need it.

Mobility within Canada

In Canada the demand for mobility came from outside the profession. The federal government, as a result of the Agreement on Internal Trade, mandated a multi-year process of psychology organizations cooperating together to develop a mutual recognition agreement (MRA). The three psychology organizations, (CPA, Canadian Register of Health Service Providers in Psychology [Canadian Register], and the Council of Provincial Associations of Psychologists [CPAP]), developed the MRA and 11 provinces and one territory signed it thereby agreeing to fast track mechanisms for expediting licensure and competency based assessment for initial licensure. See Hall and Lunt (2005) or www.cpa.ca for more information.

The fast track mechanisms included in the MRA were credentialing by the National Register or the Canadian Register, graduation from an APA/CPA approved program in psychology, attainment of the CPQ or five years of licensed practice without discipline. These five fast track mechanisms expedite licensure for licensed/registered psychologists in Canada as long as their degree matches the admission requirements in the province/territory. However, for psychologists moving from the US to Canada, a separate approval of the credential had to be secured. Today, a majority of the Canadian provinces have approved the National Register and the CPQ for south to north mobility.

An additional mechanism for expedited licensure exists in Canada, the Canadian Register, which has around 3000 credentialed psychologists. However it exists as a mobility mechanism only in Canada, just as ABPP is written into only US laws.

BARRIERS TO MOBILITY

Protecting the Public

Licensing boards are tasked with protecting the public from the practice of psychology by unqualified persons. In the past and even now with several jurisdictions that are currently considering endorsing mobility mechanisms, board members have questioned if outsourcing the primary source credentialing, which was traditionally within the purview of the board, serves the public interest. It does. In the first place, all National Register credentialed psychologists have successfully applied for at least one license prior to credentialing, and then have met the National Register credentialing requirements (see http://www. nationalregister.org/criteriaforhspp.htm). In addition, almost all boards that accept the National Register credential to expedite licensure administer an oral or written jurisprudence examination to each candidate. This final step allows the board to assess the applicant's current knowledge for practicing in that jurisdiction. Although licensure applicants rarely fail that exam, this step gives discretionary authority and autonomy to the licensing board, with the board the final authority on granting the license.

Years of Practice and Disciplinary Actions

There is no minimum number of years that a licensed psychologist must practice before being eligible for the National

Register credential. This is in contrast to the requirements for the CPQ, which state that a psychologist must be licensed for at least 5 years prior to qualifying for the CPQ. Some of the ABPP specialty boards also require a minimum number of years of experience. During the early years of the National Register mobility effort, this presented a problem in that a few boards were concerned about new psychologists applying for the National Register and then using the credential to immediately expedite licensure in additional jurisdictions. Individual board members specifically noted that the National Register credentialed psychologists could have little post licensure experience and therefore no track record, and could be a disciplinary risk.

The National Register disagrees with this position for several reasons. First, the basis of licensure by endorsement is static credentialing information that will not change over time (doctoral degree, supervised experience, examinations scores). Second, new psychologists deserve mobility options, and to deny this privilege based on years of practice following initial licensure could be considered age discrimination and unfair restriction of trade. Perhaps more compelling for licensing boards is that we determined that new psychologists are not a high risk population for disciplinary action.

The National Register analyzed its national disciplinary data on psychologists to investigate if the more newly licensed psychologists had been disciplined more frequently than psychologists with five years of licensed practice (Hall & Boucher, 2003). The National Register calculated the average number of years lapsed between degree date or date of first license and date of disciplinary action.

The disciplinary database consisted of 2748 psychologists with actions taking place between 1971 and 2002. The National Register was able to locate either the degree date or date of first license and date of action on 1487 of the individuals. Information regarding the individuals' degree date / date of first license was found in data provided by state licensing boards; the National Register database/ Registrant files (for Registrants) and APA Membership Directories between 1981 and 2001.

The results showed that the average time lapsed between degree date/date of first license and date of disciplinary action was 20.8 years. More than 70% of disciplinary actions analyzed occur in practitioners who are between 11 and 35 years past degree date/date of first license. Moreover, 94.5% of the cases involve disciplinary actions occurring more than 5 years after the degree date/date of first license. The data indicate that a doctoral psychologist in the first five years after degree date/date of first license is less likely to commit an act resulting in a disciplinary action than a more seasoned psychologist (Hall & Boucher, 2003).

These results support the National Register's earlier decision in 1974 to allow licensed psychologists to apply immediately if they had completed a year of postdoctoral experience in health service provision. (At that time a majority of the states did not require a year of postdoctoral experience for admission to licensure.) These data also support the National Register's more recent decision to promote mobility for all licensed psychologists that qualify, regardless of amount of practice experience.

Promoting Multiple Pathways

Another question typically posed by licensing boards is which mechanism to adopt: the National Register, the CPQ, or ABPP? The National Register encourages adoption of all three. There are several reasons for this. First and most importantly, adopting all three significantly increases the number of psychologists affected. The National Register currently credentials ~13,000 psychologists, ~3700 psychologists hold a CPQ, and ~2600 psychologists are certified by ABPP. Although there is considerable overlap, adopting all three mechanisms affects more than 16,000 credentialed psychologists. When boards adopt

fewer than all three mechanisms, the percentage of licensed psychologists eligible for mobility significantly decreases. The other primary reason to adopt all three mechanisms correlates to the overall purpose of mobility – eliminate repetitive credentialing. For example, if a jurisdiction adopts ABPP but does not adopt the National Register or CPQ, any National Register or CPQ psychologist must apply for the ABPP to get expedited access to licensure, or they must apply through traditional means.

Licensure Mobility is a Benefit

Psychologists often describe licensure mobility in terms of a practitioner benefit that saves time and money. Consumers will come to see mobility in terms of faster access to psychological services. By relying on the National Register or another credentialing organization to thoroughly vet the credentials of each applicant and to verify the same, the board is relieved of the time consuming task of obtaining and reviewing primary source documentation. Thus expedited licensure mobility is a benefit to licensed psychologists, to the public and to the licensing boards. There is really no justifiable reason for all state, provincial and territorial boards not to endorse the available mechanisms. In time, hopefully this will be a national standard: expedite the licensure process for those licensed and credentialed psychologists with no disciplinary actions. There are many other areas in psychology where improvement is needed and opportunities are present. Hopefully we can focus on progress in the future, not re-documenting the past.

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