Psychotherapy

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BULLETIN

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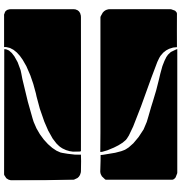

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PSYCHOTHERAPY BULLETIN

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

Contributors are invited to send articles (up to 4,000 words), interviews, commentaries, letters to the editor, and announcements to Craig N. Shealy, Ph.D., Editor, *Psychotherapy Bulletin*. Please note that *Psychotherapy Bulletin* does not publish book reviews (these are published in *Psychotherapy*, the official journal of Division 29). All submissions for *Psychotherapy Bulletin* should be sent electronically to 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).

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PSYCHOTHERAPY BULLETIN

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PRESIDENT'S COLUMN

Abe Wolf, Ph.D.

Edinburgh 2006

The Society for Psychotherapy Research (SPR) is an international, multidisciplinary, scientific organization devoted to the study of psychotherapy. In the past year, I attended several regional and international SPR meetings to strengthen ties between our organizations. The energy and enthusiasm for psychotherapy is alive and well at SPR meetings.

This was certainly true at the 37th annual meeting of SPR held in Edinburgh, Scotland, June 21-24, 2006 where the theme was "From Research to Practice." Over 600 delegates from 33 countries converged on Pollock Halls, the dormitory campus of the University of Edinburgh. It has been a number of years since I stayed in a college dormitory room and ate in a student cafeteria. While college dormitories may be the same all over the world, this campus was special. Pollack Halls is situated beneath Arthur's Seat, an extinct volcano that dominates the landscape of Edinburgh. St. Leonard's Hall, where many of the sessions were held, is a 19th century Victorian mansion with meeting rooms filled with intricate wood and stone carvings and murals. (In the middle of the session where I presented, I looked up and was distracted by the most elaborate ceiling.) The student cafeteria offered that uniquely Scottish dish, haggis (meat and vegetarian), for breakfast. The lively discussions continued well past the meetings in pubs and restaurants over pints of Guinness and glasses of single malt Scotch.

The Division of Psychotherapy and SPR have common ground and common leadership. The efforts of SPR members, led by the Chair of our Research Committee, Bill Stiles, produced the white paper on the need for increased funding for psychotherapy research published in the last issue of this newsletter. Jeff Hayes, president-elect of the North America chapter of SPR, is a past-chair of our Education and Training Committee. The North America Executive Officer is Nick Ladany, an associate editor of our journal, *Psychotherapy*. Libby Nutt-Williams, who was awarded the 2006 international early career award, is member-at-large on our Board of Directors and this year's recipient of our division's early career award. (Way to go, Libby!)

The Division of Psychotherapy made a

direct contribution to the Edinburgh meeting by sponsoring the continuing education credit. The following is a sample of some the sessions, many organized by our members:

- Challenging critical inner voices: An adjunct to clinical practice
- Empirically grounded psychotherapy training: Implications of a large international study
- Insights in psychotherapy:
  - Empirical findings about its nature and impact
  - An exploration of theoretical models and their empirical implications
- Compassion: Stupid kindness or caring for the suffering of the world?
- Emerging findings about the "real" relationship in psychotherapy
- Western psychotherapies in nonwestern societies: Clienteles and cultural adaptations
- Therapist countertransference, mindfulness, and self-awareness: Implications for training and research

Finally, the Plenary Presidential Address, "What we have learned from 10 years of measuring patient session-by-session treatment response," was delivered by Michael Lambert, a former chair of our Publication Board.

The Division of Psychotherapy will continue to support SPR by sponsoring continuing education at their North America meeting scheduled for October 26-29, 2006 in Burr Oaks, Ohio. Finally, our Executive Committee extended an invitation to the SPR Executive Officers to appoint one of their members to our Research Committee.

The efforts of psychotherapy researchers provide the empirical basis for claims that psychotherapy works and how it works. As advocates for health care policies that include reimbursement for psychotherapy and other psychological services, we in Division 29 need to keep current on the work of those who are practicing what we preach about the validity of the spectrum of evidence in psychotherapy research. We need to understand how the findings of psychotherapy researchers are not certainties that can be used by insurance companies to prescribe practice guidelines. Rather, these findings are progress reports from the research front. Psychotherapy research, like all research, has more to do with "knowledge pursued" than "knowledge found."

Congratulations to our colleagues at SPR for a great meeting in Edinburgh. To learn more about this organization and the North America meeting, visit their web site at www.psychotherapyresearch.org.

Bulletin ADVERTISING RATES

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All APA Divisions and Subsidiaries (Task Forces, Standing and Ad Hoc Committees, Liaison and Representative Roles) materials will be published at no charge as space allows.

EDITOR'S COLUMN

Introducing our new Associate Editor, Harriet C. Cobb, Ed.D.

Harriet C. Cobb, Ed.D.

Let me begin by sharing a bit about myself, looking across the eras in my professional career. My first era began after I graduated with a master's degree in school psychology from Indiana University. My intervention training was heavily behavioral, with assessment and consultation also emphasized. My experiences in the schools focused me on facilitating improvement in the quality of life for children. I came to see schools' remarkable potential for contributing (for better or worse) to a child's world view, sense of competence, and emotional well-being. In this mountainous rural school district, I was one of the few health/mental health professionals in contact with children and families. Given my training, I could develop a behavior modification plan with the best of them. However, when an exhausted mother of a depressed 11 year old boy asked me if I could talk with her son, it sparked a transformation in my thinking. I soon learned the centrality of a therapeutic relationship in delivering primary mental health care to children and families. This insight generalized to realizing how important authentic relationships are, not only with our clients, but also with, well, almost everyone we encounter.

In the process of obtaining my doctoral degree from the University of Virginia, I learned multiple approaches to understanding human behavior and intervening therapeutically.

The subsequent era expanded my clinical work to include psychotherapy with adults and couples, always looking to interactions with the ecological system as an important component of conceptualization and as a potential intervention ally to support clients' growth. My earlier work in schools and two decades of part time private practice have allowed me to follow the progress of individuals whom I first saw as children, then episodically into adulthood, and now sometimes as their own children hit rough spots in their development. I've learned an incredible amount from my clients, who have greatly influenced my integrated approach to psychotherapy.

Currently I am in my 25th year as a professor at James Madison University, teaching in the Combined-Integrated Doctoral Program in Clinical and School Psychology (while continuing to practice). We are at our best as trainers, clinical supervisors, and psychotherapists when we attend to our own and our students' self-awareness, capacity for critical thinking, and engagement in genuine, meaningful relationships. We also must continue to be open to growth—I cannot imagine practicing without the benefit of my monthly peer supervision group, or without studying psychotherapy process and outcome.

I am confident that psychotherapy has a bright future. Given the complexity and challenges of life, individuals, families, and groups will always seek a knowledgeable, skilled, and caring professional to whom they can turn for assistance. Psychologists do not have exclusive knowledge or skill in facilitating well-being, although we are sought after for our ability to put it all together: the relationships among theory, science, and practice. We plan, implement, and evaluate therapeutic interventions that are based on a broad and deep under-

standing of the client in the context of biopsychosocial systems. I am now embracing the potential for a comprehensive, unified framework linking biopsychosocial systems with a multi-component model of psychotherapy (as described in an article in the previous issue of the *Bulletin* by Anchin and Magnavita, 2006; see also Henriques, 2004.)

I am excited about serving as Associate Editor for the *Bulletin*. The content and format of this journal are very appealing. Craig first lured me into membership in Division 29 with the enticement that I would find many kindred spirits in the organization. I look forward to becoming better acquainted with my fellow members and hearing your thoughts.

REFERENCES:

Anchin, J.C., & Magnavita, J.J. (2006). The nature of unified clinical science: Implications for psychotherapeutic theory, practice, training, and research. *Psychotherapy Bulletin, 41,* 26-36.

Henriques, G. R. (2004). The development of the unified theory and the future of psychotherapy. *Psychotherapy Bulletin*, 39, 16-21.

Jack Krasner Early Career Award: The Early Career Award is made each year to a psychologist who shows exceptional professional accomplishments in psychotherapy theory, practice, research, or training within 10 years of receiving her doctorate. Dr. Elizabeth Nutt Williams is the winner of the Early Career Award. Dr. Williams is an Associate Professor of Psychology and Coordinator of Women, Gender and Sexuality Studies at St. Mary's College of Maryland. She teaches courses in psychology, mostly related to clinical and counseling issues. She also has maintained a very productive program of research with a special focus on therapist in-session self-awareness and on integrating feminism and multiculturalism into therapy. She has delivered more than 55 professional presentations and authored or co-authored more than 25 publications. She has also made major contributions to the profession by serving on numerous committees and on editorial boards.

Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy: The Distinguished Psychologist Award is based on significance of contributions to the practice, research, and/or training in psychotherapy. The 2006 award is made to Dr. Louis G. Castonguay. Dr. Castonguay is an Associate Professor in the Department of Psychology at The Pennsylvania State University, where he also served as the Associate Director for the Clinical Program and the Director of Graduate Studies. His research focuses on the process of change in different models of psychotherapy, especially for the treatment of anxiety disorders and depression. He has more than 70 publications and 100 professional presentations. He has served as president of the North American division of the Society for Psychotherapy Research. He is one of the leaders in the field of integrative psychotherapy.

Please join us on Friday, August 11th, at the Division of Psychotherapy's Social and Awards Hour, 6:00 pm at the Hilton New Orleans Riverside Hotel, New Orleans, Louisiana where we will honor these 2006 award winners.

THE DIVISION OF PSYCHOTHERAPY ON-LINE ACADEMY

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Taking care of the hated and hateful patient

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Dorothy Evans Holmes, Ph.D.
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Karen J. Maroda, Ph.D.
Chair, Abe Wolf, Ph.D.

This symposium, originally presented at the 2005 APA Convention in Washington D.C., is now available online as an audio program with accompanying PowerPoint presentations. The program brings together four experienced psychotherapists to discuss the theoretical aspects of countertransference anger and hatred and its management in practice. The online program provides four continuing education credits at a cost of $80.00. To register, go to www.apa.org/ce.

Power Plays, Negotiation and Mutual Recognition in the Therapeutic Alliance
(duration 18:08)
J. Christopher Muran, Ph.D.
Albert Einstein College of Medicine

The Vicissitudes of Race-Based Hatred in the Crucible of Transference-Countertransference Reactions
(duration 28:22)
Dorothy Evans Holmes, Ph.D.
George Washington University

Embracing Hate in the Therapeutic Moment
(duration 17:29)
Jean A. Carter, Ph.D.
Independent Practice

Countertransference Anger And Hatred: The Last Frontier?
(duration 27:08)
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STUDENT ABSTRACT

Distress Tolerance Treatment for Substance Abuse

Adam M. Leventhal, M.A., University of Houston, Houston, TX

Introduction

Many individuals who abuse alcohol, tobacco, or other substances relapse shortly after attempting cessation or drop out or out of treatment early, which often ends in resumed use (Daughters et al., 2005; Garvey et al., 1992). A significant portion of these individuals relapse within hours or days of their cessation attempt, especially in the case of cigarette smoking (Brown et al., 1998). As a result, elucidating the mechanisms that underlie early relapse and treatment drop out in substance abuse is an important endeavor.

While there are several possible risk factors for early relapse/dropout, studies have shown that early relapsers have low distress tolerance (Brown et al., 2002, 2004; Daughters et al., 2005). This finding is of considerable clinical interest because it points to a potential target for psychotherapy. The distress tolerance theory proposes that although unpleasant symptoms caused by drug withdrawal and stress following quitting (e.g., anxiety, depression, irritability, craving) are highly common, those with low distress tolerance are most vulnerable to relapse because they are unable to "tolerate" these uncomfortable states (Brown et al., 2005). On the other hand, individuals who can tolerate the discomfort of quitting can cope without resuming use (and dropping out of treatment).

The Distress Tolerance Construct

Distress tolerance is defined as the capacity to experience and withstand negative psychological states. Distress can result from cognitive, physiological, and/or environmental processes and is manifested as an emotional state that often is accompanied by tendencies to ameliorate the emotional experience. Distress tolerance is independent of distress and is considered a meta-emotion that consists of evaluations and reactions to uncomfortable states. Individuals low in distress tolerance: (1) feel that distress is unbearable; (2) appraise their own ability to cope with distress as poor; (3) are more likely to avoid negative emotions and use rapid means of alleviating negative emotions; and (4) feel consumed and psychologically disrupted when uncomfortable feelings cannot be quickly ameliorated (Simons & Gaher, 2005).

There are several standardized methods to assess distress tolerance. Laboratory-based approaches measure ability to tolerate psychological and physical stressor tasks. For example, researchers have measured persistence on stressful tasks requiring individuals to perform arithmetic, trace patterns (in which the computer mouse moves in the reverse direction), hold their breath, and keep their hand and forearm in a container of ice water (Daughters et al., 2005). A self-report distress tolerance scale can be utilized for clinicians without laboratory means. Simons and Gaher (2005) have developed a 15-item questionnaire that asks respondents to agree or disagree to self-statements relevant to the distress tolerance construct (e.g., "Feeling distressed or upset is unbearable to me"; "I'll do anything to stop feeling distressed or upset"). Unstandardized interviewing methods can be used to uncover whether a client displays patterns of behavior involving emotional avoidance and quick alleviation of negative psychological states. Another common feature is the belief that negative emotions are unbearable, difficult to cope with, and psychologically "draining." In a substance abuse setting, individuals with low distress tolerance are more likely to report using drugs as means to cope with negative emotions (Simons & Gaher, 2005). It should be noted that the distress tolerance construct has substantial overlap with other psychological tendencies such as

experiential avoidance (Hayes et al., 1996) and affect regulation (Linehan, 1993), which should be taken into account when assessing distress tolerance.

Empirical Evidence of the Relationship between Low Distress Tolerance and Relapse

The majority of recent research examining distress tolerance and relapse has been conducted by Richard Brown and his colleagues. This work has demonstrated that low distress tolerance, as evidenced by poor persistence on distress tolerance tasks, predicts early treatment dropout in a residential substance abuse treatment facility and early smoking relapse (Brown et al., 2002, 2004; Daughters et al., 2005), even after controlling for the effects of other affective risk factors, such as history of major depression (Brown et al., 2004). Distress tolerance might be especially associated with *early* lapse and treatment drop out (rather than protracted relapse) because remission of withdrawal symptoms and acclimation to drug abuse treatment procedures usually occur shortly after cessation, yet individuals with low distress tolerance levels cannot cope with this discomfort even for short periods.

Using Psychotherapy to Enhance Distress Tolerance in Substance Abusers

A common approach in substance abuse treatment is to help clients learn coping skills that will be useful in responding to situations that generally motivate relapse (e.g., stressful interpersonal experiences and negative affective states) (Wikiewitz et al., 2005). However, individuals with low distress tolerance may relapse or drop out of treatment before the therapist is able to implement these interventions. Therefore, therapy designed to enhance distress tolerance and reduce risk of early relapse should be implemented *before* cessation in some cases. For example, in the treatment of tobacco dependence, smokers with low distress tolerance may seriously doubt their ability to handle the discomfort of nicotine withdrawal. This could be challenged by prescribing specific periods of abstinence prior to quit date, that progressively increase in time and intensity (Brown et al., 2005). Similar to how patients with panic disorder can overcome their fear of interoceptive sensations during exposure exercises designed to induce panic (Craske & Barlow, 2001), substance abusing patients can counteract their fear of sensations associated with withdrawal by scheduled cessation "exposures."

During scheduled abstinence periods and throughout other portions of therapy, clinicians can use acceptance and commitment therapy approaches to help clients actively accept thoughts, feelings, and bodily sensations that might promote relapse (Wilson & Byrd, 2005), without taking a judgmental stance. In a similar vein, mindfulness-based techniques can be applied to help clients focus their attention toward unpleasant feelings and desire to ameliorate such feelings (Witkiewitz et al., 2005), which may disrupt automatic processes that promote substance use following negative affect (Baker et al., 2004). In general, these approaches can help clients with low distress tolerance de-center themselves from unhelpful relapse-promoting thoughts such as, "I can't handle feeling this way, I must do something about it immediately" and cope with uncomfortable emotional states. There is empirical support for the effectiveness and efficacy of these approaches (Alterman et al., 2004; Brown et al., 2006; Gifford et al., 2004; Hayes et al., 2005). For a more detailed discussion of how these approaches can be utilized to help substance abusing clients who are at risk for early relapse or treatment drop out, consult Brown et al. (2005), Wikiewitz et al., (2005), and Wilson & Bird (2005).

Summary and Implications

Early relapse and treatment dropout by substance-abusing clients is an important problem that may be related to low distress tolerance. There are several methods that

can be used to assess distress tolerance in order to identify at-risk clients. In addition, there are several techniques that can be implemented in psychotherapy to target low distress tolerance in order to improve substance use treatment retention and outcomes. Given that distress tolerance and related traits have been linked to other clinical syndromes, such as obsessive-compulsive disorder, panic disorder, borderline personality disorder, and suicidality (Hayes et al., 1996), treatments targeting distress tolerance may be useful for clinicians treating multiple types of substance-abusing patients with complex clinic pictures. Furthermore, similar clinical concepts may be useful in treating substance abusers with impulsive traits and low boredom tolerance. These individuals might be at increased risk of relapse because of inability to endure unstimulating psychological states characterized by low positive affect and anhedonia following cessation. Future research expanding the concept of tolerance of affective states and its role in substance abuse may be useful for the development of more effective interventions.

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CONGRATULATIONS TO THE DIVISION'S STUDENT PAPER AWARD WINNERS!

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Psychotherapy with Muslims in America: Theory and Practice

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Each of these recipients receive a cash prize of $100 and plaque to be presented at the Division 29 Social and Awards Hour, Friday August 11th, 6:00 pm at the Hilton New Orleans Riverside Hotel, New Orleans, Louisiana

STUDENT ABSTRACT

Psychotherapy with Muslims in America: Theory and Practice

Shin Shin Tang, University of Oregon

Islam is one the fastest growing religions in the U.S., where an estimated 2 to 5 million Muslims make their home (Ali, Liu, & Humedian, 2004). Most American Muslims hold a unique "dual minority" status in this society as members of a minority religion who are also ethnic minorities. The American Psychological Association code of ethics (2002) recognizes both culture and religion as factors that may be essential for effective implementation of psychotherapy. Therefore, it is imperative that psychologists begin to address the growing needs of Muslims in the U.S.

This paper first presents a brief history and overview of Islam in the U.S. and describes indigenous Islamic perspectives of psychology. Next, it provides a review of the extant literature regarding psychotherapy with Muslims and common themes that may arise. Finally, borrowing heavily from principles of cultural competence, it also suggests ways to incorporate religious competence into psychotherapy with Muslims in the areas of assessment and treatment. These include using the framework of cultural competence as defined by cross-cultural psychologist Stanley Sue (1998) and considering the varying levels of integration of religion into psychotherapy.

Sue (1998) has proposed that three main elements define cultural competence: scientific mindedness, dynamic-sizing skills, and culture-specific expertise. Scientific mindedness refers to the formation of preliminary hypotheses by the therapist rather than assuming that client processes are the same across cultures. Dynamic sizing refers to the ability of the therapist to know the appropriate time to attribute client experiences to a general cultural context and when to individualize interpretations. For some Muslims, religion may be an especially salient aspect of their presenting problem whereas for others it may seem irrelevant in the context of psychotherapy (Kobeisy, 2004). Finally, cultural expertise emphasizes a need to be familiar with cultural norms or be willing to consult with cultural experts.

Recommendations made in the literature regarding practical methods of conducting religious-cultural psychotherapy can be grouped into several levels, each requiring successively more integration of the religious beliefs and customs into the therapy. At the most basic level, one is aware of the mores of the client and strives to respect them, although they are not necessarily part of the therapeutic dialogue. For example, a male therapist may avoid offering to shake hands with a Muslim woman who may be prohibited from having physical contact with a man to whom she is not related (Rehman & Dziegliewski, 2004).

The next level of incorporating religion would be to begin to discuss religious beliefs in the counseling and use them when applicable to support the client's recovery. Doing so may require the therapist to relinquish, or at least temporarily set aside, his or her belief system in order to embrace the client's religious viewpoint. Finally, one can approach therapy from an entirely indigenous, emic, view in which the religion guides the goals and conceptualization of treatment (Khalili, Murken, Reich, Shah, & Vahabzadeh, 2002)

As the population of Muslims continues to expand rapidly in the U.S., the need for religiously and culturally competent therapy will also rise. A working knowledge of Islam, its history and indigenous views of

mental health are necessary and minimal components of competency. It is also important to understand the various cultural contexts in which Muslims live and how they affect presenting problems such as domestic violence and substance use or even seemingly mundane issues such as dating and marriage. Finally, in the spirit of dynamic-sizing, one should also have the ability to apply such knowledge judiciously and within ethical boundaries.

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RESEARCH

Involving the Family in the Treatment of Childhood Anxiety Disorders

Lynne Siqueland and Susan Bögels, Children's Center for OCD and Anxiety

The last 5 to 10 years have yielded important research developments regarding the family factors associated with anxiety disorders in children. These research findings can help clinicians assess for interaction patterns within families and guide targets for intervention. While most of the treatment studies have incorporated family interventions within a cognitive behavioral treatment (CBT), many of the interventions could stand on their own or be integrated with other treatment approaches used with anxious youth. Clearly the identified family factors are not relevant in every family that has an anxious child, but they suggest how treatment can be modified based on the specific family's needs. For this article, we focus on studies related to our own family interaction and treatment development work. For more thorough and recent reviews of family factors and family treatment see Bögels and Brechman-Touissaint (2006), Ginsburg and Schlossberg (2002), or Ginsburg, Siqueland, Masia-Warner and Hedke (2004).

Anxiety disorders run in families. Children of parents with an anxiety disorder are at risk. They are 7 times more likely to have an anxiety disorder than children of parents with no disorder, and 2 times more likely than children of depressed parents (e.g., Beidel & Turner, 1997). From the other perspective, children diagnosed with anxiety disorders are likely to have parents who have anxiety disorders (57% currently and 83% over their lifetime) (Cooper, Fearn, Willetts, Seabrook, & Parkinson, in press; Last, Strauss, Hersen, Francis, & Grubb, 1987). The first thing the clinician must be aware of is the role of anxiety disorders in the family members of the referred patient

Observed interactions of anxious children. A few studies have moved beyond self report of family environments and coded interactions of the families of children with anxiety disorders. In one of the earliest studies, my colleagues and I asked families to discuss "hot topics" together and were interested in how we could assess "psychological autonomy granting," parenting behavior found to have a role in internalizing symptoms in the developmental literature (Barber, 2001). Psychological autonomy granting was defined by such behaviors as solicits child's opinion, tolerates differences of opinion, avoids judgmental or dismissive reactions, encourages child to think independently, and uses inductive techniques. We had observers rate these interactions and asked the families to fill out self reports used in previous studies. Children with anxiety disorders experienced their parents as less warm and accepting of them than did control children, and observers generally agreed with the children, rating their interactions as lower in psychological autonomy granting than control families' interactions. Parents of anxious children rated themselves as no different from control parents (Siqueland et al., 1996).

A number of other studies have now pointed to the role of overcontrol, over-involvement and/or overprotection in anxiety disorders in children. All of these constructs speak to the phenomenon of a parent doing things for a child, taking over for a child, or shutting down a child's emotional expression or individuality. Psychological control (limiting autonomy or keeping child emotionally dependent on parent) appears to be more important than behavior control (setting rules and limits) in anxiety disorders (for review, see Bögels & Touissaint,

2006). Indeed, Ginsburg, Grover, and Ialongo (2004) found that autonomy granting at age 6 predicted lower reports of anxiety at age 12.

Interactions of anxious parents. From the perspective of parents with anxiety disorders, Whaley, Pinto, and Sigman (1999) used our coding system along with some additions, and they reported that anxious mothers were less warm and positive in their interactions with their children, less granting of autonomy, and more critical and catastrophizing in their comments. Woodruff-Borden, Morrow, Bourland, and Cambron (2002) reported that anxious mothers were more withdrawn and disengaged and more controlling, specifically in response to child displays of negative affect, than control mothers. Woodruff-Borden et al. (2002) suggested that parents may be withdrawn and disengaged because child anxiety triggers parental anxiety. Then parents focus on managing own anxiety, or they cannot share or model coping skills for their child. In addition, Siqueland, Rynn, and Diamond (2005) noted similar patterns based on clinical experience, and suggested that parents may also fear that the expression of negative affect could endanger or damage the child-parent relationship.

Taken together, next to higher levels of criticism, two contrasting behavior patterns are found in anxious parent-child dyads: over- or undercontrol. These parenting styles may either reflect differences between parents struggling with their child's and/or their own anxiety, or differences within parents. That is, parents may first overcontrol their anxious child, and switch to undercontrol (give up) if that does not help. Clearly child anxiety can elicit these behaviors highlighting the dyadic and reciprocal nature of these interactions.

Interpretation of threat and coping. It is unclear whether the family patterns noted are specific to anxiety or may simply reflect the difference between parents or children who struggle with any type of psychopathology. One pattern of family interaction that likely is more specific to anxiety is called the FEAR effect (Family Enhancement of Avoidant Responses, Barrett et al., 1996a). These researchers asked children and parents separately to describe their thoughts and response to ambiguous physical and social threats. Both anxious children and their parents perceived more threat in ambiguous situations. In addition, child avoidant responses increased following discussion with parents. Parents were encouraging avoidant rather than coping responses.

Treatment development. These findings led the researchers to develop a family CBT treatment that taught parents to reward courageous and coping behavior and to extinguish by ignoring excessive anxious behavior. They also taught parents coping skills to manage their own anxiety and worked on communication and problem-solving skills within the family. Overall, this research group reported superior outcomes of the family based treatment in both individual and group formats compared to individual CBT at the end of treatment and follow-up (Barrett, 1998, Barrett, Dadds, & Rapee, 1996b). They also found improvements in overall family functioning.

Treatment development and psychological control. We have chosen to add to these previous models and to develop and evaluate treatment modules that target issues of psychological control and parental beliefs about both parenting and anxiety (Bögels & Siqueland, 2006; Siqueland et al., 2005). The first session in our protocol includes the parents and child (and sometimes siblings) and attempts to elucidate problematic interaction patterns. We outline the dilemma for parents of finding a balance between challenging and helping. CBT techniques are taught to the child either with the family present or individually. Therapists also focus on eliciting and challenging parents' beliefs about the safety of the world, anxiety, the competency of their child, and their role as parents. All these beliefs provide targets of intervention

that encourage coping and competence rather than fear or avoidance.

In addition, therapists watch for examples in therapy sessions or in situations brought to therapy that bear on psychological autonomy. The therapist works to create new types of conversations that encourage parents to solicit their child's input and encourage independence rather than taking over or doing for. In addition, therapists help families elucidate fears that differences of opinion, conflict, or strong emotion will damage relationships. Instead, therapists guide and coach safe and productive resolution of differences or conflict. Siqueland et al. (2005) focused on adolescents where the negotiation of psychological autonomy is particularly crucial, but the Bögels and Siqueland (2006) model was used with children ages 8 to 18.

Treatment outcome. We found that the combined CBT and family approach showed equivalent results to individual CBT, with adolescents returning to non-clinical levels on both anxiety and depression and showing trends toward improvements in family functioning (Siqueland et al., 2005). Our other pilot study (Bögels & Siqueland, 2006) found large changes in children's anxiety symptoms, dysfunctional beliefs, and interpretation of ambiguous situations. In addition, parents reported less overprotective rearing and fathers reported less rejection. Children did not report change in parental behaviors, but did report improvement in family functioning. These pilot results are promising, and the Bögels and Siqueland (2006) treatment model is being evaluated in comparison to individual CBT in a multi-site study in the Netherlands led by Susan Bögels.

Role of fathers. One area that has been relatively ignored is the role of fathers in anxiety disorders in children. Many of the studies have looked at mothers only. Fathers have different roles in rearing children than mothers. They are more inclined to promote their child's autonomy, and may be in a better position than mothers to help their child with the transition to the outside world (Bögels & Phares, submitted; Plaquette, 2004). These roles might protect sensitive children against a development towards pathological anxiety. Fathers who are anxious, absent, or whose involvement is diminished by an overinvolved mother may not play these important roles in their child's life, thereby maintaining child anxiety. The study of Bögels and Siqueland (2006) found that it is often fathers that struggle with anxiety within families, and that fathers particularly benefit from family treatment. Clinicians are advised to involve fathers in family treatment, and talk with them about their unique and important role in helping their child overcome anxiety.

We hope this overview of the relevant research on family factors in anxiety disorders of children may raise awareness of what to look for or to assess in families that present for treatment. This awareness can also guide treatment planning, which should be unique to the specific child and family. Therapists can avoid a parent-blaming approach by talking to parents about behaviors that may exacerbate or maintain anxiety and by joining with parents around the difficulties of parenting an anxious child, especially if the parents suffer with anxiety themselves (Siqueland & Diamond, 1998).

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Susan Bögels is professor in developmental psychopathology at the University of Amsterdam, the Netherlands, and works as a cognitive-behavioral psychotherapist. She

is investigating the role of family variables in the etiology, prevention, and treatment of childhood anxiety disorders, and has a particular interest in the role of the father.

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Research in Theoretical Orientation: What Do We Know and What Are the Implications for Training?

James F. Boswell and Louis G. Castonguay, The Pennsylvania State University

One major debate in psychotherapy research concerns what types of variables best explain change. For several decades two major categories of variables have been viewed as the factors primarily responsible for client improvement: technique variables and relationship variables. More recently, participant variables (therapists and clients) have been defined as the primary elements of change (Bohart, 2006; Wampold, 2001). Two recent task forces (Castonguay & Beutler, 2006; Norcross, 2002) have indeed shown that a number of client variables are predictors of outcome, while others can serve as markers for determining the best interventions and/or relationships for specific clients. What we know less about, however, are the specific therapist variables that contribute to process and outcome in psychotherapy. This is important since individual differences among therapists explain a significant portion of the treatment variance (Wampold, 2001). One such important therapist factor is theoretical orientation.

Major orientations in psychotherapy (psychoanalytic/dynamic, cognitive-behavioral, and humanistic-experiential) can be easily differentiated at the theoretical level; however, we know less about how these assumed theoretical differences relate to the practice of psychotherapy. Based on a brief review of the relevant literature, we offer four broad conclusions, or themes, to help address this question: (a) therapists of varying orientations generally display high levels of adherence/competence (at least in controlled clinical trials), yet we find inconsistent relationships with positive outcome; (b) psychotherapy is effective, yet no one particular orientation can claim superiority over others with regard to a wide variety of clinical problems; (c) process/technical factors across orientations have displayed importance, yet inconsistent findings raise questions about how much change they explain; and (d) outcome variance is in part explained by common factors (e.g., the alliance), as well as variables not associated with therapists' self-identified orientation, such as emotional experiencing in cognitive therapy (Castonguay et al., 1996).

Based on these conclusions, we argue that ascribing to a particular orientation is not sufficient to guide practice and training. In addition to paying attention to particular theoretical orientations, we argue that expert and novice therapists should also be guided by principles of change (Goldfried, 1980; Goldfried & Padawer, 1982). These principles (e.g., providing a new perspective of self and establishing a working alliance) reflect general strategies of intervention that cut across different treatment orientations. As argued by Goldfried (1980; Goldfried & Castonguay, 1993), techniques prescribed by different orientations frequently serve the same principle of change. For example, interpretation, cognitive restructuring, and reflection can all be used to help clients develop a new perspective of self. We argue that a focus on principles of change (as they manifest themselves within and across different approaches) concomitantly recognizes the value of common factors (e.g., the alliance, new perspective of self), as well as those other "extra factors" that help to increase one's clinical repertoire (e.g., the use of different techniques to achieve the same change).

Finally, we offer a framework for training based on principles of change with a focus

on psychotherapy integration. Specifically, we outline the training model developed by Castonguay (2000), which consists of five training phases: (a) preparation (students begin to learn basic clinical and interpersonal skills), (b) exploration (students are given the opportunity to apply treatment protocols associated with each of the major orientations), (c) identification (students begin fostering an extensive knowledge of the clinical skills and theoretical constructs associated with a particular approach), (d) consolidation (students expand the knowledge acquired during the identification stage to a variety of clinical roles and settings), and (e) integration (students revise the constructs and treatment methods learned during previous phases by integrating contributions from other orientations).

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DIVISION 29 HOSPITALITY SUITE SPECIAL EVENT

Dr. Jeffrey Magnavita will sign copies of his book, Handbook of Personality Disorders: Theory and Practice (www.wiley.com/WileyCDA/WileyTitle/productCd-0471201162.html) at 5:00 pm on Saturday, August 12, at Division 29's suite at the Hilton Riverside in New Orleans.

Don't miss this opportunity to meet Dr. Magnavita and get a signed copy of his book.

INTERVIEW

Interview with Dr. Michael J. Lambert

Greg Chasson, M.A., University of Houston, Houston TX

Michael J. Lambert, Ph.D.

Greg: Dr. Lambert, for our readers would you please provide a brief overview of your career, starting from your graduate training and ending with your current position?

Dr. Lambert: Sure, I graduated in 1971 with a PhD in Counseling Psychology. I came here to Brigham Young University that year and worked in the health center as a clinician and taught part time for the psychology department. I worked at the Institute for Studies in Values and Human Behavior and spent two years there with the research institute. Then I joined the psychology faculty full time, and I've been teaching in the clinical psychology program since then. I went through the regular rank advancement—assistant to full professor. For the last 5 years, I've had an endowed chair at the university, a special status in the psychology department. I've seen clients since my graduate training. Nowadays, I see about six people a week in private practice—mainly adults and mainly individual psychotherapy.

Greg: Throughout your career, you seem effectively to have balanced research interests and a private practice. How has your private practice experience affected your research, and how has your research affected your private practice?

Dr. Lambert: Well, all of my research has been on psychotherapy processes and outcomes, including methods of measuring patient improvement. I've been a scholar of psychotherapy research as well. I have always been keen to apply what I have learned from research to my practice. My experience with research has strengthened my commitment to an integrative/eclectic approach to patients. [In my practice], I tend to emphasize those processes that have been empirically linked to outcomes, especially the therapeutic alliance. My research has had a strong effect on my practice. I spend a lot of time watching videotapes of psychotherapy and studying processes. I would say my private practice has affected my research, because practicing psychotherapy (which is my favorite thing to do) stimulates me to do research that matters in practice. To some extent, my own practice as a therapist has guided research questions. But, I'd say by and large the research that has been done has guided my research question. Over the last ten years, my research has involved developing an assessment device called the OQ45.

Greg: Would you please tell the readers more about the OQ45?

Dr. Lambert: The OQ45 is a 45-item measure that has about half the items looking at anxiety, depression, and somatizaton. About one-fourth is about interpersonal relationships, and the other one-fourth is about social role functioning (like school and work productivity). We give that measure to people before every session. So in the last ten years, I've basically been interested in monitoring patient treatment response on a session-by-session basis. And now, my students and I have conducted six clinical trials on the effects of informing therapists about the progress of their patients in relation to statistically derived expected recovery curves. So, we can say if a patient is on track or off track for recov-

ery. That research has been very important. Essentially what we've found is that if a clinician's practice includes monitoring and warning signals when their patients fall far enough off track, then supplying that information enhances patient outcome. We've developed some clinical tools that involve a decision tree that gives therapists guidance on problem solving in response to a signal alarm. Using these clinical/decision support tools enhances outcome even more. We've now developed a software called the OQAnalyst that makes use of this methodology. The client comes to the reception desk and fills out the 45 items on a wireless handheld device. When they press enter after they finish the items, a graph shows up on the therapist's computer screen. So, before the patient walks from the reception area to the therapist's office, the therapist has a graph of the patient's progress from the time they entered therapy up to the time of the current session, including an alarm signal if the patient is deteriorating.

Greg: Would you please describe your past and current involvement in Division 29?

Dr. Lambert: I joined Division 29 as a graduate student. So, that was back in 1970. I attended the Mid winter meetings of Division 29 for a few years. Then, later on (probably about 2000) I became a member of the editorial board and the research committee of Division 29. So, I was active with the journal and the bulletin. I always enjoyed the meetings of Division 29. It's like there are two different parts of my life. My research life centers around the Society for Psychotherapy Research, which is an international multidisciplinary organization that holds a yearly conference, to which I submit papers on research. Division 29 provides much more of a practitioner-oriented meeting. So, both of these organizations have been very helpful for my career. I've always been interested in the integration of research and practice.

Greg: You've seen some of the earlier days of Division 29. How has it changed since you first joined?

Dr. Lambert: Well, when I first joined, it was much smaller. It was much more workshop and practice based. It is much more influenced by the encounter group movement—the experiential, body therapies, and expressive therapies. More recently, you see approaches that are more contemporary, including systems approaches, which maybe were underrepresented back then.

Greg: Where would you like to see Division 29 head in the coming years?

Dr. Lambert: Well, I would really like to see it integrate some of the scientific advances that have taken place through research. I really think there is a natural fit between research and practice in that research can supply therapists with something they can use. I am a bit critical of psychotherapy research in the sense that many articles, which are written for and published in journals, are aimed at researchers and affect research. But, most articles are written in ways and with the kind of information that does not make the findings readily available to practitioners. There are some aspects of psychotherapy research that are very important for practice and can enhance a clinician's practice. But, generally I find practitioners turned off to research because it doesn't supply them with anything they can use in their day-to-day work. But, I think my current research is an example of research that can make an addition to clinical practice. For example, the clinical support tools and monitoring devices that we've put into software are actually like lab tests that you get at physical health practices. We are trying to get systematic information into the hands of clinicians so that they can make more systematic decisions. I'd say that decision support tools are superior to clinical judgment in many ways. For example, clinicians are very optimistic about their effects on patients. And the consequence of that is

that they are not very good at identifying patients whose progress is not satisfactory at all. Because of their optimism, they tend to ignore warning signs that the patient is not recovering, and in fact worsening. Clinicians can't really start a session by asking patients fifty questions about their lives over the last week. [The OQ45] is a way of collecting information efficiently and then supplying it back to therapists in a very rapid and instantaneous manner. That sort of information is quite helpful to clinicians in working with clients. It improves the outcome for clients quite dramatically, especially compared to things like using the so-called "right therapy with the right disorder."

Greg: What advice would you give to Division 29 student members who are pursing a clinical or research career?

Dr. Lambert: For student members who want to pursue a research career- research has become so sophisticated compared to how it was thirty years ago. The standard for research now is approaching clinical trial standards. You have to have large [numbers of participants], large numbers of therapists, manuals that guide the therapy, and a lot of control. In yesteryear, you could just do a pre and post design without all of these controls of what you were doing in psychotherapy. And, you could probably get that published. Nowadays, we've seen enough of those studies, and we don't need to see anymore. So, it is very difficult for a private practitioner to conduct meaningful research and make a contribution to the research literature. I think people have to join together with colleagues or a group to conduct the kind of research that is expected in the modern era. There are still questions that can be answered in private practice. For example, "How many sessions is enough to return patients to a state of normal functioning?" That's the kind of study that can be done without a control group by simply monitoring patient's treatment response and seeing the percentage of recovery at subsequent sessions of therapy. If people want a research career, the ideal placement is a research-based clinic. They have to publish of course if they want a research career. In order to publish, they've got to be asking questions and coming up with answers that are contemporary. So, they have to know the research literature. They can't just come up with questions out of the air, but come up with questions that make a contribution to the burning questions of the day. That makes it necessary for people to have a systematic program of research. I don't think individual studies generally contribute very much. You've got to have a program of research that builds over time and asks the next logical question from what's known from the first study to the next study to the next study. That requires a lot of attention and devotion. It's hard for people to do both research and clinical work.

Greg: You have sculpted quite a successful career, Dr. Lambert. Where do you go from here?

Dr. Lambert: Thank you. We are really busy trying to prevent treatment failure. All of our energy is devoted to that. So, we are continuing to try to adapt the methods in which we supply clinicians with instantaneous information about problem solving for these tough cases- these cases that either worsen or show no benefit one way or another. We are going to continue getting accurate in predicting who they are before they leave treatment and cooking up intervention suggestions that we can deliver to therapists rapidly to assist them in problem solving with these patients. Right now, we are concentrating on alliance, motivation, and social support. We just added perfectionism, and we are playing around with the idea of life events measurement, so that we can supply clinicians with information about their patient's weekly life events. So, we'll just keep following this line of research of enhancing delivery of information to clinicians and trusting clinicians to problem solve once we supply them with information that would ordinarily take too much of

their time to supply themselves with. Right now, we are moving ahead on profiling therapist outcome, searching for therapists that have unusually positive patient outcomes, and then studying the process of what those "supershrinks" are doing to make them so effective. This is a different line of research. There has been a fair amount of writing on master therapists, but it's never been based on the patient's outcome. It's based on reputation. Reputation is not the same as patient outcome. There are probably a lot of unsung heroes out there who do unusually good psychotherapy but who we've never really studied or understood. We'll move towards figuring out what they do that's so helpful and whether it's a born natural gift or whether it can actually be captured and taught to novice and experienced therapists.

Greg: Those are some very interesting aims. That will conclude our interview. Thank you very much for your time, Dr. Lambert.

Dr. Lambert: Thank you, Greg.

2006 Recipient of the APA Distinguished Professional Contributions to Independent Practice in the Private Sector Jeffrey J. Magnavita, Ph.D., ABPP

The APA Division of Psychotherapy is pleased to recognize that Dr. Jeffrey J. Magnavita has been selected as a 2006 recipient of the Distinguished Contributions to Independent Practice in the Private Sector Award. Dr. Magnavita is the Program Chair for the Division of Psychotherapy.

Dr. Magnavita is being acknowledged for his passionate devotion to the advancement of the practice and science of psychotherapy. As a full-time clinician and affiliate professor, he has published numerous volumes and articles on the treatment of personality disorders and the practice of intensive psychotherapy. His major accomplishment is his theoretical modeling of integrative and unified approaches to psychotherapy, using audiovisual analysis. His most recent achievement is a unified relational approach for patients suffering from personality dysfunction and complex clinical syndromes. He is currently undertaking the development of personality systematics, which seeks to identify the unifying processes and principles of psychotherapy, psychopathology, and personality theory.

Dr. Magnavita will be delivering his award address at the APA convention in New Orleans. We look forward to your joining us to celebrate this distinguished recognition.

Invited Address

In Search of the Unifying Principles of Psychotherapy: Conceptual, Empirical, and Clinical Convergence
APA 2006 New Orleans

FEATURE

The Outcomes Assistant: A Kinder Philosophy to the Management of Outcomes

David Kraus, Behavioral Health Laboratories; Abe Wolf, Metrohealth Medical Center; and Louis Castonguay, Pennsylvania State University

We have been hearing about behavioral health outcome requirements for nearly fifteen years now, yet the standard practice patterns of most clinicians have still not been affected. With so many years of forewarning, additional cries that "the outcomes are coming," are not likely to alarm our sympathetic nervous system. Rather than causing alarm, you could say that Peter has cried "Wolf" enough times that his story, and his pleas, are doing a better job of putting children and psychotherapists to sleep.

There are many complex reasons for the delay in outcomes management, but the following are the most important ones:

- outcomes management is far more complicated in the real world than any expert anticipated;
- first-generation outcome tools were too crude to show enough meaningful (clinically significant) change and typically measured only a narrow band of global issues we call 'psychological distress,' and ignored the multi-dimensional specificity of human psychological functioning;
- outcome reports did not provide enough assistance and advice to improve the therapeutic process and help clinicians feel that the effectiveness of their work was enhanced by the integration of outcomes management; and
- the infrastructure to process large volumes of data, generate real-time reports, track outcomes across multiple clinicians and different episodes of care, and to statistically aggregate standard analyses was not even on the drawing board.

We believe that the entire philosophy and approach to outcomes management has been off-target. We certainly believe that the pressure for accountability is here to stay; however, it should neither be the single, nor the most important use of outcome data. The entire process got off on the wrong foot when the major healthcare players gathered in the late 1980's to discuss the use of health outcomes (Geigle & Stanley, 1990); their meeting had overwhelmingly punitive tones. For example, the consensus, number-one use of outcome data was to profile clinicians on outcomes and eliminate those with 'documented poor quality.' With such approaches, there is little reason to expect clinician buy-in.

We believe the principal focus of outcomes should be to guide and assist the psychotherapist in planning the treatment process. Such a tool should never prescribe a certain intervention but provide the clinician with information tailored to the patient's assessment and condition about the relative success of various treatment options, and outline current advances in standard care by pointing to evidenced-based treatments. By properly guiding clinicians, a system of outcome management can facilitate communication between the patient and clinician while helping to identify budding problems before they become serious. Such a system is much more likely to be embraced by clinicians because it can inform and potentially improve the therapeutic process, rather than just evaluating and judging it.

The Treatment Outcome Package (TOP, Kraus, Jordan, & Seligman, 2005), and its supporting infrastructure, is designed to move the field of outcomes management in this more friendly direction, and bring to

the forefront the positive and beneficial aspects of outcomes management. The goal of this paper is to describe the TOP as a way to highlight how the business of outcome management is evolving to meet clinician needs.

The TOP was designed to meet the recommendations of the 1994 Core Battery Conference which was organized by the Society for Psychotherapy Research and the American Psychological Association (Horowitz, Lambert, & Strupp, 1997). As a Universal Core Battery, the TOP is not tied to any specific theoretical orientation and measures many categories within symptom, functional, and quality-of-life domains. The current version of the TOP is in its fourth incarnation with 48-58 questions, depending upon the age version (child, adolescent, and adult). TOP data are processed by Behavioral Health Laboratories (BHL), which has created a centralized data warehouse that currently holds de-identified assessment data on more than 600,000 behavioral health consumers.[1] Such massive archived data sets allow clinicians to learn by comparing their results to other clinicians who are treating similar patients. By identifying our successes and failures, we can learn from this valuable feedback system.

Stat Lab Test Results

The major reason previous generation outcome projects failed is because of data processing. From Georgia to Washington State there are countless examples of massive amounts of data being dumped into a black hole with only the remnants of destroyed phantom particles spinning off at the fringes of the void's reach. Needless to say, it is impossible to sustain a project that cannot deliver useful results to its key participants—the patient and the psychotherapist. To survive, the outcome assistant system needed to be inexpensive, fast, and user friendly.

Whether the data are processed electronically or on paper, the BHL TOP system is designed to return useful results with the priority of a stat blood test. Paper processing is obviously the most challenging obstacle, and BHL has been a leader in simplifying this process for more than a decade.

After the patient completes a TOP, the form is faxed to BHL's central computer system. There, it never touches paper again. A TIF file image (the computer graphic file generated by your fax machine) is transferred to three data processing engines that translate the images into data.

A human verifier looks over every form and makes sure the computers have correctly processed the information. The data are then transferred to the data warehouse where it is scored, compared to general population norms and any historical patient records, and a report generated.

These reports are returned via fax or e-mail to the clinician with an average return time (from hitting send on your fax machine) of 14 minutes.

As an alternative to a fax-based system, BHL also has an electronic/web system where the results are returned within three seconds.

BHL also provides toll-free customer service, a training video, and extensive documentation, making startup simple. By offloading the time-consuming process of warehousing and scoring reports, clinicians can stay focused on what they do best—treatment.

Patient Reports that Inform

TOP questions have high face validity to patients and psychotherapists alike. Questions are easy to read (5th grade level) and are related to key DSM symptoms when conducting an initial interview (e.g. "felt little or no interest in most things"). Years of exploratory and confirmatory factor analytic work on the TOP items reduced the number of questions to the

(Continued on page 29)

ROSALEE G. WEISS LECTURE FOR OUTSTANDING LEADERS IN PSYCHOLOGY

Saturday August 12 • 3:00pm -3:50
Meeting Room 25 • Morial Convention Center

OLIVA M. ESPIN, PH.D is Emerita Professor of Women's Studies at San Diego State University and at the California School of Professional Psychology of Alliant International University. In her long standing work as a psychotherapist, teacher and consultant, Dr. Espín has emphasized work with women. She was a pioneer in the practice and theory of feminist therapy with women from different cultural backgrounds, particularly US-born Latinas and immigrant/refugee women. She has done extensive research, teaching, and training on multicultural issues in psychology. Professor Espín has taught at McGill, Tufts, Boston University and the Universidad de Costa Rica. A native of Cuba, she did her undergraduate work in psychology at the Universidad de Costa Rica and her doctorate at the University of Florida. She did post-doctoral work at Harvard University with funds from the National Institute of Mental Health. Professor Espín has done research and published on psychotherapy with Latinas, the sexuality of Latinas, women immigrant and refugees, women's sexuality across cultures, other topics relevant to the psychology of women in multicultural contexts and training clinicians to work with multicultural populations. Most recently, she has presented and published on feminist and psychological understandings of the lives and writings of women saints. She is the author of many articles and regularly presents her work at national and international professional conferences. Her books include *Latina Realities: Essays on Healing, Migration and Sexuality*, an anthology of her collected writings on feminist theory and practice, *Women Crossing Boundaries: A Psychology of Immigration and the Transformations of Sexuality*, based on a study of women immigrants from all over the world; *Latina Healers: Lives of Power and Tradition,* and the co-edited volume *Refugee Women and their Mental Health: Shattered Societies, Shattered Lives.*

Dr. Espín has received many awards, including the 1991 Award for Distinguished Professional Contribution to Public Service from the American Psychological Association for her ground-breaking work to expand the knowledge base of psychology to include gender issues and international and cultural factors. In 1992 she was selected by the American Psychological Association to be one of 100 women included in the Women's Heritage Exhibit (Created to celebrate Women's contributions to psychology as part of the 100th Anniversary of the APA). She has also received the Distinguished Career Award from the Association for Women in Psychology in 2001 and distinguished publication awards from the Association for Women in Psychology in 1993 and 1999. The Feminist Therapy Institute and the National Latino/a Psychological Association have recently honored her as one of the founders of the respective fields. Dr. Espín is a fellow of seven divisions of the APA. In 2005 she received a Fellowship from the Association for Religion in Intellectual Life to advance her study of women saints from feminist and psychological perspectives.

DIVISION OF PSYCHOTHERAPY PROGRAM
2006 APA ANNUAL CONVENTION
NEW ORLEANS, LOUISIANA

THURSDAY, AUGUST 10

Symposium (S):
Toward Evidence-Based Practice—
An Effectiveness Research Approach
8:00 AM - 9:50 AM
Morial Convention Center
Meeting Room 241
Chair
David W. Smart, PhD
Participant/1stAuthor
Karstin L. Slade, BS
Stevan L. Nielsen, PhD
John C. Okiishi, PhD
David W. Smart, PhD
Discussant
Louis G. Castonguay, PhD

Conversation Hour (S):
Honoring Albert Ellis at 93
10:00 AM - 10:50 AM
Morial Convention Center
Meeting Room 356
Chair
Frank Farley, PhD
Participant/1stAuthor
Albert Ellis, PhD

Invited Symposium (S):
Insight in Psychotherapy—Theoretical Perspectives and Clinical Issues
12:00 PM - 1:50 PM
Morial Convention Center
Meeting Room 252
Cochair
Louis G. Castonguay, PhD
Clara E. Hill, PhD
Participant/1stAuthor
William B. Stiles, PhD
Leslie S. Greenberg, PhD
Michele A. Schottenbauer, MA
Bruce E. Wampold, PhD
Nicholas Ladany, PhD
Nancy McWilliams, PhD
Louis G. Castonguay, PhD
Arthur C. Bohart, PhD

Symposium (S):
Research on Anger Treatments—Beyond College Students and Analogue Studies
2:00 PM - 3:50 PM
Morial Convention Center
Meeting Room 342
Chair
Ray Tafrate, PhD
Participant/1stAuthor
Ray DiGiuseppe, PhD
Ryan Fuller, PhD
Frank L. Gardner, PhD
Michael S. McCloskey, PhD
Discussant
Howard Kassinove, PhD

Workshop:
Sex and Love—Treating Couples With Sexual Problems
4:00 PM - 4:50 PM
New Orleans Marriott Hotel
La Galeries 6
Chair
Lisa A. Firestone, PhD
Participant/1stAuthor
Lisa A. Firestone, PhD
Joyce Catlett, MA

Workshop (N):
Item Response Theory and the Assessment of Psychotherapy Outcome
5:00 PM - 5:50 PM
New Orleans Marriott Hotel
La Galeries 6
Chair
Abraham W. Wolf, PhD
Participant/1stAuthor
Abraham W. Wolf, PhD
Ann Doucette, PhD

FRIDAY, AUGUST 11

Workshop (S):
Love and the Erotic in Intensive Psychotherapy—Perils and Possibilities
8:00 AM - 9:50 AM
Morial Convention Center
Meeting Room 252
Chair
Allan B. Elfant, PhD

Poster Session (N)
10:00 AM - 10:50 AM
Morial Convention Center
Halls E & F
Participant/1stAuthor
Charles T. Capanzano, PhD
Heather L. Hunter, MA
Patricia A. Rupert, PhD
Emily Z. Calvert, MA
Robert J. Reese, PhD
Hilary B. Vidair, MA
Jeannette M. DeVaris, PhD
Takuya Minami, PhD
Christina Hatgis, PhD
Lorrie A. Dellinger, BA
James M. Ballard II, PhD
John H. Diepold, Jr., PhD
Georgiana S. Tryon, PhD
William T. Leonard, PsyD
Shelley A. Riggs, PhD
Barbara M. Vollmer, PhD
Andrew M. Pomerantz, PhD
Myung-Seon Choi, PhD
Zachary E. Bryant, BS
Heidi L. Fowell, MS
Richard Kinnier, PhD
Kimberly A. Hays, PhD
Carrole M. Depass, PsyD
Katherine Daly, BA
Shulamit Ben-Itzhak, PhD
Denise Briggs, PhD
Katie M. Beyl-Rollin, BS
Cynthia R. Lindsey, PsyD
Jennifer M. Hill, BA

Symposium (N):
What Revolution Would You Like to See in Psychotherapy?
11:00 AM - 11:50 AM
New Orleans Marriott Hotel
La Galeries 3
Chair
Alvin R. Mahrer, PhD
Participant/1stAuthor
Arthur C. Bohart, PhD
Jeanne Marecek, PhD
Robert A. Neimeyer, PhD
Lara Honos-Webb, PhD
Brent D. Slife, PhD

Workshop (N):
Adlerian Psychotherapy—Brief, Integrative, and Effective
2:00 PM - 2:50 PM
Morial Convention Center
Meeting Room 275
Chair
Jon D. Carlson, EdD, PsyD
Participant/1stAuthor
Jon D. Carlson, EdD, PsyD

Symposium (S):
When Multicultural Worlds Collide—Resolving Conflict Within Self
2:00 PM - 3:50 PM
Morial Convention Center
Meeting Room 276
Chair
Armand R. Cerbone, PhD
Participant/1stAuthor
Louise A. Douce, PhD
Majeda A. Humeidan, PhD
Shawn V. MacDonald, MA
Lynn C. Todman, PhD
Veronica M. Leal, PhD
Saba R. Ali, PhD
Discussant
Geoffrey M. Reed, PhD

Symposium (S):
What Do You Do When You Hate Your Patient?
3:00 PM - 4:50 PM
Morial Convention Center
Meeting Rooms 343 and 344
Chair
Abraham W. Wolf, PhD
Participant/1stAuthor
Charles J. Gelso, PhD
J. Christopher Muran, PhD
Jean A. Carter, PhD
Discussant
Abraham W. Wolf, PhD

Social Hour
6:00 PM - 8:00 PM
Hilton New Orleans Riverside Hotel
Grand Salon 15

SATURDAY, AUGUST 12

Symposium (S): Emotion-Focused Process-Experiential Therapy—-An Evidence-Based Psychotherapy
8:00 AM - 9:50 AM
Morial Convention Center
Meeting Room 282
Chair
Robert Elliott, PhD
Participant/1stAuthor
Jeanne C. Watson, PhD
Robert Elliott, PhD
Discussant
Leslie S. Greenberg, PhD

Symposium (S): Empirically Supported Treatment for Personality Disorders—-Panacea or Pandora's Box?
10:00 AM - 11:50 AM
Morial Convention Center
Meeting Room 357
Chair
Jeffrey J. Magnavita, PhD
Participant/1stAuthor
David H. Barlow, PhD
Rebekah Bradley, PhD
Arthur Freeman, EdD
Lorna Smith Benjamin, PhD
Discussant
Theodore Millon, PhD

Symposium (S):
Attachment Theory— Bridging Empirical Research and Clinical Practice
12:00 PM - 1:50 PM
Morial Convention Center
Meeting Room 353
Chair
Cheri L. Marmarosh, PhD
Participant/1stAuthor
Cheri L. Marmarosh, PhD
Rebekah Majors
Suzanne Nortier, PsyD
Discussant
Kristin Perrone, PhD
Damon L. Silver, PhD

SUNDAY, AUGUST 13

Symposium (S): Current Developments in the Cognitive Neuroscience of Psychotherapy
10:00 AM - 11:50 AM
Morial Convention Center
Meeting Rooms 235 and 236
Chair
Abraham W. Wolf, PhD
Participant/1stAuthor
Nydia M. Cappas, PhD
Stephen S. Ilardi, PhD
Seth J. Gillihan, MA
Discussant
Drew Westen, PhD

(Continued from page 24)

three-to-five most powerful questions in a broad array of clinically useful domains. For the adult version, TOP domains include: Depression, Panic, Mania, Psychosis, Sleep, Sex, Work, Quality of Life, Substance Abuse, Suicide, and Violence. In contrast with outcome tools that address only one or a few dimensions of functioning, the TOP patient reports provide a wealth of clinically useful assessment data that can be easily integrated into treatment planning. Results are reported as normalized Z-scores that represent their deviation from population norms. This includes variables like life stress (Axis IV) as well as the clinical domains discussed earlier. Diagnostic considerations are reported for Axes I, III, and IV.

BHL is also finalizing a pre-filled, yet modifiable treatment plan (based on TOP responses) that is returned along with the standard TOP report, helping the therapist save time in developing an individualized course of treatment.

With assessment of dimensions like medical utilization, prior treatments, life stress, and co-morbid medical conditions, the TOP also helps paint a full picture of the patient. Clinicians can give a new patient an access code to go on-line and complete the TOP before the appointment. The clinician then has an excellent picture of the patient's perspective of their troubles before they actually conduct the initial interview.

Links to the Research

In conjunction with Leslie Wilson and Louis Castonguay at Penn State University, each of the Adult TOP domains has been linked to a library of evidence-based practices, guidelines, and research findings that should help clinicians find the most effective treatments for patients with different TOP profiles. For example, if a patient scores very high on the Depression Scale, this TOP library integrates findings compiled by Castonguay and Beutler (2005) and other sources into an easy-to-read summary of state-of-the-art treatments.

Building on the work of Michael Lambert—who has single handedly shown that outcomes management makes us all more effective clinicians—the TOP provides early warnings if treatment appears to be heading in an unhelpful direction. Whether it might be the therapeutic alliance, or the need to incorporate adjunctive interventions like medication or family therapy, the checklist of resources to consider will help clinicians drastically reduce the number of patients categorized as "negative responders."

Reviewing the report with the patient enhances the therapeutic alliance. Self-report of clinical symptoms can be unreliable, and having something concrete to review with patients helps to further cement the trust that you have already worked hard to create. Imagine having a report that shows your patients how much progress they have already made (from their own self-report) and how far they are from achieving their goals. The TOP results demonstrate to the patient powerful evidence that their work is heading in the right direction.

Reviewing initial reports with patients provides an excellent platform for an informed discussion of the priorities and challenges of their treatment. Six controlled studies have shown that patients are more honest about shame-based issues on questionnaires than they are in face-to-face initial evaluations (Carr & Ghosh, 1983; Erdman, Klein, & Greist, 1985; Hile & Adkins, 1997; Lucas, 1977; Searles, Perrine, Mundt, & Helzer, 1995; Turner et al., 1998). Therefore, integrating an outcome questionnaire opens exciting new channels of communication.

The rich database of TOP results is also providing opportunities to study new ways of administering items to patients. Recent developments in item response theory and computerized adaptive testing indicate that clinically reliable and meaningful results can be obtained from

responses to only a few items. The BHL database of TOP results is being analyzed to identify those sets of items that have the optimal specificity and clinical "bandwidth" to evaluate symptoms and change.

Enlightening Aggregate Data

Every month, BHL sends an aggregate report that summarizes the changes of a psychotherapist's average patient from intake and plots the changes their patients report over the course of treatment. Since more than 92% of patients report clinically and statistically significant change in at least one dimension of functioning, the TOP can provide very rewarding statistics to help psychotherapists guide their work.

In addition, BHL provides psychotherapists with unlimited access to its enormous benchmarking database. Psychotherapists can profile the types of patients with whom they work best and those patients with whom they need to improve their clinical skills. We have used this database to identify the proverbial "super shrink," the ideal psychotherapist who is well above average on everything. The data suggest that there is no such psychotherapist—we all have our strengths and weaknesses. A more realistic goal is for all clinicians to monitor their personal strengths and weaknesses by comparing their clinical outcomes with other professionals using a standardized instrument. BHL's database of TOP results provides just that.

The Clinical Report Card

There is a dark side to outcome management—report cards. It is not wise for the business of outcome assessment to pursue profiling clinicians. It is premature to evaluate clinicians on the basis of one instrument. Psychotherapy is not like baseball where we can evaluate the hitters on the basis of statistics like RBIs. (And even RBIs are not that great an indicator of performance!)

Nevertheless, there are increasing pressures for accountability in our field. We cannot stop this oncoming train. We can accommodate to these pressures by using a state-of-the-art system that guides our clinical work and helps our patients. Clinical accountability may lead to the unfair use of outcome measures to profile clinicians. If we are to change our practices to incorporate measures of clinical outcome, then let us find a way to meaningfully use these instruments to guide and not just monitor treatment.

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[1] BHL do not charge any royalty fees for the use of TOP. Unless you make other arrangements, however, you do need to use their service bureau to process the data.

MEMBERSHIP ACTIVITIES

Operation "Recruit, Retain, and Recover Members" will be in full swing!

During the Suite Program and throughout our time at the convention, our Membership Committee and other dedicated volunteers will be advertising the benefits of being a member of Division 29, activities, and recruiting and welcoming new and returning members. The first 30 members to sign up at the Suite Program will get a Division 29—Psychotherapy hat! So, bring your friends who have an interest in psychotherapy and encourage them to wear their hat!

As tokens of appreciation to all members, we will raffle door prizes throughout the program, including signed copies of books donated by esteemed members of our Division 29.

Bring a friend to the Social Hour:
Friday, August 11, 2006 from 6:00 to 7:30
Rhonda S. Karg, Membership Committee Chair

The Future Is Rapidly Approaching

Pat DeLeon, Ph.D., former APA President

From a national public policy perspective, it appears that our nation is steadily evolving towards the enactment of comprehensive health care reform. We have long ago come to appreciate that the timing of change is often unpredictable. As Russ Newman described during last year's State Leadership conference: "The public focus that is now being placed on the effects of lifestyle, behavior, and stress on health and illness is unprecedented. The 'mind-body connection,' as it is often referred to by the public, is for the first time receiving mainstream media coverage. Also for the first time, real dollars are starting to flow into prevention, health promotion, and disease management, areas where behavior and behavior change provide the foundation for assuring health and treating illness. Policy makers are even looking to these areas for solutions to the country's broken healthcare system. Just recently, the Robert Wood Johnson Foundation concluded that 'The United States needs to develop a proactive approach for health, focusing on prevention of illness and injury.... This type of approach would save lives and money and improve our overall health.' Integrating mind with body, behavior with health and the psychological with the physical holds a credible promise of achieving the long sought after elusive goal of improved health care while simultaneously controlling, if not reducing, healthcare costs."

Addressing the important issue of reimbursement, Russ noted: "Prior work on the Medicare front is now beginning to pay dividends. Medicare's acceptance of our health and behavior CPT [Current Procedural Terminology] codes in 2002 did not automatically mean widespread use of the codes which recognize psychologist's ability to provide health services to health disorders in the absence of a mental health diagnosis. Yet, increased use since their creation has been quite apparent. The number of health and behavior claims submitted by psychologists to Medicare increased almost 400% from 64,000 claims in 2002, the first year they were available, to over a quarter of a million claims in 2003.... Having a way to explicitly recognize and reimburse psychological services delivered to health, not just mental health, conditions is an absolute prerequisite for our profession's role in a healthcare reform system beginning to capitalize on the relationship between behavior and health."

During this year's inspirational State Leadership conference, Russ once again laid out a vision for the profession that we wholeheartedly endorse: "Psychology's work [during Hurricane Katrina] was not lost on the national media. Educating policy makers about the value of psychological services is also a must, despite being a process that often takes a very long time. After close to a dozen years of effort, we finally succeeded in persuading Medicare that psychological and neuropsychological testing should be recognized as having a professional work value when reimbursements are calculated, that is, recognition of the psychologist's time and effort in the testing process. Historically, Medicare officials had taken the position that since physicians did not do psychological testing, the service had no 'physician' or professional work value. With this work value now included, reimbursements are increased as much as 122% for some services in some geographical areas."

Affirming the inherent unpredictability of **when** fundamental change will occur within the public policy (i.e., political) process, Russ postulated that perhaps significant

societal change happens not gradually, but at one dramatic moment when everything changes all at once (i.e., a "Tipping Point" occurs). Little causes can have big effects. Little things can make a big difference, incremental changes or almost imperceptible changes at the margin accumulate. Ultimately, significant change happens, not gradually but at one dramatic moment—the Tipping Point. "So what is the epidemic of change for which we seek a tipping point? Simply put, it is twofold: a solution to our broken healthcare system, and a role for psychologists in that reformed system that appropriately values our services and enables our ability to provide those services.... Behavior is integrally linked with the promotion of health or the opposite, the development of disease. The six leading causes of death in this country are related to behavior. According to the Centers for Disease Control, the obesity rate in America is approaching 30%, and 65% of the population is either obese or overweight. It goes without saying, I hope, that the one thing we should do is assure that our skills as psychologists are honed to facilitate behavior change in those whose unhealthy behaviors are taking a toll. Knowing how to navigate the intersection of psychological and physical health is also key.

The bigger question for today is how do we spread the word that health care reform is really about behavior 'reform'? How do we persuade policy makers, that the solution to at least some of their biggest problems is right at our finger tips? And, how do we create the social epidemic that flows from the single tipping point and leads people to literally demand healthy lifestyles; how do we create the epidemic that leads people away from feeling entitled to good health care and leaves them feeling entitled to good health."

Signs of an approaching tipping point: In 2004 the Institute of Medicine (IOM) called for the enactment of legislation to provide for universal healthcare coverage by 2010, recommending adoption of the underlying principles of: 1.) universal coverage; 2.) continuous coverage; 3.) affordable coverage for individuals; 4.) affordable and sustainable coverage for society; and 5.) coverage that promotes access to high-quality care. That same year, The Wall Street Journal examined the rapid spread of prescribing power to health care providers who are not medical doctors, the "loosening rules" reflecting "a broader shift in the health care system, as more non-physicians... play a larger role in providing care." More recently, the IOM reported that in an era when the nation is concerned about a possible avian influenza pandemic, our emergency care system has become the "safety net of the safety net," providing non-emergency primary care for many of the 45 million uninsured Americans. Just under the surface, a growing national crisis in emergency care is brewing with emergency departments being frequently overloaded, with patients sometimes lining hallways and waiting hours and even days to be admitted to inpatient beds. Ambulance diversion, in which overcrowded emergency departments close their doors to incoming ambulances, has become a common, even daily problem in many cities. Patients with severe trauma or illness are often brought to the emergency department only to find that the specialists needed to treat them are unavailable. And still another IOM report gravely suggests that even while national polls show that health care is at the top of American's priority list: "The health care delivery system is incapable of meeting the present, let alone the future needs of the American public." As Past APA President Ron Levant noted during his APA Presidential year, the IOM envisions a healthcare environment in which: "(M)ost important, professionals will need to break down the silos that exist within the system, and seek to understand what others offer in order to do what is best for the patient. All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."

The 21st century will be an era of educated consumers, utilizing the unprecedented advances occurring within the communications and technology fields to ensure that they and their loved ones have access to the most up-to-date (i.e., scientifically-based) health care possible. Clinical decision making will become increasingly data-based, with providers of all disciplines being held accountable to gold standards of care. As Russ has suggested, the all important psychosocial-cultural-economic gradient of care will become an integral component of society's expectation of quality care. Organized medicine clearly sees these changes coming. Earlier this year, the American Medical News reported: "Physician task force confronts scope-of-practice legislation. With 31 states and the District of Columbia expected to face legislation that asks to alter or expand the scope of more than 20 allied health professionals this year, organized medicine says it's time to join forces to oppose any changes that jeopardize the health and safety of the public.

"With the American Medical Association's support, a steering committee of six state medical societies and six national medical specialty groups [including the American Psychiatric Association] has been looking for solutions over the past year. In January they released their answer – the Scope of Practice Partnership, a coalition of physician organizations that will bring their collective experience and resources to the fray to replace what often has been a fragmented approach to scope-of-practice battles. The effort is particularly important, committee members say, because all of medicine suffers, not just a single state or medical specialty, when the practice of medicine is put into hands without the training to practice it. 'The driving need for such a group is to ensure quality care for patients,' said AMA Executive Vice President and CEO.... 'While nonphysician providers have been, and will continue to be, important elements in the provision of health care, it is important that our patients know and receive the care that only physicians are uniquely qualified to provide.'... 'Our goals for the upcoming year are to serve as a forum for discussion of scope-of-practice issues, to conduct research of value to state and specialty societies facing scope battles and to share lessons learned across geographic and specialty societies.'"

Earlier, the Texas delegation to the AMA House of Delegates submitted Resolution #814 (1-05) titled "Limited Licensure Health Care Provider Training and Certification Standards." "Whereas, The physicians of America voluntarily perform a vital role through initial and subsequent credentialing and privileging of limited licensure health care providers at health care facilities and through peer review of the quality of care provided by these providers at these facilities; and Whereas, In comparison to the uniform national standards of undergraduate and graduate medical education and board certification for physicians, the education and certification standards for limited licensure health care providers may not be uniform nor well defined nor generally understood by physicians and the public; and Whereas, The American public and health care facilities' governing boards properly rely upon physicians to be well-informed about the education, training, and certification standards of all health care professionals when performing voluntary credentialing, privileging, and peer-review; and... Whereas, While our American Medical Association has well defined the training and certification of 65 allied health professionals in its 33rd edition of Health Professions Career and Education Directory, 2005-2006, there is no similar source of information on such limited licensure health care providers as chiropractors, optometrists, nurse anesthetists, advanced practice nurses, podiatrists, or psychologists; and Whereas, The standards for admission, graduate education, postgraduate training, education, testing, graduation, board certification, board governance, ethics, professional discipline, and licensing of limited licensure health care providers are neither well-defined nor generally known by physi-

cians or public members who voluntarily evaluate and recommend them, grant them privileges, and conduct peer review of the quality of care they provide; and Whereas, The uniformity of training, autonomy of accrediting organizations, independence of peer review, and the role played by the professions' trade associations of limited licensure health care providers are neither well defined nor generally known by physicians or public members who voluntarily evaluate and recommend them, grant them privileges, and conduct peer review of the quality of care they provide; therefore be it RESOLVED, That our American Medical Association along with the Scope of Practice Partnership and Interested Federation partners, study the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes, and peer review of the limited licensure health care providers, and limited independent practitioners, as identified by the Scope of Practice Partnership, and report back at the 2006 Annual Meeting."

On June 8th, 2006 Russ and Rose Gonzales from the American Nurses Association spoke out on behalf of the Coalition for Patients' Rights, representing 24 health care organizations united to ensure that educated consumers have a full range of health care provider options and the right to choose among them as they may so desire. The coalition represents more than three million licensed professionals who provide a diverse array of safe, effective, and affordable health care services. Russ: "Psychologists, too, have been surprised and dismayed by the time, energy and resources organized medicine has devoted in an effort to stop our profession from enhancing our scope of practice to help meet the currently unmet need for mental health services, and in an effort to stop us from engaging in activities we are already licensed to perform. As I think is now well known, psychologists in many states are working to get prescriptive authority for appropriately trained psychologists. This has already happened in New Mexico and Louisiana, as well as in the military. Since the laws went into effect in these states last year, in Louisiana alone, well over 10,000 prescriptions have been written by psychologists without incident. Importantly, with the ability to prescribe, psychologists have been able to help improve access to needed mental health services, where waiting times to see a psychiatrist can range from several weeks to several months.

"While the unmet need has been most frequently recognized in rural areas, it can be just as true in urban areas where waiting times to see a psychiatrist have been found to be significant as well. A detailed study by the Tennessee Psychological Association, for example, found waiting times in urban areas in that state to be on average four weeks. This delay in providing care rises to over 7 weeks in rural areas and to almost 12 weeks for TennCare patients. Waiting times aside, the availability of appropriately trained psychologists who prescribe offer patients the option of seeing a healthcare professional whose training enables the use of medications to be integrated with a full range of psychological and behavioral treatments.

"But, organized medicine has not just targeted prescription privileges for psychologists. It continues also to attempt to prevent psychologists from practicing to the full extent of our licensed scope of practice in hospitals. In California, for example, the Union of American Physicians and Dentists recently sued to block the Department of Health Services from issuing regulations enabling psychologists to practice fully and independently in state hospitals. Unbelievably, this latest effort to restrain psychology's scope of practice comes in the face of a 1990 California Supreme Court decision supporting full hospital privileges for psychologists, and two statutory clarifications making it explicit that existing law supporting psychologists' scope of practice in hospitals applies to state hospitals, as well as private hospitals. Additionally, this action by orga-

nized medicine is occurring at the same time that a Department of Justice investigation into California state hospitals is raising questions about access to necessary and adequate care. The DOJ investigation has also found that in some instances medical and psychiatric departments limit the participation and input of other clinicians, including psychologists, to the detriment of patient care.

"There is, of course, ample history of efforts to restrain psychologists' scope of practice. Organized psychiatry opposed independent outpatient treatment by psychologists in the 1960s and 70s; opposed independent practice by psychologists in Medicare in the 1980s; opposed independent hospital practice by psychologists in the 1980s, continuing through to today; and now opposes prescription privileges for appropriately trained psychologists. What makes these actions even more egregious today is the current disarray and fragmentation of our healthcare system. The one prospect we have of fixing the system is to provide more integrated, interdisciplinary, collaborative care delivered by all the health professions working as a team on behalf of the patient. Now, more than ever, is the time for all healthcare professions to work together, not against each other, to provide the level of treatment our patients deserve."

Heathcare must be interdisciplinary and collaborative in nature. During this year's prescriptive authority (RxP) battle in Hawaii, the Executive Director for the Hawai'i Nurses Association testified: "...in support of HB 2589 Relating to Psychologists. This bill allowing qualified psychologists in federally qualified health care centers and health clinics in medically underserved areas to prescribe psychotropic medications will enable patients in those areas to have access to health care that is not now readily available.... Passage of this legislation would increase the availability of timely, efficient, and cost-effective treatment of mental illness to a greater number of residents in medically underserved areas. Thank you for this opportunity to testify in support...."
Aloha,

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

Division 29 is pleased to announce that **Dr. Frank Farley**, former President of the American Psychological Association, Connoisseur of Comedy, Program Organizer of the Off-Beat, SAAVY SOURCE for SEXUAL SYMPOSIA, and PLANNER OF PROVOCATIVE PROGRAMS, will be OUR SUITE SHOW-STOPPER. Dr. Farley, AKA, DR. THRILL for his EXCITING EXPERTISE, WILL BE SHARING HIS "SHTICK," "AN INTERVIEW WITH THE INCREDIBLE 2013 YEAR OLD PSYCHOLOGIST."

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FEATURE

Comments on the State of Psychotherapy Research (As I See It)

David Orlinsky, University of Chicago, Chicago, IL

Note: This essay was written in response to an invitation by Chris Muran, North American SPR regional chapter president, to contribute my views on the current state of psychotherapy research for the past-president's column of the NASPR Newsletter. It appeared, sans references, in the January 2006 issue. Comments on the essay are welcome at d-orlinsky@uchicago.edu.

I must start by confessing that I don't really *read* psychotherapy research when I can help it. Why? The language is dull, the story lines are repetitive, the characters lack depth, and the authors generally have no sense of humor. It is not amusing, or at least not intentionally so. What I do instead of reading is *scan* or *study*. I do routinely *scan* the abstracts of articles as issues of journals arrive to assure myself there is nothing I need or want to know in it, and if the abstract holds my interest then I scan tables of results. Also, at intervals of years, I have agreed to *study* the research on psychotherapy systematically, usually with a specific focus on studies that related process and outcome (Howard & Orlinsky, 1972; Orlinsky & Howard, 1978, 1986; Orlinsky, Grawe & Parks, 1994; Orlinsky, Rønnestad & Willutzki, 2004). I have been doing this for 40 years more or less, and on that basis (for what it is worth) here is what I think about the state of psychotherapy research.

I think in recent years that psychotherapy research has taken on many of the trappings of what Thomas Kuhn (1970) described as "normal science"—meaning that research by and large has become devoted to incrementally and systematically working out the details of a general "paradigm" that is widely accepted and largely unquestioned. The research paradigm or standard model involves the study of (a) manualized therapeutic procedures (b) for specific types of disorder (c) in particular treatment settings and conditions. This is very different from the field that I described three decades ago (Orlinsky & Howard, 1978) as "pre-paradigmatic," and in some ways it represents a considerable advance. However, I refer above to the "trappings of normal science" as a *double entendre* to suggest that the *appearance* (trappings) of normal science with its implicit paradigmatic consensus may also represent *entrapment* (trapping) in a constricted and unrealistic model.

The paradigm is familiar. It holds that psychotherapy is basically a set of specific and specifiable *procedures* ("interventions" or "techniques") that can be taught, learned, and applied; and that the comparative potency or efficacy of these procedures in treating specific and specifiable psychological and behavioral disorders defines more or less effective forms of psychotherapy—if patients are willing and able to comply with the treatment provided by a competently trained therapist.

In this process, therapists are assumed to be active subjects (agents, providers) and patients are assumed to be reactive objects (targets, recipients). Researchers may well believe *theoretically* that patients as well as therapists are active subjects, and that what transpires between them in therapy should be viewed as interaction, but *in practice* the paradigm or standard research model that they typically follow implicitly defines treatment as a unidirectional process.

Evidence of these implicit conceptions of the patient, therapist, and treatment process is to be found in experimental designs that randomly assign patients to alternative treatment conditions, just as if

they were 'objects' (rarely bothering to inquire about *their* preferences) whereas they never assign therapists to alternative treatment conditions, randomly or systematically (because it seems essential to consider *their* subjective treatment preferences). The consequence is that comparisons between treatment conditions reflect treatment-x-therapist interaction effects rather than treatment main effects—as Elkin (1999) and others have made clear—but it is an embarrassment that is conveniently ignored by all (as in the tale of the emperor's new clothes).

In addition, the dominant research paradigm constricts our view of the phenomena that psychotherapy researchers presume they are studying by focusing on certain *abstracted* qualities or characteristics of patients and therapists. The target of treatment is not actually the patient as an individual but rather a specifically diagnosed *disorder*. Other personal characteristics of patients are presumed to be "controlled" either through random assignment (another embarrassing myth, since the effectiveness of random assignment depends on the law of large numbers, and the number of subjects in a sample or of replicated samples is rarely large enough to sustain this), or controlled statistically by using the few characteristics of patients that are routinely assessed in studies as covariates. The covariates most typically are *atheoretically* selected demographic variables assessed for the purpose of describing the sample—age, gender, marital status, race/ethnicity, and the like—since there are no widely accepted theories to guide the selection of patient variables. (More recently, "alliance" measures have been routinely collected from patients, reflecting the massive accumulation of *empirical* findings on the impact of therapeutic relationship.)

Psychotherapists are likewise viewed in terms of certain *abstracted* qualities or characteristics. The agent of treatment studied is not actually the therapist as an individual but rather a specific set of *manualized treatment skills* in which the therapist is expected to have been trained to *competence* and to which the therapist is expected to show *adherence* in practice. The few other therapist characteristics that are routinely assessed—professional background, career level, theoretical orientation, and perhaps gender and race/ethnicity—are used largely to describe the sample or, occasionally, as covariates. Again, this is because there are no widely accepted theories, or extensively replicated empirical findings, to guide the selection of therapist variables.

The constricted and highly abstracted view of patients, therapists, and the therapeutic process in the dominant research paradigm is supported by cognitive biases in modern culture that all of us share. One of these was well-described by the sociologist Peter Berger and his colleagues as *componentiality*. This is a basic assumption that "the components of reality are self-contained units which can be brought into relation with other such units—that is, reality is *not* conceived as an ongoing flux of juncture and disjuncture of unique entities. This apprehension in terms of components is essential to the reproducibility of the [industrial] production process as well as to the correlation of men and machines. … Reality is ordered in terms of such units, which are apprehended and manipulated as atomistic units. Thus, everything is analyzable into constituent components, and everything can be taken apart and put together again in terms of these components" (Berger, Berger, & Kellner, 1974, p. 27).

This componentiality is reflected in the highly individual and decontextualized way that we think about persons. We tend to think of individuals as essentially separate, independent and basically interchangeable units of 'personality' that in turn are constituted by other internal, more or less mechanistically interacting components—whether those are conceptualized as traits that may be assessed quantitatively as individual difference variables, or more holistically but less precisely as clinical components of personality (e.g., *ego*, *id*, and *superego*). Thus when researchers seek

to assess the (hopefully positive but sometimes negative) impact of psychotherapy on patients, they routinely focus their observations on componential individuals abstracted from life-contexts, and on the constituent components of individuals toward which therapeutic treatments are targeted—symptomatic disorders and pathological character traits. They do not generally assess individuals as essentially embedded in sociocultural, economic-political and developmental life-contexts. A componential view of psychotherapy and of the individuals who engage in it is implicit in the dominant research paradigm, and produces a comforting sense of cognitive control for researchers—but does it do justice to the *realities* we seek to study or does it distort them?

Another widely shared bias of modern culture that complicates and distorts the work of researchers on psychotherapy and psychopharmacology (and medicine more broadly) is the implicit assumption of an essential distinction or dichotomy between *soma* and *psyche* (or matter and mind), notwithstanding the efforts of modern philosophers like Ryle (1949) to undo this Cartesian myth. Because of this, findings that psychological phenomena have neurological or other bodily correlates (e.g., using MRI or CT scans to detect changes in emotional response) are viewed as somehow amazing and worthy of note even in the daily press. The materialist bias of modern culture also fosters a tendency to view this correlation in reductionist terms, so that the physiological aspects of the phenomena studied are assumed to be more basic, and to *cause* the psychological aspect.

Thanks to a conversation at the recent SPR conference in Montreal among colleagues from different cultural traditions (Bae et al., 2005), I became aware of how unnatural the body-mind dichotomy (with its consequent distinction between 'physical health' and 'mental health') appears from other cultural perspectives, and of how grossly it distorts the evident *psychosomatic continuity* of the living human person. When this basic continuity is conceptually split into 'psyche' and 'soma', a mysterious quality is created as the byproduct (much as energy is released when atoms are split)—a mysterious quality that is labeled (and as much as possible viewed dismissively) as "the placebo effect." This effect, mysteriously labeled in Latin, is viewed as a "contaminant" in research designs—but, struggle as researchers do to "control" it (rather than understand it), they typically fail in the attempt because the 'effect' reflects an aspect of our reality as human beings that *cannot* be eliminated.

The reality, as I see it, is that a person (a) is a *psychosomatic unity*, (b) evolving over time along a specific *life-course trajectory*, and (c) is a *subjective self* that is objectively connected with other subjective selves, (d) each of them being *active/responsive nodes in an intersubjective web* of community relationships and cultural patterns, a web in which those same patterns and relationships (e) exert a formative influence on the psychosomatic development of persons.

The reality of psychotherapy, as I see it, is that it involves (a) an intentionally-formed, culturally-defined social relationship through which a potentially healing intersubjective connection is established (b) between persons who interact with one another in the roles of client and therapist (c) for a delimited time during which their life-course trajectories intersect, (d) with the therapist acting on behalf of the community that certified her (e) to engage with the patient in ways that aim to influence the patient's life-course in directions that should be beneficial for the patient.

Neither of these realities seems to me to be adequately addressed by the dominant paradigm or standard research model followed in most studies of psychotherapeutic process and outcome. Instead, the dominant research paradigm seriously distorts the real nature of persons and of psychotherapy (as I see them). Why then does this paradigm dominate the field of psychotherapy research, and why do

researchers persist in using it if it is as uncomfortably ill-fitting a Procrustean bed as I have claimed?

The answer is *partly cultural*, as the paradigm neatly reflects the componential, psycho/somatically split, materialist cognitive biases of Western culture. It is also *partly psychological*, with supporters of the paradigm becoming more militant as a result of cognitive dissonance generated by the incipient failure of the paradigm's utopian scientific promise (see, e.g., Festinger, Riecken & Schachter, 1956). It is *partly historical* too, as the field of psychotherapy originated and initially evolved largely as a medical subspecialty in the field of psychiatry—as well as the field of *clinical* psychology that overlapped with, imitated, and set out to rival psychiatry. Again, the answer is *partly economic*, since it is necessary to please research funding agencies (the *real* 'placebo' effect) in order to gain funding for research and advance one's career by contributing publications to one's field and reimbursement for "indirect costs" to the institution where one is employed.

It may be ironic that the paradigm adheres so closely to the medical model of illness and treatment at a time when the psychiatric profession which historically represented medicine's presence in the field has largely (and regrettably) withdrawn from the practice of psychotherapy (Luhrmann, 2000). The apparent solidity of the paradigm that survives is based (a) on the fact that psychotherapeutic services still are largely funded through health insurance which had been politically expanded (after much lobbying) to include non-medical practitioners, and (b) on the fact that psychotherapy research still is largely funded through grants from biomedical research agencies. Although there is no for-profit industry promoting psychotherapy and supporting research on it as Big Pharma does with the psychopharmacologic treatments of biological psychiatry, most of the money that can be had in psychotherapeutic practice and psychotherapy research comes from sources that implicitly support a medical model of mental health. As ever "they who pay the piper call the tune," though perhaps it is more subtle and accurate to say that pipers who need and seek financial support (therapists *and* researchers) play their tunes in ways that they hope will be pleasing to potential sponsors. Necessity drives us (always), but we (all) have an uncanny ability to persuade ourselves that advantage and merit coincide.

A sociology-of-knowledge confession: I know full well that I can say these things mainly because I am privileged by having an old-fashioned, tenured, hard-(but small)-money position in an arts and sciences faculty, and because I am not really in the competition for funds. As a producer of psychotherapy research, I am free to go my own way through my work as participant in the SPR Collaborative Research Network; but as a consumer of psychotherapy research, I have serious misgivings about the state of the filed stem from a perception that the prevailing paradigm which permits research to pursue their studies in the manner of "normal science" represents a risky *premature closure* in understanding the actual nature of psychotherapy and the people who engage in it. If it is not overtly corrupting (as may be true of some research on psychopharmacological treatments funded by pharmaceutical firms), it is nevertheless constricting in ways that seem to me highly problematic.

If we are indeed to have evidence-based psychotherapies grounded in systematic, well-replicated research (e.g., Goodheart, Kazdin & Sternberg, 2006), and evidence-based training for psychotherapists (e.g., Orlinsky & Rønnestad, 2005), then it would be very nice—in fact, I would think essential—for that research to be based on a standard model or paradigm which more adequately matches the actual experience and lived reality of what it presumes to study. I don't know what that new paradigm or model for research will turn out to be. Constructing it is the task of the next generation—but from it will come the sort of psychotherapy research I think I would *like* to read.

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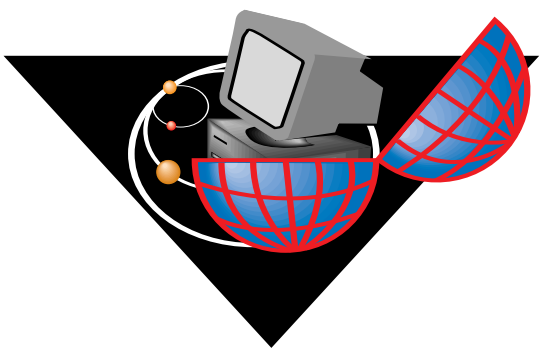

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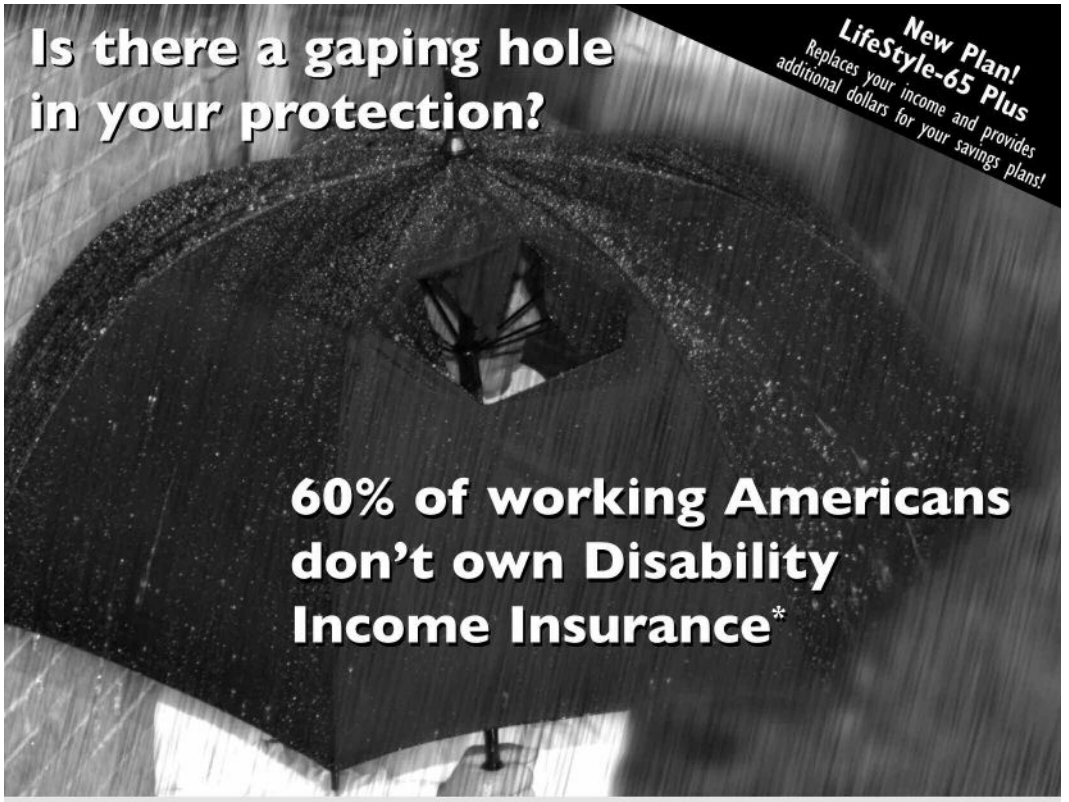

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Outcome Research on Psychotherapy Integration

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Studies consistently show that one-third to one-half of American clinicians consider themselves to be either "eclectic" or "integrative" in theoretical orientation (Norcross, Karpiak, & Santoro, 2005), and psychotherapy integration is widely believed by experienced clinicians to improve the effectiveness of psychotherapy. Yet despite a large theoretical and clinical literature, empirical research on psychotherapy integration has for many years lagged behind. However, when John Norcross and Marv Goldfried asked us to write a chapter on this subject for the second edition of the *Handbook of Psychotherapy Integration*, we discovered that the outcome literature had grown tremendously since we last reviewed the literature (Glass, Arnkoff, & Rodriguez, 1998).

In this article, which is based on our chapter in the *Handbook of Psychotherapy Integration* (Schottenbauer, Glass, & Arnkoff, 2005), we will briefly review the existing outcome literature on psychotherapy integration and suggest future directions. The *Handbook* also includes chapters on many of the treatment approaches that will be discussed below. We will primarily focus on individual psychotherapy for adults, since very little empirical research exists on integrative therapy for children, although several interventions for groups, couples, and families are included.

In conducting our review of empirical outcome research on psychotherapy integration, we encountered a number of challenges. First, it is difficult to identify what constitutes **integrative/eclectic therapy**. We chose to stick to the integration of psychotherapies, thus omitting research where psychopharmacology and psychosocial treatment were combined, and also omitting literature on the integration of treatment formats and modalities (such as individual and family therapy). We restricted our review to those therapies that explicitly describe themselves as eclectic or integrative. Thus, therapies that may acknowledge their eclectic heritage, but primarily retain a pure-form identity, were not included (for example, feminist therapy, rational-emotive behavior therapy).

A second problem in conducting such a review relates to what constitutes **outcome research**. A wide range of integrative therapies have been studied with case studies and purely process studies. However, for the purposes of our review, the standard for inclusion was set much higher: there had to be outcome research consisting of at least one group study with or without a comparison group, preferably with randomization to treatment or to a control group. We classified studies as having one of three levels of empirical support: **substantial** empirical support (four or more randomized controlled studies), **some** empirical support (one to three randomized controlled studies), or **preliminary** empirical support (studies with no control group or a non-randomized control group). We will briefly review these therapies here; more detail can be found in Schottenbauer et al. (2005).

A third source of difficulty relates to the process of identifying and accessing research conducted and published **in languages other than English**. Although great efforts were made to locate and include integrative treatments from Europe and South America, the results of our review are largely restricted to studies published in the English language.

Finally, a fourth problem in reviewing the integrative psychotherapy outcome literature is the **wide variety of ways** in which psychotherapists integrate. Various attempts have been made to categorize what eclectic and integrative clinicians do, and for our purposes, we will distinguish among four types of psychotherapy integration. Within each type of integration, it is possible to distinguish between therapies originally designed for multiple disorders and those created to address a specific disorder.

Assimilative Integration

A variety of therapies have been developed within the framework of a particular system of psychotherapy, in which the assimilative integration consists of supplementing that primary therapy by incorporating specific techniques or perspectives from other systems of psychotherapy.

The two assimilative therapies with substantial empirical support (four or more randomized controlled studies) are *Mindfulness-Based Cognitive Therapy for Depression* (MBCT; Segal, Williams, & Teasdale, 2002) and *Emotionally Focused Couples Therapy* (Greenberg & Johnson, 1988). MBCT was developed to help prevent relapse in recurrently depressed clients. In this approach, cognitive therapy is supplemented with mindfulness techniques, which are techniques based in Buddhist practice that involve being aware of thoughts and feelings and therefore achieving a sense of separateness from them, as well as a sense of their impermanence. *Emotionally Focused Couples Therapy* is on the empirically supported treatments list (Chambless & Ollendick, 2001) as a "probably efficacious treatment." This approach includes an integration of the experiential tradition, emphasizing the role of affect through the use of client-centered and Gestalt methods, and the systemic tradition, focusing on communication and interaction patterns, within the context of attachment theory.

Several assimilative integration approaches have only some empirical support, typified by one to three randomized controlled studies. These include individual *Process-Experiential Therapy* (Greenberg, Rice, & Elliott, 1993), or as it is often called now, *Emotion-Focused Therapy* (Greenberg, 2002), which integrates process-directive and experiential interventions for specific client markers with the facilitative conditions of client-centered therapy. Castonguay and his colleagues (2004) have developed and tested an *Integrative Cognitive Therapy* for depression, which uses techniques from humanistic and interpersonal therapies to help repair alliance ruptures in traditional cognitive therapy.

Finally, two therapies we considered to be examples of assimilative integration have received only preliminary empirical support, that is, research with no control group or a non-randomized control group. The Bergen Project on Brief Dynamic Psychotherapy (Nielsen et al., 1987) included a therapy in which supportive, behavioral, and cognitive interventions were added to psychodynamic techniques. *Functional Analytic Psychotherapy* (Kohlenberg & Tsai, 1991) utilizes behavioral analysis of the therapeutic relationship to improve manualized cognitive therapy. The interpersonal relationship between the client and therapist is a major focus of the work, in that problematic interpersonal client behaviors are noted and elicited by the therapist, who then contingently responds to client improvement and helps the client understand the function of these behaviors.

Sequential and Parallel-Concurrent Integration

Forms of psychotherapy integration that are not often explored empirically are what we term "sequential" and "parallel-concurrent." In sequential psychotherapy integration, two or more types of psychotherapy are given, each during a separate phase of time and in a specified order, with the aim of targeting specific problems during each stage. In parallel-concurrent psychotherapy integration, two or more types of psychotherapy are given during sepa-

rate sessions (both in the same phase of treatment, such as during the same week) or during separate parts of the same therapy session. Sequential and parallel-concurrent integration are different from other types of psychotherapy integration in that they keep the component pure-form therapies distinct, while acknowledging the importance of including both types of therapy as part of a complete treatment. We will present one empirically supported example of each approach, both of which we classified as having some, but not substantial, empirical support.

The primary goal of the *Sheffield Psychotherapy Project* (D. A. Shapiro & Firth, 1987) was to compare a cognitive-behavioral (prescriptive) treatment with a psychodynamic-interpersonal (exploratory) treatment in a cross-over research design. Clients with depression and/or anxiety received either eight prescriptive sessions followed by eight exploratory sessions, or vice versa. Newman, Castonguay, Borkovec, and Molnar (2004) developed the *CBT and Interpersonal/Emotional Processing Therapy for Generalized Anxiety Disorder*, which is an example of parallel-concurrent psychotherapy integration. This therapy is based on findings that some clients with GAD do not improve with typical CBT, and seem to have difficulty with emotional processing. Thus this therapy integrates work on interpersonal/emotional processing (IEP) with traditional CBT for anxiety disorders. One hour of CBT is followed by 1 hour of IEP, so that the therapies are kept as distinct components of the treatment.

Theoretically Driven Integration

Theoretically driven integration consists of approaches in which a clear theory guides the choice of interventions. Unlike assimilative integration, the theory is not necessarily derived primarily from one type of mainstream psychotherapy; it may be developed from an amalgam of many theories of psychotherapy, developed anew, or imported from a relevant field. The choice of psychotherapeutic techniques is guided by the theory and may include techniques from one or more systems of psychotherapy. This is the area with the largest number of empirically supported integrative therapies.

At least five examples of theoretically driven integration have received substantial empirical support. The *Transtheoretical Model* (Prochaska & DiClemente, 2005) posits five stages of change, with specific processes of change to be used at specific stages. Treatment outcome is thought to be related to stage of change, in that clients entering therapy in later stages may be more ready for change and show more progress in therapy than clients in the early stages, who are at risk for terminating therapy prematurely. Certain processes of change are thought to be especially beneficial at particular stages of change or to facilitate progress from one stage of change to the next. In addition to studies finding that stages of change are related to the amount of progress individuals make during psychotherapy, empirical support exists for Transtheoretical Psychotherapy, incorporating stage-matched interventions for primarily health-related problems and risky behaviors.

A second substantially supported treatment in this category is *Acceptance and Commitment Therapy* (ACT; Hayes, Strosahl, & Wilson, 1999), which is based on a theory that rule-governed (language-directed) behavior is excessively rigid and does not adjust to changing contextual situations. The therapy aims to influence the client toward acceptance of experience and commitment to constructive action, and it is characterized more by adherence to the theory than by specific methods. A variety of types of intervention are consistent with different phases of ACT, including the use of metaphor, experiential exercises, meditation, and behavioral techniques.

Cognitive Analytic Therapy (CAT; Ryle & Kerr, 2002) is a synthesis of cognitive-behavioral and psychoanalytic object relations that has been the topic of numerous studies. CAT includes a theory of change

and a specific series of interventions that can be applied in a time-limited format. The main emphasis of CAT is on the process of reformulating the client's problems through the use of diagrammatic descriptions, which depict problematic patterns of relating to others and the self. Additionally, Duignan and Mitzman's (1994) adaptation of CAT to a time-limited group format has received preliminary empirical support.

Another therapy on the empirically supported therapies list (Chambless & Ollendick, 2001) as "probably efficacious," and one of the most studied integrative therapies for a particular disorder, is Linehan's (1993) *Dialectical Behavior Therapy* (DBT). Initially developed for individuals with borderline personality disorder, DBT is based on Linehan's theory of borderline personality disorder and is delivered both in individual therapy and in a group skills training format. Interventions such as mindfulness, acceptance, and focusing on dialectical processes are integrated into a framework consisting of more traditional behavioral interventions such as reinforcement and problem solving. Clients' problematic interpersonal and intrapersonal processes are addressed by an emphasis on dialectical processes to resolve their tendency to vacillate between the extremes of the dialectical poles.

A final example of a substantially supported approach is *Multisystemic Therapy* (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), an integrative individual and family treatment for youth with antisocial behaviors. Grounded in systems theory and social ecology, MST utilizes a wide range of interventions couched within a sensitivity to developmental level and a positive, present-oriented focus. Many interventions are CBT, structural, or family therapy, and a hypothesis-testing approach is used to develop theories regarding the reasons for behavior maintenance in order to identify areas for change.

Two additional theoretically driven integrative therapies that have received some empirical support are *Brief Relational Therapy* (BRT; Safran, Muran, Samstag, & Stevens, 2002), and the *Cognitive Behavioral Analysis System of Psychotherapy* (CBASP; McCullough, 2000) to treat chronically depressed clients. BRT combines results from research on maintaining a therapeutic alliance and resolving alliance ruptures with elements of relational psychoanalysis, humanistic/experiential psychotherapy, and contemporary theories of cognition and emotion. CBASP is derived from a combination of developmental (Piagetian), cognitive, and interpersonal theories, where interventions include a mix of cognitive, behavioral, and interpersonal techniques intended to comprehensively address the multiple targets identified by the theory.

Finally, there are two integrative therapies with only preliminary empirical support. Ivey's (2000) *Developmental Counseling and Therapy* is a co-constructive theory based on Piagetian cognitive/emotional theory, Erik Erikson's work on lifespan development, attachment theory, and Lacan. Therapeutic interventions are matched to client developmental level and cognitive/emotional style. The Chilean Institute for Psychotherapy Integration (Calderón, 2001) has developed an integrative model of psychotherapy for cluster C personality disorders, which is based on an integrative understanding and assessment of the disorders.

Technical Eclecticism

The fourth type of psychotherapy integration we will discuss is technical eclecticism, which has typically been defined as the use of psychotherapy techniques without regard to their theoretical origins, and is often systematic in the choice of interventions. While a number of authors also include "common factors" integration (for example, the use of elements identified as common to many pure-form therapies), we did not include this approach due to a lack of outcome research.

There are two therapies in this category with substantial empirical support.

Perhaps the hallmark of eclectic psychotherapy are the twin ideas that certain clients do better in certain types of treatment, and that techniques can be used from different systems of therapy regardless of their theoretical origin. Several systems of client-treatment matching have been developed with the aim of improving therapy outcome, and Beutler and Harwood's (2000) *Systematic Treatment Selection* has the greatest empirical support. Two variables for which the empirical research clearly shows treatment matching effects are the client's internalizing/externalizing coping styles (blaming oneself and generating internal distress as a result vs. acting-out or blaming others) and reactance level (defined as a personality tendency to oppose following directives). Clients who externalize seem to do better in CBT than in insight-oriented or relationship-oriented therapies, and clients who are obsessively constricted or who internalize do better in interpersonal therapy, insight-oriented, or relationship-oriented therapy. Clients high in reactance appear to respond more favorably to interventions low in directiveness (such as client-centered therapy), whereas clients low in reactance respond better to interventions high in directiveness (such as CBT).

Eye movement Desensitization and Reprocessing (F. Shapiro, 1995), which was also placed on the empirically supported treatment list (Chambless & Ollendick, 2001) as a "probably efficacious treatment" for PTSD, is an integrative psychotherapy that synthesizes key elements of major pure-form systems, including psychodynamic, behavioral, cognitive, and experiential components. While Shapiro admits that she did not create the therapy based on theory or research, she now frames it within an information-processing model, although some argue that EMDR is largely exposure-based behavior therapy.

Surprisingly, although Lazarus's (1997) *Multimodal Therapy* is probably one of the most widely known systems of eclectic psychotherapy, little empirical research has evaluated its effectiveness, leading us to classify it as a therapy with only some empirical support. Multimodal treatment is based on an assessment that identifies a client's problems and also predominant modalities (aspects of functioning) from among the BASIC I.D.: Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs/biological functioning. Treatment is then tailored to the client's problem, needs, and characteristic modalities. Lazarus employs approximately four dozen techniques, including medication, imagery and fantasy, client-centered reflection, and gestalt empty chair exercises, with an emphasis on cognitive and behavioral techniques.

Another eclectic therapy with some empirical support is *Brief Eclectic Psychotherapy for PTSD.* Gersons, Carlier, Lamberts, and van der Kolk (2000) adapted a treatment for PTSD that uses cognitive-behavioral techniques (psychoeducation, imaginary guidance, homework tasks, and cognitive restructuring), focal psychodynamic work, and a farewell ritual.

A final eclectic approach with only preliminary support is the *Client-Directed, Outcome-Informed Therapy* developed by Duncan and Miller (2000). This psychotherapy is focused on tapping client resources, enhancing the therapeutic alliance, and adopting the client's world view regarding his or her problems. Any number of interventions are then utilized in service of meeting the client's needs, as perceived by the client.

Conclusions and Future Directions

Outcome research on psychotherapy integration has progressed dramatically since we first reviewed this literature, but much work is left to be done. Some of the most influential types of eclectic/integrative psychotherapy, such as Lazarus' (1997) Multimodal Therapy, still have little empirical support. While Beutler and Harwood's (2000) Systematic Treatment Selection is based entirely on empirical work, the number of variables on which

sound empirical evidence exists is quite small compared to the possible number of treatment matching variables. There have also been a number of approaches that have been proposed for quite some time, such as Wachtel's (1997) cyclical psychodynamics, that have not yet been rigorously evaluated. Finally, it is important to note that while outcome research on psychotherapy integration is growing, the number of approaches that have been studied remains far less than the profusion of integrative approaches that have been presented in the theoretical and clinical literature.

There are several recurrent themes in the integrative or eclectic therapies that have been studied thus far. First, some of them, such as Dialectical Behavior Therapy (Linehan, 1993) and Multisystemic Therapy (Henggeler et al., 1998), were developed for disorders that are thought to be difficult to treat. Others, such as Cognitive-Behavioral Therapy with Interpersonal/Emotional Processing Therapy for generalized anxiety disorder (Newman et al., 2004), have been developed for clients who do not benefit from the standard treatment. These appear to be particularly fruitful avenues for integrative treatments to make a contribution above and beyond pure-form therapies.

Second, it has been thought that it is particularly difficult to study the outcome of psychotherapy integration empirically if not all clients receive the same treatment, as in, for example, Lazarus' (1997) Multimodal Therapy. However, the extensive research on Multisystemic Therapy (Henggeler, 1998), Acceptance and Commitment Therapy (Hayes et al., 1999), and Systematic Treatment Selection (Beutler & Harwood, 2000) have shown that it is possible, as long as there is a systematic model for choosing the interventions. In these cases, adherence to the *model* is measured, rather than the implementation of standard interventions.

One factor that is hopeful for the future of psychotherapy integration is a growing interest in investigating empirically supported principles of change, as evidenced by Norcross' (2002) book, *Psychotherapy relationships that work,* that was the result of a Division 29 task force, and Castonguay and Beutler's (2006) book, *Principles of therapeutic change that work,* that was the result of a Division 12 task force. In addition to examining the effects of whole therapies, it is valuable to test components of therapies empirically, such as the therapeutic alliance, empathy, and technique factors. Since many forms of psychotherapy integration focus on integrating specific techniques or components, this focus of research may have great rewards for the psychotherapy integration field. Further, these books present the available research on matching treatments to specific client characteristics. Since many forms of psychotherapy integration profess to match treatments to clients, this research also holds great promise.

Finally, an area that needs further exploration is the effectiveness of psychotherapy integration as it is carried out by clinicians when they practice as they usually do. This is a difficult task to accomplish, however. On one hand, outcome research on psychotherapy integration has focused on specific types of manualized integrative psychotherapies. Since it is well known that most practicing psychotherapists do not follow manuals (Goldfried & Wolfe, 1998), the promising results of existing studies of psychotherapy integration may not apply to therapy as rendered in real life. On the other hand, studies examining the improvement of clients receiving eclectic psychotherapy in practice yield minimal conclusions if they have not clearly defined what the therapists did during treatment, and so the findings cannot be replicated.

This problem is central to studying psychotherapy integration as practiced. Although most "eclectic" or "integrative" therapists state that they tend to use whatever works best for the client, they use dif-

ferent combinations of theories and techniques, as well as different decisional processes to determine which theories and techniques to use (Norcross, Karpiak, & Lister, 2005). For instance, when a number of integrative clinicians were asked to provide case formulations and treatment recommendations for the same client, there was little agreement among them (Giunta, Saltzman, & Norcross, 1991). This leaves a virtually infinite number of types of integration that would need to be studied. The solution is not to study each therapist separately, but to glean the principles of decision-making that substantial numbers follow.

Therapists in the trenches are constantly making decisions to integrate therapies in an effort to improve service to their clients. Although it is a challenge to study their decision making and link it to outcome, the field can benefit from the wisdom of those who spend the majority of their time providing services. Such "bottom-up" research strategies can complement and ultimately inform the more standard "top-down" strategy of creating and studying manualized treatments.

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Expand your sphere of influence. Join us in helping to shape the future directions of our chosen field. There are many opportunities to serve on a wide range of Division committees and task forces.

MEMBERSHIP REQUIREMENTS

APA Member (Fellow, Associate, Member), payment of divisional dues: once you are a member, your division 29 dues will appear on your APA membership dues invoice.

JOIN US TODAY!

LAST NAME _____

FIRST NAME _____

DEGREE _____ YEAR _____ INSTITUTION _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

( ) _____
DAYTIME PHONE

( ) _____
FAX

COMPLETE E-MAIL ADDRESS _____

Please add me to Division 29's LISTSERV

APA Membership Number

APA Status:
____ Member ____ Associate ____ Fellow

MC / VISA # _____

EXPIRATION DATE _____

_____
Signature

CLINICAL AND RESEARCH INTERESTS:

_____

REASONS FOR JOINING DIVISION 29:

_____

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

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

Code FD

ACT NOW FOR

- ✲ **LEADERSHIP OPPORTUNITIES**
- ✲ **FREE SUBSCRIPTIONS**
- ✲ **DISCOUNTS / REDUCED FEES**
- ✲ **MARKETING TIPS**