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BULLETIN

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Division 29 2007 APA Conference Program

2007 VOLUME 42 NO. 2

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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 with the subject header line *Psychotherapy Bulletin;* 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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PRESIDENT'S COLUMN

Jean Carter, Ph.D.

We Have Lots to Offer you in 29!

As we move toward the halfway mark on this year, your Board members, Committees and Editors are busy working on what we have to offer the members of this great Division. We are committed to psychotherapy, whether as practitioners, researchers, educators or theorists, and the work of the Division is to support that commitment through resources, policy proposals, tools and publications/presentations. This column is dedicated to the hard working members of governance whose efforts allow us to offer you—the members—much of value. I will highlight a few of these initiatives and the people who make them happen!

Our Program

We all owe big thanks to Jeffrey Magnavita who has put together a stellar program for convention this year. Putting a convention program together is a big job, starting from developing the Call for Programs for the Monitor each year, receiving proposals, organizing reviewers and reviews to select the best programs, and developing invited presentations. When you come to the APA Convention [you have registered, haven't you??], look for the wonderful Division 29 programming and remember to thank Jeffrey for his work. He will be working with Associate Chair Nancy Murdock for a smooth transition.

Two special events to watch for this year:

- Awards and Recognition Hour and Social Hour: Join us in honoring our award winners, recognizing outgoing governance and Board members, and celebrating the accomplishments of our members. Families join together in celebration, and the family of 29 is no different!
- Student/Early Career Luncheon: Early Career Board Member Libby Nutt Williams and Membership Chair Annie Judge are developing a luncheon at convention for students and early career members of the Division. They have big plans underway, so watch for this opportunity to welcome new members to our field and to our division.

Psychotherapy Education and Continuing Education

Division 29 maintains a strong and solid commitment to lifelong education and training for our members. We have a very active Education Committee, chaired by Jean Birbilis, whose columns in the Bulletin offer you updates on their activities.

Mike Constantino, our Continuing Education Chair, has also been busy. Division 29 will offer the continuing education component of the Society for Psychotherapy Research meeting in late June in Madison, Wisconsin, and Mike has been working with SPR to develop that program. He has also been working with our Journal editor Charlie Gelso and internet editor Bryan Kim to expand our Journal CE offering and facilitate its effectiveness. We thank our past CE Chair, Steve Sobelman, who left that position to become our Treasurer.

We also offer thanks to Abe Wolf who is not only our past president, but also coordinates the OnLine Academy, which partners with APA in creative CE offerings that are available through the internet. The range of these courses continues to expand, thanks to Abe's hard work.

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A Tribute to our Editors

Our Editors—Internet Editor Bryan Kim, Bulletin Editor and Associate Editor Craig Shealy and Harriett Cobb and Journal Editor Charlie Gelso—provide a solid backbone of information for our members. Their work, along with the work of authors, reviewers, and editorial board members, have built a library of resources that stand out for the quality, breadth and depth of information. Send them silent—or not so silent!—thanks whenever you access any of our publications. Publications Board Chair Ray DiGiuseppe coordinates the various publications, and we thank him as well.

And on through the year!

- Remember to register for convention—come to convention, check out our offerings!
- Go to the website—Bryan updates it regularly!
- Read the Bulletin and the Journal—they are always informative and stimulating, full of ideas!
- Look to Division 29 for continuing education—we have a variety of media and a range of topics to expand your knowledge of PSYCHOTHERAPY.

A WORLD OF PSYCHOTHERAPY

Reflections on the Vietnamese and Cambodian People

Norine Johnson, Ph.D.

In November of 2006 I had the privilege of leading a People to People professional delegation of psychologists to Ho Chi Minh City in Vietnam and to Cambodia. We were the first official delegation of psychologists to visit these particular university and hospital sites. Dwight D. Eisenhower founded People to People as a way to forge peace in the world through cross-cultural exchanges. Most know the organization through its high school student exchanges.

My first People to People experience was with an inspirational psychology delegation led by Dr. James Jones to South Africa. Later, my husband and I traveled to Egypt in a delegation led by Mary Jane Eisenhower, the late president's granddaughter. In both delegations I had the opportunity to dialog with leaders who were committed to world peace and improving people's lives through intellectual and cultural exchanges. I was eager to experience Vietnam and Cambodia through professional exchanges rather than as a tourist.

Our experiences were not what we had anticipated and I believe changed, in some way, each of our lives. One of my responsibilities as leader was to suggest discussion topics and to invite fellow psychologists with interest and expertise in those areas to join the delegation. The professional program I planned included significant dialog about post-traumatic stress as well as sexual abuse of women and the impact of psychological issues on health. In Vietnam we heard flat denial of any post-traumatic stress. Sexual and physical abuse was acknowledged in Cambodia and the people we met spoke openly of the atrocities of the Khmer Rouge. From conversations, I came to believe that most middle aged and old Cambodians had lost from 6 to 8 family members. Their resiliency is powerful. I would be interested in understanding more how they have managed to survive and even thrive after such atrocities.

We also anticipated significant residues of anger toward Americans from the Vietnam war. Instead we found wonderfully warm, energetic, hopeful, welcoming professionals and faculty, with manifest resiliency, high expectations and dedication to learning. Physicians, students and faculty struggle with little to no resources except their own gifted minds and seemingly boundless energy.

Ho Chi Minh City

The streets of HCMC are vibrantly alive with young people. Most looked between eighteen and thirty-five, smiling, friendly, and energetic. The city pulsates with streams of motorbikes, frequently carrying two persons hurrying to work. According to one of our guides, the high cost of living in HCMC requires that many men and women have two or sometimes three jobs to afford housing. So instead of our 8:00 AM and 5:00 PM rush hours, roaring motorcycles jammed the roads and boulevards at all times, making crossing the streets on foot a major risk. A few remnants of the old French Saigon remain but primarily the city has been rebuilt with expansions both upward and outward. A few of the stately old trees and boulevards remain but primarily the color is from the clothes of the people and the wares in the open market places.

Having arrived in HCMC four days ahead of the delegation, each day I visited a

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different site in or around the city which included the market place, Buddhist Temples, and the National Museum which I loved for its accessibility of cultural artifacts dating back thousands of years. I also visited the tunnels which concealed a Viet Cong city under the surface of the earth. The Viet Cong began the tunnels during the conflict between the Communist North Vietnam and the Catholic-dominated South Vietnam before the US entered the war. A labyrinth spanning scores of miles with hidden entrances and exits, and scooped-out spaces for a hospital, a school, dining centers, sleeping bunkers—level after level, up and down, lacing under the surface with the complexity of an underground ant hill.

When the US entered the war on side of South Vietnam, the area around the tunnels became one of the sites of extensive droppings of Agent Orange. American tanks and others remnants of the US participation in the Vietnam War remained and despite the disavowals of our guides and the professionals we met about holding no animosity toward Americans, the Tunnels Memorial and the Vietnam War Memorial on the grounds of the former South Vietnam Presidential house (from which the infamous helicopter took off) spoke of the continuing impact on both sides of the world by this shameful war.

Structure of our visit

Our visit included five professional sites, stunningly beautiful cultural experiences and emotionally jarring museums with remembrances of the violence, horror and trauma both cultures have endured. In Ho Chi Minh City our professional exchanges included the Vietnam National University and Bien Vien Tam Than, a large public mental hospital. In Cambodia the programs we visited were all located in Phnom Penh. These included the Royal University of Phnom Penh, the Khmer-Soviet Friendship Hospital, and the Cambodian Women's Crisis Center.

Our cultural experiences in Vietnam included a visit to the Vietnam War Museum, a trip down the Mekong Delta, shopping and, for the non-psychology guests while we were engaged in professional meetings, a trip to the countryside to see the rubber trees and the startling remnants of the extensive underground tunnels the Viet Cong had dug into the countryside outside of the then Saigon. In Cambodia, our cultural experiences including the astonishingly beautiful temples of Angkor Wat outside Siem Reap and the horrific Torture Museum and Killing Fields in Phnom Penh.

Our professional exchanges

The following description of our professional visits is drawn in large part from our delegation's journal which was compiled by my co-leader, Cammarie Johnson, and ably edited by Dr. Mary Halas. I asked Cammarie, a specialist in the psychological treatment of autism spectrum children and adolescents, to co-lead the delegation. I anticipated our professional counterparts in Vietnam and Cambodia might be interested in current ways of treating such disorders given the birth defects associated with the chemicals used during the war. The fact she was also my eldest daughter added an unreplicable joy to the experience.

Vietnam National University

At Vietnam National University, three faculty members, Dr. Nguyen Phuong (who trained in the United States), Dr. Huang Mai Khanh, and Nguyen Thi Thanh Hang, informed the delegation of the structure of higher education in Vietnam, the Vietnamese family structure and the education and training of psychologists. From these three well-spoken, engaging faculty women our journal entries by Cammarie Johnson, Dr. Julia Shiang, and Dr. Shoshana Kerewsky note that the study of psychology currently culminates in a B.S. or B.A. The Educational Psychology

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Department at the Vietnam National University enrolls 100 students with 170 graduates of the program. The presentation on family suggested that the current structure is still father-led although with so many women working, there appears to be more equality in the traditional family. As noted by Dr. Kerewsky, there is "no acknowledgement of differing family structures or same-sex couples in Vietnam."

Dr. Phuong's presentation included an organizational chart that described Vietnamese education as overseen by the Communist Party Central Committee, National Assembly and the Ministry of Education and Training. Apparently, currently 6-12% of the population will receive some exposure to higher education. The presentation suggested that there was an increased emphasis on higher education with resultant increased funding and greater autonomy.

Presentations from our delegation at Vietnam National University included Dr. Shoshana Kerewsky on Bronfrenbrenner's ecological model as a culturally sensitive assessment tool. She had studied the Vietnamese language before the trip and with great respect included our greetings and other comments in their language. Dr. Louise Silverstein presented her cutting-edge research for utilizing a multicultural approach to activate parents within an educational setting, using a Participatory Action Research framework.

We were delighted to see approximately 30 students at the presentations. Over 150 people jammed into a concrete-sided classroom on the third floor, with window air conditioners that periodically hummed and stopped, hummed and stopped. Most of the students sat in the back of the room although after the seats filled up a few of them, initially timid, wandered up front looking for a seat. During the question and answer period some of the students stepped forward and asked insightful questions about the presenters.

Benh Vien Tam Than Hospital

Dr. Le Quoc Nam, Chief of the Community Psychiatry Department presented us information about Benh Vien Tam Than, the HCMC mental hospital. (Summaries of which were ably recorded by Drs. Mary Halas and Ellen Faryna for our journal.) For over twenty minutes he read an extensive list of statistics from a small notebook that he withdrew from an inside pocket of his white physician's coat. As I watched him and listened to the translation of his presentation, I wondered about the importance of numbers to the Vietnamese as he clearly valued the information the numbers represented and was giving us a gift. His small hospital is the only inpatient mental health facility servicing the 8 million people in HCMC. The staff of 317 health care professionals is responsible for the 16% of this population with mental health disorders, over one million people.

During our tour we saw the enormity of issues this dedicated staff faced daily. The woman physician guiding my section of the delegation informed us that a line of people which stretched all the way down a long hall, curved around the pharmacy, and snaked out into the trees so far that I could not see its end, were approximately 400 patients who come weekly for their medications. Most were standing. Some were lucky enough to be able to wait on benches. Our guide informed us that most patients were accompanied by their families, which increased the numbers patiently waiting to be seen.

In the living units we saw inpatients in active delusional states, a few extremely agitated, others friendly and curious about us as we were of them. Smiles were exchanged. Our guide informed us that a family member frequently stays in the hos-

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pital with a patient and that each small cot size bed was shared by three patients. Not all the beds had mattresses. When a few patients became increasingly agitated, we left, fearing that our visit might be disturbing their customary routine.

A tour of the pharmacy revealed a small room, similar to a 1950s drugstore with painted white open shelves and a small wooden desk. The shelves were practically empty. After the tour, we gathered again with the medical staff, as the chief psychiatrist shared openly their needs for medication, sufficient staff to service their clients, increased personnel and training in psychotherapy which does not exist currently.

When members of our delegation talked later, each one of us expressed tremendous respect for this dedicated staff. We have committed to telling their story in the hope of interesting others in helping to provide ongoing ways for the staff to receive the journals, books, consultation and training in current methods of psychotherapy appropriate for their population, plus medication, and other medical and psychological tools which research has indicated helps patients with a range of mental health issues.

Drs. David Ciampi and Rachel McNair from our delegation gave professional presentations on the global challenges facing us in the 21st century and the severity of post-traumatic stress disorder among soldiers who had killed or witnessed atrocities of killing women, children and prisoners.

Cultural Visit to the Mekong Delta

We concluded our visit to south Vietnam with a bus trip through the countryside to the Mekong Delta, where we went by boat to a village and spent the afternoon eating beautifully prepared food (including dragon fruit and artfully presented fish), admiring the handicraft of the villagers and experiencing a dugout ride navigated by two women strong enough to swiftly pole four large Americans through a narrow waterway.

Our brief visit to south Vietnam—days for the delegation and a week for me—left us with the impression of HCMC as thriving with its new economy. The people we saw and had the opportunity to interact with appeared intensely industrious, bustling with energy, now that the trade barriers are down. Certainly the professionals are eager for our professional knowledge. At no time did I sense continuing resentment of the atrocities and hardships caused by our country during the Vietnam War. I would like to learn more about what in their culture promotes such forgiveness and resiliency.

Cambodia

We left Vietnam for Cambodia and first went to Siem Reap where we spent two days visiting the Angkor Wat ruins, which are magnificent. I can't do justice with words to these impressive and empowering ancient structures. Unlike what I thought from the images carried on tourist flyers or in our American films, such as with Marlon Brando in *Apocalypse Now* and more recently Angelina Jolie fighting the bad guys among the roots of gigantic trees which tower over these awesome structures. There are at least six or seven different temples, built over hundreds of years by several rulers of Cambodia. Like many from the delegation, I plan to return to Siem Reap and the ruins when there is time to leisurely wander among the stone structures, feast my eyes on the red lily pad pools, meditate and just stay still absorbing the incredible aura.

In preparation for the visit I read several books by Vietnamese and Cambodian writers. One of the most memorable was, *First They Killed My Father*, an autobiography written by a woman who survived the

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Khmer Rouge's indescribable horrific reign. As tragic as the wars in Vietnam are, the story of Cambodia is of such unbelievable magnitude of murder, violence, torture, degradation, and madness that I'm still unable to write the words or describe my feelings.

To even begin to understand the Cambodian people today and the magnitude of mental and physical health issues emanating from their brutal history, it is necessary to know that history. Our delegation visited the buildings where thousands of Cambodians were imprisoned and tortured before they were killed, a memorial to those who suffered so. On the walls of the buildings which cover perhaps half a city block, floor to ceiling with partitions of make-shift walls to hold them, are pictures of each prisoner before his or her execution. They were made to stand and look into the camera. The eyes haunt my thoughts even as I write this. In the delegation we asked ourselves such questions as, "What madman ...." and then the questions trailed off as we knew the evil we saw was beyond madness.

Upon leaving the museum we silently boarded our buses and drove to the outskirts of Phnom Phem where the killing fields have been preserved as another memorial to those killed by the Khmer Rouge. The fields at first glance look like an expanse of wild grass and low lying shrubs, with unpaved foot paths crossing them. As we debarked the buses, before us stood a three-story high tower of skulls. On the first story are children's skulls. I could not be with any one at this point and chose to walk each of the paths alone. In the back, far from the skull memorial, a cluster of red butterflies flew low over the grass and scrub bushes. I wept.

Khmer-Soviet Friendship Hospital

At the Khmer-Soviet Friendship Hospital in Phnom Penh, the capital of Cambodia, we again met dedicated staff, committed to servicing the needs of their patients. Cambodia has had the benefit of more interaction with other countries than the facilities we saw in Vietnam. Several of the staff had been educated abroad and they spoke of the educational support they received from European countries. We concluded that the professional staff had a sophisticated understanding of both the needs of their patients and the current methods for treatment. What they lacked were resources, which they were very direct in expressing. As our recorder, Dr. Mary Halas, summarized their concerns, "We are hungry for knowledge ... we do not have Internet access in the hospital; our state-run library for the hospital has no books. We want books (in English) on sexual abuse, drug abuse, and domestic violence.... We would like to learn more and more."

During our discussion with medical staff which became increasingly open, the hospital director shared that after 1979 there were only 50 doctors left in Cambodia and no psychiatrists. Other psychiatric staff shared about the significant stigma attached to mental illness, "... especially in the ladies." Mental health patients are primarily supported by their families except for victims of domestic violence who do not receive family support. Both I and Joe Matazzaro spoke, when asked, about health psychology in the United States. We learned that in Cambodia there is a program to train general practitioners in psychiartic disabilities.

Cambodian Women's Crisis Center

Sin Ly Pao greeted us as we entered the administrative offices of the Cambodian Women's Crisis Center. Journal entries by Dr. Regina Gerstman, Dr. Edna Baginsky and Dr. Carolyn Hicks provide extensive information about the Crisis Center which underscores the incredible work of this dedicated facility for women. Cambodia, not yet recovered from the ravages and

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unthinkable inhumanity of the Khmer Rouge, continues to suffer from violence perpetrated today upon some of its women and children, both by family members and by sex traders. Statistics vary, but hundreds of kidnapped women and children are returned to Cambodia monthly, having been expelled from Thailand and other neighboring countries because disease makes them no longer marketable in the "sex trade industry." In addition to these victims, untold others are abused regularly within their homes, primarily by male relatives.

The Cambodian Women's Crisis Center was established to provide safety, recovery, and training for abused women and their children. With a dedicated staff, such as Sin Ly Pao, who was one of the Center's three founders, they treat 1800 clients a year. They provide a full range of services beginning with assessment, daily counseling and expressive therapies, medical assistance and progressing to training the women in marketable skills. We were privileged to be allowed to visit one of the secure homes for the women and had an opportunity to see the children studying, playing, and seemingly happy with their mothers inside a barbed wire compound in the outskirts of Phnom Penh. The location of the compound must be kept secret for the women's protection from husbands and families whose beliefs include the right to continue abusing their wives and/or daughters. Dr. Sheila Erlich from our delegation presented her work with holocaust survivors with a focus on countertransference issues.

At the previous professional sites, our delegation had given an extensive amount of professional material, books, journals, etc. Here, members of the delegation reached inside their hearts and donated over $1000.

The Royal University of Phnom Penh Psychology Department

Our final professional exchange was hosted by Ms. Nhong Hema, Head of the Psychology Department. The audience included faculty and students from the Royal University of Phnom Penh along with mental health providers from the community. Our delegates preferred small group exchanges, if they could be arranged. Because we were a large delegation, this was limited in Vietnam. In Cambodia the professional delegates were divided in half to visit the hospital and women's crises center. The groups of 35 rather than 70 made for a somewhat better personal exchange but individual conversations were still difficult to achieve.

When I saw the facility in which we were to met, a large lecture room with tiered seating and equipment for power points, I stood at the doorway as our delegates entered and recommended to each that they spread out so that students who wanted could sit beside them.

The room soon became alive with sound, like the Boston Symphony Orchestra warming up to play Beethoven's Fifth, as multiple conversations all occuring at the same time bounced off the walls. With 200 students present a delegate might be surrounded by three or four young adults, most fluid in English, all clamoring for information, exchanging email addresses with the delegates, and laughing with pleasure.

Ms Hema planned a full day of incredibly interesting presentations. Our recorders, Dr. Sharon Lash and Dr. Shoshana Kerewsky, fortunately kept excellent notes. Cammarie and I were seated up front with Ms. Hema as was the customary courtesy afforded us as leaders of the delegation. I looked up and saw Joe Matarrazzo busily scribbling notes on bits of paper as Cammarie started lightly punching my arm. "Mom, I think you're going to want to see this."

She showed me the program. There on the

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third line after Ms. Hema's opening remarks, and after Joe's name, was my name. But the program, unlike for the other presenters, did not note what our topics were to be. Yet somehow Joe knew. I could tell from his vehement scribbling.

Ms. Hema's remarks are a blur (thank heavens for the recorders) and then Joe came forward and delivered a thoughtful, fact-filled presentation on the *History of Psychology*. As he sat down, I heard (despite the loud beating of my heart pulsating in my ears) Ms. Hema introduce me. She said the title of my talk was *Psychology and Health*. With relief, I launched into my favorite topic, the importance today of developing health systems that reflect the biopsychosocial-cultural model espoused in my 2001 APA Presidential Initiative.

I can only cover in this report a small amount of the information exchanged during this extremely dynamic and emotionally day long program and thank our recorders, Drs. Sharon Lash and Shoshana Kerewsky, for their notes. The presentations represented the partnership model developed by the professional communities in Cambodia to begin to address the mental health needs of their country.

According to Ms Hema, her department, the only psychology program in Cambodia, began the undergraduate program in 1994. Currently 245 students are enrolled, most of them males. What we saw in Cambodia which had not been apparent in Vietnam was how the psychology department had linked with other mental health resources in Cambodia. Our speakers represented some of these programs: Maryknoll's Little Sprouts, Social Services of Cambodia, Cambokids, Cambodian HIV/AIDS Education and Care, the Center for Mental Health and others. Given the enormity of the mental health issues in the country, trauma and enormous loss for those who survived, the continuing issues of sexual and physical abuse, various addictions and other issues of a developing country, we left with admiration and enormous respect for the professionals and volunteers who are dedicated to providing quality mental health services to their peoples.

Follow-up

On our last night in Cambodia, a small group gathered for dinner. We had all been significantly moved by our experiences and made a commitment to develop a follow-up plan for all the of Vietnamese and Cambodian programs we had visited. The members of the Follow-up group are Drs. Diane Elmore, Joe and Ruth Matarazzo, Julia Shiang, Louise Silverstein, and myself.

Our assessment of needs prioritized the following:

1) on-line access to current journals and other publications for the psychology departments and also for the two hospitals' psychiatry departments if possible;
2) affiliations of US psychology departments within universities, colleges, and professional schools that will support exchanges of the Vietnamese and/or faculty and students as well as information flow;
3) current psychology textbooks;
4) affiliation with the American Psychological Association for the two psychology departments;
5) recommending to People to People that a psychiatry delegation to Vietnam and Cambodia be assembled to assess the current need for medication, appropriate equipment such as ECTs, and to facilitate collaboration with US medical schools.

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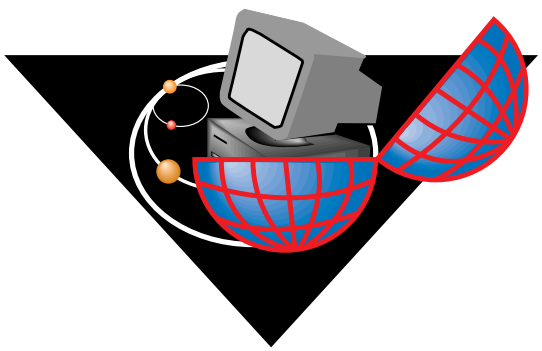
APA's August Convention. We invite you to be part of the follow-up.
We have invited Ms Hema, the Director of Psychology at the Royal University of Phnom Phen, to the United States to attend the American Psychological Association's Annual Convention in San Franscisco and she has accepted if appropriate arrangements can be made. Plans are still in the early stage. We welcome involvement in her visit by all who are interested. We are looking for space in the program for her to present her psychology program at the university; financial assistance and indi- vidual donations to support her stay here; informal opportunities, such as division suites for informal discussions, and other opportunities for those interested in Cambodia and psychology to gather.

A final note. Among my most personal memories are the Vietmese and Cambodian children. I was captured by their beauty, entranced by their peacefulness and and enchanted by the mixture of joy and shyness emanating from their faces. Unfortunately many children from the villages are kept from school by their parents in order to sell hand crafts, food and souvenirs to the tourists. Among my most painful memories are the missing faces in Cambodia of a whole generation wiped out by the Khmer Rouge.



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INTERVIEW

Interview with Dr. Norine G. Johnson

Hugo J. Schielke, MSMFT, Miami University

Dr. Norine G. Johnson, former APA President (2001) and current Division of Psychotherapy APA Council Representative, has long been an advocate for a view of health that incorporates both the psychological as well as the physical elements of a person, and a view of a person (and a person's health) that incorporates attention to the context within which they are situated. This attention to the interplay between individual and context has also led her to emphasize the importance of multiple perspectives and diverse voices in any effort in which she is involved. These views have informed her contributions to feminist theory and practice, her work in relation to the development of adolescent girls, and can be readily seen in the goals of her 2001 APA Presidential Initiative, "Psychology Builds a Healthy World," an initiative that led to the incorporation of an explicit emphasis on the promotion of health into the APA's mission statement. Dr. Johnson was gracious enough to agree to do this interview on one of the first days of a long-deserved vacation.

Interviewer: I'd like to first thank you for taking time out of your vacation to do this interview!

NGJ: I'm pleased to do it.

Interviewer: You've accomplished a great deal in your career, having made significant contributions in psychotherapy practice, education/training, research, administration, professional organization, and public interest advocacy—to describe you as enthusiastically engaged and involved would seem to be an understatement; you seem to really thrive when engaged in the process of being able to make a difference.

NGJ: You know, as I was thinking about this interview, one of the things that jumped out at me about myself that I hadn't really seen in these terms before, is that I'm a real fighter; I get really passionate about things, and that allows me to find the energy to bring resources together. Right now I'm fighting with everything I know and have learned for psychotherapy. I just absolutely believe in psychotherapy as given by psychologists, and I think that we need to come together as a discipline and as people interested in psychotherapy, and really re-draw the country's attention to how valuable it is to have doctoral level psychologists administering this health service. It's that passion that got me to run for Council for Division 29 and then to start pushing for changes both in APA policy and focus to really draw more resources to the practice, research, and teaching of psychotherapy.

Interviewer: Could you speak a bit about the roots of this effort?

When I was APA President, my "Psychology Builds a Healthy World" initiative really caught on; psychologists throughout the nation voted overwhelmingly to include health in the American Psychological Association's mission statement, and since then, there's been tremendous growth at all levels: in the educational institutions, in what's being funded privately and publicly, in knowledge, and in what is practiced in the interface between psychology and health and psychologists' work. And at the same that this has been going on, there's been a flooding of the market with other types of counselors, so that psychologists are being underpaid, underrepresented, and, I think, at times, undervalued—certainly by the

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managed care companies. So when I took a look at what we could do about it, I felt that what we needed to do was look at our home base—take a look at our policies, our mission statement, increase our advocacy—because we've got the research there; we really can demonstrate the value of this and how important it is to have psychologists in the front row.

That's what John Norcross, my fellow Council member, and myself, are working on right now—we're going to push for revising the mission statement so it really emphasizes the importance of the psychology part of psychotherapy—and that's what we've done with our first resolution, which is coming in front of Council. It has tremendous support from throughout the governance of the American Psychological Association. We need to bring back the word psychology into therapy and stop referring to it as "therapy" or "counseling" and talk about it as "psychotherapy" and "psychological counseling." We also need to advance the causes of psychotherapy, which include quality education and training of future psychotherapists, and ensuring that there are opportunities to use our skills and be appropriately reimbursed; we need the freedom to use our acquired knowledge and expertise responsibly, not to be limited by arbitrary rules that are solely financially motivated and harmful to our clients.

Also, psychotherapy was my first passion within psychology. My first position after training was the Director of Psychology at Franciscan Hospital for Children in Boston. When I arrived there with all these grandiose ideas about what I would accomplish, I found that the hospital did not initially accept the idea of psychologists doing psychotherapy. So I really had to begin at the beginning: demonstrating the value of psychotherapy, introducing the staff and administration to the research, showing the validity of it for their population. I ended up staying at the hospital for 18 years, and we developed a premier education and APA approved training facility as well as a full-service psychology department. Because of the experience of developing the training program, I got involved in APPIC; I was the first chair of the post-doc training component of APPIC, and really loved developing that and then getting involved in the accreditation committee.

The course of my work, in some ways, has really been an involvement with psychotherapy from differing perspectives: looking at the research and developing research myself for evaluating children with special needs and the variety of different strengths and weaknesses that they bring into the therapy situation, and then as an educator and supervisor, and then also, of course, as a practitioner, both in the hospital, and then, later, in private practice. As far as the public interest and advocacy goes, that was probably the last piece of the puzzle to fall in place for me, but once it fell, it really took my heart, because I began to see that if you can change things at the broader, larger, level, it can really have an impact. So working on the policy level at the state, on the national level, and of course, within the APA, became a real passion.

Interviewer: ...a passion that has led you to make a number of important contributions to the organization in a number of different areas; I understand in addition to your current APA role as a Division 29 Council Representative, for example, that you've also recently returned from leading an APA mission to Vietnam and Cambodia.

That was so exciting—that was just a privilege. I was asked to be the first psychology leader of a delegation of psychologists to southern Vietnam and Cambodia. We were honored to have seventy psychologists join his delegation. In each country, we went to see a mental hospital, and visited a university—at one we had one hundred

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students in the audience, in the other we had two hundred students. They're currently facing a lot of challenges: they don't have journals, they don't have books, and, in some places, they can't even get online—and yet, their interest, their involvement, and their enthusiasm is just tremendous. So it was very eye opening for all of us, and we are now engaged in follow-up efforts; we hope to establish links between these universities and universities, colleges, and professional schools back here in the states. In fact, I just recently extended an invitation to the Director of Psychology at the Royal University in Cambodia to come to the APA convention in the summer, and she's accepted. We also hope to open up a stream of online journals and current research to be available to these countries. Of the two, Cambodia definitely has greater access to online services; southern Vietnam has more difficulty in this area. Members of the delegation have continued to email correspond with the students they sat next to in Cambodia.

What we found when we went over there was a great deal of heart, a great deal of enthusiasm, a great deal of energy put in to teach the next generation, but a poverty of resources, and, interestingly enough, a denial of post-traumatic stress. We did not expect that. We also saw a great deal of resiliency: very happy people engaged in meaningful lives, rebuilding their country, just going about; but underneath it, is all of this untreated post-traumatic stress, and it does take its toll, as you can imagine, both on individuals and the country as a whole. Psychological services are accepted now, and valued. Everywhere we went, on all levels, there was a strong desire for more involvement from the States to help them build. They want to establish a master 's program and then, eventually, a doctoral program. The desire is there, but they need help.

Your description of this trip reminds me of one of your key interests: the impact of culture.

That's been a tremendous thrust of mine, starting first with my emphasis on including women and on broader diversity. My advocacy for women to be included on an equal basis has been an important part of my development as a psychologist and of the contributions I've made; the first book I co-edited was with Judy Worell and it was on feminist psychology (*Shaping the Future of Feminist Psychology*, Worell & Johnson, 1997), and it came out of a conference that Division 35 had on feminist psychology in Boston, Massachusetts, for which Judy and I were co-chairs. In it, we proposed a model of feminist process which is still accepted today and has become part of the book on feminist leadership that is due to be published within the next month. The next book, *Beyond Appearances: A New Look at Adolescent Girls* (Johnson, Roberts, & Worell, 1999) really focused on strengths and focusing on diversity; the consulting I did for the 2001 PBS film *5 Girls* was also incredibly rewarding from this perspective.

Then, in the health initiative, as you know, I really placed a great deal of focus on looking at culture, looking at race, ethnicity, social class—all those variables that have been ignored in the past that are so crucial for understanding health and then integrating psychology into it.

That speaks to another theme that seems to run throughout your work—your attentiveness to systems and to working with multiple levels of systems to effect change.

NGJ: I like the way you said it—it's true—it's definitely true. This is why I recommend that we change our bio-psycho-social model of health to a bio-psycho-social-cultural model of health. The culture, of course, is a critical part of the system; unless we really understand cultures and formally address integrating the role of culture into our theories, our practice, our research, and our teaching, we run the

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risk of not paying enough attention to them. Certainly in health there have been strides towards this attention to culture. I was just thrilled when, during my APA Presidency, the then-Surgeon General, David Thatcher, said that he wanted to come and introduce his new initiative on the role of culture in mental health to the nation from the APA convention in San Francisco; he did, and spoke to an audience of over two thousand people. I was just thrilled to be part of that.

More recently, I've also been doing a lot of thinking, presenting, and writing on doing psychotherapy with men, specifically about women as therapists in psychotherapy with men, stressing the importance of gender from both perspectives (e.g., Chapter 19 in *The New Handbook of Psychotherapy and Counseling with Men*, 2005, Glenn E. Good and Gary R. Brooks, eds.).

I'm also still a real fighter for the incorporation of a diverse set of voices. Sometimes I think I shouldn't have to still be fighting this hard, that this should just be taken for granted, but it isn't, so it is important to raise people's consciousness. What is different today is that once you raise people's consciousness, they really get it. We have to have different voices at the table—these voices bring perspectives and knowledge that we need.

Interviewer: Thank you, Dr. Johnson—I enjoyed this time with you.

NGJ: My pleasure.

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DIVISION 29 2007 APA CONVENTION PROGRAM
San Francisco, California

FRIDAY, AUGUST 17, 2007

Symposium: Forgiveness Reconsidered—Exploring Underlying Constructs and Their Application to Psychotherapy

8/17 Fri: 8:00 AM - 9:50 AM

Moscone Center, Room 310

Chair: *Donna S. Davenport, PhD*
Participant/1st Author: *Andrew Reichert, BA*
Participant/1st Author: *Rod Hetzel, PhD*
Participant/1st Author: *Donna S. Davenport, PhD*
Participant/1stAuthor: *Randolph Pipes, PhD*
Discussant: *Michael Duffy, PhD*

Symposium: Emotion-Focused Therapy of Depression—An Evidence-Based Psychotherapy

8/17 Fri: 10:00 AM - 11:50 AM

Moscone Center, Room 3007

Chair: *Leslie S. Greenberg, PhD*
Participant/1st Author: *Leslie S. Greenberg, PhD*
Participant/1st Author: *Jeanne C. Watson, PhD*
Participant/1st Author: *Robert K. Elliott, PhD*

Symposium: Can We Identify MVPs (Most Valued Psychotherapists)—Therapists Effects in Psychotherapy

8/17 Fri: 12:00 PM - 1:50 PM

Moscone Center, Room 2006

Chair: *Raymond A. DiGiuseppe, PhD*
Participant/1st Author: *Jeb Brown, PhD*
Participant/1st Author: *Stevan L. Nielsen, PhD*
Participant/1st Author: *William B. Stiles, PhD*
Discussant: *Raymond A. DiGiuseppe, PhD*

Symposium: Lying in Psychotherapy—Clients' Views, Therapists' Views, Theoretical and Practical Considerations

8/17 Fri: 2:00 PM - 2:50 PM
Moscone Center, Room 3012

Chair: *Randolph Pipes, PhD*
Participant/1st Author: *Randolph Pipes, PhD*
Participant/1st Author: *Leslie Martin, PhD*
Participant/1st Author: *Caroline Burke, PhD*
Discussant: *Annette S. Kluck, PhD*

Poster Session One

8/17 Fri: 3:00 PM - 3:50 PM

Moscone Center, Halls ABC

Participant/1st Author: *Megan M. MacNamara, MA*
Participant/1st Author: *Priscilla R. Fleischer, PhD, MSW*
Participant/1st Author: *Satoko Kimpara, MS*
Participant/1st Author: *Matteo Bertoni, MS, MA*
Participant/1stAuthor: *Anne C. Erlebach, MA*
Participant/1st Author: *Sarah Knox, PhD*
Participant/1st Author: *Barbara M. Kaplan, PhD*
Participant/1st Author: *Georgiana S. Tryon, PhD*
Participant/1st Author: *Rafael S. Harris, Jr, PsyD*
Participant/1st Author: *Mona Bapat, MS*
Participant/1st Author: *Chris Brown, PhD*
Participant/1st Author: *Michele B. Hill, PhD*
Participant/1st Author: *Courtney A. Swatta, PsyD*
Participant/1st Author: *George J. Kallas, PsyD, PhD*
Participant/1st Author: *Shelah D. Adams, MA*
Participant/1st Author: *Pedja Stevanovic, BA*
Participant/1st Author: *Sara J. Lederer, MA*
Participant/1st Author: *Hung-Bin Sheu, MA, MEd*
Participant/1st Author: *Gregory S. Chasson, MA*
Participant/1st Author: *Clara E. Hill, PhD*
Participant/1st Author: *Shelley N. Osborn, BS*
Participant/1st Author: *Satoko Shiraishi, MA*
Participant/1st Author: *Lee A. Thrash, PhD*
Participant/1st Author: *Zac E. Imel, MA*
Participant/1st Author: *Kristin M. Perrone, PhD*

Conversation Hour: Awards and Recognition

8/17 Fri: 5:00 PM - 5:50 PM
San Francisco Marriott Hotel, Golden Gate Salons B1 and B2

Social Hour

8/17 Fri: 6:00 PM - 6:50 PM
San Francisco Marriott Hotel, Golden Gate Salons B1 and B2

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SATURDAY, AUGUST 18, 2007

Symposium: Unifying Principles of Psychotherapy—What Have We Learned From 100 Years of Clinical and Empirical Investigation?

8/18 Sat: 8:00 AM - 9:50 AM

Moscone Center, Room 3009

Chair: *Jeffrey J. Magnavita, PhD*
Participant/1st Author: *Jacques P. Barber, PhD*
Participant/1st Author: *Jay L. Lebow, PhD*
Participant/1st Author: *Lorna Smith Benjamin, PhD*
Participant/1stAuthor: *Arthur Freeman, EdD*
Discussant: *Theodore Millon, PhD, DSc*

Luncheon for Graduate Students and Early Career

8/18 Sat: 12:00 PM - 1:50 PM
San Francisco Marriott Hotel, Nob Hill Rooms A and B

Symposium: Evidence-Based Psychodynamic and Cognitive Therapies—Recent Findings and Future Challenges

8/18 Sat: 2:00 PM - 3:50 PM

Moscone Center, Room 307

Cochair: *Jacques P. Barber, PhD*
Cochair: *Robert J. DeRubeis, PhD*
Discussant: *William B. Stiles, PhD*

Poster Session Two

8/18 Sat: 4:00 PM - 4:50 PM

Moscone Center, Halls ABC

Participant/1st Author: *Tamara S. Shafer, BA*
Participant/1st Author: *Timothy P. Melchert, PhD*
Participant/1st Author: *Jennifer L. Wilson, BA*
Participant/1st Author: *J. Alison Bess, PhD*
Participant/1st Author: *Zohar Itzhar-Nabarro, PhD*
Participant/1st Author: *Matthew J. Taylor, PhD*
Participant/1st Author: *Nancy A. Fry, MBA*
Participant/1st Author: *Christy D. Hofsess, MEd*
Participant/1st Author: *Robinder P. Bedi, PhD*
Participant/1st Author: *Rebecca Oakes, PhD*
Participant/1st Author: *Rachel E. Crook Lyon, PhD*
Participant/1st Author: *Lana O. Beasley, MA*
Participant/1stAuthor: *Frank Fedde, MA*
Participant/1stAuthor: *Scott A. Baldwin, PhD*
Participant/1st Author: *Jill C. Slavin, MA*
Participant/1st Author: *Brian H. Stagner, PhD*
Participant/1st Author: *Jeffrey A. Rings, MA*
Participant/1st Author: *Melissa S. Roffman, MA*
Participant/1st Author: *John L. Powell, MA*
Participant/1st Author: *Arne Kristian Henriksen, PhD*
Participant/1st Author: *Robert J. Reese, PhD*
Participant/1st Author: *Steven G. Benish, MSE*
Participant/1st Author: *Melissa K. Smothers, MA*
Participant/1st Author: *Frances A. Kelley, PhD*
Participant/1st Author: *William K. Lamb, PhD*
Participant/1st Author: *J.R. Fuller, PhD*
Participant/1st Author: *Diana L. Sanchez, MA*
Participant/1st Author: *Yun-Jy Yeh, MEd*
Participant/1st Author: *Valerie R. Wilson, MA*
Participant/1st Author: *D. Brian Smothers, MA*
Participant/1st Author: *Erlanger A. Turner, MS*

Symposium: Psychotherapist Self-Care—Leaving It at the Office

8/18 Sat: 4:00 PM - 5:50 PM

Moscone Center, Room 307

Chair: *John C. Norcross, PhD*
Participant/1st Author: *Judith S. Beck, PhD*
Participant/1st Author: *Laura S. Brown, PhD*
Participant/1st Author: *Lillian Comas-Diaz, PhD*
Participant/1st Author: *Florence W. Kaslow, PhD*
Participant/1st Author: *Michael P. Leiter, PhD*
Participant/1st Author: *Alvin R. Mahrer, PhD*
Discussant: *James D. Guy, PhD*

SUNDAY, AUGUST 19, 2007

Symposium: Psychotherapists Around the World—-Meeting Needs of the Global Village

8/19 Sun: 9:00 AM - 10:50 AM

Moscone Center, Room 309

Chair: *Craig N. Shealy, PhD*
Participant/1st Author: *Gregg R. Henriques, PhD*
Participant/1st Author: *Shagufa Kapadia, PhD*
Participant/1st Author: *Noelle Robertson, PhD*
Participant/1st Author: *Eleanor H. Wertheim, PhD*
Discussant: *Jeffrey J. Magnavita, PhD*

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Symposium: Guiding Evidence-Based Practice With Outcome Data

8/19 Sun: 11:00 AM - 12:50 PM

Moscone Center, Room 309

Chair: *David W. Smart, PhD*
Participant/1st Author: *David D. Dayton, BA*
Participant/1st Author: *Takuya Minami, PhD*
Participant/1st Author: *Russell J. Bailey, BS*
Participant/1st Author: *Richard L. Isakson, PhD*
Discussant: *Brent S. Mallinckrodt, PhD*

MONDAY, AUGUST 20, 2007

Symposium: Culturally Competent Intervention for Abused, Suicidal African American Women

8/20 Mon: 8:00 AM - 9:50 AM

Moscone Center, Room 3003

Cochair: *Nadine J. Kaslow, PhD*
Cochair: *Natalie C. Arnette, PhD*
Participant/1st Author: *Natalie C. Arnette, PhD*
Discussant: *Nadine J. Kaslow, PhD*

Symposium: Cognition and Suicide—-Theory, Research, and Therapy

8/20 Mon: 10:00 AM - 10:50 AM

Moscone Center, Rooms 202/204/206

Chair: *Lisa A. Firestone, PhD*
Participant/1st Author: *David Jobes, PhD*
Participant/1st Author: *M. David Rudd, PhD*
Participant/1st Author: *Gregory K. Brown, PhD*

Workshop: Two Become One and Then There Are None! Relationships and Couples Therapy Revisited

8/20 Mon: 11:00 AM - 11:50 AM

Moscone Center, Room 2006

Cochair: *Robert W. Resnick, PhD*
Cochair: *Rita F. Resnick, PhD*

Symposium: International Perspectives on Feminist Multicultural Psychotherapy—-Content and Connection

8/20 Mon: 12:00 PM - 1:50 PM

Moscone Center, Room 262

Chair: *Elizabeth Nutt Williams, PhD*
Participant/1st Author: *Laura S. Brown, PhD*
Participant/1st Author: *Norine G. Johnson, PhD*
Participant/1st Author: *Ellyn Kaschak, PhD*
Participant/1st Author: *Kathryn L. Norsworthy, PhD*
Discussant: *Oksana Yakushko, PhD*

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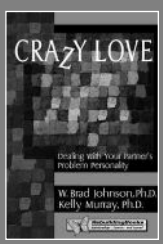

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Researchers and Practitioners Working Together: Process Studies at a Research Center

Gillian Hardy, University of Sheffield, UK

This article describes a way of shared working between practitioners and researchers (cf. Barkham, 2006; Knapp & Keller, 2006) and a program of small projects that have taken interesting psychotherapy outcome findings and tried to burrow down to understand what was happening. The projects were practice-based in the sense that questions arose out of observations of practice and local research findings; nevertheless, they were embedded within the research literature and theory.

Practice-based research involves collecting evidence from routine settings and applying a range of methods, from the collection of large data sets using common measures to single case and case studies. It makes a powerful addition to the traditional evidence-based top down research (Cape & Barkham, 2002). Practice-based research can be innovative, pragmatic and relevant research while remaining rigorous. The partnership clinic described below is one example of this type of research; it sits within a service delivery framework and aims to collect high-quality data on the progress of clients through their psychotherapy sessions.

Partnership Clinic

Through an agreement between the University of Leeds, UK and the local National Health Service (NHS) a psychological therapies clinic for people who are depressed was staffed by NHS clinical psychologists on a one-day a week basis. In return for seeing clients, therapists were offered some training, regular supervision and the opportunity to contribute to a program of research. Clients seen at the clinic consented to taking part in a research program. The therapists and researchers met regularly to discuss the research, clinical issues arising from the research process and research questions arising from clinical practice. Diagnostic, outcome and session data were routinely collected from both clients and therapists. All sessions were audio-recorded.

Process Research

Burrowing down into outcome findings involved what is called process research: "The content of psychological therapy sessions and the mechanisms through which client change is achieved, both in single sessions and across time" (Llewelyn & Hardy, 2001, p 2). The aims of process research are to improve treatment outcomes and to improve the quality of therapy; this fitted the aims of the therapists, who wished to understand better what contributed to success (and failures) in their practice and how they could improve their therapeutic skills. Below are examples of how we have taken some outcome findings and tried to look in greater detail at what was happening. The first examples consider what was associated with good outcomes, and the second examples what might account for poor outcomes.

Good Therapy Outcomes

Clients were referred to the jointly managed clinic from primary care services or specialist secondary care services. If they received a diagnosis of depression, clients were offered 12 sessions of CBT, plus one clinical assessment session. Outcome was assessed using the Beck Depression Inventory (BDI), which showed an average improvement from 32 (severely depressed) to 17 (mildly depressed) across 110 clients

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(Saatsi, Hardy, & Cahill, 2007). However, only 54.6% achieved reliable and clinically significant change—indicating that a client has moved to BDI scores within the normal population range and shown a change that is over and above what could be expected from the fluctuations of an imprecise measure.

Burrowing Down into Good Outcomes

Why do some clients do better than others in therapy? The therapists were interested in this question from two perspectives. They wanted to know if their knowledge and skills were associated with outcome, and they were interested in what clients thought was helpful. To address the first issue, we investigated the relationship of therapist competence and of the therapeutic relationship to outcome. To assess competence, an expert cognitive therapist rated 30 tapes of sessions; therapists did not know in advance which of their sessions would be rated for competence. The therapeutic relationship (alliance) was assessed using client ratings completed at the end of therapy sessions.

Analyses showed that both competence and the therapeutic relationship were significantly correlated to client outcome. The more competent the therapist, as rated by an observer, particularly in specific CBT skills, the better the outcome. The same was true for the therapeutic relationship: the better the relationship the better the outcome. Both competence and alliance independently predicted client outcome. That is, the relationship between the alliance and outcome was not a consequence of the technical skill of the therapist, nor was the relationship of the skill of the therapist and outcome a consequence of a good relationship. (Trepka, Rees, Shapiro, Hardy, & Barkham, 2004).

Interestingly when clients, who had good outcomes, were asked what had been helpful in therapy, they spoke about similar things. At the end of therapy, five clients were interviewed using a semi-structured interview. A qualitative analysis of their accounts of therapy led to the identification of a number of themes, the most important of which were The Listening Therapist, The Big Idea, and Feeling More Comfortable with Self. (Clarke, Rees & Hardy, 2004). Using a different language, clients seemed to be speaking about alliance and competence. They spoke about the importance of making a personal connection and of feeling understood before being able to make use of the therapeutic tools offered in CBT (The Big Idea), but that the tools helped them manage their difficulties and give them a sense of competence.

Poor Therapy Outcomes

Clients who dropped out of therapy before their agreed number of sessions did less well (on the BDI) than those clients who completed therapy; for example, of the 69 clients who completed therapy, 67% showed reliable and clinically significant change, whereas only 16.6% of the 24 clients who did not complete therapy showed such a change (Saatsi et al., 2007). Clients who dropped out of therapy attended an average of seven sessions out of the 12 sessions planned.

Burrowing Down into Poor Outcomes

What, if anything, was different about the clients who did not complete therapy? Could we see where therapy began to go wrong, and could we identify ways in which sessions for these clients were different than for clients who continued with therapy and achieved better outcomes? These questions have a practical importance, as we know that, although therapy is helpful for many clients, there are many who do not benefit, and it is often these clients that challenge mental health services. Our research aimed, therefore, to develop ideas about those clients who may be at risk and about how to prevent their dropping out of therapy.

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We found no differences in age, gender, marital status, employment status, or current medication. The only factor we identified was that clients who had an overinvolved interpersonal style (measured using the scales derived from the Inventory of Interpersonal Problems and a measure of attachment style) were more likely to drop out of therapy than clients with an underinvolved or neutral style (Saatsi et al., 2007). Overinvolved clients were less positive about their relationship with their therapist, and a poor therapeutic relationship in itself predicted non-completion.

We also looked at the pattern of change across early sessions to see if the clients who did not complete therapy were changing at similar rates as those who completed therapy. Perhaps their poorer outcomes were simply a function of dropping out at an earlier time point. In tracking the BDI scores across sessions, it became clear that around session 4 the rate of change for clients who did not complete therapy slowed down for the remainder of therapy, unlike the completers who continued to make therapeutic gains. We do not really understand why some clients lost the momentum of change, but it is clear that such loss of momentum put clients at risk for dropping out of therapy. In this connection, we were reminded that the occurrences of *sudden gains* (where clients show a large and sustained improvement between two therapy sessions) tend to occur around session 4 (Hardy et al., 2004; Tang & DeRubeis, 1999).

To try and understand this further we looked at the penultimate session of four clients who dropped out of therapy and the equivalent session of four clients from the same therapist who did not drop out of therapy. A qualitative, grounded theory analysis of the session transcripts was conducted, focusing on the therapists' attitudes to their relationship with the client and on their interventions. Clear differences between the sessions of the non-completers and completers, even with the same therapist, were observed. These differences were brought together under four main themes: Strains in the therapeutic relationship; Engendering of hope; Active involvement of the client in the session; and Readiness for change (Saatsi, 2004). When working with clients who completed therapy, therapists were more able to respond flexibly to the clients' moment-to-moment needs. They noticed when there were difficulties in the relationship, expressed more hope and positive expectations for the future, and were able to recognise when to 'push' clients into thinking about change and when to hold back and be supportive. This links to the concept of therapist *responsiveness* (Stiles, Honos-Webb, & Surko, 1998) and suggests areas where therapists might profitably focus supervision in order to recognise where clients may be at risk.

Our next stage was to consider what happens in cognitive therapy when there are strains in the relationship, or *ruptures*, that are often observable through the client withdrawing from the therapeutic tasks and the therapeutic relationship or the client confronting or attacking the therapist (Safran & Muran, 2000) To undertake this work we employed a different form of qualitative analysis called task analysis (Greenberg, 1984). Using this method, an initial, ideal rational model was developed from discussions with expert cognitive therapists. Examples of ruptures and repairs were identified in the taped therapy sessions and the ideal model was then modified using the observations from the tapes to form an empirical model. Observers found that a rupture often occurred because the therapist was not attending to the client's experience or the significance of a problem. When recognised, therapists tended to change their behavior through summarising, exploring or validating and then attempted to restore the collaborative relationship by encouraging clients' active participation on therapy or by affirming clients' contribution and seeking feedback about agreement with

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the task. One of the main differences between the ideal and empirical model was that the therapists did not openly acknowledge the rupture (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2007).

Conclusion

We believe studies that burrow down to try and understand a phenomenon or outcome pattern can have direct implications for practice as well as for theory. Using process research to understand the meaning of outcome findings, in studies like those described above, have provided an important element in supervision and training. For example, the task analytic study provides a starting point for identification and exploration of ruptures that could help therapists recognise and deal with problems in the therapeutic relationship and so potentially keep clients in therapy and improve client engagement in the therapeutic tasks and eventual outcomes.

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Exciting Transformation into the 21st Century

Pat DeLeon, former APA President

One of the most rewarding aspects of being involved in the public policy process is the opportunity to reflect upon the "bigger picture," often years before contemplated changes come to pass. As a former APA President, it is particularly nice to see psychologists actively participating in these deliberations. As one of the learned professions, we have much to offer society but to contribute, we must "be at the table." Recently the Robert Wood Johnson Foundation (RWJ) highlighted the vision of colleagues **Laura Leviton** and **Elaine Cassidy** regarding the appropriateness (and exciting potential) for community-based organizations reaching rural populations and those facing special cultural and language barriers, as well as the need for developing strong theories of change. Former APA Congressional Science Fellow **Brian Smedley's** cutting-edge research was similarly noted. Since 1972, RWJ has been the nation's largest philanthropy devoted exclusively to health and health care of all Americans.

Highlights: Greatness is largely a matter of conscious choice and discipline—disciplined people, disciplined thought, and disciplined action. RWJ can make a real difference by systematically addressing the complex issues surrounding "Quality of Life." It is not single blockbuster programs that produce impact, but rather the combination of disciplined peoples' thoughts and actions that create greatness over a sustained period of time. The key is to rigorously and routinely assemble the evidence—be it quantitative or qualitative—that allows one to assess performance, discipline, and momentum. And, especially as psychologists, we should never forget that people genuinely want to feel the excitement of being involved in something that just flat out works. When they begin to see tangible results—when they feel the momentum of the flywheel beginning to build speed—that's when more people line up to throw their shoulders against the wheel and enthusiastically push.

Looking back over the Decade: 1996—American voters elected Bill Clinton to a second term as President. That year, both the public and health care professionals focused their attention primarily upon managed care, AIDS, and tobacco. Ten years later, the major health issues had changed dramatically, bearing little resemblance to the issues that had captivated the nation only a decade earlier. By the year 2006, managed care had been largely transformed from a tiger to a pussycat. The restrictive systems that could, in theory, better manage patients' care and hold down costs were replaced by more open systems where cost saving was not the dominant feature. At the same time, the number of uninsured had spiraled steadily upward, reaching nearly 46 million in 2005. This strains safety net providers, such as community health centers, and has serious health consequences as uninsured individuals frequently delay seeking care until their illness becomes too serious to ignore. Health insurance coverage has emerged as the number one issue in labor contract negotiations. Medicaid, the backbone of insurance coverage for the poor, is in serious financial trouble. Yet, the issue has become so highly politicized that few, if any, analysts expect significant change in the near future, without a major transforming event. While the nation was certainly

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aware of racial, ethnic, and class differences in health status in 1996, these were not a dominant issue. After Hurricane Katrina graphically exposed an American society of haves and have-nots, reducing racial and ethnic disparities in health moved somewhat higher on—though nowhere near the top of—the nation's policy agenda, notwithstanding Brian's impressive work. Efforts have evolved to develop quality standards, based upon objective measures; yet unfortunately, "Quality is of concern to policy makers, but it hasn't crossed into the public's consciousness yet." We would further suggest that it is psychology's professional responsibility to insure that the all important psychosocial-economic-cultural gradient of care becomes an integral component of society's definition of "quality care" and its expectation for services rendered.

Under its new President, RWJ has strategically decided to take an increasingly targeted approach to its priorities, honing in on a limited number of objectives whose impact could be measured quantitatively—i.e., the adoption of an "impact framework." In 1996, almost nobody was talking about obesity as a national health problem. This spring, RWJ announced a $500 million initiative, over five years, to Reverse Childhood Obesity, noting that about 25 million kids and teens in the nation are overweight or obese. "Childhood obesity is one of the most urgent and serious health threats confronting our nation. It deserves a serious response." Historically, RWJ has been committed to supporting a broad range of programs that encourage healthy behaviors and lifestyles. Accordingly, we would rhetorically ask: What better foundation priority could there be for psychology and particularly for health psychology? Will our training programs and service delivery leaders be up to the challenge? RWJ has increasingly stressed the importance of targeting the unique and pressing needs of those with chronic ailments and addressing environmental components of quality care. "Improving the quality of care and reducing disparities did not resonate loudly with the public in 1996 and still do not. But they are important to the Robert Wood Johnson Foundation. Making issues such as these a priority gives the foundation an opportunity to play a leadership role and to help make them more prominent. Or, simply, to promote values it believes are important for the nation's health." Again, we would ask: Are these similarly important priorities for psychology? Are we willing to provide the necessary proactive leadership?

As one of the nation's premier healthcare professions, it is important that we become aware of, and appreciate, the critical clinical and public policy importance of the Wennberg Dartmouth studies, ongoing since the 1970s, which objectively demonstrate just how crucial geography is to the health care we all receive. ■ That the biggest determining factor for the enormous variations in care are the practice style of the clinicians themselves. ■ That there is great uncertainty about how best to treat many conditions. ■ That much of the excess, unwarranted care could be reduced if patients were better informed about their treatment choices—i.e., became the Educated Consumers of the 21st century. ■ And, that more health care can actually mean worse health care, not to mention more expensive care. These are but graphic examples of practice patterns that best practice guidelines and gold standards of care will be expected to systematically address as we enter the 21st century.

During the past year I have had the distinct pleasure of participating with **Russ Newman** at a number of psychological conferences. I admire his vision of "The Changing Face of Psychological Practice," for example, most recently at President **Richard Sherman's** outstanding California Psychological Association (CPA) Annual

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Conference. At the Practice Directorate State Leadership conference—"Welcome to the 'new' Washington, where the Democrats have taken control of Congress for the first time in twelve years... a woman has been elected Speaker of the House for the first time in the history of the United States' Congress and health care reform is back in the news and back on the agenda. Change does, indeed, appear to be in the air.... (L)ast year's conference, in fact the last two conferences, have capitalized on the growing public awareness in this country that lifestyle, behavior and stress have a significant effect on health and illness. We underscored the central and unique role psychology can play at the intersection of psychological and physical health, sometimes referred to as 'mind-body health.' We highlighted our belief that integrating mind and body, behavior and health, and the psychological and the physical, all hold a credible promise of helping to achieve the long sought after goal of improved health with controlled, if not lowered, costs. We emphasized that health promotion and the prevention of illness are critical to healing an ailing health care system all too preoccupied with simply responding to symptoms or chasing after diseases. We concluded that in the absence of any comprehensive health reform plan for the country, a focus on health promotion, prevention, lifestyle and behavior may be just what the doctor ordered. There is now growing evidence that this tipping point may have occurred, or at least be close by....

"A future vision of a health system that relies on connections between behavior and health actually reaches squarely back into psychology's past. What policy makers and the public are now beginning to appreciate, psychology has known for years, if not decades—the research, the knowledge base, and technologies to change behavior in ways that promote good health do exist. And, much of the research, the knowledge base and technologies are psychology's work.... (I)mportant shifts are occurring—in health care, in technology and in our culture. It is incumbent upon us as psychologists to use our research, our knowledge base and our technologies in the service of those shifts. Our expertise in behavior—both for solving problems and enhancing performance—makes our profession well suited to help manage these changes around us. But we must also effectively manage change within our profession as well. We must continue to diversify our way of practicing to take advantage of the varied roles psychologists are capable of filling.... Undertaking activities that do not depend on shrinking third-party reimbursement is critical if we are to thrive economically.... We must continue to be curious and creative, walking around keeping our eyes and minds open, looking for good solutions to our profession's problems, and looking for solutions to society's most pressing problems.... To truly expand our roles, maximize our influence and increase our value, we must continue to build our relationships with communities beyond our walls. This is especially key at a time when the health care system is changing, when the world is changing, and when we are changing. Shift happens. Now we know. Now we must act." Unprecedented change is definitely here. Accordingly, I was very pleased with the number (and depth) of presentations at Richard's convention which addressed the unique and pressing needs of those citizens residing in nursing homes, as well as in long term care facilities. Our colleagues in CPA are effectively demonstrating our profession's commitment and relevance to our nation's elderly (and ever-aging) citizenry. Mahalo.

Legislative Examples of Russ' Vision: [Addressing Mental Health Stigma]: This Spring the House Committee on Veterans' Affairs recommended legislation (H.R. 327) directing the Secretary of Veterans Affairs to develop and implement a com-

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prehensive program designed to reduce the incidence of suicide among veterans. "Over the course of combat operations in Afghanistan (Operation Enduring Freedom - OEF) and Iraq (Operation Iraqi Freedom - OIF), there has been a growing concern with the number of suicides that have occurred in the OEF/OIF soldier and veteran population. The Mental Health Advisory Team (MHAT-III), established by the Office of the Surgeon General, United States Army Medical Command, at the request of the Office of the Surgeon, Multinational Force-Iraq, issued a report on May 29, 2006, which found for calendar year 2005, the suicide rate for the OIF area of operations was 19.9 per 100,000 soldiers. That rate is considerably higher than the national average, and the Army's overall reported rate of 13.1 per 100,000. The stress of combat, along with the stigma that exists for soldiers and veterans seeking mental health care, can intensify and trigger a complex set of behaviors that may lead to thoughts of suicide. It is vital that suicide prevention, education, and awareness programs be strengthened throughout the VA health care system. Just recently, VA announced that research concerning suicides among OEF/OIF returnees was underway and that it was implementing a comprehensive education and training effort within local communities, as well as VA facilities. H.R. 327 addresses this need to strengthen suicide prevention, education, and awareness programs within the VA by mandating a comprehensive program for suicide prevention among veterans.... (W)ould express the sense of Congress that suicide among veterans suffering from post-traumatic stress disorder (PTSD) is a serious problem.... (W)ould mandate that VA to research the best practices for suicide prevention among veterans, including best practices for helping veterans who have experienced military sexual trauma. It requires the VA to work with the Department of Health and Human Services, the National Institutes of Health, the Centers for Disease Control, and the Substance Abuse and Mental Health Services Administration [now led by psychologist **Terry Cline**] when conducting research."

[Advances in Technology]: The Senate Committee on Indian Affairs recommended legislation (S. 322) which would authorize an Indian Youth Telemental Health Demonstration Project, pursuant to discussions with **Doug McDonald** of the University of North Dakota. The Secretary of Health and Human Services would award grants to five tribes and tribal organizations with telehealth capabilities to use in youth suicide prevention, intervention and treatment. The newly authorized demonstration project would permit the use of telemental health for psychotherapy, psychiatric assessments and diagnostic interviews of Indian youth; the provision of clinical expertise and other medical advice to frontline health care providers working with Indian youth; training and related support for community leaders, family members and health and education workers who work with Indian youth; the development of culturally-relevant educational materials on suicide prevention and intervention; and data collection and reporting.

"Several American Indian and Alaskan Native communities around the country have experienced clusters of youth suicide completions and suicide attempts in recent years, including the Standing Rock Sioux Tribe in North and South Dakota.... According to statistics collected by the Substance Abuse and Mental Health Services Administration, suicide is the second leading cause of death for American Indians and Alaska Natives between the ages of 15 and 24, following unintentional injury and accidents. The rate of Indian youth suicide on reservations is two and a half times higher than for the rest of the country, with a rate that is 10 times higher

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than the national average in the Northern Great Plains. More than one-half of all persons who commit suicide in Indian Country have never been seen by a mental health service provider. Significant risk factors for suicide and suicide ideation exist in Indian communities, such as substance abuse and mental health disorders.... During the 109th Congress, the Committee held three hearing on Indian youth suicide, including a field hearing in Bismark, ND, and received testimony from the Surgeon General of the United States... tribal elected officials, Indian psychologists and health professionals....” Concerned colleagues ***can*** make a difference. Aloha.

THEME ANNOUNCED FOR THE 2008 INTERNATIONAL COUNSELING PSYCHOLOGY CONFERENCE MARCH 6 – 9, 2008, CHICAGO, ILLINOIS

"Creating The Future, Counseling Psychologists in a Changing World" is the theme for the 2008 International Counseling Psychology Conference, to be held March 6 – 9th, at the Chicago Hilton & Towers in Chicago, IL.

This is the fifth time the counseling psychology profession has hosted its own conference. Unlike previous conferences reflecting a national perspective, this will be the first counseling psychology conference promoting an international mission.

According to Linda M. Forrest, Ph.D., University of Oregon, conference co-chair, "The conference agenda will include four days of keynote presentations, symposia, roundtable forums, continuing education, professional training organized to promote interchange, dialogue, collaboration among counseling psychology practitioners and academicians, mid-career professionals, early career professionals and students from around the world. Topics of great importance to counseling psychologists include but are not limited to the intersection of science and practice, multiculturalism and diversity, a developmental, strength based, and prevention approach to psychological problems, career and vocational psychology, attention to global and international psychology, supervision and training, health psychology, and counseling processes and outcomes."

Laura Palmer, Ph.D., Seton Hall University, conference co-chair, remarks, "This conference will offer a platform for dialogue, professional development and networking for academics, practitioners and researchers. There will be opportunities for mentoring of students and early career psychologists by leaders in the field. National and global issues facing the field of counseling psychology will be addressed - through training, work groups, discussion and legislative advocacy."

Lawrence Gerstein, Ph.D., Ball State University, conference committee member, claims, "Counseling scholars and students from around the globe will present and participate in this meeting. The conference will provide a unique forum for persons interested in counseling research, training, theory, and practice to discuss critical cross-cultural issues and challenges. It will also offer an opportunity for conference participants to develop and strengthen a worldwide network of counseling professionals and students."

A call for proposals will be issued on or around July 1, 2007. Active promotion of the 2008 International Counseling Psychology Conference will take place through international, national, regional, state, and local psychology associations via their newsletters, websites, listservs, mailing lists, and publicity at other conferences. Nearly 1,000 individuals are expected to attend.

The three primary sponsoring organizations of the event are: The Society of Counseling Psychology, Division 17, of the American Psychology Association (APA), the Council of Counseling Psychology Training Programs (CCPTP), and the Association of Counseling Center Training Agencies (ACCTA). The leadership of these organizations invites interested individuals to learn more by going to the conference website at www.internationalcounselingpsychologyconference.org or by sending an email to conferenceplanner@icpc2008.org.

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