Psychotherapy

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BULLETIN

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The Amazing Albert Ellis

Student Paper Award: Perceptions of Trainee Attachment in the Supervisory Relationship

Division 29 2008 Nomination Ballot

2007 VOLUME 42 NO. 4

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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.

Reflections on a Year Gone By

This is my last column as President of this great Division. It startles me to note a whole year gone by, a year of satisfaction for what we have done and disappointment for what is not yet accomplished. Fortunately, the Division will be in good hands with **Jeff Barnett** coming in as President and **Nadine Kaslow** to follow him. I am also deeply appreciative of the mentoring, support, collegiality and friendship of **Abe Wolf**, Past President.

Appreciating What Works

I am proud of our Journal under the editorship of **Charlie Gelso**. He is a masterful and dedicated editor who has brought *Psychotherapy: Theory, Research, Practice and Training* up to new standards of excellence. Submissions are up, quality is up, and ratings are up. Moving the Journal to APA Publications has brought us into the electronic age, with the entire history of the Journal available electronically, increasing its accessibility, and bringing the Division significant annual revenues from electronic licensing fees. Always a significant member benefit, we can be justifiably proud of the Journal as a major incentive for belonging to the Division. Our thanks also go to **Ray DiGiuseppe**, who provides excellent oversight of our Publications Board and our editors.

Under Abe Wolf's leadership, the Online Academy, which is developed and managed in partnership with APA, has several successful offerings. We hope to continue to offer new programs for the benefit of our members. Abe has been creative and daring in his selection of programs, as well as attending to the organizational detail that makes it all work.

Our relationship with Society for Psychotherapy Research has continued to develop as we work to enhance the research and scholarly aspects of the Division. We have served as the CE Sponsors for recent SPR Conferences and will continue to do so. **Mike Constantino** served as CE Chair and liaison on this partnering, while Abe Wolf attended SPR meetings to officially represent the Division, and we welcomed **Jacques Barber** to our Awards and Recognition Meeting at the APA Convention.

At the APA Convention in San Francisco, **Libby Nutt Williams** chaired a highly successful luncheon for early career psychologists and students, with great help from **Annie Judge** (Membership Chair), **Michael Garfinkle** (Student Development Chair) and members of various committees. Books that had been donated by members of the Division and bright green Division 29 hats were handed out as door prizes. Thanks to **Norine Johnson**, **Ray DiGiuseppe**, **Laura Brown, Nick Ladany, Bev Greene, and Ted Millon** who joined me in hosting tables.

Making Big Changes

We are in the process of implementing big changes in the structure of the Board. Thanks to the creativity of your Board of Directors and Committee Chairs and with your approval, we have transformed our members-at-large into Domain Representatives who will carry portfolios and help us better address the major issues that the Division and psychotherapy itself face in the changing world of psychology, psychological research and training and the

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healthcare system. We are also in a position to respond more actively and appropriately on issues of social justice and human welfare. These changes are exciting, but will require significant attention over the coming year to be sure that they are implemented well. Organizational change is not easy, but can be tremendously important in enlivening the organization and enriching the lives of its members.

Psychotherapy and Social Justice
I have a deep personal commitment to issues around diversity and social justice, and I have been heartened and warmed by the extent to which this commitment is shared by other members of the Board and the Division.

Throughout this year we have strengthened the Division's attention to issues of public interest, social justice and diversity, recognizing that the principles of psychotherapy and our shared goals of psychological well-being should apply very broadly to human welfare and social concerns. The Division has joined the Divisions for Social Justice (a group of Divisions that devote significant attention to issues of social concern and the application of psychology to the betterment of society and its members). We have created a Domain Representative seat for Public Interest and Social Justice; **Irene Deitch** has already made several proposals for Division initiatives. We have created two Domain Representative seats for Diversity, allowing us to attend properly to all aspects of diversity among our members, our clients, our research applications and our teaching. These positions are intended not just to include new faces on our Board but much more importantly, to strengthen our knowledge and involvement in issues related to the increasingly diverse and global world in which we live. We participated in a cross-cutting convention program in San Francisco on the applicability of evidence-based practice within a context of multiculturalism; thanks to **Bryan Kim** for his efforts in putting this program together to create a successful submission. We began diversity training at the Board level at our January meeting and will continue in the coming year.

Personally and on behalf of our Division, I have been concerned by recent increases in hate crimes that target both individuals and groups. At this time in history, few minority groups seem exempt. Although we have been motivated to action by the targeting of a good colleague at Columbia University Teachers College, it is essential to see the on-going and cumulative nature and impact of hate crimes. The Division extends its deep regret and dismay to Madonna Constantine and our other colleagues at Teachers College. With the assistance of the American Psychological Foundation, I have begun collection of money for a special fund designated to research, policy and programs addressing hate crimes within the violence prevention funding category. I have made a personal contribution and the Division, along with other Divisions, has made an initial contribution. I hope you will join me in contributing to this as well. Please make contributions to APF with the designation "Violence and Hate Crimes" and your contribution will be credited to this special fund.

And Thank YOU
I have been honored to serve as your president this year. It has been a year of exciting challenges and rewarding results. I look forward to next year as I can offer Jeff Barnett my assistance, as Abe Wolf offered me his! Thank you to all of the members—my friends and my colleagues. This has been a wonderful year!

Jean Carter, PhD
President, 2007, Division 29

PRESIDENT-ELECT'S COLUMN *Jeffrey E. Barnett, Psy.D., ABPP*

It is with great please that I write this column as your incoming 2008 President of Division 29. Rather than waiting to write my first column as President in the next issue of the *Psychotherapy Bulletin* I wanted to share a bit with you about myself, my activities this past year as President-Elect, and my plans for the coming year.

First, I want to say how delighted I am to be serving in this leadership position in Division 29 and what a great experience it has been for me so far. I can attest that your elected Board members and appointed committee chairs and members are a hard working group who are committed to advancing psychotherapy. It has been a pleasure to work with each of them thus far and I'm excited about our work in the coming year.

One of the major projects I've been involved with this year has been the planning of Division 29's joint Midwinter Board Meeting with Division 42, Psychologists in Independent Practice. In past years Divisions 29 and 42 collaborated on a number of successful projects and the midwinter conferences were very well attended and well received. One of my Presidential Initiatives has been to revitalize this connection. Thus, we are holding a joint meeting January 11-13, 2008 in St. Petersburg Beach, Florida. The two Boards will meet separately to conduct their own business and will then meet jointly to discuss areas of mutual concern and to develop ways of working together toward shared goals. Additionally, on January 12 we are hosting a six-hour continuing education workshop that is presented by Division 29 member, Donald Meichenbaum, Ph.D., "Core Tasks of Psychotherapy: What 'Expert' Psychotherapists Do." I strongly encourage members to register and attend. It should be a great event. You may register at www.division42.org .

Another new initiative has been the expansion of our online newsgram, *Psychotherapy E-News,* to include a new feature "News You Can Use." The goal of this feature is to help better bridge the gap between psychotherapy research and practice. Psychotherapy researchers write brief (2-3 double spaced typed pages) reviews of an area of research and explain how psychotherapists may utilize these findings and integrate them into their practices now to enhance the quality and impact of their work as psychotherapists. Several have already been published and can be read at http://www.divisionofpsychotherapy.org/. I welcome submissions for our upcoming issues. If you have an idea and would like to discuss it please contact me right away. I'm actively seeking submissions to help reduce the length of time between research being done and it making its way into the everyday practices of psychotherapists. Your participation will provide a valuable service to our members and those we serve.

Please note that we are actively soliciting articles for this publication, the *Psychotherapy Bulletin.* If you have an idea please contact our Editor, Craig Shealy. I would also like to welcome the *Psychotherapy Bulletin's* new Editorial Assistant, Crystal Kannankeril. Crystal is a second year Psy.D. student in Clinical Psychology at Loyola College in Maryland. She's doing a great job and already making a significant contribution.

Your Board has also been working to develop diversity training for the Board in the coming year, we are developing processes and mechanisms for the effective use of our newly appointed Domain Representatives on the Board of Directors, we are developing an exciting convention program along with special plans to cele-

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brate the division's 40th Anniversary this summer at the APA Convention in Boston, and we have numerous other activities ongoing. If you are interested in becoming more involved in your Division of Psychotherapy, if you would like to join a committee, if you would like to write an article for *Psychotherapy E-News* or the *Psychotherapy Bulletin,* if you would like to get involved in any other way, or even if you have ideas for issues we should be addressing, please contact me directly. I do want to hear from you and do want to work with you to advance our division and the interests of psychotherapy. My e-mail address is drjbarnett1@comcast.net . I look forward to working together over the coming year. Best wishes to all.

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

INTERVIEW

An Interview with Dr. Jeffrey Barnett, APA Division 29 President-Elect

By Paul Monson
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I interviewed Dr. Jeffrey Barnett to offer the readers of *Psychotherapy Bulletin* a portrait of the President-Elect of APA Division 29. Dr. Barnett will be assuming the role of President of the Division of Psychotherapy on January 1, 2008. As a first-year graduate student in clinical psychology, I feel fortunate to have had the opportunity to speak to Dr. Barnett. He has had a distinguished career as a public servant, scholar, educator, and psychotherapist. He has served as a president of APA's Division 31, State and Provincial Psychological Association Affairs; president of the Maryland Psychological Association; president of APA's Division 42, Psychologists in Independent Practice; Chair of APA's Board of Convention Affairs; member of the APA Ethics Committee; and as a member, chair, coordinator, and trustee in numerous other state and national organizations. In addition to maintaining a full-time private practice (four days each week) Dr. Barnett currently holds faculty appointments at Loyola College in Maryland and the University of Maryland, Baltimore County. (When I spoke with him, he was in the process of grading papers for a graduate practicum he teaches on psychotherapy skills at Loyola.) For over a decade he has been an approved ethics training provider for several licensure boards, and has extensively presented on and taught ethics at the state and national level. He has both edited and authored books on ethics, and has authored chapters on a wide range of issues facing practicing psychotherapists. He has also published widely in journals on a wide range of topics facing the practitioner, most notably on ethics and professional practice issues. As a psychotherapist, Dr. Barnett has been in private practice for nearly 20 years, was a group psychologist with the US Army, and a staff psychologist at a Baltimore psychiatric hospital.

This year as President-Elect of Division 29, Dr. Barnett has been laying the groundwork for next year when he will be president. Two specific Presidential Initiatives are already planned for the upcoming year. The first is fostering greater involvement in APA and collaboration with other APA groups. As part of this initiative, a joint midwinter meeting and Continuing Education program will be held in St. Petersberg Beach, Florida for Divisions 29 and 42 (Psychologists in Independent Practice) on January 11-13, 2008. Leaders from these two divisions, who in the past have met separately, will have an opportunity to interact through the Board meetings of the two divisions and at an all-day continuing education workshop presented by Don Meichenbaum, Ph.D. titled "Core Tasks of Psychotherapy: What "Expert Psychotherapists Do." The event will be advertised both locally and nationally and will hopefully bring together both psychologists and other health care providers from across the nation. Dr. Barnett sees this joint event in the larger context of stimulating greater involvement in Division 29 and APA.

The second Presidential Initiative is the cultivation of a stronger link between research and clinical practice. As part of

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this initiative, Dr. Barnett has created a new section of the Division 29 email newsletter, *Psychotherapy E-News*. The section, "News You Can Use," is designed as a part of his Presidential Initiative to create links between research and practice. Dr. Barnett noted during the interview that there is typically a 7 to 14 year gap between research being conducted and its results being implemented in by practitioners. Appearing Bi-Monthly, each "News You Can Use" will be written by psychotherapy researchers, and will summarize findings that are directly relevant to practicing psychologists. The focus will be on important areas of psychotherapy research that can be integrated and put into practice right now by practicing psychotherapists. If you are not already subscribed to the email newsletter, Dr. Barnett encourages you to contact him directly at drjbarnett1@comcast.net to be placed on the list. You can also find Psychotherapy E-News archived on the Division 29 website at http://www.divisionofpsychotherapy.org/PsychotherapyENews/home.php .

During our interview, I spoke to Dr. Barnett on a number of issues. One consistent theme emerged in all the topics we discussed: the need to be pro-active and forward thinking. The clearest example of this in his own career is his work on ethics. As a member of the Ethics Committee for the Maryland Psychological Association, most of his time was spent adjudicating complaints. In response, he moved to an active role of outreach and education on good ethical practice. Rather than focusing entirely on the punitive side of ethics, he finds it just as important to approach ethical practice as something that can be integrated into all professional activities. As section editor of *Focus on Ethics* in the APA journal, *Professional Psychology: Research and Practice*, Dr. Barnett has brought the role of ethics in professional practice and development to the forefront through brief, relevant, and applicable articles.

During our talk, Dr. Barnett highlighted the importance of being pro-active to other important areas in psychology. In particular, we spoke about the need to have the greatest possible representation of perspectives at all levels of psychology. To best serve our clients, it is imperative to actively bring underrepresented groups into leadership, practice, and education roles through active outreach and mentorship initiatives. Principle E of the APA Code of Ethics focuses on diversity in its broadest sense. Dr. Barnett spoke passionately about the need to use this comprehensive definition of diversity as a guide for infusing our profession with the broadest possible representation of individuals of diverse backgrounds. Without opening ourselves to alternative perspectives through such initiatives, Dr. Barnett noted, we do not know what we are missing and ultimately limit our competence and effectiveness.

The importance of a positive, aspirational approach extends from diversity to advocacy in the larger context of issues we face together as psychologists and human beings. Dr. Barnett has a deep belief that each psychologist needs to see her/himself as an integral part of the whole solution. The most effective way that we can positively impact the whole health care system is through self-advocacy. Psychologists, he noted, can do more to be involved in the political process, advocating real solutions to the current healthcare crisis. Essential to a solution is a movement from the current focus on disease management to health promotion. An important part of health promotion is psychotherapy and all psychotherapists have to offer clients that enhances their mental and physical health. From the beginning, think tank stages, psychologists need to be involved in the change the health care system faces. We can bring specific research and experience to planning of changes, education of legislators, and implementation of changes. To be a part of this process will require involvement in the political process

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beyond lobbying. Dr. Barnett encouraged psychologists to involve themselves in APA and state psychological associations; to form relationships with representatives in state and national organizations; to serve as consultants in policy making; and perhaps most importantly, to develop ongoing relationships with representatives at the local, state and national levels. Political life does not only occur on voting day, but is an ongoing process which deserves our involvement.

At the end of our interview, I found myself inspired by Dr. Barnett's vision of pro-active engagement. I have thought about many of the topics we spoke about, and have wondered how to participate in civic engagement. Dr. Barnett highlighted the importance of active involvement in our profession and the place of the individual in the larger picture. Concordant with his view of integrating research and practice, he emphasized the role of the relationship in advocacy for psychologists in all areas of practice and policy.

Paul Monson is a graduate student in the Clinical Psychology program at Miami University of Ohio. His research interests include significant dreams, narrative, and identity.

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DIVISION 29 STUDENT PAPER AWARDS

Each year, the Student Development Committee of the Division of Psychotherapy calls for papers for three awards, which are then juried by the members of the committee. In 2007, the committee received nearly 30 submissions of high caliber from students across North America. Each winning submission receives a commemorative plaque and a cash prize, presented at the annual meeting of the APA in San Francisco. *Psychotherapy Bulletin* is pleased to publish the winning paper from each award category.

Ms. Jesse Metzger, of Columbia University, is the recipient of this year's Donald K. Freedheim Student Development Award. The Freedheim Award is conferred on the author of the best paper written on psychotherapy theory, practice, or research. This year's winner, written by Ms. Metzger is titled: *Between Patients' Representations of Therapists and Patients.*

Mr. Peter Panthauer, of Adelphi University, is the recipient of this year's Diversity Award. The Diversity Award is conferred on the author of the best paper that address issues of race, gender, and cultural issues in psychotherapy. Mr. Panthauer's award-winning paper is titled: *Therapy with Lesbian Couples*.

Ms. Deleene Menefee, of the University of Houston, is the recipient of this year's Mathilda B. Canter Education and Training Award. The Canter award is conferred on the author of the best paper on education, supervision, or training of psychotherapists. Ms. Menefee's paper on *Perceptions of Trainee Attachment in the Supervisory Relationship*, was this year's award winning paper.

Michael S. Garfinkle
Chair, Student Development Committee

STUDENT AWARD PAPER

Perceptions of Trainee Attachment in the Supervisory Relationship

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ABSTRACT: The strength and nature of the supervisory relationship has been supported as a common factor in psychologist training. The influence of adult attachment among trainees on supervision outcomes has merit for informing supervision practice. However, traditional adult attachment measures do not account for the presence of evaluation in supervision The purpose of this research was to develop and validate an empirically supported measure, the Supervisee Attachment Strategies Scale (SASS) that would provide a framework for exploring trainee attachment strategies while accounting for the evaluative nature of supervision. Participants were recruited through their training directors at APPIC internship member programs in the US and Canada. Data were nationally collected from 352 trainees representing programs in Canada and 49 US states. In this sample, the mean age was 30, 78% identified as females, 67% as Caucasian, 8% Hispanic or Latino/Latina, 13% African American, 5% were Asian/Pacific Islander, and 6% were bi-racial or multi-racial. The majority of trainees were doctoral-level (78%, n = 259) and 42% of all trainees were enrolled in counseling (n = 139), 47% in clinical (n = 158), and 11% were in school psychology programs (n = 36). On average, participants had completed four practicums prior to their current placement, 65% were providing psychological services to adults, and were distributed among placement types (e.g., counseling centers, medical centers, schools, correctional facilities, community based centers, and private practice). Construct validity with a panel of experts in clinical supervision established the initial SASS 200 items. An alpha factor analysis with varimax rotation of the SASS reduced the items and yielded three interpretable factors that accounted for 53.8% of the total variance in the scores. The SASS scale factors (avoidance, anxiety, and evaluation) for the final 25-item SASS converged with adult attachment theory and explained additional variance specific to the evaluative nature of the supervisory relationship. SASS reliability estimates demonstrated coefficient alpha for the total scale at r = .75, avoidant scale r = .94, the anxiety scale r = .88, and evaluation scale r = .80.

When participants were asked, "In the overall scheme of things, how does the time you spend with your supervisor impact your training?" they responded with either "no impact on training/ waste of time" (51%) or "big impact/very helpful in shaping training" (49%). A hierarchical, logistical regression revealed that SASS avoidance, anxiety, and evaluation scores accurately classified perceived impact of supervision while controlling for length of training time and state anxiety. SASS scores accurately predicted high impact (SENS = .92) and low impact group membership

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(SPEC = .66) and added incremental validity over variance found in working alliance, c2 (6, n = 249) = 198.89, $p < .001$; Nagelkerke $R2 = .75$. Higher avoidant, anxious, and evaluative attachment strategies predicted diminished perceptions of the impact of training by the supervisory relationship. Trainees who engage in secure attachment strategies may be more likely to address conflict, negotiate additional explorative opportunities in training, and may be more likely to seek out their supervisors in times of uncertainty.

Introduction

Clinical supervision is a transtheoretical mechanism that allows psychologists to be self-regulatory gatekeepers while trainees are developing skills that could not be obtained solely through laboratory experiences (Lambert & Ogles, 1997). The off-campus supervisor functions as a safety net for trainees, thereby allowing them to explore their range of skills, take risks with increasingly challenging client circumstances, and formulate professional identities (Bernard & Goodyear, 2004). The clinical supervisor provides performance feedback, guidance, and a secure base when trainees experience confusion, feel uncertain, or need additional support for challenging circumstances. The supervisory relationship aims to provide corrective adjustments of inaccurate perceptions of competence, or counseling self-efficacy, and illuminates emotional experiences related to interpersonal processes. Given the demands of the training environment for immediate application and transfer of theory to practice, research is needed that examines the dynamic processes in the supervisory relationship in order to provide optimal training and practice guidelines for supervisors. The influence of attachment behaviors among trainees on the supervisory working alliance has merit for informing clinical supervisors and training programs about enduring strategies that have been hypothesized to contribute to trainee supervision outcomes (Bernard & Goodyear, 2004).

Significance of the Study

The strength and nature of the supervisory relationship has been confirmed as a common factor in successful counselor training (Lampropolous, 2002). Researchers have hypothesized that the supervisory working alliance, a term borrowed from a psychodynamic explanation of the client-therapist relationship, explains facets of the supervisory relationship. The working alliance between the supervisor and trainee has been shown to be a relatively stable and predictable variable for explaining components of the supervisory relationship (Bernard & Goodyear, 2004) and associated with role conflict and role ambiguity (Ladany & Friedlander, 1995).

Despite the increased empirical investigation over the past 25 years on supervision variables, there are still few measures of the supervisory relationship that are both psychometrically robust and driven by theory (Ellis & Ladany, 1997). Stable and enduring attributes for forming relationships, such as attachment styles, have received only conceptual address (Bernard & Goodyear, 2004). Pistole and Watkins (1995) offered a brief attachment theory application to counselor training and supervision. Case examples of a secure counselor were provided by Neswald-McCalip (2001) that supported Pistole and Watkins' conception of attachment behavior in supervision. Watkins (1995) proposed a conceptual framework based on early childhood attachment theory (Bowlby, 1979; 1988) that potentially explains trainee pathological styles in supervision. Only one empirical investigation of attachment behaviors in supervision exists in the literature (White & Queener, 2003), and no studies have investigated Watkins' pathological styles in supervision (Bernard & Goodyear, 2004).

Research is needed to understand how trainees' perceptions of the supervisory relationship might differ due to attachment dimensions, subsequently affecting how

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trainees utilize the secure base (Ainsworth & Bowlby, 1991) offered by their clinical supervisors. Given the advanced empirical findings on adult attachment (F.G. Lopez & Brennan, 2000), this theory potentially offers a grounded conceptual framework that could predict, explain, and empirically test both healthy and unhealthy behaviors in the supervisory relationship. However, there are no identifiable measures that have been designed and validated to measure the characteristics of adult attachment behaviors in supervisory relationships. Existing measures of attachment generally were not designed to assess adult attachment in the presence of evaluative, power-laden relationships.

The purpose of this proposed study is to develop an empirically supported Supervisee Attachment Strategies Scale (*SASS*) that will 1) provide a framework for exploring attachment behaviors in the supervisory relationship, and 2) contribute to and expand existing knowledge about the nature of trainees' perceived supervisory working alliance and self-reported attachment behaviors with a supervisor. This proposed study will describe the scale design, development, reliability and validity findings for the SASS among counseling and clinical psychology trainees who are actively engaged in supervisory relationships. Researchers have suggested that attachment variables explain resistance to supervision and poor training outcomes (Bernard & Goodyear, 2004); yet, there is a significant gap in the literature that fully explores or supports these suggestions. Findings from this study may increase our current understanding of the trainee's interaction within the supervisory relationship and provide a grounded framework for explaining both positive and negative supervision outcomes.

Conceptual models traditionally based and formulated from clinical observations (Bernard & Goodyear, 2004) have attempted to explain the role of the supervisor (Bernard, 1979; Holloway, 1995) and the developmental processes of the trainee (Loganbill, Hardy, & Delworth, 1982; Skovholt & Ronnestad, 1995; Stoltenberg, McNeil, & Delworth, 1998). The nature of the interaction between the supervisor and trainee appears to have mediating or moderating effects (Ellis & Ladany, 1997) on training outcomes. However, the supervisory relationship remains largely understudied, and its characteristics lack the depth and breadth of understanding and empirical validation needed to accurately inform training and practice. Further, these therapeutically-modeled approaches to supervisory relationships often fail to take into account the evaluation component and potential power differentials absent from the therapeutic relationship (Lampropolous, 2002). There are limited empirical findings that explain aspects of the supervisory relationship.

The Application of Adult Attachment Theory to the Supervisory Relationship

Adult attachment has been studied as a predictor of feelings about conflict (Pistole & Arricale, 2003), self-image (Mikulincer, 1995), stability in romantic relationships (Roisman, Madsen, Hennighausen, Sroufe, & Collins, 2001), attention and memory (Fraley, Garner, & Shaver, 2000), and social support seeking behavior (Collins & Feeney, 2000). Adult attachment processes involving affective regulation have been associated with college student distress (Lopez, Mitchell, & Gormley, 2002) and self-other similarity (Mikulincer, Orbach, & Iavnieli, 1998). Further, adult attachment theory has been applied to the therapist-client relationship (Mallinckrodt, Gantt, & Coble, 1995).

Trainees' complex and dynamic internal processes and skill-sets are continuously evolving over the trajectory of their training program experiences. The supervised trainee transitions from observing professionals, to providing basic counseling skills (e.g., establishing rapport), and, finally, to independently engaging in increasingly

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more complex interactions with clients that involve multiple subskills. As this transition occurs, the supervised trainee is no longer simply demonstrating or performing a basic skill, such as attending to the client, but becomes challenged to adjust and integrate his or her thoughts and behaviors in accord with the client, the client circumstances, and the supervisor's expectations. This guided push towards independence is likely to signal increased risk and provoke at least mild distress among trainees. Given that attachment theorists have found that individual differences in attachment are most apparent when people are mildly distressed (Lopez & Brennan, 2000) and that the supervisory relationship, which is usually somewhat worrisome but not calamitous, is likely to signal mild distress, supervision may be an exemplary arena for the appearance of individual differences in attachment style.

From the perspective of attachment theory, the supervisor offers a safe haven for protection and basic needs as well as a secure base from which trainees can explore increasingly more challenging skills (Collins & Feeney, 2000). In line with Bowlby's theory, under these assumptions, trainees' attachment systems would be activated and they would subsequently act upon their internalized dispositions to engage in relational processes with either adaptive or maladaptive strategies. Adaptive strategies would theoretically enlist supervisor responsiveness in a contingent manner to help trainees manage their internal responses to distress. On the other hand, trainees who engage in maladaptive strategies could potentially need excessive reassurance or be compulsively self-reliant (Pistole & Watkins, 1995; Watkins, 1995).

Watkins (1995) provided a conceptual paper on the pathological styles of attachment in supervision. Relying on case examples from his own experiences as a supervisor, Watkins identified three pathological attachment styles; compulsive self-reliance, anxious attachment, and compulsive caregiving. Watkins suggested that trainees with pathological attachment styles are frequently resistant to supervision and can create problems for graduate training programs. Watkins suggested that preventing such applicants from gaining entry into training programs might be worthy of additional consideration. More importantly, one might argue that the emphasis should be on the potential corrective nature of the supervision environment to recalibrate these types of relations processes among trainees. This calibration seems especially true given that it may be the evaluative component of supervision that brings about the heightened and affectively charged environment and activates the attachment system. Watkins' conceptualization also fails to account for the style or responsiveness of the supervisor, which is essential to understanding the interactional nature of the supervisory relations and the perceived attachment strategies of the trainee. Consistent nonresponsiveness, unavailability, and rejection among supervisors have been cited causes for negative experiences in supervision (Nelson & Friedlander, 2001) and potentially lead to trainee doubts about self-worth, impaired self-efficacy, mistrust, chronic distress during internship and failure to adequately disclose important information to supervisors (Ladany, Hill, Corbett, & Nutt, 1996).

Attachment theory informs our understanding of trainee resistance and provides supervisors with interventions to help their trainees benefit from corrective feedback, engage in increasingly more sophisticated self-appraisals, and successfully manage their own internal affective states. Further, attachment theory might lend explanations as to why many trainees are able to benefit from the supervision process. Attachment theory provides explanations for healthy adult processes and has been associated with self-reflective processes that allow for self-regulation and metacognitive functions and making infer-

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ences about mental states of others. Theorists have hypothesized that the presence of these types of inner resources (Mikulincer & Florian, 1998) for cognitive and affective self-regulation lead to higher order and healthier interpersonal interactions and prevent anxiety-driven or avoidant behaviors. These types of self-reflective processes are needed in order to benefit from the supervisory relationship.

Some researchers have asserted that the emotional bond in the working alliance significantly overlaps with attachment behaviors (Robbins, 1995). However, empirical evidence is lacking that provides confirmation of this assertion. In a study on client-to-therapist attachment, Mallinckrodt et al. (1995) differentiated attachment behaviors from the emotional bond in the working alliance. Mallinckrodt et al. noted that attachment behavior is more likely to be measured from a sound theoretical base and contain essential components that would not be captured by pantheoretical measures of the working alliance (Bernard & Goodyear, 2004) as it was originally proposed by Bordin (1979).

One study has been reported that examined the supervisory alliance and attachment among trainees. White and Queener (2003) surveyed 67 supervisory dyads in order to examine the influence of the ability to form attachments on the working alliance. These researchers hypothesized that both the ability to make attachments and the level of social support would predict the nature of the working alliance between the predominantly masters' level trainees and their site supervisors. They reported that trainees' self-reported abilities to make attachments failed to predict the working alliance with their supervisors. However, the supervisors' self-reported attachment style positively predicted their perceptions of the working alliance with their supervisees. Furthermore, the supervisors' self-view of attachment predicted the trainee perceptions of the alliance. The level of social support was not a significant predictor in this study. These researchers addressed the limitations of their study and provided some reasoning for why their model accounted for differences in the supervisors' perceptions of the working alliance but not those of the trainees.

White and Queener accounted for the lack of significance by discussing the hierarchical relationship in supervision and suggested that for the trainee, attachment has less importance in the relationship with their supervisor than other issues. More plausible explanations for the findings of this study may be related to the choice of instruments. They utilized the supervisee and supervisor forms of the *Supervisory Working Alliance Inventory* (Efstation, Patton, & Kardash, 1990) to measure the working alliance. Internal consistency for both forms is below .77 on all but one of the subscales, and the two forms are nonparallel (Ellis & Ladany, 1997). This instrument is further limited by the limited evidence that it is consistent with the working alliance originally theorized by Bordin (1979). In addition, they measured "the ability to make attachments" with the AAS (Collins & Reed, 1990) instead of a retrospective instrument, such as the Adult Attachment Interview (George, Kaplan, & Main, 1985) which would allow a more conclusive argument to be made about early attachments. Given that this instrument was not designed to measure relationships where there is an imbalance of power in a relationship with an evaluative nature, it is not surprising that it did not capture the nature of attachment behaviors among trainees. The supervisors in the White and Queener study were not under the same evaluative constraints as their supervisees and were freer to engage in traditional relationship attachment strategies with their trainees. The component of evaluation is always present within the supervisory relationship and has the potential to impact the student and the supervisor differently.

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The White and Queener study provides support for the development of a measure that assesses the construct of adult attachment strategies when an evaluative or power-laden characteristic is present in the relationship. The validity of such a scale would add to the existing adult attachment theory without creating redundancy in the literature with the addition of a new scale (Netemeyer, Bearden, & Sharma, 2003). Further, the validity of this scale could increase our understanding of the emotional bond in a dyadic working alliance as well as its relation to attachment strategies. Understanding the nature of attachment relationships among supervisors and trainees could also lend to understanding about the weakenings and repairs in these relationships (Burke, Goodyear, & Guzzardo). However, a theoretically driven measure of supervisee attachment strategies is needed in order to determine the nature and extent of such attachments and their relations to other supervision constructs. The development and construct validation of the *SASS* was the primary purpose of the current study. It was hypothesized that trainees' attachment to supervisors, as measured by the self-report scores on the SASS, would indicate that dimensions of anxiety and avoidance in relationship to their supervisors are clear interpretable factors. It was anticipated that items that reflect the evaluative component of supervision would be reflected in the final factor analysis. Further, it was predicted that trainees' attachment to supervisors would uniquely and incrementally account for variance in perceived impact of supervision.

Method

Participants

Data were collected online from a national sample of 352 trainees representing graduate training programs from Canada and 47 of the United States. Graduate student trainees in APA-accredited counseling or clinical psychology programs were eligible if they were enrolled in a masters' or doctoral practicum or in an advanced internship for predoctoral students. The participants who provide demographic information (n = 333) ranged in age from 22 to 63 (mean age = 29.2) with 90% of the sample under the age of 35. Seventy-six percent of the participants identified as females (n = 252). As for ethnic composition, 67% were Caucasian (n = 224), 13% were African American (n = 44), 8% were Hispanic/Latina/Latino (n = 26), five percent were Asian/Pacific Islander (n =18), and six percent were bi-racial or multi-racial (n =21).

The majority of participants were doctoral-level trainees (78%, n = 259). Overall, 42% of trainees were enrolled in counseling psychology (n = 139), 47% in clinical psychology (n = 158), and 11% were in school psychology programs (n = 36). Over 98% of the trainees in this study had completed at least one practicum before their current supervision placement (mean number of practicums = 4.8). Current training sites were identified as community based clinics (29.4%), hospitals or psychiatric facilities (21.6%), university counseling centers (19.5%), Veteran's Administration services (14.4%), school districts (10.5%), private practice (2.4%), or correctional institutions (2.1%). Trainees reported providing adult therapy and assessment (54.6%), child or adolescent therapy and assessment (26.4%), or combined services (18.9%) in their current placements. Supervisor gender was reported as 52% female and 48% male. Supervisor ethnicity (n = 289) was reported as 73% Caucasian, 11% African-American, nine percent Asian/Pacific Islander (n =18), four percent Hispanic/Latina/Latino, and two percent bi-racial or multi-racial.

Participants were notified in the informed consent that they were under no obligation to participate in this voluntary study and that if they chose to participate, they could withdraw from the study at any point. The online informed consent required a response, either "agree to participate" or "decline participation," before entering the actual survey.

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Instrument Development

The initial pool of items for the proposed *SASS* was developed using a multi-step process that ensured adherence to the construct of adult attachment theory. An a priori approach was used to ensure the development of the avoidance and anxiety domains in this scale as well as to explore other potential dimensions that are related to the power-laden relationship (Brennan, Clark, & Shaver, 1998). A panel of experts reviewed the sample of items in order to ensure that the items accurately represented the domain of attachment theory and were relevant to the supervisory relationship. Intraclass correlation coefficients ranging from 0 to 1 were calculated for all judges simultaneously across items (.65), by domains (.78), and by expert type (.79; student, faculty, or community agency supervisor). It was hypothesized that the final items would represent orthogonal, bipolar continuums for the domains of anxious and avoidant supervisory attachment strategies.

Procedures

In order to assess the psychometric integrity of the *SASS*' generalizability, graduate students (Haynes, Nelson, & Blaine, 1999) enrolled in a psychology practicum or internship were recruited to participate in a confidential study regarding their "perceptions of the supervisory relationship." A link to the online survey was posted on the Association of Psychology Postdoctoral and Internship Centers (APPIC) listserv through an email that went out to all subscribers. Interested trainees completed an online survey through an encrypted internet provider.

Measures

Supervisee Attachment Strategies (SASS). The final draft of the SASS contained 36 items that were scaled constructed using a 6-point anchor response format of strongly disagree to strongly agree. Participants responded to items regarding their current supervisors. The psychometric properties of the SASS are presented below in the Results section.

Working Alliance Inventory – Supervisee Form (WAI; Horvath & Greenburg, 1992). The supervisory working alliance was measured with the supervisee form of the WAI. In this study, Cronbach's alpha for the subscale of task agreement was r = .95, for goal agreement r = .93, and r =.94 for emotional bond.

Results

SASS scores were examined for their properties of central tendency, variance, covariance, and correlation for each of the initial 36-items. Internal consistency estimates were calculated with Cronbach's (1951) alpha or the mean of all possible split-half coefficients calculated by the Rulon method. During the conceptual aspects of the scale development, it was hypothesized that two clearly interpretable factors would emerge congruent with the structure of adult attachment theory; one representing trainees' avoidance and the other representing their anxiety in the supervisory relationship. Given the anticipated finding that the *SASS* would be a multi-dimensional scale, an exploratory factor analysis was conducted to determine its factor structure. The "eigenvalue-greater-than-one" rule was used to determine the number of factors that account for independent variance in the correlation matrix that are greater than any one item (Netemeyer et al., 2003; Nunnally & Bernstein, 1994). Before factor extraction, a Kaiser-Meyer-Okin (KMO; Kaiser, 1974) statistic was generated to determine sampling adequacy for the 352 trainee responses with the a priori expectation that the statistic be higher than .60 in order to proceed. In this study, the KMO statistic was .94, indicating a sufficient sampling adequacy and that the data were likely to respond to factor analysis.

An initial principal components analysis was conducted in order to estimate the maximized shared variance across the items (Kim & Mueller, 1978). A uniform random variable with a range of one to six (anchor format for SASS items) was inserted into the data set to discriminate error

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variance from other correlates. Missing data were replaced with the item mean. Based on the initial factor analysis, six factors emerged that accounted for 54% of the variance in the scale. The six factor model failed to reproduce the observed correlates in the model. There was substantial error found in the residual matrix with a substantial number of residuals with absolute values greater than .05 indicating a poor fit between the observed and reproduced matrices (Tabachnick & Fidell, 2001).

Given that principal component analysis does not take into account the communal and unique variances in the structural elements, alpha factoring with varimax rotation with Kaiser normalization was conducted over multiple iterations. Alpha factoring with the 36 items of the SASS and the random variable revealed a six factor model. Examination of the 6-factor scree test plot revealed that the slope of the line approaching zero significantly deviated after factor 3. Items were removed for redundancy and to control for multicollinearity.

The final exploratory factor analysis was conducted on 25 items. Factors were retained from the rotated solution where there was a minimum of three items loading on each structural element. Retained factors were compared to the a priori hypothesis where the final solution was restricted to the orthogonal dimensions hypothesized in this study related to adult attachment and the evaluative nature of supervision on the relationship. From the rotated solution of the 25-item SASS scale, three interpretable factors were extracted that accounted for 53.84% of the total variance in the scores. The first factor was congruent with the adult attachment avoidance construct and accounted for 53% of the model variance. The second factor was similar to the adult attachment anxiety constructed and accounted for 34% of the model variance. The content of items in the third factor was specific to the evaluative nature of the supervisory relationship and accounted for 13% of the model variance in the scores. The SASS rotated pattern matrix for the three-factor model is presented in Table 1. Reliability estimates for the 25-item SASS were calculated and coefficient alpha for the total scale was $r = .75$, the avoidant scale was $r = .94$, the anxiety scale was $r = .88$, and the evaluation scale was $r = .80$.

In order to establish criterion validity for the SASS, mean scores from the WAI were examined with the SASS subscales. Moderate to high correlations were found for the WAI subscales. Scores on the SASS avoidance scale were negatively correlated with WAI task agreement ($r = -.80$, $p. < .01$, two-tailed), goal agreement ($r = -.81$, $p. < .01$, two-tailed), and emotional bond ($r = -.82$, $p. < .01$, two-tailed). Scores on the SASS anxiety scale were negatively correlated with WAI task agreement ($r = -.28$, $p. < .01$, two-tailed), goal agreement ($r = -.30$, $p. < .01$, two-tailed), and emotional bond ($r = -.35$, $p. < .01$, two-tailed). Scores on the SASS evaluation scale were negatively correlated with WAI task agreement ($r = -.60$, $p. < .01$, two-tailed), goal agreement ($r = -.61$, $p. < .01$, two-tailed), and emotional bond ($r = -.69$, $p. < .01$, two-tailed). Higher avoidance, anxiety, and evaluation attachment strategies were related to reports of less task agreement, goal agreement, and emotional bond among trainees.

A logistic regression analysis was conducted in order to test the incremental validity and clinical utility of the SASS compared to the working alliance and role conflict/ambiguity. However, high intercorrelations between the WAI subscales were found in this study. Bivariate correlations showed multicollinearity for task and goal agreement, $r = .95$, for task agreement and emotional bond, $r = .89$, and for goal agreement and emotional bond, $r = .88$. Given these psychometric concerns and in accord with other researchers (Patton and Kivlighan, 1997), it was decided to use the summated WAI score as the measure of working alliance rather than the subscales. When participants were asked, "In the

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overall scheme of things, how does the time you spend with your supervisor impact your training?" they responded with either "no impact on training/ waste of time" (51%) or "big impact/very helpful in shaping training" (49%). T-tests were used to examine high and low impact group differences from this item for the WAI scores and the SASS subscales (see Table 2). Results showed that the lower impact group endorsed more role conflict and ambiguity and less strength of a working alliance than the high impact group. A series of t-tests revealed that high and low impact groups significantly differed on the SASS subscales by gender, type of degree sought, and length of time with supervisor but not on items of ethnicity or type training program. Gender, type of degree sought, and length of time with supervisor were used in the first block of the subsequent regression models to test incremental validity.

Nagelkerke R2 was derived to assess incremental validity of the SASS over the WAI. The Nagelkerke R2 is the most frequently reported of the R-squared estimates (Nagelkerke, 1991). Given that Nagelkerke R2 will improve as the number of variables increases, diagnostic efficiency statistics were computed for overall correct classification (OCC), sensitivity (SENS), specificity (SPEC), and Cohen's kappa (see Streiner, 2003) using the decision rule of a predicted probability of .50 or greater. In the current study, OCC refers to the proportion of individuals correctly identified as having perceived low or high impact of supervision on training, SENS is defined as the proportion of people identified with high impact who are detected as such; SPEC is the proportion of people who do not meet diagnostic criteria for high impact and are correctly identified as low impact, and Kappa represents the level of agreement between the predictor(s) and the diagnostic criteria beyond that accounted for by chance alone. As illustrated in Table 3, gender, type of degree sought, and length of time variables were entered in Block 1, followed by the addition of WAI summated scores and the SASS subscales in Block 2. A stepwise regression was employed to determine the best predictor model among the variables. In Block 1, gender and degree did not contribute to the prediction of group membership but length of time in supervision was significant, $c2$ (3, n = 249) = 20.90, p <.001. The Nagelkerke R2 was .11. The OCC rate using the demographic variables was 64.6%. The Hosmer-Lemeshow test, a test of the model goodness of fit, produced a fail to reject decision c2 (7, n = 249) = 4.34, p > .05, a result consistent with the assumption that the specified logistic model was correct. The demographic variables explained less than 10% of the variance in the group differences in perceived impact on training. The length of time in supervision accurately predicted high impact group membership, (SENS = .80) but was less likely to accurately predict low impact group membership (SPEC = .35). In Block 2, the SASS variables were entered in a forward, stepwise regression method. Table 2 outlines the significant discriminabilty of the stepwise model with WAI score entered in step one, the SASS avoidance scale entered in step two and the anxiety score entered in the final step. Entry of the SASS and WAI scores was significant in predicting group membership, c2 (6, n = 249) = 198.89, p < .001 with a good fit of the data to the model, c2 (8, n = 249) = 1.7, p > .05. The Nagelkerke R2 was .75. The OCC rate using a combination of ECR subscales and SASS subscales were 88% with a good fit of the data to the model, c2 (8, n = 213) = .39, p > .05. Diagnostic efficiency statistic improved with the addition of the SASS in Block 2 indicating increased clinical utility over the WAI in predicting impact of supervision group membership, change in c2 (1, n = 249) = 45.3, p < .001, change in Nagelkerke R2 to .72. The SASS accurately predicted both high impact group memberships (SENS = .92) and low impact group membership (SPEC = .66).

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Discussion

Clinical supervision is a transtheoretical mechanism that allows psychologists to be self-regulatory gatekeepers while trainees are developing skills that could not be obtained solely through laboratory experiences. The strength and nature of the supervisory relationship has been supported as a common factor in successful counselor training and development. Stable and enduring strategies for forming relationships, such as those in adult attachment theory, had previously received only conceptual address in the supervision literature. This study developed an empirically supported Supervisee Attachment Strategies Scale (SASS) that 1) provides a framework for exploring attachment behaviors in the supervisory relationship, and 2) expands existing knowledge about the nature of trainees' perceived supervisory working alliance and self-reported attachment behaviors with a supervisor.

Factor analysis of the participant responses on the SASS yielded a three-factor scale that converged with adult attachment theory and explained additional variance specific to the evaluative nature of the supervisory relationship. The initial item development for the SASS was based on assumptions that adult attachment strategies would be activated given the stressful nature of training and supervision. Therefore, items were created to gauge the importance of supervisor accessibility, desire for closeness, and security for exploring new opportunities and evaluating outcomes. The final, 25-item SASS demonstrated high internal consistency among the three factors.

The pantheoretical construct of the working alliance has been consistently used to examine variability in training and supervision. However, researchers have established that the WAI has psychometric problems that limit its clinical utility. In this study, the high correlations between the three subscales of the WAI resulted in the collapse of all items into one composite score, further limiting the interpretability of the findings from this measure. SASS scores were found to be positively related to scores on established measures of the supervisory working alliance, role conflict and role ambiguity in supervision.

Given that the SASS was developed in grounded-theory, it was anticipated that this scale would add incremental validity to the supervisory working alliance in predicting satisfaction with supervision. SASS scores added incremental validity and clinical utility beyond the WAI in explaining satisfaction with supervision. Those participants endorsing high avoidance strategies and low working alliance were most likely to report low impact of supervision on training. Conversely, those with low avoidance strategies, limited evaluation concerns, and high working alliance reported high impact of supervision training.

Limitations of the Study

One potential limitation of this study may be the influence of a strictly online survey data collection on the response to requests for participation in this study. It is not known how many trainees preferred the convenience of an online survey to a written survey that has to be returned by mail. Additional participants were recruited beyond the 300 desired due to early discontinuations of the online survey. It is not known if participants discontinued due to the length of the survey, the ease of closing a browser versus the demand of a written survey, or other circumstances related to electronic data collection. Another potential limitation of this study is that generally the supervisory working alliance is measured by examining both the trainee and supervisors perceptions in order to capture the interactive feature of the working alliance (Efstation et al. 1990). Future studies should aim to collect data from both members of the dyadic relationship to explore the relationship of trainee perceived attachment to supervisors' perceptions of the relationship.

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Implications

The influence of adult attachment behaviors among trainees on supervision outcomes has merit informing supervision practice. While the WAI has reliably predicted role conflict, role ambiguity, and perceived satisfaction, both the construct and the instrument have limitations. On the other hand, the SASS provides a framework for explaining variability in the supervisory relationship based on adult attachment theory. In line with Bowlby's theory, trainees' attachment in supervision could entail either adaptive or maladaptive strategies. Adaptive strategies would theoretically enlist supervisor responsiveness and help the trainee manage their internal responses to distress. On the other hand, trainees who engage in maladaptive strategies could potentially need excessive reassurance or be compulsively self-reliant. Implications for future research could include an outcome studies that examine the relationships between trainees' perceived attachment and supervisors' ratings of trainees' capacity for benefiting from corrective feedback, engaging in self-reflective processes, and regulating affect, variables informed by adult attachment theory. Future research could also explore mediational variables that explain coping with distress with negative supervisory events.

One strength of this study is the construction of an instrument that could explain weakening and repairs in the supervisory relationship (Burke et al., 1998). Trainees who are engaging in avoidant strategies with their supervisors may be less likely to address conflict, negotiate additional explorative opportunities in training, and may be less likely to proactively seek out their supervisors in times of mild distress. On the other hand, those trainees who are actively engaged in the relationship may be able to capitalize on the relationship, thereby allowing them greater exploration of new learning and to seek out their supervisors in times of uncertainty. Further, those trainees who are avoidant may appear to be autonomous and independent rather than disengaged in supervision. This possibility speaks to a concern that perhaps supervisors are not influencing trainees in the way that they are. Additional research is needed that compares the congruency of trainees and supervisors' perceptions of attachment strategies in the supervisory relationship.

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Table 1.

Structure Coefficients, Communality Estimates, Eigenvalues, and Variance in a Three-Factor Rotated Solution from Alpha Factoring for the Supervisee Attachment Strategies Scale Items with Varimax Rotation (N = 352)

SASS Item	Factor Structure Coefficients Factor 1	Factor 2	Factor3	h^2
12. My supervisor seems attentive to my needs.	0.83	0.16	0.21	0.59
27. I feel encouraged by my supervisor to continue trying new things.	0.82	0.00	0.00	0.42
7. I rely on my supervisor as a sounding board for problem-solving tough issues.	0.80	0.00	0.00	0.51
24. The relationship I have with my supervisor helps me manage the stress associated with training.	0.77	0.10	0.15	0.64
16. The interactions that I have had with my supervisor make me feel good about the profession of psychology.	0.75	0.00	0.35	0.48
1. I look to my supervisor as an experienced person that I can depend on.	0.74	0.00	0.20	0.57
32. I trust that my supervisor is nearby and ready to help.	0.73	0.21	0.12	0.61
10. It is difficult for me to depend on my supervisor to help me solve problems.	0.70	0.26	0.14	0.76
34. When my training experiences are distressing, I actively seek my supervisor for support.	0.68	0.00	0.00	0.30
20. I rely on my supervisor to help me gain competence.	0.65	-0.13	0.00	0.70
21. It is difficult for me to predict how my supervisor will behave.	0.56	0.28	0.50	0.54
15. I look to my supervisor to provide a protective environment while I am in training at his or her site.	0.55	0.00	0.00	0.45
25. I worry about my supervisor rejecting me.	0.26	0.76	0.13	0.58
11. I worry that I don't measure up to my supervisor's expectations.	0.19	0.74	0.15	0.63
22. I wish that I could be sure about whether or not my supervisor really likes me.	0.24	0.72	0.00	0.66
26. I need a lot of reassurance that my supervisor approves of my work.	-0.18	0.69	0.00	0.51
33. I worry about my supervisor finding out how incompetent I feel.	0.00	0.62	0.00	0.68
18. Even when my supervisor reassures me that I am doing okay, I have a hard time believing it.	0.00	0.61	0.00	0.45
2. I worry about displeasing my supervisor.	0.10	0.59	0.26	0.50
9. I feel bad about myself when my supervisor gives me corrective feedback.	0.11	0.58	0.37	0.59
36. My supervisor has reassured me that I am performing well but I still feel that I will be negatively evaluated.	0.10	0.56	0.27	0.39
5. I am worried that no matter how well I perform that my supervisor will give me a weak evaluation.	0.37	0.33	0.57	0.64
17. My supervisor only seems to notice me when I make mistakes.	0.25	0.25	0.49	0.38
28. I feel defensive when my supervisor gives me feedback about my performance.	0.11	0.44	0.49	0.47
31. My supervisor sometimes sees my desire for autonomy as resistance to supervision.	0.36	0.21	0.47	0.40
Eigenvalue	7.19	4.56	1.70	
Variance accounted for in the three factor model	28.78	18.25	6.80	

Note. Structure coefficients extracted with Alpha Factoring using the Varimax with Kaiser Normalization rotation method.

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Table 2

Descriptive and T-Test Statistics and Effect Sizes for SASS, WAI, RCRAI, and STAI scores for the Total Sample and the High and Low Impact Groups

SASS/WAI/RCRAI	Total Sample (n = 352)				High Impact Group[a] (n = 165)				Low Impact Group[b] (n = 102)				t	d[c]
	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max		
SASS Avoidance	25.70	11.3	12.0	70.0	21.2	5.2	12.0	37.0	34.6	14.0	13.0	70.0	11.09**	.40
SASS Anxiety	23.40	8.4	9.0	51.0	42.0	7.7	9.0	51.0	24.5	8.3	10.0	42.0	2.98**	.12
SASS Evaluation	7.78	3.7	4.0	21.0	6.49	2.2	4.0	15.0	10.2	4.8	4.0	21.0	8.07**	.21
WAI	198.33	39.3	36.0	252.0	217.59	18.2	143.0	252.0	167.2	44.9	36.0	246.0	-12.79**	.60

Notes. [a]High impact n = 165. [b]Low impact group n = 102. [c]Cohen's effect size = eta squared. SASS = Supervisee Attachment Strategies Scale; WAI = Working Alliance composite scale; ** $p < .001$

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Table 3

Hierarchical, Stepwise Logistic Regression Analyses with SASS Subscales, Working Alliance, and State Anxiety to Predict Low and High Groups Perceived Impact of Supervision (N = 249)

Variable	*B*	SE *B*	Nagelkerke R^2	ΔNagelkerke R^2	OCC	SENS	SPEC	PPP	NPP	Kappa
Block 1			.11	–	.64	.80	.35	.68	.55	.21
Constant	.21	.439								
Gender	-.01	.008								
Degree[a]	-.06	.007								
Time[b]	.33**	.008								
Block 2			.75	.65	.88	.92	.66	.82	.84	.76
Constant	–	4.76								
Time	18.48**	.143								
WAIc	.68**	.016								
SASS Avoidance	.07**	.047								
Anxiety	-1.25*	.046								
	.24**									

Notes. aDegree = Master's or Doctorate Degree Sought. bTime = Length of time in supervision. cWAI = working alliance. OCC = Overall correct classification; SENS = Sensitivity; SPEC = Specificity; PPP = Positive predictive power; NPP = Negative predictive power. *$p < .01$. **$p < .001$.

Special CE Event for Division of Psychotherapy Members

Division 29, in conjunction with Division 42 (Independent Practice) is pleased to present the following workshop that is offered to all Division 29 members in conjunction with our mid-winter board meeting. We hope all members will attend.

Core Tasks of Psychotherapy: What 'Expert' Psychotherapists Do

Presented by: **Donald Meichenbaum, Ph.D.**

Saturday, January 12th, 2008
from 9:00am – 4:00pm (6 CEs)
Tradewinds Resort, St. Pete Beach, FL

Registration fee includes breakfast and lunch
Member Fee: $120.
Nonmember Fee: $150.

Earn 6 APA-approved CEU's. Learn from an internationally renowned clinician, researcher, and teacher of psychotherapy, Donald Meichenbaum, a founder of Cognitive Behavior Modification and voted one of the ten most influential psychotherapists of the past century. Learn how to implement the core tasks of psychotherapy, learn his Constructive Narrative Cognitive Behavioral approach to behavior change and his case conceptualization model that informs both assessment and treatment decision making, learn strategies to prevent relapse, to reduce noncompliance, to increase resilience, and more. This workshop is intended for practicing psychotherapists interested in learning to apply the latest psychotherapy research findings to their daily practices and for researchers and teachers interested in cutting edge research on psychotherapy effectiveness. This will be an interactive workshop with demonstrations of the strategies and techniques to be taught.

Registration opens October 1, 2007 at www.division42.org
To learn more about the Tradewinds Resort visit:
http://www.tradewindsresort.com/

Plan your stay now. A limited number of rooms are available at the reduced rate of $185. (this includes the resort's activities fee). Call 1-(800)-808-9833 (Group Reservations) and tell them you are with the 2008 Joint APA Division Meeting before December 20, 2007 for this great rate. Join your colleagues for an outstanding weekend at one of Florida's premier resorts. Don't miss this special opportunity to meet and learn from Donald Meichenbaum, one of the greatest psychotherapy researchers, teachers, clinicians, and innovators.

WASHINGTON SCENE

Signs of Change for the 21st Century

Pat DeLeon, Ph.D.

During the Presidency of Lyndon Johnson, America enthusiastically rallied around his vision for a "Great Society." During those years, psychologist **John Gardner** served as Secretary of the Department of Health, Education, and Welfare (HEW)—"What we have before us are some breathtaking opportunities disguised as insoluble problems (1965)." The Administration's laudable (and admittedly ambitious) underlying objectives were to: end poverty, promote equality, improve education, rejuvenate cities, and protect the environment. Medicare was launched and the Corporation for Public Broadcasting was created. A little noticed program, a demonstration initiative called the Neighborhood Health Centers Program, was begun through the Office of Economic Opportunity (OEO).

Today, this Community Health Centers (CHCs) initiative serves as the true "safety net" for more than 15 million Americans, including many of our approximately 45.5 million citizens without health insurance, at 3,745 centers across the nation. Unfortunately, few CHCs include psychology training programs and it has been quite difficult to obtain a definitive count of the number of employed health center psychologists. It is our judgment, however, that CHCs are the venue for psychology's future participation as integrated, primary care professionals within our nation's evolving national healthcare environment. The Commonwealth Fund has reported increasing concerns that these centers currently lack the capacity to provide the full range of services required, especially when it comes to providing effective off-site specialty care, including referrals to medical specialists and mental health and substance abuse treatment. Not surprisingly, the most commonly reported barriers to care are providers' unwillingness to take Medicaid patients or those without insurance, the inability of patients to pay for services up front, and inadequate coverage for needed services.

Participating in the public policy (i.e., political) process, one soon learns that there is never enough money or resources. And yet, as our colleague John Gardner might have suggested, perhaps the unprecedented advances occurring within the communications and technology fields may ultimately provide a viable solution. With exciting new demonstrations in providing psychological care via virtual realities (for returning Iraq veterans with PTSD, as but one example) and the potential for telehealth linking-up health centers with specialty hospitals and specialists in private practice in "real time," we expect that psychology will soon have a greater presence—especially as society comes to appreciate the critical importance of the psychosocial-cultural-economic gradient of quality care. As an aside, during my APA Presidency, at the suggestion of **Ruby Takanishi**, I was honored to award Secretary Gardner with an APA Presidential citation for his decades of service to our nation. Ruby reported that he always considered himself to be a psychologist and that he was very pleased to receive this recognition from his colleagues.

Bill Gates, Chairman of the Microsoft Corporation, in *The Wall Street Journal:* "Health Care Needs an Internet Revolution—We live in an era that has seen our knowledge of medical science and treatment expand at a speed that is without precedent in human history. Today we can cure illnesses that used to be untreatable and prevent diseases that once seemed

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inevitable. We expect to live longer and remain active and productive as we get older.... But for all the progress we've made, our system for delivering medical care is clearly in crisis. According to a groundbreaking 1999 report on health-care quality published by the Institute of Medicine (the medical arm of the National Academy of Sciences) as many as 98,000 Americans die every year as a result of preventable medical errors. That number makes the health-care system itself the fifth-leading cause of death in this country.... At the heart of the problem is the fragmented nature of the way health information is created and collected. Few industries are as information-dependent and data-rich as health care. Every visit to a doctor, every test, measurement, and procedure generates more information.... Isolated, disconnected systems make it impossible for your doctor to assemble a complete picture of your health and make fully informed treatment decisions.... There is widespread awareness that we need to address the information problem.... In his 2006 State of the Union address, President Bush called on the medical system to 'make wider use of electronic records and other health information technology.'

"What we need is to place people at the very center of the health-care system and put them in control of all their health information. Developing the solutions to help make this possible is an important priority for Microsoft. We envision a comprehensive, Internet-based system that enables health-care providers to automatically deliver personal health data to each patient in a form they can understand and use.... I believe that an Internet-based health-care network like this will have a dramatic impact. It will undoubtedly improve the quality of medical care and lower costs by encouraging the use of evidence-based medicine, reducing medical errors and eliminating redundant medical tests. But it will also pave the way toward a more important transformation. Today, our health-care system encourages medical professionals to focus on treating conditions after they occur—on curing illnesses and managing disease. By giving us comprehensive access to our personal medical information, digital technology can make us all agents for change, capable of pushing for the one thing that we all really care about: a medical system that focuses on our lifelong health and prioritizes prevention as much as it does treatment. Putting people at the center of health-care means we will have the information we need to make intelligent choices that will allow us to lead healthy lives – and to search out providers who offer care that does as much to help us stay well as it does to help us get better. The technology exists today to make this system a reality. For the last 30 years, computers and software have helped industry after industry eliminate errors and inefficiencies and achieve new levels of productivity and success.... Technology is not a cure-all for the issues that plague the health-care system. But it can be a powerful catalyst for change, here in the U.S. and in countries around the globe where access to medical professionals is limited and where better availability of health-care information could help improve the lives of millions of people."

This fall, the Centers for Medicare and Medicaid Services (CMS) announced a five-year demonstration project that will encourage small to medium-sized physician practices to adopt electronic health records (EHRs). "EHRs can help reduce adverse drug events, medical errors, and redundant tests and procedures by ensuring doctors have access to all their patients' relevant health history at the place and time care is delivered. During the five-year project, it is estimated that 3.6 million consumers will be directly affected as their primary care physicians adopt certified EHRs in their practices. In order to amplify the effect of this demonstration project, CMS is also encouraging private insurers to offer

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similar incentives for EHR adoption. 'This demonstration is designed to show that streamlining health care management with electronic health records will reduce medical errors and improve quality of care for 3.6 million Americans,' [HHS] Secretary Leavitt said. 'By linking higher payment to use of EHRs to meet quality measures, we will encourage adoption of health information technology at the community level, where 60 percent of patients receive care. We also anticipate that EHRs will produce significant savings for Medicare over time by improving quality of care. This is another step in our ongoing effort to become a smart purchaser of health care – paying for better, rather than simply paying for more.'" The CMS demonstration will be open to participation by up to 1,200 physician practices by spring. Financial incentives will be provided to those using certified EHRs to perform specific functions that CMS believes will positively affect patient care. A bonus will be provided each year based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care. The demonstration supports HHS's efforts to shift health care toward a system based on value, through its Value-Driven Health Care initiative, with Four Cornerstones: interoperable electronic health records, public reporting of provider quality information, public reporting of cost information, and incentives for value comparison. Organized psychology should, of course, work to ensure that non-physician group practices qualify for the project – if for no reason than "to be at the table" and "have a voice" during the ongoing public policy deliberations.

The Past is Prologue For the Future: It is important to appreciate that fundamental change does not occur in a policy vacuum and instead, is almost always based upon past experiences. We all owe **Marilyn Richmond** of the APA Practice Directorate our sincerest appreciation for her efforts over the past decade on behalf of the enactment of federal mental health parity legislation. Most mental health policy experts predict that President Bush will sign a parity bill this Congress. Collectively, we should not forget that Marilyn has been working on this legislative agenda since 1996, when the limited law was passed. Mahalo.

June, 2004 – Senator Specter: "The Institute of Medicine published a report identifying up to 98,000 deaths a year due to medical errors. They specified a program for saving up to $150 billion over a 10-year period by reducing medical errors. The Subcommittee on Health and Human Services, which I chair, had provided funding to move ahead in implementing the reduction in those errors. There would be savings from improving health care quality, efficiency, and consumer education, and there would be considerable savings in primary and preventive care providers. There needs to be a great deal of additional education.... We know that the lack of insurance ultimately compromises a person's health because he or she is less likely to receive preventive care, is more likely to be hospitalized for avoidable health problems, and is more likely to be diagnosed in the late stages of disease....

"Accordingly, today I am introducing the Health Care Assurance Act of 2004.... A provision is included that would provide for demonstration programs to test best practices for reducing errors, testing the use of appropriate technologies to reduce medical errors, such as hand-held electronic medication systems, and research in geographically diverse locations to determine the causes of medical errors. To assist in the development by the private sector of needed technology standards, the bill would provide for ways to examine use of information technology and coordinate actions by the Federal Government and ensure that this investment will further the national health information and infrastructure....

The legislation would set up demonstration projects to educate the public regarding wise consumer choices about their health care, such as appropriate health care costs and quality control information.... Language is included to encourage the use of non-physician providers such as nurse practitioners, physician assistants, and clinical nurse specialists by increasing direct reimbursement under Medicare and Medicaid without regard to the setting where services are provided.... An adequate number of health professionals, including doctors, nurses, dentists, psychologists, laboratory technicians, and chiropractors is critical to the provision of health care in the United States."

June, 2005 – Senators Frist, Clinton, Obama, and others: A bill to reduce healthcare costs, improve efficiency, and improve healthcare quality through the development of a nation-wide interoperable health information technology system: "[Senator Frist] (W)hen it comes to health information, when it comes to electronic medical records, we are in the Stone Age not the information age.... [Senator Clinton] (W)e certainly do need to bring our health care system out of the information dark ages.... I introduced health quality and information technology legislation in 2003 to jumpstart the conversation on health IT. I am very pleased that I have had the opportunity now to work with the majority leader for more than a year on realizing what we believe would work, that would enable patients, physicians, nurses, hospitals – all – to have access electronically in a privacy-protected way to health information." We would suggest, along the lines of John Gardner's visionary challenge, that aggressively addressing the unacceptable "medical errors" crisis also provides a vehicle for ultimately ensuring that psychology's contributions to quality healthcare are appropriately recognized.

Interdisciplinary Care: The Institute of Medicine has called for the various healthcare disciplines to forgo their traditional "silo" mentalities and begin to systematically and respectfully work closely with other disciplines (including training) to ensure that health care is patient-centered and data-driven (i.e., utilizing "gold standards" of care). This fall, I had the opportunity to participate in the White Coat Ceremony for the inaugural class of the college of pharmacy at the University of Hawaii at Hilo. The Pharm.D. typically takes four years of post-baccalaureate training with 15 to 20 percent of the graduates (from 100-plus pharmacy programs across the nation) annually pursuing post-graduate residency training, for example, in mental health. The 90 first year students proudly took the Oath of a Pharmacist: "At this time, I vow to devote my professional life to the service of all humankind through the profession of pharmacy. I will consider the welfare of humanity and relief of human suffering my primary concerns. I will apply my knowledge, experience, and skills to the best of my ability to assure optimal drug therapy outcomes for the patients I serve. I will keep abreast of developments and maintain professional competency in my profession of pharmacy. I will maintain the highest principles of moral, ethical and legal conduct. I will embrace and advocate change in the profession of pharmacy that improves patient care. I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public." As we indicated, very few psychology programs have reached out to community health centers to establish training experiences for our next generation as primary care providers for the truly underserved. Clinical pharmacy appreciates the critical importance of professional socialization and we fully expect that in Hawaii pharmacy will become active partners with our 13 federally qualified community health centers as they develop their clinical practicum sites. For those colleagues interested in psychology's prescriptive authority (RxP) agenda, they should appreciate that over 25 years ago pharmacy

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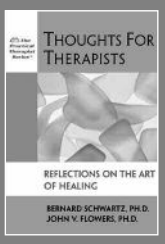
leaders in the State of Washington were able to obtain their profession's first legislative recognition of "collaborative practice" authority and that today 44 states formally recognize pharmacy's impressive drug expertise. Aloha,

Pat DeLeon, former APA President – Division 29 – November, 2007

Resources for the Practical Therapist



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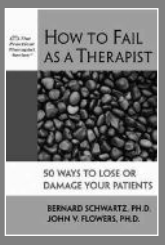

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Metacognition Disorders: Research and Therapeutic Implications

Giancarlo Dimaggio, Antonino Carcione and Giuseppe Nicolò
Third Center for Cognitive Psychotherapy – Rome

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Clinicians find it very difficult to reduce the malaise of patients with Avoidant Personality Disorder (AvPD), as these patients usually describe their emotions only vaguely and generically. How can one agree on goals when it is difficult even to guess at why a patient has requested psychotherapy? Patients with Narcissistic Personality Disorder (NPD) acknowledge what they feel and think, but when asked, for example, the causes of any gloominess, they often reply with abstract theories such as "How can't you be in a bad mood at times like these?" – or with quasi-biologistic explanations such as "My mood tends to always be black". Personality Disorder (PD) patients' problems are not restricted to describing their inner states, a question discussed recently by Ogrodniczuk (2007) in his article on alexithymia, a difficulty in distinguishing and naming one's emotions. PD patients often describe others' minds in a stereotyped – schema driven – and egocentric fashion. For example, patients with Paranoid Personality Disorder (PPD) are quick to see deceit in others' eyes but have difficulty forming alternative readings of their behaviors. To frame it more generally, patients with PDs, and, more seriously, patients with schizophrenia, experience varied difficulties with metacognition, that is, with thinking about mental states, both their own and others'.

Our group has concentrated on PD patients' metacognitive problems. We were inspired by Fonagy's (1991) early work on poor thinking about thinking in patients suffering from Borderline Personality Disorder (BPD; see also how this concept has been translated into a therapy model for BPD; Bateman & Fonagy, 2004) and by Frith's (1992) work on the mindreading deficit in schizophrenia. We have studied, for example, PD patients' difficulties in understanding how relationships influence their emotions and decisions, in decoding facial expressions and in making multiple hypotheses about the motivations behind others' actions (Semerari, 1999; Semerari, Carcione, Dimaggio et al., 2003).

The picture is not so simple as the patients having an overall impairment in a single-faceted skill. Simply saying that a patient has a metacognitive disorder conveys little information, like observing that a person has a memory deficit. The clinicians want to know what aspect of memory is impaired: Working memory? Digit memory? Autobiographical memory?

Metacognition does not refer to a single ability that can be intact or impaired to different degrees. Instead, data increasingly suggest that metacognition involves a number of related but distinct capacities. Some can operate or be impaired independently of one another and others may require a number of distinct cognitive processes (Harrington, Seigert & McClure, 2005; Saxe, 2005). Evidence from studies employing an array of methodologies have suggested that, in both clinical and community samples, the capacity for thinking about one's own thoughts and the ability

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to think about or make inferences about others' thoughts are not reducible to one another. Individuals may have more difficulties with one ability than with another, and the brain regions activated by one task may not completely overlap with those activated by the other (Mitchell, Macrae & Banaji, 2006). Nevertheless, the two skills appear to be linked. Individuals with problems reading their own mental states, as in alexithymia, simultaneously have difficulty understanding others' minds (Moriguchi, Ohnishi, Lane et al., 2006).

In our opinion the different dysfunctional features of patients' metacognition should be distinguished during therapy (Carcione, Dimaggio, Semerari & Nicolò, 2005). It is one thing to help individuals with AvPD to define their emotions better and another to help BPD patients to think that the intense emotions they feel are the product of their imagination and not reality. Stiles' work (1999; Stiles, Elliott, Llewelyn et al., 1990) has been fundamental for transforming such clinical observations into a research program. Stiles noted how patients have various levels of awareness of their problems: from a vague awareness of their distress, surfacing as intrusive thoughts, to higher levels, in which they describe the contents and causes of their suffering. Similarly, he observed that therapeutic interventions should foster the skill level immediately above the one possessed by a patient, thus working on the Zone of Proximal Development (Leiman & Stiles, 2001; Vygotsky, 1930/1978; see Bateman & Fonagy, 2004 for a similar approach). Interventions outside the zone are not likely to be effective. For example, it is pointless explaining to patients that they get angry when others impose something on them, when they are not even aware of being angry.

Metacognition Assessment Scale: The tool and Research Results

The Metacognition Assessment Scale (MAS) was created in Italian (Carcione, Falcone, Magnolfi & Manaresi, 1997) and then translated into English (Semerari et al., 2003). It sees metacognition as composed of sub-functions. Its purpose is to pinpoint mental understanding problems in transcripts of psychotherapy sessions or other conversations. It contains sub-scales for assessing whether a patient succeeds or fails in: a) understanding of his or her own mind, b) understanding of another's mind, and c) mastery, i.e. command of relational problems and subjective suffering through a knowledge of mental states.

Understanding of one's own mind includes items such as: *relating variables*, i.e. the ability to grasp the relationships between different aspects of mental processing, such as the events provoking emotions ("I was sad because I was thinking about the reasons for failing") or the motivations behind actions. Another example is the item *Differentiation,* which assesses whether patients are capable of distinguishing between their fantasies or hypotheses and the real state of the world.

Understanding of other's mind includes items assessing whether patients are able to define how others react to stimuli, think and feel emotions in a variety of contexts. It also evaluates whether patients realize that others' actions may not involve them, for example when their partner has a somber expression because of a sick relative and not because he/she is considering leaving them.

We have used the case study method (Stiles, 2005), involving the accumulation of successive observations to test, modify or add to our initial hypotheses about metacognition in PD patients. We have recorded, transcribed and analyzed entire psychotherapies with the MAS. The results are encouraging. Taken together, the data show that PD patients have an impaired metacognition, which improves in good outcome therapies (see Semerari, Carcione, Dimaggio, Nicolò & Procacci, 2007 for a review). The hypotheses that metacognition is not

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impaired overall but only in specific aspects, and that these aspects vary from one PD to another have received support. Four BPD patients, for example, were good at defining their inner states but failed significantly both in distinguishing between their fantasies and external reality and in integrating multiple images of self-with-other into coherent narratives (Semerari, Dimaggio, Nicolò, Pedone, Procacci & Carcione, 2005). On the other hand, NPD and AvPD patients had problems mainly in seeing the cause-effect links in their own psychological processes (Dimaggio, Procacci, Nicolò et al., 2007). Preliminary results from analyses of a patient with Obsessive-Compulsive PD and narcissistic traits currently under way show problems similar to pure NPD. That is, this patient had difficulties in understanding the causes of people's actions and emotions; in addition, the patient was significantly unable to take others' perspectives and to master her own problems effectively or feel she was in control of her own actions.

Research conducted by Paul Lysaker, with our involvement, confirms that metacognition is seriously impaired in schizophrenia. Many patients analyzed display serious and ongoing deficits – unlike the PD patients, who swing between periods of good and deficient metacognition. In schizophrenia the impairment involves basic aspects of the ability to understand that human beings are driven by intentions (not a problem in PDs). However, the deficit is not homogeneous: some patients display larger impairments, whereas others' functioning is somewhat better. Moreover, the MAS scales show a relative independence in schizophrenia; for example, they correlate differently with symptoms, neurocognition tests and executive function (Lysaker, Carcione, Dimaggio et al., 2005; Lysaker, Dimaggio, Buck, Carcione & Nicolò, 2007; Lysaker, Warman, Dimaggio et al., in press).

Therapeutic Implications

Expanding on Ogrodniczuk's observations (2007) about alexithymia, poor metacognition makes treatment problematic. Being aware of a problem makes it possible to formulate treatment correctly. We have designed a manualized psychotherapy model for the PDs, Metacognitive Interpersonal Therapy (MIT) (Dimaggio, Semerari, Carcione, Nicolò & Procacci, 2007). A core MIT assumption is that PD patients should first be helped to improve their ability to think about mental states - before being pushed towards change, solving symptoms or building new ways of relating. Another MIT assumption concerns the role of interpersonal relationships, which are always problematic for PD patients. These patients often undermine the therapeutic relationship, and this generally makes the therapeutic alliance fragile and puts it in danger. With MIT a therapist concentrates from the start on identifying the relational problems occurring during sessions and on avoiding contributing to ruptures with his/her own actions. When the therapist has repaired the alliance – often by metacommunicating during sessions and suggesting the patient join in reflecting on the causes of the problems between them (Safran & Muran, 2000) – he or she can adopt strategies for improving the patient's metacognition. These include: inviting the patient to narrate autobiographical episodes with definite space and time boundaries and in which the self's and others' actions are clear, and then studying the affects experienced at that moment and why.

A therapist needs to self-disclose often. This can improve an alliance and lets patients feel that their therapist is similar to them and, therefore, less dominant or critical: "I've the feeling that you feel paralyzed and see the future as a dead end. I too feel powerless to help you at this moment and recall that I've had similar experiences at other times in my work. I realize that you must feel unwell, but I know it's something we can tackle togeth-

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er, without yielding to despair." If the alliance improves, a therapist should pass on to stimulating the patient's metacognition. A 28-year-old man suffering from NPD and BPD maintained that his problems were entirely of a biological nature and could only be cured with drugs (naturally, he had already tried every antidepressant on the market and various kinds of psychotherapy, with very limited benefit). After months of repeating these theories and of defiance and contempt and repeated therapist suggestions that he think that his emotions might depend on what had happened to him, he came to one session with a particularly gloomy expression. Towards the end of the session he said, with a neutral tone, that his girlfriend had been unfaithful. The therapist's intervention was more or less: "Gosh. It must have been really horrible finding that out! In general, everyone feels bad when they feel betrayed and I felt awful too, when I had similar experiences. Do you think your being gloomy today could depend on this?" The patient opened his eyes wide and replied with surprise: "I never thought I too could function in such a banal way!" As illustrated in this example, even if poor metacognition is an obstacle to treatment, it can respond to interventions, and patients with problems in this area can be treated successfully.

Future Directions

We are currently completing and validating a standard interview for a quick assessment of metacognition at the start of a therapy and measuring it repeatedly during treatment. Together with this, we perform tests covering the seriousness of symptoms, interpersonal functioning, personality structure, and therapeutic relationship quality. We also measure skills theoretically correlated to metacognition, like the ability to successfully interpret emotions from facial expressions.

The goals of this research concern: a) psychopathology: Does metacognition correlate with personality diagnoses? Does it depend on global functioning? Are some dysfunctions linked more to symptoms or to interpersonal patterns?, b) the therapeutic process: In assessing wider populations, is there a confirmation of the idea that metacognition is poor at the start of treatment but improves in successful therapies? c) effectiveness: Could MIT be a choice treatment for PDs?

The preliminary data, covering about 100 patients treated with MIT and given the interview for assessing metacognition, are encouraging. Patients with PD seem to have worse metacognition than patients with only an axis I diagnosis, and different PD disorders involve different metacognitive impairments. Outcome data are not yet available, but the drop-out rate (as measured after 6 months) appears low; this encourages us to further investigate metacognition, impairments thereof, and our hypothesis that if a therapist intervenes with the aim of improving the deficient aspects of metacognition, a therapy is more likely to succeed.

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PSYCHOTHERAPY PRACTICE

Can Practitioners Love Science or is the Dialectic More than We Can Bear?

Jeffrey J. Magnavita

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In a recent session where I was engaged in co-joint individual psychotherapy with a colleague who was conducting EMDR on a complex trauma patient the seed for this article, my first, in this column was planted. The patient decided to undertake EMDR after having conducted her own research and coming to the conclusion that the only way she thought EMDR would be useful was for me to be in the room while the EMDR therapist worked. She previously had undergone a few trials with some well trained EMDR practitioners but felt that the outcome would be improved if she could use her relationship with me to ground her while she went through her significant trauma history. During one of the sessions, referring to me, the patient spontaneously reported to the EMDR therapist how much "he loves science". I was struck by the accuracy and feeling of being "located" by this comment because she is correct that I love science and enjoy reading about the clinical sciences, psychotherapy, neuroscience, anthropology, medicine and other scientific and clinical endeavors. I suspect that part of what gave me away was the *Scientific American* journals in the waiting room, my trying to explain her suffering using the latest findings from the literature, as well as my invitation for her to try some new Heart Rate Variability biofeedback that I have been incorporating into my practice and research. This experience made me ponder the tension that I have experienced as a practitioner of psychotherapy for over 20 years between the art of practice and science of psychotherapy. The tension in this dialectic compels me to focus on this in my first practice column.

I often have wondered why scientists look down at those who primarily devote themselves to practice and why practitioners believe researchers are irrelevant and "don't have a clue about real life". The criticisms are well known: "psychotherapists practice without any evidence to base what they do on" and "researchers idealize statistics from randomized, manualized treatment studies with patients who are never seen in real clinical practice". We all have heard the arguments from both corners and all suspect that there is truth to both sides of these accusations. As pressure is exerted on practitioners to base their work on the available evidence base and empirical findings the tension between these two tribes seems to be intensifying. I would like to explore the dialectic of this tension and suggest some possibilities.

What is the "real" difference between practitioners of psychotherapy and researchers? Let me begin with trying to describe what I have experienced and observed about being a psychotherapist.

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Psychotherapists spend their days sitting with and listening to stories of pain and suffering, and have been confirmed the societal role of "healer". Thus, much of the time is devoted to attempting to enter other people's frames of reference by exploring the phenomenology of what makes the suffering of the patient unique and what makes it similar to others with similar diagnostic and symptom clusters. Coming with this role of healer are a number of privileges, responsibilities, demands, and perks. There is the privilege of being a member of society who has specialized training and knowledge and the respect that goes along with this specialized role. There is also the demand of trying to understand and alleviate the suffering of those who may be in intense pain and sometimes chronic states of suffering, without hope and meaning to their lives. There is the gratification of helping individuals recover and relieve symptoms. Occasionally, there is the shear joy of assisting people in identifying and eliminating lifelong patterns of self-defeating and self-sabotaging behavior. There is also the stress of dealing with those who get worse in treatment and even more dreadful dealing with the acts of severe self-harm and suicide. Witnessing and being part of these reenactments is often vicariously traumatizing the psychotherapist. Losing a patient on our watch is nothing less than a nightmare come true. There are perks to this role and position. We are respected and privileged members of society and when people change under our care they are enormously grateful and generous in recognizing our role and commitment to the process. Psychotherapists are either paid by the institution they work for or by the patients they see. They are reliant on their integrity and word of mouth to stay in practice. When practicing fee for service they either sink or swim based on their perceived value in the free market economy.

Scientists, whether clinical, medical or psychotherapy researchers operate in a domain that emphasizes different core values and roles than practitioners. Researchers are also in the privileged position of "scientist" in our culture and thus command respect and authority for their knowledge and mastery of the principles and language of scientific discourse. Scientists value objectivity, rationality, and evidence. The best scientists are also creative and push the boundaries of knowledge, which often results in being scorned, until later they are given Nobel prizes. The demands of science are challenging and require a solid character that can withstand a lack of daily feedback and validation for some longer-term sense of gratification. They must have some level of obsessive compulsiveness to their personalities in order to persist. Effective researchers must be able to predict and envision how a particular study will unfold over time at its inception and then bring it to completion. Scientists must be conversant with statistical and research methods and be able to write coherently and have their work published. They must be able to convince others that supporting their work with funding is a worthwhile venture and risk. They must be able to decide what the impact of their findings will be on society and culture. Even something which is clearly evident in the findings may have implications that are negative for some group of people. Researchers, unlike psychotherapists, exist under the intense scrutiny of grant giving overseers and can be declared irrelevant and mocked by politicians who have a political axe to grind. There are perks for successful researchers such as joy of discovery, respect of society, opportunity to travel, and high status. The most successful often are additionally rewarded with fame and fortune and are considered rock stars and innovators of science.

Of course there are many who would describe themselves as scientist-practitioners or who practice both psychotherapy and research. It is probably very difficult to be a highly skilled psychotherapist and

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expert researcher as each role demands so much of their practitioners. Most of us admire those unique individuals like Carl Rogers who are able to "walk the line" and balance practice and research activities.

There are some inherent struggles between the healers and seekers. Psychotherapists are healers who daily face the demands of those in suffering, in the role of patient or client depending upon your preference, want to do everything they can to diminish suffering and offer hope. In medicine there are reports of physicians who never give up hope and continue to try everything possible to save the lives of those entrusted in their care, sometimes resorting to radical procedures. Practitioners often are in the position of facing challenges beyond what clinical science and evidence has to offer and will try different approaches that are based on clinical experience, intuition, and knowledge. When faced with someone in intense and chronic emotional pain it is necessary to maintain hope and do one's best to alleviate the suffering even if there is little in the literature to go by. Psychotherapists like theory and methods to guide their work and view these as their navigational and technical systems. They are often vulnerable to following gurus who offer to show the way because suffering and uncertainty can feel like more than we can bear and gurus offer hope. Theory often advances before empirical findings and thus there may be psychotherapeutic systems which are laughable to us today but seemed entirely reasonable to those of yesteryear.

Researchers are also reliant on theory to guide their work. They are in the position of trying to decide which theory is worth their research effort and then devote their energy and resources to seeing if the theory is tenable. This is a critical decision for a psychotherapy researcher as it will shape the future of his or her career path. Once a line of investigation is selected it may take years before any fruitful results are ready to be published. Research often lags behind practice and the challenge is to remain relevant as the theoretical systems evolve and gain momentum and then may be absorbed or forgotten.

Scientists like psychotherapists are data collectors whose tools and techniques have more in common than would appear to the outside observer. Psychotherapists and researchers view clinical phenomena through somewhat different lenses but both rely on observation and testing hypotheses to determine how to predict the outcome. A researcher must have a strong interest in understanding human nature and change and a psychotherapist must be able to capitalize on these forces and bring them to bear in the clinical situation.

Even though it seems like psychotherapists and researchers are from different tribes there is no doubt we are from the same nation of clinical science on which the foundation of our work rests. Science is not only for the lab or bench. We can all be clinical scientists by taking the time to read the current research findings in our discipline and related sciences and incorporating the evidence base to guide clinical practice. The psychotherapist's consulting room is a lab for hypothesis testing in determining what works and what doesn't with each patient. The scientist in us is hungry for any knowledge that can assist us in understanding and explaining the complexity of phenomena that we witness in those we work within the clinical setting. We can rejoice in our devoted researcher friends and peers who sacrifice so much in search of truth.

Recently, I had the honor to participate in an interdisciplinary conference on transcendence and science hosted by James Madison University and funded by a STARS research grant. Spending two days with a group of leading primatologists,

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anthropologists, sociologists, biologists, linguists, developmental psychologists, and others reminded me of the shared mission we are all on with our brethren from other disciplines. The study of human nature, consciousness, mind-body connection, language, personality, psychotherapy, and other topics are critical for addressing the challenges that face us on a global level. I hope that this column will reawaken your love for science and compel you to take time to read our journals and cull the research findings from them. Even more I hope that you will consider reading more broadly in other disciplines and building relationships with their members. It is also my hope that we all will accept the inevitable tension between the perspective of science and practice and not fall prey to demonizing the other. We are all charged with the mission of understanding human nature to alleviate suffering of those who need our care. We must allow ourselves to hold the tension between the dual lenses of science and practice without succumbing to anxiety and eschewing the other.

PSYCHOTHERAPY EDUCATION AND TRAINING

Empirically Validated Education and Training?

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In 1974 the federal government of the United States passed PL 94-142, which required all children to receive a free education in the least restrictive environment. This law was later revised, and is now known as I.D.E.A. As a result of PL 94-142, Individualized Education Plans (IEPs) and outcome-based education emerged.

In the early part of the twentieth century, corporations began providing medical services to their employees, and the seeds of managed care were sown. In recent years, as managed care companies have grown in size and number and have begun to control the criteria for third party reimbursement of medical services, evidence based treatment (also known as empirically supported or empirically validated treatment) has proliferated.

Whatever your beliefs about outcome based education or empirically validated treatment, they have become firmly entrenched in the education and managed care worlds. Ironically, although psychology has contributed methodologies to both (e.g., operationalizing and measuring behaviors), the field of psychology has been slower to apply these methodologies to its own education and training. Psychology has shifted to outcome based education only recently as the education and training of psychologists has evolved. The shift has correlated with the rise in popularity of Psy.D. programs, which train practitioner/scholars and most of which are based on the National Council of Schools and Programs in Professional Psychology (NCSPP) model of training.

The NCSPP model is competency based and originally included six competencies (Relationship, Assessment, Intervention, Management/Supervision, Consultation/Education, and Research/Evaluation), with Diversity described as a component of training integrated throughout the entire curriculum in concert with the six competencies to underscore its preeminence (e.g., Bourg, Bent, Callan, Jones, McHolland, & Stricker, 1987; Peterson, Peterson, Abrams, & Stricker, 1997). In 2002, NCSPP also included Diversity as a seventh, freestanding competency. Most recently, in September, 2007, NCSPP approved the Developmental Achievement Levels (DALs, which were formerly known as the "Competency Grids") for inclusion in the NCSPP educational model. The DALs describe the knowledge, skills, and attitudes associated with development of the seven competencies of the NCSPP model and can be found at http://www.ncspp.info/pubs.htm.

As Kaslow (2004) has noted:

> The past two decades have witnessed a burgeoning interest in competency-based education, training, and credentialing in professional psychology (Sumerall, Lopez, & Oehlert, 2000). Education and training groups have articulated competency-based training models, including the National Council of Schools and Programs of Professional Psychology (NCSPP; Bourg et al., 1987; Peterson, Peterson, Abrams, & Stricker, 1997), scientist-practitioner clinical psychologists (Belar, 1992), counseling psychologists (Stoltenberg et al., 2000), and clinical scientists (http://psych.arizona.edu/apcs.html). (p. 774)

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The burgeoning interest by various groups described by Kaslow (2004) converged five years ago, as representatives from a number of professional organizations within the field of psychology met for the 2002 "Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology" and developed a description of competencies deemed necessary as the outcome of the education and training of psychologists. Those competencies include ethical and legal issues, individual and cultural diversity, scientific foundations and research, psychological assessment, intervention, consultation and interprofessional collaboration, supervision, and professional development. Most recently, the October, 2007 issue of *Professional Psychology: Research and Education* (volume 38, number 5) was devoted to the assessment of competence.

A review and comparison of the competencies originating from various sources, beginning with NCSPP and culminating in the 2002 Competencies Conference, reveal recurring themes. In all cases, the salience of the therapeutic relationship in psychotherapy as a healing factor (Bachelor & Horvath, 1999; Norcross, 2002) is confirmed.

Managed care has often been criticized for ignoring, or at least diminishing, the therapeutic relationship, and for focusing primarily or even exclusively on outcomes. Indeed, managed care has shifted the very language describing psychological services from mental health care to behavioral health care. [One definition of psychology used in the 1970s was the study of mind and behavior. As psychology has chased third party reimbursement that medicine chased first, it seems that psychology drifted from mind and behavior to behavior. In the meantime, other professions have continued to focus on the mind and/or soul of human beings without becoming tied to third party payers. Someday, psychologists might benefit from reviewing the decision points that led psychology down this road, given clients' concern about therapists' level of caring as well as level of clinical competency (Bremer, 2001).] Ironically, one of the most promising aspects of the recent shift in psychological education and training towards measurable outcomes is the consistent inclusion of relational variables. As competencies become more and more formally embedded in psychological education and training, educators and trainers have a responsibility to advocate for (as well as teach students and supervisees how to build) the therapeutic relationship.

And if competencies continue to be the focus of education and training, educators and trainers also have a responsibility to make sure that they are teaching the right competencies. Competencies have been proposed by professional consensus; just as psychotherapy models were applied by consensus to supervision in the early days of supervision and then the research followed, it appears that competencies are being derived from what is already being practiced in the field of psychology, and their validation in their entirety is yet to be examined. To be sure, some already being applied to education and training have already been validated, such as the relationship competency, but the research on others has not been done. As Lichtenberg, Portnoy, Bebeau, Leigh, Nelson, Rubin, Smith, and Kaslow (2007) note:

> …psychology's shift to a competency model would be a challenging endeavor, but one that is required in view of the need to reinforce credibility in competence for the practice of psychology. Achieving *consensus* [our emphasis] within the profession and across its diversity of specialties, orientations, and models on the necessary competencies for professional practice is a critical first step. Establishing the mechanisms and systems for competency assessments, and *evaluation* [our emphasis] and building the commitment across the profession to carry it out, are important additional steps (p. 478).

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Balanced Psychotherapy Research

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Introduction

The fields of psychotherapy and psychotherapy research have fought for decades to develop generally accepted procedures for a balanced approach to psychotherapy research. Balanced means in this context:

- Truly informative for psychotherapy practice
- Not limited to or one-sidedly favoring specific approaches to psychotherapy
- Not limited to one type of patient (e.g. those falling clearly into one diagnostic category)
- Living up to the standards of psychotherapy practice AND of rigorous psychotherapy research.

There is a wealth of articles discussing one or the other aspect of how appropriate psychotherapy research should be done. Most readers are assumed to be familiar with at least part of the literature; we will not attempt to summarize it but rather concentrate on one aspect: The balance between internal and external/clinical/ecological validity. This is a crucial question in the advancement of empirical underpinnings of principle-oriented, integrative psychotherapy, as it is explicitly or implicitly practiced by a majority of psychotherapists (Stricker, 2005; Norcross, Hedges & Prochaska, 2002).

The Randomized Clinical Trials (RCT) and Empirically Supported Treatment (EST) initiative (Calhoun, Moras, Pilkonis, & Rehm, 1998; Chambless & Hollon, 1998; Kendall, 1998; Nathan & Gorman, 2002), or more generally, the experimental approach to outcome research, which has dominated psychotherapy research for many years, has its emphasis clearly on internal validity. Political arguments ("psychotherapy per se is at stake in the competition with drugs"), as well as the intrinsic logical strength of the experimental paradigm when it comes to causal argumentation, have strengthened this approach. They have also rendered colleagues with reservations against ESTs moderate and hesitant regarding statements questioning this approach, but they have obviously not silenced them (Elliott, 1998; Borkovec & Costonguay, 1998; Goldfried & Wolf, 1998 ; Westen, Novotny & Thompson-Brenner, 2004). They have also stimulated constructive activities to compensate for the weaknesses of this approach.

Improving the situation

Two initiatives are most noteworthy, as discussed in a previous article in this journal (Arnkoff, Glass & Schottenbauer, 2006):

- The initiative to balance the one-sided emphasis on techniques and on patients belonging to clear diagnostic categories by collecting and discussing evidence regarding the psychotherapy relationship and its facets, by the APA Division 29 Task Force (Norcross, 2002).
- The initiative to develop empirically supported principles which could carry psychotherapy beyond the application of empirically supported techniques by the Division 12 Task Force (Castonguay & Beutler, 2006).

Each of these initiatives has great merits as well as severe limitations that prevent them from being the last decisive step

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towards balanced psychotherapy research, although they are important stages on the stony path towards it. The main shortcoming in the relationship approach is the current lack of experimental research (although we must acknowledge the greater difficulty of experiments related to the relationship compared to technique). The main shortcoming of the principle approach is that empirical rigor in the formulation of principles bleaches out much of what would be relevant for sufficiently concrete and complete instructions for practice.

Premises and solutions of the EST approach

To understand some fundamental problems in practice relevant research, we must be aware of fundamental assumptions of the still dominating EST (empirically supported treatments) approach. A therapeutic approach is developed for a group of patients, tested in such a way that it is possible to determine causal effects of that specific procedure, and if it is successful, it is recommended for the treatment of future patients. This follows the logic of experimental research, which is the most straightforward way for causal argumentation: We try to develop instruments to bring about effects, and we must make sure that observed changes with patients are actually brought about by these instruments and nothing else. Unless we can do this, we cannot really recommend a procedure to be used with patients. Every procedure costs time and money, and prevents alternative procedures from being applied, therefore we must have good reasons for favoring what we recommend.

Much of the early psychotherapy research is of no or limited value because it has not sufficiently specified what the therapy consisted of. Postulates for specifying procedures more concretely are obviously justified. This is one of the crucial criteria of internal validity.

The EST initiative clearly specifies the way to do this: By manualisation. If a psychotherapeutic procedure under study is prescribed in sufficient detail, it can be checked in the study itself whether therapists adhere to the procedure (also: whether the extent of adherence is positively correlated to outcome, which is not always the case!). Once studies have shown effectiveness, therapists can follow the procedure and if they do this thoroughly, they can expect outcomes that correspond to those found in the studies. It is crucial that the manual be strict enough to limit the variations of possible procedures, so as to prevent as much as possible the use of procedures that remain in scope of the manual but are inferior in outcome. This is the principle. Some of the best known manuals are nevertheless rather flexible, from rather old (Beck, Rush, Shaw & Emery, 1979) to newer ones (e.g. Linehan, 1993). From a clinical practice point of view, this is desirable, as it allows adaptations to the individual patient. What if an agoraphobic patient has had already three cardiac bypass operations? What if a patient who should stick to a strict behavioral program, as far as his symptoms are concerned, is being reactant due to motives of autonomy on the level of the therapeutic relationship?

Some authors of manuals don't formulate rules algorithmically (in a narrow sense, allowing to follow them step by step, so that the procedure with patient A resembles very much the procedure with patient B), but rather heuristically (so that, while a resemblance remains in principle, on the surface, procedures may vary considerably). They do this for reasons of gain in effectiveness, applicability to a broader range of patients, or more generally, a gain in clinical or external validity of a therapeutic approach and the empirical evaluation coming along with it. The same applies to practitioners who use algorithmically formulated, high-internal-validity approaches heuristically, or extend the duration (Morrison, Bradley & Westen, 2003): They may not be aware of it, but

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they trade external for internal validity. Trying to improve applicability, quality of processes, and outcome from a clinical (external) point of view, they take the risk of jeopardizing internal validity. The range of possible concrete procedures is broadened by the flexibility allowed by the use of heuristic rules, or by using algorithmic rules in a more sloppy way than envisioned by the developers.

Apart from this first big issue, the comparability of procedures, there is a second: the comparability of patients. Specifying the type of patients was a part of the postulates by Kiesler (1966) as well as Paul (1967) to abolish uniformity myths. In the EST movement, this is typically done by using homogeneous, monosymptomatic, noncomorbid groups of patients (major depression, no other axis I or axis II diagnosis). It seems a matter of course that effectiveness found for one group of patients cannot be transferred to different patients. Unless my patient strongly resembles the patients in a study in all relevant criteria, I cannot expect comparable effects, even when precisely applying the prescribed procedure. Therefore one needs to specify the group to which a procedure has been applied. Homogeneity can certainly be increased by the procedure typical for ESTs. It should be mentioned, however, that this approach is far from perfect, because a concentration of diagnostic criteria (in the sense of DSM) usually means neglecting so called "nondiagnostic" aspects, such as interpersonal properties, which have been shown to be critical in choosing the appropriate procedure (Beutler & Harwood, 2000; Grawe, Caspar & Ambühl, 1990). One could certainly perfect the homogenization beyond the point that is typical for ESTs, and there are good clinical arguments in favor of doing so. The common critique goes, however, in a different direction: What proportion of patients in common practice can be covered if treatments are tailored to specific diagnostic groups? So far, only a small part of defined diagnostic groups have been covered by manuals (Beutler, Malik, Alimohamed, Harwood, Talebi, & Noble, 2004), and given the high standards and costs of RCTs it is completely unrealistic to think that this approach can ever come close to covering most patients. This is particularly true when one thinks of combinations of patient properties of known relevance. It would be unfair not to mention that more recently, comorbidity has been included to a larger extent by the RCT approach (Hollon, 2007), but this does not solve inherent problems of the sheer number of groups needed to be studied to avoid having to say too often to a patient "sorry, bad luck, no sufficiently comparable group for you"! In addition, even among patients who would qualify for a treatment, only a relatively small part ends up using and receiving a number of therapy sessions sufficient to make therapy effective, and providing all the data needed for evaluation. This is another threat to generalizibility.

Pragmatic solutions

Pragmatic solutions for problems with the coverage of patients in natural settings by RCTs go again in the direction of using findings for groups sufficiently similar to a particular patient in a heuristic manner, of adding rules derived from a non-diagnostic perspective (Beutler & Harwood, 2000).

This is not to argue against a clinically reasonable development and use of therapeutic procedures, but to remind ourselves of the fact that most often, a gain in external/clinical/ ecological validity means a loss of internal validity. Unfortunately, this dilemma is often personalized: In oral and written discussions, some colleagues take the role of partisans of external, others of internal validity and present arguments why one is more important than the other. By selection of examples and criteria, it is always possible to make a convincing point, and it is good that, for example in

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the activities of NIMH, the RCT initiative is complemented by a wealth of activities directed towards clinical practice and bridging the gap between basic effectiveness research and practice oriented effectiveness research. Process and process-outcome research are, of course, also needed to enhance our understanding of how and why psychotherapy works. In the following lines I will argue in favor of making a step back from commonly accepted but unnecessarily limiting solutions, and make some postulates related to the balance of internal and external validity.

Stepping back from some solutions

As mentioned above, APA prescribes manualisation. This is a self-evident solution for the need to specify the therapeutic procedure. When it is questioned, this happens for reasons of negative side effects, in particular from a clinical perspective. These side effects make developers as well as users depart from a narrow procedure thus jeopardizing the very idea behind the specification. If it is largely unrealistic that the procedure-related conditions of RCTs are met, the question of alternative solutions for the justified goal of specification arises. An obvious alternative is to specify the procedure retrospectively instead of prescriptively. This means: Instead of asking therapists to follow a precise manual and to check adherence, they can be given more heuristic rules, and by means of quantitative and possibly qualitative process research we can study what has actually been done in therapy. To study the actual process in all included therapies in detail is clearly an additional investment in favor of gaining flexibility, because in traditional RCTs adherence checks are typically considered to be sufficient, but one could argue that here too a more extensive description of what actually happens in therapy should take place. If this would be undertaken, the alternative proposed here would not be more costly.

As an example, in their 1990 study Grawe, Caspar and Ambühl prescribed different ways of doing case conceptualizations and of deriving and justifying concrete procedures. What therapists did on the level of concrete interventions was up to them, very much in the sense of Lazarus' multimodal behavior therapy (Arnkoff et al., 2006). They were even allowed to include interventions and ideas from other than cognitive behavioral approaches as long as this was plausibly justified in light of the individual case conceptualization. As the concrete procedure depended on the different ways of doing case conceptualizations (which was the prescribed experimental difference), differences in the procedures employed were expected; these were considered not as a problem, but already as a consequence and intervening variable, and described in the analysis of the data. One knows what the therapists did, but not by prescription, but by description. This opens up possibilities postulated by Arnkoff et al. (2006), which are needed for an approach to effectiveness research in psychotherapy integration with integration taking place on the level of individual patients, and it opens up possibilities for direct experimental research on the effects of using principles (Castonguay & Beutler, 2006) and therapeutic factors instead of following narrowly defined procedures. The requirement of knowing what the procedure is met, but in a different way than is common to RCTs.

As far as patients are concerned, a priori homogenization is also not the only avenue to knowing to what type of patients' results apply. Here too, we can make a step back and think of the goal rather than of the commonly accepted means. There are also alternatives. An obvious one is to include a larger range of less selected patients (those more representative of common practice), describe the sample precisely, followed by analyses of differential effects. This has also been done in the study by Grawe et al. (1990): Only psychotic, substance addicted and acutely suicidal

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patients were excluded. Effects on the whole group could equally be described as findings specific to one group of patients. It must be admitted that, corresponding to the state of the discussion at that time, diagnostic groups had not been sufficiently differentiated, but this could easily be done corresponding to the emphasis given to this criterion today. In principle, one would know what results can be related to which subgroups, the sample being more representative to patients in a natural setting due to the lack of a restrictive selection procedure. The issue here is differential outcome research – not so much as a means for increasing effects, which in general has been a rather disappointing approach so far, but to specify what effects can be expected for which patients according to the postulate of RCTs.

A panacea?

These two examples—methodological alternatives to common procedures—are not offered as panaceas for the problems discussed here. But they are illustrations for opening up the solution space by not confounding goals and means, and considering alternative means with fewer side effects. Even if discussion would reveal that one would trade one side effect for another, the variation would be an advantage when thinking of combining studies for compensation of weaknesses. The crucial point is, that with such procedures the advantage of experimental research in causal argumentation can be maintained, and the type of case conceptualisation or the application of a therapeutic principle or heuristic rule can be introduced as experimental factor.

What is the postulate? A huge problem when it comes to balancing external and internal validity is the lack of elaborate discussion of how to value criteria and advantages in terms of one against the other. This lack is not only regrettable from an academic point of view. It also brings about choices for "the safe side" by researchers as well as reviewers of grant proposals and manuscripts. The safe side is internal validity: Although some criteria of external validity have been discussed more intensely in recent time (such as exclusion of comorbidity and its consequences for representativeness), internal validity is much better specified. Researchers are therefore tempted or feel even pressured to give more attention to it and to make compromises in favor of internal validity in case of doubt. For example. they would prescribe a therapeutic procedure in a more narrow way than they might from a clinical perspective, they are more selective with patients. etc.

Reviewers are not gods with total freedom of choice: Usually they prefer judgments which they can justify as clear applications of consensual standards. As far as internal validity is concerned, standards are much farther developed and –as they correspond to the experimental paradigm valued too highly in psychology and related fields - than for external validity. This is unfortunate for approaches requiring flexibility, such as psychotherapy integration on the level of individual patients. It is also unfortunate for researchers dedicated to it, who then turn away from (funded and well published) mainstream research, with consequences for both careers and those patients who fall between the chairs.

A rationale for balancing external and internal required

The imbalance between the clarity and importance given to criteria of external and internal validity is not the only and maybe not even the main problem: It is rather the lack of rational evaluation and decision processes evaluating and balancing one and the other side. Reviewers are as helpless in this respect as researchers/authors – and of course, they are often the same individuals in different roles. It is obvious that a gain in internal validity if often paid for by a loss of external validity and vice versa. For some problems related to this, creative

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solutions may be possible as illustrated by the "stepping back" and considering alternative solutions. It is for sure that this will not solve all problems. But how much loss of internal validity and what kind of loss can be tolerated in favor of a gain in external validity, and vide versa? What are rationales for an optimal balance when even much creativity does not lead to a truly satisfactory extent of both while crucial clinical questions wait to be answered?

Unfortunately, the author is, after extensive discussions (among others in the context of the German Research funding agency DFG; Caspar, 2006) not able to provide answers. This is clearly a domain waiting for an engagement of the most knowledgeable and bright spirits in the domain – and although it might seem paradoxical that practitioners should rank methodological questions very high: They should pull for it primarily.

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THE AMAZING ALBERT ELLIS (1913-2007)

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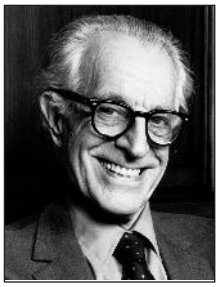

How very fortunate for the field of psychology that Albert Ellis struck out in his first two career goals: writing Broadway musicals and the Great American Novel. Instead, he went on to a brilliant career that spanned over 50 years and helped change the face of psychotherapy.

Early Years

Born in Pittsburgh, Ellis grew up in the Bronx, the oldest of three children and grandchild of Jewish émigrés from Russia and Germany. He had what could certainly be viewed as a rather difficult childhood: his parents divorced when he was 12, his traveling salesman father was rarely around and his mother, whom he often described as a "fun-loving screwball," spent much of her time playing mahjong with friends and little on the care of her children. During his approximately six hospitalizations between the age of 5 and 8 (for nephritis or streptococcal infections)—at some distance from his home—his parents rarely visited him.

Ellis made the most of this family situation, he claimed, by not taking his parent's behavior too seriously and by becoming, in his words, "a stubborn and pronounced problem-solver." His mother's "negligence" provided him with the freedom to pursue his reading, writing, and music, even though he also took on some of the household responsibilities, including helping to get his younger siblings off to school in the morning. As a teen, he held lively discussions with fascinated friends about the philosophers he had been reading in his favorite hangout, the Bronx Botanical Gardens; and it was there that he conducted his first experiment in desensitization, approaching 100 girls and being rejected by all but one (who failed to show up at their date!).

It was in the 1930's—the height of the Great Depression and with his now-divorced father unable to provide much financial support— that Ellis, concluding that it seemed unlikely that he was going to be able to support himself and his family through writing, enrolled in the City University of New York, where he earned his B.A. in business in 1934. He then started a business with his brother, matching pants to financially-strapped men's still usable jackets, and following that, became office manager at a novelty firm.

Around this time, Ellis began to read everything he could find about sex and relationships (and also did "fieldwork," having overcoming his shyness with women!). He became so knowledgeable in this area that his friends, who began to consider him somewhat of an expert on the subject, often asked him for advice. After a while, he concluded that disturbed relationships were really a product of disturbed *persons*, "and that if people were truly to be helped to live happily with each other, they first had better be shown how they could live peacefully with themselves." Discovering that he liked counseling as well as writing, but with no formal training available in marriage and sex counseling, he turned to clinical psychology, and in 1947 he completed his Ph.D. at Columbia University.

From Psychoanalysis to REBT

Believing at that time that psychoanalysis was the only truly "deep" and effective approach to understanding human behav-

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ior, Ellis decided to undertake a training analysis. At a time that psychoanalytic institutes would only accept MDs, but he was finally able to find an analyst who was willing to work with him: Richard Hulbeck, a member of the Karen Horney group. After completing his analysis at age 35, he began a part-time practice of psychoanalysis under Hulbeck's supervision, and soon thereafter, in the late 1940's, he became Chief Psychologist of the New Jersey Department of Institutions and Agencies.

During the six or so years that he practiced psychoanalysis, Ellis became increasingly dissatisfied with what he considered to be the inefficiency of psychoanalysis and by 1953 had begun to take a more active role, as he had when counseling people on family or sex problems. Impressed with how the work of philosophers such as Epictetus, Spinoza, Schopenauer and Bertrand Russell had helped him work through many of his *own* problems, he began to teach some of these principles to his therapy clients. At the heart of his emerging approach was the idea, as Epictetus had expressed it, that "people are not disturbed by things, but by the views they take of them." More and more he began to focus on helping people change the self-defeating beliefs, learned in childhood but carried into the present, which kept them stuck in their own emotional morass. He lost faith in the idea that parents are responsible for just about everything that comes later, and that analysis could provided them with some magic-bullet insights that could free them from their disturbance. "My experience when I practiced psychoanalysis," he wrote, "usually showed me…the more I helped clients focus on and understand the past, the *less* they usually thought rationally about and allowed themselves enjoyable experiences in the present and future."

Between his break with psychoanalysis in 1953 and in his first presentation of "rational therapy" at the annual A.P.A. convention in 1956, Ellis set forth the core principles of his new approach (now known as rational emotive behavior therapy (REBT), which more accurately reflects its focus not only on cognition, but on emotions and behavior). His earliest papers on his approach appeared in the *Journal of Clinical Psychology* in 1955 and 1957, and his first book on REBT for professionals, *Reason and Emotion in Psychotherapy*, was published in 1962.

In addition to the philosophers he had read in his teens—Epictetus, Marcus Aurelius, Spinoza, and Schopenauer—Ellis was also influenced by Alfred Adler's concept of the "inferiority complex" and Karen Horney's "tyranny of the shoulds." He embraced the flexibility and anti-dogmatism of the scientific method, contending that rigid absolutism was the core of human disturbance. The behavioral component of his approach—still a major emphasis—was drawn from such early pioneers in behavior therapy as J.B. Watson and Mary Cover Jones, whose techniques he had successfully applied to his own public speaking anxiety.

The Growth and Development of REBT

Ellis passionately loved his work. A devout humanist, he believed that he could help people to lead happier and healthier lives by making it his life's mission to develop and teach the approach he believed could most help them. He viewed REBT not only as a clinical approach, but a realistic philosophy of life. In this regard, he was influenced by existentialists Tillich and Heidegger, who put the responsibility for one's feelings squarely on the shoulders of the individual's beliefs and by the writings of general semanticist Alfred Korzybski, who emphasized the powerful effect of language on our emotional processes.

A cornerstone of Ellis's philosophy was that by helping people to identify and challenge their irrational beliefs, they could develop the power to relieve their emotional pain. In his writings, therapy, and presentations, he urged people to deal with

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reality in a rational way and to create a better life for themselves—as long as they did not needlessly hurt themselves or others in the process. He defined *irrationality* as "that which prevents people from achieving their basic goals and purposes." Although some critics wrongly inferred that becoming more "rational" might result in emotional constriction, Ellis's goal was to help people to change their *dysfunctional* emotions (such as rage, anxiety, and depression) to the less disturbing feelings (such as annoyance, disappointment, apprehension, or concern). Through this process, they would then be able to free up their emotional energy for achieving higher levels of life enjoyment and fulfillment.

Ellis especially challenged people to give up the three internalized demands that he saw as the root of emotional disturbance: 1) "I *must* be perfect and successful at all times, or else I'm a worthless failure (an attitude that leads to depression and self-downing); 2) "Significant people in my life *must* love and approve of me at all times and treat me well, and if not, they should be made to suffer" (beliefs leading to anger, rage, or even genocide;" and 3) "the world *must* always be comfortable and provide me with exactly what I want" (leading to depression, a low tolerance for life's inevitable frustrations, inertia, and self-pity). He felt strongly that self-evaluation (including "self-*esteem")* was one of the main sources of disturbance, and was skeptical about the existence of a "true" or "real" self that Rogers and others expounded. Rather than facilitating change, he saw self-evaluation as leading to depression and anxiety, as opposed to evaluating one's *behavior*, which was more likely to make people do better as well as feel better.

Following their disputation of their self-defeating beliefs, Ellis also strongly encouraged people to take positive *action* to achieve their goals and made individualized "homework" assignments a prominent feature of his therapy. He increasingly believed that there was also a strong biological component in people disturbance: that "practically all individuals have strong *innate* as well as learned tendencies to act like babies all their lives." Notwithstanding, people could overcome these tendencies, Ellis asserted, through hard, persistent work on their self-defeating belief systems.

Although the initial reception by some therapists, both to his therapy system and his colorful style, was not always enthusiastic, Ellis persevered. In the next 50 years his approach—considered the first expression of CBT—would become the zeitgeist of psychology, with more than two-thirds of psychologists in a 2007 NIMH-sponsored study identifying themselves as using some form of cognitive behavior therapy. In a 1982 survey of American and Canadian psychologists, Albert Ellis was rated the second most influential person in psychology—ahead of Sigmund Freud and topped only by Carl Rogers. Over the years, as he persisted in "spreading the gospel according to St. Albert" around the world, he was given numerous awards, including Humanist of the Year from the American Humanist Organization and awards for outstanding professional contributions from APA, the American Counseling Association, ABCT, the Society for the Scientific Study of Sex, and other organizations. He was even mentioned in an off-Broadway play that was based on the writings of Dalton Trumbo, who referred to Ellis as "the greatest humanitarian since Gandhi."

REBT's Wide Range of Applications

Albert Ellis was one of the earliest exponents of prevention and positive mental health. Facilitated by a foundation grant to his Institute, the Living School was founded in 1970 and housed in the Institute building for five years. In addition to the usual academics, students ages 8-13 were taught self- and other-acceptance and how to manage anxiety, anger, and frustration, and curricula based on this early work

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have been expanded and used worldwide. His approach has also had a major impact on the field of addictions. S.M.A.R.T. Recovery—an alternative to Alcoholics Anonymous based on REBT principles—was started in the 1980's and groups continue to proliferate. In S.M.A.R.T. meetings, substance-abusing individuals are provided with techniques and support for countering the kinds of thoughts that trigger urges and relapses.

One of the first to write self-help books, many of which (such as his *Guide to Rational Living)* have remained in print for decades, Ellis' writings included books both for professionals and the public on REBT's wide range of applications, including anxiety, depression and anger, workplace issues, overcoming procrastination and addictions, counseling religious clients, aging and tolerance. He also spoke about current world problems such as terrorism and nuclear weapons. To Ellis, REBT was not just a clinical approach, but a realistic philosophy of life focusing on long-range (rather than short-range) hedonism and an unconditional acceptance of self and others and high frustration tolerance for a difficult and often unfair world.

Although the theory and practice of REBT were laid out in his 1963 work, *Reason and Emotion in Psychotherapy,* Ellis continued to expand his work, writing several seminal papers over the next 40 years. These included an expansion of his personality theory (in Corsini's 1978 book *Readings in Current Personality Theory)*; emphasis on regularly doing forceful and energetic disputing in order to create meaningful, long-last change; REBT as a constructivist rather than a rationalist approach; and dealing with resistance. One of his greatest contributions was his focus on what he called *discomfort anxiety*," low frustration tolerance (*LFT*) or *I-can't-stand-it-itis*, which he believed was a primary factor in such problems as anger, addictions, procrastination, self-pity and relationship difficulties.

The Albert Ellis Institute

The not-for-profit Institute that Albert Ellis founded in 1959 moved to its present headquarters in New York City in 1965, and in 1968 was granted a charter as the Institute for Rational-Emotive Therapy by the N.Y. State Board of Regents to provide professional training, low-cost clinical services, and public education. It was one of the first psychologist-run facilities, since up to that time the N.Y. State Department of Mental Hygiene had restricted the management of mental health clinics to physicians. Under Ellis's and my helm, and with the aid of many outstanding trainers, the Albert Ellis Institute (as it was renamed in the '90s) grew from a staff of four to a world-renowned training center with affiliates around the world.

A main source of funding for the Institute's building and operations was the income from all of Ellis's books, therapy clients, lectures and workshops, all of which he donated to the Institute. He lived simply and for most of his years at the Institute, received a salary of $12,000—less than that of many parish priests.

Sexual Revolutionary and Feminist

Long before he published *Reason and Emotion in Psychotherapy* in 1962, Ellis had written several books on sex and relationships including *The Folklore of Sex* (1951), *The American Sexual Tragedy* (1954), and *Sex without Guilt* (1958)—the first widely-read books to challenge the longstanding emphasis on romance and sexual piety. In 1957 he helped found the interdisciplinary Society for the Scientific Study of Sex, later receiving its award for Distinguished Scientific Achievement. On radio and TV and in his lectures, he was almost a lone voice for sexual liberation, making a case for sex education in the schools, guilt-free masturbation, and the non-pathologizing of homosexuality.

In 1953, Ellis wrote an article on "The Myth

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of the Vaginal Orgasm," pointing out that while Freud, most men (and even many women) believed that not having an orgasm coitally was a sign of frigidity, the clitoris was where it was at for most women. He believed that this view of the primacy of the so-called "vaginal orgasm" had prevailed for so long—even after Kinsey's research was published—because men, who found intercourse to be a marvelous and reliable route to orgasm, did not want to face up to the "inconvenience" of having to do (at times lengthy) clitoral stimulation.

In *The Intelligent Woman's Guide to Manhuntin* (1963), Ellis demonstrated his commitment to feminism, encouraging women to strongly challenge their belief that their entire worth and happiness rested on having a perfect face and body and being married. He encouraged women to seek fulfillment not only in sex-love relationships, but in other areas, such as developing their careers and other vital absorbing interests. He exhorted women not to be swayed by a man who, however attractive he might appear, was a male supremacist: "Poison is his name," he wrote, and "Mrs. Dead Duck is yours if you are crazy enough to marry him!"

My own relationship with Albert Ellis demonstrates that he not only preached, but also practiced feminism. Not content to have me simply take over the administration of the newly-expanding Institute in 1965 (freeing him from the everyday tasks of managing an organization), he encouraged me to get my doctorate in clinical psychology at New York University in order to become his full professional partner, leading to a fulfilling career in which I have written and lectured worldwide on the application of REBT to women's and couples' problems. When we parted as friends in 2002, he reiterated his respect and gratitude for my important contributions to the growth of the Institute and REBT.

A Bundle of Energy with a Gene for Efficiency

Ellis's energy was boundless. He whizzed around the Institute, airports, and over a hundred lecture venues a year with such speed that he left those in his wake dazed. In a typical day during the majority of his career, he saw individual and group clients from 9:30 a.m. to 10:30 pm (approximately 140 clients a week). He conducted over 80 lectures and workshops a year and published or edited over 70 books and hundreds of articles and tapes. There is, undoubtedly, no therapist in history who has seen more clients or given more therapy demonstrations! Not infrequently, Ellis would return from a lecture tour at midnight, see a full day of clients the next day, then catch a flight that evening for someplace halfway around the world to conduct several more workshops. In the 4-day REBT certificate practica that the Institute sponsored in the U.S. and abroad, both the attendees and the trainers were pooped by the time they finished supervision at 5:30 pm: not so Ellis, who, well into his 80s, resumed from 7-10:00 p.m. to conduct a lively group therapy demonstration or give a talk on addictions. Even more remarkable was the fact that despite his jam-packed schedule, he managed to answer most of his voluminous correspondence within two days and rarely (if ever) turned in a manuscript after its due date!

Anecdotes abound of Ellis's unceasing work and disdain for leisure activities. He claimed he wouldn't visit the Taj Mahal unless he was invited to do a workshop there. In the late '60s, he took an actual "vacation" to Jamaica, mainly to please me. Once there, he came out once to the terrace, took one look at the sea, and went back inside to work on his latest book. On another occasion, when co-opted into visiting a casino (he had never been in one), he took the 50 dollars his host had given his guests to gamble with and donated it to the Institute, retreating to a corner to catch up on his journals until he was able to escape.

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Even after his hospitalization for an intestinal infection and pneumonia most of his last 1 ½ years of life (and a major hearing loss that required people to speak into a microphone connected to his earphones), Ellis continued to meet with groups of students at his bedside, refusing to cancel even when feeling under the weather. At age 91 when, in his words, he was "forced by the Board of Trustees and senior staff of the Institute to stop doing my Friday night workshop and any other work teaching or seeing clients for the Institute," he rented a hall next door and continued—before packed groups—to conducting the enormously popular Friday night workshop/demonstrations that he had been doing for nearly four decades. He calmly took successful legal action two years ago against the Institute for what the judge referred to as his "disingenuous" removal from the Board; another major lawsuit is still in process.

His rift with the Institute marked the beginning of a period of over a year and a half during which Ellis bounced back and forth between the hospital and rehab for all but the last three or so weeks of his life, when he returned to his Institute apartment. Instrumental in maintaining the round-the-clock care that extended his life was Debbie Joffe, an Australian hired as his assistance in 2002 and whom he subsequently married.

Will the Real Albert Ellis Please Stand Up?

On the personal side, Ellis was a bundle of seeming paradoxes. His colorful language, one-line zingers, his colorful and attention-grabbing style of presentation, and his munching sandwiches on the platform gave many the impression of someone going out of his way to be outrageous. In actuality, Ellis believed that his provocative language made his presentations and therapy more impactful and that far more people found it helpful than were turned off by it. His hilarious sense of humor and playfulness always left audiences howling with delight (as well as insight), and me convulsed in giggles when, over dinner, he made faces, quipped, and sang silly songs. His wit and humor were hilarious and unparalleled. In impugning the idea of an "inner child," for example, Ellis declared that "the only way to have an inner child is if you're pregnant,"and he coined such catchy phrases as "Blood is sicker than water" and "Shouldhood leads to s__hood." Strongly believing that emotional disturbance usually involved taking things too seriously, Ellis returned to his love of Broadway musicals and wrote over 100 songs to popular old tunes, including "Whine, Whine, Whine," I Am Just a F__cking Baby," and "Glory, Glory Hallelujah, People Love 'Ya Till They Screw 'Ya". Many of the terms he originated have now become part of the psychotherapy lexicon, including *awfulizing, shoulding, catastrophizing, LFT,* and *musturbation.*

As for the public sandwich-eating: Ellis was an insulin-dependent diabetic who intended to live as long and healthfully as possible. Without ever complaining, he injected himself twice a day, checked his blood sugar regularly, and made six or more sandwiches a day for 55 years so that he could maintain proper blood levels without having to interrupt his work for meals. He became a powerful role model and inspiration for hundreds of people in dealing with the frustrations of illness or impairment through conscientious health management and refusal to engage in awfulizing or self-pity.

Behind Ellis' at times somewhat prickly public persona was a person of tremendous supportiveness and compassion—a "closet *mensch*," as I referred to him at his 90th birthday party. He never refused colleagues' requests to help them sort out a crisis in their lives, and when a friend of mine needed care after his hospitalization with AIDS, Albert immediately agreed to having him stay in our apartment for as long as necessary. He mentored hundreds

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of students and professionals over the years, writing detailed critiques of manuscripts or therapy tapes and helping them in any way he could to further their careers.

At the Institute's dozens of training practica, many therapists who had cowered in fear in anticipation of Ellis' comments on their taped sessions reported that not only did he give them incredibly helpful feedback, but was also one of the most supportive and encouraging supervisors they had ever had. Although some people erroneously contend that REBT practitioners are supposed to be Ellis sound-alikes (complete with four-letter words), supervisees were encouraged to develop their own unique style. In his Friday night workshops as well as in his therapy sessions, contrary to "yelling at people," as some critics claimed, Ellis incisively helped members of the public to attack their irrational beliefs, but never attached the *person* with whom he was working. Despite his having been at times strongly attacked for his ideas and presentation style (and had his ideas frequently used, without attribution, by other self-help writers), he never engaged in self-pity or anger.

Although the world will be a lot less colorful now that this remarkable man has left us, it is undoubtedly a better place as a result of his many contributions to helping people lead happier and more fulfilled lives. He used to say to me, when he came up to our apartment, "heighty-ho," and when he went to bed, "nighty-night." So…heighty-ho, Albert, and nighty-night.

Janet L. Wolfe, Ph.D. lived with Albert Ellis from 1965 to 2002, and for 36 years served as the director of the Albert Ellis Institute. She has authored numerous chapters, articles, and books and lectures worldwide on REBT. She is currently in private practice and an Adjunct Professor at New York University.

Addendum

In reference to the article, "A Q-sort Model for the Empirical Investigation of Psychotherapy Integration" by Deborah A. Gillman and Paul L. Wachtel, published in the summer 2007 issue of the *Psychotherapy Bulletin,* please note that this research was conducted with the support of a grant from The Fund for Psychoanalytic Research of the American Psychoanalytic Association.

REPORT OF APA COUNCIL OF REPRESENTATIVES: AUGUST 2007

Norine G. Johnson, Ph.D. and John C. Norcross, Ph.D.

The APA Council of Representatives met on two days surrounding the annual APA convention in San Francisco. Following are several of the more important matters of interest to the Division of Psychotherapy membership.

Psychologist participation at US Detention Centers was the agenda item of major concern. Intense effects to find common ground were conducted for three days, culminating in a Council vote on Sunday with by-standers on the side and back cheering and booing the discussion. The national press was also present as select Council members worked extremely hard and, for the most part, collegially on a resolution that reflected outrage over acts of torture and other cruel, inhuman, or degrading treatment. The final resolution passed by a significant majority and can be viewed on APA's web page (www.apa.org). We strongly encourage you to read the entire resolution and not just base your judgment on what you might hear or read in newspapers or on listservs.

The final language is strong and unequivocal: psychologists do not participate, condone, or consult in torture and other cruel, inhuman or degrading treatment or punishment. The disagreement was whether or not APA should specify sites, such as detention centers where torture is used, as places of employment where psychologists should not work. The counter-argument was made that the presence of psychologists saves lives and improves the health of detainees. The issue is extremely complex and clearly will continue to be debated.

The Council of Representatives voted to send out to the membership for approval **an APA Bylaw change to increase the size of the Council of Representatives** to include representation of the Asian American Psychological Association, the Association of Black Psychologists, the National Latina/o Psychological Association, and the Society of Indian Psychologists. All the Associations but the ABP were present at Council and were pleased at the passage of this important expansion of governance. ABP declines the invitation at the current time.

A new Council item was passed in reaction to the forced resignations of Israeli scholars from the editorial boards of British scholarly publications to strengthen APA's position against anti-Semitism. The item condemns academic boycotts as a violation of academic freedom and a disruption of the exchange of scientific and scholarly ideas.

The item proposed by your Division 29 Representatives and supported strongly by the Division 29 Board passed to strongly encourage the use of the terms "psychology," "psychological" and "psychologists" when referring specifically to the activities of psychologists.

Council passed a resolution to **Enhance Ethnic Minority Recruitment, Retention, and Training in Psychology** by continuing the work of the CEMRRAT2 Task Force. Council also passed an increase in reimbursement for ethnic minority members of Council.

During his **CEO report, Dr. Norman Anderson**, reported his major concern about the possibility of a large deficit budget. He is also developing an APA strategic plan to begin in 2008. A Chief Diversity Officer for APA will be hired in 2008 to

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oversee the implementation of APA's prioritizing of diversity.

Significant changes in Central Office staff were announced. Russ Newman, executive director of of Practice will be leaving January 1, 2008, Jack McKay, executive director of Finance, announced his resignation, and Attorney Jim Mc Hugh also is leaving after many years leading APA's Legal Affairs.

The biggest new financial item was the approval of $7,600,000 to fund the Web Relaunch Project to make APA's site more user-friendly and relevant for our members and the public. It is believed that this expenditure is necessary to support our current activities, enhance the availability of psychological information to the public and our members, and to do the Association business in a more effective and efficient manner.

On line voting for APA elections was approved.

A revision of the Recommended Postdoctoral Education and Training Program in Psychopharmacology for Prescriptive Authority was passed in principle to amend the 1996 document. The document is posted on APA's web page where you may see the details. The document recognizes the multitude of changes that have occurred in the education and training of prescribing psychologists in the past 10 years. There was significant support for the changes recommended. The primary differences were focused on the amount of doctoral course work that may be credited toward the granting of a postdoctoral degree in psychopharmacology.

APA's Attorney Natalie Gilfoyle reported on current litigation in which APA has been engaged. One APA amicus brief spoke to the lack of scientific evidence to predict future dangerousness in certain settings such as a secure correctional facility. I recommend you go on line and read her report, which includes Justice Stevens' opinion, "Expert testimony about a defendant's 'future dangerousness' to determine his eligibility for the death penalty, even if wrong 'most of the time' is routinely admitted." Another filing of our attorneys was to the Meredith v. Jefferson County Board of Education and Parents v. Seattle School District – U.S. Supreme Court that significantly impacts desecration efforts.

Corann Okorodudu received a Presidential Citation for her important work with the United Nations, and Florence Denmark was presented the Raymond Fowler Award for lifetime contributions to the American Psychological Association.

Finally, on a personal note, this Council meeting marked the end of our three-year terms representing the Division of Psychotherapy. John Norcross completed his second term and is rotating off Council. He will be replaced by Linda F. Campbell, who will join Norine Johnson, who was elected to a second term on Council. The three of us collectively thank you for the support and, as always, welcome your input on the directions of the APA Council of Representatives.

CALL FOR AWARD NOMINATIONS

The APA Division of Psychotherapy invites nominations for its 2008 *Distinguished Psychologist Award,* which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 2008 Awards Chair:

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

The applicant's CV would also be helpful. Self-nominations are welcomed.
Deadline is January 1, 2008

CALL FOR NOMINATIONS

APF Division 29 Early Career Award

The American Psychological Foundation (APF) is a nonprofit, philanthropic organization that advances the science and practice of psychology as a means of understanding behavior and promoting health, education, and human welfare.

Background: The Division of Psychotherapy fosters collegial relations between psychologists interested in psychotherapy, stimulates the exchange of information about psychotherapy, encourages the evaluation and development of the practice of psychotherapy, and educates the public regarding the service of psychotherapists. *The APF Division 29 Early Career Award* recognizes promising contributions to psychotherapy, psychology, and the Division of Psychotherapy by a Division 29 member with 10 or fewer years of post-doctoral experience.

Eligibility Criteria:
Applicants must be:

- Members of Division 29,
- Be within 10 years of receiving his or her doctorate, and
- Demonstrate promising professional achievement related to psychotherapy theory, practice, research, or training

Application Materials:
The following are the required application materials:

- A nomination letter written by a colleague outlining the nominee's career contributions (no self-nominations are allowed)
- A current vita
- Up to four (4) supporting letters of recommendation

Application Procedures:
Application materials must be submitted online at http://forms.apa.org/apf/grants/

Deadline: January 1, 2008

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CALL FOR NOMINATIONS

Editor of *Psychotherapy Bulletin*

The Publication Board of the APA Division of Psychotherapy is seeking applications for the position of Editor of the *Psychotherapy Bulletin*. Candidates should be available to assume the title of Incoming Editor on or before March 1, 2008 for a three-year term. During the first year of the term, the incoming editor will work with the incumbent editor.

The *Psychotherapy Bulletin* is an official publication of the Division of Psychotherapy. It serves as the primary communication with Division 29 members and publishes archival material and official notices from the Division of Psychotherapy. The *Bulletin* also serves as an outlet for timely information and discussions on theory, practice, training, and research in psychotherapy. Now in its 42nd year of publication, the *Bulletin* reaches more than 4,000 psychologists and students with each issue.

Prerequisites:

- Be a member or fellow of the APA Division of Psychotherapy
- An earned doctoral degree in psychology
- Support the mission of the APA Division of Psychotherapy

Responsibilities:

The editor of the *Psychotherapy Bulletin* is responsible for its content and production. The editor maintains regular communication with the Division's Central Office, Board of Directors, and contributing editors. The editor is responsible for managing the page ceiling and for providing reports to the Publication Board as requested. The editor must be a conscientious manager, determine budgets, and administer funds for his or her office. As an *ex officio* member of the Publication Board, the editor attends the scheduled meetings and conference calls of the Division's Publications Board. An editorial term is three years.

Oversight:

The Editor of the *Psychotherapy Bulletin* reports to the Division of Psychotherapy's Board of Directors through the Publication Board.

Search Committee:

Raymond DiGiuseppe, PhD, (Chair Publications Board), Beverly Greene, and George Stricker, PhD.

Nominations:

To be considered for the position, please send a letter of interest and a copy of your curriculum vitae no later than Dec. 1, 2007 to: Ray DiGiuseppe, Ph.D. Publication Board, Department of Psychology, St. John's University, 8000 Utopia, Parkway, Jamaica, NY11439, or electronically at digiuser@stjohns.edu. Inquiries about the position should be addressed to Dr. Ray DiGiuseppe (718-990-1955; digiuser@stjohns.edu.) and/or to the incumbent editor, Dr. Craig Shealy (540-568-6835; shealycn@jmu.edu).

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CALL FOR FELLOWSHIP APPLICATIONS DIVISION 29—PSYCHOTHERAPY

Jeffrey J. Magnavita, Ph.D., Chair, Fellows Committee

The Division of Psychotherapy is now accepting applications from those who would like to nominate themselves or recommend a deserving colleague for Fellow status with the Division of Psychotherapy. Fellow status in APA is awarded to psychologists in recognition of outstanding contributions to psychology. Division 29 is eager to honor those members of our division who have distinguished themselves by exceptional contributions to psychotherapy in a variety of ways such as researcher, clinician, teacher, etc.

The minimum standards for Fellowship under APA Bylaws are:

- The receipt of a doctoral degree based in part upon a psychological dissertation, or from a program primarily psychological in nature;
- Prior membership as an APA Member for at least one year and a Member of the division through which the nomination is made;
- Active engagement at the time of nomination in the advancement of psychology in any of its aspects;
- Five years of acceptable professional experience subsequent to the granting of the doctoral degree;
- Evidence of unusual and outstanding contribution or performance in the field of psychology; and
- Nomination by one of the divisions which member status is held.

There are two paths to fellowship. For those who are not currently Fellow of APA, you must apply for Initial Fellowship through the Division, which then sends applications for approval to the APA Membership Committee and the APA Council of Representatives. The following are the requirements for initial fellow applicants:

- Completion of the Uniform Fellow Blank;
- A detailed curriculum vitae (please submit 3 copies);
- A self- nominating letter (self-nominating letter should also be sent to endorsers);
- Three (or more) letters of endorsement of your work by APA Fellows, at least two of whom must be Division 29 Fellows who can attest to the fact that your "recognition" has been beyond the local level of psychology.
- A cover letter, together with you c.v. and self-nominating letter, to each endorser.

Those members who have already attained Fellow status through another division may pursue a direct application for Division 29 Fellow by sending a curriculum vita and a letter to the Division 29 Fellows Committee, indicating in your letter how you meet the Division 29 criteria.

Initial Fellow Applications can be attained from the central office or online at APA:

Tracey Martin
Division of Psychotherapy
6557 E. Riverdale St.
Mesa, AZ 85215
Phone: 602-363-9211
Fax: 480 854-8966
Email: assnmgmt@aol.com

DEADLINE FOR SUBMISSION. The deadline for submission to be considered for 2008 is **December 15, 2007**. The initial nominee must complete a *Uniform Fellow Application*, self-nominating letter, three or more letters of endorsement, updated CV, along with a cover letter, and three copies of all the original materials. Incomplete submission packets after the deadline will

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not be considered for this year. Those who are current Fellows of APA who want to become a Fellow of Division 29 need to send a letter attesting to your qualifications and a current CV. The nomination process is ongoing but don't delay to be considered for 2008.

Completed Applications should be forwarded to:

Jeffrey J. Magnavita, Division 29 Chair,
Fellows Committee
Glastonbury Medical Arts Center
300 Hebron Ave. Suite 215
Glastonbury, CT 06033
Email: MagnaPsych@aol.com
Phone: 860-659-1202

Please feel free to contact me or other Fellows of Division 29 if you think you might qualify and you are interested in discussing your qualifications or the Fellow process. Also, Fellows of our Division who want to recommend a deserving colleague should contact me with their name.

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CALL FOR NOMINATIONS

Internet Editor

The Publications Board is seeking applications for the position of Internet Editor for the APA Division of Psychotherapy. The Internet Editor manages the electronic resources and communications of the Division of Psychotherapy, principally its homepage and listserv. Candidates should be available to assume the title of Internet Editor on January 1, 2008.

Prerequisites:

- Be a member or fellow of the APA Division of Psychotherapy
- An earned doctoral degree in psychology
- Support the mission of the APA Division of Psychotherapy

Qualifications:
The applicant should have experience with the creation and management of Internet resources and electronic publications. The applicant should be familiar with current developments in the application of computer technology to the field of mental health as well as a broad background in psychotherapy and editing skills.

Responsibilities:
The Internet Editor is responsible for *content and production* of the Division's web site and management of the member listserv. The editor regularly updates information on the website, including information about meetings, changes in governance, new publications, and links to relevant websites. The editor reviews all posts to the listserv, adds new members as required, and responds to requests for assistance. The editor is familiar with APA policies on the use of internet resources and ensures division compliance. The editor maintains regular communication with Division committees, the Division's Central Office, Board of Directors, and Publications Board. As an ex officio member of both the Publication Board, the internet editor attends the governance meetings of the Division of Psychotherapy.

Time Commitment:
Editing the website and managing the listserv requires several hours each month. The home page should be updated on a monthly basis. An editorial term is three years (2008-2011).

Oversight:
The Internet Editor reports to the Division of Psychotherapy's Board of Directors through the Publication Board.

Search Committee:
Jean Carter, PhD (President), Jeffrey Barnett, PhD (President Elect), Raymond DiGiuseppe, PhD (chair of the Publication Board), and George Stricker, PhD, Bryan Kim, Ph.D (current editor).

Nominations:
To be considered for the position, please send a letter of interest and vision for the web and a copy of your curriculum vitae no later than November 1, 2007 to Raymond DiGiuseppe, PhD at digiuser@stjohns.edu. Inquiries about the position should also be addressed to the incumbent editor, Dr. Bryan Kim (bryankim@hawaii.edu).

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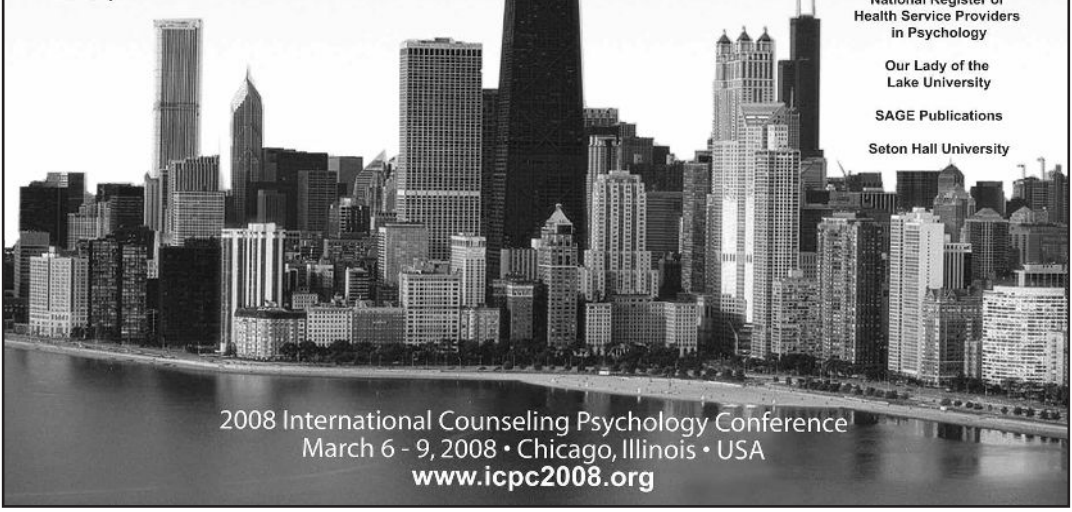

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