Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

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2008 VOLUME 43 NO. 1

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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 Jenny Cornish, PhD, 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 jcornish@du.edu with the subject header line Psychotherapy Bulletin; please ensure that articles conform to APA style. Deadlines for submission are as follows: February 1 (#1); May 1 (#2); July 1 (#3); November 1 (#4). 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

Jeffrey E. Barnett, Psy.D., ABPP

Embracing the Future: Challenges of a New Era for Psychotherapy

I invite you to join me embracing the future of psychotherapy and honoring our past during this 40th year anniversary of the Division of Psychotherapy. It is with great pride and appreciation that I assume my role as President of our Division. I am eager to work with all members of our division and send an open invitation to anyone passionate about psychotherapy looking for a welcoming home to join our division and "be connected." Our elected officials, committee members, and members all share a strong commitment to advancing the science, theory, education, and training of psychotherapy. Regardless of one's role as a researcher, educator, theoretician, practitioner, or some combination of these, we share a common belief in the now well established scientific basis for the efficacy of psychotherapy, as well as sharing the objectives of advancing psychotherapy as a profession, a science, and one of the oldest healing arts. Even though there are inherent and necessary tensions among differing professional roles, we are all part of a professional family inspired by this exciting, vibrant, and rapidly evolving field. Although the challenges are many, the opportunity is greater and I am confident that embracing our future and honoring our past will enable us to make great progress in resolving some of the essential problems of our time, especially in the continued development of methods for ameliorating human suffering.

There are powerful forces that present great challenges to the preservation and advancement of psychotherapy. Many of us have struggled with the convergent forces engendered by managed care and societal obstacles limiting access to quality mental health care for those who suffer from emotional distress and mental illness. We have survived an unprecedented historical period where the value of psychotherapy was denigrated and psychotherapists were viewed as mere technicians who should robotically apply manualized treatment "interventions" with a predetermined number of sessions, and only for some disorders: some forms of suffering, such as personality disorders not being covered. Another disturbing trend has been in the overemphasis of the biological basis of mental disorders which often leads to unqualified disregard for the scientifically validated effect of psychotherapy, which interestingly has demonstrated similar effects on brain structure as medications for certain disorders. In part this trend to dismiss and marginalize psychotherapy has been an artifact by what many consider to be financially driven motives of the pharmaceutical industry. Aggressive marketing of pharmaceuticals directly to consumers and a more general trend toward the alleged promise of a quick fix without any effort or work (McWilliams, 2005) have compounded these challenges.

Despite these powerful forces we confront and the challenges they bring, psychotherapy continues to evolve, adapt, and thrive, as evident by accumulating scientific findings from psychotherapy outcome studies and neuroscience. Bruce Wampold, last year's winner of the APA Award for Distinguished Professional Contributions to Applied Research, recently published his invited article in *American Psychologist* (Wampold, 2007) integrating and synthesizing many important findings from the accumulating evidence and shedding light on critical factors. Dr. Wampold, an

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esteemed member of our division, remarks that one can't help but be filled with optimism and pride as a psychotherapist, regardless of one's role or professional identity. His incisive review of the relevant research clearly demonstrates the effectiveness of psychotherapy for a wide range of emotional and relational difficulties many experience. The centrality of the relationship in psychotherapy is supported beyond a doubt from the available research illustrating both the art and science of psychotherapy. The quality of the therapeutic alliance between psychotherapist and client clearly maximizes treatment outcome, even when manualized treatment is offered. Highlighted in his article is his finding that "it is the therapist and not the treatment per se that is responsible for therapeutic change" (p. 868). In closing, Wampold makes the plea "for science to be applied to the humanistic aspects of psychotherapy to better understand the intricate nature of a remarkably effective healing practice" (p. 869).

Our Division is represented in its membership by some of the finest researchers, educators, theoreticians, and clinicians, who are connected by our belief in, and devotion to, this vital healing practice of psychotherapy. Division 29 provides a beacon in maintaining our focus on alleviating human suffering using the power of human connection. We encourage and support needed research, with our flagship journal Psychotherapy: Theory, Research, Practice, Training, under the expert editorial hand of Dr. Charles Gelso who has greatly advanced this important voice for relevant research to better understand and ground our work in scholarly activities The Psychotherapy Bulletin, edited by Drs. Craig Shealy and Harriet Cobb, strives to impart timely information about the work of the division and information relevant to advancing psychotherapy with our valued members. We are regularly updated with communication on our website at http://www.divisionofpsychotherapy.org and our online newsletter Psychotherapy E-News, both edited by Dr. Bryan Kim, and our e-mail list to share valuable information with you in a timely manner. In Psychotherapy E-News, one of our new features is the "News You Can Use" section. In it, colleagues distill important research findings and share their important lessons so that clinicians may integrate them into their practices now. This initiative was developed to better link research and practice for our members and to help further the advancement of psychotherapy. Past issues are archived on our website and are available there for your review and use. If you would like to submit a contribution for "News You Can Use" please contact me and let me know. I am actively seeking additional contributions.

The Board of Directors of the Division of Psychotherapy and its Committee Chairs and Committee Members each are working to advance psychotherapy. A look at the inside covers of this issue shares who these dedicated colleagues are. I and the members of the Board invite you to join us in the advancement of the field of psychotherapy. Please contact me at drjbarnett1@comcast.net to join us in this important work. If you want to get involved, we will find a place where you can make a unique contribution.

Our recent Midwinter Board meeting built on the work done last year and advanced a number of initiatives. In fact, this Midwinter Board Meeting and the clinical training featuring Dr. Donald Meichenbaum was one of my presidential initiatives. Strengthening connections, we held this meeting in conjunction with APA Division 42, Psychologists in Independent Practice. In addition to holding our own board meeting the division's leaders worked collaboratively with Division 42 board members to develop a shared advocacy agenda. This agenda includes advancing psychotherapy, creating means of better demonstrating its value and effectiveness, and for developing and hosting a practice summit. Division 29

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also did considerable work on the implementation of our new Domain Representatives board structure under the leadership of Past President Jean Carter. Our division is moving forward in a more organized and efficient way. As these efforts unfold more specific information will be shared with you. Other activities include a diversity initiative, collaboration with other organizations, and the ongoing work of effectively managing the division. Included in this is the new endorsement policy for APA Presidential elections that is described and included on pages 58–59. This was expertly developed by current and past board members Linda Campbell, Armand Cerbone, Norine Johnson, and John Norcross. This policy should be of great value to the division in the future as it enables the Division 29 Board of Directors to endorse selected candidates for the office of APA President if they meet the specified criteria that indicate they will advance psychotherapy in the role of APA President.

Our Convention Co-Chairs, Drs. Nancy Murdoch and Chris Brown have developed an exciting cutting edge convention program for you at the upcoming APA Convention to be held August 14-17, 2008 in Boston. Division 29 will be celebrating our 40th Anniversary at our Awards Ceremony and Social Hour at the convention. A number of exciting activities are planned as we celebrate 40 years of the Division of Psychotherapy and 40 years of psychotherapy. Please make plans to attend. I look forward to seeing you there.

There's much more happening in Division 29. This will hopefully be an exciting and productive year. If you have ideas, suggestions, different viewpoints, and if you want to get involved please contact me at drjbarnett1@comcast.net. With your participation, input, and support we can advance psychotherapy working together. As our new motto suggests: "BE CONNECTED" embracing our future and honoring our past. I look forward to meeting you at APA or through email.

The willingness to pitch in when there is a need has always been one of the characteristics of our members. I would like to end this column with one final call to action that I hope you seize:

> In case you're unaware, there is a non-profit organization that is recruiting psychotherapists and asking them to agree to volunteer one hour a month (when asked) to provide services to soldiers returning from Iraq and Afghanistan and to the families of such military personnel. It is called Give an Hour.

Please check the web site for more detailed information about how you can get involved: www.giveanhour.org

With best wishes to all —

Jeff

References

McWilliams, N. (2005). Preserving our humanity as therapists. *Psychotherapy: Theory, Research, Practice, Training,* 42(2), 139-151.

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EDITOR'S COLUMN

Thanks Division 29!

Craig N. Shealy, Ph.D.

The English proverb, "All good things must come to an end," seems a fitting beginning to my final issue of *Psychotherapy Bulletin.* After four years as editor of this wonderful publication—"the heart of Division 29"—I am moving on to assume other responsibilities. It has been an honor and privilege to work so closely with the distinguished leadership and vibrant membership of Division 29, and I would like to offer heartfelt thanks to everyone who has made this experience so immensely rewarding, both personally and professionally.

Undoubtedly, the best news I have to share with all of you is that Psychotherapy Bulletin will be in excellent hands as the Publications Board has unanimously endorsed Dr. Jennifer Cornish as the new editor. Those of you who have been fortunate to work with Jenny know her as a highly conscientious, collaborative, and creative colleague who walks the psychotherapy talk in her life and work as a scholar, trainer, and practitioner of psychotherapy. With Jenny at the helm, I have every confidence that Psychotherapy Bulletin will not only remain true to its primary mission, but set and achieve new and visionary goals for our members and division.

Along these lines, I'd like to take this opportunity to remind our readership that Psychotherapy Bulletin exists 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. As the articles, columns, and contributions to this issue illustrate yet again, we are blessed with an abundance of talent, energy, ideas, and initiatives which are all designed to achieve these goals and pursue the larger and essential mission of Division 29, to ensure that psychotherapy theory, research, practice, and training continues to occupy its rightful place at the very heart of our field and profession.

Toward these essential means and ends, I offer the following closing thoughts.

At its highest and best, the values and aspirations that are inherent to the art and science of psychotherapy are as, if not more, indispensible today than they were when Socrates declared, nearly 2,500 years ago, that "life without examination…is not worth living." None of the marvelous advances and extraordinary discoveries of our modern era will obviate our most fundamental challenge and opportunity as a species in the 21st century, to cultivate the courage and capacity to care more for others; understand better why we believe what we believe and do what we do; make meaning from meaninglessness; ameliorate suffering and facilitate resilience; promote equity, fairness, and justice; celebrate difference; live more fully and authentically; help others to learn and grow; and experience and express greater understanding, protection, and empathy for all living things, including the natural systems in which we are all ineluctably embedded. Can psychotherapy do all of that? If done

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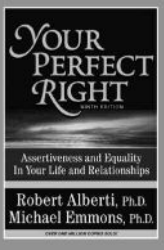
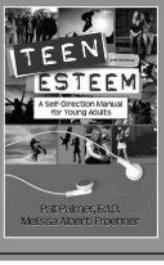
well and right, it can and does every day all over the United States, and increasingly, around the globe.

On the basis of my experience, I have reason to believe that the current and future psychotherapy theorists, researchers, practitioners, and trainers who belong to this distinguished division can and will embrace their profound potential to serve as healing agents of understanding and change—for individuals, couples, families, groups, and communities—as we strive together to create a sustainable world of peace.

Empowering Client Resources





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STUDENT INTERVIEW

An Interview with Dr. Jean Carter, APA Division 29 Past President

By Erin Howard
Lehigh University

Erin: Were there any important events or relationships that helped set you on this path, into the career that you're in now?

Jean: One of the things that I've always been grateful for in my life is that I've had a lot of mentors. There were different people who mentored me along the way and helped take what my interests were and shape them, and give me opportunities that could take me along the way and to where I am now. I've been very fortunate to have mentors at every step. There have been different people who have been important in the whole range of different ways that I've gone in my life, and particularly in psychology. Depending on whether I was looking at my practice, or at my activities within the profession in Division 29, and in the other areas in the profession that I've been active, I can pick out individuals who helped me with that.

The starting point with getting into psychology was really when I was in high school. I had always been interested in people and always interested in why they did what they did, and how they did what they did, and what made them do that, and you know, all of those questions that psychologists ask just ask! And I had a neighbor who was a psychiatrist, and his wife was a special ed teacher, and I started to babysit for them. They spent time listening to me, talking to me, and learned about that interest of mine. They then began giving me books to read, introducing me to psychiatrists and psychologists, talking to me about the difference between the two fields, and really encouraging me along the way. It was such a gift. Not long ago, a psychologist friend of mine was talking with that psychiatrist, and mentioned that he was a friend of mine. The psychiatrist said to him, "I'd like to think I had a hand in her growth and life." It was a wonderful thing. And he did indeed! Both of them. They helped me along the way very, very significantly. So then I went to college, and I majored in psychology, and two of my professors really took an interest in helping me sort through what I was doing and where I was going, and helping me think through what I wanted. Then when I graduate from college—and here's an intersecting piece in my life—I decided that I wanted to get a job because I thought, if I go into psychology and I get into a career where I'm supposed to be helping people, all I know how to help people do is be a student! That's it, that's all I know. So I thought, that's not a very good plan. I think I need to work for a little while and figure out what I want to do. I didn't even really know how to find a job. I had had a summer job, but it was the same job I'd had for four years, and this neighbor had actually arranged it for me. So I called an employment agency and thought, well, they'll at least send me on interviews. So I will at least learn how to do that! The woman interviewed me a little bit, gave me the standard typing test that they gave to any female college graduate at that point, and I typed very fast so I passed their test. She said, "Well there's one job where the guy said he might interview someone who was young and had good skills. So I'll call and find out." I went to this interview with who turned out to be the executive director

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of what is now the American Counseling Association. It was quite amazing! At that point it was the American Personnel and Guidance Association. He interviewed me and talked to me about what I was looking for. In the middle of the interview he asked me, "Have you thought about graduate school?" I said "Yes, but not right now." He said, "If I hire you, will you be here in a year?" I said, "In one year? Yes." He said, "We understand each other." And offered me the job! And I went to work for him. He began almost right away talking to me about graduate school. About how to choose a graduate school, how to think about that, what things to pay attention to in choosing a program.

Erin: Wow, and those are a lot of questions that many students have when they're trying to make that decision.

Jean: That's exactly right. And he began introducing me to all of the counseling psychologists that came through, because at that point, in the early 1970s, the American College Personnel Association (ACPA) and Division 17 Counseling Psychology were almost totally overlapping in membership. He could see what was happening in terms of things like licensure and APA accreditation, which was not a big deal at that point at all, but he could look out ahead from his position and see what was coming. He helped me think through what would be a wise career direction for me. He just walked me through the whole selection of a graduate school. He was a counseling psychologist who had been the vice president of student affairs at Penn State until just before. He was looking for a secretary. And he missed the student. That was really what he was looking for. He wanted a student because he missed the student.

Erin: It seems that he wanted to be a mentor.

Jean: Exactly. And so my needs and his just really dovetailed. And I loved working for him, and he taught me a huge amount. Both about being a psychologist and how to go about doing that, but also the value of a professional association. He brought me into many, many, many professional activities that a secretary wouldn't ordinarily be involved in, nor would someone who was just out of undergraduate school, be involved in. But he was really teaching me about the field, and about the profession, and about how to be a psychologist. So I got to sit in on all sorts of committee meetings and work on all sorts of projects that were tremendous opportunities and let me see firsthand both the value of a professional association and the pleasures of working in the professional association in terms of being a volunteer and getting engaged in the activities, but then also the value of the staff. How much the staff do to keep our profession going. And so it made getting involved in APA activities just a natural next step after I finished my graduate degree. And then this feedback loop—when I was elected President of Division 17, Counseling Psychology, my most treasured note about it was from him. Saying that he had watched my career and felt some sense of pride for having helped make that happen.

Erin: How neat that several people got to see you make some steps and watch your evolution as a psychologist and then as a leader in the field, and to be with you throughout that process.

Jean: Yes, from what I can see with it, they valued it and I absolutely did. It also gave me that perspective that it's of great value to more senior-level psychologists to be involved in mentoring and in teaching. One of the things I have always maintained is being an adjunct faculty member at the counseling psychology program in [the University of Maryland at] College Park, because it gives me the opportunity to do for some of those students what was done for me, to get in and be encouraging.

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Erin: Has the role of mentoring now become a part of your identity and your activities as a psychologist?

Jean: It's something that I always keep in mind. I have, as I've gone through my career, seen that it's not just beginning people that want and need that kind of door-opening and encouragement in taking new steps or in making changes. I really try to bring that perspective to all of what I do. That one of my most important roles in leadership is to try to both make an organization function well but help individuals function well so that they can feel that same sense of accomplishment that I've had a chance to feel. And so that together we can move things forward. So I try to work collaboratively and in ways that encourage people to, as the saying goes, be the best they can be. That's what I try to do.

Erin: Do you see a parallel between your experiences now as a mentor and your involvement of your neighbor and professors being able to comment on your own development?

Jean: It's something that we all should have an opportunity for, and we should learn from what helped us and what we needed. That's how I see my role re-playing the role the other people's role in my life. It's very generative. It's something that, being nurtured begets nurturing.

Erin: Do you anticipate any changes in yourself in your identity or in your involvement with psychology as a field, over the next few years?

Jean: I'm at a point in my life where I can see retirement out there. It's not immediately out there, but I can see that it could be there. So I'm starting to think about how my profession, my activities in my practice are set up, so that I have that as something that, when I'm ready, it will be a smoother transition. I'm thinking about what are the kinds of things that I want to do in the field before that would happen. So I'm looking at what kinds of activities I might want to be engaged in. But I also follow the model, as I watch my father, who is now 87 and still active in his professional association on a committee—he's a physicist and he's active in the American Nuclear Society and the American Physical Society—and he's still serving on a committee. So I don't anticipate that my winding down will be fast.

Erin: Good news for us!

Jean: I'm always thinking about new things that I can do. I'm always eager for them. But thank you, that was a nice comment.

Erin: Any other thoughts or notes that you want to make along this line?

Jean: The development of my practice and myself as a practitioner… I always knew that I wanted to be a practitioner. That was always my goal. One of the things that I say about myself—and people sometimes look at me with a befuddled and bemused expression when I say this—is I don't have the kind of internal drive to be an academic. And the reason people look at me sort of bemused is that I'm very busy all the time. I'm always engaged in things. But it takes a very different kind of internal drive and long-range perspective to be a faculty member or a researcher. And I don't have that. I have a different kind, I think, which is a much more engaged and in-the-moment approach to my life. And so practice where I could make a difference in individuals' lives always seemed like the most exciting thing to me. And the thing that really suited me. I have a great interest in people, in individuals, in what they're doing and why they're doing it, and in being invested in people while also encouraging them to have a lot of freedom to be the best version of who they are. Not to be somebody different than they are, but to be the best version of them. And so I always

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wanted to do that. At the same time, I loved the field of psychology, and the academic discipline of it, and learning about it. So I really have always had in my head that as a psychologist, I needed to have that broader professional perspective that included the science and scholarly part as well as the practice part. So that has forced me to think about how one does that, as a practitioner. You know it's very easy when you're in practice, to get caught thinking of yourself as sort of like a pieceworker. Where you're paid by the hour, and you work this hour, this hour, this hour, and if you don't work this hour, then you don't get paid, so you have to put in something where you get paid, and you're not going to take time out of paid work to do unpaid work. I can't think that way. It doesn't work very well for me. Because I can't see myself as this full psychologist with that perspective. So I've always tried to keep a notion of myself as a professional. And as a psychologist rather than as, just a psychotherapist. So I've built in a lot of that time for work in the scholarly part of what a psychologist does. My first love though, always my love, is practice. To be engaged in the life of an individual—this individual, that individual—to be engaged in those lives is one of the biggest gifts that anyone can give. When someone sits with me in my office and trusts me enough to walk with them in that journey that they're on, it's like they have handed me the greatest treasure, every day. It's amazing to think I get that *every day.* It's one of the most profound experiences that I can think of. It's actually very much also the way I feel with my children. And I feel in many ways, a very similar kind of commitment to the people that walk in my door and sit in the room with me, and let me help them through their lives. It's the biggest gift imaginable. So when I start talking about retirement, it would be a huge loss to really retire. A huge loss. It's hard for me to imagine doing that except that I have lots of other things I want to do in my life, and people to spend time with. That's why I do it, that's what I love about it. It is every day something new, every hour something new. It's both a great gift and a great responsibility.

Erin: Thanks so much for talking with me Dr. Carter.

Jean: You're very welcome. I just love this field so much that I could talk about it for hours. Once you start of push that button, then I can get going and I will continue until you tell me, "alright enough."

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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
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STUDENT AWARD PAPER

Therapy with Lesbian Couples

Peter D. Panthauer, Adelphi University

In all of us, throughout life, the libido normally oscillates between male and female objects
—S. Freud (1920)

This paper is a brief introduction to working with lesbian couples. It will examine some aspects of the lesbian couple, aspects the therapist needs to bring to the work, and provide a short overview of the work itself. In no way is this paper intended to provide the road map for the actual therapy. This paper is designed to challenge the therapist in thinking about how he or she might work with the growing number of lesbian couples entering treatment, and perhaps suggest ways to co-create the therapy when working with lesbian couples. It is presumed that the reader understands that this is an exploration of aspects of the couples' lives that would benefit from therapy. The issues presented here in no way suggest that they occur in the typical lesbian relationship—the areas addressed are specific to issues that are likely to emerge for lesbian couples in therapy.

Views of same sex couples have changed dramatically over the years. Acceptance seems to be increasing regarding state sanctioned marriage. Discrimination is illegal. Indeed, many cultural minorities, including gay males and lesbians have higher visibility in positive venues throughout the dominant culture. Acceptance, though, is different from knowledge.

In many ways lesbians in a committed relationship have the same issues that any dual gendered couple has. Yet some issues are quite different, and several are unique. Therapists lacking basic knowledge of issues relevant to a lesbian couple almost certainly jeopardize the success of the therapy and even risk doing harm. There is a multi-dimensionality required for working with lesbian couples. Marriage and family therapy theory, psychoanalytic theory, sociological theory and feminist theory all bring a piece of the puzzle. However effective they may have been addressing the milieu for which they were designed, all fall short in addressing the welter of complexity inherent in any lesbian relationship.

Introduction

Working with gay, lesbian and bisexual couples has been woefully neglected in the journals of marriage and family therapy. Of the 13, 217 articles pertained in 17 marriage and family therapy journals in the period from 1977–1997 only 77 (0.006%) used sexual orientation as a variable or focused on gay, lesbian, and/or bisexual issues (Clark & Serovich, 1997). While mainstream psychotherapy has non-pathologized sexual orientation (in 1973 by the American psychiatric Association, and in 1975 by the American Psychological Association), it was not until 1991 that the American Association for Marriage in Family Therapy adjusted their code of ethics to be congruent with this point of view. In fact, it was not until the year 2000 that the American Association for Marriage and Family Therapy ran a special section on gay, lesbian, and/or bisexual issues in their own periodical, *The Journal of Marriage and Family Therapy.* Fortunately, this trend towards inclusion is accelerating: in 1996–2000 the articles on diversity increased by 100%, going from 15.6% of all 1990 articles to 31% (Bailey, Pryce & Walsh, 2002). In particular, the number of articles on sexual orientation in *The Journal of Marriage and Family Therapy* has quadrupled from 3 to 12, exceeded in growth rate only by the

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number of articles on gender and ethnic/racial minority.

Reasons cited for the paucity of articles include different definitions of what constitutes a committed relationship, cohabitating, marriage, committed monogamy and that the rules differ for same sex couples regarding these issues (Blow & Hartnett, 2005). Others have cited problems with information gathering, because until recently the only places that seemed available for information gathering on lesbian relationships was at "[lesbian] organizations, bars, or personal contacts" (Saghir & Robins, 1980). Additional reasons given include homosexual bias, and the false belief that heterosexual models of relationships are transferable to gay, lesbian, and/or bisexual couples in treatment (Clark & Serovich, 1997). In retrospect, this lack of published material for working with couples in same sex relationships is a glaring omission. The invisibility of gay male therapists and lesbian therapists was poignantly stated by well-known family therapy researcher Robert-Jay Green: "Even the textbook on family therapy that I co-edited with James L. Framo in 1981 colluded with this neglect… *I edited myself—and many others like me—out of existence.*" [Italics added] (2000, p. 407).

The Lesbian Couple

The construction of the lesbian couple is similar and different from a heterosexual couple (Hare-Mustin, 1987). Feminist literature suggests that the dichotomy of male and female attributes is specious (Hare-Mustin, 1987; Goldner, 1988; 1991). Hare-Mustin highlights the commonalities of traits that both value: reason and relational (1987). To dichotomize them, and to present their use without understanding why women might tend to be more relational and men seem to be more reasoned misses how gender rules are imbedded in a dominant culture that gives men, (and I would suggest heterosexual women), more power. It is incumbent on therapists to realize that lesbian couples organize, form and create their identity under this myopic and rejecting culture, and that this alone would be reason enough to seek out therapy.

Pachankis & Goldfried suggest that lesbians are, in the main, always forming and reforming their identities (2004). Areas of uniqueness in a lesbian couple are: 1) both members of the couple are women, 2) the lesbian couple is not a [fully] socially sanctioned unit, and 3) full commitment requires acceptance of a stigmatizable identity (Roth, 1989). These couples issues are generally catagorizable into four areas : relationship boundary issues (Krestan and Bepko, 1980), the ongoing creation of a lesbian identity, both individually and for the couple, usually referred to as *coming out* (Roth, 1989; Imber-Black, 1998; Laird, 2000; Pachankis & Goldfried, 2004); dealing with the predominant culture (Hare-Mustin, 1987; Charles, Thomas & Thornton, 2005; Roth, 1989; Imber-Black, 1998; Laird, 2000; Pachankis & Goldfried, 2004); and issues around family of origin (Sanders, 1993; Roth, 1989; Imber-Black, 1998; Laird, 2000; Pachankis & Goldfried, 2004).

Boundary Issues

Boundary issues take two forms. The first form of boundary-making is how couples manage intimacy and distance within the couple, that is, between each other. The second area of boundary-making forms around the partners as a unit and reflects how the couple admits others in or keeps others out of their relational dyad. These boundaries can be markedly different from the typical heterosexual couple.

In fact, a landmark paper by Krestan and Bepko explored the phenomenon that lesbian couples maintain contact with previous romantic relationships, referred to in marriage and family therapy literature as *diffuse boundaries* (1980). They posited several explanations. One proffered explanation was that same gender couples had difficulty maintaining autonomy due to their

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numerous commonalities. They also suggested that a lesbian couple was "aping" the heterosexual couple model, but was hindered by so much cultural stigma that the couple needed to maintain lesbian community connections and supports. Krestan and Bepko at the time saw this as forming a sort of permanent triangulation with the lesbian community. Recently, however, Harkless and Fowers (2005) found that gay males maintain "similar levels of post break-up involvement that is quite similar to lesbians" (p. 172); no parallel phenomenon was found in heterosexual couples. Harkless and Fowers state this finding supports the idea that post break-up involvement [diffuse boundaries/triangulation] is not primarily attributable to women's relational sensibilities. For all living things the apposition of these bifurcations: inclusion, exclusion, regulation of intimacy and distance, the boundary of *me/not me* and of *we/not we* are the functional expression of identity.

The Creation of Identity

Lesbian Identity

The creation of a lesbian identity—*coming out*—is seen as a "crucial," "pivotal" or "watershed" event in the development of any lesbian (Beeler & DiProva, 1999; Roth, 1989; Imber-Black, 1998; Laird, 2000; Bepko & Johnson,2000; Pachankis & Goldfried, 2004). Women can feel as if they have "counterfeit relations" or experience a "masking of the self" when they have not *come out* as lesbians (Ponse, 1980).

While frequently described as an event, it is more a series of expanding circles taking place in various areas of a person's life. Coming out it has multiple metaphorical meanings (Roth, 1989), political significance (Zemsky, 1991; Pachankis & Goldfried, 2004), is related to self-identity development(Beeler & Deprova, 1999) and to the identity of the couple (Imber-Black, 1998; Pachankis & Goldfried, 2004). In actuality, coming out not only much more a developmental process than an event and continues throughout the lifetime (Groves, 1985; Beeler & DiProva, 1999; Roth, 1989; Imber-Black, 1998; Laird, 2000; Bepko & Johnson, 2000; Pachankis & Goldfried, 2004). Bepko and Johnson (2000) see coming out and the degree to which the lesbian couple come out a way of integrating a narrative about one's life and a "crucial issue in a couple relationship" (p. 411). In earlier decades it was more likely that lesbians, and presumably lesbian couples would isolated themselves from the lesbian community for fear of being labeled *lesbian* (Sang, 1977). As late as 1991 *coming out* was seen as an externally focused act, that was an "act of resistance" to the dominant culture and a way to abet one's search for a community as much as it was a declaration of one's own identity (Zemsky, 1991).

The Creation of Gender Identity

Lesbians struggle with gender identity mainly due to the prescription and proscription of this concept by the dominant heterocentric culture (Hare-Mustin, 1987; Goldner, 1988; 1991; Zemsky, 1991). Gender is very usefully seen as a false duality. Hare-Mustin and Goldner deconstruct gender as it is commonly used by the dominant heterosexual culture. Both see gender available as a multi-form construct that allows individual creativity in it's various uses.

Family of Origin Issues

Family of origin issues for the lesbian couple manifest in their relationship to their own and each other's family of origin. Beeler and DiProva also suggest that the family will go through a parallel process of coming out: whom will they tell (2004)? Friends, older family members, members of their church, people at work? Pachankis and Goldfried (2004) analogize that discovering a family member is gay is like seeing a movie with critical information revealed at the end that puts many previously recalled events in a new light. For integration into the family of origin this would

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require a reexamination and the creation of a new narrative for both the family and the individual member coming out.

The level that either partner is *out* to her family of origin has a recursive impact on the couple relationship (Imber-Black, 1998; Beeler & DiProva, 2004; Pachankis & Goldfried, 2004). Acceptance of one partner by the other's family of origin, a lack of acceptance or not coming out to one's family of origin can create great imbalances and painful tensions for both members of the couple (Imber-Black, 1998). Beeler and DiProva have listed 12 themes they noted in their research regarding four lesbians coming out to their families. These themes played out on four levels: intrapsychic, interpersonal, familial, and social.

Living in the Heterocentric Culture

Living in the heterocentric culture offers the potential for multiple problems. It affects to what degree, and where, a partner can assert their lesbian identity—work, church, heterosexual friends, to name a few areas. Therapists who treated lesbians in the 1970s, such as Josette Escamilla-Mondanaro believed that it was the minority status and pressures of a heterosexual society that brought most lesbians into therapy (Rawlings & Carter, 1977), and some see this as still true today (Ariel & McPherson,2000). Lesbians are denied housing, jobs, and the right to visit or make decisions for an incapacitated and hospitalized partner (Pachankis & Goldfried, 2004; Ariel & McPherson, 2000), along with denial of parental rights to the non-birth mother of a lesbian couple's child. A gay male couple or lesbian couple is not recognized by immigration. The lesbian couple is always aware that just the declaration of their relationship is a defiance of the dominant culture.

The Therapist for the Lesbian Couple

The feminist movement burst forth in the 1970's. Vitalized by this development, some suggested that only lesbian therapists could work with lesbian clients (Escamilla-Mondanaro, 1977). However, today there are many reasons why a lesbian couple would choose to work with a heterosexual female or even a heterosexual male therapist (Bernstein, 2000). Some of the reasons cited by Bernstein include: the clients own internalized homophobia, a client's fantasy that a straight therapist will provide the blessing of the dominant culture, fears that the client may incubate that she cannot contain her sexual feeling towards a woman or lesbian therapist, and because the couple wants to avoid possible sexual jealousy in the triangle with the therapist (2000). To that list I would like to add a few others: 1) in sparsely populated or rural areas only a heterosexual therapist is available; 2) a therapist may already have a good reputation for achieving relief and change for couples across various cultures; and 3) the reality of managed care and insurance coverage limitations. Bernstein also recounts a lesbian couple choosing her over two other therapists who were lesbian—the couple chose her because she was the only one to give a direct answer as to whether she was lesbian or straight (she is straight).

The heterosexual therapist must educate himself or herself to the culture, vocabulary, and lifestyle of lesbians. It is unacceptable for the therapist to rely on the couple to educate him or her (Bernstein, 2000). Bernstein recommends films, works of fiction that revolve around lesbian life, professional literature, along with acquainting oneself to the key resources that lesbians in therapy may benefit from.

A heterosexual therapist must also be ever vigilant for heterocentric perspectives that are invisibly imbedded in the culture and in most of the popular therapeutic modalities. The responsible and effective therapist needs an ever-expanding perspective that should, at a minimum, include the following ideas.

An understanding of *alpha prejudices* and

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beta prejudices. Hare-Mustin defines the alpha prejudice of psychodynamic theories as exaggerating gender differences and the beta prejudice in the systemic approaches that ignore differences that are really there (1987) as a way to avoid perspectives imbedded in the dominant culture (Hare-Mustin, 1987).

The acceptance of gender as an irreducible category rather than a constellation of aspects that can be dichotomized (Goldner, 1988, 1991). Goldner discusses how gender inequality abounds unseen or at least unobserved in almost all therapies—psychodynamic, systems, and feminist. Gender must be reconstructed and the therapist must willingly enter, and perhaps lead, the partners into exploration of gender roles and gender expectations (O'Donohue & Crouch, 1996).

Therapists need to take the attitude of the anthropologist, "taking care not to transpose meaning from one culture to another" (Bepko & Johnson, 2000 p. 418; Bernstein, 2000). She suggests exploring cultural differences with such questions as "Does this behavior have a different meaning in your experience than it might in mine?"

It is self-evident that the therapist must do an honest assessment for his or her own homophobia and "homosexist" attitudes (Pachankis & Goldfried, 2004; Bernstein, 2000; Long & Serovich, 2003). It bears repeating that the therapist who does not respect the sexual orientation of the patient and attempts to either pathologize a lesbian's sexual orientation or actually attempts to get the patient to consider "converting" to heterosexuality *has no place doing therapy with this population.*

Finally, a therapist needs to use the terms *gay* or *lesbian*, not homosexual; to use *sexual orientation* not sexual preference (because the degree of voluntary choice is not supported by the research), to use *partner* and not husband or wife, and to use *sexual activity* instead of sexual intercourse (Long & Serovich, 2003).

Therapy with Lesbian Couples

Lesbian couples, gay male couples, and heterosexual couples have much in common. In working with lesbian couples tools common to heterosexual couples such as genograms, family of origin, coaching, and reframing are all appropriate and helpful. But different norms are assigned to sex, and to the relationship with the family of origin. Additionally, the "family of choice," and the place of ex-partners in life are very different (Bepko & Johnson, 2000). Roth sees the six most common major issues for lesbian couples as: 1) problems of distance regulation and boundary maintenance; 2) problems of sexual expression; 3) problems related to unequal access to resources; 4) problems arising from different stages of coming out and development and management of each partner's sexual identity; 5) problems related to choosing to have children and co-parenting them; and 6) problems related to ending the relationship even when both partners have decided to do so (Roth, 1989).

Distance Regulation and Boundary Maintenance. As discussed earlier, diffuse boundaries seem to be a fact in many lesbian couples' relationships. What is important is that the therapist deconstruct and assess their meaning and function with the couple, rather than make the aforementioned alpha error or beta error, inadvertently dismissing it as an unavoidable part of lesbian life, or labeling it pathological. A stand should not be taken. The fact that a stand gets taken may also reflect an unconscious heterosexual bias that lesbian couple relationships are inherently pathological (Pachankis & Goldfried, 2004).

Intimacy and distance regulation also needs to be discussed. I would recommend that they be examined through at least three lenses: a couples-system perspective, an individual psychodynamic perspective, and various cultural perspectives. Identity making can be a part of this process that helps restore security to the individual and

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the couple (Laird, 2000). Couples need to explore the meaning, significance, and function of their relationship (Pachankis & Goldfried, 2004). Stronger identities will help the couple more easily deal with these regulation needs. Creating a narrative for their individual and couples identities in therapy is a restorying process, and as such, is a retrospective experience (Laird, 2000). Couples can use playful metaphors that can be liberating, creative and adaptive and lead to mastering new learning. Laird gives an example of an adaptive use of the *"Butch/Femme"* metaphor where one member of the couple came home and said, "You look like you had a bitch of a day. Why don't you play the tired husband while I get you a beer and finish up dinner." (Laird, 2000, p. 461).

Problems of Sexual Expression in Lesbian Couples. Some lesbians report fears of being touched, sexual inhibition and rigid lovemaking patterns (Roth ,1989). It should also be remembered that many lesbian couples report substantial sexual satisfaction, although when sexual issues exist they may be tied to any unsettled issue in the couple's relationship (Roth, 1989). Means-Christensen, Snyder & Negy report that there are indications that same sex couples have a better sexual relationship than heterosexual couples (2003). From this, one may impute that better feelings towards one's partner positively affect sexual expression. In research that used the Marital Satisfaction Inventory-Revised, it was found that positive affectivity was correlated positively and negative affectivity was negatively correlated with couples relationship satisfaction and that partners who can show positive affectivity to the other partner can positively affect the couple's affective experience (Todosijevic, Rothblum, & Solomon, 2005).

Problems related to unequal access to resources. Inequitable treatment for any cultural minority can be a shaming, infantilizing, or infuriating experience for anyone. The therapist must be prepared to tolerate a patient's prolonged raging at a discounting and denying dominant culture in which she must function. Should such expressions occur, they must be neither dismissed nor pathologized: rather they should be explored and contextualized. Our culture is imbedded with reminders that separate the lesbian from the dominant culture. In self-psychology terms, attending a wedding for "a heterosexual couple could be positive selfobject experience, whereas for a lesbian it is likely to provide a bad selfobject experience" (Abramowitz, 1997, pp. 235-236). One of the potent variables affecting the polarity of this experience is where the person is in her coming out process.

Problems arising from different stages of coming out. Pachankis and Goldfried identify three stages of coming out: feeling different, leading a double life, and coming out. Coming out in the context of a relationship is frequently an issue (Roth, 1989; Pachankis & Goldfried, 2004; Imber-Black, 1998). Each partner will almost undoubtedly come out at a different pace and in a different way than the other. Both need to explore the meaning of coming out and the meaning of not coming out for each of them, and in turn understand how it impacts on the other (Imber-Black, 1998).

When a lesbian comes out to her family of origin, the family goes through a "schema shift", much in the way a moviegoer does when a critical piece of information is revealed at the end of the movie (Pachankis & Goldfried, 2004). As a lesbian comes out to her family, the family seems to go through a parallel coming out process (Beeler & DiProva, 1999). In their observations of families going through the coming out process Beeler and DiProva identify 12 themes. Some of these themes are, establishing rules for discussing homosexuality, second-guessing the sexuality of others ("who else?" syndrome), the family coming out, and developing narrative coherency (1999).

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It is unclear if coming out to one's family of origin is helpful (Bepko & Johnson, 2000), especially for ethnic minorities who may suffer a double stigma (Pachankis & Goldfried, 2004; Bepko & Johnson, 2000). Coming out should be seen as a lifelong process with varying speeds; at times disclosure may be delayed until more control over particular areas of one's life can be managed (Pachankis & Goldfried, 2004). It is the therapist's job to reassure the couple that many families have navigated the coming out process successfully and that continuing contact increases comfort levels (Beeler & DiProva, 1999). I would also recommend that they be supported, even urged, to follow no imposed template, and instead blaze their own trail in ways that have meaning and provide comfort for them.

Each person brings their own unique history. Some women have begun clear forming of their identities while still in their teens, while others may still be in the midst of doubt and struggle. The level of acceptance from their families of origin is an important factor that varies for all. Some leave a heterosexual marriage and are raising their children.

Problems related to having children and co-parenting them. Many variations of this problem can manifest. If the couple has a child, the courts frequently do not recognize the non-birth mother. For a woman who had a child through a previous heterosexual marriage, the ex-husband may try to use the child's mother coming out as a weapon in court against her, despite evidence that children of lesbian parents do not have gender confusion, no difference in moral reasoning, intelligence or issues in individuation-separation (Ariel & McPherson, 2000). Other complicating issues may be surrogate fathers or identified sperm donors that seek parental rights.

Problems related to ending the relationship. When a lesbian is in a secret relationship and loses a partner she is denied the comfort and supports that usually follow (Roth, 1989). Krestan and Bepko's work also suggest that new opportunities are available for the relationship to evolve into another form that permits both distance and continuity. In contrast, others suggest that lesbians need clear mourning periods of no contact after a relationship ends to find closure (Harkless & Fowers, 2005).

Conclusion

The unique nature of any couple offers an infinite number of ways to enjoy life and each other. It is the job of therapy to catalyze the potential of any relationship, and it is the job of the therapist to recognize and support the strengths that derive from this uniqueness.

There are many reasons that a lesbian couple might work with a heterosexual therapist. Moreover, gay males and lesbians use therapy at higher rates than the average population (Pachankis & Goldfried, 2004). A constructionist-contextual approach allied with sound psychodynamic principles and systemic explorations makes therapy with lesbian couples at once new and exciting. Any therapist planning on working with such couples would benefit from some words written by Beverly Burch regarding the creation of the lesbian couple's individual and dyadic identity:

> To provide a foundation of substance for a relationship, the story needs to be consensual and flexible, sometimes even contradictory. It needs a thread of continuity, however, through time and changing version. Most important, the story needs to explain how each person makes use of the other, in the highest sense. It informs the couple about how to handle their differences, how to appreciate and profit from them (1993, p. 148).

[1]This does not preclude a therapist helping a person truly struggling with their sexual identity to examine their lesbian, gay or heterosexual

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thoughts and feelings to create an identity and self-narrative that fits his or her life experience.

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Insight in Psychotherapy: Toward a Consensus About Definition, Process, Consequences, and Future Research Directions

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Insight, or the acquisition of a new perspective about self or others, has been frequently identified as a common factor across therapeutic approaches (Castonguay, 2006; Goldfried, 1980; Grencavage & Norcross, 1990). However, this rich and complex process has yet to be fully understood. Insight can vary is so many ways, in terms of content (e.g., links between the past and present, links between conscious thoughts and underlying schema) and dimensions of functioning (e.g., emotional and intellectual), that it is not surprising that many definition have been proposed and many theories have been developed to explain how and when it works.

In order to better understand this complex process of change, two of us (Castonguay and Hill) invited some of the most influential psychotherapy process researchers in Canada and the Northeastern United States to a series of meetings at Penn State University—hoping to create, as Hatcher (2007) kindly put it, a think tank on insight. The first two of these meetings involved open and intense discussions among these leading figures in the field—no formal talks were presented, as we assumed that the best way to foster creative and synergic thinking about the process of change was to gather a relatively small number of smart, knowledgeable, and friendly people in the same room and ask them to talk together about insight for several hours! A third conference was also organized with the goal of achieving a consensus about what we currently know and what remains to be known about insight.

The Penn State Conferences culminated in the book, *Insight in Psychotherapy* (Castonguay & Hill, 2007), which provides a wealth of theoretical, empirical, and clinical information related to insight in psychotherapy. The current paper (which is based on the last chapter of the book, Hill et al., 2007, and on the subsequent chapter by Hill & Knox, 2008) is a summary of the agreements that were achieved during the consensus meeting regarding four core questions: What is insight? What leads to insight? What are the consequences of insight? What other issues need to be considered in thinking about insight?

As in the book, these ideas are not offered here as definitive statements. Rather, these ideas are offered as heuristics about the phenomenon of insight that deserve particular attention, with the hope that they will spur further theoretical and empirical investigation.

Definition of Insight

Insight is an exciting but challenging construct, in part because it has many different meanings. Thus, the first task of the final Penn State Conference was to determine if some type of agreement could be achieved about what we mean by insight. Most of the participants agreed that insight is usually conscious (as opposed to unconscious or implicit) and involves both a sense of "newness" (i.e., the client understands something in a new way) and making "connections" (e.g., figuring out the relationship between past and present events, the therapist and significant others, cognition and affect, or disparate statements). Hence, it was largely agreed that insight in therapy could be defined as: A conscious meaning shift

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involving new connections (i.e., "this relates to that" or some sense of causality).

Possibly due to differences in theoretical orientation, additional elements of insight were suggested but not incorporated in the primary definition because of lack of consensus. These suggested dimensions included: complexity (e.g., richness, number of neural connections, extent of elaboration of a schema, degree of integration of various elements, level of abstraction), intensity of feelings or arousal related to the new meaning, salience or centrality to clients' conception of self, suddenness (i.e., whether the insight is gained gradually or suddenly), nearness to conscious awareness (conscious vs. unconscious, implicit vs. explicit) of the material prior to the insight event, and the quality of insight.

Furthermore, it was thought that the quality of an insight could encompass various components, such as accuracy, coherence, consensus (how much the client, therapist, and significant others would agree on the truth of the insight), and usefulness (the extent to which the client has a sense that the insight does or will lead to resolution of a problem, or the extent to which it objectively leads to a resolution of the problem or generates further therapeutic work).

Because the effectiveness of insight depends on the needs of the client at a particular time within therapy, the contributors were hesitant to say that being at particular levels on any of these dimensions would necessarily make for "better" or "more therapeutic" insights. Hence, a simple insight might be best early in therapy for a given client whereas a more complex insight might be better later on in therapy when the client has been able to assimilate more of the material that emerged during treatment. However, it was thought possible that better or more therapeutic insights would involve the higher levels of at least several of these dimensions (e.g., greater complexity, emotional arousal or deepening, suddenness, believability, accuracy, coherence, consensus, and usefulness).

The conference participants stressed that other therapists and scholars might think of insight in different ways. Rather than a process or state, for example, insight could be viewed as an ability (i.e., capacity to engage in the insight process; insightfulness). In addition, insight could be considered as a goal or outcome (a desirable achievement in itself) rather than as a process (i.e., means or task that helps one achieve another end such as a way to promote symptom change). On this particular issue, it was assumed that individuals would differ primarily along theoretical lines, such that many psychoanalytic therapists might consider insight as a desirable outcome of therapy, whereas a large number of behavioral therapists would likely consider the attainment of new understanding to be important only if it leads to other outcomes such as behavior change.

Most of the conference participants agreed that the terms "understanding" and "new meaning" are synonyms of insight, and that these constructs could be used interchangeably. However, insight can be differentiated from awareness, which does not involve a sense of a new connection or causality (e.g., being aware of the sensation of feeling angry is not the same as understanding where the anger comes from). Another related construct is self-knowledge, which differs from insight both in terms of newness (i.e., self-knowledge is not necessarily new) and level of conscious awareness (i.e., self-knowledge can be implicit or unconscious). Finally, "hindsight" can be similar to insight since the making of new connections often involves looking back and constructing meaning (in fact, psychoanalytic therapists clearly value making connections between past and present events).

As a caveat, we note that the basic construct of insight is hard to pin down because the meaning of the term is socially constructed. The definition and dimen-

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sions delineated above should make it easier to measure insight, but insight is still a complicated construct that is hard to capture completely. Relatedly, although insight appears to be valued across theoretical orientations, it is often described using different terms (e.g., psychoanalysts talk about insight whereas cognitive-behaviorists talk about understanding underlying assumptions). One should be cognizant of different terminologies when attempting to understand and/or investigate insight.

The Process of Gaining Insight

Predisposing Factors

Conference participants suggested that clients are more likely to gain insight if several predisposing client and therapist factors are present. These participant characteristics exist solely within the person of the client or therapist and are brought to the therapy situation. Although the presence of these variables might well be associated with the client subsequently attaining insight, they are not likely to cause insight attainment. Furthermore, none of these variables should be viewed as absolutely essential for insight-generation for every client. Instead, each one may increase the probability that insight will occur under certain circumstances or with certain clients.

Some client factors include personality or dispositional variables, such as psychological mindedness (openness to experience, insightfulness, reflexivity, self-awareness), cognitive ability (intelligence), creativity, motivation, goal orientation, level of functioning, and belief that insight is desirable. Other client factors include environmental variables, such as social support and reliable feedback from others about one's behavior/impact on others. Some therapist factors include credibility, skill/competence, empathic capacity, lack of hindering self-awareness or countertransference, and belief that insight is desirable or necessary for change.

Stages of Insight Attainment

We speculated that the process of gaining insight often involves five stages (although these stages are certainly not invariant).

Stage 1: Setting the stage for insight. Some conditions are likely to be important to generate or begin a movement toward insight: state/mood/stress of client (clients may be more receptive to insight at some times than others), belief of the therapist in the value of insight for this client at this time, and a productive therapeutic alliance.

Stage 2: Preparation for insight. Therapists might use one or more types of interventions to set the stage so that clients will be poised to gain insight. These interventions may be enough to foster insight in some clients; however, they often set the stage for later interventions that directly promote insight. Among them are procedures aimed at: decreasing client avoidance, defenses, rumination, worry; motivating clients to seek insight by educating them about the benefits of gaining new understanding and by reinforcing attempts to gains insight; encouraging client exploration to elicit material from which insight can develop; eliciting memories or narratives from clients, helping clients activate relevant schema (e.g., trigger core views of self by working in an emotionally immediate way with clients), increasing client arousal to an optimal level (e.g., "strike while the iron is hot for many" but "strike while the iron is cold" for clients with borderline diagnoses), and increasing the state of dissonance to make the client more aroused and ready for insight.

Stage 3: Markers of client's readiness for insight. Clients often demonstrate a readiness for moving forward with the insight process. They may indicate puzzlement (e.g., "I just don't understand"), a desire for understanding (e.g., "I wish I understood why I do that"), or bring up recurrent dreams or problematic reactions ("I don't know why I reacted that way; it is so unlike me"). This client state of puzzle-

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ment seems to motivate active self-exploration, which can lead to new emotional awareness and insight.

Stage 4: Promotion of insight. Most insights seem to be co-constructed (i.e., developed collaboratively between therapists and clients), although some emerge solely from the client and others are suggested by the therapist. Irrespective of the person who initiates the insight, the client ultimately must claim the insight as his or her own and integrate it into his or her schema.

The therapist typically uses one of several different types of interventions to directly or indirectly help clients construct insight. Interventions that facilitate clients gaining their own insight include probes for insight (questions asking about causes or connections) and empathic reflections, as well as pointing out or challenging discrepancies, conscious (or explicit) thoughts or behaviors, and underlying (frequently implicit) assumptions. Interventions developed to more directly aid the attainment of client insight include interpretations and reframing. It should also be mentioned that interventions intended to help clients change specific behaviors, including behavioral assignments and paradoxical directives, can in turn facilitate insight.

Stage 5: Consolidation of Insight. For insights to create lasting shifts in meaning, therapists often have to work with clients to help them consolidate the insights (what psychoanalysts refer to as "working through"). Therapists attempt to achieve such consolidation through various means, including reinforcing the client for gaining insight, helping the client symbolize or articulate the insight in a clear or memorable form, and repeating the insight numerous times, in different ways, and applying it to multiple areas so that the client generalizes the learning, incorporates the insight into existing schemas, and creates new, more adaptive schemas (new schemas reinforced and strengthened through continued discussion and practice).

Consequences of Insight

As the contributors deliberated on the possible consequences of insight, they developed a long list of possible positive and negative effects. However, they agreed that not all of these consequences arise for every client, as the outcome of insight probably depends on its intensity, complexity, accuracy, content, and timing. Furthermore, the attainment of insight may, in the short term, be experienced as a life-changing realization, and later be viewed as an invalid view of self or others (or vice versa). Furthermore, insight may on occasion be an important outcome in and of itself, while at other times it may primarily be a mediator of other important changes (e.g., insight leads to behavior change).

In terms of possible positive consequences, it was thought that insight can lead to symptom change or serve as a preparation for behavior change, enable clients to make difficult decisions, increase client involvement in therapy, engender more differentiated and meaningful emotional experiences, enhance the therapeutic alliance, increase the client's sense of hope, mastery, self-efficacy, and/or agency, and increase the client's ability to gain insight on his/her own outside of therapy.

Possible negative consequences include feelings of pain/regret over missed opportunities or lost time, being forced to make decisions prematurely, being stuck or paralyzed about making a change, or becoming over-involved in gaining understanding rather than (or instead of) making needed life changes. In addition, insights can lead clients to feel more negatively about self (e.g., client becomes critical of self for past choices) or begin to proselytize.

Again, a number of concerns were voiced by the participants. First, the list of positive consequences may be too grandiose, implying that insight is a "cure-all" and has more far-reaching influence than is the case. Second, some of these consequences

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may overlap (e.g., increased client involvement and the therapeutic alliance), whereas others may need to be differentiated more (e.g., the sense of hope, mastery, freedom, self-efficacy, and agency may not all cluster together). Third, the sequence through which these consequences of insight take place is likely to vary. Insight may lead to an emotional shift or to action, or both, and either of these may lead to insight (e.g., once a person has made a major behavioral change or had a novel emotional experience, he or she may be more in a position to reflect on what caused his/her behavior or feeling). Furthermore, the sequence may be cyclical (e.g., insight leads to emotion and/or action, which leads to more insight, which then leads to more emotion and/or action, etc). Taking all of these caveats into consideration, it should be noted again that these lists of positive and negative consequences are speculative at this time and are in need of empirical validation.

Research Questions

Although the participants were able to derive and agree upon a long list of conclusions with regard to insight, a substantial number of questions were also raised and left unanswered. This outcome, in our opinion, clearly reflects that the field is ripe for investigations of insight.

Definitional Issues

Because insight is such a slippery, elusive term, considerable attention is needed to define it carefully. More specifically, insight needs to be distinguished theoretically from related phenomena (e.g., awareness, explanation, revelation, self-knowledge, creativity). Further work is also needed in distinguishing insight as an experience, process, state, or ability. Finally, the prototypical insight ("aha," gold nugget) needs to be distinguished from less complete or smaller insights (gold dust).

Measurement Issues

Once insight is conceptualized and defined clearly, better methods are needed for assessing it. Having adequate measures will help in distinguishing insight from related phenomena. These measures should involve different kinds of methods (self-report, observer ratings, interview methods) to reduce measurement bias and allow for testing of consistency across perspectives.

Methodological Issues

It would be ideal to study insight from many different approaches. For example, because the insight process appears to be idiographic and heavily context-bound, case studies are likely to be a suitable method of investigation. Qualitative methods may also be particularly useful for capturing the conscious inner processes of participants. In addition, quantitative studies will likely be useful for measure development and for assessing the overt presence of insight in therapy sessions. Furthermore, assessments of insight should be included in clinical trials when investigating the effects of major theoretical approaches.

Moreover, it is important to recognize that therapists, clients, significant others, and trained judges will, by definition, have different perspectives on the phenomenon of insight. For instance, therapists who believe fervently in insight might be motivated to overrate its frequency and significance. On the other hand, some clients might not understand what is meant by insight, or may not value insight unless educated about it. Likewise, judges might have their own biases (positive or negative) about insight, which would likely influence their evaluations. In addition, it is important to be aware that clients may have insights that they cannot or do not choose to articulate to therapists. Accordingly, the observable record of therapy (i.e., transcripts, audiotapes, videotapes) may not always be the best place to search for insights.

In addition, researchers need to examine the entire process (including both overt and covert factors) leading up to insight.

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Rather than being the consequence of specific and discrete events that immediately precede it, insight may often result from many processes occurring over a long period of time. Therefore, the immediately preceding events most likely represent the final impetus for insight (the tipping point) rather than the whole process. Alternatively, the insight could have occurred (either inside or outside of the session) much earlier than when the client reports it. In such a case, the interventions immediately preceding the report of insight may have had little to do with the insight attainment.

Investigations of the Nature of Insight
What is the role of schemas and schema change in insight generation and maintenance?

Does insight need to be true or historically accurate? Does insight need to be related to current events that maintain problematic behaviors? Does it make a difference if insight is sudden vs. gradual? Are insights better if they are client-generated, therapist-suggested, or co-constructed?

Finally, do more complex, emotionally intense, and/or central insights lead to stronger and longer lasting changes?

Investigations of the Process of Insight Attainment
The stages described above (i.e., preparation, identification of client's markers, promotion, consolidation) need to be investigated. Researchers also might validate the list of possible markers expressed by clients that indicate that they are ready for or eager to attain insight. They might also investigate whether different types of insight (e.g., in terms of object or target, the complexity or depth) are facilitated by different types of therapy (e.g., psychoanalytic therapy might foster insights relating past events to current experiences; cognitive-behavioral therapy might facilitate insights about underlying assumptions and their relationship with current events; experiential therapy might generate insights about the process of one's ongoing subjective experience).

Furthermore, research is needed on the role of positive and negative emotions in insight generation and maintenance. For example, is emotional insight (as opposed to intellectual insight) necessary for long standing change? If so, what are the optimal levels of emotional and intellectual arousal?

Investigations of the Consequences of Insight
It seems important to validate the list of positive and negative consequences presented above, deleting ones for which no evidence is found and adding others that were overlooked. Also, researchers should study the possible interaction among potential consequences, particularly in determining whether insight plays a direct or mediating role in eventual treatment outcome (e.g., emotional well-being, symptom reduction, increased interpersonal functioning).

Other Research Questions
A number of other research questions merit empirical attention. For example, why is it that clients often do not come to therapy explicitly asking for insight, although many report post-therapy that they valued gaining insight? What can be learned from other areas of psychology (social, cognitive, developmental, biological) and other disciplines (philosophy of science, sociology, anthropology, biology, history) about insight? Does the insight process have an evolutionary value? Perhaps healthy people engage in insight processes (self-examination) on a regular basis as a way of solving problems. Perhaps, it is only, or mostly, when this process gets stuck that therapeutic intervention is needed.

Final Thoughts
Clearly, the Penn State Conference participants reached a number of agreements with regard to the nature, processes leading

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to, and consequences of insight. In addition, there was a fair amount of consensus about future directions of research on insight. This level of agreement may be surprising to many, as it is frequently assumed that therapists, scholars, and researchers associated with different theoretical persuasions are unlikely to achieve extensive consensus on complex issues related to change. Clearly, more research is needed to test the ideas that were generated by the conferences. At the minimum, however, open (and friendly) dialogues and the search for consensus appear to be appropriate (and exciting) vehicles for thinking deeply, broadly, and creatively about complex issues, and thus for advancing knowledge.

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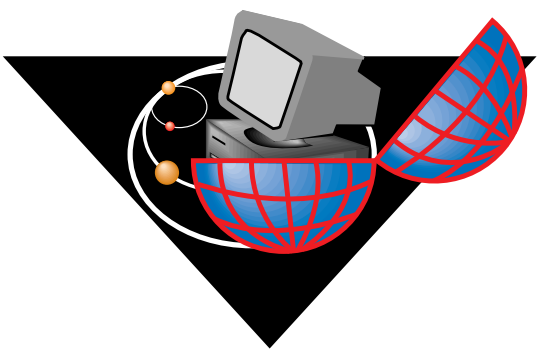

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PSYCHOTHERAPY RESEARCH

Assimilating Common Factor Treatment Components into Cognitive Therapy for Depression

Michael J. Constantino
University of Massachusetts-Amherst

A voluminous and ever-expanding research literature points to the general effectiveness of psychotherapy (Lambert & Ogles, 2004). Through the use of controlled clinical trials, psychotherapy researchers have identified many empirically-supported treatments for specific clinical phenomena (Roth & Fonagy, 2005). The extant research also suggests that, with just a few exceptions, different therapy modalities yield comparable clinical effects (Lambert & Ogles, 2004). From a *glass-half-full* perspective, the field has made impressive strides in legitimizing the power of psychosocial interventions. Furthermore, as reflected in the long-standing "Dodo bird" interpretation of the comparative outcome literature, it can be asserted that everybody has indeed won and all should have prizes.

From a *glass-half-empty* perspective, psychotherapy's general effectiveness is tempered by its clear limitations. For example, effective treatments for some psychological conditions have yet to be established, and the generalizability to everyday practice of treatments tested in controlled efficacy contexts remains tenuous. Furthermore, even when provided the "gold standard" treatment for a particular condition, some patients fail to respond, only partially respond, or respond but relapse; others drop out of treatment or even deteriorate (Lambert & Ogles, 2004). Thus, it seems that the Dodo verdict can be reconsidered to suggest that all therapies can be improved (Castonguay, Reid, Halperin, & Goldfried, 2003).

Although efforts toward improvement can come in many shapes and sizes, some scholars have argued that improvement may perhaps best be achieved through (a) theoretical humility and openness to the contributions of other (and perhaps historically incompatible or rival) orientations (e.g., Castonguay et al., 2003), and (b) treatment modifications based on process research (e.g., Grawe, 1997). Such approaches preserve the field's advances in empirically supporting certain treatment packages, while inherently recognizing the complexity of change and the need to move forward creatively in refining treatments to both embrace and address such complexities.

Both of the aforementioned pathways to improvement reflect a specific model of psychotherapy integration (see Norcross & Goldfried, 2005). The former captures *assimilative integration*, or the attempt to improve an established system of psychotherapy by carefully considering the potential contributions of other systems. The latter captures *common factors* integration, which focuses on the conceptual and empirical contributions of pantheoretical and pandiagnostic therapeutic ingredients, and the inevitable influence of the momentary and dynamic context on the treatment process.

Among others, process research has persuasively implicated two common factors in the change process—the therapeutic alliance and patient expectations (see Castonguay, Constantino, & Holtforth, 2006; Greenberg, Constantino, & Bruce, 2006). To date, a facet of my research program has been directed at developing, systematizing, and experimentally testing alliance and expectancy-based treatment

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modules as a means to improve the efficacy of a particular empirically-established treatment (i.e., cognitive therapy; CT) for a specific condition (i.e., adult major depressive disorder; MDD). Although CT is an efficacious treatment for depression, recent estimates from controlled trials suggest that over half of MDD patients do not remit at posttreatment (De Matt, Dekker, Schoevers, & De Jonghe, 2006), while an even higher percentage fail to maintain lasting improvements (Hollon et al., 2005). Thus, there is room for significant improvement in CT for depression, and there remains a pressing need to refine treatments to increase response and decrease relapse. My collaborators and I have embarked on two such efforts. The alliance-based effort focuses on incorporating humanistic and interpersonal alliance-rupture repair strategies into standard CT and, thus, fits the assimilative *and* common factors models. The expectancy-based effort focuses on incorporating into CT systematic and responsive efforts to foster, manage, and change patients' treatment expectations, which follows the common factors pathway. Below I describe each research line, including (a) a brief review of process findings that led to the treatment development, (b) a brief overview of the treatment module, and (c) a summary of our preliminary research to date.

Therapeutic Alliance Process Research and Integrative Cognitive Therapy

Pantheoretically defined, the therapeutic alliance reflects the quality of the patient-therapist working collaboration and affective bond (Bordin, 1979). As reflected in our own reviews and process-outcome studies (e.g., Constantino, Arnow, Blasey, & Agras, 2005; Constantino, Castonguay, & Schut, 2002), the alliance is a well-established predictor of treatment success across a variety of psychotherapies and presenting problems. The alliance not only predicts outcome, but it also provides a dynamic context for the implementation and utility of other interventions. For example, in a study of CT for depression, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that strict therapist adherence to prescribed CT techniques in the context of an alliance rupture was negatively related to outcome. Inspired by these findings, and guided by an assimilative integration model, Castonguay (1996) developed Integrative Cognitive Therapy (ICT), which is an approach to depression that remains grounded in CT but systematically incorporates humanistic and interpersonal strategies for identifying, addressing, and repairing emergent alliance ruptures.

Based on the contributions of Burns (1989) and Safran and Segal (1990), ICT presupposes that CT therapists can be more effective in dealing with alliance strains by exploring the source of the difficulty (including their own contributions) rather than increasing their adherence to core CT interventions. In this vein, the ICT manual outlines a 3-step rupture-repair sequence in which the therapist: (1) *Invites* the patient to discuss his negative reaction to the therapy or therapist; (2) *Empathizes* with the patient's feelings and invites additional emotional disclosure in the service of understanding, respecting, and validating the patient's subjective experience; and (3) *Disarms* the patient's antagonism, anger, and/or other negative feelings by acknowledging his or her own contribution to the rupture. Such action promotes a restoration or enhancement of the collaborative working relationship, at which time the therapist then resumes standard CT techniques.

In an initial pilot investigation of ICT, Castonguay et al. (2004) found that ICT produced significantly superior outcomes than a wait-list control condition. As a follow-up, my research team conducted a pilot study (Constantino et al., 2008) to test further ICT's efficacy and specificity by directly comparing it to standard CT. In this sense, the study employed an additive design, the strength of which resides in its

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high level of control across the independent treatment variable (e.g., Behar & Borkovec, 2003). With the exception of ICT's additional rupture-repair strategies, the treatments were delivered according to the same CT protocol, thereby reducing the likelihood that outcome differences are a function of "nonspecific" factors and strengthening the causal inferences that can be made about the alliance manipulations. Furthermore, by using CT-as-usual as a control group, the additive design (a) transcends the specific versus common factors debate by assessing whether rupture-repair interventions work *additively* or *synergistically* to improve an already established treatment package, and (b) adds a cause-and-effect dimension to the alliance-outcome link. In our study, using clinicians-in-training, we found preliminary evidence that ICT could be distinguished from CT, and that ICT outperformed CT (small to medium effects) in terms of reducing depressive and global symptomatology. Furthermore, relative to CT, there were fewer dropouts, higher quality alliances, and higher perceived therapist empathy in ICT (medium to large effects). Thus, ICT may be considered a *promising limited support treatment* (Roth & Fonagy, 1996) worthy of future rigorous study.

Although preliminary, our emerging ICT findings suggest that psychotherapists should not only strive to foster good initial alliances with their patients, but also constantly assess for any deviations in the relationship climate. In the face of potential or actual alliance ruptures, clinicians should resist rigid adherence to the techniques they have been employing (e.g., standard CT interventions) and work through such relationship issues directly, openly, and nondefensively. The use of gentle probing, active listening, empathizing, and disarming may not only help to get the relationship back on track, but such metacommunication strategies may also promote a corrective relational experience (see also Safran & Muran, 2000).

Expectancy Process Research and the Expectancy Enhancement Treatment Module

Patients' expectations have long been considered a common treatment factor (e.g., Frank, 1961). Outcome expectations refer to a prognostic belief that therapy will help, while process expectations reflect beliefs about what will transpire during therapy. As reflected in our own review and process-outcome studies (e.g., Constantino et al., 2007; Greenberg et al., 2006), expectations have been shown to be important contributors to adaptive during- and post-treatment outcomes. However, the expectation construct has been remarkably undervalued (Weinberger & Eig, 1999). Although many therapies include elements that address patient expectations in some manner, expectancy strategies are often neither explicit nor systematic. Moreover, in experimental treatment studies, expectations have been traditionally viewed as artifacts to be controlled – a perspective that now seems outdated. Thus, we have developed a treatment manual that outlines an explicit and systematic approach to enhancing patient expectations about therapeutic change and the treatment course.

The expectancy enhancement (EE) manual (Constantino, Klein, & Greenberg, 2006) addresses pre- and during-treatment expectations. Specifically, it comprises (a) an initial session EE interview to enhance patients' outcome expectations and their expectations about the length and nature of treatment, (b) ongoing standard and reactive EE strategies, (c) general relationship strategies to be considered in light of patients' expectations, and (d) a termination component that aims to enhance patients' posttreatment expectations for maintaining their treatment gains. The present version of EE was designed as a companion manual to CT for depression. However, we suspect that such strategies can eventually be adapted for a wide range of clinical conditions and for other treat-

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ment modalities. We are currently conducting another pilot study, again utilizing an additive design, to foster the development of the EE manual and to test preliminarily its causative enhancement of standard CT. Although the outcome data are still forthcoming, we have been able to successfully train graduate trainees on the protocol, and they have been able to implement the treatment with good fidelity and competence.

Despite not yet having data on the specific efficacy of our EE manual, psychotherapy process research points consistently to the clinical importance of patients' process and outcome expectations. Moreover, most psychotherapies involve some level of manipulation, exploration, challenge, and/or revision of patient expectations (Greenberg et al., 2006). Thus, clinicians should carefully assess patients' expectations at the beginning of treatment in order to inform prognosis, case formulation, and treatment-planning. Regarding process expectations, clinicians may need to spend time socializing patients to the treatment process (e.g., typical role behaviors; duration), as well as checking in on patients' met and unmet expectations as the therapy work unfolds. Regarding outcome expectations, clinicians should make a concerted effort to offer personalized hope-inspiring statements (e.g., "Your problems are exactly the type for which this therapy can be of assistance") at the treatment's outset, and to respond appropriately to hope-diminishing moments with both alliance-based sensitivity and expectation-enhancing strategies (e.g., reminding patients of depression's recurrent nature; drawing on past successes) (Constantino et al., 2006).

Conclusions

The lines of research discussed above are representative of my overarching research program that focuses on understanding patient, therapist, and relational processes that influence the course and outcome of psychosocial treatments, and on the development and systematization of therapeutic interventions that address pantheoretical principles of clinical change. The overarching aim of the program is the development of empirically-grounded skills on which therapists can be trained to negotiate effective therapeutic relationships and to enhance patients' treatment expectations. This focus on two key common factors adds a much-needed complement to the testing and training of theory-specific treatment techniques that have, to date, received much more empirical attention. Of course, the efficacy findings discussed above should be interpreted within their preliminary spirit. However, our hope is that when the jury returns, we will have uncovered two promising common factor treatment modalities that can be assimilated into CT to augment its effectiveness. If so, our work will have helped substantiate a *glass-not-yet-full-but-still-full-of-promise* perspective on psychotherapy outcome research.

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THE DISTINGUISHED PUBLICATION OF PSYCHOTHERAPY RESEARCH AWARD

In consultation with the Division 29 Board of Directors, the Division 29 Research Committee is instituting The Distinguished Publication of Psychotherapy Research Award. This award recognizes the best empirical (i.e., data-based) published peer reviewed article on psychotherapy in the preceding calendar year. Articles appearing in any journal (i.e., they need not have appeared in the Division's journal) are eligible for this award.

We ask members of the Division to nominate articles for consideration by April 15. Nominations should include the complete citation for the article, and should be emailed to the Chair of the Research Committee, Dr. Sarah Knox, at sarah.knox@marquette.edu.

A selection committee appointed by the Chair of the Research Committee, in consultation with the President of the Division, will evaluate all nominated articles, and will make a recommendation to the Division's Board of Directors by June 1. Upon approval by the Board, the author(s) of the winning article will be notified so that they may be recognized and receive the award at the upcoming APA Convention. Accompanying this award is a plaque.

All methods of research will be equally valued (experimental, quasi-experimental, qualitative, descriptive/correlational, survey). Nominations of articles addressing issues of diversity in psychotherapy are especially encouraged. Current members of the Research Committee and the Selection Committee will not be eligible for the award, so no articles by members of the Research Committee will be considered. Also, committee members will recuse themselves from voting on articles by current or former students, as well as collaborators. Self-nominations are accepted.

The criteria for the award appear below:

- the rationale for the study and theoretical soundness
- the methods
- the analyses
- the explanation of the results
- the contribution to new knowledge about psychotherapy (e.g., the work is innovative, creative, or integrative; the work advances existing research in a meaningful way); greater weight will be given to novel/creative element than to methodological/statistical rigor
- relevance to psychotherapy practice.

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CALL FOR NOMINATIONS: CHAIR, STUDENT DEVELOPMENT COMMITTEE APA DIVISION OF PSYCHOTHERAPY (29)

This is a call to nominate a new Chairperson of the Student Development Committee for a two-year term beginning January 1, 2009, and ending December 31, 2010. The duties of the chair include:

- Serving as a voting member of the Division's Board of Directors and attending two meetings of the Board of Directors annually (Division pays meeting and travel expenses in accordance with its reimbursement policies).
- Coordinating the student award process for the Division's three student paper awards.
- Facilitating recruitment of students to write an article for each issue of the division's quarterly publication *Psychotherapy Bulletin.*
- Collaborating with APAGS to coordinate division and APA student initiatives.
- Chairing and coordinating the activities of the Student Development Committee.

The Division of Psychotherapy (29) of APA is committed to the exchange of ideas, policies and resources for members pertaining to the practice, science, education and theory of psychotherapy and has a commitment to diversity in all of its activities. The Student Development Committee provides a unique student voice in the Division, promoting the interests of students in programs and activities sponsored by the Division. The chair has opportunities to form personal relationships with leading psychotherapists and to become better acquainted with APA governance and the activities of professional organizations.

Nominees for chair must be student members of the division, but need not have prior experience working within the APA. Self-nominations are welcome. All applications should include a cover letter, CV, and a biographical statement limited to 200 words that will be published in the Psychotherapy Bulletin prior to the election. All nominations must be received by Sunday, March 30, 2008. Student members vote in the election, which is held in May.

Send all nominations to the Division 29 Central Office, c/o the Nominations and Elections Committee, 6557 E. Riverdale St., Mesa, AZ 85215

For more information, please contact the current Student Development Chair, Michael Stuart Garfinkle (2007-2008) at michaelgarfinkle@adelphi.edu.

NOMINATION BALLOT

Nominees for Student Development Committee Chair

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What Constitutes "Evidence" in Clinical Practice? Streams of Convergence

Jeffrey J. Magnavita, Ph.D., ABPP, Glastonbury Psychological Associates, Hartford, Connecticut

While driving to my office one wintry morning, listening to National Public Radio as I often do, an advertisement for a residential treatment program for adolescents caught my attention. The advertiser stated that they provide treatment which is "evidence-based." It occurred to me that psychology's evidence-based movement had reached the mainstream, if that is how you can describe NPR. I began to think about this evidence-based movement, the subject of a book which I am in the process of editing. Recently I have noticed a trend which has made me slightly uncomfortable: many of us, including myself, are putting the words "evidence-based" before various schools of psychotherapy, as if this changes what we do and how we do it. This seems similar to a movement in psychotherapy in the 80s which favored "brief" treatment. During the ascendancy of the managed care movement there was a call for briefer and more effective treatments. For almost two decades almost every type of psychotherapy began with the words "brief" or "short-term". In many cases it seemed that not much changed about the way the psychotherapy was practiced but marketing demands made books about brief treatment popular. We even had single session psychotherapy where the patient was supposed to be better after one session. As most of us have noticed, this trend has begun to fade as others have emerged, one of which is evidence-based treatment.

As practicing psychotherapists what constitutes the evidence in "evidence-based" treatment is of ultimate importance to what we do every day in our private office, hospital, or in the clinic. The more I wrestle with this issue the more compelling and complex this movement appears. We all can agree that we should, and want to practice psychotherapy, which is solidly based in "empirical" evidence. Who can disagree with this? I imagine all of you are agreeing, so I will take the liberty to proceed with my exploration. Some questions that I think we are struggling with include: "What constitutes reasonable evidence?" And, "What is empirical?" Here is where we get into some murky intellectual, philosophical, and scientific waters. There are many models of the world which we construct to organize the complexity and many epistemologies or ways of knowing. All of them are essentially metaphorical attempts to map and test the veracity of what we perceive. For example, the drive theory of psychodynamics was based on a hydraulic model and a family systems model is based on a cybernetic or feedback model, using a computer metaphor. The evidence which we select then is in large part based on our epistemologies.

There are many of us in this movement who believe unequivocally that the gold standard of knowing comes from empirically-based evidence which is derived from randomly-controlled treatment studies (RCTs). RCTs compare one form of treatment to another using random assignment. Thus, the thinking goes, using manualized treatment which everyone adheres to, using a large enough sample, can demonstrate which treatment is most effective with a particular disorder. I am sure

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you all agree that if you choose a disorder, and have a manual that describes effective treatment, you should apply to the patient in question. I imagine that you are thinking that the nosology and diagnostics themselves are totally straight-forward. There is rarely a single entity disorder, and the manual never fully explains what to do when patients refuse to follow the plan as explicated, and so on. For example, we have a great many technological aids for reducing anxiety, such as portable biofeedback equipment, but many patients refrain from using them on their own. The technology and protocol is empirically supported but the patients motivational system may not be operative in the way we expect. Some readers I am sure are thinking," well this is how science proceeds, you want to know if what you are doing works, so you need the research evidence to validate the approach." Those treatments which aren't supported fall by the wayside and the field progresses.

I agree that you don't want to be offering psychoanalysis to someone with a simple phobia who can effectively be cured with exposure treatment in a few sessions. There is another issue that we have regarding our evidence and that is how the research from scientific journals gets translated and put in the clinicians' toolbox. I am told that it usually takes 10 to 15 years to have effective treatment actually be incorporated into clinical practice. Wow, this is a long time to get the word out and for the uptake to occur for effective treatments. Medicine struggles with the same problem of uptake as psychotherapy. Following a protocol checklist for inserting lines into a patient can reduce infections by 30% or more and reduce mortality but many hospitals don't use the checklists which are known to be effective in reducing clinical error.

There are others who adhere to the "Dodo bird effect" using meta-analysis to show that all dominant schools of psychotherapy are about equally effective. This draws our attention to another perspective of "what constitutes evidence?" This group believes that psychotherapy is relational and the positive benefits that have been demonstrated in the literature are primarily the results of the common factors such as placebo that permeate all types of treatment and even account for a large part of the variance in medication outcome. It may be the case that the techniques are not as important as the psychotherapist's belief in the type of psychotherapy he or she practices, the expectancy of the patient, and relational factors such as warmth, caring, and empathy. Using this relational framework the critical evidence may be derived from measures of the quality of the therapeutic relationship and presence of core factors identified in the literature as related to positive outcome. Clearly the best evidence is the result that you achieve when you work with your patients. I am sure the next question that arises in your mind brings us back to: "What is the evidence that what you do is working?" The answer to this question seems to be "if they have gotten better" which leads us to what is better and how do you measure the treatment effect? If you are like me, you are probably struggling with the questions of what constitutes evidence and how do I use the best evidence in my work to ensure the best outcome. There are many validated measures that psychotherapists can use to track patient improvement. This then makes our office our clinical laboratory and our interventions and outcomes our proofs.

Another way that we can get a handle on this problem of evidence is to think of how we really work in our practices. What do we view as evidence in our office while we practice our livelihood? Evidence comes from a variety of convergent sources and reducing the evidence to any one manual makes me squeamish. I do want to know what the evidence is from the "horse races" among the various schools of psychotherapy. For example, I know there is support

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for schema-focused, cognitive-behavioral, and psychodynamic forms of treatment of severe personality disorders. I also want to know what happens when I utilize a certain strategy with patient x, y or z. As a clinical scientist, I develop theoretical-clinical formulations, I apply a set of strategies, and then I observe what occurs. I am continually modifying what I do, based on the patient response to the intervention. Evidence comes from what I observe as well as what the patient reports. We also can ask, "Is what we are doing helping?"

An alternative line of often overlooked evidence in the debate comes from other sources outside of psychotherapy research. Developmental psychopathology, neuroscience, affective science, cultural anthropology, and epidemiology all offer useful evidence streams. Returning to personality dysfunction as an example, I know that certain behavioral constellations are associated with future adult personality dysfunction. This type of evidence is critical to prevention as well as the type of treatment which will be required. Other streams of evidence are also vital in that they orient us toward our patient's genuine communication. Reading the affective system is a critical skill for psychotherapists, as well as airport screeners. One of the leaders in affective science, Paul Ekman, has isolated the 44 muscles in the face and combinations which are associated with various feelings. Out of the 19 different combinations that indicate a smile, only one, called the Duchenne smile, expresses spontaneous joy. The vital piece of evidence is whether the orbicularus oculi muscle contracts. I can't see if you are smiling from my vantage point but what does seem obvious is that practicing evidence-based psychotherapy is no mean feat. Attempting to keep up with new research findings, learn new methods, and read related literature in psychopathology can be daunting, but this is what I believe makes psychologist-psychotherapists unique. We are trained in scientific methods and hopefully have a healthy dose of skepticism when we wrestle with evidence. No one perspective on what constitutes evidence is sufficient and we are probably better off remaining open to multiple lines of convergent evidence about what is effective. Does that treatment program the advertiser plugged really provide evidence-based treatment? My scientific training makes me approach any claim with a healthy skepticism and a hunger for the evidence.

I just finished watching a program on childhood treatment of "mood disorders" and was appalled by the fact that there are now "brain" clinics which charge unsuspecting consumers large sums of money for brain scans to assist in diagnosis. There is no evidence that brain scans for behavioral diagnosis have reached the level of sophistication being marketed. The language of neuroscience was being used to create a false impression of what the scans mean. We are bound as psychologists-psychotherapists to stay close to the evidence wherever we can find it.

Author's caveat: This column represents the opinions of the author who is solely responsible for the content. To respond please Email: MagnaPsych@aol.com

POLICY & PROCEDURES FOR ENDORSING CANDIDATES FOR APA PRESIDENT-ELECT

I. Why it is important to endorse candidates for President-elect:

- It is in the interest of the Division to be active in APA politics to advance its mission;
- It is in the interest of the Division to support the election of APA Presidents who will advance psychotherapy in practice, in education and training, in research, and in the public interest;
- It is in the interest of the Division to maximize its effectiveness in advancing psychotherapy by engaging in the endorsement of APA candidates for President-elect.

II. Criteria for Candidates

- The candidate shall be a member of the Division:
- The candidate shall evidence a record of commitment to advancing psychotherapy in education and training, in research, in practice, and/or in the public interest.

III. Procedures

- Written Statement: Candidates seeking endorsement must submit written statements that include why they are seeking the endorsement, an explicit commitment to advance psychotherapy, and a record of their contributions to the field of psychotherapy;
- The Executive Committee, or a subcommittee of the Executive Committee appointed by the President, will review the applications for endorsement and make recommendations to the Division's Board of Directors;
- The Division's Board of Directors, with the advice and recommendations of the Executive Committee, shall determine to endorse or not endorse a candidate(s);
- The Division's Board of Directors shall make its endorsements public at a time that it deems most effective; and,
- At its discretion and to maximize the impact of its endorsement, the Division's Board of Directors shall employ multiple strategies and venues to publicize its endorsement(s).

At its winter meeting in January 2008, the Board of Directors considered the advantages of developing a policy for endorsing candidates for President-elect of the American Psychological Association. The Board determined that making endorsements served the interests of the Division in several ways. First, the Division through its endorsement could actively support and elect Presidents-elect who had proven records supporting or advancing psychotherapy in practice, research, education or training and would commit to advancing psychotherapy. Second, endorsement would promote the visibility and awareness of our mission and agenda. Third, it would enhance the Division's participation in the political process that influences the election of Presidents-elect.

Consequently, the Board would like to inform the membership of this strategic change in policy, and encourage the membership to both become involved in the APA elections process, and consider a candidate's support of psychotherapy and the Division when voting.

Identifying Competencies: Beyond Consensus

Jean M. Birbilis, University of St. Thomas
Mary M. Brant, Private Practice, Kansas City, Missouri

In the previous issue of the *Psychotherapy Bulletin,* we noted that psychology has come to the assessment of outcomes in psychological education and training relatively late compared to the fields of education per se and of managed care (Birbilis & Brant, 2007a). We also noted that the outcomes deemed by various constituents of the profession (via the 2002 "Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology") as appropriate to assess are competencies derived by consensus (Lichtenberg, Portnoy, Bebeau, Leigh, Nelson, Rubin, Smith, & Kaslow, 2007) which have yet to be validated. Furthermore, we noted that the field is now in the process of examining the validity of competencies identified by consensus through such venues as the upcoming Accreditation Assembly in May, 2008 ("Evidence-Based Outcomes: Assessing Achievement of Educational Goals, Objectives and Competencies") being sponsored by the Commission on Accreditation of the American Psychological Association.

We now turn our attention to an inherent blind spot that appears to have eluded the attention of those involved in the validation process. In particular, the identification and possible validation of particular competencies by consensus may verify the veracity of at least some of what is being taught and may possibly provide an empirical basis for eliminating other aspects of what is being taught, but ignores that which has yet to be identified and which should be taught.

How should educators and trainers proceed, given the rapidly-evolving nature of psychology education and training? There is a tradition in the field of psychology of allowing the application of emerging treatments and subfields, under the appropriate conditions (e.g., American Psychological Association, 2002; Committee on Accreditation, American Psychological Association, 2005).

A case could be made that incorporating innovative educational methods and content is a corollary.The logical question arises: How and where might educators and trainers find innovative educational methods and content? We propose several potential sources to stimulate further conversation on this issue.

The field of psychology— It is possible that those involved in the education, training, research, and practice of psychology have not been fully mined. It is also possible that data have been mined, but have not yet been applied. For example, data were recently gathered on the National Council of Schools and Programs in Professional Psychology's listserv regarding how many professional psychology programs require their students to obtain personal psychotherapy. Some might argue that although not every program has this requirement, enough do to suggest that successful completion of one's own therapy could become a competency.

Other disciplines— It is possible that the field of education has much more to offer psychological education than methodology for outcome assessment. For example, education has led the way for many years in the development of critical thinking and writing skills, which are arguably the most important skills that psychologists can

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possess. It is also possible that other disciplines could contribute to the competencies of successful graduates of psychological education and training. For example, business could contribute to the competent independent practice of psychology, and technological training could provide the basis not only for using technology (e.g., using computer software and hardware), but also, for engaging in emerging areas, such as online teaching of psychology and practicing via telehealth.

The general public— Clients and former clients have long been tapped as a source of information regarding perceptions of what was efficacious about their treatment. Less is known about the perceptions of the general public regarding what they would look for and consider in choosing a therapist, a psychology teacher, and/or a researcher. What might the public be able to reveal about the profession's own blindspots?

In a previous article (Birbilis & Brant, 2007b), we noted that the step prior to teaching competencies involves gatekeeping via character and fitness assessment. Might the education and training of psychologists, particularly practitioners, include the further development of character and fitness?

Although some might wish to deny it, we must consider the very real possibility that innate talent is a factor in the success of psychotherapists and that educators and trainers could benefit from assistance in identifying and strengthening such talent. For example, such talent might include intuition as measured by the Myers Briggs Type Indicator, i.e., the tendency to view things as they could be vs. how they are. Louis Pasteur once said, "Chance favors the prepared mind;" preparing psychotherapists to expect and respond effectively to chance in therapy could include cultivating intuition.

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Over its next few issues, *Psychotherapy Bulletin* will publish a 4-5 part series that will focus on first-hand accounts from early career psychologists (ECPs) in diverse positions that value psychotherapy practice, training/teaching, and/or research. In these papers, the authors will (a) describe the nature of their position, (b) outline how they got to their current position, (c) share the most satisfying aspects of their job, (d) discuss the most challenging aspects of their job and how they have negotiated such challenges, and (e) provide pearls of wisdom for achieving and succeeding in their type of position.

Michael Constantino, Ph.D.
Early Career Series Editor

EARLY CAREER PSYCHOLOGISTS

The Many Hats of a Clinic Director

Christopher Overtree, Ph.D.
University of Massachusetts – Amherst

Time has not has changed the importance of the old maxim "if you want something done right, you better do it yourself." After completing my training as a psychologist, I always imagined that I would fulfill this principle practicing, not surprisingly, psychology. But that was before I became a clinic director and began shopping for things like power drills, window shades, and "do not disturb" signs. Before I knew it, I had become a repairman, webmaster, and interior decorator, and the *Frequently Asked Questions* section of our staff manual had rocketed to the top of my "to do" list. Adding insult to injury, donning my psychology "work" pants occasionally meant dungarees instead of gabardine.

I have always told my students that their career trajectory would inevitably make more sense when examined in hindsight. By the time you look back, the path has already been tread and understanding the twists and turns is only a matter of examining your footprints. But this is unsatisfying advice for people making decisions they believe will greatly impact their larger life goals, and it underestimates the confusion one can feel when forced to look ahead. Like most, my early career path has been a combination of hard work, careful planning, the influence of colleagues and friends, significant choice points I faced along the way, and of course, luck.

Position Description
Currently, I am the Director of the Psychological Services Center (PSC), the training clinic for the Clinical Psychology Program at the University of Massachusetts-Amherst. As a training clinic, we provide mental health services, primarily psychotherapy and assessment, using graduate student clinicians working under licensed clinical psychology faculty. The PSC is the first and primary clinical training site for our graduate students, though all of them also work in outside clinical agencies to gain specialized experience and exposure to different client populations. The PSC is thus comprised of our student clinicians, a student clinic coordinator, a professional-level office manager, clerical-level secretary, clinical faculty supervisors, and a number of graduate and undergraduate research assistants. Several of our clinical faculty members supervise as part of their normal course load. Supervisors include tenure and non-tenure line faculty, spanning the range from part-time Lecturers to Assistant, Associate and Full Professors. We also utilize the generous *pro bono* services of many adjunct clinical faculty, full time practition-

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ers who volunteer to supervise a single graduate student clinician and their caseload. As Director, I create the system in which all of these people go about their work. This can be extremely complicated given the different constituencies represented and our many program goals, the highlights of which include quality clinical training and service, evidence-based practice, and the development of strong skills in academic scholarship.

When the UMass-Amherst Clinical Psychology Program began shifting from a Scientist Practitioner to a Clinical Scientist Model (meant to emphasize our goal of training academic clinical psychologists), the PSC Director position was created to move some of the administrative burden associated with our clinical training program away from research faculty and into the hands of someone who had more interest in clinical administration and training. As a UMass-Amherst graduate, I returned with the excitement one experiences when returning home, and I had the unique pleasure of being recruited and ultimately hired by my former research mentor Mort Harmatz, now Professor *Emeritus*. I continue to enjoy the privilege of informal consultation with him at our local coffee shop, perhaps the only place I can work quietly without the interruptions that have become a constant aspect of my job as a clinic director. I work on a multi-year contract, outside the university tenure system. While to some this would create a sense of instability, some of the most rewarding aspects of my position are simply incompatible with the tenure process at our university. Thus, my non-tenure status has allowed my role to evolve as my own interests and the needs of our clinical psychology program have shifted over time. And because my job includes managing and strengthening the clinical training our students receive, as well as supporting our department in meeting its broader scholarly, clinical, and instructional goals, my position remains important in the overall success of our program, and thus far, secure as a result. Although I am speaking primarily of my position as a clinic director, I should mention that I wear two other hats, one as the Associate Director of Clinical Training and the other as a Lecturer in the Psychology Department. I teach one large undergraduate course in abnormal psychology and two graduate courses in clinical interviewing and diagnostic assessment, as well as providing programmatic assistance to our Director of Clinical Training (DCT). Apart from this, I spend most of my time in the following ways.

Program Development

Because my position was recently created, much of my time and effort in the beginning was spent developing systems to streamline the functioning of the PSC, which had suffered from a low client census, financial difficulties, and some aesthetically challenged clinical offices and waiting areas. The PSC had always been well known by students and internship sites for the excellent clinical training it provided, but our reputation as a treatment center in the local community was not as strong. I focused my efforts on reinventing our local image as a community mental health center, knowing that this could only improve our training. Because much of our basic operating costs are provided for in the Psychology Department budget, targeting low-income individuals in our local community has been an excellent and sensible niche service for us to provide. Thus, over the last several years, we have begun to see our census increase as more clients select our services based upon a reinvigorated clinical reputation.

One of the other major projects that drew my attention early in my tenure was developing an improved infrastructure for conducting naturalistic psychotherapy research within our clinic. Working closely with one of our tenure-line faculty, Michael Constantino, we developed a more rigorous initial evaluation procedure for screening clients, including measures we felt

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would provide useful data about psychotherapy process and outcome. Although this change was ultimately beneficial for the quality of our training and clinical services, it also represented a major source of transitional stress for the faculty and students working in our clinic. Thus, as might be easily imagined, I spent much time writing protocols, conducting trainings, addressing complaints, and creating new clinical materials to be used for client informed consent.

Staff Management

Another large part of my job involves staff management. I supervise our office manager and secretary, establishing priorities for their day-to-day work, conducting regular evaluations, and supporting their ongoing professional development. Though our clinicians are unpaid graduate trainees, I work with them as staff too, creating expectations for their work, but doing so in a manner that is commensurate with their training level. I work with the DCT to make supervision assignments, set treatment team priorities or areas of specialization (e.g., adult or child services), and hire adjunct faculty when necessary. I solicit student evaluations of their supervisors and supervisor evaluations of their students, dealing with resulting problems that may emerge. And though I supervise the initial screenings of all our incoming clients, I almost always defer to clinicians and their supervisors when it comes to clinical decision-making. The exceptions include situations where safety is an issue or, conversely, where more mundane administrative problems (e.g., unpaid balance, record-keeping, etc.) present as part of the clinical picture.

Marketing

The need for creative marketing talents took me by surprise, but I have now developed a successful and comprehensive marketing strategy for the PSC. Because one of my primary areas of interest is in community mental health, I am interested in seeing the PSC fill a necessary niche for mental health services in our local community. After four years in my position, I have had to become proficient in web and graphic design, as well as the appropriate use of internet advertising. I have also made certain that my office manager and secretary could conduct the perfect mail-merge. I have made a concerted effort to keep our university press office, the local media, local agencies and clinicians aware of our ongoing programs by direct, personal communications. In fact, one of my biggest marketing successes has been the creation of an email list serve of local clinicians and agencies. Because I use this list serve primarily to distribute information that benefits the recipients (e.g., notices of training opportunities, special programs, etc.), when I make announcements about the PSC, people do not immediately hit the *spam* button.

Clinical Supervision and Teaching

Obviously, most of my time is spent actively in the provision of clinical services, either directly as the clinician, or indirectly as the clinical supervisor or consultant. I take this aspect of my work very seriously, and I fully appreciate the importance of simply being available to our clinicians, faculty and staff. To this end, I set aside a significant part of each day to sit in the front office, greeting clients, assisting clinicians with paperwork, and responding to questions or problems that arise during the day. I have found this time to be extremely valuable, both in terms of the assistance I can provide and the relationships I have developed with our clinicians and staff. By simply making myself available, I am able to be a hands-on manager, not a micro-manager, and I come to know the strengths and weaknesses of individual students. Thus, when a student comes to consult with me about a clinical issue, I can often incorporate aspects of their clinical development that I have observed over several years of knowing them (something that is usually a valuable contribution in a clinical consultation).

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Daily Nuts and Bolts

Like any university, ours provides many services that I can call upon in need. But as previously mentioned, there are times when it is simply easier for me to tackle a mundane problem that occurs in the PSC. Occasionally, I deal with problems of my own creation, such as recently, when my aggressive hand washing led to cascading pools of industrial hand soap from the broken dispenser. But other times, it is just simpler for me to troubleshoot a computer, make a quick change to our website, take a client payment, hang a new framed picture in the hall or change the toner in the copier. I once asked a mentor of mine, an employer at the time, why he had taken his time to complete a small menial task that could easily have been assigned to someone else. He explained that there are times when a leader's job is to take action, even in small matters. Failing to do so can distance you too greatly from the details that make a larger organization successful, advice I try to remember.

Road to Current Position

Before returning to UMass in my current role, I took several other steps that later proved instrumental in my development as a clinician and administrator. My clinical internship year took me from Amherst to New Hampshire, where I worked in child and family community mental health at Dartmouth Medical School. As is true for all clinical internships, I quickly learned how intense a full-time clinical practice can be, particularly when one's clients are children who bring a chain of clinical contacts that extends to parents, teachers and in one of my favorite cases, the baby-sitter. But perhaps more important to my current career path, I began to observe some of the programmatic difficulties experienced by the agency I worked for, and I realized that my interest in clinical administration was strong. Understanding ways to improve access to mental health treatment in underserved communities became a personal passion, and clinical administration quickly emerged as an obvious path. Of course, this was not something that was entirely new to me. As a graduate student, I sought out leadership opportunities in both clinical and academic realms. I viewed these activities as opportunities to expand the impact of my own clinical training well beyond the lives of the clients on my caseload.

Like all community mental health centers, my internship site suffered from a rather common problem; our costs outpaced our income. Frustratingly, this seemed to have nothing to do with our business model or clinical services. Our client census was high enough to support a robust waiting list, and thanks to universal health care for children in our state, almost all our clients had some form of insurance. In our local community, personal living expenses were modest, making office space more affordable and justifying relatively lower (yet competitive) salaries for psychotherapists. At the same time, our reimbursement rate was commensurate with third-party contracts in other areas of the country. We had a solid staff of dedicated psychologists with very low turnover and these excellent clinicians supported an internship program that consistently attracted outstanding students from across the country. We had free parking.

But we also had many problems. Our client no-show rate was quite high while our collections rate remained low (we collected slightly more than 60% of what was billed). When our more economically disadvantaged clients' insurance stopped approving psychotherapy sessions, we were faced with the dilemma of continuing to provide treatment without reimbursement or discharging clients still in need of ongoing mental health care. Delayed or overlooked clinical paperwork meant delays in mental health approvals, errors committed by clinicians and administrative staff alike. Ever changing financial circumstances led to inconsistent employee benefits, workload requirements, and job insecurity. And finally, each change in the upper level

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administration affected the climate in our office, and even the relationships between psychologists, social workers, and psychiatrists as new priorities trickled down to the clinical staff. I soon realized that I wanted to participate actively in improving the models of delivery for mental health services, something I felt was crucial for our field's growth.

I surprised myself by deciding not to march directly to a post-doctoral fellowship in pursuit of my licensure. Instead, I sought out opportunities to teach at the undergraduate level, something I had enjoyed and excelled at during graduate school. Because of personal connections to the area, I conducted a targeted, regional search and found myself at New England College. What it lacked in financial resources was made up for with the energy of the extremely dedicated faculty and staff, small classes, and active student engagement. I encountered a wealth of potential faculty mentors, each of whom respected my talents and encouraged me to work in my areas of strength. Because we were small, I worked closely with the sociology department, the education department, as well as the campus mental health service. I quickly gathered experience teaching a range of courses from basic introduction to psychology to the most advanced courses in clinical psychology. It was not a difficult transition, having finished graduate school with several courses fully prepared and under my belt, and I certainly did not miss the grueling clinical schedule I would have maintained as a post-doctoral fellow and full-time clinician. What I did not expect was a call from the Dean of the Graduate School asking me to take over the position as Director of their Community Mental Health Counseling Program, a graduate program that led to licensure at the masters level in New Hampshire. Although I felt quite prepared to take on this challenge, I also felt lucky to be in the right place, at the right time, and with the right training. I had the privilege to gain invaluable experience in program development, budgeting, the admissions process, and of course, university politics. Working as the director of this program for two years was an excellent counter-point to my previously intensive clinical training. I felt I had a new tool in my belt that could extend the influence of my clinical training.

So when my wife decided she wanted to return to school to become a Nurse Midwife, I looked for clinical teaching and administrative positions, with an eye towards completing my post-doctoral hours required for licensure. Unexpectedly, I received two international offers, one in Scotland and one in Australia, each of which would allow me to provide clinical services and work in clinical administration. But while both were attractive in their own right, I worried about losing touch with my family, and about completing my licensure in the United States. Perhaps magically (luck again shows itself), this was very near to the time when my former advisor had first approached me about the clinic director job, a new position being created in two stages from part- to full-time. When he offered to supervise a part-time position as a post-doctoral fellow to help me complete the clinical hours needed for licensure, it was practically a done deal. Since that time, my wife and I have been extremely happy returning to the area where we both attended school.

Most Satisfying Aspects of Current Position

Being a clinic director has enabled me to explore methods of service provision, staff training, and program management with the goal of improving the quality of care we provide to our clients. Because I have the autonomy to make adjustments along the way without excessive bureaucracy, I have been able to intercept some problems before they became entrenched in clinical or administrative practice. When I identify an area of need in our local community, I can respond with a service that is targeted and timely. The positive feelings I always experience when I help a client change

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his/her life are amplified immeasurably when I manage a clinic in which many clinicians can experience the same success. Similarly, working in the role of supervisor for clinicians in training has improved my own clinical work, both from exposure to the brilliant minds of the students and faculty with whom I work, and from being forced to consider the implications of my work at all levels, administrative, financial, clinical and professional.

Ironically, because we are a training clinic, there is an upper boundary to our growth. While this is frustrating in some respects, it also helps me to remain focused on our primary mission. In doing so, I hope we continue to improve in our areas of clinical specialty, as well as to generate solid and reliable data for psychotherapy research.

Most Challenging Aspects of Current Position
I do feel the burden of responsibility for the lives of the clients in the PSC, often becoming concerned about particular clinical situations that have arisen. It takes a great deal of discipline not to bring these concerns home at the end of the day. While this is something we as clinicians have all had to learn, as a clinic director, the possibility of experiencing this on a magnified scale can be great.

My work also extends into many different areas of our clinical psychology program, and I have learned to navigate the university's ocean of red tape with some skill. Because of this, I am often asked to assist in projects that are not necessarily part of my job, and may not even fit into my day. Because I have been generous with my time in the past, the number of these requests has increased over time. Unfortunately, this has left me in a situation I particularly dislike; that is saying no to people I would like to help.

Finally, I am quite happy to be exempt from the tenure requirements of the current system at our university. However, I am often frustrated by the subtle ways in which clinical work, community outreach, administration, and teaching can be undervalued at a research university. I would be lying if I did not admit that there have been times when I felt I had to work twice as hard to garner the same level of respect that might have been given to me automatically had I come to the university as an Assistant Professor.

Pearls of Wisdom
If you are thinking of going into clinical administration, I hope the following suggestions will help.

Let Clinicians and Supervisors Do Their Job
Regardless of how much you might wish to affect the lives of the clients in your clinic directly, it is important not to take on that responsibility. Leave the primary responsibility for clinical care where it belongs, with the clinician and his/her supervisor. Only get involved when it is clinically or ethically necessary or when consultation is requested. Be a resource, not a back-seat driver.

Always Clarify Your Role
When you are asked to assist with a clinical issue, research project, or other task, always take the time to clarify your role. Are you being asked to do a personal or professional favor or are you being asked to be a formal collaborator with whatever benefits this might entail? When you take on new tasks, will they become part of your job in perpetuity or is there a plan for them to revert to their rightful owner? Although these conversations can occasionally be awkward, I am never more disappointed than when I find myself saying "yes" when I should have said "no" or when I had to pull myself off a project because I was overcommitted.

Start a Consultation Group
Find a group of similarly experienced colleagues that you do not work with directly and arrange a formal or informal consultation group. This can be an amazing way to

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create a network of support to assist you with problems you encounter with your work colleagues or job responsibilities. It is refreshing to be able to seek assistance without concern for how doing so might affect your standing at work.

Don't Try To Do Everything
Because being an administrator often means a lot of autonomy in terms of defining one's priorities and projects, it is tempting to try and tackle too many problems at once. It is important to remember that your job will follow a developmental progression. Things you do not have time to work on this year will still be around next year.

Try Everything Once When Possible
It is easier to understand your staff's perspectives and jobs when you have tried them yourself. When our secretary was out sick for several consecutive days, I decided to clear my schedule and work her desk as a way of learning more about her job. By the time she returned, not only was I more excited about returning to my own job (a built-in morale booster), but I was more effective at troubleshooting our procedures for managing client appointments, payments, and records. Perhaps more importantly, I had a new respect and appreciation for the importance of her position in the overall functioning of our clinic.

Remember That Bad News Flows Up and Good News Stays Put
If I could only impart one kernel of newly earned wisdom, it would be to remember that bad news always makes its way to your doorstop, while good news may not. When things are going well, people generally do not need you as much as they do when problems arise. Identify ways of keeping yourself in the loop when good things happen so you can share in the feeling of success, and give credit where credit is due. Not only will your presence improve your rapport with your colleagues and staff, but it will work wonders on your own job satisfaction and happiness.

Author Note
Anyone who may wish to learn about the Psychological Services Center and our programs can visit us on the web at www.umass.edu/psc. I also welcome any follow up communications or questions at overtree@psych.umass.edu.

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APA's Division of Psychotherapy is pleased to announce:

THE DISTINGUISHED PUBLICATION OF PSYCHOTHERAPY RESEARCH AWARD

In consultation with the Division 29 Board of Directors, the Division 29 Research Committee is instituting The Distinguished Publication of Psychotherapy Research Award. This award recognizes the best empirical (i.e., data-based) published peer reviewed article on psychotherapy in the preceding calendar year. Articles appearing in any journal (i.e., they need not have appeared in the Division's journal) are eligible for this award.

We ask members of the Division to nominate articles for consideration by April 15. Nominations should include the complete citation for the article, and should be emailed to the Chair of the Research Committee, Dr. Sarah Knox, at sarah.knox@marquette.edu.

A selection committee appointed by the Chair of the Research Committee, in consultation with the President of the Division, will evaluate all nominated articles, and will make a recommendation to the Division's Board of Directors by June 1. Upon approval by the Board, the author(s) of the winning article will be notified so that they may be recognized and receive the award at the upcoming APA Convention. Accompanying this award is a plaque.

All methods of research will be equally valued (experimental, quasi-experimental, qualitative, descriptive/correlational, survey). Nominations of articles addressing issues of diversity in psychotherapy are especially encouraged. Current members of the Research Committee and the Selection Committee will not be eligible for the award, so no articles by members of the Research Committee will be considered. Also, committee members will recuse themselves from voting on articles by current or former students, as well as collaborators.

The criteria for the award appear below.

- the rationale for the study and theoretical soundness,
- the methods
- the analyses
- the explanation of the results
- the contribution to new knowledge about psychotherapy (e.g., the work is innovative, creative, or integrative; the work advances existing research in a meaningful way); greater weight will be given to novel/creative element than to methodological/statistical rigor
- relevance to psychotherapy practice

Different Perspectives Perhaps?

Pat DeLeon, Ph.D., former APA President

The Foundation World

One of the most rewarding aspects of working on Capitol Hill is the constant exposure to futuristic, highly creative thinkers. Today, our nation's healthcare system is undergoing unprecedented change. Accordingly, it is imperative that the leadership of professional psychology be responsive to the challenges of the 21st century and particularly, by developing comprehensive strategies to assist our next generation of practitioners in their efforts to establish viable practice niches over the coming decades. Since 1972, the Robert Wood Johnson Foundation (RWJ) has been the nation's largest philanthropy devoted exclusively to health. It is the nation's fourth-largest foundation, awarding between $400 and $500 million annually, while possessing a very broad definition of what constitutes "health." Fortunately for psychology and the behavioral sciences, RWJ enthusiastically endorses data-based decision making and has funded a number of projects over the years which we would consider fundamentally psychology-oriented. A critical question for the readership is to what extent are psychologists involved in RWJ's programs; or perhaps equally important, is psychology helping to shape RWJ's priorities?

For the past eleven years, RWJ has published its *Anthology* series through which it systematically shares information with the public regarding its goals, accomplishments, and hopes for the future as it addresses our nation's health challenges. The most recent volume highlights the Foundation's efforts over time to improve the overall **quality** of health care which is available to our citizens, a focus which has often been unrecognized by many. "Quality is an area, like health services research, tobacco control, and end-of-life care, where the Foundation has spurred the creation of a field. It did so by funding research, strengthening the capacity of researchers, financing demonstration projects, developing standards, supporting professional organizations, and backing champions who have played and continue to play critical leadership roles." "Americans everywhere are subject to the dangerous vagaries of the health care system: uncoordinated care that leaves patients open to too many mistakes, care that falls short of what science tells us is the best treatment, little recognition that the patient's active involvement is invaluable to the healing process, and almost no use of the information technology that has transformed the world outside of health care.... At the dawn of the twenty-first century, however, a nationwide movement to improve health care quality was attracting considerable attention. 'In the area of quality, there's probably been more traction gained than in anywhere else in health care over the last ten or fifteen years'.... For much of the previous century, it was simply assumed that American health care was the best in the world and that doctors didn't need anyone meddling in how they approached their practice. Besides, doctors often said medicine was both an art and a science, and quality was not something that could be dictated or defined.... Although the longtime confidence about American health care persisted, the people at the front lines knew a different story. The doctors and nurses had what amounted to a closely guarded secret among themselves about the dangers patients faced...."

From a public policy and especially a clinical training perspective, professional psychology must systematically address the

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importance of the reality that today care for those with chronic illnesses accounts for nearly 70 percent of health care spending and further, that the services presently available in the community are simply inadequate to help patients manage their conditions. The current payment system rewards providers for doing more, including correcting their own mistakes, rather than for good outcomes. The Institute of Medicine (IOM) has dramatically stated that: "The current care systems cannot do the job.... Trying harder will not work. Changing systems of care will." Calling for health care to be "safe, effective, patient-centered, timely, efficient, and equitable," the IOM has instigated a seismic push to transform the lumbering giant that is American health care. Reflecting the findings of the IOM, RWJ has focused its quality efforts on five areas: • Measuring the quality of care; • Reengineering hospitals and health systems; • Improving the working conditions of hospital nurses; • Changing the payment system to give incentives for care that meets quality standards; and • Providing patient-centered care. A sixth area of considerable importance to psychology—reducing health disparities—would eventually be integrated into the RWJ quality care agenda. In 2006, the RWJ Board of Trustees took the dramatic step of deciding to consolidate their grantmaking into a single priority area targeted to improve quality and to decrease disparities. One national healthcare policy expert opines: "We have managed over the last few years to break down a lot of myths about how health care can't get any better, that it's just the way it is, [that] there are always going to be errors.... People realize now that it doesn't have to be this way. We can make it a whole lot better."

Another *Anthology* chapter focuses upon the mental health and substance abuse needs of our citizens, noting that: "It is ironic that the most vulnerable members of American society face the difficult, sometimes nearly impossible, task of dealing with multiple systems." The large number of people who suffer from co-occurring mental illness and substance addiction is not widely appreciated, even though it affects about three percent of the adult population of the United States. Looked at from a different perspective, as our colleague **Steve Ragusea** has pointed out on numerous occasions, approximately half of the people with severe mental illnesses also have a substance abuse problem. Individuals with an existing mental illness consume roughly 38 percent of all alcohol, 44 percent of all cocaine, and 40 percent of all cigarettes in the United States, and those who have ever experienced a mental illness consume about 69 percent of all the alcohol, 84 percent of all the cocaine, and 68 percent of all cigarettes.

A particularly thoughtful chapter focuses upon how the "built environment" – that is, the physical and social environment in which we all live—has over time become inhospitable to physical activity. And, how partly as a consequence of sedentary lifestyles, obesity rates have climbed dramatically over the last half-century, leading to significant increases in diabetes, heart attacks, and other illnesses. In 2000 and 2001, RWJ developed a series of Active Living programs designed to restructure the "built environment" in ways that would make it easier for people to take walks, go for bike rides, or otherwise get physical exercise. The idea is not a new one, as it had been fashionable in urban planning circles for decades. What **was** new was that a foundation dedicated to improving **health** would seize upon an idea that was basically an urban planning one. Developing and overseeing these programs required Foundation staff members – most of whom were trained in the medical care system, public health, or social science research – to expand their horizons and learn about behavioral psychology, urban planning, education, and transportation. Perhaps "new" for America; however, colleagues interested in international healthcare might suggest that the British National Health

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Service (NHS) has long appreciated the importance **and** cost-effectiveness of providing a highly holistic, broadly conceptualized approach. That healthcare is more that than providing "medical care;" that the psychosocial-economic-cultural gradient of care is absolutely fundamental to **quality** care. RWJ recently announced a $500 million programming effort to reverse the epidemic of childhood obesity. The lessons learned from their Active Living grant portfolio are being actively applied to the development of programs addressing this issue. From my perspective, psychology's systematic evolution into the integrated healthcare arena is highly consistent with the overall trends occurring within our nation's broader healthcare environment and thus, speaks well for our next generation's future.

Bringing Public Policy Development Closer To Home

A summary of the work of the APA Task Force on External Funding is presented in a December, 2007 *American Psychologist* article titled, "Corporate Funding and Conflicts of Interest: A Primer for Psychologists." The Task Force was developed as a Presidential initiative of visionary **Philip Zimbardo** and was co-chaired by **Wendy Pachter** and **Ron Fox**. Ron is a former APA and Division President, as well as a dedicated advocate for prescription privileges (RxP). Wendy's work as the sole clinical psychologist in a rural community health center (interestingly, a RWJ demonstration project), subsequent work as a full-time faculty member in Family Medicine at the College of Medicine at the University of Vermont, and earlier research in basic psychopharmacology provided some background for her work on the Task Force. She is also a lawyer who came to Washington, DC as an APA Congressional Science Fellow where she served as a legislative assistant to U.S. Senator Bill Bradley (and also debated RxP with state medical society presidents at meetings in several states), practiced food and drug law with an international law firm, assisted the Judicial Conference of the United States with the development of the first Long Range Plan for the federal courts, and directed the Institute of Medicine's study on Health and Behavior: Research, Practice and Policy. She has experience in conflict resolution in policy development and also chaired the ethics committee for the Maryland Psychological Association, in addition to serving on APA committees and holding public interest positions.

Wendy:

"When Phil proposed the Task Force in 2002 after observing the role of pharmaceutical companies at an annual meeting of the American Psychiatric Association, it was very controversial because it was viewed by some leaders within the RxP movement as an effort to undermine efforts to obtain prescription privileges for psychologists. For that reason, very careful efforts were made to ensure a balanced composition of proponents and opponents of RxP in addition to finding Task Force members who were qualified by virtue of their experience, knowledge and skills. I had some familiarity with problems of pharmaceutical influence and the Food and Drug Administration, having worked briefly for a pharmaceutical company after college and later practicing food and drug law. Coincidentally, just before the Task Force was formed, I had been an invited guest at an American Institute for Biological Sciences meeting where I heard a paper about experts (the example was an ecologist) being 'bought' by industry (in this case land developers). At that meeting, I participated in discussions of whether and how codes of ethics could help with the newer problems posed by corporate funding. Some of us realized that the issue was much broader than just one industry or one field.

"It is important for APA members to know that the charge to the Task Force was not about prescription privileges. It was instead to review APA policies, procedures and practices regarding external funding

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(which we limited to corporate funding given our time and resources) and to recommend any changes and policies deemed necessary to enhance and protect the integrity and ethical standards of psychology. As described in the *AP* paper, we used pharmaceutical funding and the experience of medicine as a case study for several reasons, but recognized that funding from other industries can also pose a threat to the independence of psychology. Our recommendations are meant for individual psychologists and for the governance boards and committees of APA to consider as they develop and implement policies to address the problems identified.

"While Task Force members started with very different perspectives, experiences and some strongly held positions, I think it is fair to say that as we worked we were all amazed at the nature and scope of the problems we found in the conduct of science, education, practice, administration, and development of policy. For example, one of the tactics we learned about was the use of front organizations and 'grassroots' groups to fund 'science' or promote 'consumer-friendly' policies, or provide 'medical education' without anyone knowing that it is industry that funds the activities and controls the agendas, outcomes and dissemination. More recently, we have learned about data-mining—a practice in which pharmaceutical detailers use data about the prescribing practices of individual physicians without their knowledge and consent to structure their sales pitches to those individuals. And, that more than two-thirds of the ApA's task force charged with revising the ever-expanding Diagnostic and Statistical Manual of Mental Disorders (DSM) have financial ties to the pharmaceutical industry. Several members, including the task force chair, failed to disclose significant elements of their dealings with the industry.

"The paper and recommendations have received favorable reviews on blogs outside psychology, including one dealing with human research subject protections, and one that addresses reform of medical prescribing. The fact that the recommendations of a group that started with such divergent perspectives were unanimous should convince skeptics to consider seriously the problems and recommendations we described, apart from whether or not you believe psychologists should seek prescription privileges. The bottom line is that the recent history of corporate involvement in science and in health professions education demonstrates that we cannot assume that the interests of psychology as a science and profession are aligned with those of industry. Instead, we need to be proactive on behalf of the integrity of psychology and the trust of the public we serve.

"The first phase of the relationship between corporations on the one hand and sciences and professions on the other, has been skewed to allow corporations to exert enormous influence on many sciences and professions. It is time for a correction in the balance of power. This is a time when scientists and practitioners, those in favor and those against prescription privileges, should be able to unite on behalf of psychology as a whole. And we should also unite with honest scientists and practitioners in other related fields to maintain the integrity of science, education, and health care."

Wendy and I urge the readership to please read, debate and discuss her article and encourage the APA Council of Representatives to act on its recommendations. We both hope APA will also develop a discussion list, conduct research on the experiences psychologists have already had with corporate and other external funding, and develop educational and continuing education materials, perhaps a casebook, to demonstrate potential problems and ways to deal with them. Wendy would be happy to hear from anyone with other ideas [wsp9@verizon.net].

Aloha,
Pat DeLeon, former APA President – Division 29

Documentation, Record Keeping, and the APA Record Keeping Guidelines

Jeffrey E. Barnett, Psy.D., ABPP, Independent Practice, Arnold, MD, and Layola College in Maryland
Crystal A. Kannankeril, M.S., Loyola College in Maryland

Documentation and record keeping are important aspects of each psychotherapist's clinical work. They serve a range of important functions. For example, timely and effective documentation can:

- **Improve ongoing services**: Our documentation can help us to keep track of services provided to current clients and provide us with useful reminders of important issues to follow-up on. It can alert us to trends in treatment that need to be addressed.
- **Help if a client returns to treatment at a later date**: At times clients may leave treatment for a variety of reasons, but should they return for further treatment at a later date having comprehensive treatment records to review can be of great value. For those conducting evaluations and psychological testing, having the results of previous evaluations to compare current findings to may prove very useful.
- **Assist other clinicians who work with our former clients**: If a client completes treatment with us and at a later date returns to treatment with a different clinician having comprehensive treatment records (or at least a summary of important aspects of treatment provided and results achieved) to share with the new clinician can greatly assist their treatment.
- **Enhance communication among treatment team members**: For those working on a treatment team, such as in inpatient settings, sharing relevant treatment related information among team members can be essential for quality services to be provided. The clinical record is the mechanism for documenting such information that is then immediately available to other treatment team members.
- **Meet accountability requirements**: Those working within insurance and managed care will often be required to document services provided for accountability purposes. Timely and comprehensive documentation can demonstrate services provided and outcomes achieved to utilization review personnel.
- **Meet legal and ethics requirements**: Beyond these potential clinical benefits of documentation it also serves legal and ethical functions as well. For most licensed psychotherapists, the documentation of all services provided is a legal requirement. Additionally, the documentation of the services we provide is essential for demonstrating our efforts to meet the standards of care of our profession should a complaint or malpractice suit ever be filed against us. As is widely accepted in the legal setting, if it is not documented, it did not happen (Slovenko, 1979). Thus, as Wilbert and Fulero (1988) found, most clinicians find effective documentation of all services provided to be an important risk management strategy.

As an example of legal requirements for documentation, the *Code of Ethics and Professional Conduct* (COMAR, 2004) states: "A psychologist shall document and maintain appropriate records of professional and scientific work" (Title 10.36.05 (7)). Additionally, the Medical Records Act (Health General Article, 1992) mandates specific documentation requirements for all licensed health professionals in Maryland to include how long records must be maintained, who may have access to them, when they may be disclosed, and the like. For example, this law requires that

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all records be maintained for a minimum of five years from the date of last professional contact and for minors, for this time period or until age 21, whichever is later (Title 4-403, b, c). Most other jurisdictions have similar legal requirements.

The *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) (APA, 2002) also provides enforceable standards for all its members in Standard 6. Record Keeping and Fees. This standard requires psychologists to document all professional services provided, and to "maintain, disseminate, store, retain, and dispose" of them with the following purposes in mind: "to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law" (p. 1067). Additional standards are provided for the maintenance, dissemination, and disposal of records and for withholding records for nonpayment. But, unfortunately, many aspects of these standards are quite general and specific guidance is not offered in the Ethics Code for the application of these standards.

In recognition of the fact that the APA Ethics Code may not provide sufficient information to guide psychologists in their efforts to achieve the highest ideals of ethical practice with regard to documentation and record keeping, the APA has developed and recently revised its Record Keeping Guidelines (APA, 2007). Like all other practice guidelines provided by APA, these are aspirational in nature and intended to provide helpful guidance for psychologists in meeting their ethical obligations. At the same time, the guidelines are clear in stating that relevant laws supersede the guidelines should the two ever be in conflict. Thirteen specific guidelines are provided. Each offers a rationale and specific application recommendations for psychologists. The guidelines are summarized below.

Responsibility for Records: Psychologists are responsible for the development, maintenance, and preservation of clients' records. The documentation should clearly describe the psychologist's work such that the psychologist or others legally authorized to the record would be able to understand the content and rationale of the session. Efforts should be made to keep the clients' records accurate, legible, organized, and in accordance with legal and ethical standards.

Content of Records: Psychologists have jurisdiction over what content will be included in a client's record. These decisions may be based on providing high quality care, assisting other involved professionals, making treatment decisions, receiving supervision, providing reimbursement information, and being prepared for possible legal involvement. Thus, psychologists must determine the level of detail appropriate for documentation in each client's record. In this decision, psychologists should include the nature of services and clinically relevant information in line with legal and ethical standards, while taking into consideration the client's wishes, intended uses of the record, third party contracts, and the rules of the agency with which the services were provided. More detailed records may be helpful in providing the psychologist and other involved personnel with valuable treatment information; however, it may bring up concerns over privacy or feasibility, as in emergency settings. The APA Record Keeping Guidelines also outline three types of information that should be included in a client's record: general information such as informed consent and client history, documentation about each substantive contact with a client including date and type of service, and other specific information such as current risk factors, plans for future interventions, case-related contacts, and prognosis, among others.

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Confidentiality of Records: Psychologists should establish and maintain confidentiality with regard to clients' physical and electronic records, as mandated by law and ethical standards. Not only does confidentiality help protect the client's information, but it also promotes trust and safety in the therapeutic relationship. Psychologists should be educated on state and federal laws as well as ethical standards surrounding confidentiality, and endeavor to use them as a guide in their documentation and professional work. Psychologists should set up procedures to ensure that confidentiality is maintained to include obtaining legal consent to disclose confidential information and educating staff about confidentiality laws and ethical standards.

Disclosure of Record Keeping Procedures: As part of the informed consent process, psychologists may disclose record keeping procedures when it is indicated that the client may have a desire or need to know such information. This disclosure may be important for clients who have concerns about confidentiality, such as those with legal involvement or child custody cases. In addition, clients whose expectations about recording keeping procedures differ from the actual procedures may benefit from such a disclosure. Examples may include unwanted re-release of records when forwarded to another psychologist for continuation of care or specific policies related to the work setting, such as having an electronic file at a hospital which is accessible by various staff members.

Maintenance of Records: Psychologists aim to actively update and maintain accurate and logically organized records. Such procedures will benefit the client, particularly with continuation of care, as well as the psychologist who will be able to monitor the client's progress and response to interventions. Recommendations for maintenance of records include dividing the records into psychotherapy notes as defined by HIPAA, which are stored apart from other treatment-related materials to include client information, materials from the client or third parties, and any psychological test data.

Security of Records: Psychologists should take appropriate steps to safeguard clients' records from unauthorized access, damage, and destruction. Security procedures should be followed in two main areas: maintenance and accessibility of records. For paper records, psychologists may maintain records by keeping condensed records in separate locations in case of building damage; storing records in locked drawers, and offices may restrict access from unauthorized personnel. Given the security risks of electronic records, psychologists are encouraged to archive and backup electronic data in addition to establishing passwords and setting up firewalls on their computers.

Retention of Records: Without any other overriding requirements, clients' full records should be kept for at least seven years after the last date of service or until three years after a minor reaches the age of maturity, whichever is longer. Psychologists should also take into consideration costs and benefits of keeping records for a longer period of time. By keeping records, psychologists will be able to provide for continuation of care as well as provide information for any legal issues or hearings. However, costs may include logistic difficulties and expenses for the psychologist as well as preserving potentially embarrassing or obsolete information about the client.

Preserving the Context of Records: Psychologists strive to preserve information about the context of content in the clients' records. Every so often, a client will disclose information that is situation-dependent and may not be an accurate representation of the client's overall functioning. As such, psychologists should attend to these factors and be sure to reflect such context in the client's record.

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Electronic Records: Electronic records should be created, maintained, and disposed of in ways that ensure confidentiality, compliance with legal and ethical standards such as the HIPAA Security Rule, and that restrict access by unauthorized personnel. Though advances in technology may make record-keeping easier to maintain and organize, psychologists should still be cautious and knowledgeable about the associated risks of electronic records. Psychologists should develop security methods, such as using a case identification number instead of one's Social Security number as well as using passwords or encryption procedures.

Record Keeping in Organizational Settings: Psychologists working in organizational settings such as hospitals and schools may encounter conflicts between the organization and APA Ethics Code and Record Keeping Guidelines. When conflicts between the organization and other requirements occur a review of relevant laws and consultation with colleagues and legal experts about record-keeping practices are recommended. Uncertainties about the ownership of records and who has access to records should also be determined prior to treatment to help minimize the likelihood of misunderstandings. Conflicts should be identified and resolved as consistent with managing conflicts according to the Ethics Code or superseding laws. Also, multidisciplinary records are not typically afforded the same level of confidentiality as psychological records; psychologists should take this into consideration when creating and maintaining accurate but minimally invasive records.

Multiple Client Records: As couple, family, or group psychotherapy involves more than one person, psychologists should maintain accurate records while striving to protect the privacy and confidentiality of the other parties involved. In an effort to avoid such situations, psychologists may define the identified client(s) and who has the right authorize record release in the informed consent process. In situations that include multiple individuals such as group therapy, the psychologist may keep a separate record for each identified client. In cases where the identified client may include several people such as family or couple, psychologists may opt for one single record, but release only parts of the records that are relevant to the client designated in the release form.

Financial Records: Keeping accurate and complete financial records allows complete documentation for reimbursement of third party payers and an outline of which services are being billed. Financial records also ensure up-to-date billing that will alert both the psychologist and client of unpaid bills, which if left unattended may have an adverse impact on the professional relationship. Financials records may include the type, date, and duration of services rendered, as well as fee agreements, and the date, amount, and method of payment. Special attention should be given to records with fee agreements, copayments, and barter agreements, which should be carefully documented due to balance of power risks. Specific considerations may include who is responsible for payment, collection policies such as charging for missed appointments or suspension of confidentiality with collection procedures, how financial disputes will be resolved, and payment schedules.

Disposition of Records: As required by the APA Ethics Code and other health care laws, psychologists should have a plan for the transfer or disposal of records that ensures continuity of treatment and preserves confidentiality. Psychologists should develop a plan to protect or transfer records to another qualified individual or agency in case of unexpected events such as involuntary withdrawal from practice or death. Similar arrangements should be made for anticipated events, such as retirement; the psychologist may also decide to retain custody of the clients' records. When changes

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in the custody of clients' records occur, psychologists should strive to notify clients and may consider notifying the public such as by submitting a notice in a local newspaper. Psychologists should also take steps to ensure that confidentiality is maintained when disposing records, such as personally shredding records or using commercial vendors who provide this service. Additionally, psychologists should consider seeking consultation with technical specialists to aid in the full destruction of electronic records since merely deleting them does not render them inaccessible to others.

Additionally, the Record Keeping Guidelines provide a bibliography of helpful references and resources for the following:

- General References
- Content
- Disposition of Records
- Informed Consent
- Multiple Client Records
- Technology
- Privacy and Confidentiality
- HIPAA Resources

In addition to the original publication in *American Psychologist*, the APA Record Keeping Guidelines may be accessed online at: http://www.apa.org/practice/recordkeeping.html. Psychologists are encouraged to familiarize themselves with the details of these important guidelines and to utilize them in their efforts to meet the highest standards of care possible in their clinical work.

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Michael D'Andrea, Ph.D.

Michael D'Andrea is a professor in the Department of Counselor Education at the University of Hawaii and the Executive Director of the National Institute for Multicultural Competence. His scholarly work, which includes the publication of six books and over two hundred book chapters, journal articles, research publications, and other scholarly works, has impacted the fields of counseling and psychology in many ways.

One of his most respected scholarly achievement involves the publication of the 6th edition of a well-used textbook in the field entitled, "Theories of Counseling and Psychotherapy: A Multicultural Perspective" (published by Allyn and Bacon in 2007). This textbook is distinguished from others in that it, not only provides a detailed and comprehensive presentation of the central theories of psychotherapy that are commonly used in the United States, but does so in a way that fully integrates multicultural, social justice, and feminist perspectives in each chapter.

Dr. D'Andrea received his training at Vanderbilt University and graduated with his doctoral degree in 1982. Over the past twenty-five years his research endeavors have focused on the effectiveness of various psychotherapeutic approaches with adults who have experienced serious and chronic mental health problems.

In addition to the research area stated above, Dr. D'Andrea has conducted a 40-year review of the professional literature to assess the impact that White psychotherapists and counselors have in promoting positive psychological changes among persons from diverse cultural, racial, and ethnic backgrounds. The results of this recent research endeavor will be published in a special issues of the *Journal of Counseling and Development* in the Summer of 2008 in a section that discusses the efficacy of counseling and psychotherapy in multicultural situations as reflected in research publications in the fields of psychology and counseling over the past 40 years.

Dr. D'Andrea is the recipient of 12 national and international awards for his scholarly achievements and clinical accomplishments. This includes being recognized as a fellow in two divisions in the American Psychological Association (APA). This awards were presented by Division 17: The Society for Counseling Psychology and Division 45: The Society for the Psychological Study of Ethnic Minority Issues.

While his scholarly contributions and professional awards are well respected, he is equally known for the strong stands he has and continues to take on a broad range of multicultural, social justice, and peace issues in the fields of psychology, counseling, and education. In this regard, Dr. D'Andrea's publications, presentations, and professional endeavors frequently focus on the important roles psychologists and psychotherapists can play in fostering positive transformative changes in our contemporary society.

Jeffrey J. Magnavita, Ph.D., ABPP

I am honored to accept the nomination from Division 29 and place my name on the ballot for President-elect. Division 29 represents an elite group of practitioners, clinical scientists, and teachers and is one of the most important voices for the advancement of the art and science of psychotherapy. This Division has been one of my professional homes for over 25 years and I have grown immensely from my involvement as a member, keeping abreast of developments, presenting at division meetings, and publishing in the *Psychotherapy Bulletin*. I have learned a great deal from past and current presidents of the Division, as well as many others who have contributed to my development and mentored me. Recently, I have had the opportunity to work with the Division during what has turned out to be a period of growth and development. An urgent call for inclusiveness to all who share our keen interest in psychotherapy has been advanced under the fine Presidents, both past and current, as well as committee chairs and members, who have restructured the division and strengthened our flagship journal *Psychotherapy: Theory, Research Practice Training*, the *Psychotherapy Bulletin*, and our webpage. I feel personally compelled to accept the nomination for President-elect because of my belief in the value of our Division. I am fueled by the enthusiasm and excitement of many of those who have worked diligently to advance psychotherapy as a scientifically based healing art.

In my roles as the Chair of the Program Committee for two years and currently as the Fellows Chair I have met many of you personally as well as electronically and heard about your various interests and your passion for psychotherapy. I have also served as a member of the editorial board for our journal *Psychotherapy* and have been impressed by the quality of the submissions that I have reviewed. I have practiced psychotherapy for 25 years in full time private practice and feel privileged to have had the opportunity to serve in this way. I have published extensively on psychotherapy, personality and psychopathology and conduct psychotherapy seminars around the country and occasionally internationally. My work has been recognized by APA with the 2006 *Distinguished Contribution to Independent Practice of Psychology* Award for my work in personality systematics and unified theory.

If you elect me to serve as President of Division 29, I plan to advance an agenda which will emphasis *Service, Practice, and Science*. Our members are amazing in the amount and quality of service that they provide to those in need. Many of you offer your much valued services to those in need, quietly and under the radar. I would like to spark more widespread interest in community service. I have recently co-founded a not-for-profit organization called *Community Health Alliance of Mental Health Professionals Inc*. (CHAMP) to serve as a mechanism to match the needs of community agencies who serve the mental health needs with professionals on a pro bono basis. I would like to encourage others to heed the call to serve. I would also like to strengthen psychotherapy practice by advancing and integrating cutting-edge technology in our Division. In this respect I would like to create a state-of-the-art internet site where learning and information is easily accessible in the form of video conferences, podcasts, speakers, and research updates, where we share and discuss cutting-edge research applicable to practice. Although we have numerous "hits" on our site, unfortunately, few make return visits. We must fully join the age of technology to enhance our presence and disseminate our knowledge. I would also like to strengthen our scientific foundation by encouraging interdisciplinarity and unification, integrating findings from related disciplines such as anthropology, neuroscience, economics, and ecology. I envision having think tanks either on-line or at summits in the future! I look forward to your support if you have a similar vision of our future.

Cheri L. Marmarosh, Ph.D.

I am extremely honored to be nominated for the position of Secretary for Division 29.

I bring to the candidacy years of experience in the field of psychotherapy as a clinician and psychotherapy researcher. All of these experiences provided me the necessary skills to serve as division secretary. Currently, I am a full-time assistant professor in the Clinical Professional Psychology Program at the George Washington University. As a faculty member, I am involved in psychotherapy training and have published and presented research that explores the psychotherapy relationship and group therapy treatment. In 2006, I was awarded the Samuels Foundation Fellowship to fund my psychotherapy research. I have been involved in all aspects of the management of this funding. In addition to writing and research, I am on the editorial boards of Division 29's *Psychotherapy: Theory, Research, Practice, and Training* and Division 49's *Group Dynamics: Theory, Research, and Practice.* Although faculty work certainly does require administrative responsibilities, I believe I enhanced my executive skills the most as an internship training director. I implemented the internship program at the Counseling Center at Catholic University in 2002. I was responsible for creating the internship brochure and multiple administrative duties that included drafting the manual, developing policies and procedures, and maintaining records.

Although I have dedicated years to academic life, I am also a licensed psychologist who maintains a part-time private practice. I am active in post-graduate psychotherapy training and am a faculty in the Institute of Contemporary Psychotherapy and Psychoanalysis. Over the years, I have worked as a clinician in university counseling centers, as a faculty member, and as a private practitioner. All of these opportunities have necessitated strong organizational and leadership skills. Perhaps more important than these abilities is my understanding of the issues that face our field, my empathy for psychotherapists who are facing complex challenges ahead, and my strong desire to contribute to the success of our Division.

Neil A. Massoth, Ph.D.

I will make no claims as to why I will be a better secretary than my opponent. My interest in running for office is my desire to become more actively involved in Division 29. I have been a member of this division for decades, but have limited my involvement to attending Convention Social Hours.

I am a self-confessed association junkie. I served on the Board of the New Jersey Psychological Association for approximately 15 years. I was Associate Editor and Editor of the Newsletter, President, Director of Academic & Scientific Affairs, and APA Council of Representatives delegate for two terms.

I served on the Board of Division 51 (Society for the Psychological Study of Men & Masculinity) for approximately 15 years. I was Editor of the Newsletter,

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Neil A. Massoth, Ph.D. Candidate Statement, continued from page 62

Member-at-Large, and delegate to the APA Council of Representatives for one term.

I am currently a member of the Membership Committee of Division 31 (State, Provincial, & Territorial) and have served as a member of the Continuing Education Committee of Division 20 (Adulthood and Aging). Other APA Work includes a term on the APA Ethics Committee, three terms as a member of the Board of Directors of the APA College of Professional Psychology, and I am currently in the third year of a term as a Commissioner of the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP).

Aside from serving on CRSPPP, I am currently not a member of any Board. I see this as an opportunity for change. Why Division 29? I am primarily a psychotherapist and a teacher of psychotherapy. *Psychotherapy* is the only journal that I read cover-to-cover. But the simple truth is that I like the people I have met in this division and wish to become more of a contributor.

Chaundrissa Oyeshiku Smith, Ph.D.

I am honored to be nominated for the position of secretary for Division 29. I received my Ph.D. in clinical-community psychology from the University of South Carolina, completed my predoctoral internship and postdoctoral fellowship in the Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine at Grady Health System, and have been on the faculty within this department since 2006. My primary research interest includes the development and implementation of evidenced-based, culturally sensitive preventive interventions for underserved, minority youth in order to promote healthy and adaptive psychological functioning.

It is my belief that the science and practice of psychotherapy serve as the foundational hallmarks of psychology. As such, I view myself as a practitioner and scholar of psychotherapy. I am dedicated to education and training in psychotherapy, view client advocacy as an integral part of the therapy process, support continued collaboration and communication between clinicians and researchers in psychotherapy, and recognize the importance of the development of culturally relevant psychotherapy practices for an increasingly diverse client population. As a discipline, I believe that it is our obligation to continue to increase public awareness about mental health and the benefits of psychotherapy services.

I am wholeheartedly committed to serving Division 29 and achieving the goals of the Board. My previous experiences managing federally funded research projects highlight my strong organizational skills, dependability, and time management, qualities that are imperative to serving in the capacity of secretary. I look forward the opportunity to serve Division 29 and work closely with Board members in advancing the missions of this division.

Candidates Statements for Secretary, continued on page 64

Jeffrey N. Younggren, Ph.D., ABPP

I am very pleased with this opportunity to run for the office of Secretary of Division 29. I have greatly enjoyed my involvement with APA and with Division 29, having been a member and fellow of the division for many years. I have long been committed to the value of psychotherapy as a core function of professional psychology. In that spirit, if elected, I will bring to the office of Secretary my 35 years of experience as a practicing psychotherapist in both institutional and private practice. I also will bring to the table my experience in ethics and law, gleaned from having served on the APA Ethics Committee and my work as a Risk Management Consultant with the APA Insurance Trust. Finally, I will be able to offer a perspective of our profession from the direction of education and training in professional psychology, knowledge that comes from having just completed six years on the APA Committee on Accreditation.

I truly believe that professional psychology has a bright future, but it also is a profession under siege. With this reality in mind, not only must we work to maintain the identity of professional psychology as an independent and distinct profession, but we must address the realistic reimbursement crisis that currently exists in the profession. Although great care must be taken to avoid the creation of antitrust difficulties, the stark reality is that reimbursement rates for psychotherapy services and psychologists are extremely low and must improve. Finally, we must continue our efforts to better educate the public on the value of psychotherapy as a core health care function.

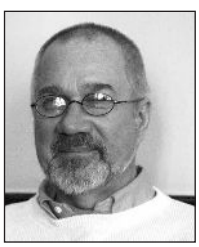
Candidate for Social Justice and Public Policy Domain Representative

Rosemary Adam-Terem, Ph.D.

Aloha. I am honored to be nominated for the important position of social justice and public policy representative for Division 29, my professional home in APA. As a full-time private practitioner, sometime graduate school instructor, and active member of my State Psychological Association I am always aware of the impact of our work, both direct and indirect, on the welfare of others. A long-standing member of the Division of Peace Psychology, during my term on the Council of Representatives I was involved with the debates and initiatives of the social justice divisions. As a member of the Committee on Rural Health, I work with colleagues to try to improve access to care and quality of service available to rural and frontier populations, and to support psychologists working in these regions. Practicing in Hawaii allows me to work with people of many different cultural, ethnic, and linguistic groups, and I am very concerned that psychology address the needs of all minority groups in our society. I have an international background myself: born in India to British parents, and married to a Turkish man, I have lived in Europe, the Middle East and Hawaii. In my current capacity as president-elect of the Hawaii Psychological Association, I am dealing with many aspects of public policy that affect our clients and us as practitioners. Besides constant vigilance on the third-party payment front and the RxP agenda, we are working hard to broaden parity for mental health.

Thank you for considering me as a candidate.

John C. Gonsiorek, Ph.D.



I received my Ph.D. from the University of Minnesota in Clinical Psychology in 1978, and am a Diplomate in Clinical Psychology, ABPP. I am a Past-President of APA Division 44, and have published on professional misconduct and impaired professionals, sexual orientation and identity, professional ethics, and other areas. I am a Fellow of APA Divisions 9, 12, and 44. I am a Clinical Assistant Professor in the Department of Psychology, University of Minnesota. For 25 years, I maintained an independent practice of clinical and forensic psychology, providing therapy services; expert witness evaluation and testimony; and training and consultation. I am currently a consulting editor for *Professional Psychology: Research & Practice*; and work primarily now as a consultant and educator. Major publications include: *Breach of trust: Sexual exploitation by health care professionals and clergy*; *Homosexuality: Research implications for public policy*; *Male sexual abuse: A trilogy of intervention strategies, and Homosexuality and psychotherapy: A practitioner's handbook of affirmative models*.

While new to Division 29, I am not new to APA. My earlier writing and efforts with Division 44 focused on translating what psychology knows about sexual orientation into public policy recommendations. Similarly, my work on impaired professionals involved strong public policy and social justice components. I firmly believe that no discipline is in a better position than psychology to help craft critically thinking and empirically grounded responses to pressing social issues, and I welcome the opportunity to work with

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DIVISION 29 FELLOW JAMES H. BRAY WINS APA'S PRESIDENTIAL RACE

Members elected APA's 2009 president: **James H. Bray, PhD**, a Baylor College of Medicine associate professor of family and community medicine and psychiatry. Active in APA's governance for over 15 years, Dr. Bray is perhaps best known for his clinical work and research on developmental and family factors in divorce, remarriage, adolescent substance use, and collaboration between physicians and psychologists. He has been a Member at Large for the Division for two terms.

Dr. Bray ran to advance psychology as a health profession and to be recognized as a partner and an equal in all the health professions. But while on the campaign trail, he shifted his priorities because in talking with hundreds of psychologists he learned that they are hurting. Practitioners in particular are hurting very badly in their practices. Their reimbursement is going down, not up. APA needs to do something to help by refocusing our energy on this issue.

Dr. Bray also wants to shine a light on those who are homeless. Many homeless people are there because of psychological trauma, mental illness, problems because of drug and substance abuse, physical and sexual abuse. When you give them the help they need, they can become productive citizens. Homelessness is increasing. Dr. Bray would like to see what we can do to turn that around.

Dr. Bray will also continue to highlight the importance of prescription privileges for appropriately trained psychologists. His goal is to have at least three more states adopt the privilege during his tenure. He will do everything he can to make that happen.

For more information, visit www.bcm.tmc.edu/familymed/jbray.

John C. Gonsiorek, Ph.D. Candidate Statement, continued from page 65

Division 29 on such projects. While psychotherapists typically focus on micro levels of changing one individual, couple or family, I believe our observations and skills are also germane to macro, public interest issues. Particularly with the erosion of psychotherapists' professional independence and pressing needs to re-tool our techniques for underserved populations, there is no dearth of timely projects for psychologist psychotherapists to tackle.

The Division of Psychotherapy

The only APA division solely dedicated to advancing psychotherapy

MEMBERSHIP APPLICATION

Division 29 meets the unique needs of psychologists interested in psychotherapy.

By joining the Division of Psychotherapy, you become part of a family of practitioners, scholars, and students who exchange ideas in order to advance psychotherapy.

Division 29 is comprised of psychologists and students who are interested in psychotherapy. Although Division 29 is a division of the American Psychological Association (APA), APA membership is not required for membership in the Division.

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This quarterly journal features up-to-date articles on psychotherapy. Contributors include researchers, practitioners, and educators with diverse approaches.

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Connect with other psychotherapists so that you may network, make or receive referrals, and hear the latest important information that affects the profession.

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As a member, you have access to our Division listserv, where you can exchange information with other professionals.

☐ **VISIT OUR WEBSITE**
www.divisionofpsychotherapy.org

MEMBERSHIP REQUIREMENTS: Doctorate in psychology • Payment of dues • Interest in advancing psychotherapy

Name _____ Degree _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Email _____

Member Type: ☐ Regular ☐ Fellow ☐ Associate
☐ Non-APA Psychologist Affiliate ☐ Student ($29)

If APA member, please provide membership #

☐ Check ☐ Visa ☐ MasterCard

Card # _____ Exp Date _____/_____

Signature _____

Please return the completed application along with payment of $40 by credit card or check to:
Division 29 Central Office, 6557 E. Riverdale St., Mesa, AZ 85215

You can also join the Division online at: www.divisionofpsychotherapy.org