Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.divisionofpsychotherapy.org

BULLETIN

In This Issue

Personal Reflections From Diverse Early Careers
Opportunities in Private Practice

Perspectives on Psychotherapy Integration
Enhancing Emotion Regulation: An Implicit Common Factor Among Psychotherapies for Borderline Personality Disorders

Ethics in Psychotherapy
Psychotherapy for the Psychotherapist: Optional Activity or Ethical Imperative?

Washington Scene
Steadily Evolving Into The 21st Century—Working With Others

Division 29 APA Convention Program Summary

2008 VOLUME 43 NO. 3

Division of Psychotherapy ■ 2008 Governance Structure

ELECTED BOARD MEMBERS

President
Jeffrey E. Barnett, Psy.D., ABPP
1511 Ritchie Highway, Suite 201
Arnold, MD 21012
Phone: 410-757-1511 Fax: 410-757-4888
Email: drjbarnett1@comcast.net

President-elect
Nadine Kaslow, Ph.D., ABPP
Emory University Department of Psychiatry and Behavioral Sciences
Grady Health System
80 Jesse Hill Jr Drive
Atlanta, GA 30303
Phone: 404-616-4757 Fax: 404-616-2898
Email: nkaslow@emory.edu

Secretary
Armand Cerbone, Ph.D., 2006-2008
3625 North Paulina
Chicago, IL 60613
Ofc: 773-755-0833 Fax: 773-755-0834
Email: arcerbone@aol.com

Treasurer
Steve Sobelman, Ph.D., 2007-2009
2901 Boston Street, #410
Baltimore, MD 21224-4889
Ofc: 410-583-1221 Fax: 410-675-3451
Cell: 410-591-5215
Email : steve@cantoncove.com

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

Domain Representatives
Public Policy and Social Justice
Irene Deitch, Ph.D., 2006-2008
31 Hylan Blvd 14B
Staten Island, NY 10305-2079
Ofc: 718-273-1441 Fax-1-718-273-1445
Email: ProfID@AOL.COM

Professional Practice
Jennifer Kelly, Ph.D., 2007-2009
Atlanta Center for Behavioral Medicine
3280 Howell Mill Rd. #100
Atlanta, GA 30327
Ofc: 404-351-6789 Fax: 404-351-2932
Email: jfkphd@aol.com

Education and Training
Michael Murphy, Ph.D., 2007-2009
Department of Psychology
Indiana State University
Terre Haute, IN 47809
Ofc: 812-237-2465 Fax: 812-237-4378
Email: mmurphy4@isugw.indstate.edu

Membership
Libby Nutt Williams, Ph.D., 2008-2009
St. Mary's College of Maryland
18952 E. Fisher Rd.
St. Mary's City, MD 20686
Ofc: 240- 895-4467 Fax: 240-895-4436
Email: enwilliams@smcm.edu

Early Career
Michael J. Constantino, Ph.D., 2008-10
Department of Psychology
612 Tobin Hall - 135 Hicks Way
University of Massachusetts
Amherst, MA 01003-9271
Ofc: 413-545-1388 Fax: 413-545-0996
Email: mconstantino@psych.umass.edu

Science and Scholarship
Norm Abeles, Ph.D., 2008-2010
Dept of Psych
Michigan State University
110C Psych Bldg
East Lansing, MI 48824
Ofc: 517-353-7274 Fax: 517-432-2476
Email: abeles@msu.edu

Diversity
Caryn Rogers, Ph.D.
Johns Hopkins University
Department of Health, Behavior and Society
624 N. Broadway, HH280
Baltimore, MD 21205
Ofc: 443-287-5327 Fax: 410-502- 6719
Email: caryn_rodgers@yahoo.com

Diversity
Erica Lee, Ph.D.
55 Coca Cola Place
Atlanta, Georgia 30303
Ofc: 404-616-1876
Email: edlee@emory.edu

APA Council Representatives
Norine G. Johnson, Ph.D., 2008-2010
13 Ashfield St.
Roslindale, MA 02131
Ofc: 617-471-2268 Fax: 617-325-0225
Email: NorineJ@aol.com

Linda Campbell, Ph.D., 2008-2010
Dept of Counseling & Human Dev
University of Georgia
402 Aderhold Hall
Athens, GA 30602
Ofc: 706-542-8508 Fax: 770-594-9441
Email: lcampbel@uga.edu

Student Development Chair
Michael Garfinkle, 2008
Derner Institute
Adelphi University
1 South Avenue
Garden City, NY 11530
Ofc: 917-733-3879
Email: michaelsg@verizon.net

STANDING COMMITTEES

Continuing Education
Chair: Annie Judge, Ph.D.
2440 M St., NW, Suite 411
Washington, DC 20037
Ofc: 202-905-7721 Fax: 202-887-8999
Email: Anniejudge@aol.com

Associate Chair:
Rodney Goodyear, Ph.D.
Email: goodyea@usc.edu

Education & Training
Chair: Jean M. Birbilis, Ph.D., L.P.
University of St. Thomas
1000 LaSalle Ave., TMH 455E
Minneapolis, Minnesota 55403
Ofc: 651-962-4654 Fax: 651-962-4651
Email: jmbirbilis@stthomas.edu

Associate Chair: Gene Farber, Ph.D.
Email: efarber@emory.edu

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

Associate Chair: Jeffrey Hayes, Ph.D.
Email: jxh34@psu.edu

Finance
Chair: Bonnie Markham, Ph.D., Psy.D.
52 Pearl Street
Metuchen, NJ 08840
Ofc: 732-494-5471 Fax 206-338-6212
Email: drbonniemarkham@hotmail.com

Membership
Chair: Sonja Linn, Ph.D.
2440 M St, NW, Suite 411,
Washington, DC 20037.
Ofc: 202-887-8088
Email: sglinn@verizon.net

Associate Chair:
Chaundrissa Smith, Ph.D.
Email: csmit33@emory.edu

Nominations and Elections
Chair: Nadine Kaslow, Ph.D.

Professional Awards
Chair: Jean Carter, Ph.D.

Program
Chair: Nancy Murdock, Ph.D.
Counseling and Educational Psychology
University of Missouri-Kansas City
ED 215 5100 Rockhill Road
Kansas City, MO 64110
Ofc; 816 235-2495 Fax: 816 235-5270
Email: murdockn@umkc.edu

Program, continued
Associate Chair: Chrisanthia Brown, Ph.D.
Email: brownchr@umkc.edu

Psychotherapy Practice
Chair: John M. O'Brien, Ph.D.
465 Congress St. Suite 700
Portland, ME 04101
Ofc: 207-773-2828 x1310
Fax: 207-761-8150
Email: jobinport@aol.com

Associate Chair: Patricia Coughlin, Ph.D.
Email: drpcoughlin@gmail.com

Psychotherapy Research
Chair: Sarah Knox, Ph.D.
Department of Counseling and Educational Psychology
Marquette University
Milwaukee, WI 53201-1881
Ofc: 414/288-5942 Fax: 414/288-6100
Email: sarah.knox@marquette.edu

Associate Chair: Susan Woodhouse, Ph.D.
Email: ssw10@psu.edu

PUBLICATIONS BOARD

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

Laura Brown, Ph.D., 2008-2013
Independent Practice
3429 Fremont Place N #319
Seattle , WA 98103
Ofc: (206) 633-2405 Fax: (206) 632-1793
Email: Lsbrownphd@cs.com

Jonathan Mohr, Ph.D., 2008-2012
Clinical Psychology Program
Department of Psychology
MSN 3F5
George Mason University
Fairfax, VA 22030
Ofc: 703-993-1279 Fax: 703-993-1359
Email: jmohr@gmu.edu

Beverly Greene, Ph.D., 2007-2012
Psychology
St John's Univ
8000 Utopia Pkwy
Jamaica , NY 11439
Ofc: 718-638-6451
Email: bgreene203@aol.com

George Stricker, Ph.D., 2003-2008
Argosy University/Washington DC
1550 Wilson Blvd., #610
Arlington, VA 22209
Ofc: 703-247-2199 Fax: 301-598-2436
Email: geostricker@comcast.net

William Stiles, Ph.D., 2008-2011
Department of Psychology
Miami University
Oxford, OH 45056
Ofc: 513-529-2405 Fax: 513-529-2420
Email: stileswb@muohio.edu

EDITORS

***Psychotherapy Journal* Editor**
Charles Gelso, Ph.D., 2005-2009
University of Maryland
Dept of Psychology
Biology-Psychology Building
College Park, MD 20742-4411
Ofc: 301-405-5909 Fax: 301-314-9566
Email: Gelso@psyc.umd.edu

***Psychotherapy Bulletin* Editor**
Jenny Cornish, PhD, ABPP, 2008-2010
University of Denver GSPP
2460 S. Vine Street
Denver, CO 80208
Ofc: 303-871-4737
Email: jcornish@du.edu

***Psychotherapy Bulletin* Associate Editor**
Lavita Nadkarni, Ph.D.
Director of Forensic Studies
University of Denver-GSPP
2450 South Vine Street
Denver, CO 80208
Ofc: 303-871-3877
Email: lnadkarn@du.edu

***Psychotherapy Bulletin* Editorial Assistant**
Crystal A. Kannankeril, M.S.
Department of Psychology
Loyola College in Maryland
4501 N. Charles Street
Baltimore, MD 21210
Email: Crystal.Kannankeril@gmail.com
Phone: (973) 670-4255
Email: cakannankeril@loyola.edu

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

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

PSYCHOTHERAPY BULLETIN

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

Contributors are invited to send articles (up to 2,250 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).

DIVISION OF PSYCHOTHERAPY (29)

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

www.divisionofpsychotherapy.org

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

www.divisionofpsychotherapy.org

PSYCHOTHERAPY BULLETIN

Published by the
DIVISION OF PSYCHOTHERAPY
American Psychological Association

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

EDITOR
Jennifer A. E. Cornish, Ph.D., ABPP
jcornish@du.edu

ASSOCIATE EDITOR
Lavita Nadkarni, Ph.D.

CONTRIBUTING EDITORS

Diversity
Erica Lee, Ph.D. and
Caryn Rodgers, Ph.D.

Education and Training
Jean M. Birbilis, Ph.D., L.P.

Practitioner Report
Jennifer F. Kelly, Ph.D. and
John M. O'Brien, Ph.D.

Psychotherapy Research, Science, and Scholarship
Norman Abeles, Ph.D., Sarah Knox, Ph.D., Michael J. Murphy, Ph.D., and Susan S. Woodhouse, Ph.D.

Perspectives on Psychotherapy Integration
George Stricker, Ph.D.

Public Policy and Social Justice
TBA

Washington Scene
Patrick DeLeon, Ph.D.

Early Career
Michael J. Constantino, Ph.D.

Student Features
Michael Stuart Garfinkle, M.A.

Editorial Assistant
Crystal A. Kannankeril, M.S.

STAFF
Central Office Administrator
Tracey Martin

Website
www.divisionofpsychotherapy.org

PSYCHOTHERAPY BULLETIN

Official Publication of Division 29 of the American Psychological Association

2008 Volume 43, Number 3

CONTENTS

President's Column 2

President-Elect's Column 4

Psychotherapy Research, Science, and Scholarship 5
Counseling South Asian Immigrant Communities: Identities and Contexts

Division 29 Welcomes New Members to the Board of Directors 9

Psychotherapy Research, Science, and Scholarship 10
Psychological Treatments and Psychotherapy with Older Adults

Personal Reflections From Diverse Early Careers 15
Opportunities in Private Practice

Practitioner Report 20
Practice Domain Update: Progress and Challenges

Practitioner Report 22
Outcome Measures in Psychotherapy: Blessings or Curses

Division 29 APA Convention Program Summary 25

Perspectives on Psychotherapy Integration 29
Enhancing Emotion Regulation: An Implicit Common Factor Among Psychotherapies for Borderline Personality Disorders

Ethics in Psychotherapy 36
Psychotherapy for the Psychotherapist: Optional Activity or Ethical Imperative?

Student Interview: Jeffrey Magnavita, Ph.D. 42

Washington Scene 46
Steadily Evolving Into The 21st Century—Working With Others

Membership Application 52

PRESIDENT'S COLUMN

Jeffrey E. Barnett, Psy.D., ABPP

Exciting Times for 29: Be Connected!

It is with great pleasure and pride that I write this President's Column for the Psychotherapy Bulletin. There are several events I am excited about that help make this issue a special one for me. First, in this issue you can see the division's outstanding program at the upcoming APA Convention. Our Convention Program Chair, Nancy Murdoch, and her Co-Chair, Chris Brown, have put together a truly outstanding convention program for you. Please see the complete listing of convention offerings elsewhere in this issue.

One important event at the convention will be our "Lunch with the Masters" event. Building on our success last year when we had attendees waiting in line out the door and in the hallway, we have expanded this popular program to ensure even greater success. Division 29 Board members Michael Constantino, Annie Judge, Nancy Murdock, and Libby Nutt Williams, have put together a great group of "masters" (senior psychotherapists who have made significant contributions to the advancement of our profession and who have an interest in mentoring students and early career psychotherapists) who will have lunch with all interested students and early career psychologists who attend this free event. Additionally, each of the "masters" as well as a number of others who are not able to attend the event have donated signed copies of books they have published, to be raffled off free to those in attendance. It should be an exciting event and a singularly great opportunity for those in attendance to spend time chatting informally with some of the top leaders of our field. Please spread the word to all students and early career psychologists you know. The event will be on Saturday, August 16 from 12:00pm – 1:50pm in the Commonwealth Room of the Sheraton Boston Hotel. This year's masters are Judith Beck, Lorna Benjamin, Linda Campbell, Charles Gelso, Norine Johnson, Jeffrey Magnavita, and Jeffrey Barnett. I express my deep appreciation to each for the valuable contribution they are making to our next generation of psychotherapy clinicians, researchers, educators, and supervisors.

An additional major source of excitement about this year's convention is the fact that this year we mark the 40th Anniversary of the founding of Division 29. This is a major milestone. I personally invite each you to join us at our special Awards Ceremony and 40th Anniversary Celebration which is immediately followed by our Social Hour. At the Awards Ceremony we will be honoring and recognizing a number of colleagues who have made singular, and actually quite remarkable, contributions to the field of psychotherapy. Our Award winners include:

- 2008 Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy: Bruce E. Wampold, Ph.D.
- 2008 Division 29/American Psychological Foundation Jack D. Krasner Early Career Award: Kenneth N. Levy, Ph.D.
- 2008 Division 29 Award for Distinguished Contributions to Teaching and Mentoring: Mathilda Canter, Ph.D.
- Distinguished Publication of Psychotherapy Research Award: Scott A. Baldwin, Bruce E. Wampold, and Zac E. Imel, for their article:

continued on page 3

Baldwin, S.A., Wampold, B.E., & Imel, Z.E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852.

Additionally, our student award winners include:

- 2008 Mathilda B. Canter Education and Training Student Award: Jenelle Slavin
- 2008 Donald K. Freedheim Student Development Award: Joshua K. Swift
- 2008 Student Diversity Award: Arien Muzacz

Please join us to celebrate the accomplishments of these colleagues.

Following the award presentations, Matty Canter will provide reflections on 40 years of Division 29. Matty will share little known, yet important aspects of the history of the division along with many contributions of its members that have greatly impacted the profession and the field of psychotherapy. It should prove to be truly inspirational and should not be missed. Following this, we will hold our Social Hour where all Past Presidents and Past Award Recipients of the division will be honored. We will also have several other surprises in store for you. I hope each member can be there to participate in this historic event and celebration. Please honor us with your presence at these events as we celebrate our division and honor all the great leaders who came before us and did so much for us with their volunteer efforts.

Finally, I am excited to tell you about a new Division 29 initiative. This year we have begun an international student membership and mentoring program. While this is one of my presidential initiatives it was motivated and stimulated by the work of Division 29 Board member, Norine Johnson, Ph.D. Norine has been instrumental in assisting me with developing and implementing this program. There are students around the world who are studying psychology in the hope of obtaining the knowledge and skills needed to help ease suffering in their countries. But, they often do so with limited resources and in situations where they face significant adversity. To reach out to these students around the world the Division 29 Board of Directors has approved free electronic memberships to all interested international psychology students. Additionally, they will each receive copies of the division's journal directly from APA as members of the division. All interested international student members will participate in a mentoring program where we pair them with current student members of the division. These student mentors will develop online collegial relationships with their assigned mentees offering them support, sharing their experiences, and sharing information and resources of potential value to them. Our program has already begun. At the time of the writing of this column contact has been made with schools in Rwanda, Cambodia, South Viet Nam, and China. Contacts with schools in other countries are planned. I will hope to have more information to share with you about this important initiative in my next column. Should you have international contacts that I could use to further expand this program please contact me directly at drjbarnett1@comcast.net .

The field of psychotherapy is alive and well. It is an exciting and vibrant field. Our members regularly make significant and noteworthy contributions that greatly impact the quality of others' lives. We regularly make contributions in research, theory, education and training, clinical practice, and supervision. I hope you will join us at this year's APA Convention and especially at Division 29's 40th Anniversary Celebration. Be Connected!

Best wishes to all —

Jeff

PRESIDENT-ELECT'S COLUMN

Jeffrey J. Magnavita

It is with great pleasure that I assume the role of President-elect of Division 29! I appreciate the opportunity to serve the Division in this capacity and look forward to contributing my time and energy to shaping the future course of the Division and the field of psychotherapy. The practice of psychotherapy has been my main professional interest over the past 25 years and I continue to be privileged by the confidence that is placed in me and my training when I open the door to my waiting room and met a new patient, couple, or family. The field of psychology and the practice of psychotherapy combine two of my core beliefs in science and the art of healing. We are a very privileged group invited to bear witness to human suffering, transformation, and healing in a way that few other professions can claim.

As part of my presidential agenda I am hoping to continue to advance our Division's use of technology to provide access to information and learning. I also want to continue to strengthen alliances with our researchers and members of other disciplines to enrich our knowledge and understanding of human nature. Many of our members maintain membership in other organizations that also advance psychotherapy, such as the Society for Psychotherapy Research (SPR) and Society for Psychotherapy Exploration and Integration (SEPI). Many of the leading theorists, practitioners, and researchers are working collaboratively in an increasingly challenging professional world to assure the growth and evolution of our science and art. I also am hoping to strengthen our commitment to pubic service. There are so many people who could benefit from psychotherapy but who have limited access to the expert caring of a well trained psychotherapist. Psychologists enter the profession to make a contribution and many of our members silently give of their time and knowledge without recognition. I want to be able to hear these stories and honor the silent contributors. I am also a believer in the possibilities that neuroscience offers us in creating a more robust evidence base for what we do. As part of my summer fun I am going to be attending a three-day seminar in neuroscience and human brain dissection to further my understanding of the neural networks that are affected by both emotional and physical trauma.

I hope that the summer finds you all well and that you will be able to find time to replenish your souls, somas, and minds. We are planning a great summer celebration under the expert leadership of Jeff Barnett our current President and our devoted Board for D29's 40th anniversary in Boston. I hope to meet many of you there for intellectual, emotional, and social stimulation. We stand together at a time of enormous global and professional transformation. Division 29 plans to be a leader in addressing the challenges of the new global village. I look forward to hearing from all of you with your suggestions and concerns.

PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

Counseling South Asian Immigrant Communities: Identities and Contexts

Arpana G. Inman, Lehigh University

Counseling Immigrant Communities: Identities and Contexts

With the significant shift in the U.S. demographics, the counseling profession has provided a strong impetus to examine how life's issues are influenced by contextual variables (e.g., ethnicity). The importance of these variables has led to the development of multicultural counseling competencies, providing guidelines for effective and ethical clinical practice (Sue, Arredondo, & McDavis, 1992). Immigration from one country to another is one such life experience that entails complex psycho-social processes, influenced by varying contexts.

Literature suggests that immigration poses significant pressures on first and subsequent generations (Inman, Howard, Beaumont, & Walker, 2007). In essence, immigration involves the crossing of cultural and national boundaries, creating significant opportunities and dilemmas impacting both individual and familial identities (Akhtar, 1999). Although educational and economic successes are important gains that immigrant families experience, immigration also creates significant cultural incongruence for these families. These cultural inconsistencies heighten the experience of loss as old ways of being no longer work within the new context (Hedge, 1998). Within this context, families engage in an active process of self-exploration and decision-making about the role that different cultural values and contexts play in one's life (Phinney, 1989). In effect, families experience a parallel process of identity negotiation, one based in an internalized sense of cultural expectations based in one's own ethnic culture (e.g., interdependence) and another based in externalized societal expectations of the host culture (e.g., independence or autonomy). In understanding this diasporic existence, as practitioners, we need to ask: What is the influence of immigration on personhood and how does immigration and the evaluation and valuation of constructs such as ethnicity and race impact personal identities?

What we know about a diasporic identity is that negotiating identity is often complicated by factors such as migration histories, pre- and post-immigrational expectations and experiences (Inman, Howard, et al., 2007), visa statuses (Akhtar, 1999, Inman Yeh, Maden-Bahel, & Nath, 2007), shifts in familial roles (Uba, 1994), generational conflicts (Inman, Constantine, & Ladany, 1999; Inman, Ladany, Constantine, & Morano, 2001), minority experiences (Inman, 2006), and related coping mechanisms (Inman & Yeh, 2007). Because of the diversity in immigration histories, the factors that influence the extent to which individuals hold onto their own culture or adapt to the host culture varies by generation. In fact, in recent research on South Asian and in particular Asian Indian immigrants, the notion of cultural conflicts has been identified as an important variable influencing both first- and second-generation individuals (Inman, et al., 1999; Inman, et al., 2001). How first- and second-generation Asian Indians navigate their relationships within multiple cultural contexts has significant implications for intergenerational interac-

continued on page 6

tions, parenting practices, and individual and group identities, resulting in specific challenges.

Specific Immigrant Challenges

Research has noted specific challenges among first- and second-generation Asian Indian immigrant communities. While both generational groups tend to compartmentalize their roles and behaviors (i.e., being more Indian at home and American outside the home), Inman and colleagues (1999, 2001, 2006, 2007) have found that national, linguistic, religious, and communal identities dominate the ideologies of first-generation Asian Indians, with ethnic identity serving as a buffer in situations of stress. As parents of second-generation Asian Indians, these first-generation individuals have a strong desire to maintain a traditional cultural identity because of their fears of cultural dilution. Due to the lack of a social support system (e.g., familial guidance, cultural social structure) and systemic barriers (e.g., work schedules) that prevent families from practicing their cultural activities, parents experience feelings of isolation but also pressure to create a sustainable process of cultural transmission. These pressures evolve from a fear that their children's cultural awareness and commitment may decrease as a result of the children's acculturation to the U.S. culture and marrying outside of the ethnic community. Further, the challenges of needing to learn about their own cultural practices in order to transmit cultural knowledge to their children can be time consuming without adequate support systems. This can create significant dilemmas regarding aspects of culture that parents should retain and those that they can forsake. In addition, managing their children's bicultural struggles that do not reflect their own personal experiences can create feelings of helplessness in these parents.

Second-generation Asian Indians, on the other hand, experience significant social censures and restrictions due to not being "ethnic" enough. They perceive their identity in constant flux based on their age and phase of life, with dissonance varying as a function of time (Inman et al. 1999). The maintaining of a "true" cultural identity (Dasgupta, 1998) that was conceptualized at the time of the parents' immigration becomes a litmus test for an authentic identity. Rather than acknowledging that immigrant children live in a plane of many truths and develop an identity that is based in a "third space" (i.e., a hyphenated existence of being both Indian and American), children are perceived to be Americanized and not appreciative of their own cultures. Due to these issues, second-generation Asian Indians have been known to experience intergenerational conflicts related to career decisions, identity issues, family conflicts, dating, and sexuality concerns. Further, given their socialization within the dominant culture, race and racial identity play an important influential role in their lives, and racial identity has been identified as a buffer against stress for second-generation Asian Indians (Inman, 2006).

Assessment and Intervention

When working with first- and second-generational diasporic communities, it becomes important to assess and intervene in culturally sensitive ways and across generational lines. For instance, constructs of enculturation and acculturation, cultural values, and minority status are important considerations for immigrant communities in the U.S. Enculturation refers to socialization within one's own cultural values, whereas acculturation refers to socialization within the dominant cultural values and the inherent decision to choose aspects of the two cultures. Interestingly, literature suggests that immigrants tend to selectively acculturate to the host culture (Ramisetty-Mikler, 1993). Thus, while being more adaptable to work practices or clothing choices, we see that first-generation Asian Indians tend to hold on to core values related to family relations, gendered roles, and issues related to intimacy and marriage. For instance, filial obligations to elders (e.g., children taking care of

continued on page 7

the elderly in their old age), career choices being made with family interests in mind, family members maintaining a strong sense of interdependence, women serving as carriers of tradition and bearing the responsibility of preserving cultural identities, children marrying within their community and culture, and dating occurring in committed "engaged" relationships are some of the values that influence the first-generation expectations of their children. Illustrations of these issues are evident in the following examples: *a 23-year-old college senior struggling with graduation, going into a profession in which she had no interest and disappointing her father; a 25-year-old woman dealing with the anxiety of her father making plans to arrange her marriage.* Conversely, *parents noting that the challenge of bringing up children in the U.S. is that as children grow up in America, they want to be more like their American friends; that outside influences create difficulty for children in having the same kind of respect that these parents would have for elders back home*. These examples highlight how culturally bound values can influence one's perception and assessment of events and create potential for intergenerational conflicts.

As immigrant communities migrate to the United States, the notions of minority status and its related consequences are also important considerations. What is evident in the long history of immigration is that all communities have experienced discrimination in the form of stereotypes, prejudice, and racist acts that can have a negative influence on their wellbeing. Despite a long history of racism and discrimination (e.g., denial of land ownership and citizenship, anti-miscegenation laws, racial profiling, targets of racial slurs and violence, Sue & Sue, 2003), communities may have varying views of and acceptance of racism within and outside of this community. This is true of Asian Indians as well. Although this community has experienced prejudice and racism, their discriminatory experiences have been masked by several factors: the model minority myth, the related politics of economic success, and the limited racial socialization as well as a language to speak to racial issues among new immigrants (Inman & Alvarez, in press). This is reflected in the following example: *a father of a 6-year-old Indian girl being taken aback when his daughter asks if she can wash off the brown color of her skin to look more like her "fair-colored" friends.* Yet others may appreciate the impact of differences as highlighted in the following example: *parental recognition that although children were born in the U.S., they would always be treated differently because of their ethnic/racial background*. Issues of skin color or sense of difference can have significant implications for self-perceptions of attractiveness, familial feelings about interracial relations, and the family's ability to deal with race-based discrimination (Mehta, 1998).

Because families can function as both risk and protective factors, understanding family histories of immigration and discrimination, familial structures and alliances, patterns of communication, levels of acculturation, and ethnic/racial identification is important when negotiating intergenerational conflicts and challenges. Within this context, narratives become important tools in immigrant counseling experiences (Almeida, 1996). They help contextualize the experience and provide a systemic frame for issues that ensue. Thus, having parents share their stories of immigration, their struggles with acculturation, and their particular coping styles can help acknowledge their losses, but also put into context the expectations that parents have for their children (Inman & Tewari, 2003). Additionally, use of the therapeutic self and self-disclosure has been found to be a beneficial tool among collectivistic cultures (Das & Kemp, 1997). This reduces a voyeuristic stance on part of the therapist and allows for greater trust and rapport that can help build a stronger working alliance. Finally, use of bibliotherapy brings a level of objectivity and distance while also normalizing issues that may otherwise be stigmatizing and create a loss

continued on page 8

of face for these communities (Inman & Tewari, 2003).

Conclusion

The varied characteristics associated with the multiple, overlapping, and often conflicting definitions of a personal identity and group membership are important considerations in examining issues for immigrant communities. However, to prevent stereotyping or overgeneralizations, it is essential to assess individual differences that exist within and across generations. Given the individual, systemic (e.g., relational), and environmental influences (Sue & Sue, 2003), it becomes important to contextualize immigrant experiences and examine issues from an ecosystemic perspective.

Reference

Almeida, R. (1996). Hindu, Christian, and Muslim families. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy.* (pp. 395-423). New York: Guilford

Akhtar, S. (1999). *Immigration and identity: Turmoil, treatment, and transformation.* New Jersey: Jason Aronson.

Dasgupta, S. D. (1998). Gender roles and cultural continuity in the Asian Indian immigrant community in the U.S.. *Sex Roles, 38,* 953-974.

Das, A. K., & Kemp, S. F. (1997). Between two worlds: Counseling South Asian Americans. *Journal of Multicultural Counseling and Development, 25,* 23-33.

Hegde, R. (1998). Swinging the trapeze: The negotiation of identity among Asian Indian immigrant women in the United States. In D. Tanno & A. Gonzalez (Eds.),
Communication and identity across cultures (pp. 34-55). Thousand Oaks, CA: Sage Publications, Inc.

Inman, A. G. (2006) South Asian Women: Identities and Conflicts. *Cultural Diversity and Ethnic Minority Psychology, 12,* 306-319.

Inman, A. G. & Alvarez, A. N. (in press). Individuals and Families of Asian Descent. In Hays, D. C., & Erford., B. T., (eds)., *Developing Multicultural Counseling Competency: A Systems Approach*. Pearson Merrill Prentice Hall.

Inman, A. G., Constantine, M. G., & Ladany, N. (1999). Cultural value conflict: Anexamination of Asian Indian women's bicultural experience. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and Concerns for Counseling and Psychotherapy* (pp. 31-41). Commack, NY: Nova Science Publishers.

Inman, A. G., Howard, E. E., Beaumont, L. R. & Walker, J. (2007). Cultural Transmission: Influence of Contextual Factors in Asian Indian Immigrant Parent's Experience. *Journal of Counseling Psychology, 54.* 93-100.

Inman, A. G., Ladany, N., Constantine, M. G., & Morano, C. K. (2001). Development and Preliminary validation of the cultural values conflict scale for South Asian women. *Journal of Counseling Psychology, 48*, 17-27.

Inman, A. G., & Tewari N (2003). The power of context: Counseling South Asians within a family context. In G.Roysircar, D. S. Sandhu, & V. B. Bibbins (Eds.*). A guidebook: Practices of multicultural competencies* (pp. 97-107). Alexandria, VA: ACA publishers.

Inman, A. G., & Yeh, C. (2007). Stress and Coping. In F. Leong, A. G. Inman, A. Ebreo, L. Lang, L. Kinoshita, M. Fu (Eds.), *Handbook of Asian American Psychology* (pp.323-340). (2nd ed.). Thousand Oaks, CA: Sage.

Inman, A. G., Yeh, C. J, Madan-Bahel A., & Nath, S. (2007). Bereavement and Coping of South Asian Families post 9/11. *Journal of Multicultural Counseling and Development, 35, 101-115.*

Mehta, P. (1998). The emergence, conflicts and integration of the bi-cultural self: Psychoanalysis of an adolescent daughter of South Asian immigrant parents. In S. Akhtar, & S. Kramer, (1998). *The colors of childhood: Separation-individuation across cultural, racial and ethnic differences* (pp. 129-168). Northvale, NJ: Jason

continued on page 9

Aronson, Inc.
Phinney, J.S. (1989). Stages of ethnic identity development in minority group adolescents. *Journal of Early Adolescence, 9,* 34-49.
Ramisetty-Mikler, S. (1993). Asian Indian immigrants in America and sociocultural issues in counseling. *Journal of Multicultural Counseling, 21,* 36–49.
Sue, D.W., Arredondo, P., & McDavis, R.J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20,* 64-68.
Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice.* (4th ed.). New York: Wiley.
Uba, L. (1994). *Asian Americans: Personality patterns, identity, and mental health.* New York: Guilford Press.

DIVISION 29 WELCOMES NEW MEMBERS TO OUR BOARD OF DIRECTORS

Jeffrey Younggren, Ph.D., Secretary – 2009-2011

Dr. Jeffrey N. Younggren, a Fellow of the American Psychological Association, is a clinical and forensic psychologist who practices in Rolling Hills Estates, California. He also is an associate clinical professor at the University of California, Los Angeles, School of Medicine and is a Risk Management Consultant for the American Psychological Association Insurance Trust.

Jeff has always focused on the importance of developing new and expanding roles for psychologists and this continues to be an area of his primary interest. He believes that, not only should we secure prescriptive authority for those psychologists who want to provide these services, but we must also look forward to developing new and creative avenues for the delivery of psychotherapeutic services. Finally, we must work to maintain a clear identity for psychology as a distinct profession separate from other mental health providers and that we maintain high standards in training and that training programs prepare psychologists for the complexity of their profession.

Rosemary Adam-Terem, Ph.D., Domain Representative for Public Policy and Social Justice – 2009-2011

Aloha,
I have been a practicing psychotherapist specializing in women's, health, and divorce/custody issues in Honolulu, Hawai`i for over 20 years and have been active in our state psychological association for even longer. I teach clinical classes occasionally as an adjunct faculty member at the University of Hawaii Department of Psychology. Currently president-elect of HPA, I am the chair of the Ethics Committee, and co-chair of the Convention Committee. I was HPA's Council representative from 2005-7 and now serve as a member of APA's Committee on Rural Health. This is the first time I have been involved in any role in the division, and I am happy to be part of the board of Division 29 where I look forward to working on issues of importance to the psychotherapy community in the realm of public policy and social justice.

PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

Psychological Treatments and Psychotherapy with Older Adults

Norman Abeles, Ph.D., Michigan State University

The core identity of most practicing psychologists is psychotherapy and this practice is directed at the treatment of psychopathology or psychological components of physical disorders, David Barlow (2004) reminds us. He recognizes (in a footnote) that there are many individuals who seek psychotherapy for improvements in problems of living, better adjustment and personal growth (p. 871). I am reminded of discussions that were ongoing when there was consideration of the adoption of the Guidelines for Psychological Practice with Older Adults (APA, 2003). Several of my colleagues asked whether or not such guidelines were necessary. After all, they argued, all of us can recognize when an older adult becomes demented or severely impaired. In all other cases we can continue doing psychotherapy as we had in the past. We can grow older with our clients so let us not get too preoccupied with Guidelines, since a smart attorney can use them against therapists even though they are only Guidelines and not standards.

Barlow suggests we differentiate between psychological interventions which are specifically designed to assist the individual to deal with impairment and stress and psychotherapy. Psychological interventions have been designed to impact panic disorder, insomnia, Irritable Bowel Syndrome, and other impairments. Older adults at times complain of problems associated with urinary incontinence, while caretakers may note aggressive behavior and wandering (often noted in nursing home patients) especially for individuals suffering from mild to moderate dementia. He argues that these psychological interventions are different from psychotherapies or more generic treatments that deal in problems of living, growth, and self-understanding. He is certainly supportive of these more generic therapies but believes they are simply different from psychological interventions. He also argues that psychologists are well trained in psychological interventions and are good at performing them, while the more generic psychotherapies are often conducted by a range of therapists from many areas of specialization. Barlow (2005) argues that psychologists have declared themselves health service professionals and evidence-based practice appears to be policy in health care. His suggestion is that the term psychological treatment be used for health care related disorders, while psychotherapy be used for non-health care problems. Both psychological treatments and psychotherapy can be evidence-based, but psychological treatments are designed specifically for use in the health care system. He insists that psychologists would be in a better position by targeting some of their interventions to well defined pathologies which are generally accepted as being reimbursable. Let me illustrate this issue by discussing treatments for older adults.

In a recent issues of Psychology and Aging, Scogin (2007) presents a range of evidence-based treatments including treatments for late-life anxiety, insomnia, disruptive behaviors in individuals with dementia and treatments for distress in family caregivers of older adults. In the introduction to this special section, Scogin notes that the

continued on page 11

APA Presidential Task Force on Evidence-Based practice (2006) incorporates three elements which are listed as client preference, clinician expertise and the use of the best available scientific information (p. 1). He points out that there is considerable controversy about evidence-based treatments. These include concerns about their impact on the independence of clinicians and the dangers inherent in endorsing brand name therapies. On the other hand, he argues that older adults do not necessarily share these concerns. He points out that Section II (Clinical Geropsychology) of the Society of Clinical Psychology, initially investigated treatments for depression in older adults and identified those that met criteria based on a coding manual. They selected six evidence-based treatments. These included behavioral therapy, cognitive-behavioral therapy, cognitive bibliotherapy, problem solving therapy, brief psychodynamic therapy and reminiscence therapy.

Aside from depression, late life anxiety is a frequently occurring problem in older adults. Ayers et al (2007) propose that the best estimate for general anxiety disorders in older adults is about 10% with diagnosable anxiety disorders in older adults ranging from 2-19%. These authors found support for four kinds of evidence-based treatments including relaxation training, cognitive behavioral therapy, supportive therapy and cognitive therapy, though there was somewhat less support for the latter two therapies. They stated that their findings are consistent with other reviews that found psychosocial interventions to be moderately efficacious and that some treatments were more effective than others. However, they caution that findings for treatments of late life anxiety are limited. Out of 77 studies reviewed, only 17 warranted inclusion criteria for additional analyses. Further, the authors note that there has not been any research to investigate the mechanisms underlying successful treatment of late life anxiety (p. 13) and data for late life anxiety disorders such as phobias, panic disorders, obsessive compulsive disorders and PTSD appear to be limited at best.

Another study in the special section on psychological treatments for older adults focused on caregivers of older adults. The majority of studies reviewed were efforts at psychoeducational-skill building but they also included psychotherapy-counseling as well as multicomponent programs. The largest effect sizes were found in the psychotherapy area where caregivers treated by means of cognitive-behavioral therapy showed reductions in their depressive symptoms. The authors concluded that the identification of interventions which demonstrate empirical support are more likely to obtain private or public funding support and there may be increased applications to more ethnically diverse caregivers (p. 49).

Treatments and various dimensions of diversity

In their book on evidence-based practices in mental health (Norcross, Beutler, & Levant, 2006), the editors raise the issue of the extent to which evidence-based treatments and treatment as usual address ethnic minority issues. Sue and Zane (2006) agree that psychological treatments should be supported by research evidence but note that little research has taken place with clients from ethnic minority groups. They argue that the lack of research is a function of systemic reasons because it is too costly, samples are difficult to obtain, and research is difficult to conduct. Further, research with ethnic minorities is often controversial because it deals with topics of differential treatment, prejudice, values, and other difficult questions. Finally, psychologists want to be sure that internal validity is obtained and there is less interest in the extent to which research findings can be generalized to other populations or situations (p. 332). They also raise the issue of cultural competency defined as the knowledge and skills need-

continued on page 12

ed to deliver services to those of a given culture. Therapists may change their approach almost without awareness by becoming more cautious about making inferences, and may place more emphasis on the intervention rather than its context. This refers to include client characteristics, therapist characteristics, type of intervention, and treatment settings (p. 336). In order to understand cultural competency, we need to deconstruct the treatment process into components. Interestingly enough there is no discussion of the concerns of older adults in this book. Let me describe a brief vignette to highlight issues concerning older adults, culture and ethnicity.

A physician refers a 72 year old second generation Korean American to you. The client has a high school education and worked as a wait person in a Chinese restaurant until he retired at age 70. The problem cited by the physician includes concern about memory loss, and the physician asks for a report from you as to the outcome of assessment and treatment. The client arrives accompanied by his 40 year old daughter who talks about her concerns regarding her dad. She notes that he does not remember where he parked his car at the supermarket parking lot, misplaces his keys, forgot to turn off the burners on his stove on one occasion, has lost weight in the last year and does not seem like his old self. The psychologist asks the client about all this. The client does not maintain eye contact and says only that his daughter worries too much, that there is really nothing wrong with him except for old age and that he came mainly to please his daughter. You, a Latina psychologist become a little uncomfortable at this point because this situation reminds you of your relationship with your own father. You note that the daughter maintains excellent eye contact with you. You continue to ask questions of the daughter and begin to wonder whether you should administer a memory test to the client. Instead you decide to take a break and have a cup of tea with the daughter and her dad.

What should the psychologist do after the break? Is this TAU (therapy as usual) or is the therapist dealing with the issue of cultural competence? Is this an evidence-based treatment session or is this an assessment or is it both? Should she have accepted the referral in the first place? What will she tell the referring physician? What will she tell the client? Is the daughter a client also? Should the client be referred for a neuropsychological evaluation? These are all difficult questions to answer in the absence of evidence-based treatments for ethnic minority individuals and older adults. Will the APA Guidelines for Psychological Practice with Older Adults (2003) be of help? Are there signs of diminished capacity and is a formal assessment required? These are just some of he concerns therapists need to consider when they are working with older adults. Of course some of the general issues can be reviewed by reading the article by the APA working group on older adults (1998) but for those who limit their practice to working with older adults more education and training is very desirable as is suggested in the APA Guidelines.

Working with older adults at times interacts with the topic of working with people with disabilities. Olkin and Taliaferro (2006) suggest that evidence-based practices for people with disabilities have been ignored and there is a lack of knowledge generally concerning the disability community and culturally competent practice with regard to disability is not the norm (p. 355). The interested reader may want to consult Olkin's (1999) discussion on aging and long-term care which discusses individuals with disabilities who are aging and those who acquire disabilities as they become older. She points out that while most older adults do not have disabilities, many individuals do retire because of ill health. Further, people who do have disabilities may have more pronounced problems as they become older and may need increased support from family members

continued on page 13

and service agencies.

The focus on cultural competence is also very relevant for lesbian, gay, bisexual and transgendered clients (Brown, 2006) and is also relevant for older adults. Brown argues that LGBT clients require therapists who take an affirmative stance whereby the therapist avoids making the client's sexual or gender orientation the problem and focuses instead on the distress that brings the client into treatment. In addition the therapist should not ignore the client's LGBT identity (p. 350).

The treatment of personality disorders in older adults

It is easy to forget that personality disorders persist into old age and are likely to warrant treatment. There has been little research designed especially for the treatment of older adults (Segal, Coolidge and Rosowsky, 2006.) Recently Hinrichson and Clougherty (2006) adapted interpersonal psychotherapy (IPT) for older adults, but it has not been applied to older adults whether or not they suffered from depression. Dialectical behavior therapy has received some research attention with regard to older adults but some studies are beginning to be done with older adults who manifest comorbid depression. Since DBT is described as a skills based approach according to Segal, Coolidge and Rosowsky, it ought to be suitable for older adults. These authors also contend that the most appropriate treatments for older adult with personality disorders are those that focus on the symptoms rather than the characterological infrastructure (p. 282). Cognitive behavioral therapies are likely to be helpful once a therapeutic alliance has been established. There is a high comorbidity rate of Axis I and Axis II Disorders, and comorbid depression is frequent as is anxiety and somatization disorders.

Is evidence-based therapy transferable to clinical practice?

The current President of the American Psychological Association, Alan Kazdin, comments on the split within clinical psychology (Kazdin, 2008) between those who support evidence-based practices and those who raise concerns about these treatments. He points out that patients in controlled trials may suffer from less severe disorders and less comorbidity than patients routinely seen by practitioners. He also reiterates that much of psychotherapy is less concerned with symptoms and more concerned with the ability to cope and agree that psychotherapy is much broader in attempting to deal with multiple stressors (p147). However, similar to Barlow, Kazdin argues that we need to be concerned with state legislatures and third party payers who are trying to determine what will be reimbursed and what will not be reimbursed. He describes two guiding questions: "Are there better ways to bridge the divide between clinical research and practice; and, how can we improve the quality of patient care (p. 157). I would submit that working with older adults is an excellent example of dealing with these guiding questions. Many older adults do need help in coping with the aging process and will clearly benefit from psychotherapy. On the other hand there are other older adults who may suffer from specific problems which clearly need psychological treatments. Whether or not Barlow's distinction will be helpful to psychologists is a topic that is worthy of investigation!

Summary

I began this article by describing Barlow's differentiation between psychological treatments and psychotherapy and utilizing evidence-based treatments with older adults to provide examples of treatments. I talked about the dearth of research with regard to the treatment of ethnic minority elders, those with disabilities, and older LGBT clients. I presented a vignette concerning an older ethnic individual and the dilemmas faced by therapists in providing treatments. I then returned to the knotty issue of whether or not evidence-based treatments are transferable to clinical prac-

continued on page 14

tice. Hopefully my discussion will stimulate your thinking about all these areas.

References

Abeles, N. (in press) Supervising novice geropsychologists. In Hess, A., *Psychotherapy Supervision, Theory, Research and Practice.* New York: Wiley.

American Psychological Association (1998) What practitioners should know about working with older adults. *Professional Psychology*, 29, 413-427.

American Psychological Association (2003). *Guidelines for Psychological Practice with Older Adults*. Washington, DC: Author.

APA Presidential task force on evidence-based practice (2006).Evidence-based practice in psychology. *American Psychologist*, 61, 271-285.

Ayers, C, Sorrell, J, Thorp, S., and Wetherell, J.(2007). Evidence-based treatments for late life anxiety. *Psychology and Aging*, 22, 8-17,

Barlow,D. (2005) Clarification on psychological treatments and psychotherapy. *American Psychologist*, 734-735

Barlow, D. (2004). Psychological Treatments. *American Psychologist*, 869-878

Brown, L. (2006) The neglect of lesbian, gay, bisexual and transgendered clients. In Norcross, J, Beutler, L., & Levant, R. *Evidence-Based Practices in Mental Health.* Washington, D.C: American Psychological Association.

Gallagher-Thompson, D. & Coon, D. (2007) Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology of Aging*, 22, 47-51.

Hinrichson,G & Clougherty,F. (2006). *Interpersonal Psychotherapy for Depressed Older Adults*. Washington,D.C: American Psychological Association.

Kazdin,A. (2008) Evidence-based treatment and practice. *American Psychologist*, 63,146-159.

Norcross, J., Beutler, L. & Levant, R. (2006). *Evidence-Based Practices in Mental Health*. Washington, D.C: American Psychological Association.

Olkin,R, (1999). *What Psychotherapists Should Know About Disability*. New York: Guilford Press.

Olkin, R. & Taliaferro,G. Evidence-based practices have ignored people with disabilities (p 359). In Norcross,J. Beutler,L and Levant, R.(2006). *Evidence-Based Mental Health Practices in Mental Health.* (359).

Scogin, F. (2007) Special section: Evidence-based psychological treatments for older adults. *Psychology of Aging*, 22, 1-55.

Segal,D., Coolidge,F. and Rosowsky, E. (2006). *Personality Disorders and Older Adults*. Hoboken, NJ: Wiley and Sons

Sue, S .and Zane, N. Ethnic minority populations have been neglected by evidence-based practices. (pp 329-337). In Norcross, J. Beutler, L. & Levant,R. (2006). *Evidence-Based Practices in Mental Health*. Washington, D.C: American Psychological Association.

PERSONAL REFLECTIONS FROM DIVERSE EARLY CAREERS

Michael J. Constantino (Series Editor)
University of Massachusetts, Amherst, Massachusetts

This is the third installment of a 4-5 part series that focuses 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.

OPPORTUNITIES IN PRIVATE PRACTICE

Julianne I. Yanko

Throughout graduate school, I repeatedly heard the faculty warn, "don't plan on hanging a shingle and having a private practice." With such clearly worded commentary, I initially believed that a career in private practice was not a realistic option. Yet, today, my professional interests and personal needs have been satisfied in, yes, private practice!

POSITION DESCRIPTION

I am a part-time, solo private practitioner in Amherst, Massachusetts, a small town that is also home to five colleges. My time is divided between the provision of psychotherapy, administration and consultation, and supervision.

Psychotherapy

I spend most of my time as a therapist, seeing adult clients presenting with a variety of mood and anxiety disorders and health-related issues. These clients are referred by medical providers, local college counseling staff, mental health colleagues, academic psychologist colleagues, and an insurance plan in which I participate. I see these patients in my primary office three days/week. In the four years since beginning my practice, the only consistency in my caseload has been change. The referral types and percentages of college student vs. non-college student clients in my caseload are always changing.

In addition to the cases noted above, I see clients one morning a week in a family practice office, in one of the same exam rooms used by the medical providers. I usually offer the time slots that I have in that office to the clients referred by the family practitioners who work there. In some instances, coming to a familiar office is an important factor in helping clients to access mental health services.

Administration

I also spend time on administrative activities, such as submitting insurance claims, returning calls to prospective clients, and mailing questionnaire packets to new clients. When I first began my practice, a key activity was developing connections (i.e., having coffee or eating lunch!) with some of my referral sources and getting to know other providers to whom I might make referrals. For instance, I met with a

continued on page 16

psychologist and medical providers at a large medical center that is about 20 miles away. They offer specialty medical services there and some of their patients live closer to where I practice, so I am a viable referral possibility. I have also maintained open communication with staff at the local colleges and have become part of their referral networks. Finally, I met with psychologists at one of the larger mental health clinics in the area and several in solo private practice and have been able to refer out cases to them. This bidirectional referral process has made for satisfying professional relationships and has promoted important partnerships from a business perspective.

Consultation and Training

Several times a year, I provide consultation or training for psychologists and providers from non-mental health disciplines, as well as give talks to community groups or medical patients. For example, I have consulted with clinic nurses regarding psychosocial interventions for women undergoing infertility treatment. I have presented on the psychosocial impact of polycystic ovarian syndrome as part of an informational series at a medical center for patients with the disorder. I have also consulted with a local nutritionist on issues surrounding behavior change and eating for family practice patients. I have also trained graduate students and led a continuing medical education workshop on integrating mindfulness techniques with cognitive behavioral therapy (CBT). As a final example, I conducted an inservice on CBT for anxiety disorders for the staff at a college counseling center. These types of trainings require that I stay current with the mental health and psychotherapy literatures, and they provide me the opportunity to meet other providers in the community (who often become new referral sources).

Supervision

Another regular part of my practice is supervision. I meet twice monthly with a peer consultation group to discuss clinical cases, ethical issues, and other aspects of private practice. I have also provided individual and group supervision to doctoral students in clinical psychology, including cases that were part of a clinical research trial.

ROAD TO CURRENT POSITION

I arrived at my current position thanks to the breadth and depth of my clinical training, as well as a fair amount of luck! My fascination with psychology began with the courses I took to fulfill my undergraduate general education requirements and led me to enter a masters program of general psychology at California State University Long Beach. While there, I became involved in a research project at the neighboring Veterans Administration Hospital and also gained clinical experience co-leading groups at a day treatment center. These experiences led me to pursue additional clinical research, to train in empirically-validated therapy techniques, and to focus on populations with health issues and older adults. After completing this master's program, I began the doctoral program in clinical psychology at the University of Massachusetts-Amherst (UMass), which emphasized the scientist-practitioner training model.

At UMass, outstanding mentors encouraged me to engage in a broad diversity of clinical and research experiences. I obtained clinical training with populations across the lifespan, in outpatient and inpatient settings, and with serious mental illness. I also received extensive training in psychological testing. Because I was still interested in empirically-supported techniques and behavior change, I sought out specialized training in behavioral medicine during an 18-month practicum at an academic medical center. I thoroughly enjoyed working in a hospital setting, learning about the interrelationship between mental and physical health, and collaborating with other disciplines. For internship, I wanted to receive additional behavioral medicine training and to develop other competencies. Internship afforded me a great mix of training experi-

continued on page 17

ences. For example, on an inpatient psychiatric unit, I primarily conducted therapy and some assessment. In an interdisciplinary outpatient clinic, I provided therapy for homeless and medically ill clients. And finally, in the behavioral medicine clinic, I conducted outpatient individual and group therapy, as well as inpatient consultation-liaison work.

Finally, I completed a two-year post-doctoral fellowship in behavioral medicine to sharpen skills in that specialty and to engage in research on end-of-life issues. This professional environment fulfilled my ideal training goal—i.e., working in an academic medical center, simultaneously immersed in providing clinical services, being involved in medical student and resident education, supervising psychology practicum students and interns, developing clinical programs, and working on a grant and an article. Not incidentally, though I did not realize it at the time, one of the aspects of my internship and fellowship training that proved to be most informative was learning about the constraints and pitfalls associated with third-party payment, productivity requirements, and other factors that affect the "bottom line."

The shift from postdoctoral fellowship to private practice was not my original plan, but my perspective on the ideal career began shifting. Throughout graduate school and fellowship training, I enjoyed being active in numerous clinical, research, and teaching activities, and I held the belief that I would most enjoy a career where I was involved regularly in all of them, perhaps adding some administrative duties and political advocacy for additional professional fulfillment. However, as I envisioned a family life, I began to think of my career in terms of a series of stages in which I would emphasize different activities at different times. Subsequently, as each of my three children has come on the scene, I have adjusted my professional priorities and expectations according to family needs. Clinical work is my core interest and I enjoy it most when I can collaborate with other medical providers, college staff, or therapists-in-training.

After my post-doc, I moved to the five-college area knowing that there would be ample opportunities for adjunct teaching. I hoped to teach and to find a part-time, clinical position. I had never given any serious thought to private practice; besides being warned against it, I had no exposure to it whatsoever. Unexpectedly, there were referrals from former patients and providers at my post-doc site and as soon as I could wrap my brain around "hanging out a shingle," I decided to start a practice. I found that it was a better fit, both time-wise and economically, with raising a young family, and I have been doing it ever since.

MOST SATISFYING ASPECTS OF POSITION

I love having the opportunity to conduct therapy with heterogeneous individuals with a variety of presenting problems. It is interesting, challenging, and rewarding work. Initially I was concerned that not being in a medical setting would be a disappointment, but those feelings soon dissipated as I found a niche providing behavioral medicine services for patients referred by their local medical providers or specialty providers at the nearest medical center. I also enjoy having a relationship with a busy, local family practice.

Being in solo practice also made it necessary for me to connect with other mental health providers in my area. Although it is important for me to have trusted colleagues to whom I can refer cases that I do not have room to accept or that require specialties other than my own, the social connection with colleagues is also very enjoyable. Furthermore, it would be hard to overestimate the importance of the functions served by my peer supervision group. They have provided consultation on complex ethical issues, rich perspectives on clinical issues, and saved me from

continued on page 18

having to figure out all of the nuts and bolts of private practice administration on my own.

Working in private practice has also been wonderful for me personally and as a mother. I was able to choose a practice location minutes from my home, enabling me to spend the bulk of the time away from my children and family life doing clinical work rather than commuting. At different times, I have shifted my schedule in ways that best balance work and family needs. For instance, this year I had a greater percentage of college students in my caseload who leave the area during summer, leaving me with the opportunity to have a smaller caseload if I choose not to take new cases for several months. I am considering the possibility of making this a practice when all of my children are school age. I was also able to reduce my caseload when my children were infants and to build it back up as my family's needs allowed. Overall, I feel that I have been able to have an engaging, rewarding practice that is a strong base from which I can expand to other areas in the future. Not insignificantly, at least in this area, salaries for part-time or fee-for-service psychologists are on the low side and not likely to cover the cost of childcare. By managing my own overhead and referrals, the percentage of the reimbursement that I earn is significantly greater than that paid by local clinics. This is what has made it financially possible to be more flexible in my schedule.

To some extent, being in private practice has let me be guided by my own values as I make business decisions, which can be wonderfully efficient. I am not affected by seemingly random decisions made by administrators, and by being aware of all of the factors, I can make the decisions that I think are best. I never waste time on a meeting or wait for someone else to make a decision that impacts my work.

MOST CHALLENGING ASPECTS OF POSITION

Some of the most rewarding parts of this work are closely related to the most challenging aspects. Though I relish making decisions that affect the direction of my practice, there are times when administrative duties demand more time than I would like. Working part-time compounds this problem, as it requires comparable mundane administrative activities as full-time practice. Thus, tasks that seem least important and interesting can consume a greater percentage of my time than they would of a full-time schedule. I also miss having colleagues an office door away, but that is what compelled me to join a peer consultation group. Of course, I am also affected by the larger forces at play in the current health care climate, which is as disastrous for mental health as it is for medicine. In the short time I have accepted reimbursement from third-party payers, there have been depressing, rapid developments that I have had to react to despite my best-laid plans to make choices about my practice in a pro-active way. Finally, the flexibility that I value in terms of lighter schedules at particular times means that I have a very demanding schedule at other times.

PEARLS OF WISDOM

I realize that admonitions against "hanging out a shingle" were likely motivated by concerns about the third-party payer debacle. Yet, my shingle is out and referrals are steady. People will continue to have mental health needs and the key is to figure out how to serve them while making a good living. To that end, there are several guidelines that might be useful to those considering private practice.

The first is to know what you need from your practice. As with any other job, you will consider the schedule, workload, and income that you require. In thinking about how to structure your practice, there are

continued on page 19

numerous invaluable resources, such as books, articles on the APA website, and your state psychological association. The second critical piece is to formulate what you would like the content of your work to be – i.e., what types of referrals, what types of involvement with other professionals, etc. Then you can start developing a plan that integrates your basic job requirements and your desires regarding the work content. It might be helpful to think in terms of multiple steps leading to the ultimate, ideal position. Once you have a plan, flexibility is essential. All obstacles have the potential for being opportunities. Finally, be present and enjoy the work. You have spent thousands of hours in training and jumped the hurdles of comprehensive exams, dissertations, and licensing exams to be at this point!

AUTHOR NOTE: I welcome any follow up communications or questions at julianneyanko@aol.com.

ATTENTION GRADUATE STUDENTS AND EARLY CAREER PROFESSIONALS

You are invited to our second annual

"Lunch with the Masters: For New Professionals Interested in Psychotherapy"

at the APA Convention
Saturday, August 16th from 12 – 1:50 pm
at the Sheraton Boston Hotel, Commonwealth Room

Come have lunch with the Masters of the profession and learn more about Division 29. Invite others to come as well!

PRACTITIONER REPORT

Practice Domain Update: Progress and Challenges

Jennifer F. Kelly, Ph.D.

I am so excited about having the opportunity to be a part of Division 29, and to be serving you as the Practice Domain Representative. I would like to start my tenure by introducing myself and the persons working with me in this domain. My name is Jennifer F. Kelly. I am a Past President of the Georgia Psychological Association and currently represent the state of Georgia on the Council of Representatives. I am Past-Chair of the Board of Professional Affairs (1997) and currently serve on the Committee for the Advancement of Professional Practice (CAPP) and the Board of Trustees of the Association for the Advancement of Psychology (AAP)-current Chair. I am an independent practitioner in Atlanta, Georgia, primarily working with individuals with health related conditions. I have a special interest in advocacy, especially for the underserved populations. I feel that my involvement with Division 29 fits very well into my experience, practice, and goals.

I would like to welcome Dr. John O'Brien to the Division as he is serving as 2008 Chair of the Psychotherapy Practice Committee. John is an independent practitioner living in Portland, Maine. He is a graduate of Michigan State University and specializes in substance abuse, trauma, LGB issues and grief. He currently serves as president of the Maine Psychological Association. Coordinating the practice section of the *Psychotherapy Bulletin* is one important aspect of John's responsibilities and you will be hearing more from him in the near future.

Dr. Patricia Coughlin will be serving as the 2008 Associate Chair of the Psychotherapy Practice Committee. She will be working with us to assist in developing the Practice agenda for the division. Dr. Coughlin has been a licensed Clinical Psychologist for over 25 years. In addition to seeing patients in her private practice in Philadelphia, PA, Dr. Coughlin conducts training and supervision groups for mental health professionals around the world.

When I think about our profession, I feel that we are facing interesting times. At times there is much uncertainty and anxiety about our future, while at other times it is exciting to see what APA is doing to meet the challenges. The practice community of the American Psychological Association has seen exciting changes over the past year. As you all know, we have a new Executive Director for Professional Practice, Dr. Katherine Nordal. Dr. Nordal brings a unique set of background and experience to the position, including public policy, APA governance and independent practice for 27 years. Being an independent practitioner helps her to understand the challenges that practicing clinicians face. Because she has experience on Capitol Hill as well as the state legislature, she understands legal, regulatory, legislative and marketplace issues in the field, all the things that affect the way we do business. She has served on APA's Council of Representatives, Board of Directors, and was chair of the Committee for the Advancement of Professional Practice. In addition, she is a past president of the Mississippi Psychological Association and has served on the Mississippi Board of Psychological Examiners. We look forward to collaborating with Dr. Nordal as she works to advance the psychology agenda.

continued on page 21

The primary mission of the Practice Domain is to focus on the issues related to practice, and we would like to provide you with an update of the progress and challenges.

This spring, on March 5, 2008 the U.S. House of Representatives passed the Paul Wellstone Mental Health and Addiction Equity Act, also known as Mental Health Parity. With this passage we are closer to ensuring equal treatment for millions of Americans with mental health and substance use disorders. Last September, the Senate unanimously passed the Mental Health Parity Act. Although there are differences in the two bills, they are similar in many important aspects. Both preserve strong parity and consumer protection laws at the state level while extending federal parity protections to millions more Americans. We have worked to end discriminatory health insurance coverage for over a decade; we are finally seeing the payoff for all the hard work. Although we are almost there, the work is not over. We now need to advocate for Members of Congress to complete the negotiations on a parity bill that can pass both chambers. Our goal is to have it passed this year!

Another issue the Practice Directorate/Organization has been addressing and following is Pay-for-Performance programs and other quality improvement efforts. As noted by the Practice Organization, the programs are already widespread in medical settings, and insurance companies and government agencies have been applying these programs to mental health services delivery.

Federal initiatives include the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) and the Hospital Quality Initiative. Professional organization and federal efforts to improve care have been supported and extended by purchasers (employers) and commercial health plans. In addition, some insurers have been developing their own approach to assessing the quality of the care they provide to insured populations. Pay-for-performance is now directed toward consumers, as some companies offer individuals reduced premiums, lower deductibles and co-payments for selecting practitioners who meet quality standards. There is growing concern that they are moving toward including behavioral health care in performance measurement development, quality improvement efforts and pay-for-performance initiatives.

Medicare's Physician Quality Reporting Initiative (PQRI) initiative is one of the most well known pay-for-performance efforts, and was implemented in 2007. At this time it is rewarding independent practitioners for reporting data on a selected series of measures. There are six measures that relate to mental health services delivery. These include medication assessment, developing a treatment plan with the patient, screening for cognitive impairment, depression screening, performing a diagnostic evaluation and assessing suicide risk.

To close on a positive note: It is nice to see that, under the leadership of APA's President-Elect, Dr. James Bray, and co-chars, Drs. Carol Goodheart and Paul Craig, there will be a Practice Summit on the Future of Psychology in 2009. Hopefully, this will help prepare us to meet the challenges in providing adequate mental health care to our clients.

Although there is anxiety about the future of practice, it is reassuring to know that our leaders are working hard to address our concerns.

We will be providing you updates about what is happening in practice in future issues of the *Psychotherapy Bulletin.* We look forward to working together to further advance the practice agenda.

PRACTITIONER REPORT

Outcome Measures in Psychotherapy: Blessings or Curses?

John O'Brien

Background

Evidence-based treatment has become an increasingly important concept in numerous fields of practice over the past several years (Reed, 2006). In particular, physicians have come under escalating pressure to use evidence based interventions as opposed to "folklore" in treating patients (Kihlstrom, 2006). Physicians' pay and performance are now being tied to their adherence to evidence-based practices and to the treatment outcomes of their patients. Insurers are rapidly moving in the direction of measuring outcomes to determine the treatments for which they will (and will not) be willing to pay (Bachman, 2006).

The field of psychotherapy is being asked for similar evidence (Asay, Lambert, Gregersen & Goates, 2002). Numerous insurance providers are now requiring psychologists to utilize different outcome measures to demonstrate the benefit and impact of psychotherapy. These measures vary widely in their clinical utility and validity/reliability. Yet in partnering with business and industry, psychologists will increasingly be required to present evidence of their effectiveness.

However, there has been significant resistance to the uses of outcomes in psychotherapy, particularly among private practitioners. Reasons for this resistance are numerous but include lack of funding, time constraints, lack of appropriate instruments and lack of skill in research design (Asay, et al., 2002). In addition, the process of evaluating one's skill as a therapist can be threatening (Asay, et al., 2002). Psychologists may believe that they have received sufficient feedback in their clinical training and they do not wish to have any further evaluation of their work. However, these practitioners will be left behind as psychotherapy practice becomes increasingly structured through the use of outcomes. The question is no longer whether or not to use outcomes. At present, the question is how to use outcomes in providing psychotherapy.

Voice from the Frontline

I'll admit it. I was not excited about the use of outcome measures in psychotherapy when I initially learned of this trend. I was trained in an era just prior to "evidence based practice." In my training, we focused on how to establish and manage a therapeutic relationship with a client and viewed technique as important but secondary. My clinical instructors guided me in understanding patient dynamics and how they manifest in the therapeutic relationship. We talked about how it could be useful to use measures of depression or anxiety to chart client progress but this process was not emphasized.

I first heard of a large scale plan to use outcome measures in psychotherapy in a Quality Assurance meeting for a local managed care company. As I sat in this board meeting, I learned of the plan to use a depression measure designed for primary care offices to assess depression in patients with co-morbid medical issues. This measure would be used with psychotherapy clients. I asked what the reliability and validity of this measure were. I was assured that they were excellent. I then asked about the group on which this measure was normed. "Patients in primary care" was the answer. I pointed out that

continued on page 23

this was a different population from the psychotherapy population, to which the response was, "It doesn't matter."

I then heard a physician staff member of the group talk very excitedly about how we would be able to chart individual client progress based on this measure. He talked about how this would allow for greater communication between primary care physicians and behavioral health "providers." This sounded reasonable.

The physician then went on to talk about how we could use these measures to judge therapist effectiveness and integrate these outcomes into quality ratings. "We can then reimburse providers with better outcomes at a higher rate." The hair on the back of my neck stood up straight. Once again, I could not contain myself. "We will use these data to judge therapist effectiveness? How about those therapists who are seeing a more seriously impaired population? Their clients will not be showing as much progress on this measure, if any. I see many clients with trauma issues and their progress is often slower and more complicated. How will that be accounted for?" There was no clear answer. "This will be punishing those therapists who see more seriously impaired clients. If that is the case, why would a therapist continue to see those clients? Their ratings will be pulled down. I would imagine that the next step would be for therapists to dump their more seriously impaired clients so that their ratings will improve. What will prevent this?" Again, there were no answers. However, I was the only member of the Board who had concerns about this. So, the group moved ahead with the plan to implement this process. I was horrified.

I decided that I needed to learn more about these issues. Rather than just sit and whine (which I do quite well) about this state of affairs, I have focused on exploring how outcomes are being used and have learned ways that they can be effective. I have attended many professional seminars/ trainings. I helped to coordinate a study in our state psychological association that looked at if and how to use measures. We hope to publish our findings.

I am happy to report that through this process, I have worked through my initial resistance to the use of outcomes. I now integrate some symptom measurement into all the treatment that I do. Through this process, I continue to learn about my practice and about my clients. Outcome measurement in psychotherapy is not all bad. However, I am still concerned about many of its aspects. In the interest of fairness, I thought that I would first share what I consider to be the benefits ("blessings") of outcomes and then identify some of my concerns ("curses").

Blessings:

Corroboration of symptoms. I find it very interesting to see how a client's self-report of symptoms compares to my clinical interview. It is not unusual, especially with my male clients, to see a discrepancy between what is verbally reported versus what is reported in writing. This can lead to interesting conversations with clients. Measures can also help me to confirm my thinking diagnostically.

Tool in psychotherapy. I will sometimes use outcome measures as a point of discussion in treatment. For example, a female client in treatment rated her depression as very low. In sessions, she would easily become tearful, expressed negative thoughts about self, had difficulty getting motivated to do things, and was socially isolated. This led to a discussion of the difference between her behavioral indications of depression versus her self report. She was able to see that her lack of acknowledgement of her symptoms was impeding her recovery process.

Tracking individual client progress. I can easily see client progress (hopefully) in therapy and I will often articulate my impressions

continued on page 24

for clients during treatment. Although this can be beneficial, I also realize that having an "objective" measure that clients can review provides another more concrete piece of evidence of their progress. It is one thing to HEAR about progress but it seems very powerful for clients to SEE their progress. People often forget how bad things have been.

Evidence (hopefully!) that the psychotherapy I provide makes a difference. I like to believe that what I do is helpful to clients and that I help them change. Using outcomes can be beneficial in demonstrating that my work in therapy with clients is effective.

Curses:

And what are we measuring? As a psychologist, I work with my client for 50 minutes a week (on average). How much of an impact am I having in my client's life as compared to (1) appropriate psychotropic medication being prescribed (if needed), (2) medication adherence, (3) exercise, (4) ensuring healthy sleeping patterns, (5) ensuring healthy eating patterns, (6) healthy socialization, and, (7) use of skills as recommended. Outcome measures may be reflecting a client's motivation, their treatment adherence, or other life circumstances impinging on their treatment.

And what can we conclude about the patient? Sometimes conclusions may be drawn about a client that are not reflective of their clinical presentation. For example, I had a client who started in therapy and completed an outcome measure for his insurance company to get sessions authorized. This client was having panic attacks, was drinking daily, had significant marital conflict and was questioning whether or not to stay in his marriage. After he completed the outcome measure, I faxed it off to the insurance company. The letter that I received in return was a surprise. "We are authorizing 3 sessions based on this client's symptoms. Congratulations! This client is ready for discharge! Thank you for your excellent work with this client." Fortunately, I was able to appeal this decision and explain my client's needs. Outcome measures can be reified to represent the BEST representation of a client's functioning. In truth, they are one in a number of data points to consider.

And what can we conclude about the therapist? Many outcome measure systems are incorporating measures of the effectiveness of the therapist based on client responses. Therapists are compared across clients and with each other. As I reflect on my caseload, I am aware of the differences that my clients have in how much independence they demonstrate in their treatment, the speed with which they can learn and utilize skills, and how much they are able to follow through with treatment recommendations. The conclusions about my effectiveness as a therapist will vary widely, depending upon the sample of my client population that is drawn.

And where is this information going? Some of the measures that I have used in practice that are required by insurers are faxed off to the company. The only feedback that I received was an authorization letter for further sessions (or not). No other clinical feedback came to me. This process provided no helpful information to me. In addition. I had no way of knowing what the company was using the information for or how it was being tied to a client's overall record. Could the information that a client completes come back to haunt them one day in applying for other health insurance? Life insurance? I try to highlight this for my clients but I worry that they are not fully understanding the potential implications. I think that there are significant ethical issues inherent in this process.

In closing, I can happily report that my resistance to the process of outcome measurement in psychotherapy has been successfully managed. I don't believe that the use of outcomes and the movement toward "evidence-based practice" is all bad. There

continued on page 28

DIVISION 29 APA CONVENTION PROGRAM SUMMARY

THURSDAY, AUGUST 14, 2008

Symposium: *Psychotherapy for Cardiac Patients—Translating Research Into Practice*
8:00 AM – 8:50 AM Boston Convention and Exhibition Center, Meeting Room 155
Chair: Ellen A. Dornelas, PhD
Participant/1st Author: Matthew M. Burg, PhD
Participant/1st Author: Ellen A. Dornelas, PhD
Discussant: Leigh McCullough, PhD

Symposium: *Supervision From Multiple Theoretical Perspectives—Integrating These Approaches*
9:00 AM – 9:50 AM Boston Convention and Exhibition Center, Meeting Room 251
Chair: Nadine J. Kaslow, PhD
Participant/1st Author: Josh S. Spitalnick, PhD
Participant/1st Author: Marianne Celano, PhD
Participant/1st Author: Eugene W. Farber, PhD
Participant/1st Author: Chaundrissa O. Smith, PhD
Discussant: Nadine J. Kaslow, PhD

Workshop: *Sexual Relationship Satisfaction, Sexual Dysfunction, and Differentiation—Research and Treatment*
10:00 AM – 11:50 AM Boston Convention and Exhibition Center, Meeting Room 209
Chair: David Schnarch, PhD
Participant/1st Author: Susan Regas, PhD

Symposium: *Real Relationship in Psychotherapy—Latest Findings About a Controversial Concept*
12:00 PM – 1:50 PM Boston Convention and Exhibition Center, Meeting Room 101
Chair: Charles J. Gelso, PhD
Participant/1st Author: Charles J. Gelso, PhD
Participant/1st Author: Eric B. Spiegel, PhD
Participant/1st Author: Jairo N. Fuertes, PhD
Participant/1st Author: Frances A. Kelley, PhD
Discussant: Dennis M. Kivlighan, Jr., PhD

Symposium: *Therapist as Human—Crying, Lying, and Expressing Anger*
2:00 PM – 2:50 PM Boston Convention and Exhibition Center, Meeting Room 150
Chair: Annette S. Kluck, PhD
Participant/1st Author: John Westefeld, PhD
Participant/1st Author: Randolph Pipes, PhD
Participant/1st Author: Caroline Burke, PhD
Discussant: Melba J.T. Vasquez, PhD

Workshop: *Challenges in the Integrated Practice of Psychotherapy and Psychopharmacology*
3:00 PM – 3:50 PM Boston Convention and Exhibition Center, Meeting Room 254B
Chair: Jeremy Kisch, PhD

FRIDAY, AUGUST 15, 2008

Symposium: *Emotional Healing in Tibet—Implications for Psychotherapy*
8:00 AM – 9:50 AM Boston Convention and Exhibition Center, Meeting Room 207
Chair: Lillian Comas-Diaz, PhD
Participant/1st Author: Alan Pope, PhD
Participant/1st Author: Frederick M. Jacobsen, MD
Participant/1st Author: Ellen Littman, PhD
Participant/1st Author: Fayth M. Parks, PhD
Discussant: Norine G. Johnson, PhD

Symposium: *MySpace, YouTube, Psychotherapy, and Professional Relationships—Crisis or Opportunity?*
2:00 PM – 3:50 PM Boston Convention and Exhibition Center, Meeting Room 261

continued on page 26

Chair: Jeffrey E. Barnett, PsyD
Participant/1st Author:
Jeffrey E. Barnett, PsyD
Participant/1st Author: Keren Lehavot, MA
Participant/1st Author:
David P. Powers, PhD
Discussant: Stephen Behnke, JD, PhD

Poster Session I
4:00 PM – 4:50 PM Boston Convention and Exhibition Center, Exhibit Halls A and B1
Marjan Ghahramanlou-Holloway, PhD
Jennie Sharf, PhD
Barbara M. Vollmer, PhD
Cheri L. Marmarosh, PhD
Cheri L. Marmarosh, PhD
Karen L. Jacob, PhD
Karen E. Godfredsen, PsyD, MA
Raia S. Gorcheva, MA
Diane Hiebert-Murphy, PhD
Denise H. Bike, MS
Robert J. Wright, PhD
Luo-Wen Wong, MA, No Degree
Cortney S. Warren, PhD
Joan M. Farrell, PhD
Sunyoung Kim, PhD
Danielle R. Probst, MS
Pedja Stevanovic, MA
Arlene Barrow, MA
Angela Fang, BA
Sandra L. Perosa, PhD
Myeong Seon Choi, PhD
Geetanjali Sharma, MS
Peter A. Weiss, PhD
Megan M. MacNamara, MA
Nancy L. Murdock, PhD
Katreena L. Scott, PhD
Christopher G. Black, BS
Tamar J. Kairy, MA

Business Meeting and Awards Ceremony: Celebrating the 40th Anniversary of the Division of Psychotherapy
5:00 PM – 5:50 PM Boston Marriott Copley Place Hotel, Wellesley Room

Social Hour: Celebrating the 40th Anniversary of the Division of Psychotherapy
6:00 PM – 6:50 PM Boston Marriott Copley Place Hotel, Suffolk Room

SATURDAY, AUGUST 16, 2008

Symposium: *New Look at Grief—Evidence on Process and Treatment Outcome*
8:00 AM – 8:50 AM Boston Convention and Exhibition Center, Meeting Boom 156B
Chair: Dale G. Larson, PhD
Participant/1st Author:
George A. Bonanno, PhD
Participant/1st Author:
William T. Hoyt, PhD
Discussant: Stephen R. Connor, PhD

Symposium: *Eminent Psychotherapists Revealed—Microanalysis of Essential Components of Psychotherapy*
10:00 AM – 11:50 AM Boston Convention and Exhibition Center, Meeting Room 258C
Chair: Jeffrey J. Magnavita, PhD
Participant/1st Author:
Jeffrey J. Magnavita, PhD
Participant/1st Author:
Lorna Smith Benjamin, PhD
Participant/1st Author:
Arthur Freeman, EdD
Participant/1st Author:
Judith S. Beck, PhD
Discussant: David H. Barlow, PhD

Conversation Hour: *Lunch With the Masters—For Graduate Students and Early Career Psychologists*
12:00 PM – 1:50 PM Sheraton Boston Hotel, Commonwealth Room

Workshop: *Treatment of Body Dysmorphic Disorder*
12:00 PM – 1:50 PM Boston Convention and Exhibition Center, Meeting Room 251
Cochair: Sabine Wilhelm, PhD
Cochair: Luana M. Miller, PhD
Participant/1st Author: Anne Chosak, PhD

Committee Meeting: *Psychotherapy—Theory, Research, Practice, Training*
Editorial Board Meeting
3:00 PM– 3:50 PM Sheraton Boston Hotel, Berkeley Room

continued on page 27

Poster Session II
4:00 PM – 4:50 PM Boston Convention and Exhibition Center, Exhibit Halls A and B1
Ehsan Gharadjedaghi, BA
Jun Jung-Mi, MD
Shana L. Markle, MA
Veronika Karpenko, MS
Kathleen Chwalisz, PhD
Robert J. Reese, PhD
Daniel L. Hoffman, MA
Michael M. Omizo, PhD
Aaron H. Carlstrom, PhD
Jeana L. Magyar-Moe, PhD
Wendy L. Dickinson, PhD
Amanda G. Ferrier-Auerbach, PhD
Robert W. Lent, PhD
Paul M. Spengler, PhD, MA
Narine Karakashian, PhD
Jason K. White, PhD
Dominick A. Scalise, MA, BA
Laura Smith, PhD

SUNDAY, AUGUST 17, 2008

Symposium: *Practice, Training, and Outcomes in Walk-In, Single-Session Therapy*
8:00 AM –9:50 AM Boston Convention and Exhibition Center, Meeting Room 213
Chair: Monte Bobele, PhD
Participant/1st Author: Arnold Slive, PhD
Participant/1st Author:
Bernadette Solorzano, PsyD
Participant/1st Author: Teresa Corriea, MS

Symposium: *Innovating Evidence-Based Practice With Session-by-Session Outcome Measures*
10:00 AM – 11:50 AM Boston Convention and Exhibition Center, Meeting Room 213
Chair: David W. Smart, PhD
Participant/1st Author: John Okiishi, PhD
Participant/1st Author:
Stevan L. Nielsen, PhD
Participant/1st Author:
Jason Southwick, BS
Participant/1st Author:
Kenichi Shimokawa, BS
Participant/1st Author: Karen Evans, PhD
Discussant: Raymond A. DiGiuseppe, PhD

Symposium: *Role of Psychotherapy in Health Care*
12:00 PM – 1:50 PM Boston Convention and Exhibition Center, Meeting Room 158
Chair: Norine G. Johnson, PhD
Participant/1st Author:
Armand R. Cerbone, PhD
Participant/1st Author:
Michael F. Hoyt, PhD
Participant/1st Author:
Lillian Comas-Diaz, PhD
Participant/1st Author:
Susan H. McDaniel, PhD

Practitioner Report, *continued on page 24*

are numerous positives to this, some of which are noted above. However, it is also important to be clear about the potential problems. We as psychologists need to be strong advocates for how these systems are implemented and monitor the ethical issues inherent in the process.

References

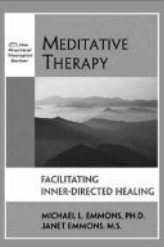
Asay, T., Lambert, M., Gregersen, A., and Goates, M. (2002). Using patient-focused research in evaluating treatment outcome in private practice. Journal *of Clinical Psychology*, *58*, 1213-1225.

Bachman, J. (2006). Pay for performance in primary and specialty behavioral health care: Two concept proposals. *Professional Psychology: Research and Practice*, *37*, 384-388.

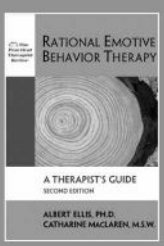
Kihlstrom, J. (2006). Scientific research. In Norcross, J., Beutler, L. and Levant, R. (Eds). *Evidence-based practices in mental health*. (pp. 338-345). Washington, DC: American Psychological Association.

Reed, G. (2006). Clinical expertise. In Norcross, J., Beutler, L. and Levant, R. (Eds). *Evidence-based practices in mental health*. (pp. 13-23). Washington, DC: American Psychological Association.

Resources for the Practical Therapist



Meditative Therapy
Facilitating Inner-Directed Healing
Michael L. Emmons, Ph.D. and Janet Emmons, M.S.
Softcover: $27.95 *232 pages*
Describes the therapeutic procedures that facilitate inner-directed healing and the therapist's role in guiding clients' growth.



Rational Emotive Behavior Therapy
A Therapist's Guide *(Second Edition)*
Albert Ellis, Ph.D. and Catharine MacLaren, L.C.S.W.
Softcover: $24.95 *176 pages*
Detailed theory, techniques, illustrative case examples, exercises for therapy. Co-authored by the originator of Rational Emotive Behavior Therapy.

Since 1970 — Psychology you can use, from professionals you can trust.

Impact Publishers®
P.O. Box 6016, Dept. A05, Atascadero, California 93423-6016
Ask your local or online bookseller, or order direct: 1-800-246-7228 or www.bibliotherapy.com.

Enhancing Emotion Regulation: An Implicit Common Factor Among Psychotherapies for Borderline Personality Disorder

Shelley F. McMain, Ph.D., Centre for Addiction and Mental Health and the Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada

Susan Wnuk, M.A., Centre for Addiction and Mental Health and York University

Alberta E. Pos, Ph.D., York University

Borderline personality disorder (BPD), once regarded as untreatable, now has a more favorable prognosis due to growing empirical support for the effectiveness of psychotherapies for BPD. These include Dialectical Behavior Therapy (DBT) (e.g. Linehan. 1993; Linehan et al., 2006), Schema Therapy (ST) (Giesen-Bloo et al., 2006), Transference Focused Psychotherapy (TFP) (Clarkin, Levy, Lenzenweger, & Kernberg, 2007), Mentalization-based psychodynamic day treatment (MBT) (Bateman & Fonagy, 1999; Bateman & Fonagy, 2001), Cognitive Behavior Therapy (CBT) (Davidson et al., 2006), and Cognitive-Behavioral Systems-Based group treatment (STEPPS) (Blum et al., 2008). At present, there is no compelling indication that one particular therapy for BPD will emerge as superior. Consistent with research on other disorders, all therapies may prove to be equally effective. Still, controlled trials for the treatment of BPD have produced meaningful results, the most important being that psychotherapy for BPD is effective. This alone has revolutionized treatment for this disorder. Now more important than a "horse race" to find the "winning" treatment, a priority must be to understand how effective treatments for BPD work.

Many researchers advocate turning attention to the mechanisms of action in successful treatment for BPD. While examining the specific change factors within treatments is important, equally important is to consider change mechanisms common to all effective therapies for BPD.

This paper argues for a central factor operating across diverse psychotherapies for BPD: emotion regulation. Not only do all schools of psychotherapy for BPD aim to improve emotion regulation, this process has been suggested as a common factor underlying all psychotherapies for psychiatric disorders (e.g., Burum & Goldfried, 2007). This article defines emotion and core features of emotion dysregulation, examines emotion dysregulation in BPD, and common principles underlying techniques associated with the major schools of therapy for BPD.

Emotion, Emotion Dysregulation, and Borderline Personality Disorder

Emotion is viewed as a complex, full system response that includes: biochemical changes; physiological changes; cognitions; expressive-action tendencies; and subjective

continued on page 30

experiences (Frijda, 1986). It provides important information, organizes the individual for action, communicates intentions to others and signals that important needs are at stake (Scherer, 1984). Therefore, accessing emotions facilitates awareness of motivations, needs, and goals and mobilizes individuals to engage effectively in the world (Greenberg & Safran, 1987).

The inability to access emotions and related adaptive action tendencies leads to difficulties in emotion regulation and functioning (Greenberg & Safran, 1987). Emotion regulation difficulties can take a variety of forms. Gratz and Roemer (2004) identified four key features of emotional dysregulation: (a) lack of awareness, understanding, and acceptance of emotions; (b) lack of access to adaptive strategies for modulating emotional responses; (c) an unwillingness to experience emotional distress; and (d) the inability to engage in goal-directed behaviors when experiencing distress.

Emotion dysregulation is a defining feature of BPD characterized by unstable emotions, emotional inhibition, intense negative emotions, emotional crisis, feelings of emptiness, chaotic interpersonal relationships and impulsive behaviours. Emotion dysregulation figures centrally in diverse theories of the pathogenesis of BPD. In MBT emotion dysregulation is assumed to develop as a consequence of deficits in mentalizing capacities; the capacity to differentiate and recognize one's own and other's states of mind (Bateman & Fonagy, 2004). Mentalization deficits develop as a consequence of disorganized and insecure early attachment. DBT's biosocial theory assumes that pervasive emotion dysregulation is the core problem underlying the disorder, and develops as a consequence of inherent emotion vulnerability and pervasive invalidating environmental experiences (Linehan, 1993). Similarly, TFP's psychodynamic theory assumes that BPD develops as a result of a constitutional propensity for high levels of negative emotions, particularly aggression, interacting with early relationship factors, leading to a failure in the integration of disparate representations of self and other (Clarkin, Yoemans & Kernberg, 2006). In ST theory, BPD is again thought to develop as a consequence of the interaction between the emotional temperament and painful childhood events (Young, 1999). Symptoms associated with the disorder are viewed as responses to underlying dysfunctional schemas, which are defined as self-perpetuating and self-defeating emotional and cognitive patterns that develop in early life. In the STEPPS approach, BPD is again defined as an "emotional instability" disorder (Black & Blum, 2004). Therefore, there is convergence that emotion dysregulation, whether a primary or secondary phenomenon, is a key feature of BPD.

This assumption is supported by a growing body of empirical evidence (Putnam & Silk, 2005). BPD individuals report problems with awareness of emotions, intense negative emotional responses, (Levine, Marziali, & Hood, 1997), more trait-negative affect (Trull, 2001), and less tolerance of emotion distress while pursuing goals (Gratz et al.2006). Support for the centrality of emotion dysregulation in BPD has also emerged from physiological and neuroimaging research with data suggesting a dysfunction in the prefrontal, limbic, and corticostriatal pathways that process emotions and modulate behavior (Johnson et al., 2003).

Facilitating Emotion Regulation in Psychotherapies for BPD: Common Principles

Notwithstanding important differences in technique and theory within specific therapies for BPD, we argue for three common guiding principles to facilitate client emotion regulation: 1) the promotion of awareness and acceptance of emotion; 2) the modulation of emotion; and 3) changing or restructuring emotional experience through access to new information.

continued on page 31

Promoting awareness and acceptance of emotions, essential to emotion regulation, is a common strategy in all therapies. Therapists from all major schools use a range of strategies such as reflection, empathy, and validation to increase client awareness and acceptance of emotions. In DBT, validation counters emotional inhibition and avoidance, and functions to decrease emotional arousal, thereby helping clients to value and accept their experiences. In MBT, therapists employ validation to help clients recognize and label thoughts and feelings (Fonagy & Bateman, 2006). In TFP, therapists use reflection and clarification to help clients attend to and integrate emotional experience, and to connect cognitions to disorganized affect (Clarkin & Levy, 2006). Similarly, ST therapists focus on clients' current feelings and problems and the expression of related needs to enhance clients' awareness of schemas (Young, 1999).

Attending to here-and-now emotional experience also leads to increasing awareness of emotions. For example, MBT therapists work in the "emotional present" to promote the capacity to mentalize, viewed as a prerequisite to understanding and regulating intense emotional experience (Bateman & Fonagy, 2004). In TFP, there is an emphasis on affect-laden here-and-now enactment of the transference, as well as articulation of immediate feelings. In ST, therapists utilize experiential techniques such as imagery and role-plays to explicitly activate dysfunctional schemas in session so they are more accessible to restructuring (Kellogg & Young, 2006). Similarly, in DBT, therapists maintain an emotion focus and stimulate inhibited emotions as indicated. DBT therapists attend to the components of emotional responses (e.g. physical sensations, posture, body and facial expressions) and use exposure strategies to enhance in-session emotional experience.

Different therapeutic schools increase awareness of emotional experience by identifying the relationship between cognitions, behaviors and emotions. ST, DBT, and STEPPS help clients identify triggers to emotions and to specify important links between cognitions, emotions, and behaviors. Psychodynamic approaches underscore the importance of connecting reflective functioning and mentalization to affect and behavioral patterns to help clients gain an understanding of the precursors to emotions and to recognize and modify future responses (Fonagy & Bateman, 2006). TFP therapists also make links between disorganized affect and cognitions to help clients contain, contextualize and promote understanding of emotional experience.

CBT approaches for BPD also utilize skills training and psycho education to enhance clients' emotional awareness and acceptance. DBT, ST and STEPPS, all explicitly teach clients the adaptive value of emotion (Blum et al, 2008; Linehan, 1993; Young, Klosko, & Weishaar, 2003). As well, in DBT, clients are taught to observe, describe, and label emotions. In STEPPS, clients are taught to notice physical sensations, thoughts, emotional intensity and action urges associated with emotions,

Effective therapies for BPD also help clients modulate the intensity of emotional experience. Common strategies for promoting emotional modulation involve increasing clients attentional control and their capacity to maintain cognitive distance. In DBT, mindfulness skills are taught to increase clients control over their attentional processes. Clarkin and Levy (2006) have noted the similarity between DBT mindfulness training and mentalization in MBT, and reflective functioning in TFP. All are processes that promote reflection and observation of experience, which in turn helps to modulate emotional arousal.

Another attentional control strategy involves helping clients shift their attention away from arousing stimuli. In DBT, STEPPS, and other CBT treatments for BPD (e.g., Beck & Freeman, 1990; Gratz &

continued on page 32

Gunderson, 2006), clients are taught skills such as distraction in order to tolerate intense negative emotions and inhibit mood-dependent behaviors.

Finally, modulation of emotional experience also occurs through interventions targeting emotion action tendencies. DBT and STEPPS teach clients how to self-soothe and decrease emotional distress though balanced diet, sleeping, and exercise. Additionally, DBT, ST, and STEPPS also use role-playing and behavioral rehearsal to help clients develop adaptive behaviors that can be utilized in the context of intense negative emotional states.

Changing emotions through accessing new information is emphasized by all schools. In ST, experiential techniques and homework are employed to activate schemas and enhance awareness of relevant emotions and cognitions. This new information helps clients develop and practice adaptive responses and modifies dysfunctional schemas (Young et al., 2003). Through exposure techniques in DBT, clients unlearn problematic reactions and develop new associations to negative emotions. Irreverent and provocative communication in DBT helps clients see a different point of view and to shift emotional experience. In TFP, clarification and interpretation helps clients understand how emotions are associated with various self-states. Similarly, in MBT, the client is encouraged to experience, verbalize and express internal states. This new experience increases the client's capacity to mentalize and modulates the client's reactivity and vulnerability to emotions (Fonagy & Bateman, 2006).

Therapy Relationship and Treatment Structure

In all therapies for BPD, both therapeutic relationship and treatment structure are critical to emotion regulation. All approaches stress the importance of being empathic, supportive and non-judgmental as a means to increase client safety and to reduce anxiety. MBT therapists employ empathy and validation as a means to help clients feel understood, mentalize experience, and regulate emotions (Fonagy & Bateman, 2006). In ST, bonding and "limited reparenting" are viewed as critical to enhancing emotion regulation. ST therapists respond with warmth and in a sympathetic manner in an effort to compensate for clients' unmet emotional needs. In TFP, therapists' active engagement and non-judgmental stance, reduces anxiety, thereby allowing representations to arise in the interaction. Similarly, DBT therapists communicate using a warm, supportive, and non-judgmental style to provide an environment that enables clients to work on emotionally difficult material.

As well as providing warmth, many schools emphasize the importance of maintaining a calm, strong and steadfast manner, especially in the face of a client's emotional storms. This may include a direct, intense, and confrontational communication style. For example, sometimes DBT therapists intentionally respond to clients in a provocative, and irreverent manner as a means of shifting a client's affective response. Likewise, in TFP, the therapeutic style is emotionally intense and provides "emotional holding" (Levy et al., 2006).

Providing a well-structured treatment is common to therapies for BPD and is assumed to enhance clients' emotion regulation. Practical elements such as a treatment manual, clarification of roles and responsibilities, and supervision for therapists are emphasized in most major schools. For example, ST therapists establish a safe and predictable atmosphere in order to facilitate emotional expression (Young et al., 2003). In TFP, treatment contracting is employed to help clients experience safety and express emotions fully without becoming overwhelmed. In MBT, the treatment structure helps to "catch things when they get out of control" (Bateman & Fonagy, 2004, p. 184). In DBT, the treatment structure similarly allows the client to interact and be protected

from uncontrollable negative emotions (Linehan, 1993). In sum, structured treatment provides a predictability and familiarity that is regulating.

Summary

While there are important differences in the theories and techniques associated with different psychotherapies for BPD, all approaches view the enhancement of emotion regulation as essential to successful treatment outcome. This paper delineated common emotion regulation principles underlying psychotherapy techniques associated with diverse approaches. Enhancing emotion regulation in therapies for BPD, enables clients to approach, describe and use the adaptive information contained in emotions, as well as to disengage from and act independently of highly aroused, unproductive emotional states. Achieving emotional balance may be the hallmark of effective treatment for BPD. Focusing on this common principle may counter fractions between different therapies for BPD and help us enhance all treatments for this disorder.

Correspondence concerning this article should be addressed to: Shelley F. McMain, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1. E-mail: shelley_mcmain@camh.net.

Reference List

Bateman, A. & Fonagy, P. (1999). Effectiveness of partial hospitalisation in the treatment of borderline personality disorder: a randomised controlled trial. *American Journal of Psychiatry, 156,* 1563-1569.

Bateman, A. & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalisation: an 18 month follow-up. *American Journal of Psychiatry 158*, 36-42.

Bateman, A. W. & Fonagy, P. (2004). Mentalization-Based Treatment of BPD. *Journal of Personality Disorders, 18,* 36-51.

Beck, A. T., Freeman, A., & Davis, D. D. (2004). *Cognitive Therapy of Personality Disorders*. (Second ed.) New York: Guilford Press.

Black, D.W., and Blum, N. (2004). The STEPPS Group Treatment Program for Outpatients with Borderline Personality Disorder, *Journal of Contemporary Psychotherapy*, *34*,193-210.

Blum, N., St. John, D., Pfohl, B., Stuart, S., McCormick, B., Allen, J., Arndt, S., & Black, D.W. (2008). Systems training for emotional predictability and problem solving (STEPPS) for outpatients with borderline personality disorder: A randomized controlled trial and 1-year follow-up. *American Journal of Psychiatry, 165,* 468-478.

Burum, B. A. & Goldfried, M. R. (2007). The centrality of emotion to psychological change. *Clinical Psychology-Science And Practice, 14,* 407-413.

Clarkin, J. F. & Levy, K. N. (2006). Psychotherapy for Patients with Borderline Personality Disorder: Focusing on the Mechanisms of Change. *Journal of Clinical Psychology, 62,* 405-410.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: a multiwave study. *American Journal of Psychiatry, 164,* 922-928.

Clarkin, J.F., Yeomans, F., & Kernberg, O.F. (2006). *Psychotherapy of borderline personality: Focusing on object relations*. Washington, dc: American Psychiatric Press.

Davidson, K., Norrie, J., Tyrer, P., Gumley, A., Tata, P., Murray, H., & Palmer, S. (2006). The Effectiveness of Cognitive Behavior Therapy for Borderline Personality Disorder: Results from the Borderline Personality Disorder Study of Cognitive Therapy (BOSCOT) Trial. *Journal of Personality Disorders, 20,* 450-465.

Fonagy, P. & Bateman, A. W. (2006). Mechanisms of change in mentalization-based treatment of BPD. *Journal of*

continued on page 34

Clinical Psychology, 62, 411-430.
Frijda, N. H. (1986). *The emotions.* Cambridge: Cambridge University Press.
Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., Kremers, I., Nadort, M., & Arntz, A. (2006). Outpatient Psychotherapy for Borderline Personality Disorder: Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy. *Archives of General Psychiatry, 63,* 649-658.
Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T. et al. (2006). Outpatient Psychotherapy for Borderline Personality Disorder: Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy. *Archives of General Psychiatry, 63,* 649-658.
Gratz, K. L. & Gunderson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy, 37,* 35.
Gratz, K. L. & Roemer, L. (2004). Multidimensional Assessment of Emotion Regulation and Dysregulation: Development, Factor Structure, and Initial Validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26,* 41-54.
Gratz, K. L., Rosenthal, M. Z., Tull, M. T., Lejuez, C. W., & Gunderson, J. G. (2006). An experimental investigation of emotion dysregulation in borderline personality disorder. *Journal of Abnormal Psychology, 115*, 850-855.
Greenberg, L. S. & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognitions and the process of change.* New York: Guilford.
Johnson, P. A., Hurley, R. A., Benkelfat, C., Herpertz, S. C., & Taber, K. H. (2003). Understanding emotion regulation in borderline personality disorder: Contributions of neuroimaging. *Journal of Neuropsychiatry and Clinical Neurosciences, 15,* 397-402.
Kellogg, S. H. & Young, J. E. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology, 62,* 445-458.
Levine, D., Marziali, E., & Hood, J. (1997). Emotion processing in borderline personality disorders. *The Journal of Nervous and Mental Disease, 185,* 240-246.
Levy, K., N., Clarkin, J.F., Yeomans, F.E., Scott, L.N., Wasserman, R.H. & Kernberg, O.F. (2006). The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *Journal of Clinical Psychology, 62(4),* 481-501.
Linehan, M. M. (1993). *Cognitive Behavioural Treatment of Borderline Personality Disorder.* New York: Guilford Press.
Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060-1064.
Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L.,Korslund, K.E., Tutek, D.A., Reynolds, S.K., & Lindenboim, N. (2006). Two-Year Randomized Trial + Follow-up of Dialectical Behavior Therapy vs. Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. *Archives of General Psychiatry, 63,* 757-766.
Putnam, K. M. & Silk, K. R. (2005). Emotion dysregulation and the development of borderline personality disorder. *Development and Psychopathology, 17,* 899-925.
Scherer, K. R. (1984). On the nature and function of emotion: A component process approach. In K.R. Scherer & P. Ekman (Eds.), *Approaches to emotion* (pp. 293–318). Hillsdale, NJ: Erlbaum.
Trull, T. J. (2001). Relationships of borderline features to parental mental illness, childhood abuse, Axis I disorder, and

continued on page 35

current functioning. *Journal of Personality Disorders, 15,* 19-32.
Young, J.E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach. 3rd Ed*. Sarasota, FL: Professional Resource Press.
Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy: A practitioner's guide*. New York: The Guilford Press.

Bulletin ADVERTISING RATES

Full Page (8.5" x 5.75")	$300 per issue
Half Page (4.25" x 5.75")	$200 per issue
Quarter Page (4.25" x 3")	$100 per issue

Send your camera ready advertisement, along with a check made payable to Division 29, to:

Division of Psychotherapy (29)
6557 E. Riverdale
Mesa, AZ 85215

Deadlines for Submission

February 1 for First Issue
May 1 for Second Issue
July 1 for Third Issue
November 1 for Fourth Issue

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

ETHICS IN PSYCHOTHERAPY

Psychotherapy for the Psychotherapist: Optional Activity or Ethical Imperative?

Jeffrey E. Barnett, Psy.D., ABPP, Independent Practice, Arnold, Maryland and Loyola College in Maryland and Ian Goncher, M.S., Loyola College in Maryland

In addition to a variety of other professional roles, the vast majority of practicing psychologists regularly function as psychotherapists. As such, it might make great sense that all future psychotherapists participate in their own psychotherapy as part of the training process. Experiencing the role of client as they address their own issues can greatly impact how psychotherapists see the process of psychotherapy as well as their role and their clients' role in it. Additionally, personal psychotherapy during one's training may be valuable for addressing personal issues that, if left unresolved, may adversely impact one's clients.

Sherman (2000) reports that only 5% of all doctoral programs in clinical psychology require their students to participate in personal psychotherapy as a requirement for receiving their degree. Yet, it is believed that many trainees participate in their own psychotherapy. Importantly, Dearing, Maddux, and Tangney (2005) found that faculty attitudes about personal psychotherapy significantly impact trainees' help seeking behaviors, indicating that faculty mentors play an important role in their students' decisions about pursuing personal psychotherapy.

For practicing psychologists, Pope and Tabachnick (1994) found 84% of psychologists surveyed to have been a client in psychotherapy, with 85.6% reporting it to be a very helpful or exceptionally helpful experience. Mahoney (1997) found that 88% of practicing psychotherapists surveyed had participated in personal psychotherapy and of these, 90% rated this experience as positive. Similarly, Norcross, Dryden, and DeMichele (1992) found that 96% of psychologists they surveyed who had participated in personal psychotherapy viewed it as crucial for effectively working as a psychotherapist themselves.

Benefits of Personal Psychotherapy

In reviewing the current literature, Bellows (2007) summarizes the benefits of psychotherapists' personal psychotherapy as including:

- Enhanced self-understanding and self-awareness
- Enhanced self-esteem and self-confidence
- Improved interpersonal relationships
- Enhanced therapeutic skills (empathy, in using countertransference, in structuring their treatment, in understanding the process of psychotherapy)
- Reducing characterological conflicts and enhanced symptom alleviation (p. 208)

Orlinsky and Ronnestad (2005) found that, of 4,000 psychologists surveyed, personal psychotherapy was one of the principal factors cited as being most influential in their clinical training. McWilliams (2005) recommends that all psychotherapists participate in their own psychotherapy as part

continued on page 37

of their training and throughout their careers "…to explore their own vulnerabilities" (p. 142). Furthermore, Pearlman and Saakvitne (1995) describe the psychotherapist's own psychotherapy as "…a place in which to process the impact and effect of our therapeutic work on ourselves, to take all of our needs, our wishes, our fears, all of our feelings and thoughts" (p. 394). Holzman, Searight, and Hughes (1996) found that among the 1,018 clinical psychology graduate students surveyed, 74% endorsed the importance of participating in personal psychotherapy. The reasons cited for seeking treatment included, personal growth (71%), improvement as a therapist (65%), dealing with adjustment issues (59%), and depression (38%).

Norcross, Strausser-Kirtland, and Missar (1988) identified six common themes in the literature that suggest that personal psychotherapy will likely improve each psychologist's ability to care for their clients. These themes include an improvement in the emotional functioning of the psychotherapist, developing a clearer perception of client dynamics, learning ways to manage stressors unique to the practice of psychotherapy, participating in a profound socialization experience, becoming sensitized to the personal needs of our clients, and providing a first-hand account of psychotherapeutic methods.

An Ethical Imperative?

Beyond enhanced personal functioning and enhanced skill as a psychotherapist, personal psychotherapy may be seen as an ethical mandate at different points in psychologists' careers. It is well documented that psychologists and other mental health professionals experience a range of difficulties as a result of our personal issues and predispositions, the nature of the work we do, and ongoing life and work stresses (see Barnett, Johnston, & Hillard, 2006 for a review of these data). Practicing psychologists experience distress with significant frequency and left untreated, can lead to burnout and impaired professional competence.

The practice of psychotherapy is very demanding and regularly can lead to distress. Clients may not improve or may even relapse or deteriorate. Psychotherapists may have clients attempt or commit suicide, they may have clients assault them, and they may experience vicarious traumatization as a result of working with trauma clients. Further, financial stressors and administrative demands of working with insurance and managed care, managing a staff, professional isolation, and the risk of malpractice suits all may contribute to the stress of work as a psychotherapist (Sherman & Thelen, 1998).

In a study of the members of the APA Division of Psychotherapy, 85% of participants reported the belief that working when too distressed to be effective is unethical. Yet, 60% of those questioned in this study acknowledged having previously done so (Pope, Tabachnick, & Keith-Spiegel, 1987). In another study, Guy, Poelstra, and Stark (1989) found 36.7% of psychologists surveyed acknowledging experiencing distress with 4.6% indicating they realized that the quality of care they were providing to clients was inadequate. Further, beyond the effects of distress and burnout on our clinical competence, the deleterious effects of the many stressors we deal with may also lead to impaired objectivity and judgment. As a result, we may engage in a range of unethical behaviors as a result of inadequate attention to these issues.

What Ethics Codes Have to Say

The *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) (APA, 2002) requires psychologists to "undertake ongoing efforts to develop and maintain their competence" (p. 1064) and to "take reasonable steps to avoid harming their clients/patients… and to minimize harm where it is foreseeable" (p. 1065). Further, the Ethics Code states in Standard 2.06, Personal Problems and Conflicts:

- Psychologists refrain from initiating an activity when they know or should

continued on page 38

know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
- When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (p. 1064)

Accordingly, an argument can be made that participation in personal psychotherapy can be seen as an important aspect of every psychotherapist's professional training and development as well as an essential activity for promoting ongoing competence and clinical effectiveness in addition to other stress management and self-care activities (see Barnett, 2008 for recommendations on general self-care strategies). As stated in our profession's ethics code, each psychologist is required to work toward the highest ideals of competence in his or her work as well as to be alert to factors that may impact his or her personal and clinical effectiveness and then to take appropriate actions to ensure that clients are not harmed. Rather than wait until experiencing the symptoms of burnout or having a colleague confront us regarding potentially unethical behavior, it is recommended that each psychotherapist engage in ongoing self-reflection and self-monitoring and then to take corrective action as needed, which may very appropriately include seeking personal psychotherapy.

Why Some Don't Seek Out Personal Psychotherapy

There may be a variety of reasons why some psychologists do not seek out personal psychotherapy. For those trainees who do not have role models that emphasize and encourage it, they may not internalize the importance of personal psychotherapy for themselves. Further, for those trainees experiencing some distress or impairment who do not have supervisors and faculty members recommend treatment, they may see this as minimizing the value of personal psychotherapy and may carry this attitude with them throughout their careers. Additionally, for those trainees who desire participating in personal psychotherapy, financial limitations have been repeatedly cited as one of the primary obstacles present (e.g., Holzman, Searight, & Hughes, 1996; Macaskill & Macaskill, 1992).

For practicing psychologists, studies have found a number of reasons given for not seeking out personal psychotherapy, even when it clearly is needed. These include feeling the need to maintain an image of professional competence and invulnerability (O'Connor, 2001), feeling that they should be able to work out difficulties themselves (Gilroy, Carroll, & Murra, 2002), experiencing embarrassment or having concerns about confidentiality (Stevanovic & Rupert, 2004), and fear of disclosure to colleagues and risking sanctions for unethical behaviors (Deutsch, 1985).

Although these fears and concerns may exist for some psychologists and trainees, it seems that better education and professional role modeling should help assuage these concerns. After all, available data on the experiences of those who do participate in personal psychotherapy highlight the generally positive outcomes experienced. Still, more active education and outreach by professional associations and training institutions may go a long way to advancing this cause.

Moving Forward

This approach is in keeping with the aspirational ideal of Beneficence (working to help others and provide the highest quality of care possible) from the APA Ethics Code and the goal of a preventive approach and an ongoing aspiration to achieve the highest standards of promoting

continued on page 39

self-care, clinical competence, and clinical effectiveness. It is hoped that personal psychotherapy will be seen as an essential aspect of each psychotherapist's professional training and identity development as well as an essential resource for maintaining clinical competence and effectiveness throughout our careers. Finally, as Norcross (2005) recommends, it is hoped that training programs will recommend personal psychotherapy for their students, integrate its role into all aspects of training, and develop low-cost resources for their students to increase the availability of accessible personal psychotherapy. It is also hoped that faculty will demonstrate to students that personal psychotherapy is an important aspect of each psychologist's lifelong professional development process.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57(12),* 1060-1073.

Barnett, J.E. (2008). Impaired professionals: Distress, professional impairment, self-care, and psychological wellness. In Herson, M., & Gross, A.M. (Eds.), *Handbook of Clinical Psychology* (Volume One) (pp. 857-884). New York: John Wiley & sons.

Barnett, J.E., Johnston, L.C., & Hillard, D. (2006). Psychotherapist wellness as an ethical imperative. In VandeCreek, L., & Allen, J.B. (Eds.), *Innovations in Clinical Practice: Focus on Health and Wellness,* (257-271). Sarasota, FL: Professional Resources Press.

Bellows, K.F. (2007). Psychotherapists' personal psychotherapy and its perceived influence on clinical practice. *Bulletin of the Menninger Clinic, 71,* 204-226.

Dearing, R.L., Maddux, J.E., & Tangney, J.P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice, 36*(3), 323-329.

Deutsch, C.J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16,* 305–315.

Gilroy, P.J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33(4),* 402-407.

Guy, J.D., Poelstra, P.L., & Stark, M.J. (1989). Professional distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology: Research and Practice, 20(1),* 48-50.

Holzman, L. A., Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice, 27,* 98–101.

Macaskill, N. D., & Macaskill, A. (1992). Psychotherapists-in training evaluate their personal therapy: Results of a UK survey. *British Journal of Psychotherapy, 9,* 133-138.

Mahoney, M.J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28(1),* 14-16.

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

Norcross, J.C. (2005). The psychotherapist's own psychotherapy: Educating and developing psychologists. *American Psychologist, 60*(8), 840–850.

Norcross, J.C., Dryden, W., & DeMichele, J.T. (1992). British clinical psychologists and personal therapy: III. What's good for the goose? *Clinical Psychology Forum, 44,* 29-33.

Norcross, J.C., Strausser-Kirtland, D.J., & Missar, C.D. (1988). The processes and outcomes of psychotherapists' personal treatment experiences. *Psychotherapy: Theory, Research, Practice, Training, 25,* 36-43.

continued on page 40

O'Connor, M.F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice, 32(4),* 345-350.

Orlinsky, D.E., & Ronnestad, M.H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, D.C.: American Psychological Association.

Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist-Counter-transference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton.

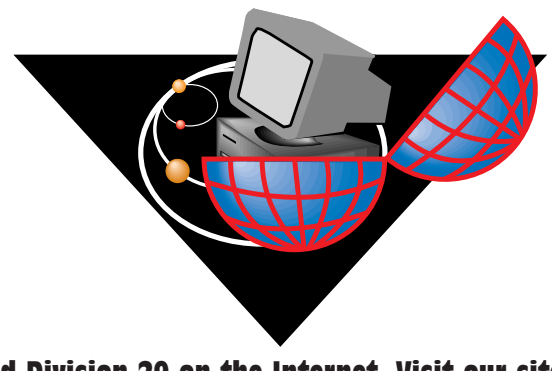
Pope, K.S., & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25(3),* 247-258.

Pope, K.S., Tabachnick, B.G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993-1006.

Sherman, J.B. (2000). Required psychotherapy for psychology graduate students: Psychotherapists' evaluation of process. *Dissertation abstracts international: Section B: The Sciences and Engineering, 60*(9-B), 4910.

Sherman, M.D., & Thelen, M.H. (1998). Distress and professional impairment among psychologists in clinical practice. *Professional Psychology: Research and Practice, 29(1),* 79-85.

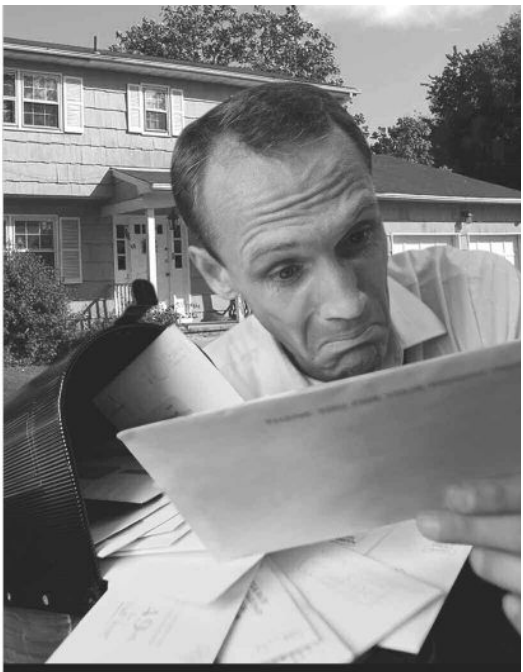
Stevanovic, P., & Rupert, P.A. (2004). Career-sustaining behaviors, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training, 41,* 301-309.



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

Rates Recently Reduced 15% Lowest Premium in 50 Years

When you become disabled and can't work who will pay the bills?



Income Protection Insurance (disability income insurance) through the Trust is the simple, affordable answer.

Trust endorsed LifeStyle Plans are designed to replace your income in the event of total disability, and the LifeStyle-65 Plus plan can even provide funds to continue contributions to your pension or savings plan while you are totally disabled.

Remember, your earning power is your most important asset. It's the force that makes other things in your life possible! Call us today at 1-800-477-1200 to find out how you can secure your family's financial future for less than a cup of coffee and your morning newspaper.

Coverage is individually underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of Liberty Mutual Group. Plans have limitations and exclusions. For costs and complete details, call the Trust or visit www.apait.org.

Trust LifeStyle Plans Feature:

- ★ "Your own occupation" definition of disability
- ★ Monthly benefits up to $10,000
- ★ Choice of benefit payment periods (5-year or to Age 65)
- ★ Choice of benefit Waiting Period (28, 90, or 180-day)
- ★ Residual benefits to ease your return to work
- ★ Guaranteed Insurability Option, which allows you to purchase additional monthly protection as your earnings increase
- ★ Benefit Booster, which prevents inflation from eroding the value of your benefit during an extensive period of disability
- ★ **Additional dollars** to replace retirement plan contributions with Lifestyle 65-Plus plan

THE TRUST

www.apait.org • 1-800-477-1200

STUDENT INTERVIEW

Eva Schmidt, M.A.

Interview With Jeffrey Magnavita, Ph.D.

Eva Schmidt, M.A., University of St. Thomas
Jessica Mijal, M.A., University of St. Thomas

Jeffrey Magnavita, Ph.D.

Eva Schmidt, M.A., and Jessica Mijal, M.A., doctoral students at the University of St. Thomas, interviewed Jeffrey J. Magnavita, Ph.D., ABPP, FAPA, a Fellow of Divisions 12, 29, and 42, with an active history of governance positions within Division 29 including his current role as President-Elect. Dr. Magnavita is the Founder of Glastonbury Psychological Associates, P.C. and an Affiliate Professor of Professional Psychology at the University of Hartford in Connecticut. He has been in clinical practice for over 20 years, specializing in intensive psychotherapy for children, adolescents, and adults manifesting personality dysfunction, relational disturbances and complex clinical syndromes. Dr. Magnavita is the recipient of the 2006 *Distinguished Contribution to Independent Practice in the Private Sector Award* from the American Psychological Association for his work in developing integrative and unified models of psychotherapy. He has authored a number of acclaimed works, including *Personality-Guided Relational Therapy: A Unified Approach, Handbook of Personality Disorders: Theory and Practice, Restructuring Personality Disorders: A Short-Term Dynamic Approach, Theories of Personality: Contemporary Approaches to the Science of Personality,* and *Relational Therapy for Personality Disorders*. He has published extensively on personality disorders and psychotherapy and is interested in pursuing the unification of clinical science and psychotherapy.

Schmidt and Mijal: How do you define your theoretical orientation?

Magnavita: At this point I would define my theoretical orientation as unified, by which I mean moving beyond single school approaches or even integration to a new unified framework which seeks to understand the organizing principles and processes in all evidence-based domains of psychotherapy and more broadly clinical science.

Schmidt and Mijal: What are the challenges of working with clients with personality disorders?

Magnavita: There are many challenges that are inherent in working with people and systems with personality disturbances. One of the central problems is the challenge of developing a working alliance when the nature of one's difficulties includes problems in establishing secure attachments with others. We are always working with the underlying attachment system (i.e., insecure, ambivalent) and with the severe personality disorders (i.e., disorganized). These systems are reawakened in the therapeutic relationship and re-enactment is often an expression of the interpersonal script which attempts to draw the psychotherapist into treating the patient as he or she was treated by earlier attachment figures. The other challenge is not becoming demoralized or burned out when working with people who often have pretty severe neglect and trauma histories. Vicarious retraumatization is a risk for the psychotherapist. This is not a specialty for one who is not patient and

continued on page 46

essentially optimistic about the capacity for change and growth.

Schmidt and Mijal: How do you define brief therapy?

Magnavita: There are many definitions, depending on the type, from one session to 40, although with the severe personality disorders this may be intermittent over the course of years. The patient may return for another block of therapy then go out and live, returning during transition periods which are often stressing their system's tolerance.

Schmidt and Mijal: What types of brief therapies do you use with clients with personality disorders?

Magnavita: I utilize a range of approaches from psychodynamic, interpersonal, family and couples depending on the patient's life circumstances, motivation, and resources.

Schmidt and Mijal: Does the type of brief therapy you use depend on what type of personality disorder the client has and/or particular client characteristics?

Magnavita: Yes, with cluster C patients you can use more anxiety arousing approaches to activate and process affect. The cluster B patients need a mixed empathic and structural approach where you build defenses and emotional competency. The cluster A patients generally need a multimodal approach with medication, supportive psychotherapy, skills building, cognitive, and behavioral methods.

Schmidt and Mijal: What research supports the type of brief therapy that you do?

Magnavita: There is an accumulating body of evidence that support the efficacy of brief psychotherapy with some PD patients. The best results show up with cluster C but there is evidence that even borderline patients improve with transference-focused therapy and schema-focused therapy after a year of treatment, which is very promising.

Schmidt and Mijal: What are your selection criteria for using brief therapy with a client who has a personality disorder?

Magnavita: Generally speaking, the faster you go the more ego adaptive capacity the person needs to tolerate the impact of change on self and others. Even positive changes can destabilize a marriage or family when that person shifts from their previous role. I like to use the Psychodynamic Diagnostic Manual to determine level of capacity. The more the person is toward the neurotic level the faster they can go and the more toward borderline the slower.

Schmidt and Mijal: How do the brief therapies differ from long-term therapy?

Magnavita: Basically there is a higher level of therapist activity, greater focus on core issues, and more structure.

Schmidt and Mijal: What do you view as the mechanism of change in brief therapy?

Magnavita: The mechanism of change is a comprehensive restructuring of the internal schema (attachment patterns), enhancement of defensive capacity (more mature defenses), and greater emotional capacity as a result of emotionally processing and integrating affect and cognition while in a regulating relationship that modulates the intensity with an attuned other.

Schmidt and Mijal: How do you determine a focus and set goals in brief therapy?

Magnavita: The focus is derived from the patient's goals and then expanded or contracted as more information is gathered. The initial focus might, for instance, be depression and then a link might be made to non-metabolized grief over a lost relationship which needs to be processed therapeutically.

continued on page 47

Schmidt and Mijal: What are the advantages and disadvantages of brief therapy?

Magnavita: The rapidity of change is much faster and the possibility of iatrogenic disturbance much higher when you mobilize so much affect and challenge or unbalance a system which may be in homeostasis even though uncomfortable.

Schmidt and Mijal: What types of changes or improvements do you see in clients with personality disorders in brief therapy?

Magnavita: There is a spectrum from an occasional quantum change where there is a massive transformation, to baby stepping, which is gradual change.

Schmidt and Mijal: Does this differ depending on the type of personality disorder the client is diagnosed with?

Magnavita: In part this is based on the personality diagnosed but the DSM tends to be a crude system. What is more telling are the active convergence of forces in the system such as pressure from a spouse or legal system, or an optimal period where someone may be really looking at their patterns of self-defeating behavior and deciding it is time to do something different.

Schmidt and Mijal: How do you track client progress in brief therapy?

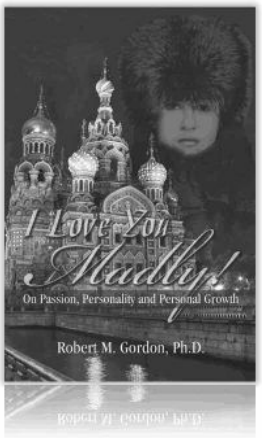
Magnavita: We track what is going on in their lives outside the session: quality of relationships, ability to seek and attain goals, capacity for emotional experience, etc.

Schmidt and Mijal: What have your clients reported to you about their experiences in brief therapy?

Magnavita: I could write a book on this question. They tell all kinds of stories from changing their lives in ways they could never imagine to developing a greater awareness of living in their skin in the here and now as opposed to worrying and acting in self-sabotaging ways.

Schmidt and Mijal: Are there resources you would recommend?

Magnavita: There are many. I have a DVD with APA, *Treating Personality Disorders*, and have just completed a series on psychotherapy over time which depicts the course of treatment over six sessions. These are excellent resources that allow you to really witness the process of assessment and change. I am editing a book, due out with APA next year, on Evidenced-Based Treatment of Personality Dysfunction with contributions from many of the leading clinical researchers in the field. Also, I am very excited about writing a book for the public called *Stuck: Prisoners of Our Past,* which will explain many of the concepts in lay terms for those stuck in self-defeating patterns. There are many other resources available, but for those who are interested in the field of personality disorders the International Society for the Study of Personality Disorders is a wonderful organization that presents cutting edge work in the Journal of Personality Disorders and offers international and national conferences where you can meet those doing cutting edge work. Our division has many resources and was seminal in developing the APA video series with Jon Carlson.



I Love You Madly!
On Passion, Personality, and Personal Growth

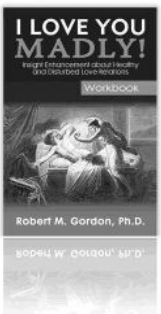
Robert M. Gordon, 2008. Second edition. 256 pages. Paperback. ISBN 978-1-4196-2354-7 $15.99
Read Free Sections at IAPTPress.com
Earn 10 Home Study CE

What does it take to have a lasting love relationship? The author integrates the research and theories of evolutionary psychology, psychoanalysis and social psychology in the context of dramatic stories of love and psychotherapy.

I Love You Madly! Workbook:
Insight Enhancement about Healthy and Disturbed Love Relations

Robert M. Gordon, 2007. 112 pages. Paperback. ISBN 978-0-9779616-1-0 $12.99

This workbook informs about the personality dynamics that are often the reasons behind problems with intimacy.



An Expert Look at Love, Intimacy and Personal Growth:
Selected Papers in Psychoanalytic Social Psychology

Robert M. Gordon, 2008. 152 pages. Paperback. ISBN 978-0-9779616-5-8 $12.99
Earn 5 Home Study CE

Order at IAPTpress.com, Online or bookstores near you, or call 1-800-247-6553.

View Free Continuing Education Slides at IAPTPress.com

Steadily Evolving Into The 21st Century — Working With Others

Pat DeLeon, Ph.D., former APA President

From a public policy perspective, it is increasingly evident that our nation is steadily evolving towards the enactment of a comprehensive National Health Insurance program. The form of coverage and roles of federal and state governments are still far from determined. Similarly, it is too early to predict the role that will exist for psychology and other non-physician healthcare providers. Will the all important psychosocial-economic-cultural gradient of health care finally become an integral component of society's definition of "quality" care? Those colleagues who have had the opportunity to participate in the Practice Directorate's State Leadership conferences, under the leadership of Dan Abrahamson, have had a unique glimpse into the world of one of the most critical players in this ongoing national debate - the American Business community. The Psychologically Healthy Workplace program each year recognizes organizations from across the nation and Canada which implement exemplary programs and policies that foster employee health and well-being, while enhancing organizational performance. Through this innovative initiative, David Ballard and his colleagues in our state associations have developed critical relationships with the business community, as well as an appreciation by both parties of the importance and cost-effectiveness of data-based, psychological interventions.

David's vision integrates the two dominant approaches to organizational health (the organizational effectiveness approach and the employee benefits approach) in a way that optimizes outcomes for both employees and organizations. In practice, this leverages psychology's expertise in human behavior to create significant and sustainable changes at both the employee and organizational level. Utilizing primary, secondary, and tertiary level interventions, it relies on an action research model, which includes needs assessment, customized program design and implementation, and ongoing evaluation. Many organizations implement health and wellness initiatives, but fail to consider that these initiatives do not exist in a vacuum. Every program or policy interacts with the organization's other programs and policies, thus requiring custom-tailoring.

Business's Interest In Cost-Effective Health Care: The Chairman of the Board of Governors of the Federal Reserve System (i.e., the central bank of the United States) testifying before the Senate Finance Committee stated:

Improving the performance of our health-care system is without a doubt one of the most important challenges that our nation faces. In recent decades, improvements in medical knowledge and standards of care have allowed people to live healthier, longer, and more productive lives… But health care is not only a scientific and social issue; it is an economic issue as well.

By any measure, the health-care sector represents a major segment of our economy. Spending on health-care services currently exceeds 15 percent of the gross domestic product (GDP). Indeed, health-care spending is the single largest component of personal consumption—larger than spending on either housing or food.

continued on page 47

Importantly, health care also has long been, and continues to be, one of the fastest-growing sectors in the economy. Over the past four decades, this sector has grown, on average, at a rate of about 2-1/2 percentage points faster than the GDP. Should this rate of growth continue, health spending would exceed 22 percent of GDP by 2020 and reach almost 30 percent of GDP by 2030....The Congressional Budget Office (CBO) projects that, under current policies, health spending will account for almost one-half of all federal non-interest outlays by 2050....

Challenges for Health-Care Reform: Access to health care is the first major challenge that health-care reform must address. In 2006, a total of 47 million Americans, or almost 16 percent of the population, lacked health insurance. Although the federal and state governments spent more than $35 billion to finance uncompensated care in 2004, the evidence nonetheless indicates that uninsured persons receive less health care than those who are insured and that their health suffers as a consequence.... People who are uninsured are less likely to receive preventive and screening services, less likely to receive appropriate care to manage chronic illnesses, and more likely to die prematurely from cancer—largely because they tend to be diagnosed when the disease is more advanced....

Quality: …The quality of medical research, training, and technology in the United States is generally very high. However, the quality of health care is determined not only by, say, technological advances in preventing and treating disease but also by our ability to deliver the benefits of those advances to patients.

For maximum impact, advances in medical knowledge must be widely disseminated and consistently and efficiently implemented. But evidence suggests a disturbing gap between the quality of health services that can be provided in principle and the quality of health services that actually are provided in practice.... Inconsistent use of best practices by doctors and hospitals is also surprisingly widespread.... Although some patients do not receive the care they need, others receive more (and more geographic variation in health-care practices and costs confirms this point. For example, Medicare expenditures per eligible recipient vary widely across regions, yet areas with the highest expenditures do not appear to have better outcomes than those with the lowest expenditures; indeed, the reverse seems to be true.

Cost:.... The problem here is not only the current level of health-care spending (U.S. spending exceeds that of most other industrial countries) but, to an even greater degree, the continued rapid growth of that spending. Per capita health-care spending in the United States has increased at a faster rate than per capita income for a number of decades... A piece of wisdom attributed to the economist Herbert Stein holds that if something cannot go on forever, it will stop. At some point, health-care spending as a share of GDP will stop rising, but it is difficult to guess when that will be, and there is little sign of it yet.... (A)s we all know, although testing and treatment decisions may be undertaken on the presumption that 'someone else will pay,' the public eventually pays for all these costs, either through higher insurance premiums or higher taxes.... Rapid increases in health spending also portent increasingly difficult access to health services for people with lower incomes. As health spending continues to outpace income, health insurance and out-of-pocket payments will become increasingly unaffordable....

Taking on these challenges will be daunting. Because our health-care system is so complex, the challenges so diverse, and our knowledge so incomplete, we should not expect a single set of reforms to address all concerns. Rather, an eclectic approach will probably be needed. In particular, we

continued on page 48

may need to first address the problems that seem more easily managed rather than waiting for a solution that will address all problems at once.... (T)he types of reforms we choose will depend importantly on value judgments and the tradeoffs made among social objectives. Such choices are appropriately left to the public and their elected representatives....

The solutions we choose for access and quality will interact in importan ways with the third critical issue—the issue of cost. Greater access to health care will improve health outcomes, but it almost certainly will raise financial costs. Increasing the quality of health care, although highly desirable, could also result in higher total health-care spending.... "improving access and quality may increase rather than reduce total costs. From the economist's perspective, the question of whether we are spending too much on health care cannot ultimately be answered by looking at total expenditures relative to GDP or the federal budget. Rather, the question, whatever we spend, is whether we are getting our money's worth. In general, good information and appropriate incentives are necessary to allocate resources efficiently. In health care, the necessary information should include not only the clinical effectiveness of certain tests or courses of treatment but also their cost-effectiveness.... In devising policies to reform our health-care system, we must take care to maintain the vitality and spirit of innovation that has been its hallmark."

Miguel Gallardo, President of the California Psychological Association (CPA), has fostered the theme "Building Coalitions, Creating Change, and Shaping CPA's Future" during his tenure. His most recent message to his membership describes the CPA's Board's efforts to Build External Relationships:

"I have invited guests to each of our CPA Board Meetings with the goal of beginning a dialogue with other associations/entities. It is important that we talk to others outside the association and develop ways to work more closely together towards mutual goals. This year we have invited representatives from the California Primary Care Association, the Mental Health Services Act and the California Institute for Mental Health; and finally, representatives from the California Latino Psychological Association, the National Latina/o Psychological Association, the Asian American Psychological Association, and the Southern California Chapter of the Association of Black Psychologists. Thus far we have met with the Primary Care Association and MHSA/CA Institute for Mental Health. As a result of our first two meetings with these associations, we have continued the dialogue and are beginning to develop ways to work collaboratively. At the last board meeting of the year, in October, various representatives from the ethnic-specific associations will be joining us. I am hopeful for a similar outcome after this meeting.

We must use time creatively—and forever realize that the time is always hope to do great things [Martin Luther King, Jr.]. ..(C)reative focus and shared responsibility make all the difference….other people's perceptions of the power leaders hold can be more impactful than power alone. There are few opportunities to be in a leadership as a President on the state level in psychology. While attempting to create change can be rewarding, it does not come without challenges…. few psychologists will argue about the overarching changes and progress needed to enhance the field of psychology, both statewide and nationally. But … there is debate about how we move in these directions and what decisions we make to get us there….when we stay focused on our common goals and shared vision, dialogue happens, our shared intellectual capacity is more creative, and of course, we have more power as a whole. The strength of an associa-

continued on page 49

tion/organization comes in the strength of its members and leadership, and how these two entities work together.

…One of the most fascinating aspects of leadership is the nature of people's interpretations about who you are, what you do, and how you do it. One of the most salient comments that a colleague made to me was, 'You do not recognize the power you have.' My response to this colleague was, 'What makes you think I do not recognize it? What if I told you that I recognize the power I have, but choose to use it differently?' At that point, I realized that other's perceptions of power placed upon leaders are, at times, more powerful than power itself."

Miguel's reflections remind me of an equally astute observation made by Bonnie Straiger, Executive Director of the North Dakota Psychological Association, that many of our practicing colleagues seem almost clinically depressed about the future of their practices and the profession of psychology. We would suggest that more of our state associations should embrace the inclusive-oriented leadership style Miguel has followed and actively encourage our practitioners to become involved, and thereby accept personal responsibility for their own destiny.

The Alliance For Health Reform, co-chaired by U.S. Senators Jay Rockefeller and Susan Collins, notes that America's health care system is always a work in progress. Every year brings new challenges and new proposed solutions. Since 1991, the Alliance has organized more than 200 forums around the nation. No matter who wins the White House and control of Congress this fall, health reform legislation will likely be a front-burner issue in 2009. The debates around reform and the behind-the-scenes meetings of 1993 and 1994 produced a wealth of knowledge on what should be done differently.

Nine lessons learned: 1) Strike while the iron is hot—in the first year after an election, 2) Go for the easiest procedural path, 3) Involve Congress from the very beginning, 4) Raising taxes is tough, but NOT raising taxes can also carry a price, 5) Don't try to put everything into one bill, 6) Be willing to deal, 7) Expect pushback—major health reform means change, and many resist change, 8) If you're from Venus, listen to the people from Mars, and 9) It won't happen if it's not a priority.

Aloha,

Pat DeLeon, former APA President -
Division 29 - July, 2008

CONGRATULATIONS TO OUR AWARD WINNERS!

Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy: The Distinguished Psychologist Award is based on significance of contributions to the practice, research, and/or training in psychotherapy. The 2008 award is presented to Bruce E. Wampold, Ph.D in recognition of his outstanding accomplishments and significant lifetime contributions to the field of psychotherapy.

American Psychological Foundation Division of Psychotherapy Early Career Award is presented to Kenneth N. Levy, Ph.D for distinguished early career contributions to the field of psychotherapy and the Division of Psychotherapy.

The Award for Best Empirical Research Article in 2007 is presented to:
Scott A Baldwin, PhD, Bruce E. Wampold, PhD, and Zac E. Imel
Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. Journal of Consulting and Clinical Psychology, 75, 842-852

In 2008, the Division is instituting an award for **Distinguished Contributions to Teaching and Mentoring,** which is presented in its inaugural year to Mathilda Canter, PhD, in recognition of her significant contributions to the field of psychotherapy through her impact on the lives of developing psychologists in their careers as psychotherapists.

The Division is also pleased to announce the following student paper award winners:

Mathilda B. Canter Education and Training Student Award
Jenelle Slavin
Adelphi University
The Effects of Training, Clinical, Supervisory, and Scholarly Experience on Supervisors' Views of Therapuetic Techniques

Donald K. Freedheim Student Development Award
Joshua K Swift, MS
Oklahoma State University
The Impact of Client Treatment Preferences on Outcome: A Meta-Analysis

Student Diversity Award
Arien Muzacz
City College of the City University of New York
Older Adults, Sexuality and Psychotherapy: Implications for Ethnic and Sexual Minorities

You're Invited!

APA's Division of Psychotherapy Invites You to our 40th Anniversary Celebration

Friday, August 15, 2008

Business Meeting and Awards Ceremony

5:00 PM - 5:50 PM Boston Marriott Copley Place Hotel, Wellesley Room

Social Hour

6:00 PM - 6:50 PM Boston Marriott Copley Place Hotel, Suffolk Room

Hear Matty Canter's reflections on 40 years of the Division of Psychotherapy

Help Recognize this year's award winners

Enjoy good food, friends, a great celebration, and a number of surprises!

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.

JOIN DIVISION 29 AND GET THESE BENEFITS!

☐ **FREE SUBSCRIPTIONS TO:**

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

Psychotherapy Bulletin
Quarterly newsletter contains the latest news about division activities, helpful articles on training, research, and practice. Available to members only.

☐ **EARN CE CREDITS**

Journal Learning
You can earn Continuing Education (CE) credit from the comfort of your home or office — at your own pace — when it's convenient for you. Members earn CE credit by reading specific articles published in *Psychotherapy* and completing quizzes.

☐ **DIVISION 29 PROGRAMS**
We offer exceptional programs at the APA convention featuring leaders in the field of psychotherapy. Learn from the experts in personal settings and earn CE credits at reduced rates.

☐ **DIVISION 29 INITIATIVES**
Profit from Division 29 initiatives such as the APA Psychotherapy Videotape Series, *History of Psychotherapy* book, and *Psychotherapy Relationships that Work*.

☐ **NETWORKING & REFERRAL SOURCES**
Connect with other psychotherapists so that you may network, make or receive referrals, and hear the latest important information that affects the profession.

☐ **OPPORTUNITIES FOR LEADERSHIP**
Expand your influence and contributions. Join us in helping to shape the direction of our chosen field. There are many opportunities to serve on a wide range of Division committees and task forces.

☐ **DIVISION 29 LISTSERV**
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