Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.divisionofpsychotherapy.org

BULLETIN

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2009 VOLUME 44 NO. 1

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PSYCHOTHERAPY BULLETIN

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

Contributors are invited to send articles (up to 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).

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EDITORS' COLUMN

Jenny Cornish, Ph.D., ABPP, Editor
Lavita Nadkarni, Ph.D., Associate Editor

With the advent of this first issue of the *Psychotherapy Bulletin* in 2009, we are delighted to announce several new contributing editors. Jeff Barnett has agreed to make Ethics in Psychotherapy a regular feature, co-writing articles with students about important ethical issues; in this issue, his paper focuses on preventing and addressing impaired professional competence. Rosemary Adam-Terem is the new contributing editor in the area of Public Policy and Social Justice; be sure to read her report about the recent Division 29 governance diversity training. Sheena Demery is the new contributing editor for Student Features; the current paper considers adolescents in residential treatment. Michael Murphy and Eugene Farber (Education and Training) will submit their first contribution in the next issue. Continuing contributing editors include Erica Lee and Caryn Rodgers (Diversity), Jennifer Kelly (Practitioner Report), Norman Abeles and Susan Woodhouse (Psychotherapy Research, Science, and Scholarship), George Stricker (Perspectives on Psychotherapy Integration), Pat DeLeon (Washington Scene), and Michael Constantino (Early Career).

Also note in this issue the candidate statements for various Division 29 offices. We have been fortunate to enjoy excellent leadership in the division and are grateful for the many talented individuals willing to run for office and serve in such important positions.

It was a privilege to participate in the recent Publications Board meeting on January 29 in Washington DC under the excellent leadership of Jean Carter, Chair. After discussion, we now plan to coordinate the Bulletin with the Journal around special issues (e.g., supervision in February 2010, diversity in August 2010). The idea will be for the Journal to present scholarly articles on the topic with the Bulletin showcasing papers that are more applied. If you are interested in submitting articles on either of the special topics, please let us know! We will also be publishing the Bulletin on the web at the same time as the hard copies are mailed in order to reach as many readers as possible. Finally, we are investigating changing the cover (send us your creative ideas!) and possibly the size and some of the formatting of the Bulletin to make it more user friendly.

Participating in the Pub Board meeting and the Division 29 governance diversity training was incredibly enriching. Division 29 seems currently able to honor our history and traditions, yet move forward in exciting ways to help us meet the needs of our membership and the challenges of 2009. We are glad the Bulletin can help represent all Division 29 members, and welcome any of your ideas, suggestions, and submissions!

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PRESIDENT'S COLUMN

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Be Connected: Connect with Your Patients, Colleagues, and the Division

It is a pleasure to serve as the President of Division 29, the Division of Psychotherapy. I follow in the footsteps of many gifted psychotherapists who have contributed countless hours, innovative ideas, and superb leadership in an effort to advance psychotherapy practice, science, education and training, and policy-related efforts. My roots in this division date back to when I was in graduate school and I received a student award from the division. The check was so helpful to me, as it enabled me to get four much needed tires for my car. Anyone who is a graduate student can relate to that. I have remained engaged with the division in myriad capacities over the years, because of my love for the practice of psychotherapy.

As President of the Division 29 for 2009, I welcome the opportunity to connect with as many of you as possible. My goals for this year are to enhance the sense of connection and community among Division 29 members, to ensure that there is greater sensitivity to and appreciation of diversity defined broadly within our division and within the field of psychotherapy, and to strengthen the emphasis and quality of psychotherapy supervision that individuals receive throughout the professional life cycle. This column focuses on connection.

Be Connected

"Be connected" is the theme of the Division of Psychotherapy (Division 29) of the American Psychological Association. It is not surprising that this would be the motto for our division, as being connected with our patients in a collaborative relationship, as evidenced by the therapeutic or working alliance or attachment bond, is the cornerstone of effective psychotherapies. Engaging effectively with our patients is associated with better treatment adherence, more secure interpersonal attachments, and more positive outcomes across diverse treatment orientations and modalities. The therapeutic alliance is a subtle, interactive dynamic relationship and is the vehicle within which therapeutic progress is facilitated. On the part of the psychotherapist, the formation and maintenance of this emotional bond requires respect, care and compassion about the other party's feelings and experiences, sensitivity, empathic understanding, emotional validation and support, empowering action in the context of safety, and successfully managing negative emotions in all concerned parties and helping promote affect regulation in patients. True warmth and genuineness in the therapeutic context must be guileless and sincere, it cannot be forced. Psychotherapists invested in the formation of a positive connection with their patients convey that they are trustworthy, fair, reliable, and open. They judiciously engage in therapist self disclosure. Psychotherapists who care about forging a sustaining a meaningful connection with their patients are committed to a spirit of collaboration, such that the psychotherapist and his/her patients work in a reciprocal fashion to develop and make progress toward a set of achievable goals, co-create a coherent formulation of the situation and the person's strengths and areas for improvement, and improvise and implement a specifically tailored treatment plan. Much of our connection with diverse groups of patients takes place through nonverbal behaviors and tone of voice. It is

continued on page 4

often less what the psychotherapist does for or says to the patient, and more about how the is with the person. When psychotherapy is ineffective or breaks down, this typically is because of a failure to establish a connection in the first place or some relationship rupture a failure to repair a disruption in the connection. Of course, thepsychotherapist-patient connection is not sufficient for effective psychotherapy. It must occur in conjunction with an integrative theoretical frame and the use of state of the art, evidence-based psychotherapeutic techniques. In addition, the psychotherapist-patient bond depends on the psychotherapist-patient fit, as well as the patient's personality qualities and strengths, capacity for attachment and collaboration, and investment in the process. Not only is the therapeutic alliance key to effective patient outcomes, but experiencing deep connections with our patients is empowering to us as psychotherapists, adds richness to our lives, and affords us many growth opportunities.

Given that as psychotherapists, we devote ourselves to connection with our patients, as a community of psychotherapists within the division, it is essential that we have the same dedication to connection with one another. Thus, one of my personal goals as President of the Division is to strengthen the sense of community among Division 29 members by increasing our communication efforts within the Division and conveying a sense of inclusiveness for all psychologists, graduate students, interns, and postdoctoral fellows who identify themselves as psychotherapists. Individuals whose professional identity includes being a psychotherapist may be practitioners, scientists, educators and trainers, and/or those interested in advancing psychotherapy through their public interest efforts. Of course, most of us wear many hats and want to be part of a division in which all aspects of our professional functioning are valued and welcomed. As someone who identifies as a scientist-practitioner-educator-public servant myself, I want to warmly engage all psychologist psychotherapists into the Division 29 fold.

One strategy that I will use to increase communication within the Division is to utilize Psychotherapy E-News to communicate bimonthly with the membership about division activities. If you want to communicate with me about any Division related issues, feel free to email me directly at nkaslow@emory.edu. I welcome your input. If you want to engage with other division members, I encourage you to join the Division 29 listserv (see http://www.divisionofpsychotherapy.org/listserv_info.php) for instructions on doing so. I encourage you to explore our website (http://www.divisionofpsychotherapy.org/). We are in the process of significantly revamping our website, and your thoughts on the materials that you would like us to place on the website to help you feel more connected would be most appreciated. Our Student Development Committee is also reaching out more to students and is implementing a Student Mentoring Program, where senior psychotherapists and members of the division are paired with students, including international students.

One key way that the division leadership interacts with our members is at the annual convention of the American Psychological Association. Our Convention Co-Chairs, Drs. Nancy Murdoch and Chris Brown, have worked tirelessly and thoughtfully to craft an intellectually stimulating and varied program for the upcoming APA Convention, which will be held in Toronto, Canada, August 6-9. Details on division programming and social activities will be shared when they become available.

It is my sincere hope that more of you become actively engaged in our division and that you will encourage your students to become involved as well. I would like to hear from you about ways in which you would like to participate and suggestions

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that you have for improving our division. Your input will be invaluable to me as the division leadership takes this year to focus on strategic planning.

Division 29 Board

The success of the division depends in large part on the high quality of my colleagues in leadership positions. I am delighted that this year I will have the opportunity to work very closely with the Executive Committee of the Division: Drs. Jeffrey Barnett (Past-President), Jeffrey Magnavita (President-Elect), Jeffrey Younggren (Secretary), and Steve Sobelman (Treasurer). In addition, I am pleased to be collaborating with the following domain representatives, who are also voting board members: Drs. Rosemary Adam-Terem (Public Policy and Social Justice Domain Representative), Jennifer Kelly (Professional Practice), Michael Murphy (Education and Training), Libby Nutt Williams (Membership), Michael Constantino (Early Career), Norm Abeles (Science and Scholarship), and Caryn Rodgers and Erica Lee (Diversity). It is our good fortune that our two APA Council Representatives will remain on the board: Drs. Norine Johnson and Linda Campbell. Given our growing focus on students, it is wonderful that Ms. Sheena Demery is on board as our Student Development Chair, which is also a voting position. I am also delighted that the following individuals will serve as chairs of various standing committees: Drs. Jean Carter (Publications Board), Charles Gelso (Editor of *Psychotherapy: Theory, Research, Practice, Training)*, Jenny Cornish (Editor of *Psychotherapy Bulletin)*, Abraham Wolf (Editor, *Internet)*, Jeff Hayes (Fellows), Chaundrissa Smith (Membership), Jeffrey Magnavita (Nominations and Elections), Jeff Barnett (Professional Awards), Bonnie Markham (Finance), Eugene Farber (Education and Training), Annie Judge (Continuing Education), Nancy Murdock (Program), Bonita Cade (Psychotherapy Practice), and Susan Woodhouse (Psychotherapy Research).

I want to take this opportunity to express my gratitude to a number of individuals who made major contributions to the board whose terms ended in 2008: Drs. Jean Carter, Armand Cerbone, Irene Deitch, and Michael Garfinkle. I also am grateful to those people who chaired various standing committees in 2008, who have rotated out of these roles: Drs. Raymond DiGiuseppe, Sonja Lim, Jean Birbilis, John O'Brien, and Sarah Knox.

Of course, last but certainly not least, it will be wonderful to continue to collaborate closely with Tracey Martin, in our Central Office. Without a doubt, she is the glue that helps us all stay connected.

Closing Comments

I hope that all of you have a 2009 that is productive in a meaningful way, fun, and full of joy and peace, and a year in which you prioritize connecting with your loved ones, friends, patients, colleagues, and members of our division and our profession.

I am honored to serve as your President and excited about our new initiatives and projects. I am confident that this year will be productive, engaging, and fun, and will enable us the chance to bolster current connections and forge new ones. I welcome your ideas, recommendations, and perspectives. Please contact me at nkaslow@emory.edu with feedback or so we can dialogue about ways to get you more connected to the division.

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PUBLIC POLICY AND SOCIAL JUSTICE

A report on the Winter Diversity Training Retreat for Members of the Division's Boards

Rosemary Adam-Terem, Ph.D., Independent Practice, Honolulu, Hawaii

What is your name? How often do we say our full names? Do we ever really think about the wealth of information transmitted in that simple act? Deborah L. Plummer, Ph.D. led a retreat for the governance members of Division 29 and opened it up with this apparently simple task. Names can tell a lot about us and they can also mislead, but naming is an important cultural variable with rules and conventions of which we often remain unaware until we are brought face to face with them. We have only to remember the Inauguration of President Obama and the flurry of emotion and reaction when he spoke his full name to see that there is much meaning and connotation to a name.

Dr. Plummer, with 20 years experience of facilitating workshops on cultural sensitivity, competence and diversity, both on an individual and an organizational level, was working with Division 29's boards on diversity training. Out of concern that an aging and unrepresentative demographic composition of board and division members might lead to increasing irrelevance and alienation from the newer generations of psychologists practicing psychotherapy, the board of directors last year voted to hold the diversity training workshop. Diversity is a dynamic concept. Over the last three or four decades it has moved away from simple demographics to more complex psychographics as trends grow beyond geographic and demographic boundaries. Historically, the diversity movement began in the 50's and 60's with basic civil rights and affirmative action seen as righting the wrongs. By the 1980's the focus had shifted to issues of access and legitimacy, and from the 90's on diversity has become integrated into multiple organizational and business strategies.

Dr. Plummer invited the participants to introduce themselves twice, once in their Division 29 roles and then in their cultural contexts. Invoking several of the "Big Eight" variables—race, ethnicity, gender, class, religion, age, sexual orientation and ability status—she drew attention to what is hard to talk about and the language used to describe oneself. It became clear that there was much diversity amongst those present and that the differences were very salient and interacted dynamically. People perceived things in strikingly different ways and were sometimes unable to see the perspective of the other. Dr. Plummer used well-known figure-ground reversals to illustrate the concept of holding multiple realities and the inability to perceive them simultaneously.

If Division 29 is to be the welcoming home for all who practice, research, or are interested in the core skills of psychotherapy its governance bodies aspire to, Dr. Plummer pointed out that representation was only the beginning of a truly diverse organization; there needs to be inclusion too, learning from the differences. In addition, empowerment in economic terms, and equity or social justice, including the promotion of minority interests, are required. We have to think in terms of influence, status, power, whom you know, who listens to you, and financial ability to be involved. For example, since participation in governance requires a financial and temporal commitment, some potential members are excluded because they cannot afford the time or the money. This differentially affects early career and minority psychologists and, in turn, can lead to an inadvertent alienation through oligarchy. There is a circularity that tends to work against inclu-

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siveness. If we examine how people come to be in governance, they tend to know someone who is in governance. How do you get to know these people? The skill required here is to reach out and that is already underway in Division 29.

Dr Plummer noted the importance of the schemas we hold, whether in the "Old Reality" or the "New Reality":

Old Reality	**New Reality**
Nuclear family	Households of all types
Homogeneous culture	Mosaic culture
Middle class	Economic & digital divide
Young adult baby boomers	Middle age & aging
Employer health care	Public health care
Monocultural dominance	Ways of knowing from many cultures

Those of us who hold, consciously or unconsciously, to the old ways are working on sets of assumptions that may no longer be valid. An important extension of this concept is privilege, the set of unearned opportunities and conditions available to some but not all. Privilege is a slippery concept for the privileged; fish in water know nothing about wetness. The privileged are generally unaware of their good fortune because it is often intangible and invisible, like the default settings on the computer. The world is just easier to navigate when you have it. Privilege can be felt in one's way of knowing and thinking, for example those raised with a linear analytical style fit into the education or work setting more easily. Privilege can be seen in religion where for instance the dominant religion's holidays are the standard holidays, while members of minority religions have to specific take time off to celebrate their holy days. There may be a significant problem when privilege attaches to a group identity. Leveling the playing field is vital. How do we do it? The first skill here is that of self-awareness, or organizational awareness.

How can those who benefit from subtle privilege be aware? One apparently simple suggestion is to ask what it would be like not to have the privileges we have. We may scoff at the story of Marie Antoinette who when told "The people have no bread." responded "Well, let them eat cake" for her haughty ignorance of the realities of ordinary people but we are all prone to her tendency. People on the downside of privilege know a lot more about the upside than those on the upside know of the downside. People with disabilities know more about the world of the able and healthy than the able and healthy know about the world of the disabled. When you are of one group, you may not be able to appreciate the experience of another group even if you think you do. Dr. Plummer urged the group to suspend its "mental boxes", to be willing to be uncomfortable at times, to avoid creating simple solutions to complex problems just to make ourselves feel better, and of course to avoid blaming the less privileged for their lack of privilege. She also reminded us that the use of privilege could be a skill, if directed for good.

Addressing diversity leadership requirements, Dr. Plummer made a distinction between good decisions and quality decisions, describing a process of "triple loop learning" beginning with identification of errors or problems and problem-solving while checking ones assumptions and validating hypotheses, and including prediction and planning for the sociopolitical implications of decisions made. This type of process is effective across diverse groups, focuses on the impact rather than the intention of a decision or statement, and considers the long-term influence.

Dr. Plummer reminded us that decision making is affected by our emotional brain response, noting that we are hard-wired and have to work to manage our tendencies around pattern identification, schemas, cognitive shorthand, and "emotional tagging", bringing our memories of similar events or people to bear and reacting to these rather than the present experience. She pointed out

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that many of our modern "isms" reside in the unconscious and unacknowledged quadrant. This makes them hard to ferret out, but they are felt.

OVERT
COVERT
INTENTIONAL
UNINTENTIONAL
modern isms

For optimal governance, Division 29 needs to address access issues to ensure openness to all. The requirements have to be clear and transparent. Traditions, conveniences, and preferences that deny opportunities to other people look like requirements but are not. Governance belongs to a particular culture in which certain people and attributes automatically have a better fit; for example, people comfortable with speaking up or speaking out, people who think in parliamentary ways, people who feel that they will be accepted or heard will seem to belong more naturally. This is a challenge for our organization: to ensure that there is a place at the table for those who do not match the traditional mold, and hear the diverse voices.

DR. SILVERMAN ELECTED PRESIDENT-ELECT FLORIDA PSYCHOLOGICAL ASSOCIATION

Wade H. Silverman, a Division 29 Past President and former editor of the Division 29 journal, *Psychotherapy: Theory, Research, Practice and Training*, was recently elected President-elect of the Florida Psychological Association. **Congratulations, Dr. Silverman!**

PSYCHOTHERAPY EDUCATION AND TRAINING

What Psychotherapy Education and Training Doesn't Provide

Jean M. Birbilis, Ph.D., University of St. Thomas and
Mary M. Brant, Ph.D., University of St. Thomas

While we have previously explored the competencies that the psychotherapy profession acknowledges must be conveyed in the education and training of psychotherapists in this column (Birbilis & Brant, 2007a, 2007b, 2008; Brant & Birbilis, 2008), we have also attempted to remind readers that there are important aspects of providing psychotherapy that are not routinely included in psychotherapy competencies, education, and training as currently defined (Birbilis, 2006). We have chosen to take this opportunity to share an example from each of our practice lives that reflects some of those important aspects that are omitted. We hope that each reader will reflect on what s/he does that was not a part of formal education or training, yet has profoundly impacted the course of psychotherapy with one or more clients, and add to this discourse as a part of moving psychotherapy education and training forward.

Psychotherapy Practice and the End of Life (M. M. Brant)

One of the many important lessons about psychotherapy that I didn't learn in graduate school was that, "Old age isn't a battle, it is a massacre" (Roth, 2006) and that in my long term care practice, I would meet bigger foes than unimpressed physicians and exhausted nurses, namely, the repeated loss of cherished clients to expected death. The truly surprising part of all this loss is that the families and the clients are at times not ready for this impending death. They have existed in a denial that has helped them manage the tasks of everyday life in the nursing home, a place of potentially grinding similarity, but that denial keeps the important from being brought to consciousness and the essential from being said. Conversations with these client families are often about the new medication and the next procedure, without discussing the crucial content of the heart. Families may be afraid to discuss death and may assume that the health care providers will tell them that death is imminent. Residents may be ninety years old with multiple health challenges and congestive heart failure, but no one has brought up funeral planning or discussed what really mattered in this human being's life.

A recent example of this denial phenomenon helps to illustrate the complex walk of long term care practice that is never fully described in any training. I had been providing therapy for an eighty-some-year-old long term care resident with cancer and depression. As we entered into this therapy, the resident had her feeding tube removed after surviving surgery, weight-loss, and infection, only to be diagnosed with a metastasized cancer. This resident had been cycling between home and the facility; she had a very strong belief in her ability to go home, but an inability to ask for a hospice referral to provide needed medical support because this would admit defeat and the end. The nursing staff and social worker were very concerned for the resident, as she often made "unrealistic" statements about her prognosis and appeared emotionally distraught with staff, but upbeat with all her visitors, especially her middle aged son. The resident had begun chemotherapy and was again losing weight, now with scar tissue impairing reinstatement of a feeding tube. I asked if the physician or the staff had talked about her prognosis, and no one had conveyed a time frame. Furthermore, the physician wasn't due in to the facility for rounds for another three weeks.

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Our therapeutic interchange to this point had focused on depression in an interpersonal therapy format, yet had contained the typical life review which opened the door to what I see as the therapeutic pivot, when one moves from the focus on the tasks of life to the important tasks of the end. As a psychologist, I have always approached the therapeutic relationship with gentle empathy, focused listening, strengths-based interventions, and client-led conversations, but as we move into this territory of the end, sometimes the conversations are much more blunt. We move from dealing with depression to managing the details of dying, from hope and future to letting go.

In this case, the client stated, "This is **it**, right?" "Yes, it looks soon," I replied. She said, "I know, I'm ready, but I've messed up with my son….I had him hold out hope. We are a hopeful family. We never talk about this. We never talked about his father's death." "You can do this differently, you know," I said, "You can die at home or here, hospice can help if you decide to stop chemotherapy, and it is okay to refuse it. You can say the important things that haven't been said, like 'I love you, thank you , I forgive you, or forgive me'." (Byock, 1997). "If I start, I know the waterworks will keep me from finishing. How can I start?" she asked with tears already forming. "Well, here's something called an Ethical Will (Baines, 2002)….or you can just write it out now," I said, handing her the brief outlined example. "But, let's do it now, and later, after lunch, we can call your son."

This client died. She made it through the week, but the nursing staff reported in their own closing statements that she was "ready" and "peaceful," but also "tearful" and "exhausted." She wrote out her love for her friends and family in a letter, and she talked with her son, who knew she was dying, of course, but couldn't talk about it without her lead. I processed the client's death with the staff and her son and shared my own warm feelings about her within this necessary closure. This was a simple example of what has been called the "good death," where goodbyes are said, pain is not too great, and the end comes quickly and quietly.

Psychologists have often been conspicuously absent at the end of life, not often a part of the hospice team, and, frankly, not often practicing in long term care. As the more psychologically-minded baby boomer generation reach the end of life, any psychologist may face this therapeutic pivot and should be prepared to say, "Yes, this is it," to clients, even if the nursing staff or physicians have not uttered the exact phrase. As a less experienced therapist, I might have waited too long and not named death soon enough. In training, we need to address this change of therapeutic focus and have students face the death of clients with the dignity of closure, the opportunity to acknowledge that the end is near, and the chance to say the unsaid. We cannot depend that hospice will be called in or that the priest or minister will have addressed the tasks of death. Instead, we need to teach students to be ready to say the word "die" with clients, client families, and professionals who may linger in that denial of death a bit too long.

Psychotherapy Practice and Meaning/Purpose (J. M. Birbilis)

Over the years I have observed in awe clients' struggles to simultaneously obtain emotional health and to find meaning and purpose for their lives. While the topic has been addressed at length from certain perspectives (from the integration of psychotherapy and religion/spirituality to the application of existential philosophy), I personally have experienced gaps between what I was taught and what clients seem to need and respond to in the moment.

One avenue that has filled that gap and resonated for me and my clients repeatedly has been artistic creation. Possibly the

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most poignant example that I have experienced came from a client who experienced a Major Depressive Disorder that resulted in complete disability and removal from the work force. Prior to the emergence of her mental illness, she was a successful financial expert; after the mental illness began, she could barely manage her own checkbook. She struggled with poor memory, lack of concentration and attention, and meager comprehension. She would bring long lists of topics to discuss and medications that she was taking so that she would remember what to talk about, and she would take notes during sessions because she reported that she could remember nothing of what had been said following each session. She quickly became completely demoralized and could find little reason to live, despite a history of strong religious beliefs and affiliation and despite having a few meaningful relationships with others who she did acknowledge cared about her.

During the weeks and months that we began working together, I discovered that she was sewing, both with a sewing group at church and on her own. At first, I attempted to explore the purpose and meaning that seemed to be provided by making items with the sewing group for those living in poverty. However, she was struggling with her affiliation with the sewing group itself; she reported having difficulty agreeing with others on fabrics and items to be made, having difficulty concentrating when she was with the group, and sometimes feeling marginalized as a result of her decline in self-esteem. Consequently, the activity itself seemed to lose meaningfulness for her, and her attendance at the sewing group declined. She then tried to sew on her own at her home for residents of a nursing home, but soon became overwhelmed by requirements imposed on her by others for what she could bring home to repair, and she quit.

I became disillusioned with the seeming uselessness of talking about sewing and concerned about her increasing isolation, as demonstrated by her declining involvement in the sewing activities involving others. However, we continued to periodically check in regarding her sewing, which she sporadically did on her own, and I encouraged her to find other ways to affiliate, which she only did in very limited ways.

Her treatment continued, including psychotherapy and multiple medical interventions for medical problems that were exacerbating her mental illness. Eventually, she stabilized, and she began to talk about a renewed sense of purpose through her relationships with her extended family. It was at that point that she and I discovered that the act of sewing new items to commemorate special occasions (e.g., weddings, births, anniversaries, graduations) and that would become keepsakes for members of her extended family provided immense purpose and satisfaction for her. I asked her to bring in completed items, and I began encouraging her to take pictures and to create a portfolio of her work. She seemed to appreciate my interest in her work and went to great effort at times to bring in large items to show me. Pictures of her work that she brought in evolved to include pictures of the events where she gave away her work and the people to whom she gave it. Conversations about the items she sewed evolved to include discussion of how they would be used and by whom, the reactions of the recipients, and new sewing projects that she was beginning to plan for the future. Her affiliations with others began to grow, and her sense of marginalization appeared to wane. She seemed to be joining me and others on a more level playing field with her newfound awareness of expertise in an area different from her professional expertise that had lapsed, and she seemed to be able to internalize the feedback that what she was doing was beautiful and meaningful.

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Although I received no training in how to integrate clients' artistic creations into their search for meaning and purpose in a way that facilitates mental health, I believe that such integration can be a defining aspect of the shift that clients who are in transition from disability, retirement, and other losses must make. Psychotherapists may be torn when facing this opportunity; will they be assisting clients in strengthening their support networks, creating outlets for emotional expression, and identifying meaning and purpose, or will they be "wasting time" and "off topic"? The need for resolution of this question is heightened by the need in today's psychotherapy marketplace to demonstrate tangible outcomes from psychotherapy. We must be able to work holistically, even as we experience increasing pressure to focus on behavior and to demonstrate measurable results. We need, as noted above, to teach students to be ready to say the word "die," and we need to teach students how to listen to their intuition and respond to clients in ways that incorporate intangibles like meaning and purpose, sometimes in unusual ways. The profession of psychotherapy needs, in sum, to embrace the fullness of what psychotherapy is and can be and to educate and train new practitioners in that fullness.

References for this article can be found on our website: divisionofpsychotherapy.org

CALL FOR PROPOSALS

APF VISIONARY AND WEISS GRANTS

The American Psychological Foundation (APF) visionary and Weiss grants seek to seed innovation through supporting research, education, and intervention projects and programs that use psychology to solve social problems in the following priority areas:

- Understanding and fostering the connection between mental and physical health to ensure well-being;
- Reducing stigma and prejudice to promote unity and harmony;
- Understanding and preventing violence to create a safer, more humane world; and
- Supporting programs that address the long-term psychological needs of individuals and communities in the aftermath of disaster.

Amount (New in 2009):
One-year grants are available in amounts ranging from $5,000 to $20,000. Multi-year grants are no longer available. Additionally, a $10,000 *Raymond A. and Rosalee G. Weiss Innovative Research and Programs Grant* is also available for any program that falls within APF's priority areas.
Deadline: March 15, 2009

Eligibility:

- Applicants must be affiliated with 501(c)(3) nonprofit organizations. APF will NOT consider the following requests for grants to support:
- political or lobbying purposes
- entertainment or fundraising expenses
- anyone the Internal Revenue Service would regard as a disqualified group or individual
- localized direct service
- conference/workshop expenses

APF encourages proposals from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

For more information and to access the grant application form, please visit:
http://www.apa.org/apf/grantguide.html

Please contact Emily Leary with questions:
E-mail: eleary@apa.org
Phone: 202.336.5622

STUDENT FEATURE

The Influence of Adolescent Brain Development on Operant Conditioning Motivation Systems

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Operant conditioning has been used regularly for over fifty years to shape behavior, parent, and teach youth in the United States. This method is effective in producing desired behaviors for many children and adolescents. However, it is not always effective, especially in the adolescent clientele that I work with on a regular basis. This paper will explore why this type of behavior modification does not seem to work with all youth, in particular adolescents.

In many residential treatment programs, a system using levels of rewards is employed in order to motivate clients to change their behavior. In this paper, I will use an example of a typical motivation system that can be found in a variety of out-of-home care programs working with teenagers. The motivation system used in this example incorporates points, with a certain number of points equaling predetermined rewards or privileges. For many youth, such a reward system works just fine. They do what they are asked, receive rewards when they achieve their goals, and lose privileges when they do not, and are motivated to correct their behavior in the future.

While this system can be highly effective, I have found that it does not work with for all adolescents. Time and again, I wonder why certain youth are not motivated to change. Is the reward not interesting enough? Is the bar set too high? Is this behavior an act of rebellion on their part? The treatment team will make adjustments, change the reward, change the consequences, have the youth be more involved in their treatment, have them be less involved, and still there is no change in behavior. I have often wondered if this is really a matter of stubbornness, or is there something below the surface that we, as clinicians, are not seeing.

New research and insight into the development of the adolescent brain may help to explain this phenomenon. It is possible that for some of these youth, the lack of response to a motivation system is more physiological than psychological. With this in mind, operant conditioning may fall short when it comes to changing the behavior of all teenagers.

B.F. Skinner developed the concept of operant conditioning through his studies with animals and birds. He believed that a person's behavior could be shaped by providing positive and negative reinforcement (Davis & Pallidino, 2005, p.201-203). For example, "Sara" is a 15 year old youth in an out-of-home care setting. She has five target skills that she is currently working on. She also has basic daily requirements such as making her bed, brushing her teeth, doing chores, and practicing her target skills. If she completes all of the requirements for the day, she earns 100 points.

These points will earn her privileges that she has previously designated, such as one hour of "my space" time on the computer. This privilege acts as a positive reinforcer. The reinforcer is relatively immediate, given within the day of the achievement. If she does not earn all of her points she will earn no privileges. If Sara earns 80 points or less she receives a negative reinforcer, such as doing an extra chore. Sara consistently

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achieves 81 points or more; enough to either avoid a consequence, or achieve a reward.

"Josh," a 15 year old boy in the same program is also on a 100 point a day system. Josh, however, consistently does not achieve 81 points or higher. In fact, Josh does not seem to respond to any type of reward or consequence. After many problems at school, Josh is eventually removed from regular school and now attends a shortened school day at the independent learning center on campus. This is hugely disappointing to Josh, yet he never changes his behaviors leading up to this decision. He wants to attend regular high school like other kids, yet he is unable to control his behaviors in a way that would allow him to remain in regular school. When asked about the moments in which he had the ability to choose to do the right thing or the action that he knew would get him in trouble, Josh responds that no matter what the reward or consequence would be in the end, at the moment, he just gets "carried away. "

Josh's response seems consistent with that of other teens who do not seem to make their point requirements on a daily basis. In the moment, they are not thinking about the future consequences. Taking risks has been a phenomena long associated with teenagers. These risks can be small, such as getting to class a few minutes late, or larger, such as skipping school to get "high" in the parking lot.

The examples of Josh and Sara highlight two youth who are the same age and respond differently to motivation systems. While this may be related to the youth's personality or demeanor, it might also be related to brain development.

> The adolescent behavioral profile involving risk taking and reward-or novelty seeking suggests that during this period, *adolescence,* there are critical developmental changes in brain pathways controlling emotional expression, cognitive and attentional functions, and reward sensitivity... Functions of the prefrontal cortex (PFC) in particular deserve focus. (Kelley, Schochet, & Landry, 2004, p.28)

The prefrontal cortex (PFC), "is critical for insight, judgment, the ability to inhibit prepotent but inappropriate responses, and the ability to plan and organize for the future" (Arnsten & Shansky, p. 2004, 143). In essence, it controls complex intellectual functioning, including the ability to think beyond the moment and to take future considerations into account. These are two important components of impulse control and are needed for a motivation system to be effective.

It has been found that the PFC is one of the last brain regions to mature, and it does not reach its full adult dimensions until the early 20's (Giedd, 2004, p. 77). This is important to consider as the PFC interacts with several other parts of the brain, encouraging the ability to choose appropriate behaviors and resist behaviors that lead to negative reinforcement.

The PFC's interactions with the amygdala, hippocampus, and the straitum (Kelley, Schochet, & Landry, 2004, p.28) are of particular interest to this topic. The amygdala plays a key role in processing emotion, particularly fear and anger. The hippocampus plays an important role in processing memory (Klien &Thorne, 2007, p.61- 62). The straitum is responsible for reward functions, incentive activation, and learning (Kelley, Schochet, & Landry, 2004, p.28).

Not only do the specific regions of the brain mentioned above continue to develop throughout adolescence, the communication links between these areas also are developing. "For example, active myelination is still occurring, and the prefrontal cortex is the last brain region to undergo this process"(Kelley, Schochet, & Landry, 2004, p.28).

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> Myelination is the result of oligodendrocytes wrapping neuronal axons in a fatty sheath that speeds up transmission between neurons-up to 100 times the speed of unmyelinated neurons. The greater speed of neuronal processing may facilitate cognitive complexity and the ability to adeptly combine information from multiple sources. (Giedd, 2004, p. 80)

It could be concluded from this research, that while the ability to process cause and effect may be present in adolescence, it is still developing and may be slower, leading to an increase in impulsive behaviors. Thus, impulsiveness is greater amongst teenagers than adults. This may explain why Josh has such a hard time controlling his behaviors in the moment, even when positive and negative reinforcement are present.

Impulsiveness is certainly a distinct characteristic of a teenager, but why do some teens seem to have greater control over their behavior than others? The answer may be found in considering the vulnerability of the adolescent brain. "It is clear that the teenage brain is very different from both the child and adult brain, and may display particular vulnerabilities to disruption by drugs, alcohol, and stress" (Kelley, Schochet, & Landry, 2004, p.29).

Adolescence in general can be described as very stressful. There are many levels of changes going on, physiologically, socially, and emotionally for a teen at any given time.

> Given the large number of transitions faced by adolescents, they have been viewed to be "...in a chronic state of threatened homeostasis," with their adaptive responses during this period (being) crucial. Stress likewise has been characterized as a state of threatened homeostasis that requires adaptive processes to restore and sustain this equilibrium. (Spear, 2000, p. 428)

Therefore in times of stress the brain may be working on overdrive. While it is trying to grow and develop, it is at the same time attempting to self regulate and find homeostasis in order to decrease the perceived level of stress.

Stress, and coping with stress, is an important part of developing into an adult. The buildup of stress, however, can have very negative effects and can lead to the inability to cope with daily occurrences. Josh is a youth in an out-of-home care setting. By the pure fact that he is in this level of care, it can be assumed that he has endured stressful and/or negative life experiences, beyond that of a "normal" teenager. Being in residential treatment bears its own level of stressors, including having to adhere to point and level systems designed to shape behavior on a daily basis. As opposed to helping to shape behavior, the motivations system might be adding to the dis-regulation already occurring do to heightened stress levels.

Research in the realm of resiliency has focused on determining why some teenagers are able to self regulate and cope with stress while others are not. The ability to self regulate and the ongoing development of the brain might help to explain the differences between the way Josh and Sara manage the added stressors of being in an out-of-home came setting. The research between the biology, neuroscience, and resilience is still fairly new (Masten, 2004, p.317). It is clear however, that regulation skills are an important part of adolescent development.

> The emergence of adolescent regulatory skills and their maturation to adult levels requires a solid foundation... Children who enter adolescence with weak regulatory skills are at a risk for developing problems during transition from childhood into adulthood... The emergence of "collaborative brain function" requires the individual to draw on and integrate activity in different regions of the brain to "orchestrate"

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> brain function across regions. If any of the constituent "parts" playing in the orchestra are weak, the entire integration that is required and demanded by adolescent contexts, such as school, job, or social group, can lead to a spiral of dysfunction that may surface as a mental health problem or psychopathology. (Kupfer & Woodward, 2004, p.320)

When operant conditioning models do not take into consideration both the changes and development of the brain and the teen's ability to cope and adapt to outside stressors, they may be doing more harm than good. I gave the example of both Josh and Sara in order to illustrate how adolescence is not a cookie cutter time. Each youth is going through his or her individual process. What may work for one youth in terms of addressing desired behaviors, may not work for another.

As addressed earlier in the paper, the prefrontal cortex is one of the last parts of the brains to develop in adolescence. Therefore, a teen's ability to think about cause, effect, and either positive or negative consequences is still developing. Teens may not be able to pick up on internal cues or if they do, have the higher level intellectual capacity to make sound choices. Providing a safety net in which they can learn effective ways to self-regulate is essential.

Even a thorough safety net developed by concerned adults may not prevent a teenager from acting impulsively and making poor choices. However, how that safety net responds to the choices that are made, may not only help with the sound psychological development of the youth, but may also help create a more homoeostatic environment for neurological development to occur.

In conclusion, operant conditioning in the classic form of positive and negative reinforcement is effective for many teenagers. In some youth, the increased stress of a motivation system may inhibit development. Further neurological and biological research might shed light into why some teens, like Josh, do not thrive in traditional motivation systems. Research may conclude that the developing ability to cope with stressors and a less than fully developed prefrontal cortex impedes their ability to use higher level functioning and thus respond to traditional motivation systems in different manners.

Referencesfor this article can be found on our website: divisionofpsychotherapy.org

THE 2009 MID WINTER BOARD MEETING

PERSONAL REFLECTIONS FROM DIVERSE EARLY CAREERS

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

This is the fifth and final installment of a 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 (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.

AN EARLY CAREER PERSPECTIVE ON WORKING IN A RESEARCH-ORIENTED MEDICAL CENTER

Jason C. Ong, Ph.D., Rush University Medical Center, Chicago, Illinois

Why would a psychologist want to work in a medical center? Isn't it mostly about inpatient work, turf battles with psychiatrists, disrespect from medical staff ("you're not a real doctor"), or having to learn a bunch of medical terminology? Although some of these issues are real, there are also many rewarding aspects of working as a psychologist in a medical center. For example, as an early career psychologist (ECP), I have found that there are numerous advantages to conducting patient-oriented research that can be both fun and fruitful if one is interested in an academic career.

POSITION DESCRIPTION

Institutional Environment and Structure

I am an Assistant Professor in the Department of Behavioral Sciences at Rush University Medical Center in Chicago, Illinois. Rush is unique in that our Department is independent from Psychiatry and we have our own Chairperson and budget within the University and Medical Center. Our Department consists of five services: Sleep Disorders, Geriatric and Rehabilitation Psychology, Psychosocial Oncology, Outpatient Psychotherapy, and Neuropsychology. These services consist of both inpatient and outpatient coverage. I am housed in the Sleep Disorders Center, a multidisciplinary center with an eight-bed facility where patients and research subjects undergo overnight and daytime polysomnograhpy (PSG) sleep evaluations and the staff includes pulmonologists, neurologists, psychologists, and PSG technicians. Our Department also contains an APA-approved internship with three tracks: Health Psychology, Child Psychology, and Neuropsychology. Interns on the Health Psychology track complete a six-month rotation in the Sleep Disorders Center. Because my research and clinical interests are in Behavioral Sleep Medicine, Rush is an excellent match for me.

Like most academic positions, my job includes a combination of research, clinical, teaching, and administrative activities. There are some differences between working in a medical center compared to working in a Psychology Department on a main campus. For example, and as expected, we tend to have more direct clinical responsibilities as part of our basic job description. Furthermore, many of our patients have

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complicated medical histories and, thus, we interact more frequently with physicians. We also wear lab coats and carry pagers, and we are frequently mislabeled as "attending physicians," a traditional term in academic medicine. The teaching load is considerably less than on a main campus, as most psychology faculty at my institution teach only one 12-week course annually. Finally, there are fewer holidays and extended breaks compared to the main campus schedule.

Research

The majority of my time is spent in research-related activities with 80% of my time funded through a NIH-sponsored Career Development Award. My primary line of research is in developing and testing the efficacy of mindfulness-based treatments for insomnia. My current research project is a pilot-scale randomized clinical trial comparing the efficacy of Mindfulness-Based Stress Reduction (MBSR) and a Mindfulness-Based Therapy for Insomnia (MBTI) that is a combination of MBSR and cognitive-behavioral therapy (CBT). This project examines how traditional CBT may be augmented with a form of complimentary and alternative medicine. One of the reasons why I chose to work in a medical center is to have access to the resources necessary to conduct sleep research; i.e., PSG equipment, bedrooms, technicians, a pool of insomnia patients, and an overall climate conducive to conducting treatment-outcome research.

Clinical

Approximately 20% of my time (i.e., two half-day clinics) is spent doing clinical work in Behavioral Sleep Medicine (BSM), an exciting sub-specialty that combines psychological approaches in behavioral medicine with the evaluation and treatment of sleep disorders. The Rush BSM Clinic provides evaluation of all sleep disorders, as well as the delivery of cognitive and behavioral treatments for sleep disorders when indicated. The BSM clinic is staffed by me, Dr. James Wyatt, Director of the Sleep Disorders Center, and the psychology trainees (i.e., practicum students, interns, and postdocs). I serve as the primary clinical supervisor for the BSM students and postdocs. Our evaluation consists of an intake interview focused on gathering information about sleep/wake patterns, symptoms suggestive of sleep disorders, and medical and psychiatric history. If an underlying sleep disorder (e.g., sleep apnea, Periodic Limb Movement Disorder, Parasomnia) is suspected, an overnight PSG evaluation is ordered. The PSG data are then scored by the sleep technician and the results are reviewed by a board-certified sleep specialist, who then recommends a treatment plan. If the evaluation reveals that the patient might benefit from behavioral treatment, the patient is seen by me or a trainee under my supervision. Our treatment approaches are primarily behavioral or cognitive-behavioral in orientation. The most common cases we treat are insomnia. In addition, we also work with patients who need behavioral modification for circadian rhythm sleep disorders, adherence to Positive Airway Pressure treatment, or help coping with a chronic sleep disorder such as narcolepsy or Restless Legs Syndrome. Although it might be possible to run a psychotherapy clinic for insomnia outside of a medical center, working at a BSM clinic within a medical sleep center provides exposure to an array of complex and interesting cases and to more comprehensive care in sleep medicine.

Teaching and Administrative Activities

My formal teaching responsibilities include an annual brief workshop on clinical interviewing given to first and second-year medical students. At Rush, all medical students are required to take a short course on clinical interviewing during the M1 and M2 years that is taught by a Psychology faculty member. It is a rare opportunity for a psychologist to be involved in training medical students and to have an impact on their bedside manners and the way they interact with patients. Other teaching occurs in the form of seminars to the

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interns, grand rounds presentations to other departments within the Medical Center, and occasional guest lectures. In addition to teaching, there are administrative duties in terms of committee involvement, as well as participation in Departmental and University meetings. Although these can present scheduling challenges, it is exciting as an ECP to have the opportunity to serve in areas of administrative decision-making, such as budgets and faculty searches.

ROAD TO CURRENT POSITION

I have always had an interest in studying human behavior and my education was grounded in the scientific inquiry of the mind and body. As an undergraduate, I majored in psychology, with a minor in philosophy and a concentration in premedicine. It was during this time that I became interested in the area of sleep and I spent nine months working in a sleep laboratory after college. Upon entering graduate school, my interests were a natural fit with the behavioral medicine track offered at Virginia Commonwealth University. Although no faculty shared an active interest in sleep and behavior at that time, I continued to learn more about behavioral sleep medicine independently and I found ways to integrate this into my training in a broader behavioral medicine background.

My career path has consisted of a breadth of behavioral medicine training, funneling toward a depth of training in insomnia and mindfulness meditation that also included the good fortune of timely networking at national conferences. As a second year graduate student, I met Dr. Edward Stepanski, who was the Director of the Rush Sleep Center at that time, while attending an event at the annual Society of Behavioral Medicine conference. Although I was unaware at that time that he was a prominent psychologist within the Sleep Medicine field, I quickly developed a rapport with him, maintained contact throughout my graduate training, and completed my internship at Rush. Dr. Stepanski's mentorship and guidance were extremely valuable in helping me to decide on pursuing a career in BSM. During my internship, I had a second fortuitous networking encounter. While seeking a post-doc at the meeting of the Association of Behavioral and Cognitive Therapy, I met Dr. Rachel Manber, Director of the BSM program at Stanford University, who was looking to fill a research-track post-doc in BSM. Working with Dr. Manber, I discovered an interest in mindfulness meditation and began pilot testing a mindfulness-based intervention for insomnia. This project became the harbinger of an NIH (K23) Career Development Award. As part of this grant, I have attended meditation retreats and received more in-depth training in mindfulness-based interventions. After receiving the grant, I was attending the annual meeting for Sleep Medicine when I bumped into Dr. James Wyatt, the current Director of the Rush Sleep Center. Dr. Wyatt was recruiting a faculty member with experience in insomnia to help with the BSM clinic and to supervise interns. And the rest, as they say, is history!

MOST SATISFYING ASPECTS OF CURRENT POSITION

Although it is easy to get caught up in daily stressors, I feel very fortunate in my current position. First, I have an opportunity to make a difference on several levels. Whether it is investigating a new mindfulness-based approach to treating insomnia, helping a patient improve his or her sleep, or mentoring future psychologists in Health Psychology, there are many ways that I feel that my work contributes to the field. In my clinical work, CBT for insomnia is an efficacious treatment and it is rewarding to see tangible improvements in patients. Because my research program is aimed at developing and testing new treatments, I also feel that my position allows me to be a scientist-practitioner in the truest sense. Second, I enjoy the rich environment where I am constantly challenged by new cases, new students, and new research ideas. I interact frequently with

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physicians, nurses, and technicians and I feel respected by my peers. Finally, the autonomy that Psychology holds within the medical center at Rush allows me to feel like a "big fish in a small pond."

MOST CHALLENGING ASPECTS OF CURRENT POSITION

The most challenging aspects of my current position involve the constant pressure of clinical and research accountability, the so-called "business end of things." In many ways, establishing a lab and maintaining a research program at an academic medical center is similar to running a small business within a larger institution. You need to have grant funding to build a lab and you need data and a track record of publications to get a grant. Once you get a grant, you cannot relax, but instead you have to think about the next grant. This can feel like an endless cycle, where it is difficult to enjoy the present moment (ironic given my background in mindfulness). Another challenge with grant-funded research is that the specifics of the projects are frequently determined by the review process, which can take months before funding is awarded. Thus, spontaneous or original ideas are difficult to pursue and it is easy to find yourself in the role of a project manager rather than a scientist. In addition, most clinicians have billing targets that must be met, so it is difficult to take extended time away from the office (i.e., no summers off). Finally, the hierarchy of a medical center can still be an issue where a PhD psychologist might not have the same privileges or compensation as MDs despite having similar qualifications or even doing the same work.

PEARLS OF WISDOM

Working in an academic medical center can be a challenging, but very rewarding experience. A medical center can provide resources that can make a research program more competitive for grant funding, especially in terms of access to patients, equipment, and medical colleagues. Below are some pearls of wisdom for students and ECPs who might be considering a position in an academic medical center.

Networking. I always encourage students to attend professional conferences or find ways to connect with notable researchers in the field. The path I have taken in my early career is a good example of how this can be very helpful in obtaining positions and identifying future research mentors.

Align with a good mentor. I feel extremely fortunate to have had the opportunity to work with several outstanding mentors who have provided invaluable career advice. If you are interested in developing a research program, it is essential to find a good mentor who can show you the ropes, provide guidance on grant funding, and potentially share resources.

Understand the institutional structure. Medical centers vary in terms of faculty positions and expectations for promotion and tenure (i.e., research track versus clinical track). As a student or ECP, these might seem confusing or even unimportant (who cares if you are an assistant professor or clinical assistant professor?). If you are considering a position in a medical center, find out what level the position is, if there are different tracks, and whether tenure is offered to PhDs. Finding out this information up front can avoid surprises down the road.

Teamwork. The current trend in medical centers is to work in teams. As a psychologist in a medical center you will often be the mental health or behavioral expert on the team. It is important to understand your role and to learn how to work with physicians and nurses. Part of this is to learn how to "speak their language." Becoming familiar with medical terminology and the hierarchy on medical teams can be useful in developing rapport on a multidisciplinary team.

AUTHOR NOTE:

I welcome any follow up communications or questions at: jason_ong@rush.edu.

ETHICS IN PSYCHOTHERAPY

Preventing and Addressing Impaired Professional Competence Among Graduate Students in Psychology

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Like all professionals in the field of psychology, graduate students are not immune from experiencing problems, challenges, stresses, or distress in their everyday lives. They not only experience personal challenges, such as possible relationship and financial difficulties, but also professional ones, which may include taking on several different roles at once and changing geographic locations away from loved ones and sources of social support to find educational opportunities (Dearing, Maddux, & Tangney, 2005). Additionally, several studies have indicated that psychologists have higher rates of past personal trauma, which may have been a factor in them entering the field of psychology in the first place (Brems et al. 1995; Elliot & Guy, 1993; Pope & Feldman-Summers, 1992). Left unchecked, stressors faced by many graduate students may lead to distress, impaired professional competence and burnout. Despite these risk factors, few graduate programs have taken steps to address this issue. Proper methods of assessment, intervention, and remediation techniques are needed to provide assistance to impaired students and trainees. Further, students need to be made aware of preventative steps, such as adequate self-care and self-reflection, in order to reduce incidences of impairment and distress.

Terminology

Distress, impairment, and burnout are not mutually exclusive, but instead occur on a continuum. Distress is a natural condition that all people experience and cannot be avoided. It is a subjective emotional reaction that all people experience in response to stressors, conflicts, or demands in one's life, be they personal or professional in nature (Barnett, 2007). Impaired professional competence, or impairment, occurs as a result of distress left untreated over time and can negatively affect a professional's competence (Barnett, 2007). Burnout is described as the end stage of psychotherapist distress (Baker, 2003). It results from distress being insufficiently addressed over time and can result in emotional exhaustion, lack of emotional satisfaction in one's work and depersonalization (Barnett, 2007). While distress does not necessarily lead to impaired professional competence or burnout, a lack of attention to factors causing distress increases one's risk factors.

Psychology Students' Backgrounds

Many who enter the field of psychology do so because of their personal history. Psychology graduate students report experiencing higher rates of trauma, such as abuse, and family dysfunction as children than graduate students in education, business, or engineering, (Brems et al., 1995). One study found that, as children, one-half of the psychologists surveyed provided the primary parenting or caregiver role in their family of origin (Racusin, Abramowitz, & Winter, 1981). A study by Elliot and Guy (1993) found that nearly 70% of psycholo-

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gists had experienced some type of childhood trauma as compared to 49% of people not in the mental health field. Similarly, a study by Pope and Feldman-Summers (1992) found that almost 70% of female psychologists surveyed and almost 33% of male psychologists surveyed acknowledged a history of physical or sexual abuse as children.

One might wonder why an individual with such a history would enter a profession where they are continuously hearing about more incidences of abuse and trauma. One theory suggests that psychologists have been primed by their backgrounds to enter a caregiver role. Students may become more attracted to the field of psychology since it allows them to continue being the caregiver to others (Barnett, 2007). As O'Connor (2001) shares, "the mental health professional may be drawn to the role in part because they have been well prepared for it. A traumatic childhood may allow greater identification with the client and an opportunity to repair or master old wounds" (p. 346). However, students with unresolved personal issues and conflicts may be more vulnerable to blind spots that may result in mismanaging countertranferential reactions with clients experiencing situations similar to their own. Additionally, psychotherapeutic work with clients may uncover hidden emotions and feelings of the psychotherapist, leading to distress and possible impaired professional competence.

Student Specific Risk Factors

Like all others, students are not immune to distress in their personal and professional lives. Additionally, they may be at greater risk to experience impaired professional competence and burnout than established professionals. Students often face issues that psychotherapists who have been working in the field for several years no longer experience. For instance, students must delay personal and financial gratification in order to pursue their graduate education (Knapp & VandeCreek, 2006). Many students face significant financial challenges and hardships due to limited funding from their graduate program and limited opportunity to earn needed money while attending school. Restricted work hours due to classroom obligations while paying for their education, which can extended five to seven years or longer past their undergraduate degree, can place a significant burden on students. For those who obtain loans to fund their graduate education the pressure of knowing that they must eventually repay them is an added emotional stressor.

Additionally, in order to find educational opportunities in a very competitive field, many students must move further away than desired from their families and their networks of social and emotional support (Dearing, Maddox, & Tangney, 2005). Being away from means of support can be particularly difficult while trying to juggle the multiple roles many serve in simultaneously which include student, psychotherapist, spouse, or parent. Student psychotherapists also must be concerned not only with their clients' progress in psychotherapy, but their own progress as developing clinicians. At times, students' effectiveness in helping others may be affected by their own concern for personal competence and they may thus focus their energy in themselves rather than their clients (Zeddies, 1999). Additionally, concern over being evaluated, developing needed skills, and successfully completing each phase of one's training add to the stress and pressure experienced by students. Challenges such as comprehensive exams, dissertations, and obtaining practicum and internship placements add to the stress experienced by many students. Of tantamount importance is the fact that many students who are at risk of developing, or who are experiencing, impaired professional competence are not receiving needed support from their graduate programs. In fact, many programs discourage discussion about student distress and impairment and do little to assist stu-

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dents to help themselves prevent impairment from happening (Elman, 2007).

Challenges with Graduate and Internship Programs

One of the biggest challenges faced by graduate programs is how to help students facing impaired professional competence as well as steps to take to prevent impairment from first occurring. Currently, there is a great deal of inconsistency in the frequency of student and trainee impairment as well as the manner in which it is addressed (Gizara & Forrest, 2004). Many programs do not have models for identifying students who are exhibiting signs of impairment or a lack of self-care and self-awareness (Elman, 2007). Additionally, there is a great deal of inconsistency in the terminology used to identify students with impaired professional competence; some students who never have achieved competence in their professional roles are labeled as impaired (Gizara & Forrest, 2004). This not only does the student who is experiencing distress and impaired professional competence an injustice by employing ineffective helping strategies, it perpetuates the stigma of suffering from distress by mislabeling it with incompetence. A number of supervisors of APA accredited programs stated in one study they were not prepared to recognize student impairment and felt isolated when dealing with such students. Thus, supervisors either did not often discuss the possibility of impaired professional competence with their students or felt an increase in emotional difficulty in talking about the topic when it was broached (Gizara & Forrest, 2004).

In addition to identifying students experiencing distress and impairment, many programs lack clear intervention plans for students who are in need of assistance. One study suggested that doctoral programs more so than internship sites are behind the curve in implementing programs that manage trainee impairment. This study found that while almost 85% of internship sites had a program to manage impaired professional competence in trainees, only 58% of doctoral programs had similar plans (Huprich & Rudd, 2004). Attitudes about help seeking behaviors also influence a student's willingness to seek out support. A student is much more likely to obtain assistance through personal psychotherapy when the faculty of a program has a positive attitude about that option (Dearing, Maddux, & Tangney, 2005). Additionally, it is crucial that those involved in the training of student psychotherapists do not portray a stigmatizing attitude about personal psychotherapy, which may decrease the chances of a student seeking much needed help.

Despite the ethical imperative put forth in the APA Ethics Code (Standard 2.06, Personal Problems and Conflicts) (APA, 2002), many programs fail to educate their students about the importance of self-reflection and self-care. Many faculty members and supervisors do not model good self-care behaviors or emphasize the importance of self-care or self reflection. As a result, many students are not aware that these are respected and important aspects of being a good psychotherapist (Elman, 2007).

Forrest, Shen Miller, and Elman (2008) highlight the importance of awareness of the many challenges that result from "naturally occurring transitions" within each student's graduate education (p.187). Examples include the fist practicum experience, leaving the graduate program for the internship year, and others. Additionally, the greater scrutiny faced in clinical experiences as students progress though their training may place additional demands on them (Lamb et al., 1987). Forrest and colleagues "recommend that trainers provide trainees with advance warning about these possibilities, and guidance about transitional self-care and coping strategies" (p.187). These authors also recommend that all training programs accept self-reflection and self-assessment as key components of professional compe-

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tence and that faculty and supervisors communicate this to students and provide them with focused training activities to implement these processes preventively both individually and with colleagues.

Forrest and colleagues further alert faculty and supervisors to the potential impact of "major changes in the environment" that may greatly increase the likelihood of impaired professional competence in students (p.189). Examples include "Trainer or leadership turnover, changes in facilities, high impact incidents in the larger organization (e.g., VA Tech tragedy), and /or funding challenges" (p.189). Overlooking the possible impact of such broader events on students may result in the cumulative effects of distress not being adequately addressed, thus impacting on the trainees' professional competence.

Developing Better Programs and Greater Student Awareness

Several suggestions have been made for reducing student impairment and burnout and for improving graduate programs and internship sites. First, students should be provided with good models of self-care behavior. Faculty members and supervisors should not be wary of demonstrating how they appropriately and successfully handle their own stressors and use good self-care techniques (Knapp & VandeCreek, 2006). Training programs are further encouraged to create positive attitudes, sufficient knowledge, and accurate skills in terms of teaching and applying self-care techniques (Elman, 2007). In addition, supervisors should be open to a positive and respectful dialogue with their students, as well as with other trusted colleagues with whom they may consult for advice on student impairment (Gizara & Forrest, 2004). Moreover, appropriate resources and faculty support should also be made available to students if they wish to take part in their own psychotherapy (Dearing, Maddux, & Tangney, 2005).

Graduate programs can include the topics of distress, impaired professional competence, burnout, self-awareness, self-reflection, self-care, and prevention in ongoing training such as through inclusion in colloquium series that students and faculty attend. Further, these topics can effectively be integrated into each phase of students' training and in numerous academic courses. Examples include practicum or internship orientation sessions, seminars, and grand rounds presentations, as well as courses such as psychotherapy and ethics. Graduate programs and internships might even provide experiential self-care programming such as meditation, yoga, and exercise. Faculty and supervisors can model effective self-care lifestyles by managing work demands effectively, exercising regularly, and striking a balance between their professional and personal lives.

In addition to teaching self-care techniques and promoting the ongoing use of prevention strategies, graduate programs should make every effort to ensure there is a model in place to effectively identify students experiencing signs of impaired professional competence and to intervene with the aid they need. Training programs and internships should also take care in training faculty and supervisors to recognize impaired professional competence in students and help them get the help they need. Training programs may also want to consider implementing programs to help faculty and supervisors, as well as other student, recognize impaired professional competence in others through role play exercises (Schoener, 2007).

Strategies for Students and Key Prevention Resources

Barnett and Sarnel (2000) offer many helpful strategies for responding effectively to distress and for preventing burnout and impaired professional competence including making adequate time for self care and enjoyable activities, setting boundaries, and focusing on prevention.

O'Connor (2001) provides recommendations regarding how to respond to colleagues who

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may display signs of distress, burnout, or impaired professional competence such as reducing the stigma of distress and impairment, and educating oversight bodies. Barnett, Johnston, and Hillard (2006, pp. 268-269) list self-assessment tools that should be useful for increasing self-awareness of risks of burnout along with appropriate or inappropriate coping strategies. In addition, a variety of online resources may be helpful including: a guide for preventing burnout (http://www.ssireview.org/pdf/2005WI_Feature_Maslach_Leiter.pdf); Thirteen signs of burnout and how to avoid it (http://www.assessment.com/mappmembers/avoidingburnout.asp?Acc n u m = 0 6 - 5 2 1 0 - 0 1 0 . 0 0 & g c l i d = COTn47vupZcCFQu-Ggod9XrO_Q); a job burnout inventory (http://www.secretan.com/freetools_assessment_burnout.php); stress, burnout, and adrenaline addiction (http://www.svahaconcepts.com/stress/stress1.html); and resources for assessing and responding to burnout (http://www.friedsocialworker.com/socialworkburnout.htm).

Conclusions

The stress placed on graduate students and interns can seem overwhelming at times. The requirements of the profession, as well as personal stressors associated with being a student can take a toll on the emotional well being of any trainee and can lead to burnout and impaired professional competence. In order to prevent this from occurring, it is essential that every program director and supervisor advocate the importance of self-care and self-awareness to students. In addition, programs need to develop clear guidelines for identifying and helping distressed students as well as advocate an open and honest discussion about what to do if burnout does occur. Training programs must be the starting point for change in the way mental health professionals view impaired professional competence and the importance of self-care.

A key feature of this progress will include ensuring healthy training environments that "would facilitate trainees fully engaging in program activities because they experience the program as safe and sufficiently protective of their training needs and interests" (Behnke, 2008, p. 215). Such a safe training environment would help balance faculty's joint obligation to serve as gatekeepers for the profession as well as mentors and proponents of their students' well functioning and professional development. Since everything students learn (and don't learn) in their training has the potential to be integrated into their identities as professional psychologists for years to come, how these issues are addressed during their training years is of tremendous importance to our profession.

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Center for Training in Psychotherapy Integration (CTPI)

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A few years back, I was asked to put forth some ideas regarding the training of integrative psychotherapists based on a single integrative theory of psychotherapy. This was part of a special series edited by Louis Castonguay for the September, 2000 issue of the *Journal of Psychotherapy Integration*. I mentioned at that time that the "task of grounding a training program on an integrative theory of psychotherapy is necessarily a thought experiment because no adequate integrative theory of psychotherapy exists" (Wolfe, 2000, p.233). By the end of this thought experiment, I had outlined a curriculum for a 3-year postdoctoral training program for psychotherapists interested in integration. I was intrigued by the results of this thought experiment but knew I lacked the time, energy, and resources to launch such an endeavor. Yet I could not let go of the idea of at least making a start.

I have been amazed over time to discover how few practicing psychotherapists in the Washington DC area had ever heard of the Society for the Exploration of Psychotherapy Integration (SEPI) or who had shown any interest in the systematic integration of the psychotherapies. I concluded that my first task was to expose the clinical practitioner to the rich variety of approaches to psychotherapy integration that have already been developed. In 2005, I started a corporation, Center for Training in Psychotherapy Integration, which allows me to sponsor programs of Continuing Education. In the autumn of 2005, I offered my first course under the sponsorship of CTPI. This is basically a survey course in psychotherapy integration and it met the second Sunday of each month, 9-5 pm from September to May. The goals of this intensive training course were to (a) expand participants' range of therapeutic interventions, (b) increase their knowledge regarding the development and maintenance of specific emotional or behavioral problems, (c) deepen their understanding of the therapeutic change process, and (d) help them systematically develop their own therapeutic integration. The format included a didactic session in the morning and an experiential session in the afternoon.

The course began with a review of three major psychotherapy orientations (psychodynamic, cognitive-behavioral, and experiential) that included a comparison of each orientation's (a) concept of normal functioning, (b) theory of dysfunction, (c) major interventions and techniques, (d) theory of change and (e) concept of the therapeutic relationship and typical stance of the therapist. The experiential session attempted to demonstrate several types of psychodynamic interventions. The second class covered the history of psychotherapy integration and the experiential session covered the various behavioral techniques. The next two classes proceeded to cover two of the major pathways to integration that have emerged over the past two decades: Technical Eclecticism, and Theoretical Integration.

Technical eclecticism refers to the selective combination of specific intervention techniques, which are combined without much concern with the underlying theories that have generated them. This is a highly pragmatic strategy that attempts to systematize the process of selecting combinations of treatment interventions tailored to the specific and idiosyncratic characteristics of the

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patient. As examples, we covered Lazarus's Multimodal Therapy (Lazarus, 2005) and Beutler's model which he calls Systematic Treatment Selection and Prescriptive Psychotherapy (Beutler, Consoli, & Lane, 2005).

Theoretical integration is based on the notion that common factors and the eclectic combination of techniques from different traditions should eventually lead us to the development of an emergent unifying conceptual framework for psychotherapy (Wachtel, 1991; Wolfe, 2005). Wachtel's (1997) theoretical integration of psychodynamic, behavioral, and systemic approaches was the subject of our next class. The experiential sessions for classes 3 and 4 included demonstrations of cognitive-behavior therapy techniques and experiential therapy techniques, respectively.

The next two classes focused on integrative models applied to specific classes of disorders. George Stricker was a guest speaker and he presented his and Jerry Gold's three-tiered model of personality disorders, which they now label Assimilative Psychodynamic Therapy (Stricker & Gold, 2005). Assimilative models of integration are based in the author's home orientation but it also *assimilates* constructs and techniques from other orientations (Messer, 1992). In the next class I presented my own integrative perspective on the anxiety disorders. Following the class on my model, Clara Hill also served as a guest speaker to present her integrative model of dream analysis. This model involves exploring the dream, gaining insight into its meaning, and having the dream's meanings shape future action (Hill, 2004). The final substantive integrative model covered was Prochaska's Transtheoretical model which combines the stages, processes and levels of psychological change (Prochaska & DiClemente, 2005). The course concluded with a focus on helping the students develop their own integrative model of therapy. The integrative models of therapy presented in this course is a significant but by no means comprehensive sample of the creative model building that currently exists in the field of psychotherapy integration.

The course was very well-received but I soon learned that the commitment of nine full Sundays was daunting for so many potential participants that the following year I reduced the course to four classes. The format was similar but we met one Sunday per month only from September to December. The course, entitled "Four Powerful Models of Psychotherapy Integration" included the models developed by Wachtel and myself, the Transtheoretical Model developed by Prochaska and his colleagues, and Fosha's Accelerated Experiential Dynamic Psychotherapy (Fosha & Yeung, 2006). Last year's course was apparently so well-received that the entire class asked me to run an integrative psychotherapy supervision group. I have been doing this on a monthly basis since March of 2008. A case conference format is employed in the supervision group but the group task is to think about the presented cases in terms of a systematic integrative approach to intervention.

This year's class made one substitution in the four models. Susan Johnson's Emotion-Focused Therapy for Couples replaced the Fosha model (Johnson, 2004). I was fortunate enough to have a former student just complete the training in Johnson's model and he therefore was selected to guest teach her approach. Johnson's model integrates Greenberg's Process-Experiential Psychotherapy with attachment theory.

In every class, the level of engagement of the students and the richness of their discussions made the course a meaningful experience for all. The group discussions are frequently supplemented by DVDs of master therapists working from an integrative model. Though the groups were small, everyone who has taken this course has understood the value of thinking integratively and on the importance of capitaliz-

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ing on the strengths of each existing perspective on psychotherapy.

This course will continue to be offered every fall. The supervision group is ongoing. In the near future, the Center will sponsor a series of one or two-day workshops on my integrative psychotherapy for emotional disorders. These are the first few tentative steps that I am able to take toward developing a full-fledged training program in psychotherapy integration.

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Deadline is March 31, 2009

APA's Division of Psychotherapy is pleased to announce:

THE DISTINGUISHED PUBLICATION OF PSYCHOTHERAPY RESEARCH AWARD

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

We ask members of the Division to nominate articles for consideration by April 15. Nominations should include the complete citation for the article, and should be emailed to the Chair of the Research Committee, Dr. Susan Woodhouse, at ssw10@psu.edu.

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

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

The criteria for the award appear below.

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

PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

The Scientist-Practitioner Model: Personal Reflections from an Early Career Psychologist

Rayna D. Markin, Ph.D., Villanova University
Department of Education and Human Services

A little over a year ago, I sat alone in my office, as a psychology intern, with my head in my hands. With 10 minutes in between clients and only a few months until the end of internship, I quickly perused psychology job advertisements on line. This had become more of an obsession for me than downloading music or checking e-mail. What exactly was I looking for among the array of perfectly fine jobs that a million people would be happy with? What I was looking for was a position for a scientist-practitioner. However, as I glossed through the advertisements, that either wanted a teacher and a researcher or a clinician, I could not quite figure out where all the scientist-practitioners go post-graduation?

When I thought about applying for the clinical positions, I felt the scientist in me squirm and the clinician in me feel relieved. When I considered the academic positions, the clinician in me felt lost and the researcher in me celebrated. I finally accepted an academic position with a sense of accomplishment and pride (if not surprise). Still, while all my mentors, friends, family, and peers congratulated me, internally, I was wrestling with my decision, as the researcher in me was working hard to silence the loss that the clinician in me felt. As a graduate student, I was taught to believe that I could be both a scientist and a practitioner, and, moreover, that this was a good idea. So, why now did I have to choose?

As a child, my vision of adulthood was that adults got to do whatever they wanted. Adulthood and higher education brought the realization that, to the contrary, in some ways, the older we get, the fewer choices we have. Even as a graduate student, I had the hidden belief that upon graduation I could have it all. I could embrace the practitioner and the scientist in me and the professional world would provide an outlet for me to do so. After all, I was trained to be a scientist and a practitioner. Then I graduated, and, in essence, grew up to the fact that there are only so many hours in a day and most professional positions want either a clinician or a researcher. While I have surely known clinicians who conduct important and impactful research and researchers who are talented clinicians with a small clinical practice, one role usually usurps the other in time and energy.

The Scientist-Practitioner Model: An Infusion of Roles

My view on the scientist-practitioner (S-P) model is that its essence is more than a practitioner who is informed by research, or a researcher who conducts clinically relevant experiments. Regardless of what model we are trained in, I think in this day and age we can all agree that a clinician should be guided by empirical data and clinical researchers should produce clinically meaningful research. What makes the S-P model unique is that it calls for psychologists to apply their research to their practice and their practice to their research. A scientist-practitioner not only has a healthy respect for both of these roles but actually steps into both of these roles in a way that fuses them together.

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Some have said that in an ideal world, the scientist-practitioner would achieve a 50-50 split between practice and research. I do not intend to argue that in order to be a S-P, one must devote 50% of one's time to research and 50% to practice. Rather that, throughout one's career, a S-P engages in research and practice oriented activities (regardless of the percentage breakdown), and, moreover, applies one to the other. Regardless of the actual amount of hours one devotes to research versus practice, I think it is a mistake to speak of these roles as "split" and that doing so misses the essence of the model. These roles are not "split" but interrelated. For example, my experiences leading psychotherapy groups led me to wonder about the impact of member transference toward other members in the group. I then carried out a study based on hypotheses that emerged from my clinical experiences running groups. Now that the study is completed and the data analyzed, I can apply the findings to how I conceptualize member to member relationships as a group leader. Carl Rogers was a striking example of a scientist-practitioner. Whether or not one agrees with his philosophy and therapeutic treatment, Rogers was the consummate researcher-clinician who experimentally tested what he experientially believed to be true when sitting with a client. It should be noted that the "practice" component of the S-P model could refer to a wide variety of practice roles that psychologists fill in addition to clinical practice, such as administrator, consultant, or advocate. In addition, science may include empirical pieces as well as theoretically sound theory papers.

The Current State of the S-P Training Model

For over 50 years, the vitality and usefulness of the S-P model in training graduate students has been debated. The main argument has focused on the vitality of a model that calls for training students, who by and large wish to become practitioners, to also become scientists. Most students become practitioners after graduation with some also producing research (Gelso, 2006). Research suggests that students enter professional psychology programs with a modest interest in conducting research and become slightly more interested in conducting research as they progress through their training (Perl & Kahn, 1983; Royalty, Gelso, Mallinckrodt, & Garrett, 1986). At the same time, there is some evidence that a program's impact on student interest in research greatly varies between programs (Perl & Kahn, 1983; Royalty et al., 1986). Although such findings are often cited as evidence that the S-P model is untenable, Gelso (2006) argues that it has not been given a fair trial to date. He suggests that programs need to structure positive research experiences for students. In addition, he offers a theory that programs can use as a guide to provide a research-training environment for their students that facilitates students' motivation and interest (and perhaps most of all their self-confidence) in research.

The S-P Model: Do or Die?

Gelso (2006) remarks that despite the challenges, the S-P model is worth pursuing in our training programs because: a) it produces practitioners who use practices based on scientific findings and theories, and b) when practitioners are involved in research, they bring with them a wide variety of clinical experiences that can be applied to the research. I wholeheartedly agree with this rationale, and, at the same time, I believe it comes from experiences where most students are primarily interested in practice and need a reason for conducting research as well. As a graduate student who entered my doctoral program primarily interested in practice, I did not need much convincing that research was interesting and valuable. I had wonderful mentors who taught me that I *could* conduct research, and once I believed that it was possible, I wanted to do research. I had questions I wanted answered and things I wanted to say. Research and writing pro-

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vided a venue for me to do just that. At the same time, my experiences with clients led me to ask questions in my research that otherwise I would not have even thought to ask. At the same time, devoting myself equally to my clinical and research training was overwhelming at times, and my desire to be an equally good, if not great, researcher and clinician bordered on unhealthy perfectionism. The scientist-practitioner training model "worked" for me as a student in that I came to identify as a S-P, probably because I had an excellent research training environment (see Gelso, 2006). However, my early-career experience has been that even when this training model "works," and a student like me graduates wanting that idealized 50-50 "split," there are not many career tracks that provide the necessary structure for such a split. If the S-P training model cannot be implemented in a professional context even when it is successful in a training context, is it all worth it?

There are several reasons why, despite the challenges and limitations, I argue that the S-P model is valuable. As Gelso (2006) notes, practitioners, trained as scientist-practitioners, are probably more likely to use research to guide their treatments and to become involved in a research team. Likewise, students who ultimately become researchers will have clinical training as a foundation for producing clinically relevant studies. For some people, research is just not their "thing," and for others practice is just not their "thing." The S-P model can still be a useful training model for students who ultimately identify more with one side of the hyphen than the other because it creates a well rounded and informed practitioner or scientist.

As for my own development, despite some initial disappointments, I still feel fortunate to have received training in a S-P model and have begun to find ways to integrate both roles into my work. Like most students, I entered graduate school believing I was capable of becoming a good psychotherapist (Betz & Taylor, 1982; Frank, 1984; Gelso, 1979) but unsure of my abilities as a researcher. Training in the S-P model allowed me to develop a sense of research self-efficacy and overall sense of competency that I carried with me into my training as a clinician as well. I do believe that I am a better researcher and teacher (when it comes to the kind of courses I teach and research I conduct) because of my clinical training and my passion for clinical work.

If I have any advice for other early career professionals in academia who might also miss their clinical work or other areas of practice, it is to try and find creative ways to integrate practice roles into your career. More specifically, I have taught clinical classes on psychotherapy skills, group, and psychotherapy theories. Teaching these courses keeps me anchored in my identity as a clinician. If you want to get licensed, be explicit with your potential employer about your desire to become licensed and ask what the program might do to help you work toward professional licensure. I also find it extremely valuable to stay connected with other clinicians and equally valuable to maintain relationships with other academics who also share a strong interest in clinical work. I have made it a priority to continue attending clinically oriented workshops and presentations (and often I get exciting research ideas from them!). Although as you begin an academic position, you will likely feel overwhelmed, when the time is right, make it a priority to continue to see in least a few clients. Sometimes this may be possible at various mental health agencies on one's campus. Other times there are volunteer opportunities in the community, and sometimes you have to get more creative and resourceful.

Some early career academics interested in administration and program development choose service opportunities that allow

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them to fill these roles. For example, one can "shadow" a Department Chair and serve on related committees. Committees on program development often are looking for new hires to give a fresh perspective. One of my colleagues interested in advocacy and program development has volunteered at various inner city schools and after school programs and has successfully advocated for these students to receive after school tutoring and mental health services. Last but certainly not least, give yourself time to strike a balance between your research (and teaching) and your practice. More importantly than the amount of hours you devote to practice, is the quality of your practice experiences and your efforts in integrating your practice with your research and teaching.

It is also my hope that if more people raise this issue, S-P programs will begin to discuss ways in which they can create practice opportunities for their new hires, with the assumption that ultimately more practice will lead to better quality teaching and research. In my very short time as an academic, I have learned it takes patience to find your way professionally. Perhaps the hardest lesson of all to learn in this is that we cannot have it "all" even when we are trained to do it "all." The idealized 50-50 split may be just that, an idealization. But like other ideals, while it may never be reached, I believe it is a worthy aspiration.

References for this article can be found on our website: divisionofpsychotherapy.org

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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.

PRACTITIONER REPORT

Parity, Medicare, and the APA Presidential Summit on the Future of Psychology Practice

Jennifer F. Kelly, Ph.D., Independent Practice and Atlanta Center for Behavioral Medicine, Atlanta, Georgia

I am currently serving in my third year as a member-at-large with Division 29, and am in my second year as the Practice Domain Representative. Practice continues to face challenges, but we have positive reports as well. We have had some changes in the domain, and I am looking forward to my continued work with the division given the changes. I would like to take this opportunity to provide you with an update of the changes.

Dr. Bonita Cade currently serves in the capacity of Chair of the Practice Domain Committee. Dr. Cade is engaged in private practice as a forensic psychologist and an attorney. She is an Assistant Professor at Roger Williams University in Bristol Rhode Island. Dr. Cade was the 2007 Chair of the American Psychological Association's Committee on Legal Issues (COLI). Dr. Patricia Coughlin will continue to serve as the 2009 Associate Chair of the Psychotherapy Practice Committee. 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. Drs. Cade and Coughlin will be working with us to assist in developing the Practice agenda for the division.

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.

There have been numerous legislative successes accomplished over the past year, thanks to the hard work of the Practice Organization and the Association for the Advancement of Psychology.

Mental Health Parity – In October 2008, history was made when the mental health parity bill was signed into law. The bill, which took effect on January 1, 2010, will hopefully end discrimination in insurance coverage for our clients.

Medicare Reimbursement – The Medicare Improvements for Patients and Providers Act of 2007 (MIPPA), was enacted on July 15, 2008. The bill included substantial restoration of the 2007 cuts in reimbursement for psychotherapy codes, a phase-in of coinsurance parity for outpatient mental health services and an 18-month postponement of the 10.6 percent Sustainable Growth Rate (SGR) reimbursement cut. Psychotherapy codes were the only codes that received specific reimbursement increases in MIPPA. This represents an unprecedented victory for psychology. It ends discriminatory co-payment rates for Medicare outpatient mental health services. Medicare has required a 50 percent copay for outpatient mental health services, compared to 20 percent for other health care services. A phase-in to MH coinsurance parity begins in 2010 and steps down to 20 percent coinsurance by 2014.

Another important development over the past year has been the establishment of the 2009 Presidential Task Force on the Future of Psychology Practice. This is a Presidential Initiative of Dr. James Bray. He provided information on the Task Force.

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The 2009 Presidential Task Force on the Future of Psychology Practice will address current issues in the practice of psychology and identify models and policies for the future of psychology practice. Psychological practice in the 21st century requires that we change our traditional ways of practice and create a vision to take advantage of the new possibilities in society.

The goals and objectives of the Task Force are to identify:

1. Models and opportunities for future practice to meet the needs of our diverse public
2. Priorities for psychologists practicing in private and public settings
3. Resources needed to effectively address the priorities
4. Roles of various practice groups in implementing the priorities
5. Key partnerships to implement our agenda and;
6. Plan the APA Presidential Summit on the Future of Psychology Practice

The scope of practice addressed by the Task Force includes both health services psychology and other forms of practice, such as business consulting and community services that address public health. The Task Force will organize the APA Presidential Summit on the Future of Psychology Practice to be held May 14-19, 2009 in San Antonio, Texas.

The Summit meeting will expand the work of the Task Force by engaging the broader practice community to develop a strategic plan to guide the work of the APA and the APA Practice Organization. The Summit will assemble leaders in the practice of psychology and other professionals who are critical stakeholders to the practice of psychology to expand the work of the Task Force and address objectives 1 to 5 above.

This Summit will be a collaborative effort among different partners of the practice community. We will address policy issues that will be considered by the APA and APA governance, business of practice and advocacy issues that will be addressed by the APAPO and Committee for the Advancement of Professional Practice, issues represented by APA Divisions and State, Provincial, and Territorial Associations. In addition, we will collaborate with non-psychology groups to incorporate a broader public perspective into our work. Developing partnerships with these outside groups will be key to implementing our practice agenda.

The Summit will be a medium to identify new models and venues for practice, to expand opportunities and to identify opportunities that traverse traditional practice domains. A primary outcome of the Summit is to develop a clear agenda for the future of our multi-faceted and diverse practice community. This effort should create the opportunity for new resource development and synergy of effort among practice leaders and their organizations and help each organization develop a strategic plan for future policies and actions.

We will invite 150 delegates to the Summit. They will be from APA Divisions, state associations, the APA Practice Organization, other practice organizations (such as primary care medical groups), government entities, consumers of psychological services, and the business and insurance industries to collaborate in developing a plan for the future of psychology practice.

In addition to the Task Force, CAPP members and APA staff, 20 psychologists and 30 non-psychologists who represent areas of content expertise and potential contributions to the initiative will be invited to attend the Summit. The Task Force will also identify practice divisions and state psychological associations to select the remaining 75 delegates. A list of criteria

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created by the Task Force will be sent with the invitation to each of the practice divisions and state psychological associations to identify delegates for the Summit.

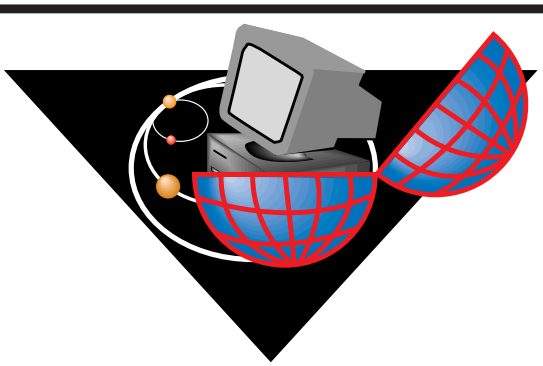
Psychological practice in the 21st century must be a vital part of our society and practitioners must create new possibilities to contribute to the well-being of our nation and the world. The 2009 APA Presidential Summit on the Future of Psychology Practice will be a collaborative effort to provide an opportunity for strategic thinking about our future. The goal is to engage the practice community in an agenda- and priority-setting meeting, to inform the work of the APA Practice Directorate (PD) and the APAPO. The mission is to assemble leaders in the practice of psychology and other professionals (other practice associations, government entities, training organizations, consumers, insurers, and businesses) to identify:

- Opportunities for future practice to meet the needs of a diverse public.
- Priorities for psychologist practitioners in private and public settings.
- Resources needed to address the priorities effectively.
- Partnerships and roles to implement the priorities.

This Summit will be a vehicle for the introduction and consideration of new prototypes, venues, and partnerships for practice; expanded thinking about practice trends; and conceptualization of intersections that cross traditional practice lines. It will not be possible to address every facet of practice in one meeting; however, the goal of this unique event is to develop a clear *agenda* for our diverse practice community. In so doing, there is promise for greater resource development and synergy of effort among practice leaders and organizations.

The Summit will be of great interest to many APA members in diverse types of practice, as well as those who train practitioners and those who conduct research related to the practice of psychology.

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



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RELATIONAL ELEMENTS IN BUILDING INTERNATIONAL INTERNSHIP PARTNERSHIPS

Judith E. Fox, Ph.D., University of Denver, Graduate School of Professional Psychology

The utility of theoretical models and practical skills in clinical psychology to assist in the international disaster context is widely contested (Reyes, 2006). Applying ideas about development, trauma, coping and treatment raise understandable concerns about the generalizability of notions advanced by our discipline, and the applicability of various concepts and clinical skills to international disaster contexts (Bracken, Giller, & Summerfield, 1995). Furthermore, concerns that clinical psychology promotes a view that medicalizes or pathologizes persons or communities affected by disaster or trauma have been raised (Summerfield, 1999). These controversies and concerns in the evolving field of international disaster psychology have been important considerations in developing our Master's Program in International Disaster Psychology. They have also been important to understanding elements of an approach to non-governmental agencies in international disaster contexts who may have interests in developing service-learning partnerships with us.

This article will discuss the application of practical clinical skills and a theoretical model, i.e. intersubjectivity theory, that seem particularly suited to working in international disaster or post-disaster contexts, and that have been important factors in building relationships with international, non-governmental agencies working in these areas. Specifically, common factors found to be effective across psychotherapies, and a theory of development and psychotherapy that is multi-culturally sensitive and depathologizing will be discussed as relevant to the process of building internship partnerships with non-governmental organizations abroad. Clinical skills that facilitate relationship-building, and theories of development and psychotherapy that focus on mutuality in relationship development, may contribute to approaching international disaster contexts in ways that depathologize the 'other' and promote collaboration that is reciprocal and sensitive to factors of socio-cultural diversity and political history.

Master's Program in International Disaster Psychology (MAIDP): The Master's Program in International Disaster Psychology (MAIDP) at the University of Denver is a 2-year program providing students with multi-disciplinary training in the multiple areas relevant to international disaster psychology. Coursework provides the necessary background for clinical, humanitarian and disaster mental health work domestically and internationally. Psychosocial, economic, political and public health processes present in natural and human-made disasters, including health-related pandemics, are studied. Students are prepared to work in a variety of positions including direct service, supervisory, administrative, program development, evaluation and research. Training in international disaster psychology is provided within the context of master's level training in clinical psychology. An important part of this training includes not only domestic field-placements in the Denver area relevant to disaster affected populations, but international summer internships in disaster and post-disaster contexts. The international summer internship experience is seen as essential to developing the skills and perspectives to enter this field. It

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provides a service-learning component with the mutual aims of student skill development and assistance to the international agency and its psychosocial mission.

Common Factors and the development of international internship partnerships: Research concerning the process and outcomes of different therapeutic approaches in clinical psychology, reveals the therapeutic alliance to be a key and consistent factor in positive therapeutic outcomes across of variety of presenting problems (Castonguay & Beutler, 2006). The development of empathic and collaborative relationships, and quality of the therapist-client relationship, form the basis from which all other aspects of treatment, including planning and intervention, successfully proceed. Identified as a common factor across treatment modalities and orientations, the formation of a therapeutic alliance is viewed as a necessary element of a collaborative, successful therapy process. A positive therapeutic alliance includes the presence of an affective bond, elements of trust and connection, an attitude of mutual collaboration and the experience of goodness of fit between collaborators (therapist and client) in the process.

Although not a treatment relationship, trusting, collaborative and affectively-bonded relationships with international internship partners greatly facilitate the development and actualization of quality service-learning internship experiences. Collaboration between partners includes the determination of goodness of fit, i.e. the goals of the MAIDP's internship training experience fit with the agency's needs for student expertise and service, logistical and programmatic planning, internship implementation, monitoring and outcome evaluation. A strong alliance between agency director, staff and the director of the MAIDP internship program facilitate this collaboration. Difficulties that arise during the internship experience are dealt with more easily when a strong alliance, including elements of trust and connection, is present.

Intersubjectivity theory and the co-construction of international partnerships: There has been a growing emphasis in psychoanalytic theory that highlights the relational elements of the therapeutic process. Intersubjectivity theory emphasizes the experience of one's self in relation to others is not seen as developed and statically existing within unconscious, intrapsychic structures, but as generated and maintained by the interplay between two subjectivities (Orange, Atwood & Stolorow, 1997; Buirski & Haglund, 2001). Through developmental experiences with important others, organizing principles of experience, i.e. "cognitive-affective schemata," are developed and continue to function in ways that create meaning and experience in contemporary relationships (Atwood & Stolorow, 1984). The therapeutic relationship is described as an intersubjective system of reciprocal mutual influence, involving the interaction of two subjective worlds (Atwood & Stolorow, 1984). This focuses us away from traditional, one-person views of relationship functioning to the experience that is created between individuals. Although international internship partnerships are not therapy relationships, intersubjectivity theory draws our attention to the interaction of personal subjectivities that influence the experience and co-construction of all working partnerships.

The intersubjective view of relationships is a depathologized one that includes the opportunity to consider the subjectivities that involve individuals, their relationship histories, and the ecological and socio-political contexts in which both parties live. Sensitivity to the details of cultural and historical experiences with Americans, including socio-political history, is critical to consider in partnership development. Clinical skills of attunement and empathic engagement are central to partnership development from the perspective of intersubjectivity theory. An understanding of one's own history and perspectives and

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those of one's partner is considered by attention to the process and co-constructed partnership

The clinician's empathic abilities to attune to the experience of the other, herself and to reflect on interactions that co-construct the quality of the partnership, help provide guidance in furthering conversations that broaden and deepen affective connection and partnership bonding. Positive affective connection not only furthers the basis from which to create meaningful internship experiences for students and agency staff, but assists in resolving difficulties or disruptions in relationships that may occur over the course of working together during the summer internship.

Collaboration Vignette: After working for over 22 years practicing as a licensed psychologist, I found myself facing some formidable tasks as director of our newly founded MAIDP Program. Traveling to the Balkans for the first time with the intent of developing connections with non-governmental agencies for internship placements for our students involved many challenges. Forming partnerships with agencies would be a difficult task, but one that began to feel familiar given my clinical background. In the context of having limited direct knowledge of this post-conflict environment, my clinical skills to empathically attune and form trusting, collaborative working partnerships would be my biggest contribution to this process of developing international internship partnerships.

Through a third party Mirjana and I were introduced. Mirjana directs a center providing psychosocial assistance to ex-military and their families. Traveling from work to the opposite side of Sarajevo where my hotel was located, Mirjana arrived late, wet from the rain and stressed by the traffic downtown. Concerned that our partnership would mean only extra work, that my students and I could have no understanding of her clients' experiences, and that we were planning on applying our knowledge to people and circumstances about which we were unfamiliar, she voiced concern and anxiety about proceeding to work together. She had, however, fought traffic in the rain to come meet with me. Her stress, weariness, sense of being overwhelmed with work and clients in need of psychosocial help was apparent. Wanting help, but leery that the partnership would 'take' without 'giving,' we started discussions to understand each other. She talked about the many American organizations that had come to Sarajevo, studied and published, leaving no trace of sustainable help behind. She described her experience of the war and losses of family and friends. I listened with motivation to understand and attune to her experience. Through our interaction, I came to understand and verbalized her reluctance to collaborate, fear that I would exploit her, yet desires for help with her agency's work. I wondered out loud how we could be helpful, how students might learn working with her, and what we could create that would be of mutual support and interest. Realizing that I came with no clear answers to these questions, I acknowledged this as something to come out of our collaboration together. Further exploration and attunement to her desires and needs regarding collaboration, and my discussion of my interests in training students, our expertise and experience, advance our understandings of the other and facilitate the experience of trust and connection. A collaborative working partnership has formed and continues to evolve, changing what were organizing principles of viewing and relating to the other.

This brief vignette illustrates how clinical skills central to the relational process and successful outcome of psychotherapy may be applied to collaborative efforts in the field of international disaster psychology. When used in conjunction with a theoretical approach that is particularly depathologizing, partnerships in international disaster contexts developed and were enhanced.

References for this article can be found on our website: divisionofpsychotherapy.org

An Era Of Hope and Determination

Pat DeLeon, Ph.D., former APA President

Observers of the national political scene cannot help but be impressed by the unprecedented enthusiasm, energy; and most importantly, hope that pervades every public policy discussion. The demand for inauguration event tickets, the larger than life crowds at the gates; and the joyous response of those unable to get in, even with tickets, was surreal. Our President: "That we are in the midst of a crisis is now well understood…. Our health care is too costly, our schools fail too many…. Today I say to you that the challenges we face are real, they are serious and they are many …But know this America: They will be met…. We will restore science to its rightful place and wield technology's wonders to raise health care's quality and lower its costs…. What is required of us now is a new era of responsibility—a recognition, on the part of every American, that we have duties to ourselves, our nation and the world."

An Exciting Personal Observation: "On an icy, snowy January day in Washington, D.C., when many of the district's schools, federal offices, and private buildings were shut down, I attended my first Democratic Steering and Outreach Committee meeting… For this session, key advocates and allies from the women's advocacy community were invited to chat about expanding access to birth control and family planning services, as well as to discuss pay equity for women… Being a novice Congressional Fellow, I will naively admit that what I experienced is not what I expected. Anticipating a somewhat empty room due to the inclement weather, I was surprised to walk into nearly standing-room only seating.

"Presentations from these community advocates, young and old, male and female, offered uplifting briefs concerning the agenda items, with a closing by the Senate Majority Leader … emphasizing the concept of prevention through education and accessible and affordable services. What struck everyone in the room … was the fact that an unprecedented twenty-two United States Senators (22% of the Senate and 38% of the Democratic Party) found the topic important enough to attend this women's advocacy meeting on a snowy, wintery day in Washington, D.C. [Captain Jacqueline Rychnovsky, US Navy Nurse Corps]."

What The 21st Century Will Bring — Reflections: "'A journey of a thousand miles….' The words of Confucius come to mind as I reviewed the 25 year history of prescriptive authority (RxP) in Hawaii… In 1984, lone psychologist Sim Granoff took that first step by having a bill – authorizing psychologists to prescribe – introduced into the Hawaii legislature. This was the first RxP bill introduced in the country and the 50th State was the one to do it… Sim was the lone person to testify in favor of the bill.

"Since that time, dozens of RxP bills have been introduced in the Hawaii legislature and, with each passing year, we see the amount of support from the community increasing. I believe this is due in no small part to the fact that community members and community organizations see that we are in it for the long haul. We have not given up, despite many obstacles… Two years ago, RxP legislation passed through the Hawaii House and Senate. The key psychologists involved in that process, e.g.,

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Robin Miyamoto and Jill Oliveira Gray, worked tirelessly to get the bill through. Their job was only made possible by community organizations that supported the effort.

"This year, the RxP bill that is being introduced in the Hawaii legislature is not 'the psychologists'' bill. Rather, it is introduced and supported by key community-based organizations. The Governor—who vetoed the RxP bill two years ago and is now faced with reduced tax revenues from an economy in recession—has cut state mental health and general health care budgets significantly. Hawaii has … a severe shortage of psychiatrists willing to work in underserved areas; psychologists, on the other hand, can be found in most of the Federally Qualified Community Health Centers (FQCHCs) in the state. This year's bill authorizes properly trained psychologists working in FQCHCs to prescribe. It is a no-cost solution that will result in significant relief to those who require but cannot access medication-related mental health services. At the opening of our legislative session this year, I could not help but reflect on the contrast between our elected officials' attitude towards psychologists now vs. 25 years ago. Mahalo to the people in the community who continue to believe in us. Things are quite different. [Ray Folen]."

Community Involvement: "Aloha! Opening Day of the Hawaii State Legislature is Wednesday, January 21st. As always, the Hawaii Primary Care Association has a short list of policy and funding issues that we ask you to support in order to improve the health of our community. These are: 1. Maintain state funding for uninsured services…. 2. Prescriptive authority for psychologists…. [Hawai'i Primary Care Association]."

Memories: "…On February 18, 2005, the first prescription was written by a civilian 'medical psychologist' in Baton Rouge, LA under the new RxP law … Dr. John Bolter wrote the first prescription…for Remeron (for the trivia folks). This was an historic moment for the Louisiana Academy of Medical Psychology (LAMP), for the citizens of Louisiana, and for psychology as a profession..." "There are currently 48 medical psychologists with certificates of prescriptive authority in Louisiana. Of those, most are indeed prescribing …. I would venture to say that we have written more than 200,000…prescriptions for a little over three years now, … in a variety of settings …doing it safely… we have not had a single complaint against a medical psychologist… Even more than the prescription writing, those of us who are working in the community mental health centers have been called upon to order and review routine lab studies (October 7, 2008). [Glenn Ally]".

Prevention: As Jacque has noted, the time has come at the federal level for providing a high priority for Preventive Services, rather than exclusively focusing upon curative care. During our annual convention in Boston, I had the pleasure of meeting with the APA Working Group ... headed by Karen Saywitz, Director of the APA Violence Prevention Office, and hearing about groundbreaking efforts at CDC (the Centers for Disease Control and Prevention) to develop the concept of a series of high quality, research-based, pilot projects targeting child and family violence within our nation's community health centers....Young people, families, and communities across the nation are seriously impacted by violence.. Homicide is consequences of violence for victims and those exposed are severe… And, 1 in 3 African American males and 1 in 6 Latino males will enter the criminal justice system unless significant action is taken. Violence is preventable. [Prevention Institute]. Both APA and the National Association of Community Health Centers have been extremely supportive of CDC's vision of framing violence prevention within a pub-

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lic health context and we expect that in the near future, a comprehensive report will be released by APA highlighting psychology's potential contributions to this evolving national priority.

Accountability: A little over three years ago, the Institute of Medicine (IOM) released its report on Performance Measurement (December, 2005). Building upon the underlying concept that our nation's health care system should be Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable, the IOM called for a informed national effort to standardize measures that can lay the foundation for an appropriate health care incentive system targeted towards nationally agreed upon goals and objectives. Calling for evidence-based approaches and strategies …formed by consensus in order to change the health care environment to improve health outcomes for all: "The only way to know whether the quality of care is improving is to measure performance." And, "(M)easurement itself must not be viewed as capable of improving care, but as a catalyst for actions that can do so." Today, on average, adults in the United States fail to receive almost half of the clinical services from which they would likely benefit. Racial, ethnic, and class disparities are pervasive, while the number of uninsured continues to rise. We anticipate that the unprecedented advances occurring in communications technology (i.e., Health Information Technology) will revolutionize healthcare delivery.

The Senate version of President Obama's Economic Stimulus legislation provides $85 million for health information technology activities within the Indian Health Service; including $30 million for clinical applications, information technology infrastructure, and national program support. The Office of the HHS Secretary (the Office of the National Coordinator for Health Information Technology) will receive $5 billion for health information technology (IT) activities. "Information technology systems linked securely and with strong privacy protections can improve the quality and efficiency of health care while producing significant cost savings…" An additional $5.8 billion has been provided for various Prevention and Wellness activities, "with every expectation that these programs and activities will be sustained through health care reform." Finally, "the Committee recommends that up to $5,000,000… be used to foster cross-state licensing agreements that allow specialists to treat patients via telemedicine…." The Past is indeed Prologue for the Future. Aloha,

Pat DeLeon, former APA President –
Division 29 – February, 2009

BOOK REVIEW

Hurry Down Sunshine

Author: Greenberg, Michael (2008) **New York: Other Press**

Erin Jacklin, M.A., University of Denver Graduate School of Professional Psychology

Michael Greenberg's *Hurry Down Sunshine* is a compelling addition to the body of literature about coping with mental illness. This book is of particular note in that it explores the experience of a father dealing with his daughter's startling "crack up" the summer before 10th grade and her subsequent hospitalization with the diagnosis of Bipolar I with psychotic features. Greenberg goes beyond the exploration of a father's attempts to deal with his daughter's sudden onset of mental illness and expands his memoir into a subtle yet powerful examination of family dynamics that feels deeply personal yet resounds with universal themes.

At times the memoir reads like a fiction book one is loath to put down. Greenberg's use of rich visual imagery engages the reader, and his well-drawn backdrop individualizes the tale. His attention to locating his story in a specific time and place works to draw the reader in while also serving as a reminder that though it may read like fiction, the events depicted really did take place to a real family, over a real summer, in a real city. The book takes place during an unseasonably hot summer in New York City; Greenberg paints the scene with rich detail, noting how after most of his neighbors have left for cooler climes over the July 4th weekend, his street "has succumbed to a state of slow-motion splendor."(9) The way the author weaves headlines and snapshots of TV news coverage into this stirring memoir fills out the richly drawn picture. This device also reminds the reader that in the midst of a family crisis, life goes on as usual; the world keeps moving forward even as Greenberg and his family remains stuck in the timelessness of a psychiatric hospital ward.

Greenberg waited many years after the transformative summer of his daughter's diagnosis before completing this memoir, and the perspective gained through the years is apparent in the text. The delicacy with which Greenberg tackles writing about his child's mental illness is notable. Greenberg took his task seriously, and discussed the potential book with his daughter, Sally, who responded by asking him to use her real name. He also shared the text with his daughter and other family members featured in the text prior to its publication.

Another potential benefit of waiting to write this memoir is that Greenberg resists the temptation to sensationalize his daughter's decent into psychosis while acknowledging the allure of mania, especially in light of the drive towards creativity. Before the crisis of her psychotic episode, Greenberg notes how excited he was to see his daughter, Sally, staying up all night engrossed in Shakespeare's sonnets. After struggling to learn to read for years, he believes "if she is up all night it's because she is savoring every minute of victory after the trails of those years." (9) Only later does he realize that this sudden zest for learning was an early sign of her mental illness.

His daughter's grand epiphany during the height of her first breakdown is that children all lose their innate genius through

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socialization,

> "Genius is not the fluke the want us to believe it is, no, it's as basic to who we are as our sense of love, of God. Genius is childhood. The Creator gives it to us with life, and society drums it out of us before we have the chance to follow the impulses of our naturally creative souls. Einstein, Newton, Mozart, Shakespeare—not one of them was abnormal. They simply found a way to hold on to the gift every one of us is given, like a door prize, at birth." (18)

Though this idea comes out of the psychosis of her first manic episode, the statement rings true on some level, and feels particularly compelling coming from a child who struggled significantly to adjust to the demands of school, one of our primary means of socializing the young. Something is indeed lost of the innate creativity of childhood when a child enters school and strives to fit within the boundaries of society. This was particularly true in Sally's case; Greenberg refers to her first day of school as, "the day Sally's childhood faded." (7) Sally's epiphany and subsequent descent into a psychotic break highlights the sometimes blurry line between creative insight and madness, especially in manic episodes associated with Bipolar 1 disorder. When first dealing with her hospitalization and diagnosis, Greenberg asks, "how does one tell the difference between Plato's 'divine madness' and gibberish? between *enthousiasmos*…and lunacy?"(49)

Hurry Down Sunshine also tackles the difficult identity issues raised by a severe mental health diagnosis. Greenberg wonders about who Sally is beyond her illness; what of the lively personality he treasured was really just a precursor to her illness? When early on Greenberg hopes aloud that this will pass and Sally will return to her "old self" his wife Pat perceptively notes, "We may have to ask ourselves who Sally's 'old self' really is." (21) As the truth of the situation sinks in, Greenberg continues his struggle to feel he *knows* his daughter, "has she changed so completely or is it that I never knew her?" he wonders (49).

Sally, already engaged in the adolescent task of forming her identity at the time of her breakdown, struggles to redefine her self-concept in light of her diagnosis with a serious mental illness. Both father and daughter toy with the hope that the summer of Sally's hospitalization will be a one time event, and that things will magically go back to the way they were before, only with medication. Thankfully, Greenberg doesn't shy from the complicated truth of managing mental illness, and his sobering postscript underlines the truth of the lifelong journey of living with Bipolar.

Greenberg does a salutary job exploring the implications of a mental health diagnosis such as Bipolar on his daughter and his family. For example, as Sally prepares to return to high school in the fall after her first episode, the family struggles with when or if to share the events of the past summer with others. Sally's brother suggests she keep the events of the summer to herself, for fear of what others may think. Even with all the professional help and family support one could hope for, Greenberg reminds the reader of the harsh reality that teens really are on their own to negotiate the sometimes perilous waters of the high school social world alone. Sally handles this challenge gracefully, and creates strong friendships with her peers. Perhaps a sign of the changing cultural meaning of mental illness is that Sally's eventual disclosure of her diagnosis to three close friends is met with surprising acceptance, "Being an alumna of the psych ward confers social status on Sally. It's a kind of credential." (227)

One of the great strengths of this book is in the author's unwavering honesty about his

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own disillusionment and fears. Though gifted with the wisdom that comes from time, Greenberg is unwavering in his portrayal of his own doubt and fears at the time of his daughter's crisis. He lends helpful insight into how confusing and frightening it can be to interact with mental health professionals, especially in an inpatient setting. There is an important lesson in the book for all mental health professionals to take to heart about how we interact with the families of our patients, and how we may be perceived.

In sum, Greenberg has made an important contribution to the literature in this area. He fills in a needed voice in the memoir literature about Bipolar, the parent's perspective. He appears to have taken on this task with grace and humility and the end result is a worthwhile read for clinicians and laypersons alike. This book gives helpful insight into the experiences of a family coping with a serious mental illness for the first time and their journey towards rebuilding their lives in the wake of a crisis. *Hurry Down Sunshine* leaves the reader hopeful about the potential to live with a mental illness such as Bipolar, but sobered by the reality of how life-altering such a diagnosis can be to the individual struggling with the disorder as well as his or her family.

ANNOUNCEMENT

Dr. Louise Evans, Diplomate of the American Board of Professional Psychology, and Fellow of Division 29, has been appointed by the American Biographical Institute (ABI) as a Founding Member of its International Women's Review Board. Dr. Evans will serve as an advisor representing the United States to recommend outstanding women worldwide for recognition whose achievements excel and inspire others. The ABI is a biographical reference publisher with over 200 separate titles in print published over the last 41 years.

Dr. Evans' biography is included in numerous ABI titles and will be in forthcoming *200 Outstanding Scientists of the 21st Century* (2009), *Great Women of the 21st Century, International Profiles of Accomplished Leaders,* the inaugural edition, and *International Who's Who of Business and Professional Women,* tenth anniversary commemorative edition. Quoting the editor's press release for the latter reference book, "Dr. Evans' appearance within the volume will add integrity to the series due to her distinguished achievements …[she] is to be commended for outstanding accomplishment that sets a standard for other women and gives future generations a role model to follow."

Nancy L. Murdock, Ph.D.

Nancy L. Murdock is Professor and Chair of the Division of Counseling Psychology at the University of Missouri-Kansas City. As past chair of the Council of Counseling Psychology Training Programs and Vice President for Education and Training of the Society of Counseling Psychology, she has been continuously engaged in furthering professional psychology for most of her career. Her book, Theories of Counseling and Psychotherapy: A Case Approach (Pearson/Merril, 2008) is in its second edition, and presents a unique video accompaniment featuring the client Helen and her six psychotherapists. Dr. Murdock is delighted to have been elected a Fellow of Division 29.

I am deeply honored to be nominated for the position of president-elect of the Division of Psychotherapy. Over the past two years, I have greatly appreciated the opportunity to serve as APA convention program co-chair (with my able colleague, Chris Brown) and serve as an editorial board member for the division's journal.

The Division of Psychotherapy provides a unique opportunity for APA members to cross professional lines to unite in the study of the intervention so critical to professional psychology. We are valuable advocates and educators, active in psychotherapy research and in the larger psychological community. As convention program chair, I have been amazed at the diversity and quality of our programs. I have also observed that our programming routinely attracts large audiences, and I suspect that many of those who attend are not members of the division.

These observations bring me to my vision for the future of Division 29, which is to *spread the word*. I humbly submit that my idea is not an original one; current initiatives in this area are bubbling in the division, led by our very able board. As president-elect, I would work to use the resources of our membership to develop new and innovative ways to further these efforts. Several tentative ideas include (a) using the convention programming to further highlight our membership's achievements through presenting awards or fellows addresses and (b) considering the development of special interest groups within the division, and (c) continuing the work on our internet presence that has been a recent focus of our current leadership and (d) initiating joint efforts with other divisions of APA that have members interested in psychotherapy.

Thank you again for the honor of this nomination.

Elizabeth (Libby) Nutt Williams

Now in my 5th year on the Division 29 Board, I am excited to run for President. I care deeply about the Division and would be delighted to have the privilege of continuing to work on behalf of its members. When I recently asked the Board to tell me why they thought people were members of 29 (in an exercise to ensure we are meeting our members' needs), one of the best responses was that we are passionate about psychotherapy and psychotherapy research. The people I have met in Division 29 are indeed passionate … about psychotherapy, about research, about social justice, and about people in general. Our new slogan (Be Connected) is all about that passion – we are connected to one another and need to develop and sustain those connections.

To that end, I see three areas of connection as critical. First, our President-Elect, Jeffrey Magnavita, has highlighted our need to be connected with our members and the public via the electronic world. I strongly support our need to re-energize our web presence (a task force is already hard at work). I am also committed to reviewing the online services we offer (and could offer) and developing new ways to connect with our members.

A second focus of mine, in contrast to the first, is to focus on the in-person aspect of connection. Though I recognize the need for virtual social networking (and the ways it can facilitate communication), I also believe we need ways to connect more personally. We need to honor the activities that bring us together in social ways, such as our social hour at APA and the Lunch with the Masters developed for our graduate students and early career psychologists. One very important piece of our interpersonal connection is the Division's commitment to diversity. Our President Nadine Kaslow has organized a committee to provide a strategic plan for diversity, which I think is absolutely critical for our Division's health and vitality.

A third connection I am very invested in is the connection between science and practice. I am, as many of you are, interested in fostering stronger connections between researchers and practitioners (with innovations already in use such as Practice Research Networks/PRNs, the News You Can Use articles initiated by Past President Jeff Barnett, the Practice Reviews in our premier journal *Psychotherapy* developed by Charlie Gelso, and our strong relationship with the Society for Psychotherapy Research/SPR).

Finally, I believe Division 29 faces a definitional challenge. We are not an "identity" division (e.g., Divisions 12-Clinical and 17-Counseling) and we are not a specific focus division (e.g., Divisions 42-Independent practice and 49-Group psychotherapy); our members reflect a cross-section of psychology. Thus, we are challenged to be a place where connections among people dedicated to psychotherapy are fostered. I would be honored to continue to work on fostering these connections as the Division 29 President. Thank you for your consideration. (Given space limitations, I did not include my credentials here. For more information, please see: http://www.smcm.edu/psyc/FacultySites/enwilliams/index.html .)

Steve Sobelman, Ph.D.

Thank you for the opportunity to continue to serve Division 29 as your Treasurer. I am pleased to report that even during the current economic downturn, the Division is in good financial shape. In addition to serving Division 29 as the Treasurer for the past term, I served as CE Chair and a member on the Finance Committee.

My professional life is split between two worlds—psychology and corporate America.

I spent many years teaching, practicing, and advocating for psychology through various leadership positions. I served as President of Division 49 as well as the Maryland Psychological Association. I currently serve on the Board of Examiners of Psychologists. I also maintain a private psychotherapy practice and was a fulltime faculty member and director of graduate programs in psychology at Loyola College in Maryland. And, I was founder and clinical director of a large private mental health facility in the Baltimore Metropolitan area.

As for my other professional world—I am the CEO of a mid-sized and growing IT company, where we specialize in Electronic Medical Records. Through my business ventures, I've had significant experience with investor relations and venture capital exploration and have learned fiscal responsibility by growing the company ceiling while being mindful of the company floor.

As your Treasurer, I have brought and will continue to bring a vigilant and progressive approach to fiscal responsibility. My early initiatives have been reached as we have: 1) created a working finance committee; 2) provided approaches for increasing non-dues revenue, e.g., online CE workshops; 3) provided an initiative for a Division stock portfolio; and 4) will continue to explore incentives for value added services to the membership.

I strongly believe that "if you want to get something done, you give it to a busy person." I'm a busy person and will "get it done" for you again. Thank you for your consideration and I welcome your vote.

Candidate for Education & Training Domain Representative

Sarah Knox

It is indeed my honor to be invited to run for Division 29's Domain Representative for Education and Training. Were I elected to this position, my goal would be to continue to build and strengthen the relationship between the Division's Board of Directors and the Education and Training Committee as each pursues vital efforts to support quality graduate training in psychology, especially that related to psychotherapy.

I have most recently served the Division as Chair of the Research Committee, and continue to serve as an Editorial Board member for the Division's journal. I have also been the Director of Training for Marquette University's counseling psychology doctoral program since 2006, and much of my research focuses on training-related concerns (e.g., psychotherapy supervision, advising, dissertation processes). Having been the recipient of superb training as a doctoral student at the University of Maryland, I know well how profoundly my experiences there shaped and influenced me not only as a student, but also in my professional career. Furthermore, I came to psychology after an 11-year career as a high school English teacher, so education and training concerns have been part of my professional identity for quite some time.

My current role as a faculty member certainly keeps me engaged in education and training, as well. Whether teaching new graduate students the basic helping skills, mentoring advanced doctoral students in their psychotherapy-related research, or shepherding future interns through the application process, I am vitalized by working with those preparing to enter our profession, knowing that the better I serve them, the better they will serve their future clients, students, supervisees, or research participants. I would be thrilled, then, to have the opportunity to give back to the profession that has given me so much, and thereby support exemplary education and training in psychotherapy.

Chaundrissa Oyeshiku Smith, Ph.D.

Like many, I maintain multiple roles. I am a professional woman, wife, mother, daughter, sister, and friend. These roles are not separate entities, but are interconnected components that comprise my identity. Professionally, I am considered an "early career psychologist" though this hardly encompasses my view of myself and my career. Here, I am an educator and a student; a mentor and a mentee. I am an individual who has been fortunate to reap the rewards of remarkable education, training, and mentorship via graduate study in clinical-community psychology from the University of South Carolina and predoctoral internship and postdoctoral fellowship at Emory University School of Medicine's Department of Psychiatry and Behavioral Sciences. I am a lifelong learner who will continue to develop and grow as a practitioner of psychotherapy.

Similar to my personal view of interconnectedness, I strongly believe in and support the Division motto "Be Connected." I

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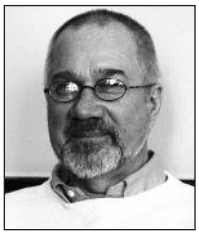
Candidate for Diversity Domain Representative

John C. Gonsiorek, Ph.D., ABPP



I received my Ph.D. from the University of Minnesota in Clinical Psychology in 1978, and am a Diplomate in Clinical Psychology of the American Board of Professional Psychology. I served on the Executive Committee of American Psychological Association Division 44, eventually being elected President. I have published widely in the areas of professional misconduct and impaired professionals, sexual orientation and identity, professional ethics, and other areas. I am a fellow of APA Divisions 9, 12, and 44, and most recently, Division 29. Currently, I am an Associate Professor in the PsyD Program at Argosy University/ Twin Cities, and a consultant to Blue Cross Blue Shield Minnesota and other organizations.

For 25 years, I maintained an independent practice of clinical and forensic psychology in Minneapolis. My clinical work focused on sexuality issues, and my forensic practice focused on expert witness evaluation and testimony regarding impaired clergy and professionals, standards of care, psychological damages, and malpractice. Since 2007, I have been a consulting editor for *Professional Psychology: Research & Practice*, and also served in that function from 1990-1994.

The current focus of my work in diversity is on the challenges of integrating multiple aspects of identity, especially when these are in conflict. Recently, I was part of the group that developed, and was one of the primary authors of, the document adopted in 2007 by APA as the *Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice*. The Resolution is an example of the nuanced balance among different aspects of identity which I believe psychology is increasingly called upon to navigate. The practice of psychotherapy is a core area where psychology must adapt its techniques across a broad range of diversities. I would be honored to play a leadership role in Division 29 as Diversity Domain Representative to help effect this evolution.

Erica Lee

I am delighted to be a nominee for Division 29's Diversity Domain Representative seat. I bring to the candidacy experience in the area of psychotherapy as a clinician, supervisor, administrator, and researcher. My publication and grant activities focus on young adults with serious mental illness from psychosocial and psychotherapy perspectives as well as psychosocial rehabilitative training. My interests are in the delivery of mental health services to diverse, disenfranchised, and underserved individuals.

Currently, I am a full time Assistant Professor in Emory University School of Medicine's Department of Psychiatry and Behavioral Sciences, and the Associate Director of Grady Memorial Health System's Department of Psychiatry Adult Day Services Program. As a faculty member, I am involved in psychotherapy training and supervision with practicum students, interns, postdoctoral fellows, medical students and psychiatry residents. As

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Erica Lee Candidate Statement, continued from page 56

an administrator, I ensure that the provision psychotherapy services are professional, collaborative, organized, and supportive. I believe these experiences have provided me with the leadership and organizational skills necessary to serve as Diversity Domain Representative. I am devoted not only to education and training in psychotherapy but also to enhancing understanding of the benefits and value of psychotherapy in mental health services at local, regional, and national levels. I serve as an advisory board member for a non profit program for survivors of domestic violence and participate in several community outreach and service efforts.

I have enjoyed tremendously the opportunity to be involved in Division 29's board activities during my appointment as Domain Diversity Representative. As an African American female, I am especially committed and dedicated to furthering the awareness of and sensitivity to diversity issues as they relate to psychotherapy at all levels and am encouraged by being a part of the division's efforts in this area. I have been fortunate to work with board members and my diversity domain co representative to organize board diversity training, to develop a diversity domain mission, to procure submissions to *Psychotherapy Bulletin* with focus on diversity, and to develop a division diversity committee.

If elected to serve, I would help ensure that APA policies were sensitive to issues related to diversity and that all APA initiatives include a diversity perspective. I would greatly appreciate the opportunity to continue to serve as Diversity Domain Representative.

Chaundrissa Oyeshiku Smith, Ph.D. Candidate Statement, continued from page 50

view this theme as essential to education and training in psychotherapy. "Be Connected" reflects the dynamic process in which ongoing dialogue and interchange between psychologists and their patients, students and supervisors, mentors and mentees, and scientists and practitioners guides the future and sustainability of psychotherapy as the foundational hallmark of psychology. As a field, we must be able to stay connected at these multiple levels, just as we stay interconnected across our own multiple roles.

I am truly honored to be nominated for the position of Education and Training Domain Representative for Division 29. I currently serve as the Chair of the Membership Committee and have worked to enhance the diversity of the Division's membership through grassroots recruitment and retention strategies. As Domain Representative of Education and Training, I will focus on maintaining collaboration, communication, and connectedness across these multiple entities in order to enhance the science and practice of psychotherapy.

Candidate for Professional Practice Domain Representative

Miguel E. Gallardo, Psy.D.

I am honored to have been nominated as a candidate for the Professional Practice Domain. I have a long history of advocacy in organized psychology, both nationally and statewide. I currently serve on the Board of Directors of Division 42 as a Member-at-large representative and as past-president of the California Psychological Association (CPA). Additionally, I was recently appointed to serve on APA's Committee on Ethnic Minority Affairs (CEMA). My involvement in advocating for the professional practice of psychology and multicultural issues reflects not only my organized psychology experiences, but also my professional experiences as a psychologist. I currently serve as an Associate Professor of Psychology at Pepperdine University's Graduate School of Education and Psychology and also maintain a part-time independent practice. My professional work involves conducting research in psychotherapy with Latino clients, operationalizing APA's Evidence-Based Practices in therapy with diverse populations, and working therapeutically with a diverse clientele in my practice.

In my most recent role as President of the CPA, I worked very hard to extend psychologists impact beyond our own borders. I believe we need to build relationships with those outside psychology, move away from only talking to ourselves, engage in active public education, and continue to strengthen the practice of psychology among the nation's long-term health-care plans. Additionally, we need to ensure that the Division, and its members, continues to evolve as we attempt to address the needs of a demographically diverse nation. It is critical that we continue to work with our colleagues in other divisions and disciplines to work towards this end.

I am pleased to be considered a candidate for this position and believe that my experience in organized psychology, combined with my professional work as a psychologist, position me well to represent the professional practice of psychology. Thank you for your consideration and vote.

Candidate for Membership Domain Representative

Annie Judge

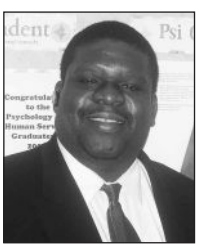
I am very excited to seek the Domain Representative for Membership position. I have served as the Chair of the Membership and Continuing Education Committees for the Division, and in both roles, I continually asked, "What can the Division do for its members?" Schedules are busy, economic times are hard, and members need to know that the Division can "do something" for them; otherwise, they will find a home elsewhere.

Practitioners and scientists benefit greatly by connecting with each other. Students, early career psychologists, and more seasoned psychologists have much to offer each other. And when psychologists with diverse backgrounds connect with others in meaningful ways, we personally benefit; our students, clients, and patients benefit; and our field broadens.

Someone just needs to facilitate those connections, and I believe Div 29 is just right for the task! I find Division 29 to be an inviting home within APA, and my goals as a Domain Representative would be to (1) strengthen connections that members have with each other; (2) expand our membership roster, not only in terms of quantity, but also in terms of diversity; and (3) work with the Board to make Division activities and offerings most beneficial for all of its members—students, early career psychologists, and seasoned professionals alike.

In my role as Chair of the Membership Committee, I helped to create the new Division 29 slogan: Be Connected. The slogan is simple, yet it captures everything that I would hope to address as a Domain Representative for Membership. I would greatly enjoy the opportunity to help members connect with each other through technological advances, research, professional consultation, mentoring, CE offerings, and the like, and I would hope to help members answer the question "What can Division 29 do for me?" with a clear response: "a great deal."

Samuel J. Maddox, Ph.D.



I am honored to be considered for nomination for the position of Domain Representative for Membership for Division 29. I earned my Bachelor of Arts in Psychology from Morehouse College in 1997 and my Ph.D. in Clinical Community Psychology from the University of South Carolina. Through internships with the Marcus Institute, postdoctoral training with the Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine and independent private practice with Floortime Atlanta, I have gained extensive experience working with families of children with a variety of developmental, behavioral, emotional and academic difficulties. The services that I have provided include psycho-educational assessments, individual child therapy, family therapy, parent training and consultation.

My desire as a psychologist is to facilitate the delivery of empirically supported treatments to youth in underserved communi-

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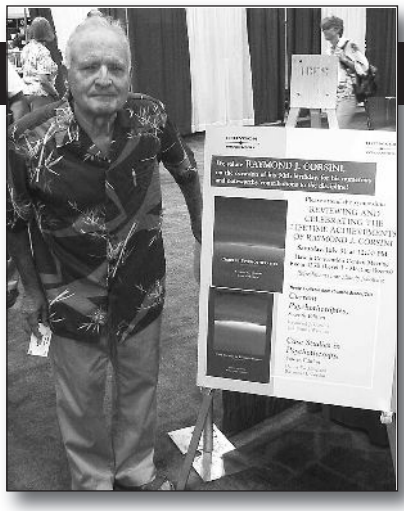
OBITUARY

Raymond J. Corsini, Ph.D. (1914–2008)



Raymond J. Corsini, one of the great psychologists of this era, passed away on November 8, 2008, at the age of 94 in Honolulu, Hawaii. With his accomplished wife, Kleona, a medical doctor, he was a resident of Hawaii since 1970, and he contributed widely to the welfare of Honolulu and its environs through his *pro bono* services to various school and church organizations. Dr. Corsini pioneered radical innovations in school psychology, prison psychology, community psychology, psychodrama, and clinical psychology, and he publishing widely in these various domains. In his own words, he sought to ". . . afflict the comfortable, and comfort the afflicted."

More remarkable still is that in his 70s and 80s he developed world-class reference works as an encyclopedist (The Corsini Encyclopedia of Psychology) and lexicographer (Corsini Dictionary of Psychology). His textbook, *Current Psychotherapies*, co-edited with Danny Wedding, is considered the best textbook in psychotherapy education and supervision. Dr. Corsini was born in Vermont to impoverished Italian immigrant parents, and spent much of his youth in New York City before accepting professional positions in California and Illinois. He received his doctorate in clinical psychology from the University of Chicago and subsequently trained at the Alfred Adler Institute in Chicago.

Dr. Corsini was an indefatigable scholar and continued to work daily in the last months of his life, when he was overcome with crippling back and pulmonary problems. His encyclopedias, handbooks, dictionary of psychology and other reference works, textbooks, and specialized books number more than 40, and many are now being digitized as an enduring part of his legacy to psychology and related mental health and educational fields. But he was not just a scholar. He worked for much of his life as a prison psychologist, a clinical psychologist, teacher, and community organizer. These signal contributions to the larger community were consistent with his profound Adlerian conviction that an individual's primary responsibility was to actively contribute to the health, integrity, and wellbeing of their community—they must demonstrate "social interest." In 2003, the Hawaii Psychological Association honored Dr. Corsini with its Lifetime Achievement Award, the highest honor the Association can bestow.

Finally, it must be noted that he considered his development of "Individual Education," (also known as the Corsini 4-R System), an educational and school administration system that has now taken root in various parts of the world, as the most important intellectual achievement of his life. This system is rooted in democratic principles of interaction between teacher, pupil, and family. Raymond Corsini is survived by his wife, Dr. Kleo Rigney, his daughter Evelyn Corsini, and three step-children, Michael Rigney, Roberta Rigney, and Jon Rigney.

Anthony J. Marsella, Ph.D.
Past President, Psychologists for Social Responsibility 2007-2008
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