Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

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2009 VOLUME 44 NO. 2

Division of Psychotherapy ■ 2009 Governance Structure

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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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PSYCHOTHERAPY BULLETIN

Published by the
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PSYCHOTHERAPY BULLETIN

Official Publication of Division 29 of the American Psychological Association

2009 Volume 44, Number 2

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EDITORS' COLUMN

Jenny Cornish, Ph.D., ABPP, Editor
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It is with great pleasure that we offer you this second issue of the *Psychotherapy Bulletin* in 2009. We are again impressed by the outstanding ideas and excellent writing provided by our wonderful contributing editors and guest authors.

In this issue you will find informative and helpful reports from our president and APA Council representatives, giving insight into and providing transparency of the governance processes in our Division and APA. The Practice submission for this issue is written by Bonita Cade, Division 29 Federal Advocacy Coordinator, who reports on the recent State Leadership Conference. Once again, Pat DeLeon has written a compelling Washington Scene article for us. In addition, the Diversity and Public Policy and Social Justice Contributing Editors have contributed an excellent article focused on concrete ways to increase diversity in Division 29 governance.

Several Research articles are included on a variety of topics including motivational interviewing, a treatment preferences interview, and what science "looks like." In addition, the Ethics contribution this issue is on the use of deception in research.

Be sure to also read the paper on integrated treatments for trauma and co-occurring disorders. Continuing the trend in recent issues, we also have another book review for you. You will also enjoy the thoughtful Education article by Michael Murphy related to changes in the sequence of training, and consequent recommendations for practicum training. While we applaud the attempt to better regulate practica, we agree that the current recommendations go too far.

The Early Career Professional submission this issue is on a topic close to our hearts: combining the roles of parent and psychologist. Jenny has three sons (ages 21, 23, and 25) and Lavita has an adorable daughter (age 5); we continue to be amazed at how much we learn from our children, and how they enrich our professional careers.

You will also note that this issue is in a slightly different size. We are experimenting with this smaller version to help reduce costs while making the *Bulletin* distinct from other division newsletters. We are also now printing the reference sections of papers online. Please let us know what you think of these changes.

Finally, please know that we retain our strong commitment to the *Bulletin* as a creative outlet for <u>all</u> Division 29 members. The next issue of the *Bulletin* will include information related to the summer APA convention in Toronto (including the Division 29 program and the super fun social hour). We warmly welcome your ideas, suggestions, and submissions!

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PRESIDENT'S COLUMN

Nadine J. Kaslow, Ph.D., ABPP
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Psychotherapy and the Economy

I am writing this column as we find ourselves in the midst of an economic recession. There is no question that this recession has deeply impacted our work as psychotherapists. More and more, our patients are talking with us about their economic woes, anxieties, and fears. Some patients are having to discontinue therapy or reduce the frequency of their sessions or are requesting reduced fees. Some psychotherapists are fearful that their practice revenues and caseload will significantly decline.

And yet, there is some indication that a down economy is associated with a boom in therapy practices. There is evidence that requests for therapists have increased 15-20% recently in response to people's concerns about their financial situation, with many people reporting that their financial worries are their primary reasons for initiating psychotherapy. It is understandable that the economic downturn and higher rates of unemployment result in people feeling more stressed, helpless and hopeless, angry, anxious and afraid, depressed, and often times suicidal because they feel they feel trapped by this economic disaster. Indeed, in recent months, we have witnessed the tragic suicides and murder-suicides of people whose lives have been dramatically altered by this economy. Not only are people suffering personally, but there appears to be more relationship discord and arguments related to increased financial strife.

In order to best help our patients during these challenging economic times, our therapeutic encounters need to assist people in both concretely and emotionally coping adaptively with the ways in which the economy is negatively affecting their lives. We need to aid people with problem-solving creatively, working collaboratively, taking action, counteracting the lethargy and apathy that often sets in when people feel economically overwhelmed, and recognizing the positives in their lives.

As more people seek our services in response to their economic struggles, there may be a decline in the stigma associated with mental health care and we need to capitalize on this greater openness within the country about engaging in psychotherapy. Interestingly, the media increasingly is recommending therapy for helping couples effectively address the relationship stresses that are magnified by the economy, as well as assisting individuals in managing their anxiety regarding how the economy is impacting their quality of life, sense of isolation, self-esteem, and relationships with family members (partners, parents, and children). Psychologists can partner more effectively with the media to convey to the public the ways in which psychotherapy can be invaluable when confronting economic hardship. It is my sincere hope that as psychologists and psychotherapists, we will commit to finding ways to make psychotherapy more affordable to people from all walks of life, so that everyone who wants our services can access them during this down economy (and in the years to come). Of course, these times also highlight for us more than ever the necessity of ensuring that parity for mental health care truly becomes a reality.

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Presidential Priorities

One of the most gratifying aspects of serving as the President of the Division is that I have the opportunity to focus on aspects of the broad field of psychotherapy that are particularly meaningful to me. In this column, I want to address two of these priorities: Diversity and Psychotherapy Supervision.

Diversity

The Division 29 leadership has prioritized diversity as a key area of focus for 2009. This emphasis is consistent with my own clinical-research focused on culturally competent, gender sensitive, and developmentally informed interventions. We held a one day diversity training for the governance of our division in January 2009 in conjunction with our board meeting. We are hopeful that through honest discourse, dialogues about cross cultural communication, attention to subtle biases, and personal self-reflection and sharing that we can strengthen our commitment to mutual respect for and understanding of one another; increase our cultural awareness, knowledge, and skills; improve the overall climate of our workgroup; and encourage greater creativity and flexibility among the members of the board. Greater sensitivity to diversity will afford us better opportunities to optimize our performance and be more innovative and responsive. I also firmly believe that this process will enrich us each individually in our own work settings and in the psychotherapies in which we engage. Further, it is my hope that the discussions that we had will lead us on a path to creating a valuable product or set of products for our membership that relate to ways in which psychotherapists can be mindful of the ways in which their own diversity characteristics influence their therapeutic endeavors with their patients. I am grateful to members of the division's diversity committee (Drs. Armand Cerbone, Jennifer Kelly, Erica Lee, Caryn Rodgers) for spearheading this effort. In addition, as a follow-up to this event, Drs. Erica Lee and Caryn Rodgers, the Diversity Domain Representatives on the Division 29 board are co-chairing a diversity strategic planning initiative for the division. We will share the details of this plan with you as they become available.

Over the past decade, there has been growing attention paid to the individual and cultural characteristics of our patients and ways to ensure that our psychotherapeutic endeavors are mindful of these factors. However, much less focus has been given to the cultural being of the psychotherapist. Therefore, I am very pleased that Dr. Jennifer Kelly and I will be co-editing a special issue of *Psychotherapy: Theory, Research, Practice, Training* on diversity characteristics of the psychotherapist and how these influence the psychotherapeutic relationship and process. It is so essential that each of us in our role as psychotherapist be mindful of the impact that our own gender, age, gender, race/ethnicity, sexual orientation, ability status, religious beliefs, social class, etc., have on the psychotherapy that we practice and the ways in which we are experienced by our patients, both those who are similar to us and those who are quite different from us.

Psychotherapy Supervision

I have a longstanding passion for psychotherapy supervision. As one of my Presidential Initiatives, I want to further advance the art and science of psychotherapy supervision. I am grateful to Dr. Charles Gelso, our fabulous and very collaborative editor of *Psychotherapy: Theory, Research, Practice, Training* who has graciously agreed to commit a special section of the journal to ways in which different theoretical approaches to psychotherapy supervision inform the development of psychotherapy competencies in trainees. I am indebted to Dr. Eugene Farber, Chair of Division 29's Education and Training Committee, who has agreed to spearhead this special section, which will include pa-

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pers related to cognitive behavior, psychodynamic, family systems, and existential/humanistic perspectives. From their respective theoretical vantage point, these articles will address the essential components of the psychotherapy competency, foundational and functional competencies informing the psychotherapy competency, and psychotherapy competencies in the supervision process. Illustrative vignettes will be used to highlight key points and dialogues between supervisors and supervisees. I am very excited about this special section.

APA Convention

I would like to take this opportunity to share with you the Division's plans for the upcoming APA Annual Convention that will be held in Toronto, Canada from August 6, 2009 – August 9, 2009. I am delighted that we have a diverse range of symposia, posters, and conversation hours. These presentations address the breadth of the field of psychotherapy, with attention paid to practice, science, education and training, and policy. Here is a brief overview of the formal and informal activities of the Division of Psychotherapy. Our programming promises to be engaging, interesting, and thought-provoking. I want to express my gratitude to our Program Committee Chair and Associate Chair, respectively, Drs. Nancy Murdock and Chrisanthia Brown. They have put together more than 15 sessions of high quality programming. More details on these events can be found in the APA Program Book.

This year, APA is organizing a Convention within a Convention, with divisions collaborating and offering more thematic programming. Division 29 is participating in the Convention within the Convention for a two- hour symposium on Evidence-based Practice— Using Evidence-Based Principles to Optimize Clinical Process and Outcome with Personality Disorders. The presenters are Jeffrey Magnavita and Kenneth Critchfield. This event is scheduled for Saturday, August 8 from 3–4:50pm in the Metro Toronto Convention Center, Meeting Room 714A.

We will sponsor symposia on Thursday through Sunday. The Thursday symposia include: Existential – Humanistic Therapy Come to Life; Two Viewpoints on Future Directions for Alliance Theory; Process and Outcome in CBT—The Importance of Cognitive Errors and Coping; Getting Real in Psychotherapy—Explorations of the Real Relationship; What We Wish We Had Known—Tips for Future Psychotherapists; and Using a Training Center Database to Promote Science and Practice. The Friday symposia include: The Art and Science of Impact: What Psychotherapists Can Learn From Filmmakers and Social Psychologists; and Eminent Psychotherapists Revealed—Audiovisual Presentation of Principles of Psychotherapy. On Saturday, symposia continue with: Psychotherapists Expertise—Developing Wisdom to Guide Theory, Research, and Practice; Mistakes in Psychotherapy—Yielding Power, Constraining Dialogue, and Nurturing Envy; and Schema Therapy for BPD— Breakthrough Treatment for Improving Life Functioning. Sunday's symposia programming includes: Affect Phobia, Treatment Approach—Two New Pathways to Change; and Culturally Informed Interventions with Ethnically Diverse Populations.

In addition to the aforementioned symposia, Division 29 is hosting a Poster Session on Friday. The focus of this Poster Session is on Research in Psychotherapy.

There will also be a conversation hour on Saturday that will consist of lunch with Masters for Graduate Students and Early Career Psychologists.

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The Division 29 Business Meeting is on Friday from 5:00 pm to 5:50 pm. At this meeting, we will honor our award recipients. In addition, we will provide an update on divisional activities and invite our members to engage with the board in a dialogue about the future of the division and of psychotherapy. We also plan to have some fun entertainment.

Finally, on behalf of the Division 29 Board, I want to cordially invite all members of the division and those interested in joining the division to our Social Hour, which will be held on Friday from 6:00 pm to 6:50 pm immediately following the Business Meeting. The Social Hour offers an opportunity to meet, talk, and socialize with members of the Division. We will be showing pictures that reflect the history of Division 29.

I look forward to seeing and interacting with each of you at our various divisional activities.

NOTICE TO READERS

Please find the references for the articles in this *Bulletin* posted on our website: divisionofpsychotherapy.org

From Lemons to Lemonade

Linda Campbell, Ph.D. and Norine Johnson, Ph.D.
Division of Psychotherapy Council Representatives

The most important information to tell you about Council is how proud Norine Johnson and Linda Campbell are to be representing you, our Division 29 members and the central role of psychotherapy in psychology.

Getting the Lemons Out of the Way First
Even though APA has been in strong financial position for recent years, the 2008 budge realized a shortfall of $3,422,700. The national economic crisis, lower dues revenue than expected, and losses in investments are the major reasons for the shortfall. Much time was spent on this item in Council and we want our members to know that the Board of Directors, Paul Craig the APA Treasurer, Archie Turner the APA CFO and the Executive Director, Norman Anderson. were very forthcoming with specific information, explanations about the APA assets, dues impact, real estate holdings, publishing operations, and other factors that affect the budget. A full and open discussion was conducted in which Council received recommendations from the Board for response to the deficit and how these would be reflected in the 2009 budget.

After thorough discussion, the Council adopted a budget with approximately $12 million dollars in spending cuts. These include (1) cancelling the fall boards and committee meetings, (2) cuts in spending on public education programs, (3) a staff hiring freeze, and (4) elimination of the Board and Council discretionary funds. The final approved budget is projected to yield a fiscal budget surplus of $309,400 for 2009.

Making Lemonade
The rest of the news from the Council meeting does, in fact, bode very well for the resilience, commitment, and dedication of our members in governance. Much has been accomplished and much will continue to be done even in these times of great restraint, ergo the lemonade.

Strategic Plan
It may be hard to believe, but APA is beginning to conduct the very first strategic plan in the history of the organization. CEO Dr. Norman Anderson commented, "The strategic planning process is going to help APA be a stronger and more focused organization in the future." A significant step in facilitating the strategic plan is the development and Council approval of a vision statement that accurately represents the spirit, hopes, and direction of the organization. If a vision statement can be energized, exciting, and hopeful, this one is it. We hope that you are as satisfied with the meaning and values represented as we and the Council are:

APA Vision Statement
The American Psychological Association aspires to excel as a valuable, effective and influential organization advancing psychology as a science, serving as:

- **A uniting force** for the discipline;
- **The major catalyst** for the stimulation, growth and dissemination of psychological science and practice;
- **The primary resource** for all psychologists;
- **The premier innovator** in the education, development, and training of

continued on page 8

psychological scientists, practitioners and educators;

- **The leading advocate** for psychological knowledge and practice informing policy makers and the public to improve public policy and daily living;
- **A principal leader and global partner** promoting psychological knowledge and methods to facilitate the resolution of personal, societal and global challenges in diverse, multicultural and international contexts; and
- **An effective champion** of the application of psychology to promote human rights, health, well being and dignity.

Council Representation
The following proposal was approved and forwarded to the Policy and Planning Committee to be drafted by the next Council meeting:

That the APA Bylaws should be amended to ensure all Divisions and SPTA's have a seat on Council. Using the proportional allocation system, in the unlikely event that the number of votes allocated to either is insufficient to yield enough seats to seat all Divisions and SPTAs

Publications and Communications
The P&C Board of APA is the highest revenue producing area of APA and certainly is one of the most active and impactful within the profession. In 2008, the P&C Board reported that sales of the APA Publication Manual reached 6.6 million dollars. APA Journals and Division 56 began a new journal, *Psychological Trauma: Theory, Research, Practice, and Policy.* APA Journals and Division 36 also began a new journal entitled, *Psychology of Religion and Spirituality*. During 2008, PsychINFO added 152,001 new records to the database and expanded coverage by adding 113 journals bringing the number of journals covered to 2,452. APA Books released 53 new scholarly titles and nine new Magination Press titles. Total revenue for APA's core scholarly and professional publishing program exceeded $72 million in 2008.

In Other Actions, the Council:

- Postponed action on proposals to reduce the costs of dues for some members including state, provincial and territorial association members, due to the restraints on the 2009 and 2010 budgets.
- Adopted updated Guidelines for Child Custody Evaluations in Family Law Proceedings.
- Received the report of the Task Force for Increasing the Number of Quantitative Psychologists.
- Established a continuing Committee on Human Research.
- Received the final report of the Div. 19 (Military) and Div. 44 (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues) Joint Task Force on Sexual Orientation and Military Experience.
- Announced the roll out of the new website due later this year.

Your Council Representatives are advocates for the voice of Division 29 members. We do report back to you on the decisions and the topics of discussion at the immediate past Council meeting, but just as importantly, we want to know in advance of meetings what your thoughts and perspectives are so that we can advance the mission of psychotherapy and our members. Please contact either Norine Johnson (NorineJ@aol.com) or Linda Campbell (lcampbel@uga.edu).

Adding Motivational Interviewing to Cognitive Behavioral Therapy for Anxiety

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Motivational Interviewing (MI) is "a client-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). Its' use is well supported in the addictions domain (Hettema, Steele, & Miller, 2005) and has been extended to the promotion of health behaviors (Rollnick, Miller, & Butler, 2008). There is strong evidence that an MI pretreatment followed by another type of psychotherapy leads to better attendance and enhanced outcomes compared to the same psychotherapy without an MI pretreatment (Hettema et al., 2005). Recently, investigators have begun to explore the use of MI either integrated with Cognitive Behavioral Therapy (CBT; i.e., a shift to MI within CBT when ambivalence/resistance arises) or in combination with CBT (e.g., as a pretreatment) in the treatment of other major mental health problems such as anxiety, depression, eating disorders, medical adherence in psychosis, and problematic gambling (Arkowitz, Westra, Miller, & Rollnick, 2008). Our own work has centered on examining MI as a pretreatment to CBT for anxiety and more specifically generalized anxiety disorder (GAD). Below I will outline the clinical application of MI to anxiety and summarize this research, as well as outline current and future directions in our research program.

MI for Anxiety

Although CBT is an effective treatment for anxiety, numerous individuals fail to show substantive benefit (Westen & Morrison, 2001; Hunot, Churchill, Teixeira, & Silva de Lima, 2007). This is particularly true for GAD, the anxiety disorder least responsive to CBT (Campbell & Brown, 2002). Client resistance to change and nonadherence to recommended treatment procedures are common clinical realities in CBT. For example, in a survey of practicing CBT therapists, problems in assigning homework were noted for 74.5% of clients and only 38.9% of cases were identified as totally compliant (Helbig & Fehm, 2004). Because treatment engagement is a critical contributor to outcome (Orlinsky, Grawe, & Parks, 1994), reducing resistance and increasing motivation through the use of MI may hold significant promise for improving the efficacy of CBT.

MI has strong roots in the client-centered approach of Carl Rogers (1956). Both MI and client-centered psychotherapies share an emphasis on understanding the client's internal frame of reference and working with discrepancies between behaviors and values. Both emphasize the importance of the psychotherapist providing the conditions for growth and change by communicating attitudes of accurate empathy and unconditional positive regard. However, unlike client-centered psychotherapy, MI is directive, with specific goals of reducing ambivalence and increasing intrinsic motivation for change. To achieve these goals, the MI therapist tries to create an atmosphere in which the client, rather than the psychotherapist, is the main advocate for and primary agent of change. The "MI spirit" of the psychotherapist is central and consists of

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attitudes of collaboration, evocation, and respect for the client's autonomy. This approach also consists of specific principles including: express empathy, develop discrepancy between values and problem behaviors, roll with resistance, and support self-efficacy.

MI is well-suited for application to the anxiety disorders since ambivalence about change and engagement with treatment procedures is common in these populations. For example, individuals with GAD have been found to hold conflicting beliefs about worry, including both negative and positive perceptions of the value of worry (Borkovec & Roemer, 1995). Although clients with GAD do see worry as a problem (e.g., that it interferes with concentration and memory), they also hold *positive* beliefs about it (e.g., that worry is motivating, ensures one is prepared for negative events) and are therefore ambivalent about reducing or relinquishing their excessive worry. There are a number of case reports supporting the utility of MI with various anxiety disorders including obsessive compulsive disorder (Simpson, Zuckoff, Page, Franklin, & Foa, 2008), social anxiety (Buckner, Roth Ledley, Heimberg, & Schmidt, in press), mixed anxiety disorders (Westra, 2004; Westra & Dozois, 2008) and GAD (Westra & Arkowitz, in press). Readers are encouraged to examine these reports to obtain more specific information about the clinical application of MI to anxiety.

Preliminary Studies Investigating the Efficacy of MI for Anxiety

To date, our research group has conducted two preliminary randomized controlled trials (RCTs) examining MI as a pretreatment for anxiety in a heterogeneous sample of anxiety disorders and for GAD specifically. These studies are summarized below, as well as a qualitative research study on client accounts of experiences in CBT with and without an MI pretreatment. A manual detailing the application of MI to anxiety used in our research studies is also available upon request (send an email request to hwestra@yorku.ca).

MI for a mixed anxiety disorders group (Westra & Dozois, 2006)

Prior to either sessions of manualized group CBT, individuals with a principal anxiety diagnosis (45% panic disorder, 31% social phobia, and 24% GAD) were randomly assigned to receive either 3 sessions of an individually delivered MI pretreatment adapted for anxiety (n = 25) or no pretreatment (NPT, n = 30). The MI group, compared to NPT, showed significantly higher positive expectancy for anxiety control and greater homework compliance in CBT. Although both groups demonstrated clinically significant anxiety symptom improvements, the MI group had a significantly higher number of CBT responders compared to NPT. At six-month follow-up, both groups evidenced maintenance of gains. Overall, the results of this investigation provide support for the viability and potential contribution of MI as an adjunct to CBT for anxiety.

MI for GAD (Westra, Arkowitz, & Dozois, 2008)

To evaluate whether MI would enhance response to CBT for GAD specifically, 76 individuals with a principal diagnosis of GAD were randomly assigned to receive either an MI pretreatment or no pretreatment (NPT), prior to receiving individually delivered CBT. Significant group differences favouring MI-CBT were observed for the hallmark GAD symptom of worry, percentage of treatment responders, and therapist-rated homework compliance. On multiple measures (worry, worry beliefs, early prognostic expectations, intrinsic motivation), receiving MI was substantively and specifically beneficial for those of high worry severity at baseline, compared to those of high severity not receiving MI. Those

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of moderate worry severity showed no significant benefit from the MI pretreatment on most indices. Moreover, large effect sizes were observed when comparing high severity individuals across MI-CBT and NPT-CBT groups. These findings suggest that MI may be a promising adjunct to CBT for GAD, and uniquely beneficial for those of high worry severity (49% of this sample), who have historically been less responsive to CBT (Durham et al., 2004). At one year follow-up, the high severity MI-CBT group did show evidence of some relapse; reducing the magnitude of post-treatment group differences. Importantly, the data do not suggest that the addition of MI increased relapse but rather that those of high severity are more vulnerable to relapse and thus may require additional treatment or booster sessions in order to maintain treatment gains.

Client Accounts of Experiences in CBT for GAD with and without MI pretreatment

Using a grounded theory approach to study client post-treatment accounts of their experiences in CBT among ten high severity clients in the Westra et al. (2008) RCT, Kertes, Westra, Angus, & Marcus (in press) found that MI-CBT and NPT-CBT groups sharply diverged in their experiences of the interpersonal style of the therapist and their experience of active engagement in CBT. MI-CBT clients reported experiencing the CBT therapist as an "evocative guide" in the pursuit of their goals and, accordingly, reported themselves as active participants in the treatment process. For example, MI-CBT clients reported "It's not like the therapist was sitting there fixing my problems. I had to do a lot of digging." and "She (the therapist) made suggestions but a lot of times she would ask me what I think." In contrast, NPT-CBT clients described the CBT therapist as directive and described their own role as primarily one of compliance with therapist direction. For example, NPT-CBT clients noted that "The therapist was there to be accountable to and to give me homework,","My role was to show up and listen,",and "My role was to do the homework and make sure I had something to report back." Considering that Kertes matched treatment groups on CBT therapist (n = 3 therapists), these findings suggest that the experience of CBT was perceived differently depending on whether the client received MI prior to CBT. These findings are consistent with the theoretical rationale for adding MI to CBT and quantitative findings indicating that a major outcome of adjunctive MI is increased engagement with subsequent, more action-oriented therapies (Burke et al., 2003; Hettema et al., 2005). The Kertes et al. (in press) study supports and strengthens these findings by demonstrating that increased engagement in subsequent treatment as a function of receiving MI is observed in client accounts of their treatment experiences as well.

Current & Future Directions

While the above studies suggest that MI holds promise as an adjunct to CBT for anxiety, neither of the RCTs discussed above ensured equivalent therapist contact time across treatment groups, nor did they rule out expectancy effects created by client knowledge of having received additional treatment. At present, we are intending to replicate the RCT of MI+CBT for GAD using a control group of extended CBT to control for these confounds. Moreover, we intend to add a relapse prevention procedure in order to facilitate maintenance of treatment gains.

In addition, we are taking a process focused approach to our research to examine key questions of moderation and mediation, such as (1) Why might MI be particularly indicated for those of high worry severity? (2) What is the interper-

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sonal impact within CBT of having received an MI pretreatment compared to receiving CBT alone? and (3) Are good outcome CBT therapists more "MI-ish" (e.g., collaborative, evocative, empathic) in their therapeutic style compared with poor outcome CBT therapists?

With respect to the first question, we speculate that high severity worriers may be more ambivalent or skeptical about change than the moderate severity worriers, and as a consequence preferentially benefit from the addition of MI to CBT. At present, we are examining this question through the use of process measures of resistance and ambivalence (change-talk, counter-change talk) in CBT to examine whether those of high severity are more resistant/ambivalent than those of lesser worry severity within CBT alone. And if so, does having received MI prior to CBT decrease this resistance/ambivalence within CBT among those of high worry severity?

With respect to the interpersonal impact of having received MI on subsequent CBT (question 2 above), findings from the Kertes et al. (in press) study converge with quantitative findings in the Westra et al. (2008) study demonstrating that therapists of those in the MI-CBT group were rated by independent observers, blind to client pre-treatment status, as having delivered higher quality CBT, compared to the same therapists of those receiving no pretreatment prior to CBT (NPT-CBT). Thus, receiving MI pretreatment appears to be associated with more positive interpersonal process within subsequent CBT. We are currently using the Structural Analysis of Social Behavior (SASB; Benjamin, 1974), which involves analyzing moment-to-moment client-therapist exchanges around the interpersonal dimensions of affiliation and interdependence, to more specifically examine the interpersonal impact on CBT of receiving MI pretreatment compared to not having received a pretreatment. Given findings of high levels of interpersonal problems in GAD (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008), the emphasis in MI on the relationship between client and therapist may provide clients with a corrective interpersonal experience, thereby improving interpersonal process in subsequent treatment.

Finally, we are also examining therapist effects (question 3 above) that emerged within the CBT alone group in the Westra et al. (2008) study. Namely, CBT therapists differed in their outcomes with client recovery rates at one year follow-up ranging from 17% to 90% across the four CBT therapists. These differences in outcome across therapists were mediated by differences in client prognostic expectations following the first session of CBT, with clients of poor outcomes therapists having significantly lower early expectations for recovery than those of good outcome CBT therapists. Using the SASB, we are currently investigating the hypothesis that CBT therapists may diverge in their management of client counter-change talk, with good outcome therapists expressing more affirming and understanding under these conditions, while poor outcome therapists may engage in less understanding and more interpersonal control in response to client expressed reservations about change and treatment.

As with any research program, our work to date has suggested more questions than answers. While adding MI to CBT for anxiety may hold promise, more rigorous, well controlled tests of this possibility are required. Examining moderators and mediators within such studies is especially important in identifying those for whom MI is indicated and not indicated, as well as the mechanisms through which adding MI to CBT may achieve its' effects. Such research will have important clinical implications for engaging individuals with CBT for anxiety in an attempt to improve outcomes.

An Examination of Integrated Treatments for Trauma and Co-Occurring Disorders

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A growing body of research supports the use of several manualized group treatment models designed specifically for individuals with co-occurring disorders (e.g., those who have both mental disorders and substance use disorders) who also have histories of trauma. These treatment models, including the Trauma Recovery and Empowerment Model (TREM; Harris & The Community Connections Trauma Work Group, 1998), Seeking Safety (Najavits, 2002), and others, are often referred to as *integrated* treatment models, and this description is applicable in more ways than one.

First, the treatment models described here are integrated in the sense that they aim to address trauma sequelae, substance abuse, and general mental health problems as interconnected parts of a whole problem, rather than as separate syndromes. This integrated approach represents a shift away from parallel treatment models, in which addiction, trauma, and mental illness are treated in different facilities with different sets of providers. It also differs from so-called sequential treatment approaches in which treatment providers maintain that substance abuse be addressed before other presenting issues (Finkelstein et al., 2004).

These treatments are also theoretically integrative. TREM, for example, focuses on the development of trauma recovery skills through cognitive restructuring, skills training, peer support, and psychoeducation (Harris & The Community Connections Trauma Work Group, 1998), while Seeking Safety emphasizes interpersonal domains as well as cognitive, behavioral, and case management elements (Najavits, 2002). The present paper will provide a brief overview of recent research evidence supporting integrated trauma treatment models, while also offering a more clinically-oriented description of TREM, including the core themes and skills emphasized in TREM sessions.

Research Findings on Integrated Trauma Treatments

The Women, Co-occurring Disorders and Violence Study (WCDVS) was a large-scale quasi-experimental study evaluating the effectiveness of integrated treatment programs designed specifically for women with co-occurring disorders and histories of interpersonal violence (Morrissey, Ellis et al., 2005). Funded by the Substance Abuse and Mental Health Services Administration, the study included more than 2,700 women across nine participating treatment sites. In each case, clinical outcomes at the sites using integrated trauma treatments were compared with sites providing usual care to a comparable population. It is the largest study to date examining integrated treatment approaches for this population.

The WCDVS findings strengthened the case for integrative trauma-focused treatments. At the 12-month assessment

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point, a meta-analysis of data across all treatment sites revealed that while there was symptom reduction for women in both conditions, sites using integrated trauma treatments yielded significantly greater improvements on measures of general mental health functioning and trauma symptoms relative to the women in usual care (Morrissey, Jackson et al., 2005). Looking at substance use outcomes, intervention site participants demonstrated statistically greater improvement on a measure of drug use severity at the 6-month assessment point (Cocozza et al., 2005), but differences between the groups were not statistically significant at 12 months.

The results of studies of individual integrative trauma treatments in the WCDVS also suggest that these approaches are beneficial for individuals with trauma histories and co-occurring disorders. Of the interventions included in the WCDVS, the Seeking Safety treatment program was the first and most frequently studied. In early and small-scale studies of Seeking Safety, the therapy was found to be effective in reducing PTSD symptoms and substance abuse (Cook, Walser, Kane, Ruzek, & Woody, 2006; Najavits, Schmitz, Gotthardt, & Weiss, 2005; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). Other studies have shown it to be helpful in reducing depression and general psychopathology (Najavits, Gallop, & Weiss, 2006; Najavits, Weiss, Shaw, & Muenz, 1998).

More recently, Gatz et al. (2007) reported promising findings with respect to reduction of trauma symptoms in their study comparing Seeking Safety to usual care among women in residential substance abuse treatment programs in Los Angeles. This study was one component of the larger WCDVS described above. The researchers found that participants in the Seeking Safety condition had significantly greater reductions in trauma symptoms and significantly greater gains on a measure of coping skills from baseline to 12 months. The two conditions did not differ with respect to participants' improvements on measures of substance use and general psychopathology.

Findings from recent studies of TREM also generally point to its effectiveness for women with co-occurring disorders and histories of trauma. For example, as a part of the WCDVS, Amaro et al. (2007) examined treatment outcomes among 342 women receiving substance abuse treatment in the Boston area. In this study, intervention group participants received a modified version of TREM in addition to substance abuse treatment, while comparison group participants received usual care in comparable substance abuse treatment programs. Relative to the comparison group, intervention group participants demonstrated significantly greater improvements on measures of PTSD, general mental health symptoms, and drug use by the 12-month interview period.

Preliminary data from the District of Columbia Trauma Collaboration Study (DCTCS), a study that was a part of the WCDVS involving 251 participants, indicate that TREM group participants experienced significantly greater reductions in PTSD and substance use symptoms at the 12-month assessment point relative to those receiving services as usual at a comparable agency. There were no significant differences between the groups on a measure of general psychiatric symptoms (Fallot, McHugo, & Harris, 2009).

A Closer Look at TREM

One way that some clinicians conduct trauma treatment with individuals with severe mental illness is by modifying some of the more well-established cognitive- behavioral treatments for PTSD. For example, some treatments have been

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changed to reduce or eliminate treatment elements that could be particularly stressful for these individuals—such as exposure—while providing a greater emphasis on cognitive restructuring. In this way, the treatments focus on the avoidance, arousal and intrusive symptoms that characterize PTSD (Rosenberg et al., 2001).

TREM, on the other hand, takes a broader view of the issues that need to be addressed among individuals with histories of trauma and co-occurring disorders. This treatment model was developed in the 1990s by clinicians working with women at Community Connections, a community mental health agency in Washington, DC. The clinicians recognized that many of their clients struggled with trauma-related sequelae that extended beyond PTSD symptoms, including a disrupted ability to trust others and sustain relationships, a sense of powerlessness and lack of self-agency, and difficulties with emotional modulation and self-soothing. The treatment was developed around four core assumptions: 1) Some current maladaptive behaviors may have initially developed as a means of coping with trauma; 2) Women with repeated experiences of childhood trauma were deprived of the chance to develop the types of coping skills they need as adults; 3) The experience of trauma cuts off one's connections to family, community, and self; and 4) Women with extensive histories of trauma feel powerless and unable to advocate for themselves (Fallot & Harris, 2002).

Based on these principles, TREM was developed as a manualized therapy that targets issues in trauma recovery over the course of 33 weekly 75-minute sessions designed for groups of 8-10 women. There are three main sections of the treatment model. The first focuses on empowerment, the second section aims to help participants better understand the experience and impact of trauma, and the third section emphasizes the development of trauma recovery skills (Fallot & Harris, 2002). Though TREM was originally developed for use with women, variations of the treatment model have been developed for both men (Fallot, 2001) and adolescent girls (Berley, Guillory, Harris, Quezada, & Seagroves, 2005).

In some instances, the empowerment section of TREM includes session topics that one might not immediately associate with trauma recovery, such as sessions focused on the exploration of self-esteem and female sexuality. For example, during the fourth week of treatment members explore their physical boundaries. The rationale for this is that the experience of physical and sexual abuse is the ultimate violation of—and intrusion into—personal space. Abuse survivors often find themselves confused about what is safe and appropriate contact, and may be either overly sensitive about personal space or not sufficiently aware of others' need for personal space (Harris & The Community Connections Trauma Work Group, 1998).

Through discussion and activities, this session allows members to explore the topic and receive feedback from one another. One of the goals for the session is to have members begin to develop an idea of how much or how little control they have over what happens to their bodies. Facilitators ask members to discuss how much physical space they need and how they might typically respond to unwanted physical contact. In one exercise, leaders block off boxes and circles on the floor with masking tape at varying distances from one another and group members discuss why they selected the boxes they did (Harris & The Community Connections Trauma Work Group, 1998).

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In later sessions, topics are geared more specifically toward trauma recovery and skill building. For example, in session 20, group members explore the links between problematic addictive or compulsive behaviors and their histories of trauma. They discuss when they first engaged in these behaviors, and how these behaviors may be a form of self-abuse. By session 28, entitled "Feeling Out of Control," one of the goals is to help the members think about effective and positive ways to modulate intense emotions. As an exercise, members brainstorm a list of coping strategies—including engaging in positive self-talk, taking a walk or exercising, or listening to soothing music (Harris & The Community Connections Trauma Work Group, 1998).

A recent study using data from the aforementioned DCTCS, examined the extent to which participants perceived that the counseling services they received were integrative, based on responses to several questions, including: "The services I receive treat me as a whole person rather than pulling me apart into separate problems." Results indicated that TREM participants were significantly more likely to perceive that their treatment was integrative relative to those receiving services as usual. In addition, among TREM participants, perceived integration was significantly correlated with symptom reduction on measures of PTSD symptoms, general mental health symptoms, and drug use severity (Swope, 2009).

While the empirical findings outlined above make the case for continued and expanded use of integrated trauma treatments, they also suggest that clinicians would be well-s erved to examine and address possible connections among disorders for those clients who come into treatment with a variety of presenting issues. Current research findings support this approach for clinicians working with individuals who have histories of trauma and other mental health problems, but additional research is needed to determine whether the development of integrated treatment protocols would be useful for other disorders with high rates of comorbidity.

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An Examination of Integrated Deception in Psychological Research: Ethical Issues and Challenges

Jeffrey E. Barnett, Psy.D., ABPP and Monica Nanda, B.A.

The use of deception in research by psychologists raises a number of ethical issues and concerns. Its significance is illustrated by its inclusion as a standard in the American Psychological Association's Ethics Code (APA, 2002, Standard 8.07: Deception in Research). While the use of deception may offer researchers greater flexibility in conducting their studies and obtaining important findings, it also creates potential risks for participants of these studies that must be addressed. The purpose of this article is to better understand what deception is, highlight the benefits and consequences of its use, examine ethical dilemmas and concerns regarding deception, and discuss the ethical use of deception and possible alternatives.

Deception has been described by Hertwig and Ortmann (2008) as the "intentional and explicit provision of erroneous information—in other words, lying" (p. 222). It is one of the most controversial topics in research ethics due to the potential for harm to research participants and the possible violation of their rights. Yet, one cannot deny the significant contributions that a study utilizing deception can add to our understanding of human behavior. On the one hand, deception can give a study greater internal validity by increasing the control that a researcher has over the experiment and eliminating certain participant biases; however, it is taking away the participants' autonomy and their ability to provide voluntary informed consent.

Deception in Research: An Historical Perspective

The first set of ethical guidelines regarding human research was put forth in 1947 in response to the inhumane human experiments that were carried out in Germany during World War II. These guidelines became known as the Nuremberg Code, named after the trials at Nuremberg where the physicians conducting these experiments were placed on trial and found guilty of war crimes and crimes against humanity. The Nuremberg Code (1947) specifies that research must be conducted for the good of society, not impose any unnecessary harm, and research participants must voluntarily consent and be able to withdraw from the research study. These guidelines were very general, not enforceable, and did not make specific recommendations regarding deception, but were an important first step toward the protection of human research participants.

In the 1960s and 70s deception was a hallmark of psychological research, and its use was the norm and not a choice of last resort. During this period, specific ethical standards were not in place to limit the use of deception. Milgram's obedience study (1963) and Darley and Latane's (1968) bystander intervention study are examples of classic studies that utilized deception during this time period and yielded valuable advancements to our knowledge of social behavior. However, these studies, specifically

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Milgram's obedience study, raised major ethical concerns regarding participant safety, highlighting the need for more specific standards to be put into place.

In 1964 the World Medical Association put forth the Declaration of Helsinki, which is a set of ethical principles for physicians conducting human research. It highlights the rights of human participants and important factors to consider when conducting research with human participants (World Medical Organization, 1996). Ethical principles in this document include respect for the individual during the research process, allowing the participant to make informed decisions, and ensuring that the participant's welfare always takes precedence over science and society. In 1974 The National Research Act was passed in Congress and created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHS) to study the ethical principles underlying research on human subjects (NCPHS, 1979). In 1978 the Commission summarized its finding in the Belmont Report and identified respect for persons, beneficence, and justice as the three fundamental ethical principles for research using human participants (NCPHS, 1979).

Ethical Issues and Standards for Psychologists

The APA Ethics Code (2002) provides the most specific standards for psychologists to follow when conducting research. Standard 8.07, Deception in Research, specifies that deception is not to be used if alternative methods not using deception are possible, if the deception will "reasonably be expected to cause physical pain or severe emotional distress", and if the deception is not "justified by the study's significant prospective scientific, educational, or applied value" (p. 1070). Furthermore, if deception is used, study participants must be notified about and be provided with an explanation of the use of the deception "as soon as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data" (p. 1070). This is usually done during a required debriefing at the completion of the study where the researcher provides the participant with information about the nature of the study as well as any deception that may have taken place. Additionally, when required, all research protocols, whether using deception or not, must be reviewed and approved by an Institutional Review Board (IRB) prior to conducting the research.

As one can see, these standards are an attempt to place a balance between not harming research participants and advancing psychological knowledge through controlled experimentation. It is obvious to not use deception when it is likely to result in extreme harm to participants. But, when the relative risks and benefits are less pronounced reaching a decision on how best to proceed may be challenging for researchers. This tension can be seen in the APA Ethics Code's aspirational Principle A: Beneficence and Nonmaleficence which recommends that psychologists endeavor to take actions that maximize benefit to those we serve while simultaneously minimizing the potential for exploitation or harm to them. While we can easily see how to apply these principles when the potential for harm is great and the likely value of a study is small (and the inverse as well) it is in those situations where these distinctions are less apparent that psychologists will struggle. Thus, a study such as Milgram's obedience study, while yielding valuable information that advances our understanding about human behavior, would not likely be approved by any IRB today. The decision to approve

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other studies in which the likelihood of harm to participants is not so clear, yet the potential benefits from the study are great, might prove more problematic for those making these decisions.

Additionally, if alternative methods that enable the researcher to study the issues in question are feasible, the researcher must refrain from the use of deception and use the alternative method. However, several studies (e.g., Cooper, 1976; Forward, Canter & Kirsch, 1976; Geller, 1982; Weber & Cook, 1972; Willis & Willis, 1970) have looked at the use of alternative methods such as role plays, naturalistic observation, and self-report methods in comparison to using deceptive methods and have reported mixed results. To eschew deception when alternative methods are available helps eliminate potential harm to the study's participants, even if only minimal. Yet, the study could be losing valuable experimental and statistical power that would make it more internally valid. In order to better understand this dilemma and the APA's stance on this issue, we must examine the consequences of the use of deception.

Risks and Benefits of Using Deception in Research

The use of deception can contribute greatly to our knowledge about human thoughts, attitudes, motivations, decision making, behavior, and the like. Some of the most fascinating experiments in the history of psychology utilized deception. For example, in Solomon Asch's conformity study (1951) participants believed they were taking part in a study on visual perception. Rather, they were participating in a study to see how often they would respond incorrectly to visual cue cards because the confederates did so as well. This study gave us considerable insight into understanding conformity. Thus, deception in research can allow us to tap into constructs, such as conformity, that would be difficult or nearly impossible to measure using other methods. Additionally, it helps eliminate participant biases such as social desirability and other demand characteristics. When participants do not know the true nature of the study that they are participating in, they cannot consciously change their behavior to make themselves look better. Also, they cannot easily discern the study hypotheses and deliberately behave in a way that confirms or denies them. Consequently, the use of deception leads to the research having more experimental control by eliminating these extraneous variables, giving the research study more internal validity, increased power, and a lesser likelihood of making a Type II error.

The use of deception also allows us to examine rare behaviors that would be difficult to study otherwise. Through the use of deception, Darley and Latane's bystander intervention study (1968) was able to help us better understand when someone is more likely to help an individual in an emergency without there being an actual emergency. Clearly, creating actual emergency situations to study bystanders' responses would raise other more serious ethical issues and be impractical. Even though studies utilizing deception can provide us significant information concerning human thought and behavior, the potential contribution of a study is an essential but not sufficient requirement to substantiate its use. This is due to the potential of harm and other consequences brought about by the use of deception.

Milgram's obedience study demonstrates many of the consequences that can come about from using deception. In this study, participants were led to believe that they were teaching another participant word pairs and shocking them with increasing voltage for each response they answered incorrectly.

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Sixty-five percent of the participants continued to shock the "learner" despite the learner's complaints because the experimenter said that they must continue (Milgram, 1963). Throughout the experiment, participants were apparently nervous, anxious, scared, and distressed, but the experimenter insisted that they continue. Not only did this study cause significant emotional distress to the participants, but it took advantage of their position as a study participant by breaking their trust and not giving the participants a chance to withdraw from participation. Additionally, in Milgram's study and in other studies that use deception, the researcher is not able to obtain informed consent since participants are not informed of the true nature of the study. This alone violates the participants' autonomy because of their inability to make informed, independent decisions. Furthermore, the use of deception could cause an invasion of privacy when participants are revealing information about themselves that they would not have revealed or wanted to reveal if it were not for the deceptive methods that were used. Not only do participants experience the consequences of deception, the field of psychology does so as well. The greater the use of deception in psychological experiments, the more suspicious participants may become when participating in any psychological study. This could cause participants to behave in unnatural ways because of their suspicions, thus eliminating the experimental and statistical benefits of using deception.

Conclusions and Recommendations

When ethically used, deception can contribute greatly to the field of psychology, but it is essential that researchers examine the risks and harm that the deception could potentially cause to the participants and make sure there are no alternatives possible that do not utilize deception. Additionally, Benham (2008) suggests examining the professional relationship between the researcher and participant as well as different forms of deception when considering its use. We further recommend that psychologist researchers utilize a structured decision making model to consider the relative risks and benefits of the use of deception in research that weighs the potential value of the anticipated results of the study with the potential for harm to participants. No easily applied formula exists to replace such a deliberative decision making process at present, but a decision making model is presented below. The APA Ethics Code makes clear when the use of deception is ethical, and although these standards may appear stringent, the potential of harm to participants and the violation of many of their fundamental rights warrant these standards by promoting integrity, autonomy, safety, and privacy.

Decision Making Model and Steps to Take

1) Determine the potential benefits of the study and the value of the findings and data likely to be obtained.
2) Determine the potential risks to individuals who may participate in the study.
3) Consider if the typical participant would agree to participate in the study if they knew of these risks in advance.
4) Delineate all possible alternatives for studying the research issue in question.
5) Consult with colleagues with expertise in ethics, research, and experimental design.
6) With the assistance of expert colleagues consider the relative risks and benefits of each alternative available.
7) Once a decision is reached, develop a research protocol that minimizes risks to the participants and that maximizes protecting their rights

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and welfare (e.g., monitoring their functioning throughout the study, determining when to terminate a participant's involvement in the study if signs of duress are noted, voluntary nature of participation and right to withdraw at any time, the debriefing process, etc.).

8) Present this research protocol to the appropriate Institutional Review Board.
9) If a study utilizing deception is approved by the IRB, implement the study with careful monitoring of each participant's functioning throughout each phase of the study. Do not allow a participant to continue in the study if the likelihood of harm is evident. Obtain needed assistance for any participant who requests it or appears to be harmed by their participation.
10) Conduct the debriefing of each participant with careful attention to their rights and welfare. Should duress or harm be evident, take appropriate remediative steps such as obtaining treatment for the participant.
11) Ensure that participants understand their right to withdraw from the study at any time and their right to withdraw their data as well.
12) If patterns of duress or harm are noted in multiple participants or if significant harm is noted in even a single participant, discontinue the study, confer with expert colleagues and the IRB, and determine what modifications need to be made to the design of the study before proceeding.

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Mommy is a Psychologist, Too

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It's true; I am. It's a new development. Although I have been telling my children since they were born that I am a talking doctor, the real story is that for the past six years, I have been a full-time parent. The psychologist part of me was an important component of my internal identity and my sense of self, but I wasn't practicing. This was a measured choice on my part; my children were very new to the world and I was new to the world of mothering, and I was clear that I wanted to carve out some time in my life for just those experiences. Frankly, I was also a little overwhelmed and just didn't have the emotional energy to be attending to any extra people. I'm glad I have spent these six years the way I have. Hindsight on this issue melds comfortably with the foresight that led me to choose staying home in the first place.

Staying home: what a misnomer. I have been busier in these six years than I ever was as a full-time student or a working non-parent. It hasn't gotten less busy, either, and there is a part of me that thinks maybe it's a little bit crazy to take on such a project as starting a business. About the time that my second child started to experiment with getting up on his feet, though, I started to dream about getting back up on mine. The therapist in me started to tug on the sleeve of my heart, gently at first, and then quite relentlessly. I took stock, took notes, and sought counsel. The message from everywhere was the same: Get back to work.

And so I'm doing it. I am building a practice, building a reputation, marketing, reading, and feeling that quickening of the pulse that comes whenever I lock in on my own right path and step forward. It is very motivating. I'm excited, energized, and brimming with ideas and possibilities. It's a sea change, though, and my family has motion sickness. "What do you mean, *office*?" my first-grader demanded. "You're our mom." And then, just to really rub it in, she added, wistfully, "Don't you love us more than you love your job?"

From my seat right now, parenting and working in combination feels refreshing. From the seat my kids and my husband are sharing, mainly everybody is just feeling the need to buckle up, because the ride has gotten a little wild. For six years, I have been available all of the time, organizing everything about my time around what the kids need and what we all want as a family. Sometimes it has been exhausting, but it has also been a lot of fun. My parenting full-time has been a pretty good arrangement for all of us for a long time, and now I have gone and shaken it up by becoming dissatisfied with it as a sole way of life. While I am busy breathing a sigh of relief and coasting on new-project energy, my husband and children are adjusting to the fact that now I disappear a lot more often.

My husband, truth be told, is not entirely crushed to hear of the prospect of me making some actual money. I have been either a full-time student or scantily paid postdoctoral fellow or a stay at

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home parent since we met, worthy occupations all, but all rendering me rather a financial deadbeat. But although he is relieved to be able to share the financial responsibility for this life we've constructed together, he is also struggling through the logistics and consequences that come from reconfiguring our division of labor on the parenting front.

Everyone except for me finds this new career move of mine a tricky alteration. I feel it too, actually, if impatience with their adjustment process counts. (I know this is neither fair nor admirable, but it's an accurate reporting of events.) Every so often I do have flashes of sadness and panic, with occasional doses of what-am-I-DOING-ness. But this is unquestionably easier for me than it is for the family with whom I share my life.

When my daughter asked if I love her more than I love my job, I answered in the affirmative. I am, first and foremost and forever, my children's mother. None of my life's roles are as vital or as unshakeable as that. The kind of mom I am, though, is the kind who also really believes that I have to be a happy *woman* in order to be a good enough parent, and I have started needing more than parenting to make me happy. Also, the kind of woman I am believes that children need a model for following their heart's desires. My heart desires to be back in practice. By honoring that, I bring more of a sense of fulfillment into my own life, enabling myself to become more of the parent I want to be for my kids, and I show them how to listen to their own instincts and dreams. Ultimately, everybody wins.

I really love being a psychologist, and it's time to do it. Thus, I will do what all good moms do when the little people in their lives are seasick. I will comfort them. I will try as much as is possible at their stages of development to get their sights fixed on the horizon in hopes that it will soothe their tummies. My husband and I will figure out these whitewaters, too, the way we have at other times when things have gotten choppy. We have a long enough history together to trust in the calm that follows storms. We will forge ahead, this family of ours, and I will hold them all close and remind them that I love them more than they can possibly fathom.

And I will keep steady on my own course, knowing that the ride will soon smooth out for all of us if I do that.

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Changes in the Sequence of Training Leading to Licensure

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Arizona, Indiana, Ohio, Maryland, North Dakota, Utah, and Washington have passed legislation changing their licensing requirements for supervised practice leading to licensure. These states require two years of supervised experience, one of which must be in a predoctoral internship training program. The additional equivalent of a year of supervised experience can be gained before or after the doctorate is conferred. At this time, most of the above states are in the process of developing rules for implementing the legislation. Students and early career psychologists (ECPs) have been very enthusiastic in their support of these changes. However, the implementation will take a bit longer and it is likely that challenges are ahead as states work to set standards and establish required documentation of supervised experience for licensure.

This article will briefly review the background and the central issues associated with implementing anticipated rules and regulations. It will also address anticipated standards for supervised professional experience and documentation. These issues raise important implications for Division 29 members who direct and teach in training programs and those who supervise doctoral students. Finally, the practical implications for students and ECPs will be addressed.

Revisions of the Model Licensing Act

It is generally acknowledged that over the years, training programs in professional psychology have increased the amount of practicum and fieldwork required for graduation. To some extent, this arises from an increase in professionally focused programs. It has also been driven by a perception that internship programs tend to select students who have more clinical experience, which has led to an increase in the amount of clinical experience in the training programs. The result has been that compared to students graduating 22 years ago, when the current model licensing act was adopted, many graduates have a considerable foundation in professional practice at the time of graduation.

In response to this and other changes in the profession, Norine Johnson, then APA President, appointed a Commission on Education and Training Leading to Licensure that presented its final report to the APA Council of Representatives (Council) in 2001. Council deferred action while APA Boards and Committees reviewed the recommendations.

In 2005, Council adopted the policy statement that:

- Affirmed the doctorate is the minimum educational requirement for entry into practice.
- Affirmed that licensure applicants demonstrate they have completed a sequential, organized, supervised professional experience equivalent to two years of full-time training.
- Affirmed that postdoctoral education and training remains an important part of continuing professional development and the credentialing process.

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The APA policy was to be incorporated in a revision of the Model Licensing Act and a Task Force to revise the Act was appointed in 2006. The Task Force has developed a revision of the Model Act and is currently in a second round of public comment on the draft. The change in the sequence of training was incorporated into both drafts of the revised Model Act and will be in the version to be forwarded to Council for action at its next meeting. The model language addressing professional experience needed for licensure can be seen on page 10 of the online version of the draft at http://forms.apa.org/practice/modelactlicensure/mla-review-2009.pdf .

It can be anticipated that states will differ in their responses to the provisions in the Model Act, particularly to those provisions that accept both pre- and post-doctoral supervised experience. The states listed above are in the vanguard and more will follow. However, others are likely to maintain the requirement for postdoctoral experience. It may take some time before the issues get sorted out. However, the process is underway.

Implementing Change in the Sequence of Training

The actual language that changes the sequence of training can be fairly simple. All that is necessary is for the statute to include language that asserts the applicants for licensure must have the equivalent of two full-time years of **sequential and organized supervised professional experience** and one of them shall be a predoctoral internship. The real issues arise in writing the rules that define the above words in bold type.

The Association of State and Provincial Psychology Boards (ASPPB) has developed and is promulgating *Guidelines for Practicum Experience that Is Counted for Licensure* in order to assist state psychology boards develop rules. A copy of the *Guidelines* is on the ASPPB website: http://www.asppb.net/files/public/Final_Prac_Guidelines_1_31_09.pdf .

The *Guidelines* state "ASPPB is committed to developing model regulations that provide guidance to jurisdictions that choose to modify requirements in the sequence of training leading to licensure, resulting in consistency between jurisdictions." However, the *Guidelines* also indicate that the authors have serious reservations about the supervised experience provisions in the draft revision of the Model Act and adopted the point of view that states: "because the postdoctoral experience is no longer required; the standards for supervised experience must to be more carefully delineated to ensure that they are organized and sequential." The *Guidelines* also emphasize that the experiences must be documented carefully and in detail. ASPPB efforts reflect a careful analysis and adherence to very high standards for training that arises from deep concern about the potential for a diminution in the preparation for licensure. Therefore, they offer standards that are based on the highest ideals for preparation. However, they do not take into account other factors that arise from the changes that will be discussed below.

A goal of the *Guidelines* is to offer specificity and they aim to achieve it by setting stringent expectations. Examination of the resulting recommendations reveals that they overlook the complexity of training, the variety of experiences, and range of settings in which it occurs. Thus, the same expectations for supervision are stated regardless of the stage of the individual's training or the nature and complexity of the services they are providing. For example, the ASPPB *Guidelines* that address supervision state that for four-hours of direct "patient/client contacts

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hours, for the sake of public protection and effective learning, the student would be required to receive two hours of supervision." This "one size fits all" method does not allow training programs to adjust the needed supervision to what is most appropriate for development of the trainees. While the *Guidelines* raise important issues, they are not likely to be seen as offering specific language to guide development of the rules. Therefore, the states currently developing rules may do better by consulting with each other in order to provide for consistency of standards across jurisdictions.

Implications for Training Programs

As noted above, the issues raised in the *Guidelines* are informative, but the requirements stated in the commentary revisits issues that the training community has addressed some time ago and resolved through developing standards for program accreditation. The best way to illustrate the potential impact of the *Guidelines* for training programs is to allow the commentary to speak for itself. The provision in *Guideline 2. Breadth and Depth of Training* calls for a detailed training plan for each practicum experience. The Commentary states:

> There should be an explicit plan developed for each student who will use the practicum experience to meet requirements for licensure that specifies the experiences necessary, within the context of the graduate training program and the student's previous experiences, to ensure competence appropriate to the level of training of the student. It is the responsibility of the graduate program to provide a rationale for the practicum training for each student, in light of previous academic preparation and previous practicum training.

The Commentary for *Guideline 2* ends by stating:

> In order for the licensing board to evaluate the quality of the practicum experiences of the applicant for licensure, it is necessary that the training program provide to the licensing board the overall training plan for the various practicum experiences, so that the organized, sequential nature of that training can be assessed by the board.

It is clear that that these provisions in the *Guidelines* would create barriers to the use of predoctoral supervised experience to meet requirements for licensure.The stridency of these standards is particularly surprising given the relatively limited specification of the training experiences, minimal standards for documentation, and absence of oversight that characterizes current provisions for postdoctoral supervision.

Furthermore, the *Guidelines* do not take into consideration that a change in the sequence will increase the quality of postdoctoral experience by removing barriers that affect ECPs' access to third-party reimbursement for their services. It is likely that ECPs will seek and obtain postdoctoral supervision in order to ensure mobility and reciprocity with states that do not modify the change that would allow predoctoral experience to satisfy the experience requires for licensure. Furthermore, quality of the settings and experiences will likely be better because better reimbursement benefits sites and ECPs. In addition, training sites will be better able to develop and offer formal postdoctoral training programs that will be supported by the reimbursement of services provided by licensed trainees that is limited by the current standards.

Implications for Students and ECPs

Students and ECPs should understand that passing legislation is only the first step and that careful attention and active monitoring and participation in the rule

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making process is necessary. Students should maintain careful documentation of the supervised training they receive. None-the-less, ECPs must be aware that they may not be able to document their predoctoral training retrospectively to meet the standards adopted for supervised expereince.

As noted above, those ECPs who do achieve licensure on the basis of predoctoral supervised experience must consider the issues of mobility and reciprocity. Therefore, those who are licensed without completing postdoctoral supervised experience should nonetheless obtain and document postdoctoral supervised experience. This will ensure that they can meet requirements for licensure in other jurisdictions that may have different requirements.

The ASPPB *Guidelines* express concern about a diminution of the quality of services to patients that might be brought about by licensing psychologists at the time of the doctorate is conferred on the basis of predoctoral supervised experience. However, it seems equally likely that an increase in quality may be noted. This arises because accountability for monitoring clinical experiences will be assumed by the doctoral training programs that can more effectively oversee and provide quality control over the required hours of supervised experience. Furthermore, it is anticipated there will be an increase the opportunities for postdoctoral training because services of postdoctoral fellows will be reimbursable and contribute to the development and funding of postdoctoral training programs.

Change in the sequence of training can be expected to have other benefits that include:

- Reducing the burden on employers who will be able to obtain more appropriate reimbursement for the services provided by ECPs who currently earn rates of master's level providers.
- Students who work under supervision while completing their dissertations would be able to count supervised hours toward licensure.
- ECPs, who are already burdened with debt from education loans, will have higher earnings.

For the above reasons the proposed changes in the sequence of training is viewed very positively by students and ECPs and those who employ them. However, even if a state passes legislation that removes the requirement for postdoctoral supervised experience, there are a number of issues that must be worked through in order to implement the change in licensure. Furthermore, the change will place greater responsibility on training programs and practicum and fieldwork settings for organizing and documenting supervised experience. As noted above, the situation is further complicated by issues of reciprocity and mobility. Professional psychology is at the beginning stages of a transition that will require close monitoring and management by Division 29 members who work in training programs and in practicum and fieldwork settings. Student members must also actively contribute to the effort. Each has a role in fostering standards for quality training as the means of driving change.

What Does a Scientist Look Like?

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What does a scientist look like? As a child, my image of a scientist consisted of an older White man, dressed in a white lab coat, tinkering with his experiments in an austere looking laboratory. Since then, I have been educated as a Counseling Psychologist, in the scientist-practitioner model, by talented women and men of diverse backgrounds, and still, my image of a scientist at 28 is not that different from my image of a scientist at 8. Do I like that this is the image of a scientist that first comes to mind for me? No. However, I do not believe I am alone in this unwanted aspect of my imagination.

I consider myself to be a scientist. This role is part of my identity, what I value, how I define myself, and what I have worked toward becoming. If you were to ask me to write down 10 things about myself, "scientist" or "researcher" would make the top of the list. Still, when I look in the mirror, I do not automatically see a scientist in the reflection staring back at me. As a woman, and a young woman at that, I am also not blind to the fact that many others do not automatically see a scientist when they look at me, and that, such a vision often requires a period of convincing on my part. After I completed my doctorate, I made what was a difficult choice for me, to pursue a career in academia rather than clinical work, and many who did not know me in this capacity seemed confused, if not shocked. Are you *really* going to do this, they would ask? It seemed to be the general conclusion at the time that I chose academia because I liked teaching, since it could not have been because I liked research, could it? Most of us have heard the following riddle (or some variation of it). A father and his son are in a terrible car accident. They are brought to the Emergency Room and as they are both rolled into surgery, a doctor appears and screams, "That's my son!" Who is the doctor? It takes many of us a few moments to realize that the doctor was the mother. A personal story may illustrate a similar point. I once submitted a manuscript that employed some advanced and complicated statistical procedures for blind review. One of the reviewers kept referring to the author as a "he" in his written feedback. I asked myself, why does he keep calling me a he? Can't girls do math too, I thought? But then I had to stop and question myself. Why did *I* assume that this reviewer was a "*he*"?

While these assumptions can feel as ancient as the scientist in my image, how can I expect others to see me as a scientist, when I am still waiting for an old man, in a white lab coat, to appear in my mirror? At the same time, we can not help but see ourselves (in least in part) in terms of what others reflect back to us. The faces and backgrounds of psychologists have changed over recent years. Although we have a long way to go, our profession is relatively more diverse in terms of gender, ethnicity, race, and sexual orientation. Many of the researchers I look up to and admire are women of different ages, ethnicities, and races. So why can I not automatically picture any woman when you ask me, *what does a scientist look like*?

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Where are all the Female Scientists?
Women are clearly underrepresented in science and university life; for example, data have shown that the proportion of female faculty members in universities around the world is almost always less than 25% (Lie, Malik, & Harris, 1994). Furthermore, women become increasingly difficult to find as one climbs up the academic ladder. In the United States, the percentage of female full time professors has been reported as only 13%, slightly higher than many European countries (Osborn, 1998). In psychology, only one-third of full professors are women, and those numbers drop even lower for department chairs, provosts, and university presidents (DeAngelis, 2008). At the same time, since 1984, the number of females in graduate schools has exceeded the number of males. Between 1995 and 2005, the number of male full-time graduate students increased by 27 percent, compared to a 65 percent increase for female graduate students (National Center for Educational Statistics, 2007). In psychology, nearly three-quarters of the field's doctorates are held by women; yet, they hold fewer than half of all tenure-track psychology positions, according to the (National Science Foundation, 2006). Given these statistics on the increasing numbers of female doctoral students and the relatively smaller number of women in science and university life, where are all the female psychologists post-graduation?

Counseling and clinical psychology doctoral programs in particular are areas of psychology that typically attract a high number of female students. Most of the students in these programs begin their studies with little interest in research and most pursue a career in practice upon graduation, despite an emphasis on the scientist-practitioner model in training programs (Brems, Johnson, & Gallucci, 1996). For some students, women and men alike, research is simply not their thing. Whether or not one chooses to pursue research or practice (or neither, or both) upon graduation is a personal choice. At the same time, I wonder what we can do in our training programs to help women feel that they do indeed have the choice.

Mentorship
Suppose we accept that increasing research productivity among male and female counseling and clinical psychology graduates is a worthy aspiration. Then, the problem becomes that despite an emphasis on research in graduate school training, the typically female dominated doctoral programs in counseling and clinical psychology, are not typically producing researchers. An important part of the solution is likely to lie in faculty mentorship of student research. Contrary to this notion, one could argue that students who are attracted to these types of programs often have personality traits that do not lend themselves to research, and faculty cannot be asked to change a student's personality after all. In fact, research has shown that individual differences, such as personality and interests, play a major role in research attitudes and productivity (e.g., Kahn & Scott, 1997; Mallinckrodt, Gelso, & Royalty, 1990). Individual differences surely play a role in the career path that both women and men choose. However, when women represent the majority of psychology doctoral students but the minority of psychology full time faculty, it does not seem plausible that personality alone is responsible for or deterministic of a woman's interest in research and science. I entered my doctoral program not exactly opposed to research but more fearful of it. I find that my own students, especially female students, are "opposed" to research because they are afraid that they will fail at these undertakings. On top of this, they often have not had adequate exposure to research to really know what it is. Research men-

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tors can be crucial in addressing these obstacles (low research self-efficacy, high research anxiety) that often stand in the way of these students pursuing research activities.

Much has been written about the role of mentorship in graduate school education and it is clear that mentorship matters, especially when it comes to students' attitudes toward research and research productivity. For example, Royalty and Reising's (1986) study found that students' interest in research was positively influenced by interacting with role models or an advisor in research activities. Similarly, O'Brien (1995) and Gelso (1997) both found that students often focused on their relationship with faculty members when reporting critical incidents. Several studies suggest that faculty modeling or mentoring in research relates to the research productivity and involvement of psychology students and recent graduates (Cronan-Hillix, Gensheimer, Cronan-Hillix, & Davidson, 1986; Galassi, Brooks, Stoltz, & Trexler, 1986; Krebs, Smither, & Hurley, 1991). Graduate students typically report that having a mentor is a critical component of graduate school training (Atkinson, Neville, & Casas, 1991; Lark & Croteau, 1998; Luna & Cullen, 1998) and ethnic minority psychologists report that faculty encouragement in research was important and useful (Atkinson et al., 1991).

Compared to the literature on mentoring overall, there is little research specifically on gender and research mentoring. Some previous research in this area suggests that gender moderates the relationship between the research training environment, self efficacy, and research productivity. The research training environment is an empirically tested model that outlines nine themes central to a research training environment that predicts student research productivity (see Gelso, 1997). Brown, Lent, Ryan, and McPartland (1996) found that for men, research self efficacy had a stronger effect on research productivity. For women, however, the research training environment had a stronger effect on their research productivity. Hollingsworth & Fassinger (2002) found that students' research mentoring experiences and research self efficacy mediated the effect of the research training environment on research productivity. Unlike Brown et al. (1996), these researchers did not find different results for women and men. More research is needed to better understand what female psychology doctoral students need from a research mentor and how their research involvement and productivity relates to mentorship, the research training environment, and their research self efficacy.

Some female doctoral students in psychology may not enter graduate school with a self-concept that allows them to think of themselves as researchers. When the cultural symbol of a scientist is a man, as a woman, it may be more difficult to picture yourself as a scientist. Future research can examine female doctoral students' prototypes of a scientist, and if these prototypes relate to the degree to which students identify as a researcher. Furthermore, future research may study how a student's prototype of a scientist and identity as a researcher relate to their attitudes toward research, and research involvement and productivity. Another potential area for future research is to identify what types of mentoring relationships are needed for female doctoral students to ultimately predict positive research attitudes, involvement, and productivity. Drawing from the psychotherapy research on the therapeutic relationship and techniques, perhaps a student's involvement in research is predicted by both a strong mentoring relationship and the techniques that the mentor uses to actually teach the

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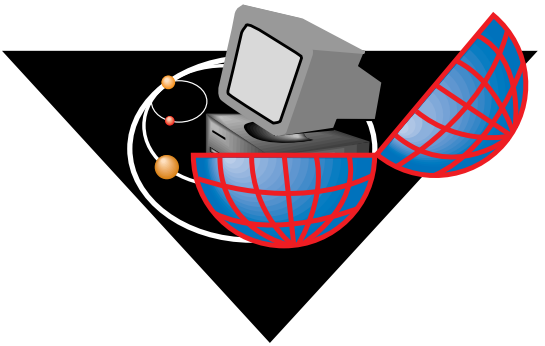
student how to conduct research. Female doctoral students may need multiple research mentors to provide relationships in which they can develop their research self-efficacy and skills.

Conclusion

I am one of those lucky early career professionals to have received mentorship in research by both men and women. These mentors have supported my scientific aspirations and sense of self as a researcher. Despite all this, when I close my eyes and picture a scientist, I still do not picture someone that looks like me, and instead, that same older man comes to mind. The scientist that lives in my imagination may always be there, no matter the amount of education, mentorship, or professional success in my life. He is an amalgamation of movies, books, cultural convention, and my own personal history that I have internalized. Perhaps this will one day change, and I will begin to envision scientists that look more like me. Yet, would envisioning myself to look more like a scientist actually make me any more of a scientist? Other female psychologists and doctoral students may have a similar image of what a scientist *really* looks like. However, in reality, a scientist does not look like anything or anyone. Rather than focusing on what a scientist looks like, it may be more helpful to focus on what a scientist actually does, and if you use the scientific method to get a little closer to some truth, then you are a scientist.



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A Therapy Preferences Interview: Empowering Clients by Offering Choices

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As the field of psychotherapy moves toward a more collaborative approach to therapy interventions, clients' expectations of treatment and therapist-client variables have become a central focus of research (Wampold, 2001). Ongoing research is being conducted at the University of Denver's Counseling Psychology Training Clinic to examine the effects of collaborative treatment planning and therapeutic choice on the working alliance and outcome. This article will describe the rationale and development of the Therapy Preferences Interview (TPI) in which the therapist asks clients about and discusses preferences for the therapist's approach and type of therapy to receive. This article presents preliminary research on whether taking additional steps to actively inquire about clients' preferences and presenting them with choices help strengthen the working alliance.

Importance of Client Choice

Ethical guidelines emphasize the importance of informed consent and disclosure of the therapist's approach and opportunity for questions and answers in the therapeutic process (American Psychological Association, 2002). Attention has been given to ways to develop treatment plans by varying approaches according to client characteristics (Beutler & Clarkin, 1990); however, Norcross (2003) proposed that clients directly be asked about their preferences for the therapist's characteristics and approach to allow the therapist to customize the therapy provided. Wampold (2001) conducted a meta-analysis of the effect of various factors on therapy outcome and concluded with several recommendations, one of which was "clients should have the freedom to select the theoretical approach of their choice" (p. 226). According to the APA Presidential Task Force on Evidence-Based Practice (2006), "psychotherapy is a collaborative enterprise in which patients and clinicians negotiate ways of working together that are mutually agreeable and likely to lead to positive outcomes" (p. 280). Based on Norcross (2003) and Wampold's (2001) meta-analyses, providing clients with a choice in treatment may be an important aspect of treatment planning in psychotherapy.

Working Alliance

Some therapist-client variables, such as empathy, warmth, and client expectancy for change have been identified across various treatment approaches and have been termed "common factors" (Lambert & Ogles, 2004). Of the common factors, the client-therapist relationship has long been considered a key common factor in facilitating a positive therapeutic outcome (Norcross & Lambert, 2006). Bordin (1994) broadened the concept of the therapeutic relationship by defining the "working alliance" as not only the therapeutic bond, but also collaboration

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and mutual agreement between the therapist and client on the goals and tasks of therapy. The working alliance suggests collaboration between the therapist and client as the key factor through which change is achieved in psychotherapy (Horvath & Symonds, 1991).

Researchers have argued that a strong therapeutic alliance is a necessary component for therapy to be effective (Norcross, 2003). Horvath (2001) suggested that a little over half of psychotherapy's positive effects can be attributed to the quality of the alliance. The alliance predicts therapy outcome equally for all theoretical orientations, and client's ratings of alliance are more predictive of outcome than either therapists' or observers' ratings. Horvath (2001) found that alliance is established within the first three sessions and remains largely stable throughout treatment, lending further support to the importance of strong alliance in positive clinical outcomes. These findings emphasize the need for the therapist to establish a positive working alliance with the client early in treatment. Horvath and Luborsky (1993) suggested that research be focused on determining specific therapeutic actions that could help to strengthen the therapeutic alliance.

Attending to clients' preferences for therapeutic approach may be a factor that helps to increase therapeutic alliance and promote other therapeutic measures of success. In recent years attention has significantly increased in practice and research on the relation between similarity of clients' preferences for treatment and important process variables, particularly the client-therapist relationship (Iacoviello et al., 2007). The effects of allowing clients choices about their treatment should be considered in terms of the treatment process and clients' outcome in therapy.

Effects of Client Choice on Outcome and Process

Arnoff, Glass, and Shapiro (2002) reported that studies on client preferences and outcome are limited, though interest is increasing. Some research has shown that providing clients with a choice of treatment produces positive results on the treatment process, such as increasing the likelihood of reaching treatment goals, increasing contact with the treatment program, and decreasing likelihood of terminating treatment early (Calsyn et al., 2003; Calsyn, Winter, & Morse, 2000; Rokke, Tomhave, & Jocic, 1999; de Shazer & Isebart, 2003; Swift & Callahan, 2009). Additionally, Iacoviello et al. (2007) found that a match between clients' preferred treatment and treatment received assisted the development of a positive working alliance. However, research on the direct effect of client choice on client outcomes has produced mixed results (Adamson, Sellman, & Dore, 2005; Glass, Arnkoff, & Shapiro, 2001; Atkinson, Worthington, Dana, & Good, 1991; Devine & Fernald, 1973; Rokke, et al., 1999).

Some studies have investigated the potential impact of matching clients to their stated treatment preference on both outcome and process variables (Atkinson et al., 1991; Goates-Jones & Hill, 2008). Goates-Jones & Hill (2008) found no difference in outcome for clients who received or did not receive their preference for an insight-oriented or action-oriented single session. Atkinson, et al. (1991) identified comparability of client's etiology beliefs about the problem with the explanations offered by the therapeutic approach as a critical ingredient. Though clients who attended at least three counseling sessions rated the process and outcome equally positive regardless of whether their preferred therapy approach matched that of their counselor, clients' perceived similarity

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of etiology beliefs was predictive of counselor credibility and satisfaction with therapy. Additionally, a recent meta-analysis of 26 studies on the impact of client treatment preferences on outcome suggests that there is a small significant effect (Swift & Callahan, 2009). However, none of these studies included in the meta-analysis specifically asked clients about their preferences for the client-therapist relationship or their choice for their type of therapy.

The Treatment Preferences Interview

The Treatment Preferences Interview (TPI) was developed to operationalize recommendations by Norcross (2003) to customize the therapist-patient relationship. In a pilot study, twenty-four clients with gambling problems were asked for their preferences related to five types of psychotherapy that had been demonstrated to be effective in previous research studies: Cognitive-Behavioral, Psychodynamic, Solution-Focused, Motivational Enhancement and Twelve Step (de Shazer & Isebart, 2003; Ladouceur, et al., 2002; McCown & Chamberlain, 2000; Petry 2005; Van Wormer & Davis, 2003). Based on results from the pilot study, Solution-Focused, Cognitive-Behavioral, and Psychodynamic therapies were incorporated into the final TPI, which was also reviewed by expert consultants who helped refine the therapy descriptions (see Tables 1 and 2 for more information).

Current Research

A larger ongoing research study is currently being conducted. Adult clients who volunteer to participate in the clinic research are randomly assigned to one of three conditions: Treatment as usual in which the therapist selects the therapeutic approach, Treatment Preference (TPI), or Assigned Treatment, in which the therapist is assigned the therapy approach. Outcome is measured by the Outcome Questionnaire, OQ 45.2, (Lambert et. al., 1996), the Working Alliance-short form (WAI-S; Hatcher & Gillaspy, 2006), therapy retention, and client satisfaction. Counselors attend weekly supervisory sessions for assistance in adhering to the selected or assigned therapy. Research is also being conducted on student-counselors' experience in collaborating with their clients and on the effects of students' allegiance to a type of therapy on outcome.

Preliminary findings on client perception of the use of the TPI with 48 clients suggest that clients who were given the opportunity to choose the therapy approach felt that it was important to be included in this decision. When asked about their preferences for therapist's relational approach, 84.2% of clients reported a positive experience and 15.9% indicated they did not like expressing a preference or were neutral.

Client therapy preferences were as follows: 37.5% Dynamic, 35.4% Solution-Focused, and 27% CBT. 25.6% indicated that they preferred to make the choice about therapy type, 33.3% were neutral and 41% indicated they preferred the therapist make the choice. While more clients tended to prefer that the therapist make the choice about therapy type used, when asked about how important it was to be included in the decision making process about type of approach employed, the majority of clients indicated they liked being offered a choice. Data about the sample's preference for a therapist who is directive and takes charge of a session may help to explain the findings regarding the clients' tendency to prefer that the therapist make the decision about type of therapy. 85% preferred that the therapist take charge while only 15% expressed a preference for more control of the session. Clients also tended to prefer a warm, expressive therapist (82%) as opposed to a more reserved therapist (5.1%). When student counselors were asked about their experience of administering the TPI, prelim-

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inary results indicate that almost all indicated they appreciated the more collaborative nature of the sessions.

Based on the review of previous literature, Wampold (2001) and Norcross (2003) emphasized the importance of allowing clients their choice of treatment. Developing the TPI was an attempt to address the limitations of previous studies and introduce a concrete tool to integrate clients' preferences into psychotherapy. While small sample sizes require that the results be interpreted with caution, the preliminary findings suggest that important information can be gained by engaging clients in collaborative treatment planning and the mere act of offering clients a say in their treatment may have a positive effect on the working alliance. The clients sampled thus far appear to prefer that the therapist make the majority of the decisions about treatment, however clients appreciated being asked to be involved in the process. Spending time engaging the client in dialogue about their preferences for treatment during the intake may pay dividends throughout the treatment, possibly by reducing the power differential and making known the value of the client's contribution to the therapy process.

Table 1: ***Description of the Treatment Preferences Interview***

Working Alliance Factor	Question content and examples
Relational Bond	**Prior therapy or experience being helped** What was most helpful? What was the worst a therapist could do?
	Preferences for counselor's characteristics Strong preferences for counselor's: gender, ethnicity, language, sexual orientation, religion
	Preferences for the counselor's approach Preferences for a therapist who takes charge, is active/talkative and expressive/warm, or client taking charge, and the therapist is more quiet and reserved
Consensus on Tasks	**Preferences for treatment modality** Individual, couple, group and/or family sessions
	Preferences for counseling tasks Try new things between counseling sessions; reading self-help books; watching self-help movies; going on-line for information
Agreement on Therapy Goals and Approaches	**Beliefs about the causes of the problem** Will of God, unlucky experiences, biological make-up, unmet emotional needs, unrealistic expectations, relationship conflicts, lack of self knowledge, life style, lack of willpower
	Preferences for type of therapy Solution-focused therapy, Cognitive Behavioral and Dynamic

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Table 2: ***Description of the therapy choices offered to clients***

Solution-Focused Therapy is a goal-oriented therapy that focuses on helping you to clarify what is important to you, changes you would like to have in your life, and steps you might take to achieve your goals. This is an active therapy where your counselor and you will be working to identify your strengths and successes and will search with you for solutions to your present dilemma. There often is discussion on what small changes and steps will improve your life, and what to pay attention to and what to think about doing differently between sessions. You will be asked to notice any progress.

Cognitive Behavioral Therapy (CBT) is a goal oriented therapy that is active and directive in nature. The purpose of this therapy is to explore thoughts and behaviors that may cause you to engage in problematic behaviors. You and your counselor work together to develop new ways of thinking about problems, and you will learn new skills to deal with them. To help identify patterns thought logs are used frequently in your session and between sessions. Your counselor will ask you to complete assignments and try change techniques that may be practiced throughout your week.

Dynamic Therapy's goals include improved relationships, attunement to feelings and/or a resolution of a conflict. Your therapist focuses on the expression of emotions, and explores wishes, attitudes, and behaviors. Your therapist will help you to talk about yourself and your relationships to identify your expectations and repetitive patterns in your life and your relationships. The focus is often on resolving past experiences and prior traumas, and identifying expectations you have for yourself and others. You will be asked to think about yourself and relationships between sessions.

A Place at the Table

Opening Up Leadership and Governance: A Need for Transparency Through the Black Box

Rosemary Adam-Terem, Ph.D. and Jeffrey E. Barnett, Psy.D., ABPP

The Black Box

There was once a Larson cartoon showing a chalk board full of complex mathematical equations and computations and an $E=MC^2$-type conclusion linked by a black box marked "and then a miracle happens." For many, entering leadership and governance of APA Divisions may feel as mysterious as that. We need to elucidate the black box.

It may be daunting just to look at the list of officers and members of the board of Division 29: luminaries of the profession, publishing superstars, past-presidents of State Provincial and Territorial Psychological Associations (SPTA's) or other psychological associations, APA divisions and societies, and even past-presidents of APA—an extraordinary group of psychologists.

There is of course great practical advantage to having senior and seasoned psychologists in governance—they know the ropes, they know the people to know, they provide continuity and "institutional memory," they carry prestige, they understand the organization, and they know how to get things done. However, there is also a risk that this may become what has been termed "a club that runs the club," an in-group harboring the power of the organization that seems impenetrable and perhaps unapproachable, or as we have heard them humorously described "APA Junkies."

Division 29 is committed to increasing diversity in our membership, focus of research, and leadership/governance. Here we will consider the issue of leadership and governance. How are we to attract, retain, inspire and learn from new faces at the table?

A couple of problems or barriers

One real issue in bringing more diversity to governance is the very model of governance itself. The rules and structures of APA and many other organizations belong to a kind of culture of their own, a type of formal, parliamentary process in which participants have to know the perhaps arcane rules and regulations, be at ease with speaking up in public forums, be willing to put their personal and professional stances up for scrutiny, and in the case of elected office, to be willing to face rejection and failure. There are many possible ethnic and cultural barriers to feeling comfortable in such a system. Take, for example, an Early Career Professional (ECP) of Asian or Pacific Islander origin and consider the values of harmony, humility, respect for elders or perceived superiors, and honor or face. All may be in apparent contradiction with the requirements for success in obtaining a leadership position.

Another major issue is the time vs. money problem—it seems that we really can have one or the other, but not both. Students come out of lengthy programs burdened with debt; ECP's are either at the lower end of the pay scale or are trying to build up their private practices, often struggling financially; mid-career psychologists may be so busy that they

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feel they cannot afford to take the time away; psychologists who live far from urban centers or in far-flung areas of the States, Territories and Provinces have to face long, time-consuming, and very costly journeys. There is a risk that leadership and governance will be populated only by those who can afford it.

Why increase diversity?
There are reasons of justice referenced in Principle D, Justice, of the APA Ethics Code (APA, 2002) that state:

> …fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. (p. 1063)

This is an aspirational goal, but one that should apply to the way APA runs its own business. Diversity is everyone's business. In addition, we hope that the work of the Division will be relevant to today's psychologists who are themselves increasingly diverse. By diversity, we mean to include more than the racial and ethnic, linguistic and cultural spectrum. Psychologists come from different age and stage of professional development groups (not always correlated), geographical and geosocial (urban or rural) areas, vary in gender and sexual orientation and identity, ability status, theoretical orientation, and professional specialty (research, training, practice) and work arena (private office, university, organization), and so on. We are committed to promoting and celebrating diversity as defined in Principle E, Respect for People's Rights and Dignity, of the APA Ethics Code, which states:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. (p. 1064)

How then can psychologists in all their diversity feel included and have an active part in the life of the Division? How did others do it? And how did psychologists from minority and underrepresented groups achieve what they have? In another article, we will feature some members' experiences.

Let us enter the Black Box—
What do you have to do to be part of leadership or governance?
There are many ways to be involved, and many paths to participation at the board and committee level. The broadest overview would be that a psychologist or a student would decide on what issues are most compelling or in which they have expertise to offer, and would then communicate with other Division and Board members in related roles. This could be done by e-mail, by listserv commentary, by the exchange of ideas in articles, through person to person contact (old fashioned idea here), by phone, at meetings, or at conferences, or even over a cup of tea.

It is important to remember that not everyone feels comfortable putting themselves forward, so it is the responsibility of board members and others in leadership roles to reach out and invite, encourage, and inspire others to join in. Every member of the Division's leadership must take personal responsibility to make the Division an open and welcoming place. We must each also actively reach out to colleagues and when attending events and meetings of the Division, actively seek out those we don't know, make them feel welcome, and encourage their involvement and participation. It's very easy to be friendly and welcoming to those we already know.

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What's really needed is creating a welcoming environment for everyone.

Probably the simplest path is for those in academia, where there is access to psychologists on site, where meetings, discussions, and seminars provide forums for interaction. It is more complicated for the private practitioner, especially in a rural or remote area, where other psychologists may be scarce indeed.

Fortunately, new developments in technology for those who can keep up (another possible barrier) offer better options for access than ever before through remote linkage. Division 29 can continue to develop new ways of connecting people.

The developmental pathway

We often speak of the "pipeline," a metaphor for the developmental sequence required to bring people into our profession. It is not enough to train students to the postdoctoral level and then declare them professional psychologists. Remember the Larson cartoon. We need to be able to see into the black box. Students need to be able to see the steps ahead—to first job, early career, mid-career, and mature career status.

Students can be encouraged and empowered to become involved in their future profession from the very start, for example by joining their SPTA, taking on committee roles and volunteer work at conferences, presenting their work at conventions and poster sessions, joining APA Graduate Students (APAGS), and attending APA conventions where they can follow APAGS programming. This fosters comfort and confidence and creates relationships, which are often the basis for involvement in professional organizations. Of course, there are financial constraints on live participation, especially at the national level. There is a need for creative solutions to help level the ground and provide more equal access.

As they begin their professional lives, ECP's need to stay involved. This can be a challenge: financial and practical pressures of the work environment can limit the ability to travel or attend meetings. This is where mentoring comes in. It is essential to stay in touch with one or more mentors, and many SPTA's have specific programs to connect ECP's with mentors. Remaining active in at least SPTA events is usually feasible, and it may be possible to have live or virtual peer support groups.

These may be some foundational steps for gaining a level of comfort with the culture of large organizations and from there it may be easier to seek office or leadership roles.

Back to the black box: so how do you actually go about being nominated and elected?

Any Division member in good standing can be nominated or self-nominate for a position. The "slates" are put together by the nomination committee, which has the responsibility of offering good candidates for every position open, taking into consideration the diversity of the Division's membership and the unique contributions that potential nominees may make to the governance of the Division. Separate slates may be developed to create opportunities for more and less experienced members, for members of underrepresented groups, or other membership groups that will benefit the Division. Each candidate writes a personal statement of interest and goals. The ballots go out to members of the Division in April and the votes are tallied centrally at APA. Results come out in the summer.

Assuming you get elected, then what? What does the position entail?

As a board member, you would expect to travel twice a year to weekend meetings in Washington D.C. (for which travel and accommodation expenses are

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covered by the Division), and to be part of e-mail and possibly 'phone discussions between times. The Division also meets at APA Convention and holds a terrific social hour where members get to mingle and meet others. There are numerous committees to be involved with also, and sometimes task forces.

Other leadership opportunities
Division members can be involved with committees even if they do not hold elected office. This is an excellent opportunity for student members and ECP's to have an active role, see how things work, and perhaps decide from there to run for office.

Division 29, like most other APA divisions and SPTAs, is always looking for new members for its various committees. See the list of Division 29 committees on the Division 29 website. Find one that is of possible interest to you and then contact the Committee Chair. Express your interest, learn more about the committee, and if it seems like a good fit, volunteer to join the committee. If you're not sure which committee might be best for you, contact the president of the Division, express your interest in getting involved, learn what the Division's needs are, and then volunteer to participate. Another great way to start off in the Division is to submit some brief articles on areas of interest or expertise for you to the Division's publication, the *Psychotherapy Bulletin*. That's a great way to make a contribution, to get noticed, and to begin your involvement.

No one is expected to know everything about the Division right away (if ever!), who the key players are, how to get things done, and the like. When you first volunteer to participate in the division, ask for a mentor. Having a senior colleague assigned to support and assist you can make all the difference. Feeling on your own, not knowing who to ask for guidance, or what to do will likely lead to dropping out of the activity. Division 29 must actively work to prevent this. Having a helpful, supportive, and caring mentor in the division is important to all newly involved members.

For more information, visit the website at http://www.divisionofpsychotherapy.org or contact any of the Division officers listed there. They will be glad to speak with you or answer questions by e-mail.

State Leadership Conference 2009: Exciting Times on Capitol Hill and Off

Report of Federal Advocacy Coordinator (FAC) for Division 29

Bonita G. Cade, Ph.D., J.D., Roger Williams University, Rhode Island and Private Practice

As the new Federal Advocacy Coordinator (FAC) for Division 29 it was my pleasure to attend my first State Leadership Conference on your behalf in Washington D. C. this past March 1-4. Nothing could have prepared me for the excitement and the energy that was in the air during the sessions prior to the Capitol Hill visits.

Katherine C. Nordal, Executive Director for Professional Practice, Practice Directorate, APA gave the keynote address. Dr. Nordal reminded us of the pivotal and unique role psychologists play in health care in this country. She informed us that in light of our training as critical thinkers and researchers and our experience as practitioners, we have a responsibility to assert ourselves in the coordination of integrated health care. Because of our knowledge of preventive measures and our development of protocols, we can facilitate measures that will ultimately lead to savings in health care cost. She reminded us that psychologists understand the relationship between mental health and physical health and should therefore become more instrumental and visible in the issues that are being addressed in the potential restructuring and delivery of the health care system.

Dr. Nordal's remarks set the tone of this year's conference and were consistent with the information that followed.

The theme of the conference *With Challenge Comes Opportunity* was underscored by Dr. Nordal and we were off to a rousing start! Sessions entitled: *The 2008 Elections and the Future of Health Care in America, The Primary Care Association Initiative: Integrated Care and Rural Health, Health Care Delivery Systems: Promoting Psychology in Hospitals and Other Facilities Through Legislation and Practitioner Advocacy, Understanding the New Federal Parity Law, Medicare: How Federal Policy Impacts Psychological Services* and *The Presidential Task Force and Summit on the Future of Psychology Practice* were just a few of the areas addressed over the next few days.

As I was beginning to feel that our responsibilities as psychologists were overwhelming, though critical, the ceremony surrounding the presentation of the awards for the 2009 Psychologically Healthy Workplace Awards and Best Practices Honors occurred. We were all reminded of the potential that can be realized as the result of commitment and knowledge dedicated to the service of our fellow human beings, which is a hallmark of our profession.

Thus, informed and invigorated we headed to Capitol Hill to speak with legislative staffers regarding the health care issues that impact psychologists and those they serve. This year we focused on four primary issues in our "hill briefings." Here is a brief summary of the topics we addressed.

1. The Centers for Medicare and Medicaid Services (CMS) reduced reimbursements for many services in 2007.

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Mental health services and psychological testing services experienced the greatest cuts. Although the Congress did cause a partial restoration for some of the cuts made in 2008 through The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), that "restoration" is slated to expire on December 31, 2009. During the visits to Capitol Hill we asked for **new legislation to continue the restoration through December 2011,** at which time there will be a 5-year review.

2. Psychologist perform many services such as establishing diagnosis and treatment options, analyzing psychological tests, counseling, the coordination of care and consultation on cases. These services are all within the purview of our licensure.

   These services are considered to be evaluation and management services (E/M) for which psychologists are not reimbursed because CMS prohibits billing by psychologists because these are labeled as "medical services." Thus we requested that **psychologists be made eligible for Evaluation and Management code reimbursement**.

3. The Medicare "physician" definition of the Social Security Act has been amended to include non-physician providers such as chiropractors, optometrists, dentists and podiatrists, who like psychologists, provide services to their patients and clients within the scope of their training and licensure. Like many other non physician practitioners, psychologists are licensed to practice independently of physician supervision. The access of older adults, who, will increase in number and often fail to obtain mental health services, would benefit from the inclusion of psychologists in the definition of "physician." In our discussions with legislative staffers we recommended that **Congress amend the Medicare "physician" definition to include psychologist.**

4. Health Care Reform is a necessary and dynamic process. It is also the case that we as psychologists have expertise to facilitate beneficial changes. Thus it is important that our professional research, training and expertise be a significant part of decisions related to health care. We have studied the psychological and behavioral factors that are related to the prevention of disease and the promotion of health and wellness. We frequently work in an interdisciplinary manner to implement and design programs that encourage healthy behaviors and lifestyles. Thus we urged our lawmakers to **pass health care reform that integrates psychological services in primary care, preventive services and benefit packages.**

We delivered these four requests to Capitol Hill and I am grateful for the opportunity to participate as the Federal Advocacy Coordinator for Division 29.

In the future I will be contacting members of the division about relevant issues. On occasion I will elicit your help in contacting your government officials. Many of you may have already developed relationships with particular lawmakers and are therefore strategically positioned to "make our case" to the benefit of those we serve. Please feel free to contact me at drbcade@gmail.com or bcade@rwu.edu. I hope that this update on the 2009 SLC has been informative and I look forward to this time of challenge!

Evidence-Based Medicine — The Devil Remains in the Details

Pat DeLeon, Ph.D., former APA President

In the Fall of 2007, the Institute of Medicine's (IOM) Annual Meeting focused upon the importance of integrating individual clinical expertise with the best available external evidence—i.e., Evidence-Based Medicine (EBM). "Technological and scientific innovations continue to expand the universe of medical interventions, treatment, and approaches to care, ushering in an era rich with potential for improving the quality of health care but also rife with increased uncertainty about what works best for whm… Reforms will be necessary to remedy existing shortfalls in access to care as well as to take better advantage of the opportunities provided by innovation, information technology, and broader stakeholder engagement."

The American Recovery and Reinvestment Act of 2009 (The Economic Stimulus legislation, P.L. 111-5) included two major, highly relevant federal investments. The first was the inclusion of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is intended to promote the widespread adoption of health information technology (HIT) for the electronic sharing of clinical data among hospitals, health care providers, and other-health care stakeholders. Today, relatively few providers actually utilize HIT, the most recent estimate suggests that only about 5% of physicians have a fully functional electronic health records (EHR) system. We wonder what the comparable figure is for psychology's practitioners? The legislation's goal is to bring utilization up to 70% for hospitals and approximately 90% for physicians by 2019.

HIT has been enthusiastically endorsed at the highest policy level. In April 2004, President Bush created by Executive Order the Office of the National Coordinator for Health Information Technology in order to develop, maintain, and direct a strategic plan to guide the nationwide implementation of HIT in the public and private health care sectors. During his January, 2009 Inaugural Address, President Obama: "Our health care is too costly…. We will restore science to its rightful place and wield technology's wonders to raise health care's quality and lower its costs…." The budget of the National Coordinator's Office was raised by the Stimulus legislation from approximately $66 million in FY'09 to $2 billion, while numerous health policy experts suggest that the federal government's overall investment for HIT will reach $19+ billion under the stimulus legislation.

The second significant investment was providing the Agency for Healthcare Research and Quality with **$1.1 billion** for comparative effectiveness research, a development which turned out to be highly controversial. "The conferees do not intend for the comparative effectiveness research funding included … to be used to mandate coverage, reimbursement, or other policies for any public or private payer. The funding … shall be used to conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition. Further, the conferees recognize that a 'one-size-fits-all' approach to patient treatment is not the most med-

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ically appropriate solution to treating various conditions and include language to ensure that subpopulations are considered when research is conducted or supported with the funds provided in the conference agreement." The Act also establishes an interagency advisory panel [the Council] to help coordinate and support the research, composed of up to 15 senior officials (including physicians and others with clinical expertise) from federal agencies with health-related programs. The Council is to submit an annual report to the President and Congress. Within this broader public policy context, the 2007 IOM deliberations are timely and prophetic. Highlights:

The IOM's vision is for a learning healthcare system that "draws upon the best evidence to provide the care most appropriate to each patient…" In effect, the learning healthcare system is one which enlists organizations, providers, and patients in driving the process of discovery as a natural outgrowth of patient care, and ensures innovation, quality, safety, and value in health care. The goal is that by 2020, 90% of clinical decisions will be supported by accurate, timely, and up-to-date clinical information, and will reflect the best available evidence. The rapid pace of scientific discovery and technological innovation over the last several decades is unprecedented and raises the prospect of achieving dramatic improvements in the nation's health and well-being. Yet stakeholders from across the healthcare system, from patients to practitioners to payers, are demanding fundamental improvements to a system that is seen as costly, fragmented, and ineffective.

The IOM discussions focused upon four fundamental themes: * the forces driving the need for better medical evidence; * the challenges with which patients and providers must contend; * the need to transform the speed and reliability of new medical evidence; and * the legislative and policy changes that would enable an evidence-based health care system. Common observations which surfaced were: * Increasing complexity of health care; * Unjustified discrepancies in care patterns; * Importance of better value from health care; * Uncertainty exposed by the information environment; * Pressing need for evidence development; * Promise of health information technology; * Need for more practice-based research [a direction espoused for years by Steve Ragusea]; * Shift to a culture of care that learns; * New model of patient-provider partnership; and, * Leadership that stems from every quarter.

Those interested in expanding their practice into health psychology should be particularly intrigued with the evolving notion that: "With the increasing complexity of care, and the need and demand for more patient involvement, the traditional 'physician-as-sole-authority' model will need to adapt to support patients as integral partners in medical decisions." And further, the prediction that our healthcare system will shift from expert-based practice, which is built upon the extensive knowledge and experience of the physician, to a systems-supported practice centered on teams supported by well-defined processes and information technology tools. The demise of expert-based practice is inevitable. The complexity of biomedical information and technology will increasingly overwhelm an individual expert's cognitive capacity. Specialization is not the answer because of the accompanying fragmentation, which is incompatible with the personalization of care that is becoming possible with progress in genomics and systems biology. Even if its demise were not inevitable, one would want to move beyond expert-based practice, as other industries have already done throughout our history.

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Equally significant is that a consistent pattern has been found in which the quality of care, as reflected in process measures of care, is actually worse when spending—and the intensity of care delivery—is greater. In fact, if all geographical regions adopted the practice patterns of the most conservatively spending regions of the country, health outcomes could be significantly improved and U.S. healthcare spending could decline by as much as 30%. There is a demonstrable need to focus resources where needed; for example, on the care and treatment of chronic conditions such as heart disease, diabetes, and asthma, which affect almost half of our population and which represent approximately 78% of our nation's healthcare expenditures. Clearly, more is not necessarily better.

Stressing the importance of personalized and individualized care, it was noted that: "For a variety of common diseases, only about 50 percent of patients will respond favorably to a given biopharmaceutical agent. Moreover, such response rates in individual patients are often highly variable in both their magnitude and their duration." Presently therapeutic interventions are frequently applied in a "one-size-fits-all" approach, and the means by which individual patients are matched to therapeutic interventions often occurs by "trial and error." Gathering long-term, longitudinal data on outcomes is challenging, but the cost of doing so is unnecessarily high because of the current organizational structures and practice patterns. Massive data sets could be built that could be used to support structured clinical trials and track the longitudinal consequences of medical interventions. Outcomes are the core value in healthcare delivery. However, we should appreciate that there is never only one outcome measure in any field or endeavor, and health care is no exception. Without true patient engagement and clear and honest communication about EBM, it is likely that many patients will perceive that "the system" is out to limit their access to the care they need. And, it is likely to be much more complicated and expensive to implement than is necessary. The key is to protect and preserve the patient-provider relationship, so that it is on equal footing with public health and epidemiological evidence.

During her confirmation hearing before the Senate Health, Education, Labor and Pensions (HELP) Committee to serve as Secretary of HHS, **Governor Kathleen Sebelius** echoed several reoccurring policy themes of the Obama Administration:

> I have also been a health care purchaser, directing the state employee health benefits program as well as overseeing the operation of health services in our correctional institutions and Medicaid and CHIP programs, and coordinating with local partners on health agencies across Kansas. I took these jobs seriously…. In these roles, I know first-hand the challenge of standing up to the special interests to protect consumer interests…. Health care costs are crushing families, businesses, and government budgets. Since 2000, health insurance premiums have almost doubled and an additional 9 million Americans have become uninsured. Since 2004, the number of 'under-insured' families – those who pay for coverage but are unprotected against high costs—rose by 60 percent. Just last month, a survey found over half of all Americans (53 percent), insured and uninsured, cut back on health care in the last year due to cost. The statistics are compelling, as are the stories…. We have by far the most expensive health system in the world. We spend 50 percent more per person than the next most costly nation. Americans spend more on health care than housing or

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food. General Motors spends more on health care than steel. The cost crisis in health care is worsening. The United States spent about $2.2 trillion on health care in 2007; $1 trillion more than what was spent in 1997, and half as much as is projected for 2018. High and rising health care costs have certainly contributed to the current economic crisis….

The Recovery Act also makes positive investments now that will yield health and economic dividends later. Through health information technology, it lays the foundation for a 21st-century system to reduce medical errors, lower health care costs, and empower health consumers. In the next five years, HHS will set the standards for privacy and interoperability, test models and certify the technology, and offer incentives for hospitals and doctors to adopt it. The goal is to provide every American with a safe, secure electronic health record by 2014. The Recovery Act … invests $1.1 billion in comparative effectiveness research to provide information on the relative strengths and weaknesses of alternative medical interventions to health providers and consumers…. The President's budget submitted in February … dedicates $634 billion over 10 years to reforming the health care system.

Psychology's Timely Response: In March, 2009, APA President James Bray testified before the IOM which has been asked by HHS to make recommendations for prioritizing its Comparative Effectiveness Research portfolio. James is a long time health psychologist who has consistently urged psychology to become increasingly involved in integrated healthcare.

Comparative effectiveness research is a critically important tool for advancing an evidence-based approach to health care decision-making. However, the full public health benefits of such research will only be realized if behavioral, psychosocial, and medical interventions for the prevention and treatment of mental and physical health conditions are evaluated individually and in combination. Even when strictly medical treatments are compared, it is important to expand the range of outcome measures to include behavioral and psychological outcomes, such as quality of life and adherence to treatment protocols. It is also essential to evaluate promising new models of care, such as the use of integrated, interdisciplinary behavioral and medical teams in primary care settings. And finally, the effectiveness of health interventions across the lifespan and for different minority and gender groups must be considered. Therefore, APA is recommending that comparative effectiveness research focus on these five areas:

We encourage research that compares different behavioral and psychosocial interventions for the prevention and treatment of specific health conditions…. Next, we strongly encourage research that compares behavioral and psychosocial interventions with medical interventions, and combinations thereof…. Next, we should pursue research that compares integrated systems of care comprised of interdisciplinary teams of medical and behavioral health providers versus routine medical care…. We also believe that all health research studies should include measures of behavioral and psychosocial outcomes, such as life quality, adherence to treatment protocols, behavioral functioning, depression, and anxiety…. And finally, research that examines health intervention outcomes across the lifespan and for different minority and gender groups is needed to understand the effectiveness of interventions within and between population groups…."

Interestingly, current OMB Director Peter Orszag was one of the 2007 IOM participants.

Aloha, Pat DeLeon

BOOK REVIEW

Blévis, Marcianne. (2009). *Jealousy: True stories of love's favorite decoy.* Olivia Heal trans. New York: Other Press.

Michael Karson, University of Denver

Of all the concerns a patient could share with a psychotherapist in hopes of finding a dialogue partner who might accept some responsibility for its presence and who might participate actively in its resolution, you would think jealousy would be near the top of the list. When a patient struggles with feelings of despair or outrage, in contrast, it is not immediately obvious that these states of mind are situated interpersonally. But jealousy can *only* exist interpersonally. You would think its presence in the psychotherapy space would tilt even a classical Freudian analyst away from thoughts about the patient's childhood and lead her to consider how the problem relates to the relationship in which it's unfolding. You would be wrong.

French psychoanalyst Marcianne Blévis has written a compendium of case studies of jealous patients in which she does not, even once as far as I could tell, consider whether she might have done something wrong that made the patient jealous. Even more startling, she does not once consider whether the patient's lover might have done something wrong to make the patient jealous. Instead, it is always the patient's mother, and sometimes the father too, who has erred. At times, her focus on the patient's childhood becomes ludicrous. For example, a patient eventually says to her, openly and blatantly, "Are you there?—it's suddenly cold." (Keep in mind that Blévis is sitting behind the patient, who is lying on the couch.) Rather than wonder what she might have done to make the patient think she had snuck out of the room, Blévis decides that the patient "lacked a mother who would have caressed her and looked upon her in a happy and loving manner" (p. 114). Similarly, when a patient dreams about what Blévis interprets as "unseen caresses," Blévis wonders not what it's like to receive care from someone the patient cannot see, but instead, "What did she not see when she was a child?" (p. 111).

This refusal to acknowledge fault or even the co-creation of meaning is specially ironic when the problem is jealousy. Surely we are not alone in hoping that our bouts with jealousy will be dealt with first and foremost by discussing the behavior of the other person that made us jealous (why are you wearing your best outfit to a business meeting?), and secondly by conversing with our lovers about what might make us feel more secure (how would you feel about wearing something else?). If the behavior of the lover is clearly not threatening, and if attempts to make the jealous person more secure keep failing, only then does it make sense to ask what the jealous person is getting out of the jealousy and to see if there is some other way to get it. Since jealous people may not have the skills to examine the behavior of their intimates objectively, and since they may not have the skills to metacommunicate about their relationships, psychotherapy would seem like a good place to acquire these skills. Blévis seems not even to consider this use of treatment, however. For example, her final case study is of a man who tortures himself about the

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fresh bouquet of flowers that Blévis has in her office every week, and not once does she consider whether it might not be a good idea to have a bouquet of flowers in one's office.

I don't distinguish between psychoanalysis and psychotherapy. I know that's a sort of heresy, but the putative distinction is one that patients—whose lives are on the line, whose courage is required, and whose vulnerabilities are accentuated regardless of the modality—should not take lying down. We may make a big deal of the differences, but to patients it's all the same—they're looking for help with a life problem from someone with power over them (the greatest aspect of which is the power to define the situation in the therapy relationship). What matters about the differences between psychotherapy and analysis is what the patient experiences. Psychotherapists should be open, for example, to metaphorical communication from patients that the sessions are too infrequent, or too conversational, or too hurried. (Indeed, the earliest structures of psychotherapy were dictated by a patient—Anna O.—not by an analyst; Freud's genius was that he listened to her.) Analysts should be open, for example, to metaphorical communication from patients that the sessions are too frequent, that the pace is too leisurely, or that it is not productive to do things behind their backs. Expressions of jealousy in all its forms could be examples of the last.

In virtually every human system, including families, couples, and psychoanalyses, a hegemony of special interests dictates acceptable behavior—a party line, in Erving Goffman's terms. The hegemony then defines behavior that challenges the system—behavior that is out of line—in a way that preserves and protects the hegemony. The terms of the derogatory definitions of out-of-line behavior change according to the type of system and its local culture, but in psychotherapy, the hegemony—that is, therapists' definition of themselves as helpful and harmless—is usually protected by defining patients' protests as pathological. You can't possibly be angry at innocent me; you must be angry at your mother. All psychotherapists, being human, are susceptible to using their power to define the situation to protect themselves at their patients' expense—call it therapeutic privilege—but they're supposed to understand this and provide a way for their patients' marginalized protests to get full voice in the treatment.

The hegemony in Blévis's psychotherapies is suggested by her sonorous pronouncements about psychology. "The child becomes jealously aware of her parents' sexual prowess and feels terribly depressed..." (p. 110). It's a posture that patients will have a hard time refuting, since any disagreement is chalked up to unconsciousness about their true feelings. She also writes, categorically, "Maternal love, far from being angelic, is an impassioned love unconsciously laced with violence" (p. 100). What's interesting, of course, is not whether maternal love is laced with ugliness, but when—under what circumstances—and what to do about it when it happens. Ironically—again—this latter proposition should alert the caregiving, authoritative therapist to her own violent feelings toward the client, but whenever Blévis experiences an undesirable thought or feeling about a patient in this book, she blames the patient's mother for producing someone so annoying rather than look inward.

This book takes us back in time—not in the psychoanalytic sense of revisiting childhood conflicts, but in the historical sense of a time before the developments of intersubjectivity, self psychology, and object relations theory, and before research on common factors foregrounded

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the therapeutic relationship. And on the subject of time, haven't classical analysts learned in a postmodern world to be suspicious of the accuracy of reports of childhood? Shouldn't they instead be treated as communications in the present? When Blévis cleverly interprets a dream as being organized around the patient's difficulty managing reactions to ambiguity, Blévis doesn't consider that her own ambiguity is occasioning projections from the patient. (It's useful, of course, to use ambiguity to occasion the patient's projections, but the idea is to understand those projections in relation to the environment in which they occurred.) Instead, she assumes that at some point in childhood, the patient "may have caught an indecipherable expression on her father's face" (p. 27). Similarly, when a patient tells her directly that he would like Blévis to precede him into the office so as to be "sheltered from [her] gaze" (p. 81), Blévis does not ask herself if she has been looking at him hurtfully, but instead she consoles herself by attributing his self-consciousness to something his mother supposedly did on the day of his birth (calling him ugly). Blévis does not consider the possibility that she and the patient co-created the story of being called ugly—that of the millions of things he might have said about his mother, he chose one that suited the moment.

The irony of ironies is that the analyst, eschewing responsibility for any jealousy constellated in her office, blames mothers for eschewing responsibility for jealousy! "Certain parents tolerate such demonstrations of intense jealousy without perceiving that these demonstrations are addressed to them; however, their refusal or inability to intervene, because they think that jealousy among siblings is normal, is worrisome for both the child who violently expresses his jealousy and for the one who endures it. In both cases, the space of the child's inner world is invaded by his parents' own conflicts" (pp. 67-8). So when someone is jealous, the person in charge needs to realize that it is about *her*, and she needs to intervene—unless the person in charge is *me*.

Jealousy can be framed as a backstage problem. We search for true, constant, and abiding love from the day we're born to the day we die, but all love—religion aside—is at best inconsistent and variable. With those we love, we learn to tactfully ignore their variable experience of us and we learn to disguise our variable view of them, largely because we can see that our own backstage fickleness does not invalidate the authenticity of our front stage devotion. Jealous people have trouble reconciling their own backstage fickleness with the authenticity of their love for the other, or else they have some reason to think their lover cannot reconcile the two. What they need, generally, are assessment skills and conflict resolution skills, and a good way to obtain these in a relevant manner is to get involved in an ambiguous, intimate relationship where the other person—a psychotherapist—has some expertise in backstage management, conflict resolution, and helping people feel secure. This all-too-human psychotherapist can use her expertise by expressing curiosity, warmth, and acceptance about the patient's confusion regarding the relationship between a backstage and a front stage. When a psychotherapist acts as if she has no backstage, the situations with the disappointing parent, the threatening sibling, and the mysterious lover are merely replicated in the treatment rather than resolved. These patients learn to blame their parents—a sort of splitting that protects the lover and the analyst rather than the parent—rather than how to resolve interpersonal conflicts. Blévis's orientation is even more distressing in light of her assertion that her book is not

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for therapists. For a lay audience, it can only be read as encouragement for blaming one's parents rather than resolving conflicts with one's lover.

Blévis has some nice things to say about jealousy. She calls it a "thrilling malady" (p. 1) and she tries to help one patient *become* jealous (a patient who reminded me of Freud's warning that people who are not jealous at all have repressed this natural state of mind and accordingly are dominated by it). But still, like many classical analysts, her vision of psychological health seems to be one of caution rather than one of relatedness. At least, she comes across as awfully cautious and defended in this volume, which is also ironic in light of Freud's daring vulnerability throughout his writings.

One patient gives up his jealousy and then considers returning to it only to be threatened with abandonment by Blévis if he reverts. He decides to stick with her and to forgo his jealousy. His choice is represented by a dream. "I am on a highway and I arrive at a fork in the road. On one road, there is a toll, one often has to stop, and there is a risk of accidents. On the other road, a vehicle awaits me, a sort of rocket in which I recognize all my fears represented by different objects—it wants to take me up the skies" (p. 43). The exciting path is one of "false hopes" according to Blévis, while the route of "real life (and of his analysis!)" is the one she approvingly describes as consisting of "obstacles ... tolls and forced stops." What a choice. A destructive rocket or a workaday rut. Blévis's preference for the latter over the former is understandable, but are these the only paths? She seems to validate Otto Rank's claim that psychoanalysis "breeds patient, docile Philistines." More importantly, both paths have the patient travelling by himself. This book does little to help jealous people with the desperate loneliness of their condition, except to tell them that they are a lot like other desperately lonely people.

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