Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.divisionofpsychotherapy.org

BULLETIN

In This Issue

Interview
Abraham Wolf, Ph.D.

Psychotherapy Research, Science and Scholarship
Engaging Underrepresented, Underserved Communities in Psychotherapy-Related Research: Notes from a Multicultural Journey

Ethics in Psychotherapy
Psychotherapy, Online Social Networking, and Ethics

Education & Training
Prioritizing Case Formulation in Psychotherapy Training

Feature
2009 Presidential Summit on the Future of Psychology Practice: Collaborating for Change

2009 VOLUME 44 NO. 3

Division of Psychotherapy ■ 2009 Governance Structure

ELECTED BOARD MEMBERS

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

President-elect
Jeffrey J. Magnavita, Ph.D.
Glastonbury Psychological Associates PC
300 Hebron Ave., Ste. 215
Glastonbury, CT 06033
Ofc: 860-659-1202 Fax: 860-657-1535
E-mail: magnapsych@aol.com

Secretary
Jeffrey Younggren, Ph.D., 2009-2011
827 Deep Valley Dr Ste 309
Rolling Hills Estates, CA 90274-3655
Ofc: 310-377-4264 Fax: 310-541-6370
E-mail: jeffyounggren@earthlink.net

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

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

Domain Representatives
Public Policy and Social Justice
Rosemary Adam-Terem, Ph.D.
1833 Kalakaua Avenue, Suite 800
Honolulu, HI 96815
Tel: 808-955-7372 Fax: 808-981-9282
E-mail: rozi7@hawaii.rr.com

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

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

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

Early Career
Michael J. Constantino, Ph.D.,
2007, 2008-2010
Department of Psychology
612 Tobin Hall - 135 Hicks Way
University of Massachusetts
Amherst, MA 01003-9271
Ofc: 413-545-1388 Fax: 413-545-0996
E-mail: mconstantino@psych.umass.edu

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

Diversity
Caryn Rodgers, Ph.D., 2008-2010
Prevention Intervention
Research Center
Albert Einstein College of Medicine
1300 Morris Park Ave., VE 6B19
Bronx, NY 10461
Ofc: 718-862-1727 Fax: 718-862-1753
E-mail: crodgers@aecom.yu.edu

Diversity
Erica Lee, Ph.D., 2008-2009
55 Coca Cola Place
Atlanta, Georgia 30303
Ofc: 404-616-1876
E-mail: edlee@emory.edu

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

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

Student Development Chair
Sheena Demery, 2009-2010
728 N. Tazewell St.
Arlington, VA 22203
703-598-0382
E-mail: Sheena.Demery@fedex.com

STANDING COMMITTEES

Fellows
Chair: Jeffrey Hayes, Ph.D.
Pennsylvania State University
312 Cedar Bldg
University Park , PA 16802
Ofc: 814-863-3799 Fax: 814-863-7750
E-mail: jxh34@psu.edu

Membership
Chair: Chaundrissa Smith, Ph.D.
Emory University SOM/
Grady Health System
49 Jesse Hill Drive, SE FOB 231
Atlanta, GA 30303
Ofc: 404-778-1535 Fax: 404-616-3241
E-mail: csmit33@emory.edu

Past Chair: Sonja Linn, Ph.D.
E-Mail: sglinn@verizon.net

Nominations and Elections
Chair: Jeffrey Magnavita, Ph.D.

Professional Awards
Chair: Jeff Barnett, Psy.D.

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

Education & Training
Chair: Eugene W. Farber, PhD
Emory University School of Medicine
Grady Infectious Disease Program
341 Ponce de Leon Avenue
Atlanta, Georgia 30308
Ofc: 404-616-6862 Fax: 404-616-1010
E-mail: efarber@emory.edu

Past Chair: Jean M. Birbilis, Ph.D., L.P.
E-mail: jmbirbilis@stthomas.edu

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

Associate Chair: Rodney Goodyear, Ph.D.
E-mail: goodyea@usc.edu

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

Associate Chair: Chrisanthia Brown, Ph.D.
E-mail: brownchr@umkc.edu

Psychotherapy Practice
Chair: Bonita G. Cade, ,Ph.D., J.D.
Department of Psychology
Roger Williams University
One Old Ferry Road
Bristol, Rhode Island 02809
Ofc: 401-254-5347
E-mail: bcade@rwu.edu

Associate Chair: Patricia Coughlin, Ph.D.
E-mail: drpcoughlin@gmail.com

Psychotherapy Research
Chair: Susan S. Woodhouse, Ph.D.
Department of Counselor Education
Pennsylvania State University
313 CEDAR Building
University Park, PA 16802-3110
Ofc: 814-863-5726 Fax: 814-863-7750
E-mail: ssw10@psu.edu

Past Chair: Sarah Knox, Ph.D.
E-mail: sarah.knox@marquette.edu

Liaisons
Committee on Women in Psychology
Rosemary Adam-Terem, Ph.D.
1833 Kalakaua Avenue, Suite 800
Honolulu, HI 96815
Tel: 808-955-7372 Fax: 808-981-9282
E-mail: rozi7@hawaii.rr.com

PUBLICATIONS BOARD

Chair : Jean Carter, Ph.D. 2009-2014
5225 Wisconsin Ave., N.W. #513
Washington DC 20015
Ofc: 202–244-3505
E-mail: jcarterphd@aol.com

Raymond A. DiGiuseppe, Ph.D., 2009-2014
Psychology Department
St John's University
8000 Utopia Pkwy
Jamaica , NY 11439
Ofc: 718-990-1955
Email: DiGiuser@STJOHNS.edu

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

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

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

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

EDITORS

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

Mark J. Hilsenroth
Derner Institute of Advanced
Psychological Studies
220 Weinberg Bldg.
158 Cambridge Ave.
Adelphi University
Garden City, NY 11530
E-mail: hilsenro@adelphi.edu
Ofc: (516) 877-4748 Fax (516) 877-4805

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

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

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

PSYCHOTHERAPY BULLETIN

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

Contributors are invited to send articles (up to 2,250 words), interviews, commentaries, letters to the editor, and announcements to Jenny Cornish, PhD, Editor, *Psychotherapy Bulletin*. Please note that *Psychotherapy Bulletin* does not publish book reviews (these are published in *Psychotherapy*, the official journal of Division 29). All submissions for *Psychotherapy Bulletin* should be sent electronically to jcornish@du.edu with the subject header line *Psychotherapy Bulletin*; please ensure that articles conform to APA style. Deadlines for submission are as follows: February 1 (#1); May 1 (#2); July 1 (#3); November 1 (#4). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.divisionofpsychotherapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or Division 29 should be directed to Tracey Martin at the Division 29 Central Office (assnmgmt1@cox.net or 602-363-9211).

DIVISION OF PSYCHOTHERAPY (29)
Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net
www.divisionofpsychotherapy.org

PSYCHOTHERAPY BULLETIN

Published by the
DIVISION OF PSYCHOTHERAPY
American Psychological Association

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

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

ASSOCIATE EDITOR
Lavita Nadkarni, Ph.D.

CONTRIBUTING EDITORS

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

Education and Training
Michael Murphy, Ph.D., and Eugene Farber, Ph.D.

Ethics in Psychotherapy
Jeffrey E. Barnett, Psy.D., ABPP

Practitioner Report
Jennifer F. Kelly, Ph.D.

Psychotherapy Research, Science, and Scholarship
Norman Abeles, Ph.D. and Susan S. Woodhouse, Ph.D.

Perspectives on Psychotherapy Integration
George Stricker, Ph.D.

Public Policy and Social Justice
Rosemary Adam-Terem, Ph.D.

Washington Scene
Patrick DeLeon, Ph.D.

Early Career
Michael J. Constantino, Ph.D. and Rachel Gaillard Smook, Psy.D.

Student Features
Sheena Demery, M.A.

Editorial Assistant
Crystal A. Kannankeril, M.S.

STAFF

Central Office Administrator
Tracey Martin

Website
www.divisionofpsychotherapy.org

PSYCHOTHERAPY BULLETIN

Official Publication of Division 29 of the American Psychological Association

2009 Volume 44, Number 3

CONTENTS

Editors' Column 2

President's Column 2

Interview 7
Abraham Wolf, Ph.D.

Psychotherapy research, science and Scholarship 10
Engaging Underrepresented, Underserved Communities in Psychotherapy-Related Research: Notes from a Multicultural Journey

Ethics in Psychotherapy....15
Psychotherapy, Online Social Networking, and Ethics

Education & Training 21
Prioritizing Case Formulation in Psychotherapy Training

Perspectives on Psychotherapy Integration 25
Making Evidence-Based Practice Work: The Future of Psychotherapy Integration

DIVISION 29 ~ 2009 APA PROGRAM 29

Early Career 33
Building a Private Practice by Being Public: From Social Networking Circles to Psychotherapy Groups

Feature 37
2009 Presidential Summit on the Future of Psychology Practice: Collaborating for Change

Feature 41
Ethics and the Interrogation of Prisoners

Student Feature 47
Journey to Adulthood in the 21st Century

Feature 50
Psychotherapeutic Treatment Implications for Obese Adolescents

Call for Fellowship Applications Division 29—Psychotherapy 54

Membership Application 56

EDITORS' COLUMN

Jenny Cornish, Ph.D., ABPP, Editor
Lavita Nadkarni, Ph.D., Associate Editor
University of Denver Graduate School of Professional Psychology

We are excited that this issue is too full to fit in more than a short paragraph from the editors. There is something for everyone: two timely papers on ethics (one related to online social networking and the other to interrogations), an important article on research and multicultural issues, a helpful piece on case formulation in training, a thoughtful submission on evidence-based practice and integrative models of psychotherapy, an interesting early career paper on social networking and private practice, and three student papers on a variety of topics, including an interview with Abraham Wolf, former D29 President and outgoing Internet Editor. In addition, be sure to read the President's Column, and an important report on the Psychotherapy Summit. Finally, information about our many award winners and the upcoming APA convention is included. We hope to see you soon in Toronto!

Jenny Cornish and Lavita Nadkarni
(303-871-4737, jcornish@du.edu)

PRESIDENT'S COLUMN

Nadine J. Kaslow, Ph.D., ABPP
Emory University Department of Psychiatry and Behavorial Sciences, Grady Health Systems

Culture of Competence
The current zeitgeist in professional psychology is competency-based. Competence refers to knowledge, skills, and attitudes, and their integration. Competencies are complex and dynamically interactive clusters of integrated knowledge of concepts and procedures, skills and abilities, behaviors and strategies, attitudes/beliefs/values, dispositions and personal characteristics, self-perceptions, and motivations that enable a person to fully perform a task with a wide range of outcomes.

Educational programs are expected to produce competence. Programs are accredited based in part on program outcomes and training in key competency domains. Professional credentialing bodies are expected to certify individuals as competent. Policy makers laud competence and consumers increasingly demand it. Thus, the time has come to embrace a culture of competence. There must be a shift within professional psychology toward the acquisition and maintenance of competence as a primary goal.

Many recent efforts have led to this shift to a culture of competence and its assessment, including the identification of the key foundational and functional competencies and their essential components. Foundational competencies are those knowledge, skills, and attitudes that

continued on page 3

serve as the foundation for the functions a psychologist is expected to carry out. The foundational competencies include: professionalism, reflective practice/self-assessment/self-care, scientific knowledge and methods, relationships, individual and cultural diversity, ethical and legal standards and policies, and interdisciplinary systems. Functional competencies refer to the major functions that a psychologist is expected to carry out. The functional competencies that have emerged by consensus within professional psychology include: assessment, intervention, consultation, research/ evaluation, supervision, teaching, management-administration, and advocacy.

In an upcoming article, a Competency Benchmarks Document (Fouad et al., in press) will appear that delineates the essential components that comprise each of these core foundational and functional competencies. The Competency Benchmarks Document also articulates benchmarks, behavioral indicators that reflect the expected level of performance at each stage of professional development for the essential components of each competency domain. As a companion to the Competency Benchmarks Document, another soon to be published paper will describe a Competency Assessment Toolkit for Professional Psychology (Kaslow et al., in press). This toolkit builds on a growing and long history of competency initiatives, both within the profession and in other healthcare disciplines. The methods include: 360-degree evaluation, annual/ rotation performance reviews, case presentation reviews, client/patient process and outcome data, competency evaluation rating forms, consumer surveys, live or recorded performance ratings, objective structured clinical examinations, portfolios, record reviews, self-assessment, simulations/role plays, standardized client/patient interviews, structured oral examinations, and written examinations. Given the tremendous strides that have been made with regard to evaluating competence, it is also time to embrace a culture of the assessment of competence. The assessment of competence fosters learning, evaluations progress, assists in determining curriculum and training program effectiveness, advances the field, and protects the public.

Psychotherapy Competence

Intervention, which includes psychotherapy at its core, is one of the functional competencies. This competency has been defined as interventions that are designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations. The essential components that have been delineated for this competency include: knowledge of interventions, intervention planning, skills, intervention implementation, and progress evaluation. Benchmarks for each of these essential components have been determined with regard to readiness for practicum, readiness for internship, and readiness for entry to practice.

I believe that members of the Division of Psychotherapy, those psychologists with a passionate commitment and dedication to the conduct of effective psychotherapeutic interventions, should take a leadership role in fleshing out the intervention/psychotherapy competence, including its essential components and benchmarks indicating competent performance at each stage of training and credentialing and in terms of life-long learning. I am excited to read the papers that will soon be published in *Psychotherapy: Training, Research, Practice, Training* in which leading authors discuss the essential components of the psychotherapy competency and the foundational and functional competencies informing the psychotherapy com-

continued on page 4

petency from various theoretical perspectives: cognitive behavior, psychodynamic, family systems, and existential/humanistic perspectives. I believe that these papers will represent an important effort toward advancing a shared articulation of the essential components of the psychotherapy competency unique to each theoretical orientation, as well as ways in which various foundational and functional competencies are linked to this competency and how these linkages may be unique depending on the theoretical frame and associated modality(ies). Hopefully, other scholars, practitioners, and educators from different orientations can build on these contributions to further hone our understanding of the psychotherapy competency across theoretical perspectives. It also behooves us to consider how this competency would appear from other theoretical frameworks, including an integrative model. Further, we need to consider benchmarks that move beyond licensure, as this will support the significant role that lifelong learning must play in our profession. Of course, most of us do not just strive to be competent, but rather we are dedicated to being capable. Capability refers to the extent to which competent individuals adapt their skills, generate new knowledge, and continue to improve their performance. The confluence of competence and lifelong learning is capability. I hope that you will join the Division and the field as we continue to advance the competencies movement, and help us bring to bear our expertise in the psychotherapy competency.

What's New In Division 29?

We are in the midst of a changing of the guard in terms of our internet editor. On behalf of Division 29, I want to publically thank Abe Wolf, PhD for doing a fantastic job for many years as our internet editor. He is the founding editor of our division's website and Online Psychotherapy Editor. Dr. Wolf has been wonderfully responsive to the members of the governance in terms of their website and listserv needs, and with regard to Psychotherapy ENews. He has been very thoughtful in his approach to responding to the various challenges and decisions associated with the website and listservs. As most of you know, Dr. Wolf is a Past-President of the Division, as well as a fellow of the division, recipient of the division's Jack Krasner Award for distinguished early career, and a member of the division's journal's editorial board (*Psychotherapy Theory, Research, Practice, Training*). Dr. Wolf is on the staff of the Department of Psychiatry at MetroHealth Medical Center, the country hospital for Cleveland, and Associate Director of Adult Outpatient Services. He is Professor of Psychology in Psychiatry at the School of Medicine, Case Western Reserve University. Dr. Wolf has a very active psychotherapy practice and he lectures and supervises psychiatry residents in individual psychotherapy. He has published in the areas of developmental behavioral pediatrics, the use of technology in psychotherapy, and the application of psychometric theory to instruments used to measure psychotherapy outcome. He is interested in the role of therapist factors in psychotherapy process and outcome, especially therapist self-awareness of countertransference reactions. He loves doing psychotherapy. We are extremely grateful to Dr. Wolf for his wonderful contributions to our division and we will miss him as he transitions out of his role as internet editor. However, he will remain an extended member of the Division 29 governance family.

I am delighted to introduce our new internet editor, Chris Overtree, PhD. Dr. Overtree received his doctorate in clinical psychology from the University of Massachusetts-Amherst. At the present time, he is the Director of the Psychological Services Center (PSC) and the Asso-

continued on page 5

ciate Director of Clinical Training for the Clinical Psychology Program at the University of Massachusetts-Amherst. His scholarship is focused on psychotherapy effectiveness in a naturalistic setting, as well as more effective methods of service provision in the community mental health system. He is a child/adolescent/adult and family therapist with specialties in anxiety disorders, depression, cognitive-behavior therapy, and family conflict. He also serves as a consultant to schools regarding bullying/harassment, climate reform, and improving academic outcomes. Dr. Overtree has hit the ground running. He is already livening up our website, so check it out. In addition, he will work with our Task Force on Strategic Initiatives to significantly enhance our website, so that it truly becomes a creative and engaging information portal. We are so pleased to have Dr. Overtree on board. Do not hesitate to contact me or Dr. Overtree if you have suggestions about ways to make the Division 29 internet presence more member-friendly, accessible, and valuable.

APA Convention

You will be receiving the *Psychotherapy Bulletin* just a few days before the annual convention. In the *Bulletin*, we have provided you details of our wonderful divisional programming. I am eager to interact with each of you at the meeting in Toronto. I particularly hope to see everyone at our Business Meeting/Awards Ceremony and Social Hour, which will be held on Friday. These events afford us the opportunity to honor our awardees; meet, talk, and socialize with one another; and enjoy some special entertainment put on by members of the Division 29 Board.

Feel Free to Get in Touch

I have really appreciated the chance to interact with so many members of our division since assuming the presidency. I really value everyone's input and ideas. Feel free to email me at nkaslow@emory.edu with questions, concerns, and suggestions. Please enjoy the rest of your summer!

(References available on-line.)

JOIN THE DIVISION OF PSYCHOTHERAPY

ON-LINE!

Please visit our website to become a member, view back issues of the bulletin, join our listserv, or connect to the Division:

www.divisionofpsychotherapy.org

INTERVIEW

Abraham Wolf, Ph.D.

Crystal A. Kannankeril, M.S.
Doctoral Student at Loyola College in Maryland

For many psychologists, joining a professional organization is another time-intensive responsibility added to the several demands involved in our profession and our already busy lives. For Dr. Abraham "Abe" Wolf, a job requirement for his faculty position at Case Western Reserve University turned into a 15 year partnership with the Division of Psychotherapy (29). When looking for a professional organization to join, Dr. Wolf was invited to join the Division by Dr. Gerry Koocher, the incoming president. Dr. Wolf related that Division 29 was a "natural Division for me to become involved with" given his interests in psychotherapy and research.

Since 1993, Dr. Wolf has been an active member and leader in Division 29, often using his interests and innovation as a way to propel Division 29 into the forefront of APA. Dr. Wolf began his service to Division 29 as the Co-Chair of the Student Development Committee, a position he held for five years. During this time, he aimed to increase student membership which he successfully accomplished with several hundred new student members. His committee selected the winner of the student paper awards, which has seen several successful recipients including Dr. Louis Castonguay of Pennsylvania State University. Pursuing even more leadership roles, Dr. Wolf became coordinator of APA's Mid-Winter Convention Committee, a joint Convention with Division 42 (Independent Practice) and Division 43 (Family Psychology) in 1998. From 1996 to 1998, he served as a Member-at-Large for Division 29 and was a member of the Division's Publication Board from 1996 to 2002. Moreover, Dr. Wolf served two terms as the Secretary for Division 29, which led up to his terms as President-Elect in 2005 and President of Division 29 in 2006.

Among these achievements and leadership roles, one of the hallmarks of Dr. Wolf's service to Division 29 occurred in 1997 when he became Division 29's first Internet Editor and World Wide Web Coordinator. Dr. Wolf's interest in computers and statistics began early in high school when he was offered to take part in a special computers program in 1967. During graduate school, these interests once again came to the forefront as he became more involved with statistical analysis and computers. Once the Internet hit in 1994, Dr. Wolf "jumped on that right away as it was the most amazing thing I've ever seen." What made Dr. Wolf a true asset and pioneer was his determination to bring his early interest and involvement with the Internet to Division 29. "No doubt, the Division needed to jump on this bandwagon—the sooner the Division had an Internet presence, the better," Dr. Wolf remarked during our interview.

His foresight and hard work over the next eight years as webmaster made Division 29 a front-runner among the APA Divisions with many Internet-based activities. His initial goal as Internet Editor was for Division 29 to have a web-based presence; this included creating a website and listserv for members. Dr. Wolf described these early tasks as a "Mom and Pop operation." The first website was originally attached to Case Western Reserve University where he has been a professor of psychology in the school's Department of Psychiatry

continued on page 8

for the past 30 years, hired right out of internship. After many versions of the website, Dr. Wolf was able to create a separate URL for Division 29 in 2004 (www.divisionofpsychotherapy.org), allowing for easier access to users.

Dr. Wolf's other achievements in his eight-year term as Internet Editor included creating and editing APA's Online Academy (www.apa.org/ce), making Division 29 one of the few Divisions to post online CE credits. This website allows members to watch archived conferences through web-streaming, making them easily accessible to members. Such CEs include Evidence-based Psychotherapy Relationships: What Works in General (2006), Treating the Hated and Hateful Patient (2006), The Proper Focus of Evidence-Based Practice (2006), and Evidence-based Psychotherapy Relationships: Customizing the Treatment Relationship to the Individual Patient (2007). This movement towards utilizing and pairing technology with psychology also became part of Dr. Wolf's presidential initiative in 2006 and serves as one of his favorite memories as Internet Editor. He recognized the importance of the Internet in psychology's future and worked hard towards keeping psychology current and relevant in this new age and growing field of technology. In addition, Dr. Wolf was named a Guest Editor for a special edition of Division 29's Journal *Psychotherapy: Theory/Practice/Research/Supervision* which focused on the technology of psychotherapy.

Dr. Wolf's achievements, however, did not come without their fair share of hurdles. He explained that what makes the position of Internet Editor unique and often challenging is facilitating communication and making this new medium meaningful to all the members of Division 29. Specifically, Dr. Wolf noted that having a website, listserv, and online newsletter may not be as simple or relevant for older, more well-established members who may have not have as much experience with these technological advancements as compared to their younger counterparts. He indicated that younger psychologists or students may take the Internet for granted, just as older members may take radio and television for granted. So, for members who did not grow up with the Internet, having these new online features may be more complicated; getting them to utilize this medium thus becomes more of a challenge. One of Dr. Wolf's goals was to help the older membership move into the 21st century. He remarked that "it is still a challenge to get people to join the listserv and effectively use the medium, which will be a continuing challenge to leadership and members [in the future]." He did note that members are excited and interested in this movement, though "it is hard to make those ideas into realistic applications."

When asked about his reflections on involvement with the Division, Dr. Wolf indicated that he has no regrets. He noted that it has been "truly one of the most rewarding activities I have ever done – [it has allowed me] to exchange ideas, collaborate on research projects, and be involved with great people whose articles you have been reading for years - and then get to have dinner with them." Dr. Wolf also joked, "for all the meetings, it is really worth it." He also wanted to acknowledge that he could not have accomplished all that he has without the support of his family.

Division 29 formally created the position of Internet Editor in 2005. With Dr. Wolf serving as Chair-Elect that year, Dr. Bryan Kim from the University of Hawaii became the next Internet Editor from 2005 to 2008. After Dr. Kim's three years of service, Dr. Wolf returned as Interim Internet Editor in 2008. The Incoming Internet Editor is Dr. Christopher Overtree from the University of Massachusetts Amhearst. In looking towards the future, Dr. Wolf is confident

continued on page 9

in the direction of this position. He explained that the website is due for "a more professional makeover" as it is now five years old. His words of wisdom for Dr. Overtree were to have a vision of where he sees the website growing and continually work towards those goals. As Dr. Wolf's leadership role in Division 29 come to a close, he also wanted to express the importance of members to get involved and "show up for our meetings—it will be a decision they will never regret!" On behalf of the members of Division 29, I would like to thank you, Dr. Wolf, for all that you have given to us—we will miss you as Internet Editor but look forward to your continued involvement with the Division of Psychotherapy.

APF ROSALEE G. WEISS LECTURE FOR OUTSTANDING LEADERS IN PSYCHOLOGY

Give an Hour: Shifting Our Nation's View of Mental Health and Psychology Care

Saturday, August 8, 2009
5:00 PM - 5:50 PM
Metro Toronto Convention Centre, Meeting Room 706

BARBARA VAN DAHLEN ROMBERG

Barbara Van Dahlen Romberg, founder and president of Give an Hour, is a licensed clinical psychologist who has been practicing in the Washington, D.C., area for 16 years. She specializes in the diagnosis and treatment of children. Dr. Romberg has spent her career interacting with and coordinating services within large systems, including school districts and mental health clinics. In addition, for many years, she served as an adjunct faculty member at George Washington University, where she trained and supervised developing clinicians. She received her Ph.D. in clinical psychology from the University of Maryland in 1991.

Concerned about the mental health implications of the Iraq War, Dr. Romberg founded a nonprofit organization called Give an Hour in 2005. The organization is creating a national network of mental health professionals who are providing free services to U.S. troops, veterans, and their loved ones. As of February 2009, the network currently has over 3,600 providers.

As part of her work with Give an Hour, Dr. Romberg has participated in numerous panels, conferences, and hearings on issues facing veterans. She also writes a monthly column for Veterans Advantage and is contributing to a book on post-traumatic stress and traumatic brain injuries. She is quickly becoming a notable source and expert on the psychological impact of war on troops and families.

PSYCHOTHERAPY RESEARCH, SCIENCE AND SCHOLARSHIP

Engaging Underrepresented, Underserved Communities in Psychotherapy-Related Research: Notes from a Multicultural Journey

Susan S. Woodhouse, Ph.D., The Pennsylvania State University

Dr. Janet Helms, well-known for her research on racial identity development (e.g., Helms, 1990), once said, "If you stay with any question long enough, it will become a multicultural question." She said this when I was still a graduate student in Counseling Psychology at the University of Maryland. I had an intellectual appreciation for what she was saying, but only later developed a deeper understanding as my research progressed. Much of my current research focuses on how to improve brief psychotherapy with parents and infants, including basic research on important aspects of the parent-infant relationship that should be targeted in such psychotherapy. I would like to share the story about how my psychotherapy-related research questions became multicultural questions, and how the journey has led to my current efforts to engage underrepresented, underserved minority group members in my psychotherapy-related research.

The story begins with a randomized controlled trial (RCT) of a brief, three-session, home visiting, preventive, psychotherapy intervention for first-time, economically stressed mothers of irritable infants and their babies (Cassidy, Woodhouse, Sherman, Stupica, Ziv, & Lejuez, 2009). The goal of the brief psychotherapy was to reduce the risk of insecure attachment. Attachment was targeted at an outcome because of the empirical evidence that insecure infant attachment is associated with behavioral problems and psychopathology (see Greenberg, 1999, and Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006, for reviews). While we were collecting data for the larger RCT, a group of investigators decided to conduct a smaller, qualitative study focused on better understanding the precursors to infant attachment (Cassidy, Woodhouse, Cooper, Hoffman, Powell, & Rodenberg, 2005). Our thinking was that outcomes of mother-infant psychotherapy could be greatly improved if we could better understand the most important precursors of attachment that should be targeted in treatment.

After three decades of research, there is still some degree of controversy about exactly how parental behavior serves as a precursor to attachment. Research has found via meta-analysis that there is a robust link between mothers' attachment representations and their infants' attachment security: mothers who are secure tend to have babies who are secure (van IJzendoorn, 1995). Attachment theory would suggest that the mechanism *through which* this link should occur is maternal sensitive responsiveness to the infant (Bowlby, 1969/1982). In fact, there is meta-analytic evidence that maternal sensitivity serves as a mediator of this link between mothers' and infants' attachment (van IJzendoorn, 1995). The problem, however, is that the effect sizes for the mediation model are much lower than theory would predict; van IJzendoorn termed this issue the *transmission gap*. In fact, the connections between maternal behavior and infant attachment are generally weaker in low-SES families (De Wolff & van

continued on page 11

IJzendoorn, 1997). The transmission gap raised many questions for us that we thought were important to resolve, particularly if our goal was to make psychotherapy for low-income, at-risk mothers and their infants as efficacious and efficient as possible. If it is important for infant-parent psychotherapy to work with parents on changing behaviors, we need to make sure that we know which behaviors really make a difference in later attachment outcomes.

The Cassidy et al. (2009) RCT was conducted in a large, metropolitan area that had a very diverse population; that diversity was reflected in the sample of the study. Participants were 169 infants and their economically-stressed mothers, including 42.6% African American/Black, 27.2% White, 19.5% Hispanic, and 10.7% mixed race or other. For the smaller, qualitative study we examined 18 mother-infant dyads (78% racial or ethnic minority group members) who were a part of the control group in the larger RCT. As mentioned earlier, our goal in the qualitative study was to try to figure out which maternal behaviors most mattered in predicting later attachment, so as to close the transmission gap. We hoped to be able to make suggestions about which maternal behaviors were most important to support and which were most important to target for change in psychotherapy.

Each research team member watched all of the available videotape (approximately 90 minutes of tape) from a lab visit (at 4.5 months) and three 30-minute videotapes of naturalistic home observations (7 to 9 months). We assessed maternal behaviors by focusing on the mother, but attended to the dyad for context using the Ainsworth, Blehar, Waters, and Wall (1978) conceptualization of sensitivity. Mothers were classified as either *insensitive* or *sensitive* according to the Ainsworth et al conceptualization of sensitivity. In order to be in the sensitive group mothers had to meet only a minimum, moderate level of sensitivity. We made extensive written qualitative notes on interactions. Based on our observations we attempted to predict the infant 12-month Strange Situation (Ainsworth et al., 1978) attachment classification and the maternal Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) classification. After independently making our predictions, we individually read the AAI and looked at the attachment classification score, watched the 12 and 18 months Strange Situation videos and looked at the scores, and made notes about what we had learned from the dyad. The team then met for a two-hour discussion of each dyad.

We were surprised at how few mothers were rated as sensitive according to the Ainsworth et al. (1978) conceptualization of sensitivity, especially given the rather moderate level of sensitivity required to be assigned to the sensitive group. Of the 18 mothers, only 3 were classified as sensitive and 15 were classified as insensitive. All of the mothers who were deemed sensitive had babies who were later classified as secure in the Strange Situation. Of the 15 mothers who were classified as insensitive, however, 6 had babies who were later classified as secure and 9 had babies who were later classified as insecure in the Strange Situation. The proportion of infants that were categorized as secure (50%) via the Strange Situation was consistent with the proportion secure in comparable samples (Spieker & Booth, 1988). Also, the 67% match of sensitive/secure and insensitive/insecure indicates that even in a small sample there is evidence for a connection between maternal sensitivity and infant attachment. Of greatest interest to us, however, were the 6 infants with mothers who would be deemed insensitive according to traditional measures of sensitivity but who later turned out to be secure. What we learned from this qualitative study was that what seemed to

continued on page 12

best predict attachment outcomes was not sensitivity as typically conceptualized, but instead whether the mother was willing to serve as a *secure base* for the infant. Insensitivity, per se, was not antithetical to security. In other words, mothers could engage in a larger number of insensitive behaviors as long as in the end, at least 50% of the time, the mother relented and allowed the baby to come in for comfort when distressed, did not activate the attachment system while the child was exploring, and refrained from certain particularly negative behaviors (e.g., frightening the baby, harsh/hostile responses to infant distress). It was as if one central thing the infants were learning from all their experiences with their mothers was whether, on the whole, their mothers would provide a secure base for them when they most needed it. Instead of taking an "average" of the mothers' sensitive/insensitive behaviors in terms of a moment-by-moment matching to infant signals, infants seemed to be thinking about how *episodes of distress* tended to turn out in the *end* when they most needed something (Cassidy et al., 2005).

Based on these qualitative findings we developed a quantitative, observational measure of *secure base provision* and found empirical evidence that secure base provision predicted later infant attachment whereas a traditional measure of sensitivity did not in a low-income, diverse sample (Woodhouse & Cassidy, 2009). I thought that these findings were very important because we need to understand which parenting behaviors make a difference in child outcomes and to have culturally-appropriate ways to assess those parenting behaviors. The Woodhouse and Cassidy (2009) findings supported the idea that secure base provision is a more culturally-appropriate measure of parental responsiveness in a racially/ethnically diverse, low-income sample of parents than was sensitivity because secure base provision allowed for prediction of attachment security, whereas sensitivity did not. I would argue that the secure base provision measure avoids emphasizing the importance of certain culturally-bound parenting practices found in white, middle class samples (e.g., sweet tone of voice, affectionate comments, moment-to-moment affective attunement) and does not pathologize other culturally-based parenting practices (e.g., what might be termed "no-nonsense parenting"). Instead the coding system focuses on behaviors that appear to predict later infant attachment across groups. Frequently, differences between racial groups are cast as an indication that minority group children deviate from typically developing children, and there is a lack of research on adaptive strategies and pathways to success (Garcia-Coll, 1990). Use of assessments of parenting that are based on white, middle class norms frequently results in the pathologizing of minority group parents' caregiving. In order to design culturally appropriate and relevant preventive psychotherapy, it is crucial to avoid pathologizing culturally-based parenting practices (e.g., "no nonsense parenting") that are not detrimental to children's attachment security.

When I moved from my postdoctoral fellowship position in a major metropolitan area to my current position at the Pennsylvania State University, I was very excited to continue my work in this area. Because there is not a great deal of racial diversity in rural Pennsylvania, I decided to pursue my research in the nearest urban area, Harrisburg, Pennsylvania. I found lab space and was able to obtain university seed money to pursue a pilot project there that focused on examining relations between observations of mothers' caregiving behavior and (a) mother and infant emotion regulation (as indexed by heart rate variability), as well as (b) mother and infant stress responses (as indexed by cortisol and alpha-amylase in saliva), during times of infant distress. The goal was to try to understand the role of mothers' own emotion regulation in the process of caring

continued on page 13

for their infants, as well as to understand how maternal caregiving was linked to infant emotion regulation and later attachment. My hope was that such basic research could help us better understand potential targets for intervention, so as to design better a better mother-infant psychotherapy protocol that could later be tested. The demographics of Harrisburg (e.g., 50% African American) struck me as ideal for continuing to explore parenting across cultures in order to help design mother-infant psychotherapy interventions that were culturally appropriate. Very quickly, though, I began to realize that doing research in underrepresented, underserved communities outside of the major metropolitan areas was going to be unexpectedly challenging.

When we tried to recruit mothers to participate in the pilot study we found that the minority group mothers simply did not trust us or research in general. I realized that we needed to build bridges with the community and find a way to build trust.

I partnered with two other Penn State researchers (Kristin Buss and Laureen Teti) who were also interested in African American families. Together we met with three African American Harrisburg community leaders that we knew through our Penn State connections. These community leaders served as cultural informants for us, telling us about the history of racism in Pennsylvania and a community memory for the history of misuse of research findings. They advised us to get to know a variety of community leaders who could help introduce us to the community. They talked about the importance of incorporating tangible ways of giving back to the community into our efforts, including community workshops and finding ways to bring the results of the research back to community members. They gave us a great deal of advice on how to talk about what we were doing and how it could be relevant to the community.

Using seed money from our university Children, Youth, and Family Consortium we established Parents and Children Together (PACT): A Place for Learning about Children and Families. We met individually with a variety of community leaders including pastors, nurses, physicians, youth arts educators, agency administrators, social workers and others and invited them to join a Task Force to help guide our efforts to engage the community in research and find meaningful ways to give back to the community. The Task Force gave us many helpful ideas including hiring from the community and finding ways to partner with community groups to do the research itself. We started to attend community events to talk about our research in the community and we hired a research coordinator/recruiter from the community. We began providing workshops for community members and building a database of families interested in research participation.

All of our efforts in the community have helped us to engage the community in our individual research projects. However, the most recent step we (Kristin Buss, Laureen Teti, Chalandra Bryant, and Susan Woodhouse) have taken is to develop a research partnership with a church-affiliated, non-profit community development corporation, Holistic Hands Community Development Corporation (led by Brenda Alton and Robin Perry-Smith). We are using community based participatory research methodology to develop a specific research question related to children's anxiety. Eventually, we expect to work with the community to develop a culturally appropriate intervention that can help to reduce the risk of anxiety disorders. The work is in process, but very interesting themes have already begun to emerge. It is very exciting to watch community members become engaged in thinking about research at a grassroots level.

(References available on-line.)

Get More for Your Dollar

With Trust Endorsed Income Protection (disability income) Insurance

You don't have to pay more to protect your most important asset – your earning power. Take a look at our rates. You'll find that you can often buy much more protection for the same dollar you may be spending elsewhere. Our rates are the lowest they've been in 50 years based solely on the exemplary claims experience of psychologists insured through the Trust program.

The Trust Income Protection plans are designed to replace your income in the event of total disability. They include a "Your Own Occupation" definition of disability and monthly benefits up to $10,000. The LifeStyle-65 Plus plan can even provide funds to continue contributions to your pension or savings plan while you are totally disabled.

Call us now at **1-800-477-1200** or visit **www.apait.org** to compare the costs of Trust-endorsed Income Protection Insurance against what you already own. You may achieve substantial savings, even in these times of rising costs and shrinking dollars.

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

Trust LifeStyle Plans Feature:

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

$2,500 Monthly Benefit – LifeStyle 65 Plan 90 Day Waiting Period	
Age	**Quarterly Premium**
35	$55.25
40	$70.50
45	$103.00
50	$121.25
55	$141.00

THE TRUST

www.apait.org • 1-800-477-1200

ETHICS IN PSYCHOTHERAPY

Psychotherapy, Online Social Networking, and Ethics

Jeffrey E. Barnett, Psy.D., ABPP and Allison Russo, M.S.

With each passing day technology plays an increasingly important role in the lives of both psychotherapists and those we serve. The Internet, E-mail, social networking sites, chat rooms, professional E-mail lists, and the like each impact how we live, work, communicate, and relate to each other. While it may seem that how psychotherapists utilize various technologic advances in our personal lives is not an ethical issue, in the digital world in which we now live there is no clear boundary or line of separation between our personal and professional lives. As will be presented, the use of social networking sites by psychotherapists (professionally and/or personally) and by their clients presents a unique set of ethical challenges and dilemmas.

Ethics and the Internet

The *Ethical Principles of Psychologists and Code of Conduct* (Ethics Code; APA, 2002) states clearly that: "The Ethics Code applies to (professional) activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions" (p. 1061). Additionally, the APA Ethics Committee has promulgated the *Statement by the Ethics Committee on Services by Telephone, Teleconferencing, and the Internet* (APA, 1997) in recognition of the growing role technology plays in clinical practice. The Canadian Psychological Association (2008) developed the *Ethical Guidelines for Psychologists Providing Psychological Services Via Electronic Media* to address the ethical challenges and dilemmas often associated with utilizing the Internet. Further, the International Society for Mental Health Online has promulgated the *Suggested Principles for the Online Provision of Mental Health Services* (2000). Thus, it is clear that psychotherapists should give thought to the role and impact of the use of electronic media in their professional roles and use these documents to inform these decisions. Familiarity with relevant ethical standards and practice guidelines and careful consideration of the impact of the use of various online media are important for each practicing psychotherapist.

Even with thoughtful utilization of available resources, psychotherapists may face a myriad of ethical challenges and dilemmas regarding the role of social networking sites in our professional and personal lives that will require our careful consideration. Examples include:

- A seasoned psychotherapist receives an E-mail invitation to join a social networking site. The site obtained his name and E-mail address from one of his clients, who hoped to learn more about the clinician by "friending" him on the site.
- A supervisor performs a Google search on one of her graduate student supervisees and finds a link to a profile he keeps on a social networking site. She views his profile and finds many pictures of him in bars holding and drinking alcoholic beverages.
- An early career psychologist who utilizes a social networking site to keep in touch with family and friends receives a "friend request" from a former client she treated for six months during her graduate training.

continued on page 16

Social Networking Sites

Social networking sites (SNSs) are described as "interactive websites designed to build online communities for individuals who have something in common - an interest in a hobby, a topic, or an organization - and a simple desire to communicate across physical boundaries with other interested people" (Carter, Foulger, & Ewbank, 2008, p. 682). The most popular of these are Facebook and MySpace, although others, such as LinkedIn and Friendster, also have followings, albeit to a lesser extent (Salaway & Caruso, 2008).

As part of their online networking practice, users typically post personal information about themselves that may include educational, occupational, and contact information, as well as descriptions of their interests and activities. Many users also post photographs of themselves alone and/or in groups. Users may communicate with each other by leaving messages on one another's pages or merely learn more about other users via viewing their personal profiles. While these sites are typically used for general networking purposes, some appeal to particular interests (e.g., LinkedIn's primary aim is career networking) or populations (e.g., Facebook initially limited its membership to undergraduates, who continue to comprise the bulk of its members; Salaway & Caruso, 2008).

The sharing of personal information across as public a medium as the Internet brings with it a number of risks, and users are wise to recognize that abuse or simply negligent use of these sites may have deleterious effects. For example, revealing excessive personal information without implementing sufficient privacy controls has led to fear of identity theft and Internet stalking. Additionally, the prominent case of Megan Meier, the 13-year-old girl who committed suicide in 2006 after receiving harassing messages on MySpace from a user who had created a fraudulent profile, has made the potential impact of SNSs in users' lives and social functioning devastatingly apparent. Conversely, it appears as though SNS usage may also have positive social effects. Ellison, Steinfeld, and Lampe (2007) found that Facebook utilization was positively related to the amount of social resources ("social capital") enjoyed by undergraduate students. This effect was exaggerated in students who reported lower levels of life satisfaction and self-esteem, suggesting the particular usefulness of SNS usage for individuals with social struggles offline.

Patterns of Social Networking Site Use

An extensive survey conducted by the Educause Center for Applied Research (Salaway & Caruso, 2008) yields statistics on SNS usage that make the phenomenon impossible for psychologists to ignore. The findings indicate that the vast majority (85.2%) of all undergraduate students frequent at least one SNS, with membership comprised of a greater proportion of younger students than older students (i.e., fully 95.1% of 18-19 year old students report SNS usage, compared with only 37% of undergraduates aged 30 years or more). Furthermore, 56.8% of respondents make SNS usage a part of their everyday activities, up from 32.8% in 2006, which demonstrates the recent and considerable rise in the integration of SNSs in users' daily functioning. The most frequently reported purpose of SNSs is to maintain connections with existing friends and acquaintances (96.8%); just 16.8% make use of these sites to foster entirely novel friendships. In addition, more than half of respondents use these sites to gather more information about people they may or may not have met (51.6%) and to share photographs, videos, and other media (67.7%).

Yet, SNS use is not limited to undergraduate students. Facebook presently has more than 175 million registered users

continued on page 17

worldwide. More than 3 billion minutes are spent on Facebook each day and more than 18 million users update their page each day (Facebook, 2009). MySpace presently has more than 185 million registered users worldwide. Approximately 25% of all Americans are active MySpace users. Almost 350,000 individuals sign up as new users of MySpace each day and it has achieved more than 4.5 billion page views in a single day. Over 1.5 billion images are shared via MySpace each day. Fifty million mails are sent each day through MySpace and there are over 10 billion active friend relationships at present (Social Network Stats, 2008). The ubiquitous nature of SNSs in the lives of so many is quite evident from the above data.

Ethical Challenges and Dilemmas

The use of SNSs by psychotherapists and their clients raises a number of ethical challenges in areas that include informed consent, boundaries, self- disclosure, and multiple relationships. Boundary violations and multiple relationships are inherent concerns when considering SNSs for psychotherapists. Practitioners who utilize these sites may receive online requests from their clients to become "friends" on these sites, and accepting these requests necessarily blurs the lines of the therapeutic relationship. Although it is generally accepted that "friends" on SNSs are often mere acquaintances, the title may still complicate expectations of the relationship and the role of the psychotherapist in the client's life. Although befriending a client online does not necessarily constitute an *exploitative* multiple relationship (See Standard 3.05 of the APA Ethics Code), it may be the first step in a series of increasingly inappropriate communications or disclosures that are not consistent with anticipated professional roles.

Declining the client's 'friend' request may be a clinical challenge and may have some impact on the psychotherapy relationship and process if not addressed appropriately. While it seems as though the simple solution to this dilemma is to either limit search options or refrain from using SNSs altogether, even these precautions may not eradicate the issue: current or former psychotherapy clients may send electronic membership invitations to clinicians who do not already have a SNS listing (as illustrated in Scenario 1 above). For those who have a SNS the use of different levels of security settings may prevent clients from having free access to the psychotherapist's online materials, but the existence of the online profile is usually not hidden and clients may still request being accepted as a friend. Further, some clients who are very computer savvy may be able to circumvent security settings and obtain access to information intended only for personal use.

In some ways, friend requests and membership invitations may be viewed as auspicious, as they may indicate that the client considers the therapeutic relationship to be a strong one. They may also indicate a client's desire to share personal information with the clinician that is relevant to the psychotherapy and this may be a valuable contribution to the psychotherapy process (Lehavot, 2009). In such cases, it may be possible to view the client's online materials together and process them as part of the ongoing therapeutic process. Alternatively, friend requests may indicate a client's suspicion of the clinician or simply a boundary crossing to obtain more information about the psychotherapist's personal life to quell curiosity. Regardless, such an event should be addressed in psychotherapy in order to determine the impetus for the request and the client's reaction if the psychotherapist chooses to decline the invitation. As Lehavot (2009) states: "By paying thoughtful attention to the function of the client obtaining information about the clinician online, the psychotherapist can examine this behavior as an opportunity to enhance the client's treatment" (p. 28).

continued on page 18

It should be pointed out that sharing information with a client in itself is not necessarily unethical. Psychotherapists have the right to decide how much personal information they are comfortable sharing with clients. But, psychotherapists should also consider the impact of such online relationships on the psychotherapy relationship and process. Considering these issues and their potential consequences before they become an issue with a particular client is recommended.

Issues of informed consent arise when clinicians decide to conduct online searches for their clients without their knowledge or prior approval. While one may argue that viewing a client's profile can be useful clinically insofar as it may provide clinicians with additional or corroborating data to enhance understanding of various aspects of the client's life, doing so clandestinely may have substantial negative implications for rapport. For example, if a psychotherapist learns of a client's experimentation with illicit substances online and the client has not disclosed this in treatment, what does the psychotherapist do with this information? Should one disclose their search and what they have learned, accepting any negative impact on the therapeutic relationship, or should one withhold the information and not address in treatment a potentially significant clinical issue? Similar issues are relevant for supervisors who search for information about their supervisees online (as depicted in Scenario 2 above). Psychotherapists and supervisors should consider issues of trust as well as professional role modeling when considering these decisions.

It should be noted that psychotherapists vary in their perceptions of the clinical impact of self-disclosure, multiple relationships, and boundary crossings and will vary in their comfort level with the intersection of SNSs and their clinical practice. Williams (1997) has pointed out that the clinician's theoretical orientation may impact views of the appropriateness and use of psychotherapist self-disclosure. Humanistic psychotherapists may be more open to the use of self-disclosure to make themselves appear more genuine and to narrow the power differential between clinician and client. In contrast, psychoanalysts and psychodynamic psychotherapists may prefer less transparency with their clients to promote the transference relationship and thus may utilize self-disclosure much more sparingly. Williams importantly portends the possibility of ethically incorporating SNS usage into clinical practice in his suggestions for a thoughtful and flexible approach to boundaries and self-disclosure. Still, if clinicians decide to use SNSs professionally, they are encouraged to do so only after carefully weighing costs and benefits and proceeding with appropriate caution so that the standards of the APA Ethics Code may be upheld and clients' best interests are addressed.

It is, however, important to keep in mind that in the Internet age, many clients are likely to search for information about their psychotherapist. This will likely be true regardless of one's decision to participate in SNSs given that individuals have been encouraged in recent years to become more informed consumers of services and to be more actively involved in their care, and that use of the Internet for such purposes is prevalent. Psychotherapists should anticipate this occurring. In fact, one recent survey of consumers found that 80% of all Internet users have searched for health care information online to include information about specific health care professionals (Fox, 2005).

Cohort Effects

Seasoned Professionals

While some senior psychotherapists may be active online, many may feel unaffected by the SNS trend in terms of its

continued on page 19

influence on their ethical practice by virtue of the fact that relatively few of them participate in online social networking. Many, although clearly not all, may also be unaware of the pervasive effects of the SNS trend, given that they came of age in a different time. However, the issue remains an important one to consider, especially when treating clients who are active on the Internet. For seasoned professionals, limited familiarity with SNSs may restrict their ability to comprehend the social substrate in which many of their clients function, particularly those in the net generation. These clients are so-called "digital natives" (Prensky, 2001) in that they have been raised in an electronic culture, speaking a digital language that is foreign to many "digital immigrant" seasoned professionals. Given the widespread use of SNSs, it is prudent to obtain at least a general awareness of the purpose, features, and potential risks and benefits of these sites so that we are able to converse with clients and understand the world in which they function.

Students and Trainees

The psychology graduate student cohort is arguably the one within our profession most associated with the SNS trend. They are in a unique position as budding professionals in the field in that SNSs are already largely a part of their social lives; that is, many trainees were undergraduates when the social networking craze began and initially thrived on college campuses (e.g., Facebook was launched in 2004). As such, the next generation of psychologists has been largely immersed in the culture of online social networking and likely hadn't considered issues of professionalism in social networking prior to entering graduate school. The recent concern about psychology graduate students' lives on the Internet has been mirrored by similar concerns in the medical (Thompson et al., 2008) and teaching (Carter, Foulger, & Ewbank, 2008) professions.

Trainees should very carefully monitor and consider the information they include in their online profiles. While it is necessary for all practitioners to be cognizant of the information they share online, many trainees will have developed a profile prior to their involvement in the field of psychology. For that reason, it is recommended that trainees review all material on their profiles in order to determine its appropriateness and make alterations as needed. For example, online videos, photos, and writings that seemed very appropriate for an audience of peers when a college sophomore may not be viewed in the same manner by graduate school admissions committee members or even by undergraduate faculty who are asked to write letters of recommendation. Then, when in graduate school, one's online presence may impact externship and internship decisions. Graduate student psychotherapists-in-training must also consider the potential impact of their online presence on their clients.

Recommendations

Psychotherapists should consider all online posts they make and profiles they keep to be self-disclosures, even if precautions are taken by setting privacy controls on SNSs. Clinicians are encouraged to remain cognizant of the fact that even if a given disclosure is not unethical per se, it still may have an impact clinically; that is, anything that is put on the Internet may influence our professional roles and relationships. Furthermore, although the Ethics Code only technically pertains to professional endeavors, materials placed on the Internet for personal relationships cannot be kept completely separate from our professional roles. Additionally, information accessed about psychotherapists in our personal lives may impact the public's view of us professionally as well.

It is recommended that psychotherapists maintain professional websites so that

continued on page 20

clients who search for us via the Internet will access the information shared there that is of relevance to our professional roles and activities. Information shared may include credentials, training experiences, areas of specialization and populations worked with, and related professional information (Barnett & Hillard, 1999). Always consider the meaning of "friend" requests from clients in the context of their psychotherapy. When appropriate, use joint review of the SNSs as a therapeutic activity. That is, if a client has invited a psychotherapist to be their "friend" online in order to share personal information, photos, or other media, suggest the option of having the client log on to their profile during session so that the profile viewing may be done together. This may help ensure a minimal likelihood of boundary violations or threats to trust and guarantees that the online content may be jointly explored and processed in session.

Consider the option of prescribing SNS use to clients to address certain challenges they may have, either as a primary intervention or as a supplement to other, more traditional strategies. For example, a client who is struggling to find a worthwhile career path may engage in standard career counseling as well as become involved in LinkedIn.com, which is largely devoted to professional development.

Teaching professionals should include their policy statement on online searches of applicants and students in their program materials. Additionally, expectations for student professionalism with regard to their online presence and activities should be included in student handbooks and be reviewed beginning at orientation and reviewed throughout their training. Assisting trainees to make the digital transition from the purely personal to the professional is an important role for supervisors and faculty.

(References available on-line.)

Bulletin ADVERTISING RATES

Full Page (4.5" x 7.5")	$300 per issue
Half Page (4.5" x 3.5")	$200 per issue
Quarter Page (2.185" x 3.5")	$100 per issue

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

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

Deadlines for Submission

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

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

EDUCATION & TRAINING

Prioritizing Case Formulation in Psychotherapy Training

Eugene W. Farber, Ph.D., Emory University, Atlanta

Increasing emphasis recently has been placed on identifying foundational and functional competencies for professional psychology practice (for review, see Rodolfa et al., 2005). A key purpose for elaborating these competencies is to inform the development of competency-based models for professional training in psychology (Kaslow, 2004). In contributing to the professional dialogue on this issue, Spruill et al. (2004) identified case formulation among a set of important clinical competencies in intervention planning. They characterized competency in case formulation as requiring skills in integrating information gleaned from the clinical assessment into a conceptual model of both the clinical problem and pathways for addressing the problem. In their discussion of this issue, Spruill et al. also cited the role of clinical supervision in helping psychotherapists in training to develop competency in case formulation. Concerns recently have been raised, however, about a relative lack of explicit concentration on the development of case formulation competencies in psychotherapy training (Ivey, 2006). An electronic search of the psychology literature using the keywords "case formulation and psychotherapy training" yields only 6 articles on this topic. This points to the paucity of professional dialogue on case formulation training. As such, there appears to be a need to raise the level of professional discussion on the issue of training in psychotherapy case formulation as part of the overall process of psychotherapy training in general. This includes the articulation of training strategies that support development of key case formulation competencies in psychotherapy trainees.

Case Formulation: Definition and Relevance to Psychotherapy Training

Psychotherapy case formulation may be defined as "…a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems…" (Kendjelic & Eells, 2007, p. 66). Teaching systematic case formulation strategies affords trainees the opportunity to organize their thinking about clinical material into a coherent plan for psychotherapy intervention. The formulation provides a conceptual framework for understanding the client, including clinical symptoms, problems, and psychological themes expressed in psychotherapy. It also informs psychotherapy planning, including the identification of themes that comprise the focus of treatment, the setting of treatment goals, the selection of psychotherapy techniques and intervention strategies, and the management of the psychotherapy relationship. Finally, case formulation can be invaluable in making sense of unanticipated and/or clinically complex events, crises, or problems that arise in the course of psychotherapy. The psychotherapist typically must improvise in responding to these unpredictable clinical situations (e.g., Binder, 2004), and having a clearly defined conceptual roadmap can provide a helpful reference point that anchors the psychotherapist in this process. This is particularly valuable for trainees, where continual and systematic use of the case formulation as a basis for psychotherapeutic decision-making provides the clarity needed to organize a well thought-out response to challenging and ambiguous situations arising in the psychotherapy process. Although research on this topic is limited, there are empirical findings supporting the usefulness of formulation-based psychotherapy practice, including the benefits of using case formulation in psychotherapy with clinically complex cases (for review, see Kendjelic & Eells, 2007).

continued on page 22

Competencies and Case Formulation Training

A competencies-based approach can help to inform thinking about the issue of training in psychotherapy case formulation. In reporting a study showing that expert psychotherapists demonstrated superior case formulations when compared with novice and experienced psychotherapists (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005), the study authors offered interpretations in explaining their findings that may point to some clues regarding competencies in case formulation. For example, they suggested that experts in their study might have a particularly well developed capacity to glean a range of patterns from clinical data and use this capacity to develop complex and nuanced formulations. Additionally, the experts appeared to utilize a consistent and systematic formulation approach that may facilitate a deep level of understanding of clinical material. The study authors also surmised that well developed self-monitoring skills also may be of benefit in the case formulation process.

In describing a specific method for psychodynamically focused case formulation training, Ivey (2006) identified several competencies required for developing good formulations. These include skills in observing and describing both verbal and nonverbal behavior, the ability to elicit a detailed description of the patient's experience that can be elaborated into an experiential account of the patient's problems, the capacity to track the patient's perceptions of and relationships to self and others, awareness of the patient's reactions to the psychotherapist, and a sufficient grasp of theory, including the capacity to apply it to the case formulation process.

Although not focusing on psychotherapy case formulation competencies per se, Binder (2004), in a discussion of psychotherapy competency as applied to the clinical practice of brief dynamic psychotherapy, has described several broad psychotherapy competencies that are instructive in thinking about psychotherapy case formulation training. One such competency pertains to having a theoretical framework for understanding personality functioning and psychotherapy process (Binder, 2004). When training psychotherapists in case formulation, it is critical that the trainee learn how to work within a conceptual model of psychological functioning and psychotherapy process to develop a theoretically informed case formulation of a given clinical case. Often trainees experience a discrepancy between their theoretical knowledge and their capacity to apply this knowledge in developing a clinically useful case formulation, and good case formulation training should provide opportunities for trainees to practice integrating their theoretical knowledge with their clinical knowledge and skills (Ivey, 2006). A second competency outlined by Binder (2004) involves skill in developing the case formulation itself. To develop this competency, the trainee must learn to make effective use of the assessment process and to organize clinical material obtained through the assessment process into a theoretically informed and coherent formulation of the problem. This formulation comprises a "story" of the problem and the factors sustaining the problem and suggests a clinical focus that guides treatment, including pathways to addressing the problem (Binder, 2004). A third competency articulated by Binder (2004) involves the capacity of the psychotherapist to utilize the case formulation in the moment-to-moment unfolding of the psychotherapy process. As such, training also needs to focus on developing skills in tracking the treatment focus specified by the case formulation over the course of treatment and to adjust the formulation where needed to accommodate new clinical findings over time.

Examples of Case Formulation Training Approaches

Despite the paucity of written accounts of systematic approaches to psychotherapy case formulation training, Ivey (2006) offers a structured model for case formulation training for psychology trainees. Although psychodynamic in focus, the general structure of this approach could be applied to the process of case formulation training across the spectrum of theoretical perspectives. The training is conducted in a module that in-

continued on page 23

cludes weekly sessions held over a 3 month period concurrent with modules on psychopathology, psychotherapy, and psychological assessment. Case formulation training occurs using an 8-step process. The first step focuses on definitions of case formulation and the clinical information domains that are relevant to conducting case formulation. In the second step, trainees are provided with written case material for practice in constructing a case formulation guided by specific instructions for doing so. Trainees use their practice case formulation in step 3 as a starting point for learning the specific criteria for what a good case formulation looks like. Trainees then are asked to evaluate their practice formulations in accordance with these criteria. In step 4, having already covered general concepts of case formulation, the characteristics that make a formulation narrative explicitly psychodynamic are outlined. In step 5, the structure of the case formulation is explained, including the conceptual elements of the formulation and how they are synthesized to provide a coherent clinical narrative for understanding the problems and concerns of the client. The sixth step involves practice in small training groups, utilizing the structure outlined in the previous step to develop case formulations drawn from written case material. These formulations are discussed and critiqued by the trainee group. Videotaped clinical material is provided in step 7 as the basis for further case formulation practice. This allows trainees to expand their repertoire of case formulation skills by learning to incorporate observations of the client's nonverbal behavior and patterns of response to the clinician. In the final step, trainees are asked to integrate their subjective emotional reactions to the client observed in videotaped samples into their case formulations.

Levenson (1995, 2003) has described an approach to psychotherapy case formulation training integrated within a 6-month program of training in time-limited dynamic psychotherapy (TLDP; Strupp & Binder, 1984). Levenson's (1995, 2003) approach includes a weekly didactic seminar and a psychotherapy supervision group. Trainees receive instruction in the theoretical underpinnings of TLDP and its theoretically grounded template for developing a psychotherapy case formulation. This template is comprised of model-specific categories of clinical data that can be organized and synthesized into a narrative conceptualization of the case. Trainees also are explicitly invited to explore their own feelings and reactions to their clients and to incorporate these experiences into their case formulations. Trainees develop written case formulations of their psychotherapy patients using the TLDP template and utilize these formulations to inform the development of treatment goals. The case formulation and goals are routinely discussed in group supervision as part of each trainee's presentation of videotaped psychotherapy sessions, providing opportunities for input from both the supervisor and trainee peers. Trainees are specifically encouraged to reflect on how the case formulation informs psychotherapeutic decision- making and how the case formulation may evolve or change as new clinical information emerges.

Kendjelic & Eells (2007) conducted a study examining the effects of clinician training in use of a so-called generic components approach to case formulation. The 4 components of their case formulation approach included symptoms and problems, precipitating stressors, predisposing events and conditions, and an inferred mechanism for conveying the psychotherapist's explanation of patient's problems. In this study, the TLDP case formulation approach was used as an example of an inferred mechanism. Clinicians in the training group received a 2 hour group presentation on case formulation. The training included discussion of why case formulation is important, and introduced the 4 generic components comprising the case formulation approach. Factors contributing to the quality of a case formulation also were discussed, and participants had an opportunity to practice the case formulation method using a sample vignette. Study results showed that even with as little as 2 hours of training, clinicians in the training group produced higher quality case formulations than clinicians in the control group.

continued on page 24

Conclusions: Toward Increasing Dialogue on Case Formulation Training

The value of case formulation for psychotherapy planning and intervention is widely acknowledged across a spectrum of psychotherapy orientations (Eells, 2007). Recent empirical research underlines the usefulness of systematic training in methods of psychotherapy case formulation (Kendjelic & Eells, 2007). Given the importance of good case formulation skills to psychotherapy practice, the issue of how best to approach training in psychotherapy case formulation warrants further discussion. This discussion should include consideration of the key competencies to be included in case formulation training and elaboration of methods to systematically develop these competencies. Approaches to evaluating the effectiveness of training methods in psychotherapy case formulation also should be considered.

(References available on-line.)

CONGRATULATIONS TO OUR AWARD WINNERS!

Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy: The Distinguished Psychologist Award is based on significance of contributions to the practice, research, and/or training in psychotherapy. The 2009 award is presented jointly to Norine Johnson, Ph.D and Jon Carlson Ed.D., in recognition of their outstanding accomplishments and significant lifetime contributions to the field of psychotherapy

American Psychological Foundation Division of Psychotherapy Early Career Award is presented to Katherine Muller, Psy.D. for distinguished early career contributions to the field of psychotherapy and the Division of Psychotherapy.

The Division of Psychotherapy Award for Best Empirical Research Article in 2008 is presented to: Michelle Newman, Louis Castonguay, Thomas D. Borkovec, Aaron J. Fisher, & Samuel S. Nordberg. (2008). *An open trial of integrative therapy for generalized anxiety disorder. Psychotherapy: Theory, Research, Practice, Training, 45*, 135-147

The Division of Psychotherapy Award for Distinguished Contributions to Teaching and Mentoring, which is presented in its inaugural year to Marvin Goldfried, Ph.D. in recognition of his significant contributions to the field of psychotherapy through his impact on the lives of developing psychologists in their careers as psychotherapists

The Division is also pleased to announce the following student paper ward winner:

Mathilda B. Canter Education and Training Student Award
presented to Sarah M. Gates

Making Evidence-Based Practice Work: The Future of Psychotherapy Integration

Marvin R. Goldfried, Ph.D., Stony Brook University

Within the past several decades, there has been an increasing interest in psychotherapy integration, with several articles on this topic having recently appeared in this newsletter. In writing still another article on psychotherapy integration, my goal here is to provide a prediction about where it may be heading in the future. Although it is very risky to predict the future, I am taking that risk because of a number of converging forces within the field that point to a likely direction.

A Bit of History

When the Society for the Exploration of Psychotherapy Integration (SEPI) was founded in 1983, the goals were twofold: (1) the integration of the different approaches to therapy, analyzing the points of similarity and differences among them, and (2) the integration of research and practice. Since that time, the vast majority of work has dealt with the first goal, which no doubt resulted in creating a *zeitgeist* that is now more favorable to the concept of psychotherapy integration than it was over two decades ago. However, relatively little attention has been devoted to the second goal: the integration of practice and research. I would suggest that the future of psychotherapy integration lies with the successful pursuit of this goal.

Although most of the work on integration has involved a focus on considering the similarities and differences among various theoretical orientations and their procedures, there nonetheless have been a number of workers in the field who suggested that, in the final analysis, it was the empirical approach to integration that was most important (see Norcross & Goldfried, 2005). As early as the 1950s, Frederich Thorne, a psychiatrist, commented that the practice of psychotherapy was very different from what he learned in medical school, which emphasized empirically based principles of bodily functioning as the guide to clinical practice, not theoretical orientation. Several other therapists and researchers over the years similarly argued that psychotherapy integration should be based on empiricism, such as the contributions of Beutler, Garfield and Lazarus. Most recently, Castonguay and Beutler (2006) edited an important volume that specified empirically based principles of change that were relevant for dealing with various clinical problems—regardless of one's theoretical orientation.

The Strained Alliance between Clinician and Researcher

As is well known to readers of this newsletter, there has been a long-standing strain in the alliance between clinicians and researchers. Living in two different professional worlds, members of each group have tended to favor their own approach to understanding human behavior and the therapeutic change process—often going so far as to denigrate the contribution of the other. Researchers have complained that clinicians do not read the literature, while clinicians have argued that the literature has little to say about their clinical practice. As recently noted by Kazdin (2008):

continued on page 26

A frequently voiced and enduring concern is that key conditions and characteristics of treatment research (e.g., therapists, patients, treatments, and contexts) depart markedly from those in clinical practice and bring into question how and whether to generalize the results to practice (p. 147).

Together with Barry Wolfe—who spent 22 years of his career funding psychotherapy and research as a staff member of the NIMH—I have argued that although randomized clinical trials can provide us with important evidence about the efficacy of different therapy procedures, many of the methodological constraints associated with the research often undermine the clinical validity of the findings (Goldfried & Wolfe, 1996). Thus, unlike what occurs in controlled clinical trials, the practice of therapy often involves more complex clinical cases, and is not constrained by a treatment manual.

As a result of the lively controversy over empirically support treatments in the literature, we happily seem to have moved in the direction of recognizing that *both* researchers and clinicians have something to offer. Acknowledging the limitations of simply identifying empirically supported treatments, the APA Presidential Task Force on Evidence-Based Practice (American Psychological Association, 2006) made it clear that randomized clinical trials represent only one approach for providing empirical evidence that can inform clinical practice. Findings from other forms of research, such as basic research on the variables associated with various clinical disorders, as well as the findings on the process of change, are all most relevant. Moreover, the task force has underscored the very important role of the clinician, defining evidence-based practice much more broadly than simply the presence of research findings. What they have emphasized is the central role that clinical expertise plays in implementing specific intervention procedures or principles of change. Thus what has been openly acknowledged is what we all have known to be true, namely that when it comes to doing effective therapy, a competent clinician is also needed. Indeed, whether we are researchers or clinicians, when we need to select a physician to perform a complicated medical procedure, we are careful to select someone who not only is aware of the state of the art, but also who is experienced and competent.

To stay with the medical analogy a bit longer, consider the interplay between research and practice in medicine. Certainly in the area of pharmacology, even when a drug has been approved by the FDA after a careful analysis of research findings, it nonetheless is subjected to clinical scrutiny. Physicians routinely file incident reports, indicating some of the adverse effects of the drug that were not detected during the research trials. This also occurs in other aspects of medicine, such as recent clinical findings by orthopedic surgeons that certain approved hip replacement parts have resulted in problematic clinical findings. Thus, despite the tension that also exists between medical researchers and practitioners, there nonetheless exists a two-way bridge, whereby each may inform the other.

Building a Two-Way Bridge Between Psychotherapy Practice and Research

In considering the relationship between psychotherapy practice and research, it is possible to view clinical work as providing us with the context of discovery. Working with clients directly and discussing clinical cases with supervisees and colleagues presents the practitioner with the challenge of translating general research findings and clinical experience so that they can be applied to the indi-

continued on page 27

vidual case at hand. It also affords the clinician with the opportunity of witnessing firsthand the ever-varying parameters of human behavior and the psychotherapy change process. In our roles as clinicians, we can *generate* clinical hypotheses that may be studied under better-controlled research conditions, designed to *verify* what had been observed clinically. The findings from such research—the context of verification—can then, in turn, readily be fed back to the clinical community.

As of January 2010, I will assume the role of President of Division 12—the Society of Clinical Psychology. The presidential initiative that I will be undertaking consists of a life-long desire to build a two-way bridge between practice and research. Taking the lead from medicine, which has such a bridge, my goal is to establish a mechanism whereby therapists can provide feedback to researchers about the successes and failures in their attempts to apply empirically supported treatments in clinical practice. Exactly how this will be done, and what the mechanism will look like, is still in the developmental stage. Fortunately, I have a group of experienced, motivated and enthusiastic researchers and practitioners who similarly have had an ongoing dedication to closing the gap between practice and research. This is a standing committee of Division 12, and includes Louis G. Castonguay (President-Elect of the Society for Psychotherapy Research); Marvin R. Goldfried (Past-President of the Society for Psychotherapy Research and President-Elect of Division 12 as of 2009); Jeffrey J. Magnavita (President-Elect of Division 29 as of 2009); Michelle G. Newman (psychotherapy researcher with expertise in anxiety disorders); Linda Sobell (Past-President of Division 12); and Abraham W. Wolf (Past-President of Division 29). In addition to their motivation and interest, members of this group have had ongoing experience in working to close the gap between practitioners and researchers, such as Castonguay's role as Co-Chair of the National Research Practice Network; Goldfried's founding of the journal *In Session*, which includes research reviews written for the practicing clinician; Magnavita and Newman serving as Guest Editors for this journal; Sobell's collaboration with therapists in designing a therapy manual and research protocol for the treatment of substance abuse (Sobell, 1996); and Wolf's professional dedication to fulfilling the model of the scientist-practitioner.

Our objective is to set up a mechanism for providing feedback to researchers, piloting this mechanism with one clinical problem for which an empirically supported treatment has been identified. We decided that a clinical problem that has received favorable research evidence, and one that occurs frequently in clinical practice, would be *panic disorder*. Despite the fact that there has been extensive research on the treatment of panic, we believe that there is still much that can be learned from the clinicians treating such patients. Although all therapists who have experience with this clinical problem would have much to offer, we decided to focus on the use of an intervention that has received empirical support—cognitive-behavior therapy. There is a promising psychodynamic treatment for panic currently under investigation, but it has yet to have achieved empirically supported status (Milrod, et al., 2007). Starting with informal interviews with practicing clinicians that make use of such cognitive-behavioral interventions with this population, we hope to be able to identify those patient, therapist, treatment, and contextual variables that are likely to influence the clinical effectiveness of the empirically supported treatment in actual practice. With this information on hand, we will then move on to apply this feedback

continued on page 28

procedure on a broader scale.

We believe that this initiative can provide an approach where everyone benefits—the clinician, the researcher, and certainly the client. It is our hope that this will afford the clinician with an opportunity to provide invaluable information for future research. For the researcher, it provides them with researchable—and hopefully fundable—hypotheses for research that is born out of clinical practice.

How does this all tie in to psychotherapy integration? A friend who is a physician once characterized psychotherapy as "an infant science," where what we do is based more on theory than evidence. In order for our field to mature, we need to move beyond theoretical schools of thought and base what we do clinically on available and research findings that also have been shown to work in clinical practice. As I have suggested in the past:

Although varying theoretical orientations have clearly been useful in helping us to develop a wide variety of therapeutic procedures, we see a need to make greater use of what actually goes on clinically as a way of generating fruitful research hypotheses. Without such close links between clinician and researcher, we face the danger of our theory and research becoming too far removed from the clinical foundations of our generalizations (Goldfried & Padawer, 1982, p. 41).

With psychotherapy in general responding to pressures for accountability, evidence-based practice is likely to be the driving force for how therapy is conducted in the future. For it to be implemented in an empirically and clinically sophisticated way, the collaborative efforts of researcher and practitioner are essential. More than ever before, this collaboration needs to become the organizing theme for integration. It is for this reason that I would suggest that empirical pragmatism—based on the converging evidence obtained from research and practice—not theory, will be the integrative theme of the 21st century.

Author Note
Correspondence regarding this article can be addressed to Marvin R. Goldfried, Department of Psychology, Stony Brook University, Stony Brook, NY, 11794-2500. Electronic mail can be sent to: marvin.goldfried@sunysb.edu

(References available on-line.)

NOTICE TO READERS

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

THURSDAY, AUGUST 6th

Existential Humanistic Therapy Comes of Age (Symposium)
8:00 AM – 9:50 AM • Metro Toronto Convention Centre – Meeting Room 202C
Chair: Kirk J. Schneider, PhD
Participant/1st Author

Alexander Bacher, MA	Pernilla Nathan, MA
Stacie L. Cooper, MA	Orah T. Krug, PhD
Dave Fischer, MA	Kirk J. Schneider, PhD

Two Viewpoints on Future Directions for Alliance Theory (Symposium)
10:00 AM – 10:50 AM • Metro Toronto Convention Centre – Meeting Room 203A
Chair: Robert L. Hatcher, PhD
Participant/1stAuthor

Robert L. Hatcher, PhD	Adam O. Horvath, EdD

Process and Outcome in CBT: The Importance of Cognitive Errors and Coping (Symposium)
10:00 AM – 11:50 AM • Metro Toronto Convention Centre – Meeting Room 206A
Chair: Martin Drapeau, PhD, MA
Participant/1stAuthor

Deborah Schwartzman, BA	Jesse Renaud, MA
Martin Drapeau, PhD, MA	Debora D'Iuso, MA

Getting Real in Psychotherapy Explorations of the Real Relationship (Symposium)
12:00 PM – 12:50 PM • Metro Toronto Convention Centre – Meeting Room 205A
Chair: Charles J. Gelso, PhD
Participant/1stAuthor
Charles J. Gelso, PhD
Cheri L. Marmarosh, PhD
Discussant: Jeanne Watson, PhD

What We Wish We Had Known: Tips for Future Psychotherapists (Symposium)
1:00 PM – 2:50 PM • Metro Toronto Convention Centre – Meeting Room 103A
Chair: Elizabeth Nutt Williams, PhD
Participant/1stAuthor

Ali M. Mattu, MA	Norine G. Johnson, PhD
Jeffrey Zimmerman, PhD	Jean A. Carter, PhD

Using a Training Center Database to Promote Science and Practice (Symposium)
3:00 PM – 3:50 PM • Metro Toronto Convention Centre – Meeting Room 714A
Chair: Cynthia E. GliddenTracey, PhD
Participant/1stAuthor
Brian Garbarini, MEd
Charles C. Claiborn, PhD
Jessica E. Rohlfing, MA

FRIDAY AUGUST 7th

The Art and Science of Impact: What Psychotherapists Can Learn From Filmmakers and Social Psychologists (Symposium)
8:00 AM – 9:50 AM • Metro Toronto Convention Centre – Meeting Room 713A
Chair: Jeffrey K. Zeig, PhD
Participant/1stAuthor
Jeffrey K. Zeig, PhD
Patricia Rozema
Discussant: Lee D. Ross, PhD

Poster Session: Research in Psychotherapy
12:00 PM – 12:50 PM • Metro Toronto Convention Centre – Exhibit Halls D & E
Participant/1st Author

Kathleen R. Bhogal, MA
Faye Mishna, PhD
Michael Basseches, PhD
Daniel L. Hoffman, MA
Geneviève Bourdeau, BS
James M. Yokley, PhD
Carey A. Heller, BA
Jennifer Grote, MA
Julie R. Ancis, PhD, MS
Joana Coutinho, PsyD
Nathaniel Thorn, BA
Shawn J. Harrington, BA
Allen K. Hess, PhD
Mari Yoshikawa, EdD
Grazyna T. Kusmierska, MA
Rebecca S. Klinger, MS
Saunia S. Ahmad, MA
Robert J. Reese, PhD
Rebecca E. Sachs, MA
Toni J. Welsh, MA
Zita Sousa, MA
Jennifer R. Henretty, MS
Patricia A. Rupert, PhD
Stephanie A. Wiebe, BA
Jessica E. Lambert, PhD
Sally M. Hage, PhD, MTS
Ennio Ammendola, MA
Denise H. Bike, MS
Erin Olufs, BS
Adam O. Horvath, EdD
Arlene J. Simpson, BA
KC L. Collins, BA
Nancy L. Murdock, PhD

Symposium (S):
Eminent Psychotherapists Revealed Audiovisual Presentation of Principles of Psychotherapy
2:00 PM – 3:50 PM • Metro Toronto Convention Centre – Meeting Room 801A
Chair: Jeffrey J. Magnavita, PhD
Participant/1stAuthor

Jeffrey J. Magnavita, PhD
Jay Lebow, PhD
Hanna Levenson, PhD
Judith S. Beck, PhD
Discussant: Nadine J. Kaslow, PhD

Business Meeting
5:00 PM – 5:50 PM
Fairmont Royal York Hotel – Territories Room

Social Hour
6:00 PM – 6:50 PM
Fairmont Royal York Hotel – Salon B

SATURDAY AUGUST 8th

Psychotherapist Expertise Developing Wisdom to Guide Theory, Research, and Practice (Symposium)
9:00 AM – 9:50 AM • Metro Toronto Convention Centre – Meeting Room 802B
Chair : Allen K. Hess, PhD
Participant/1stAuthor
Robert M. Leve, PhD
Leonard Greenberg, PhD
Barbara Schwartz, PhD
C. Alexander Simpkins, PhD
Tanya H. Hess, PhD
Discussant
Carol Falender, PhD
Edward P. Shafranske, PhD

Conversation Hour: Lunch With the Masters for Graduate Students and Early Career Psychologists
12:00 PM – 1:50 PM
Fairmont Royal York Hotel
Quebec Room

Mistakes in Psychotherapy Yielding Power, Constraining Dialogue, and Nurturing Envy (Symposium)
2:00 PM – 2:50 PM
Fairmont Royal York Hotel British Columbia Room
Chair: Randolph Pipes, PhD
Participant/1stAuthor
Randolph Pipes, PhD
Annette S. Kluck, PhD
Caroline Burke, PhD
Discussant: John Dagley, PhD

CWC/Evidence-Based Practice Using Evidence-Based Principles to Optimize Clinical Process and Outcome With Personality Disorders (Symposium)
3:00 PM – 4:50 PM
Metro Toronto Convention Centre
Meeting Room 714A
Participant/1stAuthor
Jeffrey J. Magnavita, PhD
Kenneth L. Critchfield, PhD

SUNDAY, AUGUST 9th

Schema Therapy for BPD Breakthrough: Treatment for Improving Life Functioning (Symposium)
9:00 AM – 10:50 AM
Metro Toronto Convention Centre
Meeting Room 712
Chair: Joan M. Farrell, PhD
Participant/1stAuthor
Arnoud Arntz, PhD
George Lockwood, PhD
Ida A. Shaw, MA
Michael Webber, MD
Discussant
Jeffrey Young, PhD

Affect Phobia Treatment Approach: Two New Pathways to Change (Symposium)
11:00 AM – 11:50 AM
Metro Toronto Convention Centre
Meeting Room 706
Chair: Stuart Andrews, PhD
Participant/1stAuthor
Stuart Andrews, PhD
Kristin A.R. Osborn, MA
Maneet Bhatia, MA
Discussant
Allen Kalpin, MD

Culturally Informed Interventions With Ethnically Diverse Populations (Symposium)
12:00 PM – 1:50 PM
Metro Toronto Convention Centre
Meeting Room 202A
Chair: Chaundrissa Oyeshiku Smith, PhD
Participant/1stAuthor
Guillermo Bernal, PhD
Asha Z. Ivey, PhD
Frederick T.L. Leong, PhD
Kafi S. Bethea, BA
Joseph E. Trimble, PhD
Discussant
Nadine J. Kaslow, PhD

Building a Private Practice by Being Public: From Social Networking Circles to Psychotherapy Groups

Renee Hoekstra, Psy.D., Private Practice, Boston, MA

It Starts with Your Strengths

What now? My post-doc had ended, I had no job, and I had lived in four different states in order to complete a master's degree, a doctorate degree, a pre-doctoral internship, and a post-doctoral fellowship. To this end I found myself living in Boston with a determination to get licensed and to stop moving across the universe. I wasn't looking for the 9-5 grind, I wanted autonomy and creativity in my clinical work, and I wanted to earn reasonable money. I had heard enough people complain about poor starting salaries in hospital positions. I was not interested in the responsibilities involved in administration or supervision, and I wanted the majority of my work to be direct clinical services. The one thing that I wanted to do for sure was to lead psychotherapy groups.

Shortly after obtaining my license, I took out a calculator and figured that I could make more than my post-doc salary if I conducted two psychotherapy groups a week. The question was: Given that I knew nothing about running my own practice or being in business for myself, how exactly was this going to happen?

Despite being here for one post-doctorate year, I still barely knew anyone in Boston; let alone how to get from Jamaica Plain to Somerville without a GPS! I needed a job, a professional community, and an opportunity to connect and establish myself as a professional. Boston was a huge city with many recent transplants. I wondered: Who else was in this situation? Was anyone starting his or her own practice? Who else wanted their own practice, but felt as if they had no idea where to go? And who else has been successful in starting a practice and would be willing to let me pick their brain?

Inspiration from Revolve Nation's Boston Entrepreneur Group

Two weeks after I passed the Examination for Professional Practice in Psychology (EPPP), I went to a meetup group for entrepreneurs. It was the business-networking world that I knew nothing about, and I went not only for the socializing, but also because I was thinking about selling my watercolor artwork. I was gently encouraged to come back. I started to think about the possibility of business networking, which led to more ideas about starting my practice, which led to ideas about networking with healthcare providers, which led to the current brainstorms and flurry of activity that followed over the last year.

I started joining list-serves and looking for books and articles about starting a practice. I dug up my psychology of business class material and started poring through it. I tentatively proposed a study group on various list-serves, which led to meeting other psychologists. I selected a book: *Financial Success in Mental Health Practice* (Walfish & Barnett, 2009) and proposed to the online community a study group with weekly meetings to read, discuss, and plan assignments that moved people in the direction of their own practice. I established a mission for the study group:

- To help early career psychologists

continued on page 34

build and establish their own private practices
- To learn together the relevant aspects of the business of psychology
- To decrease our vulnerability to public and private organizations interested in hiring psychologists
- To decrease our vulnerability to poor pay
- To establish and generate goals and strengths, and to be able to utilize these in a marketable way
- To develop peer consultation, networking groups, and the support and resources of other early career psychologists
- To locate available resources when we lack answers or have further questions

I posted my mission on various list-serves and started to establish a following.

The authors of *Financial Success in Mental Health Practice* contacted me and offered to answer questions via e-mail between our study groups. I began creating assignments, such as developing mission statements for our practices, working on website and marketing plans, and generating and finding resources for ourselves.

Fits and Starts

Despite my involvement with the worthwhile early career activities above, I still did not have a job. I had been interviewing intermittently while studying for licensure, but nothing yet had come to fruition. However, accessing resources, talking to psychologists, and reading the list-serves provided me with important insight during my job search. For example, I had a firm grasp on the pros and cons of joining group practices. One narrative stood out to me- psychologists in group practices were losing money that they could be retaining if on their own. Thus, I started calculating the costs of starting out on my own and the possible means to achieve this end.

I continued to attend the weekly meet-up groups hosted by the entrepreneurial law firm—the first to not bill by the hour. They served wine and cheese and were attended by a range of business professionals ranging from CEO's to interested college students. People there provided a sense of business-minded mentorship and had a plethora of resources I wouldn't have known where to find elsewhere. I met someone who agreed to help me with a business plan. I started to think seriously about my elevator speech and the audience of non-mental health professionals. I started to listen to advice and feedback about marketing and business.

I also decided to host an EPPP forum for post-docs. I rounded up recently licensed psychologists to talk about the licensure application process, studying for the EPPP, and the jurisprudence exam. My state association offered office space, and the rest was a matter of tapping the relevant list-serves. I e-mailed all of the post-doctoral training directors listed on my state association website, as well as the EPPP and early career list-serves. This was popular. I felt as if I had found an unmet need in the community and had been able to reach that need. I started to think about this as an experimental step in marketing, and I felt like it was an additional way of being connected to early career psychologists.

My business of psychology class professor had done something clever that I attempted to replicate: she brought in business-related persons to our class. This not only allowed them to market their services, but also allowed her to maintain her relationships with the business community. I started to think about the various business-related persons who might be interested in fulfilling a need for early career psychologists, and I started to put together workshops for

continued on page 35

early career and private practice-interested psychologists. Early in my endeavors, I was contacted by another early career psychologist and encouraged to apply for the early career scholarship to attend the American Psychological Association (APA) Leadership Convention. My state association nominated me to the Early Career Psychologist Committee and I was granted the scholarship.

Connecting and Including Community

I wanted to continue to give people a chance to socialize and network, and I continued to have an interest in connecting recent post-doctoral transplants who had similar confusion about driving around the Boston-cow-paths-turned-into-roads. My many transitions to get through graduate school had left with me several family-less holidays, and I often thought about hosting Thanksgiving dinner for all the family-less post-docs and interns.

I started to host social hours, which provided the opportunity for psychologists who were not interested in clinical work or private practice to connect and join. Through my social networking I found someone with a space big enough to host potlucks. I was also contacted by senior psychologists, people interested in hiring psychologists, and persons interested in mentorship. I was offered a job shortly after hosting a social hour. I also offered to cross post job offers to different list-serves and connect job-seekers with job-finders.

Through all my efforts, I have been immensely rewarded and enriched in a variety of ways that I never anticipated at the outset. The more I offered to host activities and spread the word, the more I was put into contact with persons who could help me build my practice. People became interested in me and my pursuits. I found a diverse array of mentors, both formal and informal. I met people who were a few years down the road from me and found out what they were doing and how they were doing it. People started asking me about taking on different leadership roles. People started to e-mail me and ask about job leads and other resources. I reflect back on the advice of a psychologist I met in graduate school, who stated that she made the effort to meet someone connected to the field of psychology for lunch at least once a week.

I was licensed in October of last year. I had a few false starts with jobs, but found office space to sublet and got my website up by April of this year. I was offered a job in a group practice in a different geographical area than my own practice. The offer came from someone who was clearly impressed with my early career endeavors and receptive to the idea of starting on my own at the same time.

Practical Aspects

I found someone to develop my website for a very reasonable rate. I found out how easy it was to sublet office space for a few hours a week. I found a business planner who got me started with financial bookkeeping software and developed my own personal profit and loss statement. I solicited feedback about my website from various parties before going live, and I created my own artwork to communicate my interest in psychotherapy groups. I distributed various mailings and found ways in which people advertise services in the Boston area. I tried to meet people for lunch whenever possible. I contacted people providing Dialectical Behavioral Therapy (DBT), as well as group psychotherapy, and I joined the Northeast Society Group Psychotherapy and presented at their conference. I signed up to teach a class through the Boston community

continued on page 36

college for adult education.

A Lot of Work

Like starting groups in private practice, starting the early career efforts wasn't always easy. Some things were not always well attended, but I continue to commit to doing them and meet new people every time I host an event. I get what I can out of what I do and continue to go from there.

The client referrals are starting to trickle in. My business planner tells me that 4-5 phone calls a week is good news for someone just starting out. I get impatient, but people say that all my work will pay off shortly. Someone recently was incredulous that I actually thought I might not get referrals. I panic sometimes at the thought of getting flooded, and people say that private practice has its ebbs and flows. I've almost got enough people to start a DBT group, and I'm starting to get inquiries about individual clients. I've got a mixed bag with the insurance: I'm not able to take it because most insurance companies discriminate against recently licensed psychologists. Although there is some room for negotiation, I've gotten a wide range of feedback and perspectives from private practice individuals who both endorse and hate insurance companies. It's a lot to think about. But I've worked very hard to get to where I am today and am determined to generate revenue that reflects that.

A Ways to Go

While I haven't yet climbed the ladder to financial freedom (although I've certainly met my share of financial planners!), the groundwork is being laid. I'm not going to stop the social networking anytime soon. I'm getting around Boston and I'm meeting people, and I feel more connected than I did before. I know people who work with autistic spectrum disorders, provide group therapy for substance abuse, work with deaf children, and specialize in medical hypnosis and sexual pain disorders. And the best part is that I could probably find a referral for a specific concern if I did a little searching.

I'm having fun being the center of all the attention. The good news is that there is always room for entrepreneurship and creativity, and if people are willing to invest the energy they can create their own early career networking circles. I did. I'm making this up as I go along, and this is my story of what's happened as a result. And I'm certainly receptive to a helping hand if a helping hand shows up.

I believe that if nothing else, Boston early career psychologists should have the opportunity to socialize and network from time to time. I'm currently working on establishing a "Welcome to Boston" social hour for incoming psychology interns and post-docs in September of 2009. If you've never been here, I'll teach you how to say things like "pahk" and "nor'easter" and tell you about the pros and cons of buying a GPS. If interested in this or any of my other endeavors, you can check out my website at www.bostondbtgroups.com or get in touch with me at Renee_Hoekstra@yahoo.com.

(References available on-line.)

FEATURE

2009 Presidential Summit on the Future of Psychology Practice: Collaborating for Change

James H. Bray, APA President, Department of Family & Community Medicine Baylor College of Medicine

Carol Goodheart, APA President-Elect, Independent Practice, Princeton, New Jersey

Margaret Heldring, Independent Practice, Seattle, Washington

When you bring 150 leaders from psychology, business, consumer groups, economics, insurance, medicine, and politics together to transform the practice of psychology, what do you get? The **Presidential Summit on the Future of Psychology Practice,** held May 14-17, in San Antonio, Texas, was a transforming event to move the practice of psychology forward in the 21st century. With advances in neuroscience, genetics, collaborative health care and international business opportunities, psychology is more relevant than ever and the summit illuminated many new possibilities for psychology practice.

Division 29 was well represented at the Summit with two division delegates (Nadine Kaslow and Jeff Magnitva) and a number of invited psychologists (Jean Carter, Armand Cerbone, Pat DeLeon, Jennifer Kelly, Michael Murphy). The Summit was supported by a financial contribution from the division.

Jeffrey Magnavita summed up his experience this way: "It was awesome, inspiring, frustrating, challenging, generative and hopeful." The recommendations from the Summit need to be implemented to make a real difference.

The Summit is part of the 2009 Presidential Initiative on the Future of Psychology Practice. The Task Force (working since 2008) and Summit are collaborative efforts and opportunities for strategic thinking about our future. James H. Bray, APA President, Carol Goodheart, APA President-elect and Margaret Heldring chair the Task Force that also includes Robert Gresen, Gary Hawley, Tammy Hughes, Jennifer Kelly, Jana Martin, Susan McDaniel, Thomas McNeese, and Emil Rodolfa; Sandra Shullman, Joan Brannick, and William Strickland are consultants to the Task Force on organizational psychology issues.

The Task Force is staffed by Katherine Nordal, Randy Phelps, Joan Freund, and Beth Nichols-Howarth of the Practice Directorate. Cynthia Belar, executive director of the Education Directorate, also contributed to the Task Force.

continued on page 38

The Summit's goal was to engage the broader practice community in an agenda- and priority-setting meeting to inform the work of the APA Practice Directorate and the APA Practice Organization. We assembled leaders in the practice of psychology and related professionals from other practice associations, government entities, training organizations, consumers, insurers, and businesses to identify:

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

The Summit was a vehicle for consideration of new forms, settings and partnerships for psychological practice; expanded thinking about practice trends; and conceptualizations of practice that cross traditional lines. The Task Force will use the findings from the Summit to develop clear recommendations for our diverse practice community.

There were a number of outstanding keynote addresses. Day 1 included a thought provoking talk by Dr. Ian Morrison, a futurist, who discussed how businesses change. Morrison stated that in every business there are two curves: in the first, you already do well and feel comfortable, but the second is a new way of doing things that is dramatically different from the first. To succeed, you have to manage both curves—keep doing what works while developing new opportunities. Dr. Norman Anderson addressed health disparities and the importance of overcoming them in our future work. We had a wonderful talk after dinner by Ann McDaniel, vice-president of the Washington Post Companies, who gave an update on the Obama administration and plans for health care reform.

Day 2 included a talk by health economist Richard Frank, on the changes in funding for health and mental health care. He pointed out that while health care costs as a percentage of the GNP have increased over the past 20 years, mental health care costs have stayed stable as a percentage of the GNP. In addition, there has been an increase in the use of psychotropic medications, by both psychiatrists and other physicians, while payments for psychotherapy have declined. This is a strong reason for psychology to continue to fight for prescriptive authority.

Physician Tillman Farley spoke about his model of integrated community health care that places behavioral health squarely in the primary care model. Janet Reingold, media and marketing expert, discussed how to brand the profession and distinguish psychology from other disciplines. On Day 3 Elizabeth Gibson, a consulting psychologist, described how she helped transform Best Buy from a bankrupt company to a leading retailer in America. The principles she described are applicable to transforming the profession of psychology.

The real work of the Summit occurred in small work groups. The work groups were urged to think big and outside the box. Work groups addressed questions such as:

- What are priorities for our constituents?
- What are the pathways to get there?
- What partners should we develop?
- What are the economic challenges that present future opportunities?
- What will be the impact of cross-cutting changes in the future of psychology practice in regards to diversity, science & technology developments, and partnerships?

Here are some of the issues that emerged at the summit, especially in

continued on page 39

light of national health care reform:

Practitioners are still being trained for the "first curve" — traditional practice. To thrive in the future, psychologists will need to redefine training and take advantages of new practice opportunities outside of traditional psychotherapy practice. That doesn't mean foregoing all the wonderful ways psychologists are currently trained, but it does mean adding new elements, skills, embracing best practices and getting interdisciplinary training.

The need to collaborate in primary care. As Summit speaker Frank DeGruy said, "Mental health care cannot be divorced from primary medical care, and all attempts to do so are doomed to failure." It is becoming increasingly clear that health-care reform will include a greater emphasis on primary care and prevention of chronic disease. These are both areas that psychologists can make major contributions. This will require that we partner and practice with primary-care physicians and nurse practitioners. Most practicing psychologists have not been trained to work in these settings and in the busy style of primary-care medicine. It is one of our future practice opportunities.

The need to be accountable. Whether we like it or not, there are changes in health care payments and reimbursements that require practitioners to demonstrate accountability for their work. This was a clear message from the insurance, business and legislative delegates at the summit. We have the opportunity to define how we should be evaluated by developing our own psychology treatment guidelines and methods to assess our work. Psychiatry has done this. Their guidelines are used by the insurance industry to determine treatment and reimbursements. According to the summit's insurance and legislative delegates, there are not any for psychotherapy and psychological services. We have long resisted developing these guidelines, but the time has come to define psychological treatment practices, or others will do it for us.

Health promotion and prevention. The focus on primary care also opens opportunities for prevention of health problems and enhancing the health of our population. Many chronic health problems, such as diabetes, hypertension, obesity, are caused by psychosocial and life-style problems. Psychologists have much to offer to prevent these problems and help people better manage their chronic health problems.

Creating and nurturing partners for change. One of the innovations of the Summit was to have a significant number of invited guests who represented other organizations, businesses and consumers of psychological services. They are open and interested in partnering with the APA in our advocacy efforts. These relationships need to be nurtured and strengthened in our future. There was much discussion at the summit about who is the mental health champion in the Obama administration—no one was clearly identified. We need to develop our champion. The Campaign for Mental Health Reform is a collaborative effort of 18 mental health organizations; APA is a participating member of this coalition group. William Emmet, the director for Campaign for Mental Health Reform, was the only mental health person invited to President Obama's White House health care reform meeting. He was a delegate to the summit and he provided important insights about the role of mental health in national reforms.

Future Plans

The Task Force on the Future of Psychology Practice will synthesize the ideas and recommendations from the summit. The Task Force will recommend them to the Committee for the Advancement of

continued on page 40

Professional Practice and into the APA strategic planning process and policy changes for the association. You can watch portions of the summit on the APA webpage, www.apa.org. You can also learn more about the summit during a 2-hour session at the APA Convention, Friday, August 7 from 10 AM – 12 noon.

The impact of this summit has the potential of bringing a sea change to the practice of psychology. The ideas and recommendations from the summit need to be implemented at all levels of our profession to make a real difference. As stated at the summit, "¡Lo que ocurrió en San Antonio, no puede permanecer en San Antonio! What happened in San Antonio cannot stay in San Antonio!"

ATTENTION GRADUATE STUDENTS AND EARLY CAREER PROFESSIONALS

You are invited to

"Lunch with the Masters – For Graduate Students and Early Career Psychologists"

Saturday, August 8th
12:00 Noon – 1:50 pm
Fairmont Royal York Hotel, Quebec Room

Hosted by Division 29 (Psychotherapy) at the 2009 APA Convention.

Come join Drs. Lynne Angus, Judith Beck, Beverly Greene, Leslie Greenberg, Nadine Kaslow, Arthur Nezu, and others for lunch and conversation. We will also host a book raffle and early career focus group to determine the needs of our early career constituents.

No RSVP needed, but please feel free to contact **Dr. Michael J. Constantino (mconstantino@psych.umass.edu)** for additional information.

Come find out more about Division 29 and invite others to join!

You do not need to be a member of Division 29 to attend, but we will have membership information available on site for those who are interested in joining.

FEATURE

Ethics and the Interrogation of Prisoners

Norman Abeles, Ph.D., Michigan State University

Recently, I was asked to co-author a book chapter on the history of ethics. Having taught a course on professional and scientific ethics to graduate students for over 30 years, I readily agreed to do so. I thought our readers would be interested in reading about one of the topics I was unable to include in the chapter due to lack of space: coerced therapy and the interrogation of prisoners. This topic is known to most of our readers, though they may not know the significant details which I discuss here.

Coerced or mandated psychotherapy and interrogation of prisoners

Some commentators have described psychotherapy as a means of social control (Hurvitz, 1973) and compared it in some ways to brainwashing (Dolliver, 1971; Gaylin, 1974). Others have discussed the use of coercive persuasion, deprogramming, and hypnotic suggestion techniques from the viewpoint of client manipulation (Fromm, 1980; Kline, 1976). Many other types of coercive practices have become central to some psychotherapeutic approaches with strong public approval. These include court ordered therapy for a range of conditions (e.g. anger management, driving while intoxicated, sexual acting out). Other therapeutic-like techniques include restrictions placed on non-incarcerated sex offenders (Schopp, Winick, & La Fond, 2003), restrictions in educational settings (Sidman, 1999) and coercive restraint or forced holding therapies for children (Mercer, 9003). This raises questions about the extent to which psychological techniques permit the therapist to manipulate or control the client by force or threat.

More recent concerns have focused on the possible role of therapists in dealing with alleged terrorist detainees held by military authorities. In general, a psychotherapist cannot ethically coerce a client into treatment or force certain goals or outcomes against the client's wishes. Some special problem situations exist along these lines including clients in the military or involuntarily confined in institutions such as prisons. The more subtle aspects of coercion require particular sensitivity. This might include the use of group pressure, guilt induction, creating cognitive dissonance, attempts at total environmental control, and the establishment of a trusting relationship in order to effect change in another person (Dolliver, 1971). Therapists must attempt to remain aware of potentially coercive influences and avoid any that do not offer full participation, discussion, and choice by the client. The constant critical re-examination of the strategies and goals of treatment involving both client and therapist affords the best means to this end.

Some of my colleagues tell me that they would never accept a referral for court mandated therapy, nor would they ever treat a client who is coerced into therapy. I respond by asking whether or not they have ever seen children and adolescents for treatment. They often respond by saying that in those cases the parent is the client. Then I ask them if they have ever seen a client who is contemplating divorce; usually they answer by saying yes. Then I ask them if they would terminate a client who told them during

continued on page 42

the 5th session that the main reason they came for therapy is that they were given an ultimatum by their spouse or partner to seek therapy or ace divorce or separation. The point I am making is that coerced therapy is somewhat of a slippery slope and yet many of us may have treated individuals who at least believed they were not coming of their own free will.

Psychologists' Involvement in Detention of Alleged Terrorists (a.k.a. Violent Extremists)*

In 2008, for the first time in the organization's history, a petition signed by over 1% APA members invoked a referendum provision of the by-laws calling for a vote on whether psychologists can continue to work in detention settings that exist in violation of international law or the U.S. Constitution (http://www/apa.org/governance/resolutions/work-settings.html). The final vote tally was 8792 voting in favor of the resolution and 6157 voting against the resolution. Note that this resolution itself did not deal with the APA Ethics Code but rather where psychologists could work.

*In his June 2009 speech in Cairo, President Obama used the term violent extremists rather than terrorists.

In statements accompanying the ballots, advocates of the petition argued that our first ethicalprinciple is to do no harm, yet alleged that psychologists have participated in the design and actual interrogations which equate to torture. The statement asserted that by participating in the design of interrogations, psychologists have helped to legitimize abusive treatments at such sites. They also asserted that the referendum does not prevent psychologists from working in settings which uphold international law and human rights, such as the U.S. criminal justice system. The statement in opposition to the petition argued that passage would place ethical psychologists at risk and would harm vulnerable populations by restricting the practice of psychologists who work in a variety of settings such as psychiatric hospitals, correctional facilities and places where authorities detain individuals for their own or the public's safety. Constitutional challenges may arise in a range of settings which could result in conflicts with international standards. The statement also noted that the petition provided two exemptions for psychologists: one for those who work directly for the person held in detention and the other for those who work for an independent third party involved in protecting human rights. The statement also noted that APA had already prohibited as unethical any participation in torture including knowingly planning, designing participating or assisting in torture. Finally, the opponents expressed concern about the precedent of defining settings in which psychologists may work.

Understanding some of the history of this debate provides a useful backdrop to ethics in psychotherapy, particularly when coercion applies (e.g. mandated or court-ordered treatment, involuntary hospitalization, or treatment while incarcerated). Almost 15 years ago, Johnson (1995) warned of ethical quandaries in the military and talked about collaboration between APA and the Department of Defense. Such efforts can include the determination of personal qualifications, screening leadership qualities, and examining organizational productivity. As Carter and Abeles (2009) point out, terrorist activities have provided the impetus for prisoner interrogations in a range of settings and locales; thus there was continuing need for further consultation with experts. Psychologists have served on Behavioral Science Consultation teams (BSCT's) where they observe interrogations and provide interrogators with feedback information. Okie (2005) underscores

continued on page 43

that these team members may not provide confidential information about prisoners, nor may they advise military interrogators to take advantage of psychological vulnerabilities. Carter and Abeles (2009) note that BSCT psychologists have been accused of using their training to develop interrogation programs used at Guantanamo Bay. In particular there is reference to the Survival Evasion Resistance and Escape (SERE) program; the allegations suggest that some psychologists reversed this training in order to aid prisoner interrogation, Two psychologists (not members of APA) have been associated with this effort. Evidence indicates that Michael Gelles, a psychologist at Guantanamo acted as a whistleblower and called attention to abuses (Soldz, 2007).

In part because of considerable outcry concerning the participation of psychologists in these interrogation of prisoners, APA formed a Task Force (PENS) whose job it was to review the APA Ethics Code to see if the ethical aspects of prisoner interrogation were adequately addressed. The report of this task force was published (APA, 2005) and notes that their charge did not include an investigative or adjudicatory role. The PENS Task Force pointed out that psychologists may serves in consultative roles to interrogation and information gathering processes, and acknowledged a long standing tradition for doing so in other law enforcement contexts. A recent editorial in Nature (2009) noted that six of the members of the PENS Task Force were on the Pentagon's payroll (p. 300) and states that the allegation that the Pentagon was dictating policy to APA is not obvious in the 12 principles. Additionally, the editorial points out that other professional societies including the American Medical Association, the American Psychiatric Association, and the World Medical Association have come out against having their members participate in interrogations. APA explicitly stated that it is ethical for psychologists to be involved in interrogations. The editorial continues by noting that "interrogation is necessary to prevent loss of life from terrorism and that some professionals feel it is their duty to ensure that activity is conducted responsibly" (p. 300). Even the New York Times notes that harsh interrogation tactics were considered legal (Shane & Johnston, 2009), though legality does not necessarily equal ethical behavior. Pope and Gutheil (2009) recommend that professional organizations should include specific and enforceable ethics standards when working with particular at-risk groups. Further, professional organizations should make more effort to acquaint all their members about their ethical responsibilities. Finally, they recommend that there may be complex ethical questions that arise in custodial settings where governmental authority may be in contrast to ethical responsibilities by professionals.

We turn again to the PENS report. To guide its thinking, the Task Force cited the Preamble to the Ethics code (APA, 2002) which states that psychologists respect and protect civil and human rights. They also cited Principle A (Beneficence and Nonmaleficence) which asks psychologists to safeguard the welfare and rights of those with whom they interact professionally. Additionally, Principle D (Justice) and Principle E (Respect for people's Rights and Dignity) were cited. The PENS Task Force concluded that the Ethics Code is sound in addressing ethical dilemmas that occurred in the context of national security related work. Several statements were prepared with regard to this overall issue. These noted that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman or degrading treatment, and noted that psychologists have

continued on page 44

an ethical responsibility to report such acts to appropriate authorities. This also included reference to not using health care related information to the detriment of the individual's safety and well being. It was pointed out that psychologists need to consult when facing ethical dilemmas. They must be alert to acts of torture and do not engage in behaviors that violate the laws of the United States though they may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights. The report also reiterated that psychologists may serve in various national security related roles but must remain mindful of factors unique to roles and contexts that require special ethical considerations.

The task force members did not reach consensus on all issues. They differed with regard to the role of human rights and international standards; some argued that international standards should be built into the Ethics Code. There was also disagreement on the extent to which psychologists may ethically disguise the purpose of their work, though they did agree that full disclosure of the nature and purpose
of the work is not ethically required in all instances. Finally, there was no consensus on whether the discussions of the Task Force should have been made publically available. They voted to limit what information should be discussed concerning the deliberations by the Task Force. In later developments, APA passed a resolution on the reaffirmation of the position against torture and other cruel, inhuman, or degrading treatments or punishment, and its applications to individuals defined by the United States as "enemy combatants." The resolution provided condemnation and absolute prohibitions against direct indirect participation in interrogations related to mock executions, water boarding or other simulated drowning, as well as additional humiliating practices.

It should be noted also that in 2002, President Bush ordered an executive declaration indicating that the 1949 Geneva Convention did not protect al-Quaeda captives at Guantanamo Bay because they were enemy combatants. That meant they could not be considered prisoners of war which would have entitled them to the right to refuse questioning (Carter and Abeles, 2009). Of course that does not mean that they could be tortured.

Concerning the reaffirmation against torture, there was an amendment published that included techniques listed by the World Medical Association Declaration of Tokyo and the principles of medical ethics in the protection of prisoners and detainees against torture (APA, 2008). A critique of this resolution by psychologist Arrigo and retired counterintelligence operative De Batto argues that effective ethical oversight by APA or any other outside organization is not possible (Arrigo & De Batto, 2008). They believe that the resolution is symbolic only and has no effect on operations; there are a number of institutional factors that defeat this resolution. They suggest that in intelligence operations, information is given on a "need to know basis." Further, the role of interrogation consultant is one of several roles where psychologists can facilitate abusive interrogations. Since psychologists are staff officers, they must obey field commanders of whatever rank. Most psychologists in contact with detainees are junior officers who owe service in exchange for educational scholarships. While all this may be true, the enforcement of the APA Ethics Code depends on information presented as complaints filed by individuals with the APA Ethics Committee.

We should note that allegations that APA supported participation of psychologists

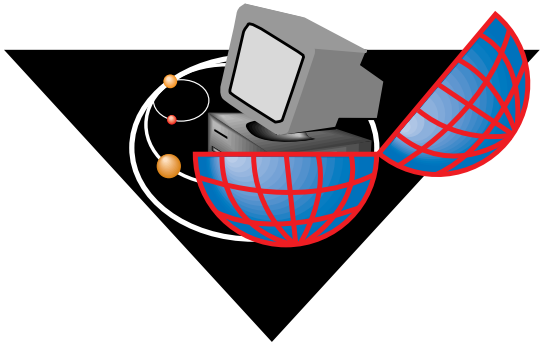
continued on page 45

in interrogations suggest that APA did not want to alienate key decision makers in the Bush Administration (Carter & Abeles, 2009). Former APA President Koocher noted in rebuttal that APA voted in favor of the McCain anti-torture resolution and past APA president Sharon Brehm argued that having psychologists consult with interrogation teams assists in keeping interrogations safe and ethical. APA also opposed the Military Commission Act (2006) since, unfortunately, this law created ambiguity concerning the types of interrogations which are permitted. The reader can come to his or her own conclusions on this difficult ethical issue. It is clear that more work needs to be done to resolve all the dilemmmas created by this complex, confusing topic. There will continue to be debate about whether or not the APA Ethics Code should include specific and enforceable provisions concerning the ethics of interrogation tactics now that a referendum has determined that psychologists can not work in detention settings that exist in violation of international law or the U.S. constitution.

Summary

This paper reports on the issue of coerced or mandated psychotherapy and the interrogation of prisoners. It begins by raising the question as to whether or not psychotherapy can be viewed as one means of social control and moves on to the possible role of psychotherapists in dealing with alleged terrorist (violent extremists) detainees held by military authorities. It notes the recent APA referendum forbidding psychologists to work in detention settings that exist in violation of international law or the U.S. Constitution. It provides background on this topic and raises the question as to whether or not the APA Ethics Code should include specific prohibitions concerning the interrogation of detainee prisoners.

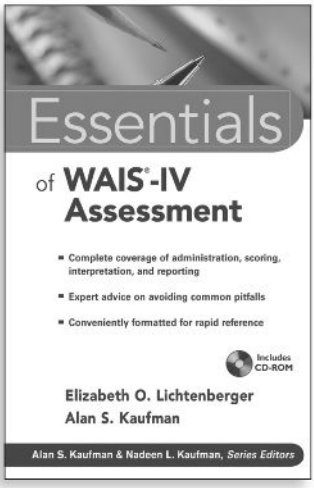
(References available on-line.)



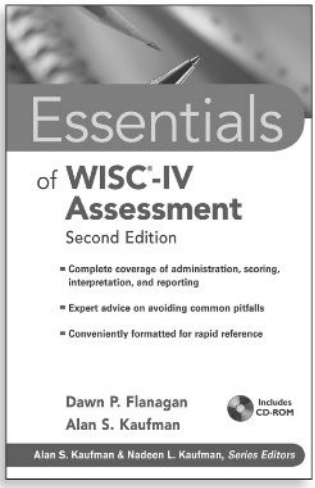
Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

New Releases from Wiley

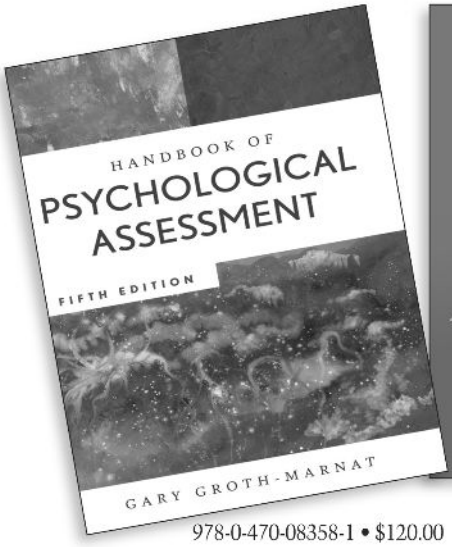
Visit us at APA Booth #1304–1409 — all Wiley books are 20% off!



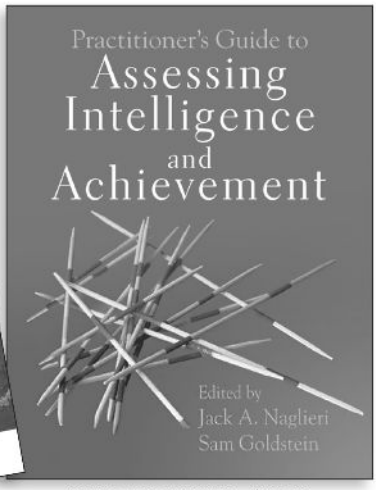
978-0-471-73846-6 • $46.95



978-0-470-18915-3 • $46.95



978-0-470-08358-1 • $120.00



978-0-470-13538-9 • $80.00

To order, call 1-877-762-2974
or online at www.wiley.com/psychology.
Also available wherever books are sold.

WILEY
Now you know.

STUDENT FEATURE

Journey to Adulthood in the 21st Century

Pekti Miles, M.A., Pacifica Graduate Institute

Adolescence is probably the most infamous of all the developmental stages. The "know-it-all" affect, rebellion, and mood swings associated with this period of psychosocial transition from child to adult in a human lifetime has received a great deal of attention in the field of developmental psychology (Spruijy, 1999, pp. xi-xii). This paper will explore one way that research on adolescent brain maturity might support the rapidly changing paradigm of adolescent development which aids understanding of multilevel systemic change and seeks to provide an agenda for promoting positive life experience (Lerner, 2004). Finally, the implication of self-regulation training on adolescent educational achievement is considered.

How Adolescence Is Viewed

Granville Stanley Hall is considered the founder of adolescent psychology. In the book *Adolescence* (1908) Hall suggested that adolescence is a developmental stage of "Sturm und Drang" (storm and stress):

> Every step of the upward way is strewn with wreckage of body, mind, and morals. There is not only arrest, but pervasion at every stage, and hoodlumism, juvenile crime, and secret vice… (2005, p. XIV). … normal children often pass through stages of passionate cruelty, laziness, lying and thievery (p.334).

More than a century after this work was conceived, Hall's take on adolescent personality continues to influence the way adults view this important juncture in human development.

Today a large part of the adult perception of adolescence emerges from portrayals tinted with the stereotypes of a previous century. A nationwide poll of adult's attitudes about teenagers, sponsored by Public Agenda in 1999, found that 71 percent of adults had a negative opinion about youth; yet in a major study on the self image of adolescents in ten countries, 73 percent of the participants reported a healthy self image (Offer, Howard, & Atkinson, 1988). This discrepancy between the way in which adults perceive teens, and the way that adolescents view themselves, may be explained by the fact that teenagers spend close to one third of their time talking with peers as opposed to 8% with adults. (Spear, 2000, p.120).

Adolescence and Society

John Santrock (2005), author of a recent book also titled *Adolescence*, proposed that conflicting perceptions about adolescence are increasingly a problem for society. "Although the majority of adolescents experience the transition from childhood to adulthood more positively than is portrayed by many adults and the media, too many adolescents today are not provided with adequate opportunities and support to become competent adults" (p.500). The gap between adult and adolescent perceptions is a broken link which threatens the sustainability of our society. In the book *Childhood and Society* (1950) Erik Erikson stated:

> …the human personality develops according to steps predetermined in the growing person's readiness to be driven toward, to be aware of, and to interact with a widening social radius; and… that society, in principal,

continued on page 48

tends to safeguard and to encourage the proper rate and the proper sequences of their unfolding. This is the 'maintenance of the human world' (p.270).

Since each stage is interdependent, Erikson's theory makes room for what he described as the variations in "tempo and intensity" (1950, p.71) presented by culture. It also facilitates bits and pieces of the founding developmental theoretical contributions as well as the biological information that is being amassed from current brain research. For this reason attention to the stages provided by Erikson's Epigenetic Chart (1950 pp.272-273) can be very helpful in our quest for a stable society.

According to Erikson's system of stages, adults in our society are responsible for providing the skills and tools necessary for young people to move into adulthood. Nonetheless, it is important to note that the advent of the Internet has completely revolutionized our daily lives. The way that children absorb information has changed drastically in the last decade. In Erikson's view, during periods of rapid social change such as the one we are experiencing now, the older generation can no longer provide adequate role models (1950, p.280). How then can we assist our children in making the transition to a culture that we have yet learned to navigate, much less master?

21st Century Technology

Many adults in this culture are dubious about the magnitude of unsupervised external stimulation that dominates the psychic space of our youth. What possible training can help to reduce the dangers associated with being an adolescent in a changing society? Like teenagers from every generation, these kids are doing their job of pushing human development in new directions.

Thus, this generation's children are processing information at a rate we cannot even imagine. As they progress from one stage to the next, adolescents have not always been able to depend on the preceding generation to provide psychosocial instruction. The fact is that even if the older generation provides informed boundaries, they will likely be rejected because adolescents are sometimes morbidly, often curiously, preoccupied with what they appear to be in the eyes of others as compared with what they feel they are and with the question of how to connect to earlier cultivated roles and skills with the ideal prototypes of the day (Erikson, 1959, p.89).

Implications are clear that a large part of adolescent success in the current milieu is based on the development of an internal locus of control. Adults are pressed to discover ways to help adolescents improve the input phase of processing.

Recently adults in our culture have taken a liking to deep breathing, meditation and yoga to help manage the stress of our new world (Barnes, 2008). Meditation research proves to be helpful in the navigation of our increasingly complex environment. The information afforded by new technology has the potential to assist in developing inner awareness skills that would augment an internal locus of control. Neuroimaging researchers have described meditation as a set of "…practices that self-regulate the body and mind, thereby affecting mental events by engaging a specific attentional set" (Cahn & Polich, 2006 p.180). In the same way that physical fitness can be enhanced through a regular exercise routine, research suggests that the mind can also be trained and improved through methodical practice.

The Adolescent Brain and Meditation

There are brain changes related to each stage of human development that contribute to responsible for sexual maturation, physical growth, emotional

continued on page 49

expansion, cognitive development, self regulation, and maturation of judgment. "Prominent developmental transformations are seen in prefrontal cortex and limbic brain regions of adolescents across a variety of species…. Developmental changes in these stressor-sensitive regions…likely contribute to the unique characteristics of adolescence" (Spear, 2000 p.418). Behaviors associated with adolescence such as risk taking, impulsiveness, poor self regulation and identity crisis might be soothed by the trait changes afforded by meditation, as brain imaging has shown the same areas of the brain most changed during adolescence are activated also during meditation.

It is important to note that adolescents have more pronounced brain activity in the amygdala than in the frontal lobe (Baird,et al.1999). The amygdala processes emotions while the frontal lobe is involved with reasoning and thinking. Neuroimaging studies of meditation show increased frontal-parietal and frontal-occipital activation and decreased posterior-anterior activation (Herzog, et al., 1990). "Trait changes from long-term meditation include a deepened sense of calmness, increased sense of comfort, heightened awareness of the sensory field, and a shift in the relationship to thoughts, feelings, and experience of self "(Cahn & Polich, 2006 p.181). Therefore, it will be advantageous to explore the nature and consequence of meditation on the developing adolescent brain; a morning meditation in high school may prove to be as effective as a midday nap in kindergarten.

Today's Adolescent

The United Nations Population Fund [UNFPA] has determined that for the first time in history more than half of the world's population will be living in urban areas and subjected to the plethora of pressures unique to that lifestyle (UNFPA 2007 p.1). "Today's generation of young people is the largest in history. Nearly half of the world's population (almost 3 billion people) is under the age of 25" (UNFPA, 2005 p.45). The potential impact of today's young people on the future is staggering. If these adolescents, who hold the power to shape humanity, are to realize their collective potential, new solutions must be found for the many stressors they have inherited. Without an understanding of the complexities of the adolescent brain, we will have little to offer their succession. An investigation of the effect of meditative traditions on adolescent development may expose far-reaching benefits for our global predicament.

Conclusion

In this essay I presented the argument that mindfulness works the mental muscle, where the mind is trained to focus even when bombarded with a web of information. Adolescents are required to synthesize more technology than the previous generation; therefore statistics nudge us toward a new pedagogy which includes intentional self-regulation of attention for self-inquiry. Can meditation (e.g., in the school system, where our children spend the majority of their day), be helpful? Research suggests that all of us, and particularly adolescents, need to stop a moment, sit silently and take a long deep breath.

(References available on-line.)

FEATURE

Psychotherapeutic Treatment Implications for Obese Adolescents

Dena F. Miller, M.A., University of Denver, Graduate School of Professional Psychology

Headlines regularly highlight the dramatic rise in the rate of childhood obesity. Photographs of 300 pound teenagers accompany headlines like, "Into the Mouths of Babes: Childhood Obesity" in the *New York Times* (Zeller, 2007), "Dear Parents: Your Child Is Fat" in *Time* Magazine (Losh, 2008), and, "It's not baby fat: Among 4-year-olds, nearly 1 in 5 is obese" on CNN (Park, 2009). These catchy headlines point to the perceived severity and prevalence of childhood obesity in the United States.

Obesity is diagnosed when a child's Body Mass Index (BMI) is at or above the 85th percentile for their age. According to the American Heart Association (AHA; 2009), 23.4 million children between the ages two to nineteen are overweight and obese. Approximately 8-13% of preschoolers and between 13% and 22% of children and adolescents are now considered overweight, and an additional 31% are at risk for becoming obese (AHA, 2009; Powell, Calvin, & Calvin, 2007). The consequences for children and adolescents who are obese can be significant and lasting, including an increased risk for numerous health problems such as coronary heart disease, type II diabetes, cancer, and hypertension (Stice, Prensell, Shaw, & Rohde, 2005).

Increasingly described as a global epidemic (Powell et al., 2007), obesity can result not only in severe physical health problems, but has significant negative psychosocial, emotional, and developmental consequences for youths. Adolescence is an often anxiety-producing developmental stage where peer pressure and psychosocial stressors abound. Teens who are overweight are at additional risk for weight-related teasing, body dissatisfaction, low self-esteem, depression, anxiety, and suicidal ideation (Fulkerson, Strauss, Neumark-Sztainer, Story, & Boutelle, 2007).

There is a clear need for effective psychotherapeutic treatments for childhood and adolescent obesity. Numerous medical treatments including drug therapy and surgical interventions exist to treat obesity, yet "successful [psychotherapeutic] treatments for obesity have been elusive" (Stice, Shaw, & Marti, 2006, p. 667). This article outlines psychotherapy interventions to address the treatment of obese adolescents. Family-based interventions, cognitive behavioral therapy, and motivational interviewing modalities will be discussed.

There are numerous obstacles to treating adolescents who are obese. Weight gain is common and difficulty can be disappointing for counselors and therapists. Mental health providers often assume that obesity can only be treated medically, rather than behaviorally. Other clinicians too readily accept that genetic blueprints for obesity preclude effective nutritional and behavioral treatments (Panzer, 2006). Despite these challenges, it is the responsibility of mental health providers to learn and develop interventions to help obese teenagers who are clearly at risk and in need of services.

Because obesity tends to run in families,

continued on page 51

researchers have developed family-based interventions, targeting eating behavior and activity change in the children and their parents (Epstein, Paluch, Roemmich, & Beecher, 2007). This model includes teaching parents behavioral skills to facilitate change in their teenagers. The therapy focus is on behavioral interventions including addressing poor parental modeling and support for overeating and under exercising. A primary goal of family-based interventions is to mobilize family resources to support the teen's healthy eating as well as increased physical activity level. At least one parent is asked to take an active role in the intervention. Treatment typically lasts 16 weeks to 8 months and includes follow-up periods of at least one year with "booster" sessions to help children maintain both healthy eating behavior and physical activity (Epstein et al., 2007). The length of treatment varies based on the family, and the level of severity of the adolescent's obesity. Some studies have taken into consideration different levels or severity of obesity (Panzer, 2006; White, 1986) given that White (1986) found, "the more obese the child, the greater the psychological consequences" (p. 263).

In addition to behavioral interventions, other family-based treatment models focus on the family environment and activities, such as mealtimes. Fulkerson et al. (2007) found that making family meals a priority and having a positive mealtime environment were positively associated with psychological well being and inversely associated with depressive symptoms and unhealthy weight-control behaviors in adolescents. Indicators of poor psychological health included family members teasing teens about their weight and parental encouragement to diet; such teasing was strongly correlated with negative psychosocial outcomes (Fulkerson et al., 2007). These findings indicate that family-based psychotherapy interventions should focus on both behavior change and parental and teen skill development, as well as increasing healthy eating behavior with an emphasis on mealtime strategies and incorporating positive family support.

Cognitive behavior therapy (CBT) is an evidence-based treatment modality designed to address the negative psychological effects of obesity. One study outlines a CBT model that incorporates psychoeducation, diet change, and increasing physical activity into therapy (Panzer, 2006). The treatment protocol states that, "Sessions should include weighing the child…reviewing food and activity charts… providing positive reinforcement, exploring and addressing various forms of nonadherence or resistance, assigning cogent homework tasks, summarizing the interview, and planning for the next visit (Panzer, 2006, p. 540)."

CBT uses behavior modification to help adolescents achieve diet and exercise goals in treatment. Sessions begin with introducing and refining specific strategies and using psychoeducation to teach adolescents about obesity. Identifying and recognizing cognitive patterns within the family is important, along with identifying negativistic and dichotomous thinking and overgeneralizations. Other cognitive techniques such as reframing can be useful for teaching adolescents coping skills to manage feelings of hunger and body image concerns. CBT is a structured psychotherapy model designed to help teenagers change unhealthy eating behavior through identifying and challenging their dysfunctional thoughts and behaviors. Helping teens identify and then change their dysfunctional thoughts about eating, and negative thoughts about themselves can significantly increase self-esteem, as well as create positive and lasting healthy lifestyle changes.

continued on page 52

Motivational interviewing (MI) is another therapeutic technique that has been used to treat obesity (Carels et al., 2007). MI was designed to enhance motivation and decrease ambivalence toward behavior change (Miller & Rollnick, 2002). Although MI was originally developed to treat addictions, it is increasingly being used in psychotherapy to motivate adolescents who are resistant to treatment and to enhance health behaviors. A recent study integrated MI into a behavioral weight loss intervention (Carels et al., 2007). When poor progress toward weight loss goals was detected, MI was used to enhance motivation. Findings showed that participants lost more weight and engaged in greater weekly exercise when MI was used. Using MI alone, or in conjunction with other psychotherapy techniques may help motivate teens to decrease sedentary behavior and increase both healthy eating and exercise and physical activity.

In addition to outlining effective psychotherapeutic treatment interventions for obese teenagers, previous research emphasizes the importance of considering adolescents' demographic characteristics in treatment. Race/ethnicity, age, gender, and socioeconomic status, all effect adolescents' presentation in therapy, and are especially important when treating obese teenagers. Latino and Black adolescents are more likely to be obese (Stice, Shaw, & Marti, 2006), and over one third of Latino and Black children ages 2-19 are considered obese (AHA, 2009). This suggests that interventions targeting these high-risk youths may be more effective because there is a greater opportunity to show a prevention effect. However, obesity is less stigmatized and associated with less body dissatisfaction for certain ethnic minority groups (Stice et al., 2006). In addition to race and ethnicity, age and development may impact psychotherapeutic outcomes for obese teenagers. For example, an insightful and mature 17-year-old may be more successful using a CBT perspective, while a younger child may benefit from more parental guidance and support using a family-based approach.

Socioeconomic status and gender also effect treatment outcomes. Children who live in single-parent homes, for example, may not have a parent who can commit to an intensive family-based intervention. Psychotherapists should be sensitive to these important potential barriers to children's success in therapy. Gender is another important consideration for the treatment of obesity. One study found that, "sex differences may exist in vulnerability to weight stigma in youths" (Puhl & Latner, 2007). For example girls tend to engage in relational aggression more frequently than boys (Simmons, 2002), and may be at higher risk for being teased and becoming depressed.

The medical and mental health risks for teenagers who are obese are great. Not only does obesity increase the probability that these teens will face future medical complications and chronic health conditions, but the psychological, social, and developmental repercussions of obesity cannot be ignored. Mental health providers can make a difference in the childhood obesity epidemic by helping adolescents develop new behaviors and skills and ultimately lead healthier lives.

(References available on-line.)

CONGRATULATIONS TO DIVISION 29 IMMEDIATE PAST PRESIDENT JEFFREY E. BARNETT, PSY.D., ABPP

APA Award for Distinguished Professional Contributions to Independent Practice

The Complete Practitioner: Still a Work in Progress
Friday, August 7, 2009 from 11:00 am – 11:50 am,
at the Convention Center, South Building, Meeting Room 703
The APA / APF Award Ceremony Friday from 4:00 pm – 5:50 pm
in the Fairmont Royal York Hotel (room to be announced)

AWARD CITATION— "For outstanding, distinguished and meritorious service in several areas of professional practice, especially in the areas of professional ethics and psychotherapy treatment. Dr. Jeffrey E. Barnett has produced hundreds of high quality publications, workshops and symposia that have had widespread impact. He has provided visionary leadership service and outstanding legislative advocacy. He is well known for his quality mentoring of students, early career professionals and members of diverse groups. He tackles projects, causes and support of people with a spirit of enthusiasm, passion, and care that is quite unique. He is acknowledged, respected, and honored by all who know him."

BRIEF BIO— Jeffrey E. Barnett, Psy.D., ABPP received his doctorate from the Ferkauf Graduate School of Yeshiva University in 1984. He is a licensed psychologist in independent practice in Arnold, Maryland where he provides psychotherapy and comprehensive psychological evaluations, primarily for children and adolescents. He is Professor on the faculty of Loyola College of Maryland. He is a Diplomate of the American Board of Professional Psychology in Clinical Psychology and in Clinical Child and Adolescent Psychology and a Distinguished Practitioner of the National Academies of Practice. He is a Fellow in seven APA Divisions.

Dr. Barnett has served in numerous leadership roles including as President of the Maryland Psychological Association (MPA); in APA he served as President Divisions 29, 31, and 42. He served on APA's Council of Representatives for six years and is a trustee of the Association for the Advancement of Psychology. Dr. Barnett served as chair of APA's Board of Convention Affairs and is presently Chair of APA's Ethics Committee. He is Associate Editor of the APA journal *Professional Psychology: Research and Practice.*

Professional interests reflected in his numerous publications and presentations include ethics, legal, and professional practice issues in psychology; mentoring students and early career psychologists; working to advance diversity in our profession; and advocacy. Dr. Barnett lives with his wife of 23 years, Stephanie, and his two children, Stuart and Madeline. He is an avid runner, swimmer, and cyclist, and continually endeavors to practice effective self-care and to strike a balance among his many interests.

CALL FOR FELLOWSHIP APPLICATIONS DIVISION 29—PSYCHOTHERAPY

Jeff Hayes, Chair, Fellows Committee

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

The minimum standards for Fellowship under APA Bylaws are:

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

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

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

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

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

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

continued on page 55

DEADLINE FOR SUBMISSION

The deadline for submission to be considered for 2010 is **December 15, 2009**. The initial nominee must enclose a *Uniform Fellow Application*, self-nominating letter, three or more letters of endorsement, updated CV, along with a cover letter, and three copies of all the original materials. Incomplete submission packets after the deadline will not be considered for this year. Those who are current Fellows of APA who want to become a Fellow of Division 29 need to send a letter attesting to your qualifications and a current CV.

Completed Applications should be forwarded to:

Jeff Hayes
Chair, Division 29 Fellows Committee
307 Cedar Building
Penn State University
University Park, PA 16802
Email: jxh34@psu.edu
Phone: 814-863-3799

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

THE DIVISION OF PSYCHOTHERAPY

The only APA division solely dedicated to advancing psychotherapy

MEMBERSHIP APPLICATION

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

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

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

JOIN DIVISION 29 AND GET THESE BENEFITS!

☐ FREE SUBSCRIPTIONS TO:

Psychotherapy

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

Psychotherapy Bulletin

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

☐ EARN CE CREDITS

Journal Learning

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

☐ DIVISION 29 PROGRAMS

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

☐ DIVISION 29 INITIATIVES

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

☐ NETWORKING & REFERRAL SOURCES

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

☐ OPPORTUNITIES FOR LEADERSHIP

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

☐ DIVISION 29 LISTSERV

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

☐ VISIT OUR WEBSITE

www.divisionofpsychotherapy.org

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

Name _____ **Degree** _____

Address _____

City _____ **State** _____ **ZIP**_____

Phone _____ **FAX** _____

Email _____

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

If APA member, please provide membership #

❑ **Check** ❑ **Visa** ❑ **MasterCard**

Card # _____ **Exp Date** _____/_____

Signature _____

Please return the completed application along with payment of $40 by credit card or check to:

Division 29 Central Office, 6557 E. Riverdale St., Mesa, AZ 85215

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

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

www.divisionofpsychotherapy.org