Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

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Psychotherapy Research Science and Scholarship
The Center for the Study of Collegiate Mental Health: A Novel Practice Research Network with National Reach and a Pilot Study to Match

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Research on Psychotherapy Integration: Throw Away the Manual

2009 VOLUME 44 NO. 4

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

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

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Division 29 welcomes Mark Hilsenroth as the new editor (as of January 2010) of *Psychotherapy: Theory, Research, Practice, Training*. Of course, Charles Gelso continues as editor throughout 2009, continuing to receive and act on submitted manuscripts, and working with those submitted through 2009 but not yet brought to completion. Hilsenroth provided his vision for the journal, which is published in this winter issue of the *Psychotherapy Bulletin.* As a way of welcoming him, we interviewed the current and former journal editors about their recollections and their recommendations for the new editor.

The list of journal editors and their many historic accomplishments is impressive indeed. Eugene T. Gendlin was first editor, serving from 1964 – 1975. Gendlin reports currently that he is "doing very well, writing a lot of philosophy, and actively participating in the international Focusing Network" (comprising over 4,000 people including 800 certified trainers, and accessible at www.focusing.org). He recalls that before the journal was established, other journals (and even the APA convention) refused to publish most papers related to psychotherapy. Together with Leonard Pearson and Larry Bookbinder, Gendlin established the journal by printing articles at the University of Wisconsin Press and giving the first issue to members of Psychologists for the Advancement of Psychotherapy (PIAP). Carl Rodgers had submitted a paper to another journal, but decided against publishing it there since the editor had insisted on a writing a type of disclaimer statement to accompany it; this article was published in the first issue of the journal much to Gendlin's delight. Many other luminaries also published papers in the journal under Gendlin's tenure including Albert Ellis, Erika Fromm, Victor Frankl, Timothy Leary, and Hans Strupp. Gendlin's philosophy was to focus on new ideas; he recruited open-minded psychologists as consulting editors, and would often edit articles himself, cutting material that had already been covered in the literature. This philosophy resulted in a "colorful journal" that was useful to psychotherapists from all theoretical orientations. Along with the journal, PIAP made other inroads into the APA culture, including establishing Division 29, and thereby providing a professional home for psychotherapists. When APA finally accepted symposia related to psychotherapy, but didn't publish the information in the printed program, Len Pearson and others put up notices advertising the symposia everywhere around the convention, including the restrooms! When PIAP members weren't invited to the exclusive APA parties for "important people," they created their own. Needless to say, the symposia and parties devoted to psychotherapy were quite well attended. Thus Gendlin became friends with many psychologists, even those outside his own interest areas, such as Ogden Linsley, a Skinnerian, and was able to grow the journal accordingly. Gendlin recommends that future editors

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continue to focus on new ideas, consciously try to avoid bias, and open themselves to learning, as he did when journal editor.

Gendlin was followed by Arthur L. Kovacs from 1976 – 1983. Kovacs recalls being recruited to the editor position by Stanley Graham, then Division 29 President. He found being editor a "wonderful challenge" and worked to create a structure for the journal that included developing a review board, finding a new publisher, redesigning the cover and artistic presentation, developing procedures to solicit manuscripts, and publishing papers grouped by themes. He credits Gene Gendlin for his pioneering approach to publishing articles from a broad range of theoretical orientations, and to establishing an excellent journal from the beginning. Kovacs hopes that the journal will continue its proud tradition of stimulating submissions from a wide variety of theoretical perspectives and avoiding becoming a mouthpiece for any particular popular approaches. It is notable that after 50 years in practice, Kovacs remains in full time independent clinical practice and also continues to teach part time at the California School of Professional Psychology.

Following Kovacs' successful tenure as editor, Donald K. Freedheim took the helm until 1993. He was encouraged by Carl Zimet to apply for the position, and found it very rewarding. Although Freedheim had already edited several publications including *Professional Psychology*, he recalls his appreciation to Kovacs for teaching him about the journal, and for his smooth transition into the editor position as a result. Freedheim reports that Kovacs has always been indefatigable, and would often type long memos on the plane to and from Washington. During that time, everything was in hard copy; Freedheim's graduate assistant eventually introduced him to the computer. Freedheim's philosophy was that the editor was king, rather than authors, as was true in publications in which scientific data had to be preserved. Rather, his approach was to produce a journal that was actually useful to practitioners, educators, and students as well as researchers. The journal's rejection rate was 75 – 80% and often more than 300 papers a year were turned down; Freedheim personally wrote to each author, acting as an educator and describing in detail what was needed to strengthen manuscripts, focusing on the work itself rather than on the writers. He was "hands on" and edited papers liberally, cutting superfluous material and even correcting grammar and sentence structure. He inherited a separate gender editor to "de-masculinize" articles, but soon learned to do it himself. Freedheim's policy was to have one special issue each year, often focusing on special populations such as ethnic minorities. He also had a particular interest in papers from international authors, and established a program in the APA International Office to recruit volunteers to assist authors for whom English was a second language. Freedheim reports that he was once described by an author as "a nice guy but tough." He believes an editor's task is to be judgmental, yet they must use wisdom coupled with diplomacy and the desire to help. His advice to Hilsenroth includes the recognition of the crucial position of an editor, who can decide what work becomes a permanent record in the field. The place of the editor is generally to "stay in the kitchen rather than the living room" of the Division. He also recommends actively seeking out manuscripts, using various conventions as mine fields for ideas and future authors.

Wade H. Silverman was editor from 1994 – 2004, following his tenure as *Psychotherapy Bulletin* editor from 1987 – 1993. He reports that being editor of the

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journal was the "crowning achievement of his career." In his heart he was "always an academic," and he thoroughly enjoyed the "honor of disseminating knowledge" to his peers. He pointed out the need for strong clinical skills in the editor role. He found it inspiring to receive excellent journal articles, and he loved interacting with his many helpful reviewers and the wonderful members of the Publications Board. For about half his tenure, he was in independent practice; obviously his organizational abilities were very helpful. Overall, Silverman concludes by stating that being editor was a "very positive experience." His main recommendation to Hilsenroth is to develop a thick skin, since often journal editors receive more complaints than appreciative comments.

Charles Gelso has served as editor since 2005, following his previous 6-year tenure as editor of the *Journal of Counseling Psychology*. Gelso states that he has "always loved this journal," and its "great mesh between theory, research, and practice" along with the "heterogeneity of theories" presented. He reports that he has greatly enjoyed his time as editor. He credits Gendlin for setting the tone for the journal, and has tried as editor to be respectful, thorough, and thoughtful in responding to authors. As a practitioner and teacher, Gelso has focused on creativity, good ideas, and clinical relevance in encouraging and reviewing submissions. High points of his tenure include editing several special issues and sections such as the December 2007 republication of Carl Rogers' famous "necessary and sufficient conditions" paper along with 11 short reaction papers. It was "such an honor" publishing this 50 year retrospective and to show the great and enduring impact of this work by one of Gelso's "heroes." Another important special issue focused on race, culture, and ethnicity in psychotherapy, and Gelso specifically asked clinicians to present case data and the "inner workings of psychotherapy" in a way that was very helpful for journal readers. Fred Leong and Steve Lopez served as guest editors of that issue with the idea to help imbed multiculturalism into psychotherapy practice. During Gelso's tenure as editor, the review process has been computerized, and he has aimed to get feedback to authors within 60 days. The journal currently receives approximately 150 submissions each year, with an 80% rejection rate excluding invited papers. Gelso sees the editor's role in part as soliciting "growing edge papers," thoughtfully reading and responding to each manuscript, and continuing the practice review (announced in each issue). When asked to give suggestions to Hilsenroth, Gelso says "respond to each author respectfully, actually read each manuscript, and respond uniquely to each author (no form letters). Gelso also recalls advice he received from his mentor Sam Osipow: "if you have an hour to spare, use it to work on the journal." We might add that this is useful advice for the editors of the Bulletin as well! Finally, Gelso wants to acknowledge the great debt of gratitude owed to his to his two associate editors, Drs. Nick Ladany and Lisa Samstag, for the wonderful editorial job they did during their tenure, which accompanied Gelso's tenure. He also wants to express appreciation to the members of his editorial board, who have made major, if silent, contribution to psychotherapy through their thoughtful reviewing.

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

Thank You to Division 29

It is with mixed emotions that I write my final newsletter column as President of the Division of Psychotherapy. I am proud of our accomplishments this year, particularly those related to my main presidential initiatives: diversity and psychotherapy supervision. We have two special issues that will appear in *Psychotherapy: Theory, Research, Practice, Training* that are focused on these two topics. Our board was very committed to seriously grappling with the theme of diversity as it plays out in board dynamics, divisional priorities, and our membership. We have made dramatic improvements in our website, with more exciting changes to come in this expanded information and networking portal (http://www.divisionofpsychotherapy.org/). Our programming at the APA convention was outstanding and well attended and our lunch with the Psychotherapy Masters was once again a big hit for not only the students and early career psychologists in attendance, but also the master psychotherapists. I am delighted to announce the creation of the Charles J. Gelso Psychotherapy Research Grant. Annually, this grant will provide a small sum of financial support to a psychotherapy process and/or outcome researcher. The naming of this grant highlights our respect and admiration for the outstanding job that Charles Gelso has done at the helm of the journal, as next year will be his final year in this role. Finally, we have made a number of changes to enhance the infrastructure of our governance, including creating an orientation manual for new members, clarifying the roles and responsibilities of our domain representatives, updating our bylaws significantly (which will soon go to a vote of the membership), and revising our policies and procedures. All of these changes have resulted in more positive and open communication among the members of the governance group.

Without a doubt, one of the highlights of my year has been the opportunity to interact with members of Division 29, via email, telephone, and at the APA convention. I have learned so much from these interactions and am heartened by the commitment that my colleagues in psychology have to the advancement of high quality psychotherapy – theory, research, practice, and training. During this past year, I was honored to have had the opportunity to work collaboratively and effectively with new friends and long time friends on the Division 29 governance. We have a wonderful team and I am particularly grateful to my presidential colleagues, with whom I spoke every week and emailed more frequently: Drs. Jeffrey Barnett (Past-President), Jeffrey Magnavita (President-Elect), and Libby Nutt Williams (President-Elect Designate). They have helped us move the division forward in exciting and innovative ways. I also want to acknowledge the other members of our Executive Committee, who devoted considerable time and energy to ensuring that our minutes were detailed, our budget well balanced, and our voices heard on APA Council: Drs. Jeffrey Younggren (Secretary), Steve Sobelman (Treasurer), Norine Johnson and Linda Campbell (APA Council).

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Of course, much of the work of our organization rests on the shoulders of our domain representatives. These individuals consistently and impressively stepped up to the plate to represent specific areas of interest related to psychotherapy: Drs. Caryn Rodgers and Erica Lee (Diversity), Drs. Rosemary Adam-Terem (Public Policy and Social Justice Domain Representative), Jennifer Kelly (Professional Practice), Michael Murphy (Education and Training), Libby Nutt Williams (Membership), Michael Constantino (Early Career), and Norm Abeles (Science and Scholarship). Dr. Jean Carter's stewardship of the Publications Board helped to ensure that we offer our members the highest quality publications possible. Sheena Demery, our Student Development Chair, was an outstanding spokesperson for student concerns and helped make our division more welcoming to students.

Many significant divisional activities occurred under the leadership of chairs of key committees and I am incredibly grateful to them for their contributions: Drs. Jean Carter (Publications Board), Charles Gelso (Editor of *Psychotherapy: Theory, Research, Practice, Training)*, Jenny Cornish (Editor of *Psychotherapy Bulletin)*, Chris Overtree (Editor, *Internet)*, Jeff Hayes (Fellows), Chaundrissa Smith (Membership), Jeffrey Magnavita (Nominations and Elections), Jeff Barnett (Professional Awards), Bonnie Markham (Finance), Eugene Farber (Education and Training), Annie Judge (Continuing Education), Nancy Murdock (Program), Bonita Cade (Psychotherapy Practice), and Susan Woodhouse (Psychotherapy Research).

Governance members come and go on an APA division board, but Tracey Martin, in our Central Office, remains a steady and permanent force in our organization. She is the consistent thread that keeps us connected and moving forward in the most productive manner possible. I have truly appreciated her guidance, wisdom, frequent emails, gentle reminders, and thoughtful suggestions and insights.

Because of the deep sense of connection that I experience with members of the divisional governance, moving out of the role of President is bittersweet. Fortunately, I am confident in the leadership abilities of my successor, Dr. Jeffrey Magnavita. I wish him the best and I will do my utmost to ensure a smooth transition and another successful year in our division.

What Makes for an Effective Leader

As my term as Division 29 President draws to a close, it offers me the opportunity to pause and reflect on the question of what makes for effective leaders. I grew a tremendous amount as a leader through my experiences with our members and the governance group and I trust that these learnings will serve me well in future leadership roles. I believe that much of the knowledge, skills, and attitudes that make for a competent and capable psychotherapist are parallel to those required for effective leaders. I hope these insights will encourage more of you to become involved as leaders in our division, within APA and other professional societies, in nonpsychology organizations, in your home institutions, as educators and scientists/scholars, and in your roles as advocates on behalf of a better world.

Leadership is an action, not a position, and a process, not a task. Effective leaders are intelligent and creative, have a strong work ethic and a high degree of self-discipline, demonstrate a sense of humor and capacity to be flexible and adaptable, and manifest undaunted curiosity. They recognize that the capacity to listen well is the cornerstone of good leadership. Visionaries, strategic planners, and committed to action, they are

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knowledgeable about themselves, the people, the politics, and the issues. Able to inspire, motivate, and guide others, they are attuned to new opportunities and willing to take on novel challenges. They surround themselves with smart, dedicated, and capable people and are committed to retaining and developing them. These interpersonally skilled, versatile, and accessible individuals hold onto their own values and high ethical standards and maintain their integrity and honesty. They demonstrate loyalty to people and ideas. Capable leaders manifest wisdom with regards to their ability to see and understand issues, set priorities, and act prudently and courageously. Fair, reliable, consistent, and sensitive in their dealings with others, they are tenacious, motivated, and take a lot of initiative. Competent leaders are able to on the one hand be reasoned and thoughtful, and on the other hand, display passion. They model values and behaviors, focus on group and team building, develop consensus, are inclusive, share power, delegate well, and are competent at conflict management. They create relationships that generate clarity, commitment, and engagement. Effective leaders distinguish themselves as mentors; they are advisory by nature, impart wisdom, care deeply about the career development of others, facilitate political navigation by their protégés, can serve as objective consultants, and celebrate and reward their protégés successes. People who are effective as leaders are good communicators and engage in all forms of social discourse at every opportunity with those internal and external to the organization. These individuals handle difficult conversations in a straightforward and balanced fashion. They have the knack for avoiding mistakes that will haunt them forever, and when they make mistakes they acknowledge and learn from them. Indeed, they consistently manifest humility. Exemplary leaders challenge the process by searching out opportunities, experimenting, and taking risks.

I concur with the current zeitgeist that a collaborative approach to leadership is optimal in most settings and situations. This perspective means creating a supportive and positive workplace environment, inspiring and communicating a shared vision, openly providing information, conveying the rationale for decisions, valuing and respecting others, enabling others to act, strengthening people, and sharing power and leadership. Collaborative leaders master the art and craft of empowerment. They empower their team by actively listening to others, valuing the viewpoints of others, developing people and organizational capacity, looking for ways to advance the careers of those who work with them, putting themselves last, and not micromanaging. They encourage the heart by recognizing individual contributions and celebrating team accomplishments. They know that they gain power by giving it and that the more people feel power, the greater their satisfaction in the workplace. They build teams for the future.

A collaborative leadership style that incorporates the tenets of appreciative leadership is appealing. Appreciative leadership represents a paradigm shift based on the construct of appreciative inquiry, the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential (David Cooperrider). Appreciative leaders encourage others to tell their story. Focusing on the system at its best, they see the positive behavior they want to develop, track the positive, and fan it across the organization so people want to do more of it. Appreciative leaders convey hope by creating inclusive communities; searching for best practices; and creating, validating, and spreading the message of hope (James Ludema). These

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individuals combine effective management and leadership skills with high emotional intelligence. Institutions populated by effective leaders value performance management. Leaders in these settings espouse a well-articulated vision and goals and ensure that bidirectional feedback processes are in place. These processes support feedback that is direct, specific, developmental, positive, and presented in an appreciative fashion. In addition, they encourage people to be receptive to input feedback from their colleagues, subordinates, and superiors.

General Electric's (GE) model of leadership (Jack Welch) is inspiring. It is based on the principle that optimal results occur when integrity and quality lay the foundation for all aspects of the organization's functioning and when the people and processes in the system facilitate the creation of high quality products. To support optimal results, leaders must engage in the five Es: energy, energizers, edge, execute, and empathy. They must have tons of positive energy and the ability to energize others. They must have edge, the courage to make tough decisions. They must be able to execute and get the job accomplished. Finally, in the GE model, good leaders must have passion, a heartfelt and authentic enthusiasm about life and work; a deep sense of caring that their neighbors, employees, colleagues and friends win; and a love of learning and commitment to personal growth.

The following are some of my favorite quotes. • Leadership is like beauty—it is hard to define but you know it when you see it. (Warren Bennis) • If you are not coaching and teaching, you are not leading. (Jack Welch) • There is no limit to what a (wo)man can do or where(s)he can go if(s)he doesn't mind who gets the credit. (Robert W. Woodruff) • A leader is a dealer in hope. (Napoleon Bonaparte) • The best way to predict the future is to invent it. Remember, of course, there is a kind of growth in the leadership domains that only comes with being a leader—in your work setting, in your community, or in another context. (Alan Kay) • Don't tell people how to do things, tell them what to do and let them surprise you with their results. (George S. Patton) • Management is doing things right. Leadership is doing the right things. (Peter F. Drucker) • We have always believed that building strong leaders is a strategic imperative. When times are easy, leadership can be taken for granted. When the world is turbulent, you appreciate great people. (Jeff Immelt)

There are many ways that you can be a leader within Division 29. You can run for an office. You can join a committee. You can contribute to our journal, bulletin, or website. You can apply for Fellow status. Or you can engage in a dialogue with me (nkaslow@emory.edu) and other members of our leadership team about ways in which we can strengthen our division, make it a more welcoming place, assure that we best meet the needs of our members, have a stronger voice within APA and for the public with regard to the value of psychotherapy.

COUNCIL REPORT

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

President James Bray: Council started with a report by President James Bray on the Summit of the future of psychology practice. Dr. Bray then filled Council in on his many activities since the last time Council met.

Norman Anderson's report:
President Bray's report was followed by APA's CEO Norman Anderson who gave an excellent update on APA's effort on Health Care Reform. He stressed that APA's priority activities included integrating mental and behavioral health care into primary care. He further illuminated how the APA staff was advocating to insure access to quality mental and behavior health promotion, develop and maintain a diverse psychology workforce, eliminate disparities, increase federal funding, maintain parity, and include strong privacy and security records protection.

APA's primary push remains with integrated health care. The organization's advocacy staff is looking to secure a provision in the health care bill to promote integrated, inter-professional care in primary care settings; capacity building; and training programs to promote interdisciplinary and team-based models.

In a Senate bill, a section was included to expand funding to train psychologists, including in geriatric care, and a definition of psychologists as health professionals.

A significant portion of Council's time was spent on financial issues. In 2008, APA ended the fiscal year with a deficit of 4.9 million. It was made clear that for 2009 a large deficit also loomed and that APA could not afford to continue with these large deficits. A board outline of APA's plan to decrease the deficit by reducing expenses in salary, reducing positions, and reductions in other areas was given. This will result in an impact on staff as there had to be staff layovers in order to remain fiscally stable.

Considerable discussion occurred about the ***budget item for Consolidated meetings in the Fall of 2010***. The discussion included the value of physically meeting and the possibilities of finding other ways such as electronic meetings for doing the work of Consolidated meetings. Discussion then ensued about how to do the work of the organization differently.

Council accepted a budget projection of $110,526,100 for 2010.
Dr. Anderson asked Council to continue its work on the ***strategic plan.*** Votes were taken on the Goals of the organization and Core Values.

The three Goals were:
Maximize organizational effectiveness; Expand psychology's role in advancing health; and Increase recognition of psychology as a science. The Core Values (listed alphabetically) were: Diversity; Education and life-long Leaning; Ethics and integrity; Excellence; Human welfare; Knowledge Dissemination; Professional practice; Scholarship; Science; Service, Transparency.

Council voted to receive the report on Interface between Psychology and Global warming. This report and other reports can be found on APA's web site.

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A motion to propose language to Council that will resolve the discrepancy between the language of the Introduction and Applicability Section of the ***Ethical Principles of Psychologists and Code of Conduct and the Ethical Standards 1.02 and 1.03*** so that these Standards can never be used to justify, or as a defense for, violating basic human rights was passed.

Council directed the Ethics Committee to revise the language in the Ethics.

A motion was presented to approve a reduction in the number of years in the step up process of ***dues for Associate members and Early Career psychologists.*** The motion was to decrease the number of years of reduced dues before an early career or Associate member had until needing to pay the full dues. Early career psychologists asked that the motion not be passed.

The bylaws will be revised so that a member is dropped from membership in the Association after non payment of dues in March instead of after a year that could extend over two years.

The Media award for 2009 went to Caroline Abraham and Nancy Shoot, reporters with The Globe and Mail respectively, on mental health, stem research, and genetics.

Two motions on lesbian and gay bisexual issues. Council voted to receive the final report of the Task Force on the Appropriate Therapeutic Responses to Sexual Orientation and on the Resolution on the Appropriate Affirmative Response to Sexual Orientation Distress and Change Efforts. The conclusion from the task force is that there is insufficient evidence to support the use of psychological interventions to change sexual orientation. These motions passed Council practically unanimously.

Council voted that the delegates from each of the four National Ethnic Minority Psychological Associations be invited to attend Council meetings for an additional three years (2010-2012).

A discussion about issues between APA and the Insurance Trust occurred in Executive Session.

Council voted to support ***approving the renewal of recognition of Assessment and Treatment of Serious Mental Illness as a proficiency in professional psychology.*** And Council approved an APA Designation Program for Postdoc Ed & Training Programs in Psychopharmacology.

Archives: Council voted to reduce the annual contribution to the Archives of the History of American Psychology to $20,000 in 2010 and that Council must reauthorize the continuation and amount of the annual contribution every 3 years beginning with the 2011 contribution.

Dr. Barry Anton gave a report on the APA National Conference on Undergraduate Education in Psychology. This report is available on the APA list serve. Ninety thousand undergraduate students graduate with a major in psychology each year.

FEATURE

Eat Hearty at the Table that is *Psychotherapy*

Mark J. Hilsenroth, Ph.D.
Derner Institute, Adelphi University

I applied for the Editorship of *Psychotherapy: Theory, Research, Practice, Training* because, put quite simply, I really love this journal. I love it because it offers a smorgasbord of all the essential elements of psychotherapy that I find so fulfilling. And I'm not talking about some skimpy haute cuisine sampling menu, but a heavy buffet with a variety of different foods, where one can come away feeling satisfied. And having eaten so heartily for almost the past two decades I wanted the opportunity to give back and help set this table for others in search of a similar meal.

Ever since I was a graduate student in the early 1990's, when I used to borrow my graduate advisor's (Len Handler) copy of the journal to the present, *Psychotherapy* is the one journal that I try to read cover-to-cover. I have found that, even if an article is not in one of my explicit areas of interest, my understanding of psychotherapy is expanded by it. Although, with my other responsibilities, it now may take me a month or two to accomplish what used to only take a few days. *Psychotherapy* is still the one journal I make certain to read in this manner. I also try to read this journal in its entirety because my interests, both research and clinical, are highly consistent with the content and breadth of the journal that range the full spectrum of topics in the field of psychotherapy. This is why I believe I fulfill one of the most important criteria for a new Editor of any journal, an absolute passion for 'what' that journal does.

I also fully recognize that, in order to have the most successful buffet experience, it must appeal to many different palates, without shortchanging portion or content. As such, I believe the Editor of *Psychotherapy* must have a deep respect for the diversity of perspectives in the field. I believe my own integrative approach to treatment and research is consistent with such a stance. It was with this goal in mind that I have assembled an editorial board of psychologists who represent an appreciation for the complexity of perspectives concerning the treatment process. I wanted to include people who don't feel overly competitive with different theoretical orientations, but rather possess a sense of curiosity as to what others can offer to their own perspective and approach. In addition, as most approaches to therapy share similar constructs of interest but not the labels for them, it was important for me to find people who are able to speak different theoretical "languages" and thus better able to effectively communicate to a broader community. While I have continued about half of the previous editorial board, I also thought it important to include a healthy complement of new voices from these varying perspectives. I believe such fresh appraisal will serve to invigorate the suggestions, feedback and discussion with authors during the publication review process.

I think this mix of perspectives is no better exemplified than in the three Associate Editors, or perhaps Executive Chefs, who will be collaborating with me to organize this dining experience. First, I am thrilled that Lisa Wallner-Samstag has

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agreed to continue on in this position; she provides some much appreciated continuity to this transition. Lisa will also continue her work coordinating book reviews for the journal and so this section will remain informative and helpful to our readers. In addition to her editorial experience, Lisa's work on therapeutic alliance, rupture and repair was among the first in these areas and is well known to all of us. Next, I am very excited to work with Heather Thompson-Brenner. Heather brings a myriad of different experiences that in part derive from working closely with several leading figures in psychotherapy research from a range of different theoretical orientations, such as Drew Westen and David Barlow. As such, Heather has developed the rare capacity to integratively translate theoretical concepts into both clinically applied research and practice initiatives that span different approaches to treatment. She also has experience in conducting research from several methodologies including practice networks, field research, and randomized trials, as well as directing an applied research clinic for eating disorders. Last, but certainly not least, I feel very lucky to be able to work with Jesse Owen. Jesse is a rising star in psychotherapy process and outcome research. In particular, his work addresses minority and gender issues in relation to focal process concepts, such as the therapeutic alliance and emotional expression, while employing cutting edge statistical methods such as multilevel modeling. If you haven't read one of his articles in these areas yet, you will soon. Given his high level of early career productivity we are very lucky to have his energy and forward thinking involved in the leadership of our journal.

Concerning potential changes to *Psychotherapy*, I believe several important improvements have already been adopted by Charlie Gelso during his term. First among these has been the conversion of the review process to an electronic format. Not a small feat I'm sure, but essential in the times we live. In my term, the editorial office will extend this process and become entirely "paperless". Second, I believe the expansion of the editorial board and addition of a second Associate Editor was a necessity. Along these lines I want to thank both the Publication Board and Executive Committee of Division 29 for recently approving the funds for adding a third Associate Editor. Third, I believe the development of the Practice Review articles, summarizing extant research in a clinically accessible manner, are a wonderful addition that directly address the main aims of the journal and I therefore plan to continue this series. I also plan to be proactive and try to obtain these applied research summaries from the top people across a number of different clinical areas.

Therefore, my goal will be to continue and extend the current positive direction of the journal with a number of related initiatives. To begin, I have organized an "Author and Reviewer Resource Page" at the journal web site that will also be linked with the division web page as a resource for all Division 29 members. On this page, are links to several different resources to help authors conduct their research. These include free statistical programs to calculate such things as effect size, reliable change, power estimates, etc. In addition, there are links to help authors present and format their research findings with aids such as the American Psychological Association (APA) Working Group on Journal Article Reporting Standards (JARS) report, the Consolidated Standards of Reporting Trials (CONSORT) articles, checklists and flow chart, the Transparent Reporting of Evaluations with Nonexperimental Designs (TREND) articles and checklist, the

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Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement, as well as reporting standards for meta-analysis including the QUOROM statement (Quality of Reporting of Meta-analysis) and its recent revision PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analyses). In addition, given that one of the primary aims of the journal is to provide research that has clinical utility for applied practice, I will be inclined to expect that authors of empirical papers report effect sizes (i.e., *d*, *g* or *r*). I would also like to see information reported using the more straightforward clinical significance variables for any psychotherapy outcome research. That is, clear and clinically relevant reporting of the percent of patients in a study who demonstrated reliable change, moved into a functional (i.e. normal) distribution, achieved clinically significant change (i.e. reliable change and movement into a functional distribution) and those who deteriorated in functioning. Parallel in purpose to the Practice Review articles, I will be developing a series of "Evidence Based Case Studies" and hope to eventually include one in each issue. The goal of these Evidenced Based Case Studies will be to integrate verbatim clinical case material with standardized measures of process and outcome evaluated at different times across treatment. That is, authors should describe clinical vignettes highlighting key interventions and mechanisms of change regarding their specific approach to treatment in the context of empirical scales. Also, I do not mean to suggest that this section is for advanced statistical time series analyses (although such articles would be welcomed), but rather for any reports on individual treatments that occur as part of an open effectiveness trial or RCT where the use of audio/videotape and collection of such measures are commonplace. In addition, I want to open an avenue for publication to those in full time private practice who are interested in integrating research measures into their clinical work. I believe such a series will be extremely useful in efforts to bridge the gap between research and practice as well as provide important templates of how to integrate basic research into applied work at the individual case level.

Finally, one thing that has become very clear to me since being named the Incoming Editor of *Psychotherapy* is that I am not alone in my love of this journal. This same passion for the journal and what it does is a sentiment that has been expressed to me by a number of members of the division. What has come across loud and clear to me from these members and from the Division 29 leadership is that the first goal of this journal is to serve the interests of the membership. That is, the primary goal of my term as Editor is not to focus on increasing the research citation Impact Factor of the journal, but rather to satisfy the varied interests and tastes of the Division 29 members for real world clinically useful articles that address theory, research, practice and training issues in psychotherapy. To this goal I am fully committed and bid you all Bon Appetit!

DIVISION 29 AWARDS CEREMONY AND SOCIAL HOUR

Awards Chair Jeff Barnett, Div 29/APF Early Career Award Winner Katherine Muller, and President Nadine Kaslow

Award for Best Empirical Research Article Michelle Newman and Awards Chair Jeff Barnett

Awards Chair Jeff Barnett, Excellence in Mentoring Award Winner Marvin Goldfried, and President Nadine Kaslow

Awards Chair Jeff Barnett and Publications Board Chair Jeanne Carter

Distinguished Psychologist Award Winner Norine Johnson and President Nadine Kaslow

Awards Chair Jeff Barnett, Distinguished Psychologist Award Winner Jon Carlson, and President Nadine Kaslow

President Nadine Kaslow, Mathilda B. Canter Education & Training Student Paper Winner Sarah Gates, and Awards Chair Jeff Barnett

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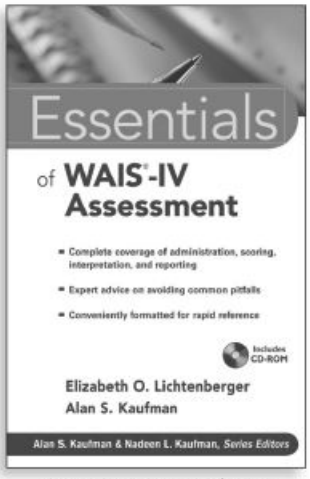

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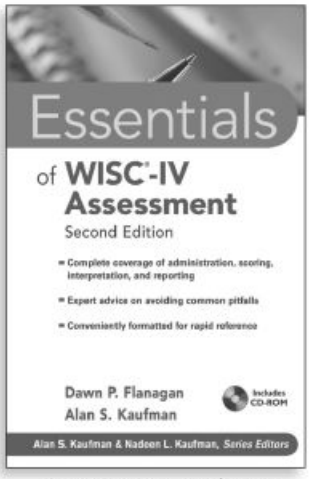

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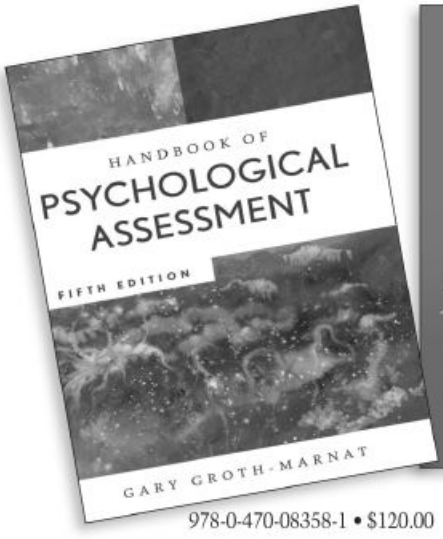

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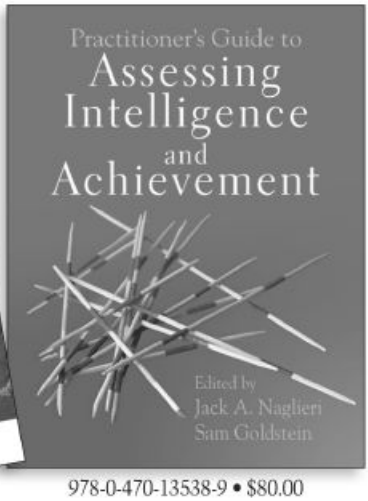

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PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

The Center for the Study of Collegiate Mental Health: A Novel Practice Research Network with National Reach and a Pilot Study to Match

Benjamin D. Locke, Amy L. Crane, Caitlin L. Chun-Kennedy, and Astrid Edens
The Pennsylvania State University

Approximately 13% of the 14 million students enrolled in United States' colleges seek help from their colleges' counseling center, and a high proportion of these students have diagnosed mental illnesses (American College Health Association, 2008). It is estimated that 10% of college students seriously consider suicide each year, 1.5% attempt suicide, and 1100 students actually commit suicide, making suicide the second leading cause of death among college students (American College Health Association, 2008; Suicide Prevention Resource Center, 2004). College and university mental health professionals have argued that today's college students are presenting with more severe and frequent psychopathology than previous generations. This trend was illustrated by Benton, Robertson, Tseng, Newton, and Benton (2003) when they examined the rates of client concerns, as reported by counselors in a college counseling center over 13 years, and found that the number of students presenting with depression had doubled and the number of students reporting suicidal ideation had tripled over the same period. In addition, 80% of counseling center directors believed that there has been an increase in the number of students with severe psychological problems on their campuses and 96% believed that the number of students with significant psychological concerns was a growing concern (Rando & Barr 2009). Given such numbers, it is clear that psychotherapy will continue to play a critical role in the future of collegiate mental health. What remains strikingly out of focus, however, is exactly how higher-education professionals (including those providing treatment) are to monitor and understand nuanced trends at the national level while also addressing the needs of practitioners and researchers within tight budget restrictions. Because many published statistics on college student mental health are retrospective, anecdotal, survey-based (with low response rates), and difficult to generalize, they cannot be used to accurately describe the nature of students in treatment, inform the training of practitioners, direct resource allocation efforts, educate public-policy efforts, or serve to evaluate the effectiveness of various treatments.

The Center for the Study of Collegiate Mental Health (CSCMH) was established in 2005 to meet the needs of clinicians, researchers, and administrators working in college student mental

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health by employing techniques more commonly seen in "business intelligence" such as integrating data collection into "point of service" contacts and using technology to efficiently pool data collected at multiple separate locations for the purpose of ongoing aggregate analysis and reporting. CSCMH represents a collaborative, long-term, multidisciplinary effort blending the expertise of mental health treatment providers, psychological researchers, information science and technology leaders, and industry partners to pursue the related goals of accurately describing college student mental health at a national level, conducting large-scale psychotherapy research, and improving the range of clinical tools available to practitioners in the higher education setting. This effort is best be described as "mental health informatics"—an infrastructure and related processes that are capable of producing a constant flow of high quality, anonymous, aggregate national data readily available for multiple purposes.

A practice research network, like CSCMH, is dependent on a sense of community and shared ownership. To achieve this, CSCMH hosted a conference and follow-up dialogues in 2006 involving more than 100 counseling centers, which led to the creation of the first Standardized Data Set (SDS) in 2007. The SDS is a data dictionary which defines a broad range of data points to be used by participating centers, thus allowing for "apples to apples" comparison of data generated during clinical service. The SDS covers a broad range of issues such as client/counselor demographics, mental health history, and a multi-dimensional psychometric instrument, for assessment and outcomes, called the Counseling Center Assessment of Psychological Symptoms (CCAPS).

The Achilles heel of data collection in a clinical setting is the burden imposed by the data-collection tasks, which forces the research effort to be short-lived and, more often than not, resented by practitioners who view it as interfering with clinical service. CSCMH sought to avoid this problem by choosing to standardize the data gathered during routine clinical practice. Once each counseling center makes the initial changes to their forms, research-related data collection becomes a part of "business as usual" for the foreseeable future.

Even with these steps in place, the most significant threat to the integrity of data standardization efforts is the gradual erosion of data standards over time resulting from modifications made by individual centers. To address this, CSCMH partnered with Titanium Software, the largest provider of electronic scheduling and medical records software for counseling centers to build the standardized data points (the SDS and CCAPS) into Titanium Schedule, the software used by many counseling centers for day-to-day business and data management. The implementation is standardized in that pre-defined questions and answers cannot be changed or edited, but it is also quite flexible because non-required questions can be turned on/off or re-arranged and new, non-standardized, items can be added to meet each center's needs. As a result, each participating center gathers high quality, standardized data as part of routine clinical service without any additional research burden. With these key steps accomplished (i.e., collaboration, operational data standardization, and centralized distribution of standards) a data "infrastructure" has been established which can be gradually refined and added to over time. Further, the infrastructure can support the future deployment of large-scale, time-limited, research initiatives with relatively minor additional effort.

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The SDS and CCAPS were made available via Titanium Schedule in January of 2008 and participating centers gradually converted over to using the new standardized materials by September of 2008. In order to assess the data standardization effort and to explore the usefulness of the data, a pilot test of the CSCMH infrastructure was conducted in January, 2009 in which anonymous, standardized data from the past semester were pooled for over 28,000 students from 66 universities. This pilot test effectively produced the largest dataset on college students in treatment with just four months of data collection. Though substantial, this accomplishment represents only one-quarter of the current theoretical capacity of CSCMH's collaborative research network and strongly underscores the potential of this research model to quickly and accurately gather vast amounts of data related to mental health, psychotherapy, and related issues.

The majority of students in the pilot study (65%) were women with 44 individuals identifying as transgender. International students comprised 4% of the sample and represented 169 countries. Among domestic students, 8% were African American, 6% were Asian American, 70% were European American, 6% were Latino, 3% were multi-ethnic, 5% were of some other ethnicity, and 2% did not report their ethnicity. Approximately 18% of the students were in their 1st year of college, 19% were sophomores, 22% were juniors, 23% were seniors, and 15% were graduate students; class standing was not reported by or applicable to 3% of students. Heterosexuals comprised 89% of the sample, 2% were gay, 1% were lesbian, 3% were bisexual, 1% reported questioning their sexual orientation, and 3% opted not to self-identify. The sample was predominantly Christian (53%), with 13% of students expressing no religious preference, 10% identifying as agnostic, 5% as atheist, 3% as Jewish, 1% each as Muslim, Hindu, Buddhist, and 11% preferring not to identify their religion or identifying some other religion.

A key characteristic of the 2009 Pilot Study which differentiates it from all related survey research in the field, is that the 28,000+ students in the dataset represent the entire population of students seen at the 66 counseling centers – a fact which dramatically enhances the generalizability of findings when compared to a typical survey with a response rate of just 25-30%. The data drawn from such a large, diverse, and complete population can be reliably generalized to other centers. For example, institutional characteristics accounted for less than 5.3% of the variance across the nine CCAPS subscales in use at the time. The largest institutional impact was on the Academic Distress CCAPS subscale (5.3%), the next largest was Depression (4.8%), and the remaining subscales ranged between 1.5% and 4.2%. Even the subscale of Substance Use, which readers might believe should vary significantly by institution, was only impacted 0.4% by institutional characteristics across the entire sample. Thus, counseling centers tend to see the same types of clients and problems regardless of their parent institution.

A wide variety of findings from the study are reviewed in the 2009 Executive Summary (http://www.sa.psu.edu/caps/pdf/2009-CSCMH-Pilot-Report.pdf) including baseline data on prevalence and severity, alcohol and depression, academics, suicidality, sexual orientation, and much more. However, one of the topics we were most excited to examine was psychotherapy outcome data. Could such a large and naturalistic dataset, gathered without the level of rigor typically employed in psychotherapy research, be used to detect symptom change in clients receiving psychotherapy? Psychotherapy research has leaned

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increasingly towards rigor, and away from relevance, as researchers carefully screen clients, standardize interventions via manuals, and carefully select/train therapists to treat clients in a consistent, replicable manner (Gelso, 1985). While rigor helps to ensure our ability to detect change, it conversely produces less relevant therapies and the results become increasingly hard to generalize to "real life" clinical settings.

The pilot study data happened to include multiple administrations of the CCAPS for more than 1500 students, representing measurements taken prior to and during/post-treatment, which were used to preliminarily assess psychotherapy outcome. Preliminary analyses of these pre-post data indicated that, with an average of approximately 6 weeks between CCAPS administrations, student-clients exhibited a statistically significant decrease in depressive symptoms, with a moderate effect size (d = .41). Additionally, students who initially presented with a higher level of self-reported depressive symptoms, relative to the rest of the sample, exhibited an even more pronounced improvement in depressive symptoms, with a large effect size (d = .87) (Boswell, 2009).

Effect sizes reported in meta-analytic reviews of psychotherapy effectiveness, across a wide range of treatments and diagnoses, have ranged from .22 to 1.05 (Lambert & Ogles, 2004). One particular meta-analysis conducted by Lipsey and Wilson (1993) reported an average treatment effect of .47. Importantly, larger effects sizes (e.g., larger than 1.05) have been demonstrated in some comparative outcome trials, which rigorously focus on optimizing internal validity by excluding clients with some co-morbid disorders and implementing manualized treatments, thereby maximizing the researchers' ability to detect treatment effects. In contrast, the CSCMH data used to preliminarily explore psychotherapy outcomes were completely naturalistic: clients had multiple uncontrolled diagnoses with a broad range of severity, were coping with scores of uncontrolled environmental stressors, and therapists varied in theoretical orientation, experience, and the actual treatments used. Of course, there are pros and cons to each approach (Borkovec & Castonguay, 1998); however, the fact that we were able to detect moderate and large effect sizes from such naturalistic data, suggests that there may be a great deal to learn about psychotherapy outcome research and treatment effectiveness via methodologies that focus on large-scale data collection in ecologically valid settings with naturally presenting clients.

The 2009 CSCMH Pilot Study represents an important "proof-of-concept" for a promising new research methodology that offers the opportunity to gather vast amounts of data related to many aspects of collegiate mental health including many aspects of naturalistic psychotherapy practice and research. Indeed, the 2009 CSCMH Pilot Study just scratches the surface of what is possible with large-scale practice research networks. To read more about CSCMH and our early findings, please visit our website at: http://www.sa.psu.edu/caps/research_center.shtml.

A key challenge in creating and sustaining collaboration in provider-based research networks is ensuring that the network is designed not only for scientific purposes but also to meet the needs of participating treatment providers (Borkovec, 2004). CSCMH currently has over 140 registered counseling centers that have actively participated in CSCMH's development via decision-making activities at two national conferences, listserv dialogues, and an advisory board comprised of counseling center

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representatives. In addition, CSCMH strives to give back to participating centers in a variety of ways including professional development; refined "data products" such as individualized reports (to compare an institution to national numbers) and two recently released CCAPS instruments (62 and 34 item versions) which utilize a normative clinical sample of 22,000 students; and a variety of relevant publications drawn directly from the daily business of practitioners. By actively striving to meet the needs of participating centers with refined products drawn from their raw materials (data), the CSCMH effort can be conceptualized as data-driven economy that generates a mutually beneficial interdependence for practitioners and scientists.

The 2009 CSCMH Pilot Study offers an exciting peek over the horizon—an opportunity to consider what the field might discover if we invested in the necessary resources to build large-scale collaborative research infrastructures to examine psychotherapy and mental health in a naturalistic setting. Consider that within just a handful of years and minimal funding, CSCMH now has the capacity to examine treatment outcome data on hundreds of thousands of clients per year, as well as the mental health needs of groups who are chronically underserved in our literature (e.g., racial and sexual minorities, international, first-generation, and military-enlisted students). In the coming years, CSCMH will continually refine its standardized materials, examine collegiate mental health and psychotherapy outcomes from a variety of perspectives, and give back to the clinicians who make the research possible while also providing a range of accurate and up-to-date data to the public. Most importantly, CSCMH will work to understand and address collegiate mental health via a national practice research network which actively seeks to fuse science and practice together.

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

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

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

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

The criteria for the award are:

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

FEATURE

A Bright Future for Psychological Assessment

Hale Martin, Ph.D.
University of Denver Graduate School of Professional Psychology

With the rise of managed care over the past 20 years, psychological assessment has seen hard times. From what some saw as an over-emphasis on assessment in the 1970s and 1980s (e.g., testing indiscriminately), the pendulum swung to arguably under-use of assessment in serving clients of the mental health service. This swing was accentuated by the forces behind managed care (e.g., working to maximize the impact of limited funds) (Finn & Martin, 1997). However, there are those who persevered in practicing assessment, believing that it offered responsible and effective service to some clients. Much of their work was done outside the confines of managed care because insurance reimbursement was time-consuming to arrange and poorly compensated. In reaction to this difficult time for assessment, many training programs around the country de-emphasized training in assessment.

However, recently there have been developments in assessment that bode well for its future. First, research to improve testing instruments has continued unabated. For example, new intelligence tests have emerged that attempt to better capture our growing understanding of the slippery construct of intelligence. The Differential Abilities Scale, already in a second edition (Elliot, 2007), a revised edition of the Stanford-Binet, Fifth edition (Roid, 2006), and the fourth editions of the Wechsler Intelligence Scale for Children and the Wechsler Adult Intelligence Scale (Wechsler, 2003; Wechsler 2008) have added to the arsenal of instruments to assess cognitive functioning. In personality assessment, the Personality Assessment Inventory (PAI; Morey, 1991) offers a psychometrically sound alternative to the second version of the Minnesota Multiphasic Personality Inventory (MMPI-2), which was published in 1989 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) as a revision of the original MMPI (Hathaway & McKinley, 1943). Furthermore, the newest version of the MMPI was released in 2008, the MMPI-2-RF (Tellegen & Ben-Porath, 2008). It is a shorter test than the MMPI-2 or PAI, with substantial changes in structure from the earlier versions of the MMPI. Its publisher, Pearson, provides evidence of its strong psychometric properties. Thus, cognitive and self-report measures have made significant advances in the past 20 years.

In recent years the Comprehensive System of the Rorschach, a performance-based measure of personality promulgated by John Exner (Exner, 2003; Exner & Erdberg, 2005; Exner & Weiner, 1995) has demonstrated validity (see Hiller et al., 1999) and reliability (see Acklin et al., 2000) and has won many converts, including courts of law (see McCann, 1998). The criticisms of the Rorschach Inkblot Method that flared in the late 1990s and early 2000s (see Wood et al, 2003) have been addressed head on by those who use and research the Rorschach (see Martin, 2003). Updated norms (Exner & Erdberg, 2005), a large international sample gathered from 13 different nations (Shaffer, Erdberg, & Meyer, 2007), research addressing reliability and validity issues (Hsiao, W. C., Meyer, G. M., Abraham, L. M., Mihura, J. L., & Viglione, D. J., 2009; Mihura, Meyer, Bombel, & Dumitrascu, 2008), new publications that fine tune scoring issues

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(Viglione, 2002), and research exploring solutions to the problem of variability in protocol length (Dean, Viglione, Perry, & Meyer, 2007) among many other studies have all contributed to the continuing evolution of a valuable assessment tool. The extensive flow of research seems to have somewhat quieted the major critics of this assessment instrument.

Finally, a plethora of new measures have been developed in recent years, ranging from the Adult Attachment Projective (George & West, 2001) to the Trauma Symptom Inventory (Briere et al., 1995), to the Wechsler Individual Achievement Test-II (Wechsler, 2001). New measures promise better tools to assess attachment, trauma, eating disorders, attention deficit disorder, learning disabilities and a myriad of other problems that clients sometimes face. It is clear that the tools of assessment cover a broader range and are better developed than ever before.

However, the most important development in the recent history of assessment is the rise of the collaborative or therapeutic model of assessment. This new approach represents a significant new paradigm for assessment that captures the phenomenological, interpersonal Zeitgeist in psychology. Constance Fischer was the first modern voice to effectively advocate that assessment can be used to directly benefit the client. Her book *Individualizing Assessment* (1985) was ground breaking and caught the eye of Stephen Finn. It catalyzed much of Finn's thinking, leading to empirical investigations, integration of knowledge from other areas of psychology, and ultimately the articulation of what he calls Therapeutic Assessment (see Finn, 2007).

Therapeutic Assessment is an approach to assessment that seeks to maximize the substantial therapeutic impact assessment can have. Beginning by focusing on what clients want to know about themselves, the assessment fosters collaboration to help clients grow from the insight and experience provided by the carefully tailored assessment process. By fanning the curiosity clients have about themselves, clients feel invested in the opportunity to understand themselves in ways that have proved elusive in life, and even sometimes in psychotherapy. Therapeutic Assessment is a semi-structured assessment process. It harnesses the insights available from traditional testing instruments but offers them back to a client in a novel but clinically informed manner. A growing base of empirical study supports its efficacy with a variety of clients with different types of problems. As well as being an effective intervention itself, Therapeutic Assessment is particularly well suited to the role of a consultation. For difficult or puzzling cases when psychotherapy is unfocused or seems stuck, a Therapeutic Assessment consultation offers an opportunity to clarify, deepen and enhance the work. Finn advocates a strong collaborative relationship with referring professionals in best serving their clients.

One important innovation that Finn has added to the assessment process is a step between data collection and discussion of results. This "assessment intervention" session goes beyond the intellectual exercise of traditional assessment by creating an in vivo experience of some important aspect of the test findings that the client and assessor can work with in the relationship in the room. Guided by insights the testing has provided, it can be a powerful intervention in the hands of a skilled assessor. The assessment intervention actualizes the emerging insight that "left brain" understanding is not enough to unhook clients from ways of living that do not work well for them. It leverages Allan Schore's (2003) revolutionary understanding that communication to the "right brain" is essential to reach certain patterns of behavior. It also parallels the

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work of Diana Fosha (2000) whose brilliant synthesis and refinement of recent psychodynamic thinking promises enormous advancement of treatment. Her Accelerated Experiential Dynamic Psychotherapy focuses on affect in the therapy session and offers ways to access the right brain in facilitating change. It is an exciting time in psychology with dovetailing developments on many fronts, and it is fortunate that assessment is near the forefront of innovation.

Another difference between traditional assessment and Therapeutic Assessment is evident in the feedback session, which Finn calls the summary/discussion session to emphasize that both client and assessor are active participants. In Therapeutic Assessment this step brings full circle the collaboration started at the beginning of the process by presenting tentative answers to the client's own questions. The therapeutic impact of the session is enhanced in that it follows the assessment intervention session, which already has informed the right brain. Now the insights are put into words a client can understand. The session is structured to maximize the therapeutic value to a client and to help the client move forward in life. Finn even advocates writing stories for young children that capture their dilemma and offer new productive avenues.

Therapeutic Assessment has been adapted to children, adolescents, couples and families. Finn's book *In Our Client's Shoes* (2007) is a significant contribution to the evolution of Therapeutic Assessment. Work by Finn, Deborah Tharinger and their students at the University of Texas at Austin (Tharinger et al., 2007) researches and establishes the application of Therapeutic Assessment to children and families, an intervention that is geared to help change the stories families hold about their children to be more accurate and offer hope for positive change. Therapeutic Assessment has also been applied in inpatient settings where research suggests it is more effective in producing positive change than other traditional treatment modalities (Little & Smith, 2009).

Others, like Len Handler (2006) and Caroline Purves (2002), have recognized that their work dovetails with this new paradigm, and clinical assessment is enhanced by new knowledge generated by a burgeoning number of talented researchers and clinicians. Programs at the annual meetings of the Society for Personality Assessment, the preeminent international personality assessment organization, are evidence of increasing study and focus on the collaborative/therapeutic approach to assessment.

The new paradigm offered by Collaborative/Therapeutic Assessment is beginning to have an impact on training. While many training programs still lament the lack of focus and opportunity in assessment, others such as the Graduate School of Professional Psychology at the University of Denver, are experiencing an increased interest and emphasis in assessment, perhaps even the leading edge of a renaissance of psychological assessment. There are now students coming into the mental health field who are excited about assessment and who have a good training foundation that incorporates the new paradigm while also re-taining the wisdom and usefulness of traditional assessment. Advanced training in Therapeutic Assessment is available through Finn's Center for Therapeutic Assessment in Austin, Texas (www.therapeuticassessment.com).

Thus, with all these developments, the pendulum of assessment's value is primed to swing back strongly from where it was pushed the past 20 years. With an array of new reliable and valid assessment instruments, assessment has much to offer to offer to today's mental health practitioners and their clients. Identification of problems and issues that can

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at times be exceedingly difficult to tease apart Furthermore, in managed care's search for effective, time-limited interventions surely the accumulating, impressive evidence that Therapeutic Assessment offers will surely soon be recognized. The coming years may well be exciting times for psychological assessment.

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EARLY CAREER

Reflections of an Early Career Psychologist: How I Ended up Working at a VA Medical Center and its Unexpected Rewards

Jay L. Cohen, Ph.D.
John D. Dingell V.A. Medical Center

Disclaimer: This essay does not represent the views of the John D. Dingell VA Medical Center or the Department of Veterans Affairs.

In the Beginning

As a first semester graduate student in clinical psychology at a Midwestern scientist-practitioner Ph.D. program, I took a required research seminar co-taught by multiple faculty. The seminar was created with the intention of jump-starting students on ideas and helping shepherd them toward developing their master's theses. In one of the first classes, the instructors offered to share how they had gone about the "systematic" process of developing their thesis. Each proceeded to tell fantastic stories about being in the right place at the right time ("It was serendipitous…"; "I was at a dinner party with the chair…"; "I joined a lab and that was what they were doing…").

With this memory in mind, I would like to share how I think I got here, and the unique challenges and opportunities that working in a Veterans' Affairs (VA) Medical Center presents for an early career psychologist. When I started my graduate training, my vision for what my career as a psychologist would look like included a tenure-track position in a Psychology Department, with a small part-time private practice. Although genuinely invested in developing my clinical skills, my primary focus was on building a research program in the area of social support and the therapeutic alliance. I was in my final year of graduate training, in 2005-06, while completing my clinical internship, when I first applied for tenure-track positions. Those who have been in this position may have had the experience that very little feedback is provided when you don't make the interview short-list. The little feedback I did receive suggested I needed more seasoning, a post-doc, as well as some time to elapse so that some of my papers would move from "in prep" to "in press." Fortunately, in the spring of 2006, one of my graduate professors with an NIH-funded study offered me a post-doctoral research associate position. My primary challenge would be to integrate my interest in psychotherapy research with his research program on the study of pain and emotion.

I hit the ground running. In addition to the grant-funded study on coping skills for rheumatoid arthritis, we developed a pilot intervention for individuals with fibromyalgia. I also oversaw a novel single session emotional disclosure intervention that would become masters' theses for at least two of his graduate students. Things were happening, and I was beginning to see myself as an academic professional. In the early winter, I had seen a posting for a position at a relatively prestigious university, but I recognized that I had not yet developed the track record I was seeking, nor was I licensed to immediately provide the clinical supervision often sought by clinical programs. However, as spring arrived, the position remained unfilled and I submitted my materials. I was very ex-

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cited to send out what I thought was an impressive package of research and teaching statements, CV, and reprints. I received very favorable feedback this time, including a phone call from the search committee chair. She shared that although they were looking specifically for someone with expertise in psychopathology research, they really liked my application. She encouraged me to consider them that fall as she anticipated a position posting that might be a better match. I felt as good as one could feel when being turned down. I was getting closer.

In late spring of 2007, shortly after sensing that I was moving in the right direction, I received a note from a former supervisor at my clinical internship. He had been conversing with a colleague at the VA Medical Center in Detroit, who shared that there were openings for psychologists. He encouraged me to inquire. At this point, I was pleased with the career trajectory I had been on in the previous nine months. I had felt that I was genuinely building a career, and that I was close to completing the mountainous climb from first-year clinical student to tenure-track professor. My plan was to complete a full second year of the post-doc, expecting to apply for and land a tenure-track position sometime during that year. The VA positions offered a unique opportunity, but would certainly deviate from a carefully constructed and cultivated career path. On the other hand, I always believed that one has to take advantage of opportunities when they present themselves. It was possible that these VA positions just might allow for the type of research and teaching opportunities and clinical challenges that would satisfy the clinical scientist in me.

The position I was being encouraged to apply for was called a Local Recovery Coordinator ("LRC"). My only experience with the term, "recovery" up until that point had to do with substance use. Yet, in researching these LRC positions, it became apparent that it involved working with individuals with serious mental illness (SMI). Although I considered myself a well-rounded clinician (for a post-doc, anyway), I had little experience working with an SMI population. Further, these positions were new to VA, so it was difficult to find an existing Recovery Coordinator to get a better sense of what he or she was doing. What I was able to determine in this initial foray into VA job hunting was that the LRC was supposed to serve as a local consultant to Mental Health and facility leadership, as each facility was expected to transform their mental health services to one guided by a recovery-oriented philosophy of care. It was literally a position shrouded in mystery. The job description was vague, expectations were not well-defined, responsibilities were broad in scope, and there was little legitimate power. In other words, it was the perfect job for which I had been preparing the last eight years of my life.

I am a staff psychologist and Local Recovery Coordinator at the John D. Dingell VA Medical Center in Detroit, MI. But that title alone does not at all describe what I do, with whom I interact, and what skills I use as a psychologist to enjoy success. To do so, I must first briefly describe the *recovery* movement in VA.

What is Recovery?

Space limitations will not allow me to do justice to describing the concepts of recovery and recovery-oriented care. Briefly, recovery is a broad construct with many different definitions. Recovery is a movement, but is also one's personal experience. It is a movement that began and continues to be driven by grassroots organizations that advocate for the rights and empowerment of

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those with serious mental illness. Recovery is also the personal journey of individuals living with mental illness; there are many outstanding first-person accounts of recovery in memoirs, essays, and blogs by esteemed individuals such as Judi Chamberlin, Pat Deegan, Dan Fisher, Fred Frese, and Elyn Saks.

In 2003, President Bush formed a New Freedom Commission on Mental Health. That same year, the State of Connecticut formed the first comprehensive state mental health strategic plan adopting recovery. In 2005, the VHA Office of Mental Health Services (OMHS) adopted these concepts in their strategic plan. The publishing of the Handbook of Uniform Mental Health Services in VA Medical Centers and CBOC's (Handbook 1160.01) in September 2008 outlines expectations to transform mental health services to one guided by a recovery-oriented philosophy of care.

One of the major steps taken by VA to ensure that medical centers would be able to engage in transforming mental health services was to fund the hiring of an LRC at each medical center throughout the country. It was within the context of this culture and systems transformation that I was hired in October, 2007. I was new to this VA. It was my first "real" job. The position was new to the facility, as it was to VA medical centers across the country. People weren't really sure what to do with me or what to make of me. For my part, I was learning about recovery and recovery-oriented care and how I was supposed to "change the system." I was getting used to working within a large, complex organization, with many stakeholders. This was quite different than the context and structure in which I was able to accomplish things in graduate school, on post-doc, or academia in general. Pretty soon, I had formed a basic outline for transforming mental health services. I had identified five component areas for the process of engaging in system transformation and recovery implementation: *(1) Facility Infrastructure Change, (2) Training/Education, (3) Clinical Program Development, (4) Working with Veterans/Grass Roots Development, and (5) Community Outreach.*

I quickly realized that I would have to form partnerships and teams—for many reasons, but mostly, that for change to be sustainable, people had to believe in it. Most people (including myself) are ambivalent about change. There had to be buy-in, and that would only happen if everyone was part of the process. The success of the transformation efforts depend upon a coordinated effort of stakeholders, including facility leadership, program coordinators, front-line providers, support staff, and our Veterans. I cannot summarize here the work that this entailed, but suffice it to say that critical partnerships have been formed between VA and Veteran consumers. Recovery is about inclusion and empowerment—and what I am most proud of is the role I have played in encouraging and empowering our Veterans, many with substantial talents, skills, and abilities, to develop an effective voice. I serve as a liaison to the Veteran's Mental Health Consumer Advocacy Council, which has become a key partner with Mental Health and Medical Center leadership.

In addition to local roles, there are also regional and national relationships. For example, I worked closely with my fellow colleagues at medical centers throughout our network (VISN 11) to establish the VISN 11 Recovery Advisory Committee. This team meets biweekly via phone to develop educational activities, as well as planning for programmatic implementation of recovery best practices in medical centers throughout our VISN. I chaired this Committee during its first year, and

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currently serve as the VISN LRC Point of Contact with the Psychosocial Rehabilitation Section of the VHA Office of Mental Health Services (OMHS). This group has been very effective in advocating for training and education for staff and Veterans and for putting recovery on the agenda of local decision-makers. In addition, linking with psychologists across the VA landscape has been a great way to engage in personal and professional development. There are many leadership development opportunities within VA, and there is at least one excellent organization (AVAPL) that encourages psychologists to take active leadership roles in the VA community.

Looking Back and Planning Ahead

I have come to see the LRC position as a hybrid *of Clinical-Community-Industrial/ Organizational Psychology*. I have structured my activities based on the five components identified above and the corresponding workgroups of our recently established Recovery Implementation Team. I oversee peer support and family education programming and have become an advocate for Veterans and their families and consumers of mental health services. I work with an incredible team of VA employees and Veterans who have worked tirelessly to transform ideas into programs.

A typical week for me includes meetings with Veterans and Veteran advocacy groups, training and education of staff, training and informal supervision of our Veteran Peer Facilitators, meetings with mental health and facility leadership to develop and implement evidence-based and recovery-oriented programming, training and supervision of clinical psychology interns, outreach events, en gaging in individual and group psychotherapy, and medical center committee activity (e.g. , strategic planning and customer service steering committees). I serve on the Psychology Education and Training Committee and the Professional Standards Board. I also make time to work on research projects and write (I am the site PI for a VA grant-funded RCT, studying the impact of peer support on the management of depression).

What I think I have Learned

It has been an exhilarating ride, with opportunities for using the full range of my professional skills and ample opportunity for developing new skills and competencies. The position continually evolves, and I remain aware of continually defining and redefining myself.

I encourage fellow members of the Early Career Psychologist community to engage in personal development. Know who you are and who you want to be. My philosophy is grounded in the belief that the greatest moments of learning occur when one is engaged in sharing one's knowledge with others. I did not expect, when I was preparing for a career in academia, that the vast majority of my "teaching moments" would occur with Veteran consumers of mental health services who are learning to become peer counselors. Yet, I dare say I have learned more from them than I could possibly learn in the lab—about resiliency and strength, loyalty, and honor, and courage. I have learned that techniques may be what we do, but healing moments often come from who we are.

Working at VA is not for everyone. It is a community, and one has to enjoy being a part of that community and all it entails. The people we work with and the people we serve and work for are like family. And that presents a unique set of challenges. The opportunities for personal and professional development, however, are endless, and the rewards are great.

Correspondence regarding this article should be addressed to jay.cohen@va.gov.

ETHICS IN PSYCHOTHERAPY

The Mandatory Reporting of Suspected Child Abuse and Neglect: Ethical Obligations, Dilemmas, and Concerns

Katherine Barteck, MA, MS, Holly Vanderwalde, B.S., and Jeffrey E. Barnett, PsyD., ABPP
Loyola University Maryland

Concerns about child abuse and neglect are relevant for all psychotherapists. These are significant problems that affect many minors with whom we will come in contact professionally. An estimated 794,000 children were reported to be victims of maltreatment and an estimated 1,760 children died as a result of abuse or neglect in 2007 (USDHHS, 2009). With abuse and neglect being so prevalent and potentially so dangerous for the victims, it is important that psychotherapists understand their obligations in abuse and neglect situations.

Why We Have Reporting Requirements

Minors are considered a vulnerable population; individuals who rely on others for their care and well being, and as a result, are afforded special protections under the law in every state that are consistent with obligations set under the federal Child Abuse and Prevention and Treatment Act (CAPTA, 2003). These laws typically mandate that educators, public safety officers, and licensed health professionals have an obligation to report all suspected abuse and neglect of minors that they learn of in their professional roles. But, since the wording, specific requirements, and limits of each state's law can vary (and thus our obligations vary) a careful reading of the relevant laws in one's own jurisdiction is of great importance. Smith (2008) provides links to each state's laws at http://www.smith-lawfirm.com/mandatory_reporting.htm.

Child abuse and neglect are of vital importance for psychotherapists to attend to due to the negative impact they may have on children throughout their lives. Childhood experiences of abuse and neglect are found to relate to adolescent delinquency (Ryan & Testa, 2005), later academic difficulties (Eckenrode, Laird, & Doris, 1993), and an increased likelihood of participation in risky behaviors such as substance abuse (Moran, Vuchinich, & Hall, 2004) and sexual activities leading to teen pregnancy (Herrenkohl et al. 1998). Additionally, abuse and neglect are associated with increased difficulty in school including lower achievement and decreased school attendance (Gilbert et al., 2009a). These children also experience increased risk of behavior problems and delinquency, depression, suicidal ideation and attempts, post-traumatic stress disorder, and somatic issues and concerns (Gilbert et al., 2009a).

Contrary to some prevalent stereotypes, child abuse and neglect victims and perpetrators do not fit any specific profile. As a result, psychotherapists must be vigilant about assessing for signs of child abuse and neglect with every pop-

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ulation. For instance, in 2007 approximately 32% of victims of child maltreatment were younger than 4 years of age, 24% of victims were between the ages of 4-7, 19% were between the ages of 8-11, and 25% were between ages 12-17 (USDHHS, 2009). In addition, boys (48.2 %) were almost equally as likely as girls (51.5%) to be victimized. Of all reported victims, 46.1% were White, 21.7% were African-American, and 20.8% were Hispanic. Asian children had the lowest rate of victimization. Mothers acting alone were the perpetrators in 39% of child maltreatment cases, fathers acting alone were responsible for nearly 18% of victims, and children were maltreated by both parents in nearly 17% of cases.

All licensed mental health professionals have an obligation to report all suspected or reported abuse or neglect of minors they come in contact with in their professional roles (although in some states these reporting requirements are present even outside our professional roles). One might therefore ask what ethical issues, dilemmas, and concerns exist since these requirements are dictated in law and appear to be quite clear. Relevant issues include the vagueness of most laws, the inadequate training most psychologists receive in assessing the presence of abuse and neglect, challenges with determining just what is and is not abuse and neglect, and the role of each psychologist's decision making process.

Ethical Issues and Concerns

One challenge in complying with this obligation is that many psychotherapists are not adequately trained to address this important responsibility. Although trained to *report* all suspected abuse and neglect, we are not often trained to *assess* for them. For example, when is spanking one's child abuse? What if the child is so sore she cannot sit in her seat at school? What if it leaves a mark? What about yelling at one's child out of anger "I wish you were never born?" How about screaming loudly at your child with your face one inch away from his own?" In essence, where does one draw the line as to when a reportable event has occurred and when the event falls below the reportable threshold and it is just a treatment issue?

First, the threshold of physical abuse can be difficult to pinpoint, especially when parents retain the right to use corporal punishment. Twenty-one states "expressly exclude reasonable corporal punishment from cases requiring report" (Mathews & Kenny, 2008, p. 59). What is "reasonable" is clearly open for interpretation. Further, corporal punishment is a form of discipline that clinicians should expect to encounter with some regularity in their practices (Giles-Sims, Straus, & Sugarman, 1995). It is therefore important to differentiate discipline from abuse. According to Gilbert et al. (2009b), signs of abuse "include bruises away from bony prominences: on the head, neck, face and buttocks, trunk and arms; large bruises; clusters of bruises; and bruises that carry the imprint of an implement" (p. 170). However, it is also a myth that physical child abuse usually results in injuries that require medical attention (Gilbert et al., 2009b). And, although bruises are common in abused children, they are also very common in school-aged children who have not been abused (80%) (Gilbert et al., 2009b). In fact, the accurate detection of actual physical abuse is so complicated that a new pediatric specialty has emerged. In November 2009, the first medical board exam will be offered in a new official specialty, child abuse pediatrics (Klass, 2009).

Another indicator of abuse rather than discipline is the presence of additional violence in the home. Domestic violence

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and child abuse are highly correlated (Banks, Landsverk, & Wang, 2008). In fact, in selected states mandated professionals must report the exposure of a child to domestic violence (Mathews & Kenny, 2008). Any type of violence in the home warrants additional investigation into other types of violence, and additional vigilance about possible future violence (Banks, Landsverk, & Wang, 2008).

Second, the difference between neglect and poverty is another area of confusion. It is important to note that most US jurisdictions exclude poverty-based neglect (Mathews & Kenny, 2008) as a form of child maltreatment. A parent cannot be held criminally responsible for not being able to provide for his/her children. However, if a parent-client has been provided referrals and assistance in utilizing social services and charitable organizations, a report may still need to be made if the caregiver is neglecting the child by not seeking assistance or using the assistance as it was intended. In fact, in 2007, 59% of verified child maltreatment cases were neglect (USDHHS, 2009).

Third, what constitutes emotional harm is difficult to determine. Children usually do not present for mental health treatment without some type of emotional difficulties. The state of Wisconsin has comprehensively defined emotional harm as "harm to a child's psychological or intellectual functioning. . . evidenced by one or more of the following characteristics exhibited to a severe degree: anxiety; depression; withdrawal; outward aggressive behavior; or a substantial and observable change in behavior, emotional response or cognition that is not within the normal range for the child's age and stage of development" (as cited in Mathews & Kenny, 2008, p. 59). This definition is important in that it recognizes that the effect of emotional abuse must be present through *severe* clinical symptomology. For example, a child who suffers from mild depression and has a tumultuous relationship with his parents does not meet the threshold of reporting. However, if the child meets the diagnosis for moderate to severe depression and symptoms are directly linked to how the parent relates to the child, reporting should likely occur.

Fourth, the definition of "perpetrator" can limit the obligations of a psychotherapist to report suspected abuse. In most states the perpetrator must be a specific person such as a "parent, caregiver, or other individual having care custody, or control of the child, or a person who is responsible for the care of the child" (Mathews & Kenny, 2008, p. 55). Various states also include anyone living in the home, any family member, teachers, or clergy. Some states also require reporting regardless of the relationship of the perpetrator to the victim.

There are other challenges psychologists face regarding deciding if they should make a report or not based on the wording of relevant statutes. For example, some states require reporting if the "child's health or welfare is harmed." Others mention a "substantial risk of being harmed." Just how the psychologist is to assess these and determine the threshold for reporting is not clear. How much harm or potential for harm is enough to warrant filing a report? Many laws define neglect as being when "proper care and attention" are not provided to the minor. Whose definition of proper is to be followed? The definitions of abuse and neglect are not entirely clear and appear subject to interpretation and subjective appraisal. The role of cultural differences further complicates this. Many clinicians' judgments and decisions in these matters are impacted by social norms, cultural beliefs, and values (Lewit, 1994; Sternberg, 1993). Most statutes allow the professional to use his or her judgment in making these deci-

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sions. But, basing such decisions on a gut feeling or some other subjective judgment or impression seems not to be the most appropriate method to use in such high stakes situations.

Reasons for Not Reporting

There are a number of factors that professionals consider when deciding on making a mandated report. Egu and Weiss (2003) report that the perceived level of severity of the suspected abuse has a significant impact on reporting decisions. As perceived level of severity decreases, concerns about the psychotherapeutic relationship appear to increase and concerns for the minor's safety decrease. The nature of the suspected abuse is also a significant factor (Brosig & Kalichman, 1992) with sexual abuse being reported more often than any other type of abuse (Warner & Hansen, 1994). The professional's level of familiarity with the reporting process (Alvarez et al., 2005) and comfort with it (Vullimany & Sullivan, 2000) are relevant as well. Characteristics of the family involved in the abuse also impact professionals' decisions about reporting to include socioeconomic status and racial minority status (Benbenishty & Chen, 2003). Further, VanBergeijk (2007) reports the three major factors impacting whether or not suspected abuse and neglect are reported are the professional's confidence level that the abuse occurred, the professional's affiliation with the institution where the abuse was reported, and the number of obstacles a psychotherapist person needs to overcome to file a report. Each of these factors must be considered in addition to the challenges addressed earlier regarding the wording of mandatory reporting statutes, how to actually assess for the presence of abuse or neglect, and how to decide if a behavior is a reportable offense. But, failure to make mandatory reports due to personal discomfort, biases, or subjective judgments may have far reaching effects and consequences for all involved. Each psychotherapist should carefully consider their obligations in this regard.

Recommendations

- Actively utilize the informed consent process to ensure that clients understand all limits to confidentiality that exist and the extent of your reporting requirements. Ensure that informed consent is an ongoing discussion and provide illustrative clinical examples to help clients understand what is or is not a reportable offense.
- Utilize assessment measures and do not rely on your subjective appraisal of symptoms of abuse or neglect such as the Conflict Tactics Scales (Straus, 2007). Obtain needed training to assess for the presence of abuse and neglect. Understand the role of bias and stereotypes and the impact of culture, religion, SES, and other diversity factors. Know the system in your local jurisdiction. Beyond knowing the reporting statutes, know the services available and how reports are handled. Attempt to collaborate with the client when making a report. This can assist in preserving the therapeutic alliance and in promoting the client's autonomy.
- Utilize colleagues, the American Psychological Association, and state ethics committees for consultation when unsure of how to proceed in a given situation.
- Document all client contacts, suspicions of abuse and neglect, your decision making process and deliberations, your assessment and factors considered, and the reporting process fully.
- Work with your local professional associations to remove the ambiguity present in many laws by including more operationalized definitions of abuse and neglect in mandatory reporting statutes.

References available on-line at www.divisionofpsychotherapy.org

PERSPECTIVES ON PSYCHOTHERAPY INTEGRATION

Research on Psychotherapy Integration: Throw Away the Manual

Paul L. Wachtel, Ph.D.
City College and the Graduate Center, City University of New York

The evolution of psychotherapy integration confronts at this point in the development of the integrative movement an intriguing and somewhat contradictory challenge. On the one hand, there are many indications that large numbers of therapists identify as integrative and eclectic and attempt to work in this fashion (e.g., Norcross, Karpiak, & Santoro, 2005; Norcross, Hedges, & Castle, 2002). On the other hand, integrative therapies have suffered because less research has been conducted on their effectiveness than "pure form" therapies (Goldfried, 1991). One reason that the latter is the case is because the criteria for meaningful outcome research that have been increasingly emphasized in our journals, in our graduate schools, and in our funding agencies are remarkably inappropriate for investigating integrative approaches, as they are for a wide swath of the therapies currently being practiced (see, for example, Westen, Novotny, & Thompson-Brenner, 2004). In what follows I wish to discuss this state of affairs and to explicate not only why such increasingly consensual criteria as manuals and a focus on a single diagnostic category are often inappropriate but also why the insistence on these criteria in fact reflects a crude, limited, and often ideologically driven understanding of science.

We live in an era in which—for good reasons and bad—there is an increasing call for evidence for the practices that therapists engage in. The good reasons are obvious—patients deserve to receive treatments that have been shown to be effective rather than being simply what the therapist likes to practice or "feels" to be effective . Moreover, not only is it important to demonstrate the effectiveness of therapy but, at least as important, to improve the effectiveness of psychotherapy. And to do so, we need to keep refining and extending our knowledge, a process in which knowledge is gained not only by learning new things but by learning what old things we thought we knew are actually not so.

The bad reasons underlying the call for evidence-based practice should be equally obvious, though—as a reflection of the very reason they are problematic— they are often buried under obfuscations and skilled public relations. Health and mental health care in this country are dominated by large profit-seeking corporations. As I write these words, the effort to create a more sane and just system for funding health care is proceeding in the Congress, and by the time these words are published it may even be the case that some of the worst abuses of the system will have been modified at least a bit. But the corporate dominance of health care, alas, is unlikely to change in the time frame represented by publication lag. This corporate dominance, with its corollary of vast sums for propaganda and lobbying, ensures that debate and discussion about issues vital to both our field and our society do not proceed on a level playing field. As everyone other than the likes of John Roberts or Samuel Alito

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understands, money talks; and when money talks, in the person of large, wealthy corporations, the voices of flesh and blood human beings—such as those whose suffering it is our business to relieve—are drowned out.

The contours of this corporate influence are not very difficult to see in the overt political realm of debate on national healthcare policy. Harder to evaluate is how the policies and grant criteria of the federal agencies that fund psychotherapy research might be influenced by the millions of dollars worth of lobbying and campaign contributions directed to the members of Congress who hold the purse strings for these agencies' budgets. To what degree is it pure coincidence that, as discussed below (see also Wachtel, in press; Westen, Novotny, and Thompson-Brenner, 2004), the criteria for funding of psychotherapy outcome research tend to favor studies of the very kinds of treatments—brief and cheap—that benefit the bottom lines of insurance companies and managed care corporations? To ask such a question is not to cast aspersions on those who set the policies and criteria for these agencies. They are simply human, no different from the rest of us. Huge quantities of research in areas such as the sociology of knowledge make it clear that scientific discourse and procedure do not operate in a vacuum, but are strongly shaped by the social context in which they operate, as well as that that social context is in turn strongly shaped by the power relations that hold within—and maintain—that context. An equally substantial body of research in cognitive science and cognitive social psychology makes it clear that when people are in this way influenced by a host of background variables, they are very often unable to consciously notice or report that influence.

One illustrative example of the influence of Congressional pressure and broader social climate that is easier to document, because it revealed itself in more overt form, was the response of APA to House and Senate resolutions condemning an article appearing in the Psychological Bulletin (Rind, Tromovitch, & Bauserman, 1998) that reviewed the available research on the psychological consequences of sexual relations between adults and children and found considerably less evidence for enduring harm than is commonly assumed. In response to this political pressure, in a highly unusual maneuver, APA requested that the American Association for the Advancement of Science (AAAS) conduct a review of the study. After studying APA's request, the AAAS Committee on Scientific Freedom and Responsibility refused to review the article, commenting that it was not appropriate to "second-guess the peer review process" and indicating that "after examining all the materials available to the Committee, we saw no clear evidence of improper application of methodology or other questionable practices on the part of the article's authors." They went on to express "grave concerns with the politicization of the debate over the article's methods and findings." (Rind, Tromovitch, & Bauserman, 2000).

This instructive incident was capable of providing clear observational data, as it were, because it occurred after the fact; the article had already been published. The influences I was primarily discussing above are more in the realm of what in legal discourse is called prior restraint. That is, my concern is with the studies that never see the light of day because their proposed methodology does not fit the ideological strictures that silently and covertly shape and constrict our thinking. Whether those strictures in some part reflect the political and economic influences I have pointed to is at this point speculative. But the existence and nature of those strictures is not. For

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DIVISION 29 BYLAWS CHANGES BALLOT

Dear Division of Psychotherapy Colleagues,

The Division of Psychotherapy Board of Directors requests your approval of the revisions to the bylaws of the Division of Psychotherapy that are presented on our website: www.divisionofpsychotherapy.org. Periodically, organizations need to update their bylaws to ensure that they reflect their actual structure and workings. For example, since the last time the bylaws were updated the division changed its governance structure so that instead of members-at-large on the board, we now have domain representatives to ensure representation of all areas of psychotherapy on our board. Thus, we have developed this revised set of bylaws for your approval. Further, bylaws are by design intended to be broad and general. In some areas changes are suggested to make the bylaws less detailed and specific.

The changes to the Division 29 bylaws that you are being asked to approve are:

In Article I, Section B is changed, updating the mission of the division. Further, Section C has been removed since APA legal counsel advises that this is not actually accurate or relevant. These are issues addressed in the APA bylaws and not needed in a division's bylaws.

In Articles II through V, wording is cleaned up to ensure accuracy and clarity.

In Article VI the bylaws are updated to authorize the board to conduct business and vote via e-mail and other electronic means. This allows greater efficiency and timeliness of the board's work and reduces expenses for the division. With this proposed change, Section G (4) is no longer needed so it being removed. Section J is redundant due to being addressed elsewhere.

In Article VII, Section L, the wording is changed to create greater clarity and to ensure fairness.

In Article VIII, Section B, the sentence being removed is redundant with information provided elsewhere.

Article X, Section A, as was written was inaccurate. It is being changed to reflect current dues practices. The division sets its dues, not APA. In Section E the wording is changed to create greater clarity.

Article XI has been revised to reflect the actual structure of the division's governance and the role and mission of each committee. All terms of office, number of members on each committee, and roles and duties have been updated for accuracy and consistency. The definition of diversity has been updated to reflect the definition provided in the most current version of the APA Ethics Code.

In Articles XI and XIII the wording has been updated to reflect clarity and accuracy.

Article XIV has been updated to authorize a student member to serve on the Publications and Communications Board. The Publications Board and Board of Directors find this to be an important change for the future of the division, ensuring student input in all deliberations about the division's publications.

In Article XV the suggested wording change clarifies duties and responsibilities with regard to amendments.

New Article XVI adds a conflict of interest statement.

Thank you for your careful reading of these proposed bylaws and for your ongoing support of Division 29. We respectfully request your approval of the revisions to the bylaws. You may indicate your vote using the ballot in this issue of the Psychotherapy Bulletin.

On behalf of the Division 29 Board of Directors,

Jeffrey Barnett, Psy.D., ABPP
Division 29 Past-President

BALLOT – DIVISION 29 BYLAWS CHANGES

❍ YES! I accept all the bylaws changes as proposed by the Division 29 Board of Directors

❍ NO! I reject all the bylaws changes as proposed by the Division 29 Board of Directors

Name (Printed) _____

Signature _____

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Division29
Central Office
6557 E. Riverdale St.
Mesa, AZ 85215

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2010 NOMINATIONS BALLOT

Dear Division 29 Colleague:

Division 29 seeks great leaders! Bring our best talent to the Division of Psychotherapy (29) as we put our combined talents to work for the advancement of psychotherapy.

NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN THE DIVISION OF PSYCHOTHERAPY. THE OFFICES OPEN FOR ELECTION IN 2010 ARE:

• President-elect • Representatives to APA Council (2)
• Domain Representatives for Early Career, Science & Scholarship, and Diversity
All persons elected will begin their terms on January 2, 2011

Domain Representatives are voting members of the Board of Directors. They are responsible for creative initiatives and oversight of the Division's portfolios in Early Career, Science & Scholarship, and Diversity (one of two Diversity Representatives). Candidates should have demonstrated interest and investment in the area of their Domain.

The Division's eligibility criteria for all positions are:

1. Candidates for office must be Members or Fellows of the division.
2. No member may be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for a position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.
5. All terms are for three years, except President-elect, which is one year.

Return the attached nomination ballot in the mail. The deadline for receipt of all nominations ballots is December 31, 2009. We cannot accept faxed copies. Original signatures must accompany ballot.

EXERCISE YOUR CHOICE NOW!

If you would like to discuss your own interest or any recommendations for identifying talent in our division, please feel free to contact the division's Chair of Nominations and Elections, Dr. Libby Nutt Williams at (240) 895-4467 or by Email at enwilliams@smcm.edu

Sincerely,

Nadine Kaslow, Ph.D. President — *Jeffrey J. Magnavita, Ph.D.* President-elect — *Elizabeth Nutt Williams, Ph.D.* Chair, Nominations and Elections

NOMINATION BALLOT

President-elect

_____

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Council Representative

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Domain Representative – Early Career

_____

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Domain Representative—Science & Scholarship

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Domain Representative—Diversity

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Indicate your nominees, and mail now! In order for your ballot to be counted, you must put your signature in the upper left hand corner of the reverse side where indicated.

Name (Printed) _____

Signature _____

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Division29
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Mesa, AZ 85215

Fold Here.

those strictures derive from a second ideological thrust, emanating from within our own profession, and the advocates of this second interest group have been far from covert or subtle. Organizing "task forces," these advocates have, to this point, successfully managed to dominate the field's understanding of and criteria for what constitutes appropriate research on psychotherapy outcome, and their views are closely paralleled in the policies of funding agencies such as NIMH. Here we may add, apropos the above discussion, that there is little likelihood that these criteria will be countered or undermined by the insurance lobby, because, whether coincidental or not, the task force positions fit their needs hand in glove.

The criteria, assumptions, and standards I wish to discuss here have, further, been associated with "lists" of therapies whose evidence comports with those standards, and, because these criteria have become influential in funding agencies as well, they operate as self-fulfilling prophecies which virtually ensure that treatments presumed not to have empirical support will continue (at least by the standards currently being promulgated) to be empirically unsupported. If one of the criteria for empirical validation is that the treatment be manualized, (I discuss other problematic elements in the EVT paradigm in Wachtel, in press), then by fiat and definition, not by data, treatments that are not manualized cannot be designated as empirically validated. This is the case, if one stays within these highly tendentious criteria, even if—as in many instances is the case—there is a very large and impressive body of data that demonstrate their effectiveness (see, for example, Shedler, in press). In graduate schools around the country, the new generation of clinicians and researchers is being very largely taught the dogma of "empirically validated" and manualized treatments—and if the limits of this advocacy version of science are not widely challenged, when these students graduate, they will in turn teach still another generation of students what they themselves were taught, and the tight circle of restricted knowledge will be further perpetuated.

Now, I am aware that in referring to "empirically validated" treatments I am not using the rhetoric du jour. The names of these lists keep mutating like they are in a race with the flu virus. In a relatively brief span of years we have already had "well established," "probably efficacious," "empirically validated," "empirically supported," and "evidence-based" as the label for the lists, and it is unclear what the flavor of the day will be tomorrow. Such rapidly shifting sands suggest a fundamental unease with what is being perpetrated that is being repeatedly covered over by strategic rebranding. The basic product, however, has remained largely the same

Now strictly speaking, as these advocates present it, these are not lists of those therapies that have been validated and those that have not, but only the former; how one views the latter (the therapies not on the list) is left up to the perceiver. But as Chevy Chase well captured on Saturday Night Live, with his sign-on for his faux news report ("I'm Chevy Chase....and you're not!"), stating one thing can quite readily evoke the neural circuits that represent its implicit opposite. The list-makers may not say that those therapies that are not listed as validated on their lists have been show to not be valid; but if they think as psychologists, not logic-choppers, the implication is obvious.

This confusion is problematic for a number of different reasons. First, the advocacy groups that have promulgated these lists have done so not simply as a summary for cutting edge researchers, a kind of abstract to an article whose im-

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plications are really only clear if one has "read the full article" (that is, if one is sophisticated enough about the nature and the limits of the research). Rather, they have advocated making these lists widely available to the general public, supposedly to guide people in choosing more wisely the kind of therapy they will seek. Indeed, they have more than advocated this; they have done it.

Such an approach to disseminating knowledge is difficult to distinguish from the ads from drug companies that saturate the airwaves (which also, after all, are based on data – and also, very often, primarily on the data congenial to the conclusions they wished to reach in the first place). Do these ads make patients more savvy consumers? Perhaps in certain ways. But in "liberating" the consumer from reliance on their doctors' knowledge and expertise, and substituting their amateur night understanding in its place, it is not clear that patients are in fact well served. Having more informed patients is a good thing. Doctors are not infallible, and they are often overworked and potentially prone to neglect a possibility that should be included in the mix of considerations. But it is far from clear that advocacy advertising is the best guarantor of useful knowledge or sophisticated understanding. (Of course, it can be countered that the doctors too are often informed more by agents looking to sell a product than by disinterested research. Where do the doctors themselves learn much of what they know about the medications they prescribe? Often from "seminars" in lovely vacation spots that are sponsored by drug companies, or at dinners in posh restaurants, where an industry rep treats a group of doctors to filet mignon while informing them of the company's latest product and the "research" that supports it. In contrast, those in our field who inform therapists about the therapies on "the list" don't need to take them out to dinner to sell their wares. These days they make their sales pitch in the classroom, where the teaching of manualized treatments often dominates the curriculum of training programs in our field.)

In the investigation of integrative therapeutic approaches, the limits of the traditional EVT methodology are especially severe. A growing number of prominent researchers have commented in different ways on the limits of promulgating lists of supposedly validated treatments or on the limits of the methodological assumptions on which those lists are based (e.g., Westen, Novotny, & Thompson-Brenner, 2004; Goldfried & Wolfe, 1996, 1998; Trierweiler & Stricker, 1998). Rather than listing the brand names of the therapies that have made the cut according to the EVT methodology, many of these critics have suggested, it is more productive to focus on the fundamental principles of therapeutic change (e.g., Beutler, Clarkin, & Bongar, 2000, Bohart, 2000, Castonguay & Beutler, 2003, Rosen & Davison, 2003). I have myself written on these issues in a forthcoming book (Wachtel, in press). I will therefore limit myself to a single issue here, a kind of sample of the larger set of issues that have concerned many critics of this "EVT list" movement. That issue is the requirement that a therapy be manualized in order to even consider it with regard to empirical validation or support.

Strictly speaking, the advocacy groups to which I have been referring rarely state that a manual is a requirement. Usually the language is some version of "a manual or some other means of ensuring that the treatment being administered is the treatment the investigators claim to be evaluating." On the face of it, this is a perfectly reasonable demand. The problem with "manuals or some other appropriate means of evaluating"

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is that in the real world this so often comes down to "manuals or no research grant." Westen et al (2004) and a variety of other commentators have noted that if one looks at the daily realities of applying for research grants, it is easier for a camel to pass through the eye of a needle than for an investigator to get a substantial grant to investigate the outcome of a non-manualized treatment. Thus, what we have is a caricature of science in which prejudices cannot be challenged because the prejudices are woven into the criteria for investigating those prejudices. This is science by methodological fiat rather than science by observation. The observations never get made, because by a self-fulfilling prophecy, certain therapeutic approaches (namely, non-manualized treatments) are not deemed worthy of receiving grants to investigate their efficacy, and so their efficacy remains unexamined and, of necessity, undocumented. Especially is this the case for many integrative therapeutic approaches. By their very nature, integrative approaches tend to be more complex. After all, they contain elements from several different approaches, and there are likely to be many more options and choice points for the integrative therapist than for the therapist who follows a manual or a strictly laid out singular path. Given that a very significant percentage of therapists describe themselves as integrative or eclectic (Norcross, Karpiak, & Santoro, 2005; Norcross, Hedges, & Castle, 2002), and that in many respects integrative practice represents the cutting edge of our field, this is a serious issue. We need to be able to evaluate these integrative approaches, and in order to do so, we need to extricate ourselves from the methodological stranglehold that has been created by the EVT list mindset and has come to be equated in the minds of many in our field with the idea of empirical validation itself. (It should be noted that a broader statement on evidence-based practice approved by the entire APA Council of Representatives in 2005 (http://www2.apa.org/practice/ebpstatement.pdf)—in contrast to the statements by the Division 12 task forces or a number of its members in separate publications—does not specify manuals as a requirement. This does not, however, alter the state of affairs in granting agencies or in classrooms in large numbers of clinical programs).

In explicating why manualization is not essential for the aim for which it was originally introduced—namely, ensuring that the treatment nominally being evaluated is the treatment actually being evaluated—I wish to return to a study I conducted many years ago which I had largely forgotten about until I began thinking about the limitations of the dogma of manualization. In a study published in 1970, Jean Schimek and I (Wachtel, & Schimek, 1970) were interested in the effects of emotionally toned incidental stimuli on the mood, fantasies, and thought processes of individuals. In contrast to most studies to that point, which, if they investigated incidental or subliminal stimuli, tended to use very specific, discrete content (particular words, pictures, etc) we were interested in the impact of a factor that influences so much of our daily life—the emotional tone of the various stimuli we encounter in the course of the day. To this end, we created an experimental situation in which subjects were administered several TAT cards and participated in various other measures while, through the walls from next door, came sounds indicating either an argument or a happy gathering with laughter. Subjects could not hear any specific words, but they could pick up the emotional tone of what was going on. After careful and intensive debriefing, only 3 out of 60 subjects indicated that they thought

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the sounds they were hearing had anything to do with the study they were participating in (many thought it was a television playing next door), but almost all, when their attention was directed after the fact to thinking about what they had heard, could reliably indicate what the emotional tone was. Thus, although the stimuli were, for most subjects, not in focal awareness, they were incidental, not subliminal, and what was registered was affective tone not explicit content.

One chief aim of the study was to assess angry content in the TAT stories the subjects told and to compare the degree of such content in the two experimental conditions. To this end we made elaborate efforts to spell out very explicitly what the criteria would be for angry content. In essence, we were trying to create a "manual" for the scoring of the stories. This approach to the assessment was tedious and laborious, but even more important, after spending quite a bit of time on this effort, we were both very discouraged; the scoring using the successive versions of the "manual" had very low inter-rater reliability and did not discriminate very well between the two experimental conditions. (Throughout the process of attempting to develop this manual, the raters were blind as to which condition the stories being rated came from; the tallying of these scores was always done by a separate party). Finally, almost in desperation, we turned to a more "naive," less methodologically "fancy" approach—we simply said, let's see what happens if the instructions are simply "rate how angry the stories seem," without any specific or detailed guidelines for what to look for or check off (that is, without a "manual"). This approach, which relied, essentially, on what Michael Polanyi (1956, 1967) has called tacit knowledge, worked like a charm. The reliabilities were quite satisfactory and the degree of anger rated in the stories varied significantly from one condition to the other.

Applying this experience to the realm of psychotherapy outcome research, the implication is that instead of requiring a manual, one might do just as well (and, since it permits more approaches to be seriously evaluated, might do better) simply by asking therapists identified with the particular approaches being evaluated in the study to determine, in blind ratings based on tapes or transcripts, how much the work in the session actually conformed to what should go on in such a therapy. Especially does this strategy make sense when one takes into account that in fact it is never "the manual" that enables the determination of whether the nominal approach was actually followed but rather it is the adherence checks—determining if the therapists followed the manual—that are the real methodological safeguard. Thus, what I am suggesting essentially entails simply using adherence checks without a manual, adherence checks based, as were the ratings of anger in the study I just described, on the human capacity to detect relational and emotional phenomena with a subtlety and adroitness that is often more than the sum of the parts of a manual (again on this point, see Polanyi). In this fashion, "non-manualized" treatments, such as many in the realm of integrative psychotherapy, may be seen to be much more accessible to rigorous evaluation than the dogma of the EVT criteria would suggest.

Even better perhaps than the approach I have just described is the employment, again without the treatment being manualized, of ratings based on measures such as the Psychotherapy Process Q-Sort [PQS] (Jones, 2000; see also Ablon & Jones, 1998, Jones & Pulos, 1993), an instrument designed not to detect the presence of brand name packages, but rather of very specific kinds of comments and behaviors. It is ironic that ad-

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vocates of the EVT list approach, who, under the banner of precision and specificity, advocate restricting the patient sample to a single Axis I diagnosis, place such enormous emphasis on the anointing of rather global "packages" of interventions, which, when closely examined, often represent a hodgepodge of actual elements and interventions (Shedler, in press; Wachtel, in press; Westen, et al, 2004).

The PQS approach addresses itself not to validating brand names, but to examining the processes and specific interventions that account for therapeutic success. The brand name approach underlying the EVT lists reflects thinly disguised turf wars rather than science and yields consistently superficial understanding. The psychotherapy integration movement evolved in good part as a counter to this "turf war" approach to science and to our field . For this alternative to evolve further, and to be enabled to develop empirical foundations as fully as possible, attention must be directed to exposing further the limitations of the false science that has restricted funding of integrative research and led to the miseducation of much of a generation of graduate students. The scientific investigation of what really accounts for success or failure in psychotherapy is too important a public need to be sacrificed to a crude caricature of the scientific method.

References available on-line at www.divisionofpsychotherapy.org

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CONGRATULATONS TO THE DIVISION OF PSYCHOTHERAPY 2009 DISTINGUISHED PSYCHOLOGISTS!

Dr. Jeffrey Barnett made the following remarks in awarding Norine G. Johnson, the recipient of the Division of Psychotherapy's 2009 Distinguished Psychologist Award:

I will offer some information regarding Norine's participation in the division in consideration of her nomination for 2009 Distinguished Psychologist of the Division of Psychotherapy.

Norine was a member of the Board as an elected member at large for two terms and during that time, supported the division in advancing psychotherapy in APA and in psychological practice. She has been a Fellow of the Division for over ten years. She was director of the Dept. of Psychology for 18 years at Kennedy Memorial Hospital for Children where she specialized in advancing psychotherapy in working with children.

Dr. Johnson was 2001 President of APA during 9/11 and devoted much of her presidency to the development of psychological services for those affected by the tragedy and the advancement of psychology as a health profession. During her presidency, she also planted the seeds of what has come to be known as the re-sequencing of training, specifically the role of the post doctoral experience in training. These years later, Norine's proposal has come to fruition in the Council vote for re-sequencing the training requirements. Norine was instrumental in the development and adoption of the Guidelines for Psychological Practice with Women and Girls. She also was the sponsor of the Council item to officially change the term "therapy" to "psychotherapy" as used by psychologists and in official documents of APA. This was an extremely important action that promoted the continued primary stance of psychotherapy in the practice of psychology. Lastly, Dr. Johnson is in her second term of representation of our Division as Council Representative. Norine Johnson has made singular and significant contributions to the division and on behalf of the division in the advancement of psychotherapy. Additionally, Norine has been a strong advocate for advancing psychotherapy internationally.

Jon Carlson, PsyD, EdD, ABPP is Distinguished Professor, Psychology and Counseling at Governors State University and a psychologist at the Wellness Clinic in Lake Geneva, Wisconsin. Jon has served as editor of several periodicals including the *Journal of Individual Psychology* and *The Family Journal*. He holds Diplomates in both Family Psychology and Adlerian Psychology. He has authored 150 journal articles and 50 books including *Time for a Better Marriage*, *Adlerian Therapy*, *Inclusive Cultural Empathy*, *The Mummy at the Dining Room Table*, *Bad Therapy*, *The Client Who Changed Me*, *Their Finest Hour*, *Creative Breakthroughs in Therapy*, and *Moved by the Spirit*. He has created over 250 professional trade video and DVD's with leading professional therapists and educators. In 2004 the American Counseling Association named him a "Living Legend." Recently he syndicated an advice cartoon On The Edge with cartoonist Joe Martin. Jon and Laura have been married for forty-two years and are the parents of five children.

WASHINGTON SCENE

Exciting Times for Those with Vision

Pat DeLeon, Ph.D.
Former APA President

Action In The Far West: For those of us who appreciate the broader public policy and particularly, the public health aspects of psychology obtaining prescriptive authority (RxP), the efforts of visionaries in Hawaii and Oregon this past legislative session were truly exciting. After the Governor vetoed their bill in July, 2007, Robin Miyamoto and her colleagues were successful in having their community health center-oriented legislation pass the Hawaii Senate in March by a wide margin. Jill Oliveira Gray:

The HPA RxP committee was encouraged by an even stronger endorsement this year by the Hawaii Primary Care Association, who announced that they were not only going to support the RxP bill, but rather, make RxP one of their top three legislative initiatives for 2009. In addition, continued support and increased lobbying efforts by the Mental Health Association of America, Hawaii Medical Services Association (HMSA), and the local chapter of the National Association of Social Workers, helped to diffuse the classic turf war between psychologists and psychiatrists and focus on the issue of access to care in medically underserved areas. Hawaii's SB 428 SD1 passed out of the Senate with an overwhelmingly supportive vote of 21-4. Unfortunately, due to the recent election year that managed to stir things up in the legislature there were some unanticipated changes we had to contend with given new members and shifting committee position appointments. In the end, SB 428 SD1 despite its success in the Senate, could not maintain its traction in the House. All in all, we remain optimistic, look forward to a 2010 Hawaii Gubernatorial race, and are determined as ever to see RxP become a reality in our state.

In Oregon, Robin Henderson reports: Oregon had a wild ride this year in pursuit of prescription privileges. We entered the Session strong, with HB 2702, and bipartisan support from every key healthcare legislator in Oregon. Starting on the House side of the building, proponents and opponents battled through details in Rep. Mitch Greenlick's Healthcare Committee—the same committee that was crafting Oregon's landmark omnibus healthcare bill—HB 2009. It was tough to get hearings scheduled, but Rep. Greenlick was a co-sponsor of HB 2702, and safely shepherded the bill through his Committee. On the House floor, HB 2702A enjoyed strong support from House members, passing easily with a vote of 47-11 for journey to the Senate. Oregon's two psychologist legislators, Rep. Phil Barnhart and Rep. Bill Kennemer gave passionate speeches about the bill and why this version was right for Oregon. Victory was sweet—but the battle was just beginning to intensify. The journey was not as easy in the Senate. Opponents of our bill used traditional means to obfuscate the facts around safety and training, and sent many Senators scrambling for the hills with the sheer volume of information both sides brought to the table. People from all over the country sent e-mails in favor and opposed to the issue, creating new small fires to extinguish each day. Our lobbying team … remained well on top of the issues … but at the end of the

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battle, this was not to be our year … Under intense political pressure, Oregon's psychologists were asked by key legislators to agree to one last workgroup, staffed by a professional mediator, to sort through the details of prescribing in Oregon. Psychiatrists proposed a large, unwieldy process for consideration, and psychologists proposed a small, time-limited workgroup with three psychologists, two psychiatrists, a primary care physician, and a pharmacist. Our version prevailed, and passed the Senate 23-4. A disappointed House concurred a few days later, emphasizing their desire that this bill prevail in February, 2010 and strengthening their resolve to see this through. Now Oregon will move to the interim work of the mandatory workgroup. Senator Laurie Monnes-Anderson and Rep. Bill Kennemer will personally oversee these proceedings and guarantee that a bill will be presented in the February, 2010 special session. Thanks to all around the country who have supported us—we're doing our very best to bring RxP to Oregon.

The Importance Of Addressing Society's Needs: Former APA State Advocacy guru, Mike Sullivan reflecting upon psychology's RxP quest: It is no coincidence that the first states to enact prescriptive authority are states that traditionally have been ranked at or near the bottom in the nation on measures of health and mental health for their citizens. Offering a new solution to enormous mental health and public health problems made psychologists credible and persuasive to their legislators and governors. As a result, prescribing psychologists in New Mexico and Louisiana have been able to offer quality care to underserved citizens in their states... by practicing a psychological model of pharmacotherapy.

As members of our nation's educated elite, psychologists have a societal responsibility to provide visionary leadership. As our nation's health care system advances into the 21st century, with its ever sophisticated communications technology (e.g., computerized records and virtual realities), psychology could and should play a major role in ensuring that patients become truly "educated consumers."

Health Literacy: During the first days of the Obama Administration the Congress enacted the President's far-reaching Economic Stimulus proposal, The American Recovery and Reinvestment Act of 2009 (P.L. 111-5). This legislation incorporated the Health Information Technology for Economic and Clinical Health (HITECH) Act, with the goal of promoting the widespread adoption of health information technology (HIT) for the electronic sharing of clinical data among hospitals, health care providers, and other-health care stakeholders. The Stimulus legislation raised the budget of the HIT National Coordinator's office from approximately $66 million in FY'09 to $2 billion, with numerous health policy experts suggesting that the federal government's overall investment for HIT would reach $19+ billion as a result of the stimulus package. This is a very impressive accomplishment for the new Administration and one with many long term policy implications, including heralding the era of "educated consumers," as the unprecedented advances occurring within the communications and technology fields are finally directly applied to our nation's health care arena.

The Institute of Medicine (IOM) has been studying an interesting (and often overlooked) aspect of this evolution. In 2004 and 2009, the IOM published reports exploring what might be considered a "silent epidemic"—Health Literacy. "Clear communication is critical to successful health care." Today, nearly half of all American adults, 90 million people, have difficulty understanding

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and acting upon health information. That is, they possess limited health literacy which is more than reading, as it includes writing, numeracy, listening, speaking, and conceptual knowledge. Approximately 40 million citizens can perform simple and routine tasks using uncomplicated materials, with an additional 50 million adults able to locate information in moderately complicated texts, make inferences using print materials, and integrate easily identifiable pieces of information. However, they find it difficult to perform these tasks when complicated by distracting information and complex texts. Over 300 studies, conducted over three decades and assessing various health-related materials, such as informed consent forms and medication package inserts, have found that a mismatch exists between the reading levels of the materials and the reading skills of the intended audience. Most of the materials exceed the reading skills of the average high school graduate.

There is the definite expectation at the health policy level that the increasing use of emerging interactive health information technology (HIT or eHealth) will help to improve the quality, capacity, and efficiency of the health care system. This should increase the capacity to provide tailored and individually customized treatment protocols, improve clinical decision making and adherence to clinical guidelines; provide reminder systems for patients and clinicians, thereby improving compliance with preventive service protocols; and help prevent many errors and adverse events. Currently, adults receive only about half of recommended health care services and less than 50 percent of adults receive the preventive and screening tests called for in guidelines for their age and sex. A recent Commonwealth Fund survey found that the highest-rated strategy by health care opinion leaders to improve the quality and safety of health care was to accelerate the development and deployment of HIT. Some analysts, however, are concerned that these systems could actually increase health care disparities by helping mainly those individuals and communities with greater resources, noting that underserved populations generally include ethnic minorities, people in lower socioeconomic groups, and individuals with lower educational and reading levels. These populations also tend to have limited access to computer technology.

A major focus of the Economic Stimulus legislation is to encourage hospitals and practitioners to more actively engage in HIT. Yet, this is within the overall context that studies have consistently shown that more than 80 percent of Internet users report searching online for health information. The rate for those with chronic conditions is 86 percent. More than half of consumers (58 percent) who search for online health information report that what they found affected their health decisions, with 39 percent reporting the information changed the way they cope with a chronic condition or manage pain. Thus, it is vitally important to provide individuals with the skills essential for accurately responding to the potentials of eHealth, while keeping in mind the "three-click rule." That is, one must get users to the information in three clicks or face the real possibility of simply losing them.

eHealth literacy is growing in importance. Consumer-directed electronic tools are transforming the way that consumers receive and utilize information. Two types of skills are necessary for eHealth—general skills and specific skills. General skills apply to a number of different contexts and settings and include traditional literacy (reading, writing, and numeracy), media literacy

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(media analysis skills), and information literacy (information seeking and understanding). Specific skills include such things as computer literacy (IT skills), health literacy (health knowledge comprehension), and science literacy (science process and outcome).

Forty percent of Americans have low literacy, making it difficult for them to function in everyday society. Thus, if eHealth interventions are largely text-based, 4 out of every 10 people who might benefit from the intervention will have a great deal of difficulty reading the material. In case of mathematical literacy (numeracy), one-quarter of the U.S. 15-year olds scored at or below the lowest proficiency level. To the extent that eHealth involves simple mathematical calculations such as addition or subtraction, or an understanding of numbers, those with low numeracy skills will likely find it difficult to understand the information presented, reading maps, or understanding simple charts. Media literacy refers to the skills necessary to think critically and to act based on information from media-based messages. Media literacy places information in a social and political context and considers issues such as the marketplace, audience relations, and the role of the medium in the message. Those with low media literacy lack awareness of bias or perspective in media pronouncements, both in terms of what is being presented and what is not presented. They also have difficulty understanding that the media has both explicit and implied messages and they have difficulty deriving meaning from media messages. The third general skill, information literacy, involves a more general understanding of information. An information literate person knows how information is organized, how to find information, and to use information in a way that others can learn from. Low information literacy individuals are unable to see connections between information from multiple sources such as books, pamphlets, and websites. They are, therefore, unable to understand that one may have to triangulate pieces of information from different sources to build an entire picture.

The specific skills involved in eHealth include computer literacy, science literacy, and health literacy. Computer literacy is a general awareness of and skills in using computer-based technology to solve problems. It relates to both computers and to the kind of technologies that surround the use of computers, such as the use of a keyboard, mouse, or printer. Science literacy is an understanding of the nature, aims, methods, application, limitations and politics of creating knowledge in a systematic manner. Approximately 17 percent of Americans are considered able to understand basic science. Thus, 83 percent lack an understanding of the cumulative, dynamic nature of scientific knowledge. They are not aware that science can be understood and used by non-scientists and they are unfamiliar with simple science terminology, the process of discovery, or how scientific knowledge is translated into practice. Finally, eHealth demands health literacy skills. Seventy-three percent of individuals with a chronic condition have searched online for information and those with chronic conditions were more likely than others to report that the results of an online search influenced their health and care behavior related to their condition. In designing a seamless system for the future, we must not forget that those with low health literacy have difficulty following simple self-care directions or prescription instructions. eHealth literacy is growing in importance. "A major goal [in implementing HIT] is to motivate behavior change that will lead to improved health. However, the people who are experts in behavior modification and behavior change don't seem to

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have played a major role to date." We were very pleased to see colleagues Dyanne Affonso, Eric Chudler, and Jessie Gruman actively involved in shaping the IOM views. The interrelationship between education, access to quality health care, and our nation's overall quality of life could not be clearer.

Aloha,
Pat DeLeon, former APA President

CALL FOR NOMINATIONS

DIVISION 29 EARLY CAREER AWARD

American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come. It executes this mission through a broad range of scholarships and grants. For all of these, it encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

The Division 29 program recognizes an early career psychologist for promising contribution to psychotherapy, psychology, and the Division of Psychotherapy. Its description, application requirements, and procedures appear below.

Description
This program supports the mission of APA's Division of Psychotherapy (Division 29) by recognizing Division members who have demonstrated outstanding promise in this field early in their career. Recognized achievements may be in the areas of psychotherapy.

Program Goals
Encourage further development and continuing contributions of early-career professionals in this field

Funding Specifics
One $2,500 award presented annually

Eligibility Requirements
Division 29 membership
Within 7 years post-doctorate
Demonstrated achievement related to psychotherapy theory, practice, research or training

Evaluation Criteria
- Conformance with stated program goals and qualifications
- Applicant's demonstrated accomplishments and promise

Nomination Requirements
Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable)
Current CV

Submission Process and Deadline
Submit a completed application online at
http://forms.apa.org/apf/grants/
by **January 1, 2010**.

Questions about this program should be directed to Kim Palmer Rowsome, Program Officer, at
krowsome@apa.org.

PRACTITIONER REPORT

Practice Update — November 2009

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

The primary mission of the Practice Domain of Division 29 is to focus on the issues related to practice. Following is an update of the progress and challenges encountered in 2009. As most of you know, the Practice community continues to face substantial challenges in a number of critical areas, but at the same time Practice has scored several hard fought victories.

Probably one of the greatest achievements of APA as it relates to Practice was the APA Presidential Summit on the Future of Psychology Practice held May 14-16, 2009 in San Antonio, Texas. The Summit was a collaborative effort among different partners of the practice community. In addition to assembling leaders in the practice of psychology, other professionals who are critical stakeholders in the practice of psychology participated. The following objectives were addressed:

1. Models and opportunities for future practice to meet the needs of our diverse public
2. Priorities for psychologists practicing in private and public settings
3. Resources needed to effectively address the priorities
4. Roles of various practice groups in implementing the priorities
5. Key partnerships to implement our agenda

During the Summit, we addressed policy issues that will be considered by the APA and APA governance, and business of practice and advocacy issues that will be addressed by the APAPO and Committee for the Advancement of Professional Practice. In addition, we collaborated with non-psychology groups to incorporate a broader public perspective into our work. We believe that developing partnerships with these outside groups will be key to implementing our practice agenda.

At the Summit we identified new models and venues for practice, looked at ways to expand opportunities and identified opportunities that traverse traditional practice domains. A primary outcome of the Summit was to develop a clear agenda for the future of our multi-faceted and diverse practice community. The Task Force met for the final meeting in September 2009, and a report with the noted recommendations will be completed and forwarded to Council.

Of equal, if not greater, importance to Practice is the ongoing legislative advocacy program undertaken by the APA Practice Organization's government relations department. There have been numerous legislative successes over the past year that impact on the Practice of Psychology. They include the following:

The Health Information Technology. The Health Information Technology bill has passed with several major components contributed by psychology's legislative advocacy team. Included in the bill is strong privacy protection for patients obtaining psychological services.

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Medicare. There is both positive and negative news concerning Medicare reimbursement. Congress has reversed two Medicare payment cuts that were scheduled to occur this year. In addition, we have been successful in getting a provision to reduce the mental health beneficiary co-payment (from 50% down to 20%) which will achieve parity with medical care by 2014. Unfortunately, The Centers for Medicare and Medicaid Services (CMS) have announced changes in 2010 to Medicare's payments for the practice expense portion of numerous services including those commonly billed by psychologists. It is expected that Medicare payments for psychological services will be reduced on average by 7% based on the practice expense changes. Efforts are underway to attempt to modify these reductions.

Health Care Reform. APA has been involved in the ongoing healthcare reform debate to ensure that psychological services are a core benefit in all health plans in the new health system and integral to patient care in all settings. On October 13, 2009, the Senate Finance Committee passed its bill after months of consideration. Health care reform legislation has now been approved by all five congressional committees of jurisdiction. The House bills and the Senate Health, Education, Labor and Pensions (HELP) Committee bill all include key provisions that are favorable for professional psychology. In addition, the Senate Finance Committee, which has jurisdiction over the Medicare portion of health reform, also passed a bill favorable to psychology.

The key provisions in health care reform pertaining to professional psychology are the 5 percent restoration of the Medicare reimbursement rate cut, integrated care, and replacing the Medicare "sustainable growth rate" (SGR) payment formula. It is good to know that the 5 percent Medicare restoration provision has the support of both House and Senate committees of jurisdiction. For integrated care, the Practice Organization favors the Senate HELP Committee bill as it includes broad provisions for care integration throughout the new health system. This integration fully incorporates all providers, including mental and behavioral health providers. It is anticipated that the Senate will still address the scheduled 21 percent SGR cut to Medicare provider reimbursements by the end of the year. However, most likely it will be a one-year fix, as originally intended by Senator Max Baucus' (Chair of the Senate Finance Committee) health care reform bill.

This will be my last column as my term as member-at-large/Practice Domain Representative will end in December 2009. It has been an honor to be a part of the Division. Finally, I would like to thank Drs. Bonita Cade and Dr. Patricia Coughlin for their service to Division 29 by serving on the Practice Domain Committee.

DIVISION 29 CALL FOR NOMINATIONS

DISTINGUISHED PSYCHOLOGIST AWARD

The APA Division of Psychotherapy invites nominations for its 2010 *Distinguished Psychologist Award*, which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 2009 Awards Chair:
Nadine Kaslow, Ph.D., ABPP
Emory University Department of Psychiatry and Behavioral Sciences
Grady Health System
80 Jesse Hill Jr Drive . Atlanta, GA 30303
E-mail: nkaslow@emory.edu
The applicant's CV would also be helpful. Self-nominations are welcomed.
Deadline is January 1, 2010

DISTINGUISHED CONTRIBUTIONS TO TEACHING AND MENTORING

Each year, Division 29 honors a psychologist who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists by presenting the Division 29 Award for Distinguished Contributions to Teaching and Mentoring. This award is given annually to a member of Division 29 who exerted a significant impact on the development of students and/or early career psychologists in their careers as psychotherapists.
Both self-nominations and nominations of others will be considered. The nomination packet should include:

1) a letter of nomination, sent electronically, describing the individual's impact, role, and activities as a mentor;
2) a vitae of the nominee; and,
3) letters of reference for the mentor, written by students, former students, and/or colleagues who are early career psychologists. Letters of reference for the award should describe the nature of the mentoring relationship (when, where, level of training), and an explanation of the role played by the mentor in facilitating the student or colleague's development as a psychotherapist. Letters of reference may include, but are not limited to, discussion of the following behaviors that characterize successful mentoring:
   - helping students to select and work toward appropriate goals
   - providing critical feedback on individual work
   - providing support at all times, especially encouragement and assistance in the face of difficulties
   - assisting students in applying for awards, grants, and other funding
   - assisting students in building social network connections, both with individuals and within organizations that are important in the field
   - serving as a role model and leader for teaching, research, and academic and public service in psychology
   - offering general advice with respect to professional development (e.g., graduate school, postdoctoral study, faculty positions), awards, and publications
   - treating student/colleagues with respect, spending time with them, providing open communication lines, and gradually moving the student into the role of colleague.

The award recipient will receive a cash award of $250 to help offset travel expenses to the APA convention for the year the award is conferred and an award plaque.

Individuals who were nominated in previous years for the Teaching and Mentoring Award may carry over their complete application to a subsequent year by writing a letter to the Chair of the Professional Awards Committee requesting resubmission of the previous application. This letter must be received by March 15 of the year of the award.

The letter of nomination must be emailed to the Chair of the Professional Awards Committee. Deadline is March 15, 2010**.** All items must be sent electronically. The Award is to be presented at the APA annual convention.
Division 29 2010 Awards Chair:
Nadine Kaslow, Ph.D., ABPP
Emory University Department of
Psychiatry and Behavioral Sciences
Grady Health System
80 Jesse Hill Jr Drive , Atlanta, GA 30303
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FEATURE

A Psychotherapist's Self-Care Guide for Our Current Economic Debacle: Some Suggestions

Leon J. Hoffman, Ph.D., ABPP, FAGPA, CGP
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How are the current economically challenging times affecting the way we psychotherapists practice?

I have some suggestions pertaining to this and any other "life ambush" to which we are exposed. The current economic debacle is but one. Other life challenges might include terrorist attacks, or other sudden, unexpected health, marital, occupational, natural (Katrina), and legal assaults. Some psychotherapists may be currently experiencing one, or more, of these ambushes. We should remind ourselves, and help our patients to realize, that financial distresses are not the only losses that may result from these financially challenging times. Some of the most pernicious results of these difficulties are not financial, but emotional.

Our psychological responses to these puzzling times contribute significantly to our anxieties. It is crucial to understand those anxieties. We must be able to discriminate between whether the anxieties we feel are "merely" discomfort or actually signal danger. We help our patients to recognize this distinction. Many psychotherapies encourage patients to become curious, to be reflective. That is a goal of this article—to help us as psychotherapists to explore and study our circumstances. Please remember: Diagnosis first, treatment second. First we evaluate, then we act.

In what ways are your psychotherapy practices influenced by current economic uncertainties? How do you maintain your centeredness and balance so that your patients receive the consistency they deserve? After all, the role of excellent psychotherapists is the same as that of excellent parents. That is, to provide well for those in their care. Perfection is never the goal; rather, the goal is always adequacy.

Some further questions may be helpful, albeit anxiety-provoking.

How do you function under this economic siege? Do you find yourself jealous of any of your patients or colleagues? Do you envy them their successes? Not all psychotherapists have financially thriving patients. If you do, what special stresses do you feel when you treat them? If you are suffering economically and your patient is thriving financially, do you notice any lapse of judgment or distortions in your usual wisdom that predispose you to moral, ethical, and perhaps even legal risk? Do you feel survivor guilt because you are doing well while some of your colleagues are suffering more than you and may even have lost their jobs? Do you experience anticipatory anxiety from awaiting that "knock on the door" announcing that you are next to lose something?

Are your patient case load and referral flow diminishing? Are your fees and receivables down? Are patients asking to end their psychotherapy, reduce the frequency of their needed sessions, or reduce their fees? Do patients simply not show up, begin to come late, attempt to reschedule often, or not pay their bills promptly? Does the area of the country in which you practice affect your specific patient population (e.g., Detroit and

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the auto industry)? Are patients relocating? What provisions are you making for their continuing psychotherapy in order to minimize disruptions in their care? These and plenty of other nightmarish scenarios are enough to cause anxiety in even the most stalwart of psychotherapists.

Are you noticing increases in negative, or ambivalent, or aim-attached countertransferences? What provisions have you made, if indicated, for your own supervision, consultation, and psychotherapy? Is your self-esteem as a psychotherapist flagging? How do you visualize improvements? How do you maintain your focus and emotional equanimity under such difficult circumstances?

So, okay. Enough questions. Now it's time for some answers. Well, at least a few suggestions. After all, these comments are meant to inform and support us.

No one is immune from being human. Let us take a deep breath, or two, and remember that our need, as well as that of our patients, is to learn to soothe ourselves. Such self-soothing may not be an easy task in such trying times, but if we don't know how to do so, how can we expect to help our patients to do so? None of us is in this alone. While subgroups are the nucleus of cohesive groups, few psychotherapists during today's economic uncertainties would find it difficult to locate colleagues with whom to commiserate.

These may be especially important times to be attentive to our use and possible abuse of electronics. "Keeping it human" will always pay dividends in our profession. Trust me on this! This is also a time to pay special attention to the contracts (agreements) that one has with one's patients. It is also crucial to pay meticulous, scrupulous attention to one's boundaries, both professional and personal. It has always been necessary to do so; it is even more so in these trying times.

Whatever our life stresses, they should never become the patients' burden. So, let's lighten the load—for us, and for them. All patients deserve and need an attentive, rested, balanced psychotherapist. Our focus must always be on them and their needs. Anything interrupting that must be identified and removed.

A well-tuned bicycle wheel with its customary forty-two spokes provides an apt metaphor. These spokes are needed to keep the rim from crumbling when it meets any unusual impacts in the course of its use. Well-adjusted spokes are required to keep the wheel "in true." When a wheel is "out of true," it is easy to diagnose which spokes need what kind of attention. Pretty simple, actually. If only it was that easy for people who get out of adjustment, psychotherapists included.

What "spokes" are in your wheel (life)? Examples of spokes include work, love relationships, religious or spiritual involvement, philanthropy, playing a musical instrument, singing in a chorus, making ceramics or rugs, painting, dance, chess, etc. Sublimations, in short. These involvements help absorb the shocks to which we are exposed.

The spoke's function is to absorb the shocks that the bicycle wheel may encounter on impact. Similarly, psychotherapists must have enough well-adjusted "spokes" in their lives to be able to absorb the impacts to which they are exposed. Not to do so courts disaster when one becomes the victim of life ambushes.

Do you pay careful attention to your sleep, dietary, physical activity, and sexual regimens? Has your weight changed recently? Are you careful to minimize

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any tendencies to act out, such as overeating, overspending, abusing sex or alcohol, or using drugs? Is your concentration and ability to focus acceptable and at your typical level? Are your relationships with your friends and family adequate, nourishing, and as they usually have been? Are you spending time in nature and involved in music and the arts? Do you make time for reading? Are you finding excuses and rationalizations for any of the above? Are you exploring your resistances to being balanced and a psychotherapist "in true"?

Well-trained psychotherapists treating well-prepared, committed patients, especially those psychotherapists who have managed to avoid, or at least minimize, third-party involvement will always have much to offer that patients will need. There is no competition for a skilled psychotherapist and a committed patient in need. Fees can always be adjusted, and even some pro bono work can help everyone maintain continuity for a period of time. Resilience may be more important than ever now.

One of my patients who recently became a new mother has become involved with what some parents do these days—namely, "nanny search." They seek a nanny who will best provide for their child's wellbeing. We psychotherapists also need to provide for our wellbeing. What sense does it make to know what our patients need, and seek it for them, but not to do so for ourselves? We must get the care we need for ourselves. We deserve and require it. High-quality care is what our patients expect and deserve. Nothing less is acceptable. To offer this, we ourselves need to be balanced and centered. Our patients will be the beneficiaries.

This is a time to come together. There is much to celebrate, even during times of adversity, for those willing to look. This is a time to congregate, in community, not a time to isolate and withdraw. It is a time for interaction, not inaction or seclusion. There are ample reasons for optimism. We will survive, thrive, and even prevail. The only thing that is permanent is change. If we are not here to treat patients in need, who will be?

I hope that you, my colleagues, take these suggestions to heart and make them yours. Our future, and that of our patients, is bright. If you think I am wrong, what would you prefer to believe? If the above hasn't convinced you, and you remain recalcitrant and inconsolable, please remember that you can always contact me, and together we will make it through. Some of our suffering is optional.

Dr. Hoffman is a clinical psychologist in private practice, specializing in individual and group psychotherapy, supervision, and consultation. His office is located at 111 North Wabash Avenue, Suite 2122, Chicago, Illinois 60602. He can also be reached at 312-332-1262 or violoncellist@live.com.

STUDENT FEATURE

Discerning Group Therapy Dynamics: Five of Irvin Yalom's Therapeutic Factors in the Context of Wilfred Bion's Group Conceptualizations

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In *The Theory and Practice of Group Psychotherapy*, the existential psychotherapist Irvin Yalom (1995) describes 11 therapeutic or primary factors of group therapy. These factors are "natural lines of cleavage" that "divide the therapeutic experience" (p. 1). Drawing from years of research during and after World War II, the psychoanalyst Wilfred Bion used Kleinian concepts to develop group therapy innovations (Bleandonu, 2000, p. 69). This paper will explore 5 of Yalom's 11 therapeutic factors in the context of Bion's innovations (1959).

Yalom's therapeutic factors are discernments of complex human experiences occurring in groups. According to Yalom change happens in groups as an "interplay of human experience," which is synonymous with Yalom's therapeutic factors (Yalom, 1995, p.1). The following therapeutic factors will be examined: instillation of hope, universality, imparting information, altruism, and the corrective recapitulation of the primary family group.

Bion (1959) held that groups consisted of and should be regarded as the interplay of individual needs, group mentality, and group culture (p. 55). Group mentality can be thought of as the unknown influences on the group, the unanimous expression of the will of the group (Bion, 1959, p. 59). It operates as a uniformity of group members in that it allows individuals to deny feelings, especially those that may be experienced as uncomfortable if exposed. Thus the group mentality is often in contradiction to the group's conscious aims of growth and progress and is in contradiction to the individuals that comprise it. In Bion's words it is "the failure to afford the individual a full life" (Bion, 1959, p. 54). Group mentality is an "anonymous collaboration" of group members, who contribute "selectively unconscious elements," as well as expressing the "the unanimous but unspoken aims and beliefs of the group" (Bleandonu, 2000, p. 70).

Group culture is simply the function of the conflict between the individual's needs or desires and the group mentality. According to Bion, group emotional activity interacts between two levels. The first is the work group, which describes only one aspect of group mental activity. Work group occurs when all individuals in the group are in touch with reality and can cooperate with each other. It is marked by cohesiveness in addressing group dynamics, working towards goals, attunement to one another, and symbolic interactions. Consequently, the work group is "characterized by its awareness of the dimension of time, and the need for progress" (Bleandonu, 2000, p. 71). A work group allows for individuals to be therapeutically addressed, promoting therapeutic progress and growth. The second level is the basic assumption group, which avoids uncertainty or anything anxiety provoking as well as growth promoting. Basic assumptions turn the group, un-

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consciously, into anti-thinking and anti-feeling, contesting the work group thus therapeutic progress.

Bion (1959) demarcated the basic assumption group aims into three types: pairing, dependence, and fight or flight. Dependence is when the group is solely dependent on the facilitator to the point that if a group member is not relating to the leader everything else feels frustrating. Pairing involves two people in the group engaging with one another, ignoring the presence of the other members. Fight or flight essentially entails the uniting of the group to fight or get away from a threat (discomfort/anxiety). A leader is usually chosen to lead the evasion or fight. Bion noticed that groups unite with little trouble "around any proposition that expresses violent rejection of all psychological difficulty, or offers means of avoiding difficulty by creating an external enemy" (Bleandonu, 2000, p. 73). In other words, groups are biased towards superficiality. If an individual is incongruent in thought or action with the basic assumption, the individual will feel uncomfortable and marginalized. Additionally, the basic assumptions do not have a conflicted relationship with one another; rather the different basic assumptions oscillate in the same group. The conflict exists between the work group and the basic assumptions.

The first of Yalom's therapeutic factors, the instillation of hope, has a place in both work group mentalities and basic assumption group mentalities. In terms of hope, Yalom describes individuals in group therapy on a coping-collapse continuum, which is not unlike Bion's fragmentation and integration (1970). Yalom says, "hope is required to keep the patient in therapy so that other therapeutic factors may take effect" (Yalom, 1995, p. 5). In Bion's model hope exists to some degree, as it is a motivating factor for individuals' desires to attend therapy, however it seems to be demonstrated in a more pronounced manner in the basic assumption mentalities. For example in the assumption of dependence, the hope is that the leader will provide security and satisfy all needs. In the pairing group the hope is for a messianic savior, an idea or person that will rid all difficulties and despair. The messiah will instill hope, as long the messiah is never actualized, remaining unborn. In Bion's (1959) words, "the Messianic hope must never be fulfilled" (p. 151). Hope functions to inspire groups and acts as a group adhesive in that it garners attendance. In Bion's model the basic assumptions tend to offer hope that might benefit the work group mentality. Perhaps the hope instilled in the basic assumption mentalities is necessary for the cohesiveness of the work group. In short, the hope of the basic assumptions might advance or be a necessary facet required for the work group to be possible.

Universality is the idea that there is no action, thought, or feeling outside the realm of other people's experience. In the early phases of a group, members often feel alone and uniquely troubled. If, however, members learn that certain frightening problems, impulses, or thoughts are also experienced by other members, they can feel relief. Universality could be an aspect of the work group and/or the basic assumption groups, as it could be an operation of avoidance, pairing, or dependence. For example, if the group wanted to avoid the feelings of disgust or fear associated with a person's fantasies the group might universalize it in order to do so; the group would act as if there is no problem with a destructive fantasy since it is universal, and the group would relate to the member without attuning to the sense of isolation associated to the fantasy. The group might focus upon the content of the member's fantasy without attuning to the underlying feelings. A cohesive

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group, on the other hand, is more likely to attune to a member's sense of aloneness and consequently to offer needed support.

Yalom (1995) categorizes imparting information into direct advice and didactic instruction. He warns the reader, "when therapists or patients retrospectively examine their experience in interactional groups therapy, they do not highly value didactic information or advice" (p. 8). Thus imparting information must be strategic; otherwise it could operate as a flight mechanisms or feed the patients' dependence on the therapist as the only worthy imparter of information. The group could also perceive information as a messiah. For example, group members might believe that if they just hear the right idea and/or concept all will be better. This optimism is out of touch with reality; if information is to be of benefit it must anchor the group in reality, not in theoretical ideas or irrelevant facts. Bion (1959) commented on addressing the group as a whole, preferring simplicity and precision when making interpretations, rather than using terms such as "group culture" or "mentality." Bion focused on what was taking place in the group as well as offered a degree of transparency in how he reached such interpretations. Accordingly, interpretations are often aimed to frame group interactions, or if in work group mode the group's and individual's dynamics (p. 60). If imparting information takes the focus away from the group or makes the group process more abstract than concrete, it would be more likely a function of the basic assumption mentality.

Yalom (1995) points out that didactic instruction can be an "initial binding force in the group until other therapeutic factors become operative" (p. 10). Explicit advice, according to Yalom (1995), has little direct therapeutic value, as the content usually carries little weight, however, the process of advice giving conveys "mutual interest and caring" (p. 11). Information can be of benefit early in the therapeutic group's meetings as long as it influences the move into work group mentality. However, information can become a type of resistance if it serves to avoid anxiety during the work group mentality.

The basic assumption group can be interpreted as essentially defending against felt anxiety. Felt anxiety then would be essential for the work group to progress. Using anxiety is crucial to not only see the group's defense structures in use as well as comment on their active presence, but more importantly to facilitate work group mentality. For example, if the group is defending against anxiety by talking about a football game or focusing on the facilitator, the facilitator might address the group as a whole, commenting on the superficiality or diversion from doing work by focusing on him/her, and subsequently allowing the group members to experience anxiety by provoking silence. Often members will begin to express feelings or offer feedback in order to reduce their anxiety produced by silence. Imparting information can be antithetical when it functions in two ways. First, reason may promote rationalization and intellectualization by possibly heightening those defenses. Second, it might preclude one's growing tolerance of and navigation through anxiety produced by uncertainty and irrationality, or stunt the individuals and/or group development of the higher level functioning, such as "negative capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason." (Keats & Scrubber,1899, p. 277).

According to Yalom (1970), altruism is essential for healing in groups. It functions in two ways. First, members tend

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to give by receiving in this way members interact by offering support, insight, challenges to self-deception or distortions, how they are impacted, and suggestions. Second:

> a sense of life meaning *ensues* but cannot be deliberately, self-consciously pursued: it is always a derivative phenomenon that materializes when we have transcended ourselves, when we have forgotten ourselves and become absorbed in someone (or something) outside ourselves. The therapy group implicitly teaches its members that lesson and provides a new countersolipsistic perspective. (Yalom, 1995, p. 13)

Work group mentality requires both giving, which translates into the cohesiveness of the group instilling focus such that a member who might need attention receives it, and transcendence. By giving to others, a transcendent experience is possible for group members in which a life meaning ensues.

Corrective recapitulation of the primary family group involves the recreation of familial dynamics in the group. Psychotherapy groups resemble families in many ways, providing parental and authority figures, sibling competition and rivalry, potent emotions, and the complexity of intimate feelings from empathy to hostility. Additionally a complex web of familial patterns and entanglements become evident: dependence upon the leader, opposition to the leader, suspicion of the leader resulting in the inciting of parental disagreements, seeking of attention even if it is negative attention, selflessly attempting to deny one's own needs in order to appease the leader, and so on. Group therapy allows for familial conflicts to arise, whereas in individual therapy those conflicts might not as readily and obviously emerge (Yalom, 1995, p. 14).
Early familial conflicts may be relived in both the basic assumption group mentality and the work group mentality. In the basic assumption mentalities, the familial conflicts might emerge but not be attended to and/or perpetuated by either freezing them "into rigid, impenetrable system that characterizes" their family structure or just not working through them. Ideally, work group will be evident when those familial conflicts are worked through correctively such that fixed roles are constantly "explored and challenged, and ground rules for investigating relationships and testing new behavior" is continually encouraged (Yalom, 1995, p. 14). Thus work group entails working through unfinished business, whereas the basic assumptions might be the reliving of the conflicts by dependence on the parent, pairing off with a certain group (family) member (possibly illuminating an emotionally incestuous relationship), or fleeing from or fighting something that might have been intolerable to the family system consciously or unconsciously. In the basic assumption mentality, when familial dynamics emerge they can be potentially useful for the work group mentality if their emergence elucidates those very early familial conflicts, which is necessary for them to be worked through. In other words, not until issues are acted out or experienced by the group can the group address them. So early familial conflict might be displayed and identified in both basic assumptions mentalities and work group mentality; the difference being the work group mentality displays an attunement to those conflicts as well as corrective or growth promoting challenges and explorations of those conflicts.

In the context of Wilfred Bion's (1959) approach to and conceptualization of group dynamics, 5 of Yalom's 11 therapeutic factors theoretically function in both the basic assumption group and

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work group. What is of importance is the utilization of what takes place in the basic assumption mentalities for the transition into work group mentality, leading to group progress. Seemingly unproductive basic assumption group time might be crucial for productive times such that what takes place in that time could have therapeutic value when used as a contrast to or an illumination of roles, conflicts, defense structures, intrapsychic, and or interpersonal dynamics. By integrating Yalom's therapeutic factors with those of Bion's ideas it seems both would benefit as one could "establish a reasonable base from which to begin to delineate," which variables are significantly related to a successful group therapy outcome (Yalom, 1995, p. 4).

References available on-line at www.divisionofpsychotherapy.org

DUES REDUCTIONS

We know that the economic difficulties of the times have had impact on APA members. In order to provide additional assistance for our members and those who wish to become members of Division 29, we have created a new process for requesting dues reductions related to economic hardships and retirement. Please find the form online on our website at http://www.divisionofpsychotherapy.org/. All cases will be decided on an individual and confidential basis by the President and Treasurer of the Division. Forms may be faxed to our Central Office at (480) 854-8966 or sent via email to assnmgmt1@cox.net.

FEATURE

Acceptance and Commitment Therapy (ACT) and Anusara Yoga: Parallel New Horizons

Tara Eastcott
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Yoga is increasingly being considered as an adjunctive or even primary therapy for numerous physical and psychological illnesses, including ADHD (Jensen & Kenny, 2004); posttraumatic stress disorder (Wills, n.d.); and substance abuse (Shaffer, LaSalvia & Stein, 1997). We have yet to determine which mental illnesses and/or populations yoga may benefit, and how to ideally combine yoga with psychotherapy. Studies examining yoga's efficacy rarely specify the style of yoga being utilized; and when they do, there is typically no theoretical justification for the pairing. I suggest that we should examine whether specific pairings of yoga styles with psychotherapeutic approaches that are philosophically compatible may be more beneficial than simply adding yoga to therapy without this level of discrimination. Towards this end, I will outline the similarities between Acceptance and Commitment Therapy (ACT) and Anusara yoga, and discuss how pairing them may provide more benefit than either can offer alone.

ACT and Anusara

Acceptance and Commitment Therapy (ACT) is a developing form of psychological intervention that emerged in the late 1990's and recognizes itself as one of the third wave of behavioral therapies. ACT is steeped in classical behavioral analysis, with the addition of Relational Frame Theory (RFT), a psychological model that explains how human cognition and language impact human behavior and experience. ACT suggests that humans' capacity for language mires us in inevitable suffering via our ability to recall painful memories, imagine the possibility of horrific future events, or just replay negative thoughts about ourselves. Some approaches to psychological treatment focus on altering or eliminating unwanted thoughts and feelings as the sole goal of treatment. Rather than attempting to alter the form, frequency or content of thoughts and feelings, ACT seeks to change our relationship to our private experiences (thoughts, feelings, physical sensations) through altering the social and verbal contexts in which they occur. ACT uses a combination of mindfulness, acceptance, commitment and behavioral change interventions. Psychological health is measured according to one's ability to accept the present moment and take action towards one's valued life directions, rather than by one's symptoms or how we feel about ourselves.

Anusara Yoga is a developing style founded in 1997 by John Friend. "Anusara" means "flowing with Grace"; "flowing with Nature"; or "following your heart." The Hatha yoga foundation means that poses or asanas are performed in accordance with precise biomechanical principles of alignment and are coupled with a Tantric philosophy. The three principles of Tantric philosophy most prominent in Anusara are:

1) belief in the universe as a concrete manifestation of the divine, which is ultimately good
2) connecting with the divine to foster greater freedom and creativity for

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the joy of it
3) connecting with the divine through alignment of the mind and body as they are, rather than by subjugating them.

The Universal Principles of Alignment outline how the body should ideally move in order to maximize the experience of oneness with one's true essence, or nature, which is seen as complete, fully conscious, peaceful, and blissful. Anusara differs from some other styles of yoga in that it focuses more on acceptance of the body, whatever its state, rather than trying to overcome or subdue it.

Theoretical Similarities

Use of Principles/Processes

Both ACT and Anusara operate according to interconnected principles or processes, rather than rules. Both emphasize that rules inevitably fail to account for situational variables and individual variability in a way that is ultimately harmful to people. Below is a very brief overview of the six core principles of ACT and the five principles of Anusara.

In ACT the six core processes are seen as interdependent and are highlighted as necessary rather than in any particular order:

1) *Acceptance*: willingness to experience things as they are.
2) *Present Moment*: ability to focus one's attention on the present.
3) *Values*: verbal representations of desired life outcomes that can guide overall life direction, without stipulating specific terminal outcomes.
4) *Self as Context*: the immutable point of view from which we can observe our internal and external experiences taking place.
5) *Defusion*: relating to thoughts as what they are (internal streams of verbal behavior), rather than what they say they are.
6) *Committed Action*: value-directed behavior (Hayes, Strosahl, & Wilson, 1999).

The five principles of Anusara are applied to each pose in the order listed:

1) *Opening to grace:* intention to align from within with the present moment, the universal divine, and one's desires.
2) *Muscular energy*: drawing energy inwards towards a focal point in the body.
3) *Inner Spiral*: an expanding spiral of energy drawing in towards the core.
4) *Outer Spiral*: a narrowing energy spiral moving away from the core and balancing the inner spiral.
5) *Organic Energy:* the expansion of energy from the focal point in the core to the periphery of the body, balancing muscular energy (Keller, 2001; Friend, n.d.).

Values

While there are no glaring similarities between the ACT processes and Anusara principles on first glance, delving into rhetoric of each uncovers some striking parallels. One critical similarity has to do with the ultimate value in the work. As Hayes (2002) describes it, the question at the heart of ACT is essentially: Given the distinction between yourself (self as context) and the stuff you are struggling with and trying to change (your thoughts and feelings), are you willing to have that stuff—fully and without defense (present moment and acceptance), as it is, not as what it says it is (defusion)—and do what takes you (committed action) in the direction of your chosen values (values), in this time and this situation (being present)?

Now consider how the Anusara web site (n.d.) describes the essence of its practice:

> Anusara yoga is flowing with Grace by saying "yes" to the whole magi-

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> cal spectrum of life. It is a willingness to be aware of all parts of ourselves-the light and the dark, the full rainbow of sensation, perception, emotion, and thought. Saying yes to life means to openly sense and know each moment fully without prejudging it. We simply open our hearts with love to the present moment without clinging or pushing. Then from this spacious place of perception we discern whether something is life-enhancing or not. Whatever we encounter, whether it is auspicious or malicious, good or bad, uplifting or disheartening, we respond in ways that are more life-affirming. To be in the flow is to feel the moment fully and then to choose to act in ways that celebrate the essence of life, Spirit, and our hearts (Anusara Principles, ¶ 6).

Both approaches begin by drawing our attention to the each present moment to contain a range of experiences, encouraging us to be with those experiences willingly and without judgment, in order that we can more clearly discern how to actively live in accordance with our values. Though different language is used, I would argue that "self as context" awareness as described in ACT is experientially equivalent to being in "Grace" in Anusara. Hayes (1984) states that: "the qualities of a metaphysical God can be understood as a metaphorical extension of the experienced qualities of seeing-seeing-from-perspective-behavior" (p. 106). (See Hayes 1984 for more on self as context and spirituality). In ACT and Anusara being able to experientially connect with self as context or Grace is viewed as critical to the rest of the work.

Defining the Problem

ACT and Anusara both to some extent redefine what is defined as the "problem" in their respective fields. Contrary to many other theoretical orientations, which view unwanted thoughts and feelings as "problems" to be eradicated through psychotherapy, ACT argues that this agenda is unworkable. ACT utilizes present moment experience, defusion, and acceptance to help people better discriminate between what our minds tell us is true and possible, and what we can experientially learn to be true and possible in the present moment.

Similarly, and contrary to some other styles of yoga, Anusara does not view the body and thoughts as corporeal "problems" to be overcome, but rather suggests alignment with and opening to these facets of human existence in order to more clearly connect with the divine. As the Anusara web site (n.d.) describes: "Our thoughts, desires, passions and emotions are not obstacles to spiritual awakening which need to be squelched or eliminated, but instead they are God-given means of glorifying and expanding our experience of the Supreme" (Anusara Philosophy, ¶ 4). Asana practice can be used to discover the actual limits of the body, versus the limits of the body as communicated by the mind, just as ACT helps people to make a distinction between the mind's story about reality and experienced reality. In both cases, this result is not achieved by rejecting thoughts or feelings, but by acknowledging their presence and then prioritizing the data gained through direct experience.

Values and Community

The discourse in ACT and Anusara is also remarkably similar in its description regarding how the work is conceptualized within a community of practitioners. As Hayes (2005) writes:

> We want a theory of human behavior that allows us truly to make a difference in our homes, schools, workplace, and clinics…a technology that works, a theory that works,

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> basic principles, AND a powerful linkage to our deepest human desires…We are using ACT / RFT to create an ACT / RFT community that is open, non-hierarchical, diverse, committed, sharing, caring, and just plain fun…By appealing to the better nature of our clients (e.g., self-acceptance, mindfulness, values, commitment) we seem to be creating change in the clinic" (¶ 1-2).

Anusara yoga endorses a remarkably parallel commitment to human desire, diversity, expansiveness and enjoyment, as described below.

> Anusara yoga's remarkable growth is due in large part to its uplifting philosophy, epitomized by a 'celebration of the heart' that looks for the good in all people and all things. Consequently, students of all levels of ability and yoga experience are honored for their unique differences, limitations, and talents. This celebratory vision sets the basis for a yoga school in which the harmony and joy of a tightly knit community of highly trained teachers and fun-loving students is exalted. This community feels like it has the tightness of a family, yet the looseness of a merry band of bohemian artists. (Anusara About, ¶ 2)

ACT and Anusara Working Together

Beyond exploring the philosophical similarities between ACT and Anusara, it is also critical to consider the practical and actionable implications of these parallels. More than many other approaches to therapy, ACT focuses on experiential interventions. ACT argues that experience is more useful in fostering behavioral change than simple verbal exchange or instruction, and that experiential exercises are best for loosening the grip that language often has upon our behavior. The asanas of Anusara yoga could thus provide a useful extension of psychotherapeutic experientials. ACT often focuses on helping people to remain in contact with painful emotional experiences; this may include awareness of physical sensations but not an overt focus on the body. Through Anusara, an individual can deepen his/her present moment awareness with a more primary focus on the body that includes, but focuses less on, thoughts and emotions. Through yoga practice, ACT clients can have another experience of how moving towards and into discomfort can ultimately help them to attain greater freedom and alignment with their values. Thus Anusara can provide further embodied contact with the processes of ACT.

Ultimately Anusara encourages practitioners to utilize asana practice to translate its lessons to daily life. It is this translation process where ACT might be most beneficial. Anusara teaches to approach and move through physical discomfort in navigating physically challenging poses. While it acknowledges painful thoughts and feelings, the practice is not explicitly focused on untangling from these particular discomforts. Anusara teaches how to move into a pose when we are frightened and think we cannot do it, but this behavior is generally trained only in yoga classes or individual practice. The idea is to take those lessons of moving and living into our lives, but those skills may not generalize well to topographically different actions (speaking versus doing an asana, for example) or other contexts (the workplace versus the yoga studio. Through metaphors, and cognitively-focused experientials, ACT provides further tools for more consistently and fully living one's values, and trains values-oriented behavior across a broader range of contexts than Anusara alone. ACT can thus generalize and reinforce Anusara's lessons.

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Future Research

It is hoped that this paper will highlight other important questions for us to consider as we explore how yoga can be utilized in the treatment of mental illness. Areas for potential future inquiry include but are not limited to the following. Given the parallels between ACT and Anusara, what are the specific ways in which each can inform and support the practice and development of the other? Are there certain ACT experientials, for example, whose lessons can be best expressed through certain asanas, and vice versa? Where ACT has demonstrated treatment efficacy, can the addition of Anusara increase this benefit? Are there certain mental illnesses that might most benefit from yoga? Are all styles of yoga equally beneficial to mental health?

References available on-line at www.divisionofpsychotherapy.org

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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 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 : assnmgmt1@cox.net

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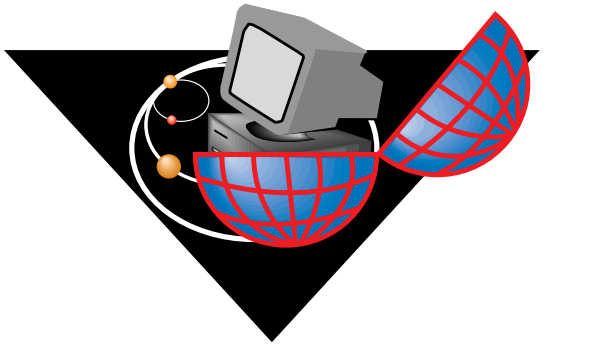
DEADLINE FOR SUBMISSION:
The deadline for submission to be considered for 2010 is **December 15, 2009**. The initial nominee must enclose a *Uniform Fellow Application*, nominating letter, three or more letters of endorsement, updated CV, along with a cover letter, and three copies of all the original 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.



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QUESTION & CONCERNS – 2010 CONVENTION HOTEL

October 6, 2009

TO: **APA Members**

FROM: **APA Board of Directors**

Subject: **Manchester Hyatt – 2010 Convention Hotel**

Some members have raised concerns about APA's planned use of the Manchester Hyatt as a headquarters hotel during the 2010 San Diego convention. The purpose of this memo is to let members know that we are aware of two areas of concern: the possibility of labor issues at the hotel—apparently unfounded based on our research—and the hotel owner Doug Manchester's political activities in support of Proposition 8.

Please see below for new information in response to a communication from Unite Here, a labor union, about the Manchester Hyatt. A number of questions that arose when the union contacted some of the APA Divisions have been forwarded to us via numerous list servs. In an effort to ensure that all members have access to the same information we are responding to the questions we've received to date via this memo. As more information becomes available we will continue to share it.

In a second section of this memo we are also providing information about Mr. Manchester's political activities and how we plan to respond to them. This information was first shared with numerous list servs last week but we include it again for the benefit of those members who did not see it.

Questions and concerns about allegations being made by Unite Here.

Q. Are there picket lines at the Manchester Grand Hyatt? What is the nature of the labor dispute?
The Manchester Grand Hyatt is a non-union hotel. According to Manchester Hyatt management, there is no labor dispute at the hotel and there are no picket lines. APA staff has confirmed that there were no picket lines at the hotel during two recent visits to the property. Unite Here has been unsuccessful in its efforts to unionize the hotel's employees. There are occasional demonstrators from the Unite Here union; these demonstrations do not involve Hyatt employees as best we can tell. It is also important to note that there is no evidence that there has been any wrongdoing on the part of the hotel or its management vis-à-vis the treatment of its employees. The Manchester Hyatt Hotel provided APA a statement that it "warrants and represents that it has had no unfair labor practice charge or complaint pending or threatened against it. The hotel has further stated in writing that the hotel has "never received any notification from the National Labor Relations Board about any group of associates within the hotel or within any department of the hotel, who have expressed an interest in organizing and there is not currently and has never been an organized labor election campaign underway."

Q: Unite Here has claimed that the housekeepers at the Manchester Hyatt are forced by management to clean more rooms than housekeepers at other Hyatt hotels and that they were holding lunch hour protests. Is this true?
The Hyatt Corporation says this is a distortion of the facts. The Manchester Hyatt participates in a corporate program that assigns "credits" to rooms depending on whether the guest is staying over

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(1/2 credit) or checking out (1 credit). Room attendants work between 14 and 15 credits per eight-hour workday. The national standard for rooms cleaned in an eight-hour day varies from 13 to 20, according to "Hotel Management and Operations," by Denney G. Rutherford, PhD, and Michael J. O'Fallon, PhD (2007, John Wiley and Sons Inc.)

Hyatt says before the program was instituted at the Manchester property, some housekeepers learned about it secondhand, which resulted in confusion among staff. Hyatt says there was a brief period of time in 2006 when workers were gathering across the street from the hotel to protest the new work policies. However, according to the Hyatt, once the new work policies were fully explained to the hotel's staff, the protests ended.

Hyatt also reports that the turnover rate among housekeepers at the Manchester hotel is under 5 percent.

Q. There have been reports that Unite Here's tactics and activities have been improper. Hyatt says one thing and the union another, so which should we believe?
There is information available about Unite Here's goals and activities on the Web. Likewise, Hyatt has posted information regarding its relationship with the union. Also provided below are links for web pages to third party entities which monitor union activities and labor issues, some of which have raised serious concerns about Unite Here's management and tactics.

Individual members can read these reports based on their interest level.

http://www.unitehere.org/

http://www.hyattpressroom.com/welcome.asp?status=0

http://www.unionfacts.com/unions/unionProfile.cfm?id=511

http://unitehereexposed.com/index.cfm

http://www.unionfacts.com/articles/democracyElections.cfm

Questions about APA's use of the Hyatt as a convention hotel given Mr. Manchester's political activities

Q. What is the background of the issue with the Manchester Hyatt?
Doug Manchester, a San Diego businessman and owner of the Manchester Hyatt, donated $125,000 to an organization supporting Proposition 8, the California state ballot initiative that in 2008 amended the state Constitution to restrict the definition of marriage to one man and one woman. This was a personal donation from Mr. Manchester. The hotel is operated and managed by the Hyatt Corporation, which had nothing to do with this contribution. However, as a result of Mr. Manchester's donation, several prominent lesbian, gay, bisexual and transgender (LGBT) organizations have called for a boycott of this hotel.

Additionally, the union Unite Here, which has been trying unsuccessfully to unionize this hotel, has called for a boycott. Some LGBT organizations are supporting the union's call for a boycott.

Q: What is APA's position on Mr. Manchester and his opposition to same-sex marriage?
APA has been a strong advocate for full civil rights for LGBT people for nearly 35 years. We are proud of that record of advocacy based on the social science research on sexual orientation. APA has supported legal benefits for same sex couples since 1997 and civil marriage for same-sex couples since 2004. Most notably, we have adopted policy statements, lobbied Congress in opposition to the Defense of Marriage Act and the Federal Marriage Amendment, and filed amicus briefs supporting same-sex marriage in legal cases in Oregon, Wash-

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ington, New Jersey, New York (three times), Maryland, Connecticut, Iowa, and California. In California, the APA brief was cited by the state Supreme Court when it ruled that same-sex marriage was legal in May 2008.

While we strongly disagree with Mr. Manchester's position vis-à-vis proposition 8, our decision to abide by our contract with the Hyatt is based on our belief that the large expense of failing to abide by the contract would be more productively spent on funding for APA activities in support of psychology and the application of psychology to help disadvantaged groups including the LGBT community. We see the San Diego convention as an important opportunity to call attention to the social science research on sexual orientation, the abilities of gay and lesbian parents, and the benefits of marriage for all people.

Q. Given APA's position supporting equal marriage for LGBT people, why is the association still planning to use this hotel?
APA signed a contract with the Manchester Hyatt in 2004 in order to reserve both sleeping and meeting rooms for the 2010 convention. It is typical that such agreements contain substantial penalties for cancellations; such penalties protect both the host organization (APA) and the hotel, and are standard in the industry. The APA Board of Directors decided in February, when it was informed by Unite Here of the boycott efforts, that APA would have to honor its contract with the Manchester for two reasons:

The official Board policy is not to cancel hotel contracts unless there is imminent danger to attendees or staff; and in a time of serious financial crisis, cancellation of the contract would cost APA more than $1 million due to its contractual obligations.

Rather than take an action that would be prohibitively expensive to APA and have no bottom-line effect on the Hyatt (the hotel would still get its money), the Board opted to meet its contractual obligations but also use the San Diego meeting as an opportunity to communicate APA policy positions on LGBT rights generally and same-sex marriage specifically to both a California and national audience. Ideas for how we will do this are outlined in a subsequent section below.

Additionally, the Global Hyatt Corporation has a long history of supporting diversity and has enjoyed a good standing with the LGBT community. The Human Rights Campaign, the largest U.S. LGBT advocacy organization, has named the Hyatt Corporation one of its "Best Places to Work" every year since 2003; Diversity Inc. and the Advocate magazine have named Hyatt among the top companies for LGBT employees.

At the same time, Board members are sensitive to the impact of this issue on LGBT and other members, and have heard the concern expressed about the Manchester Hyatt being a headquarters hotel during the 2010 APA convention. If individual members choose not to stay at the Hyatt there will be other lodging options available to them.

Q. Why can't APA cancel its contract with the Manchester Hyatt and use another property? Haven't other organizations canceled plans to meet there?
The Manchester Hyatt has indicated to APA that it would enforce the terms of the contract were APA to cancel. Those terms involve a penalty of more than $1 million if we were to cancel now. That amount escalates closer to the convention dates. Some organizations have reportedly canceled plans to meet at the Hyatt. Those organizations may have had different contract provisions than contained in the APA/Hyatt agreement. Other organizations, including the National Education Association, the

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American Public Health Association, the American Historical Association and the California Association for Health Services at Home, held meetings at the property despite the call for a boycott. Like APA, these organizations are supportive of LGBT rights and workers' rights.

Q. What about members or divisions of APA who refuse to meet in the Manchester at the convention? What is your message to them?
Initially, some groups within APA moved to support a boycott of the hotel to protest Mr. Manchester's support of Proposition 8. APA believes that in the end, a boycott, although a strong symbolic gesture, would not achieve the desired results; the Manchester Hyatt Hotel would receive the same revenue—whether the rooms are used by our members or not—because of major contractual penalties that APA would have to bear if we cannot fill our room block. Furthermore, if too many groups asked to move out of the Hyatt, there would not be enough space to house them in other hotels near the Convention Center. All meeting space in the near-by Marriott and Hilton hotels is already reserved. There are some large rooms available in the convention center but very few rooms that would work well for a small group, i.e. a division meeting. Other hotel space, if available at all, would likely be a significant distance from the Convention Center and would require payment for meeting rooms. (Divisions normally get meeting space at the headquarters hotel at no charge because of our sizable room block at the hotel).

For all of the above reasons, APA has asked groups not to formally boycott the hotel. Instead, we are asking APA divisions and other entities to focus on positive actions to highlight APA's policies and to educate the public on the science related to same-sex marriage. At the same time, we recognize there is no single point of view and understand that individual members may choose not to stay in the property. We respect that personal choice.

Q. What will APA do to call attention to the science related to same-sex marriage?
The convention provides an unprecedented opportunity to bring the weight of scientific research to the public debate about same-sex marriage. APA has supported legal benefits for same-sex couples since 1997 and civil marriage for same-sex couples since 2004.

APA's President-elect Carol Goodheart, EdD, has appointed a governance and staff work group to assist in developing a positive approach to the opportunity presented by the Convention. As a starting point, the work group has developed the following plans, which have been approved by the Board of Directors. Additional ideas for potential public education activities are welcome.

- A press conference with speakers and briefing papers focusing on the latest, best science around sexual orientation and the mental health benefits of marriage;
- A plenary program focused on same-sex marriage and the diverse public debate going on in our nation about it;
- A presidential citation to a leader in the movement for same-sex marriage;
- Informational packets on APA policies on sexual orientation and marriage rights issues for attendees and the public.

In summary, the goals of the Board of Directors and the work group are to give our members full information, respect the personal choices of convention attendees, publicize the social science research on sexual orientation, and demonstrate fiscal responsibility.

CANDIDATES FOR APA PRESIDENT

Ronald. H. Rozensky, Ph.D., ABPP

I am honored to have been endorsed by Division 29 for President of the American Psychological Association. I have been a strong advocate for psychology and psychotherapy and greatly appreciate this opportunity to provide information regarding my efforts on behalf of psychology, to briefly acquaint you with my professional activities, leadership experiences, and vision for our future.

My work on healthcare reform over the past year is a case study in my advocacy for psychology. I have been involved directly in the actual writing of healthcare reform recommendations in my role as Chair-Elect, and now Chair, of the *Advisory Committee on Interdisciplinary Community Based Linkages (Services)* within HRSA's Bureau of Health Professions. The Committee, appointed by the Secretary of Health and Human Services, makes yearly recommendations to the Secretary and Congress; it is part of my responsibility to advocate so that psychology is seen as an integral part of the healthcare system and deserving of funding for education, training, and services. We must take every opportunity to assure that assessment and psychotherapy are mentioned within the healthcare reform discussion and I have had the opportunity to do just that.

My committee participated in writing a letter to Congress regarding the role of all health professions, including psychologists, as key to a quality focused, integrated healthcare system. I have portrayed psychology as a strong, essential member of the healthcare team, an independent profession providing patient care to the fullest extent of our license and scope of practice with psychotherapeutic services as a major component of quality, cost effective healthcare.

I am a Fellow of our Division and am board certified in Clinical Psychology [ABPP] reflecting having sought peer review of both my assessment and psychotherapy competencies. I teach the Advanced Psychotherapy graduate seminar at the University of Florida and maintain a large outpatient psychotherapy practice in our hospital-based clinic that includes graduate student and intern level trainees. Our students awarded me both their *Classroom Teacher of the Year,* and twice, the *Supervisor of the Year* awards. The supervisory award states, "For dedication to and excellence in supervision." For me there is no better testimony to my commitment to advancing psychotherapy in education, training and practice than that expressed by my own students. I have published five books and numerous chapters and journal articles, the majority focused on the application of psychotherapeutic principles to the treatment of medically ill patients across the lifespan.

My leadership experiences include APA Council and Board of Directors, President of the Illinois Psychological Association, chairing both the Boards of Professional and Educational Affairs, current Chair-Elect of CRSPPP, and chair of two APA presidential initiatives each highlighting psychological treatment in healthcare.

As APA President I will continue to advance the science and practice of psychotherapy. I have the experience and skills to advocate for inclusion of our psychotherapeutic services in the details of healthcare reform. That will be a key role for the next president of our association. I would appreciate your #1 vote. **www.RozenskyforAPAPresident.com**

Melba Vasquez, Ph.D., ABPP

I appreciate the endorsement from Division 29 for APA President. I have had a strong commitment to advance psychotherapy throughout my career and will continue this endeavor.

The provision of psychotherapy is the basis of my work. Providing psychotherapy is an activity that is profound in its meaning and effectiveness as a change process. The evolving evidence base helps us to more fully understand the factors that contribute to therapeutic effectiveness. We must ensure that these services are fully included and funded in the evolving health care reform systems.

Leadership
As a member of the Board of Directors, I have advocated consistently for the Practice Directorate, and the APA Practice Organization. I currently Chair the Task Force to revise the Model Licensing Act, whose charge is to bring the MLA in line with other APA policies including proposing increase in licensure mobility, and ensuring that the doctorate is the level of credential required for the title "psychologist" and the independent practice of psychology.

I served as Chair of the Board of Professional Affairs, and as member of the Committee for the Advancement of Professional Practice. I also served on the Ethics Committee, as member of the Examination Committee for the Association of State and Provincial Psychology Boards, and helped to develop the oral exam for licensure in Texas.

Education and Training
I completed a psychotherapy videotape series as part of the APA DVD Videotape project, focusing on multicultural psychotherapy. These series are available for training students about psychotherapy skills.

I previously worked at two university counseling centers as senior psychologist and as internship training director (Colorado State University and University of Texas at Austin). I've taught various doctoral courses in supervision and training of psychotherapy. I helped to plan and coordinate the Supply and Demand Conference and the Competencies Conference, both of which yielded important directions for the training of psychotherapy.

Scholarship
I have authored/coauthored over 30 books, journal articles and chapters in the areas of ethics in psychotherapy, multicultural competency, and psychotherapy with women and with men. I am currently completing a volume, *Multicultural Theory* as part of the APA Theories of Psychotherapy Series. I have served on the editorial boards of practice journals such as *Professional Psychology: Research and Practice, The Counseling Psychologist*, and *Ethics and Behavior.*

Advocacy
I have participated in activities with the Association for the Advancement of Psychology such as raising funds for legislators and in making visits to Congress. Those efforts have included extending the restoration of Medicare outpatient mental health reimbursement cuts, and ensuring that health care reform integrates psychological services. While serving as president of the Texas Psychological Association, I helped ensure that our practice laws remained intact during the 12-year sunset review. I have received an Advocacy Award from the Association for the Advancement of Psychology (2008), and the APA Karl F. Heiser Presidential Award for Advocacy (2007).

I would very much appreciate the #1 vote from members of the Division. Please visit my website www.melbavasquezforapapresident.com.

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