Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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BULLETIN

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Supervision from a Psychotherapy Integration Perspective

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Feature
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2010 VOLUME 45 NO. 1

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PSYCHOTHERAPY BULLETIN

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

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

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EDITORS' COLUMN

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

Welcome to the first issue of the *Psychotherapy Bulletin* for 2010. We are again pleased to present you with papers that you should find informative and helpful. We welcome Jeffrey Magnavita's first column as Division 29 President. Mike Murphy has written a thoughtful paper on psychotherapy research and competency-based training. An interesting article on cultural diversity in psychotherapy is important for everyone to read. As usual, we benefit from Pat DeLeon's unique insights in the Washington Scene.

We tried to coordinate this issue of the *Bulletin* with our division's next journal and focus some of our papers on supervision. We think you will enjoy the article on supervision from a psychotherapy integration perspective as well as the paper related to research in the area of mindfulness and supervision. For the first time in our history of the *Bulletin*, we have an ethics paper co-written by a father and daughter (Jeff and Madeline Barnett)—a truly inspiring example of mentoring. We are also pleased to include an article on interns as supervisors.

Finally, we are excited that in the near future we will be offering all readers the opportunity to receive the *Bulletin* in an online format. Chris Overtree, our division's Internet Editor, has written a fascinating article on the many possibilities for us using the web, including exciting new internet publishing options for the *Bulletin*. We hope to provide you with information soon so that you can choose to Go Green with the *Bulletin*.

Here in Denver, the weather seems to finally be warming and the days are getting longer. We wish you a quick end to winter and a happy spring.

Jenny Cornish and Lavita Nadkarni
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PRESIDENT'S COLUMN

Jeffrey J. Magnavita, Ph.D.
Glastonbury Psychological Associates PC

It is with great honor and excitement that I assume my role as President of the Division of Psychotherapy. We are living during a time of great change and with that comes enormous opportunity to evolve and grow. I am delighted to lead the premier organization in the world for the advancement of psychotherapy. I have been a practitioner since 1980 when I was an intern in clinical psychology at a now defunct psychiatric hospital which was one of the leading institutions for psychosocial and family systems treatment. Since that time, I have logged approximately 34,560 sessions of psychotherapy and continue to find excitement and deep meaning in this endeavor. I was thinking about the 10,000 hour rule that Malcolm Gladwell writes about in his book *Outliers* which is how much time it is estimated that it takes to become an expert in a field. In other words becoming skilled in any endeavor is not just a matter of talent and training but practice, practice, and more practice.

Practice, science, and training are three legs of our psychotherapy stool: without one of these legs we collapse! In this column I would like to outline some of the issues we face and future trends that I anticipate as we begin to re-envision our division and evolve along with the demands of the 21s century. I have decided to pursue four presidential initiatives during my term as well as build on the work of my predecessors. These initiatives include: (1) advance technology and informatics; (2) establish a presidential *Task Force on Psychologists/Psychotherapists (TOPPs)* to clarify and make recommendations concerning various aspects of the identity of psychologist/psychotherapists; (3) establish a mechanism for listing nonprofit organizations which we endorse that provide pro bono mental health services; (4) introduce the Unified Psychotherapy Project (UPP) and continue to strengthen our science-practice-training alliances through collaboration with the Society for Psychotherapy Researchers (SPR), the Society for Psychotherapy Integration (SEPI), and related APA Divisions through an informal *Consortium of Clinical Science and Practice* dinner.

The practice of psychotherapy is changing constantly, and many new advances in clinical science have occurred recently. We have many approaches to psychotherapy, which have shown to be very robust even with those patients often considered beyond the realm of treatment, such as personality disorders and complex trauma. Technological advances are rapidly changing the way service is delivered and providing wonderful new tools to enhance our efforts to improve training such as the Internet, video technology, telehealth, electronic records, and virtual treatment. Unfortunately, as most of you know technology is advancing so rapidly that our licensing and ethical guidelines cannot keep pace. In order to address these issues, I am pleased to announce that Dr. Jeffrey E. Barnett, a leader in the field of ethics, is now offering the *Ask the Ethicist* feature on our website http://www.DivisionofPsychotherapy.org/ where any of us can ask questions about ethical concerns and issues. This will allow us to rapidly respond to the day-to-day issues that many of us in clinical practice wrestle with alone. No longer do you have to

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struggle with ethical issues without knowing where to turn. This is one of many examples of how technology can be used to assist us in our daily professional lives. Many of these ethical issues were discussed at the Practice Summit convened by our past APA President Dr. James Bray, which I had the honor to attend. Members can see the lectures of some of the most forward thinkers from various disciplines (see http://www.apa.org/practice/leadershipsummit.aspx). I found these presentations a challenge to business as usual. I urge you to watch them and let your creative juices flow. This is another way technology can enhance our professional lives through video casts of educational programming.

Psychotherapy is about being connected. Our President-elect, Dr. Elizabeth Nutt Williams, has spearheaded our membership domain. Being connected is easier now than ever before in the history of human kind. For better and worse we are now able to connect instantly with almost anyone around the globe. This has created many new opportunities as well as new challenges, and even evolving pathologies such as Internet addiction, which I am certain many of you in practice encounter. I have been encouraged to sign up for Facebook and can no longer poke fun at my three adolescent daughters for their interest in this activity because I can see how it can enhance our social networking, when used appropriately. Please join us by going to http://www.Facebook.com/Psychotherapy29/.

We are clearly moving from a membership based organization to a technology and information-based one where most of our revenue is gleaned from our outstanding journal *Psychotherapy*. This journal has been transformed under the adept editorial leadership and tireless efforts of Dr. Charles Gelso, and is now being led by an outstanding researcher and scholar Dr. Mark Hilsenroth. I am very pleased to announce that Dr. Jean Carter has agreed to serve as Chair of the division's Publications Board and continue her excellent stewardship as our publications have expanded from our journal *Psychotherapy*, our *Psychotherapy Bulletin*, and now our Web Publication. We have added to our team, Dr. Christopher Overtree, our new Web Editor to our prestigious Publication Board. He has been a central figure along with Dr. Steve Sobelman in launching the next iteration of our internet site and thus building on the work of his predecessor Dr. Abe Wolf who was a steady voice for advancing our technology. We hope to put into practice many of his initiatives such as easy to access on-line continuing education. We plan to develop this in the next iteration of our Web Publication. Wouldn't it be great to watch a video, take the CE test, pay for it, and print off your CE certificate all in one place?

A central issue that seems apparent but which may not be as evident as we would like concerns our identity. We the members of Division 29 are psychologist-psychotherapists. What is a psychologist-psychotherapist? A psychologist-psychotherapist is first a psychologist who has a deep and abiding interest in the advancement of psychotherapy through practice, teaching, scholarship, and research. Regardless of the professional emphasis, most of us agree that psychotherapy is a complex relational encounter incorporating the best evidence from clinical science that attempts to promote the growth and healing in those who seek our services.

With the rapid changes in health care and challenges to psychology that have ensued I also began to ponder the question of what differentiates the psychologist-psychotherapist from psychotherapists, and from other esteemed

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professions such as psychiatry, social work, family therapy, and nursing. In discussions with respected interlocutors I was often asked the question: "Why should I see a psychologist for psychotherapy as opposed to a less costly choice?" Is there anything we can cite that shows psychologists get better results? After a review of the literature I could not find any compelling evidence. Does our training and the expense of attaining a doctorate make sense from a cost-benefit and added-value perspective? How do we justify what we offer over other, often less extensively trained, practitioners? This question has occupied me and I think deserves our attention. As one of my Presidential initiatives I have established the *Task Force on Psychologist/Psychotherapists (TOPPs)* and am pleased to announce that Dr. Jeffrey Barnett has agreed to chair this group. The task force will serve during my Presidential term and then the initiatives that are recommended will be taken over by the related domains represented on our board of directors. We look for your suggestions, advice, and feedback which can be communicated at our forthcoming TOPPs page on our internet site.

We need to be proactive if we are going to differentiate ourselves from others and strengthen our image with the public through credible information. I am hoping that through our new and evolving website under the able guidance of Dr. Christopher Overtree, our new Web Editior, Dr. Jean Carter, Chair of our Publication Board, and Dr. Steve Sobleman, Chair of Internet Task Force, we will be able to offer the cutting edge findings in psychotherapy not only to our members but to the global village. Many other countries desperately seek information, training, and education from us. We can better provide this through easy access to our internet site. One of the initiatives of one of my presidential mentors, Dr. Jeffrey Barnett, was to strengthen our international connections and I hope we can continue to advance this vital mission to bring knowledge of psychotherapy to our international students and colleagues.

Psychotherapy represents a convergence of many aspects of clinical science, as well as many perspectives such as practice, science, research, and training. The intersection of these vital domains makes the Division of Psychotherapy unique among the science and practice divisions. There are tensions which create an inexorable force, a necessary and healthy aspect of clinical science, to examine practice, our science, and ourselves. Primary researchers and practitioners often have different perspectives and operate under somewhat different assumptions but these have been good for the field because we need each other! Division 29 has been on the cutting edge of the dialectic between research and practice. We have maintained a strong relationship with the Society of Psychotherapy Researchers (SPR). Many of us maintain joint memberships in these and other societies and believe that this research-practice marriage is a sound one for clinical science. This year my Presidential mentor Dr. Abe Wolf has put together a symposium for SPR in June **(see link on our webpage)** during which our APA President Dr. Carol Goodhart, and Division 12 (Clinical Psychology) President Dr. Marvin Goldfried, also a recipient of D29's Mentor Award, will be hosted by Dr. Louis Castonguay a recent Fellow of Division 29 and recipient of the Early Career Award, as well as this year's recipient himself of the mentor award. This symposium is a testament to the wonderful relationship that D29 has fostered with those from the research community and many of us who have our feet in both roles.

Our Division has been making progress

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in becoming more diverse under the able leadership of another wonderful Presidential mentor, our recent Past-President Dr. Nadine Kaslow. Her persistent vision and call to action resulted in a diversity training event for our leadership. I was moved by the experience and learned much about my "white privilege" which I have always taken for granted. We are becoming a diverse society and in order to maintain our relevance we need to embrace the anxiety and benefit of moving out of our comfort zones and engaging in a life-long fascination with those who are different than us. I am very proud of the work that many of our leaders have made toward greater diversity and am also pleased that our Diversity Domain Representatives Drs. Caryn Rodgers and Erica Lee have developed a strategic plan to guide us on our path to inclusiveness.

The structure of our Division has been solidified through the dedicated work of another Past President, Dr. Jean Carter, who worked diligently to create the domain representative structure that the division has incorporated. This has been an excellent and necessary precursor for creating a structure which will allow us to face the multiple demands of practice, training, and science. The Domain Representatives will be the main conduits for providing valuable and current information to all of us through our *Psychotherapy Bulletin*, which has been under the care of our Editor Dr. Jenny Cornish.

How would you like to re-envision our division as we move forward? I think we are evolving from a primarily membership based organization to an information based one (see re-envisioning the division PowerPoint at http://www.Divisionofpsychotherapy.org/). The world is changing because of technology and the new emphasis on informatics. There is no escaping this trend. We will either become adept at using this technology or risk losing our relevance. I urge our "digital immigrants" to begin learning about and taking full advantage of this technology. I have invited Dr. Steve Sobelman to offer a technology corner on our website so that those of us who need skills updates will have an easily accessible resource.

I have been privileged to travel the country and the world and present to groups of psychologist-psychotherapists. I have met many of members of Division 29, as well as many potential members. I have been inspired by the work that many of you are doing quietly, patiently, and with great skill providing needed psychotherapy to members of our society from every socioeconomic class. I am hoping that we can highlight those organizations, which we endorse as well as those individuals who are embedded in communities around the world and offering their services on a pro-bono basis. There are amazing individuals amongst us who work tirelessly for the benefit of others. Last year we were proud to select Dr. Barbara Van Dahlen Romberg for the Rosalee G. Weiss Award and Lecture for her important and outstanding work as founder and president of the Give an Hour Foundation (www.giveanhour.org). I would like to be able to feature organizations on our internet site that we endorse with easy to access links for those of us who are committed to pro-bono work and want to find worthy organizations to contribute our services. I have asked Dr. Rosemary Adam-Terem, head of the Public Policy and Social Justice Domain, to work on a mechanism where we can review organizations which we would like to endorse as good stewards for giving back to our communities. Please contact her with suggestions about worthy organizations or if you

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would like to suggest an individual we want to feature for his or her community service. I am also pleased that the Board voted to donate $500 to assist the relief in Haiti, in addition to receiving individual contributions from board members. If you would like to add to our donation please contact Dr. Adam-Terem.

My theoretical and research interests have culminated in the *Unified Psychotherapy Project (UPP)* http://www.unifiedpsychotherapy.org/, which is initiating a major effort to catalogue the techniques and methods of psychotherapy. We will be introducing the UPP and psychotherapedia at this summer's convention in San Diego. Under the stewardship of Dr. Jack Anchin we have an excellent convention program that our division will offer and of which we will all be proud. We had so many excellent submissions that we were truly awed by the quality and relevance of the work.

Our Division of Psychotherapy has many talented and devoted individuals who work tirelessly to make this our professional home. We have a capable and eager group of domain representatives, committee chairs, and committee members who conduct the work of the Division and deserve a special thank you from all of us.

And finally, I want to let you all know that Division 29 is financially sound under the leadership of Dr. Steve Sobelman, our treasurer, and our excellent finance committee under the guidance of Dr. Bonnie Markham.

We on the Board look forward to hearing from you and seeing you this summer in San Diego at our social hour to hear about your vision for the division and to meet you personally. Also, don't forget to alert your students about our Lunch with the Masters, sponsored by the Dr. Michael Constantino, our Early Career Domain Representative, and his able committee. Students who attend will be fed and will get to meet some of the luminaries in the field of psychotherapy. More to come in next month's *Bulletin* and on our Internet site.

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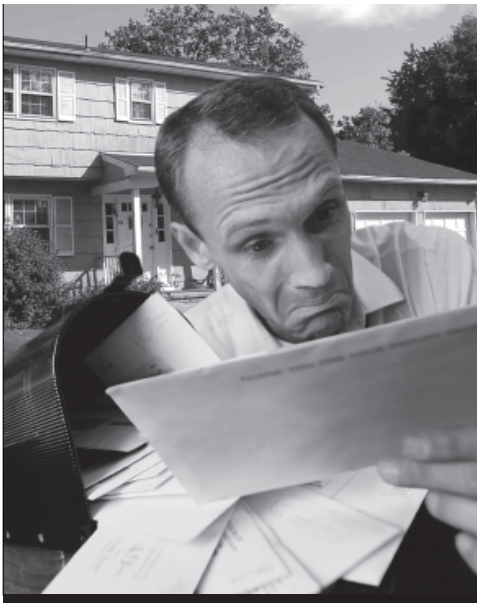

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RESEARCH

Mindfulness and Supervision: What Psychotherapists Need to Know

Daphne M. Davis, M.A.
The Pennsylvania State University

I began practicing meditation years before my formal training in mindfulness meditation during my Masters program at Naropa University. From my own journey with meditation, I can speak to the ways meditation continues to change my life, both personally and professionally. In my own practice of meditation, my hands, feet, and body have become my ears. In my work with both clients and supervisees, I use my internal landscape of visceral feelings and body sensations as an information-gathering tool about emotions they may be experiencing, dynamics in our relationship, and their relational styles. My mindfulness practice impacts both my focus on what is occurring in present moment with supervisees, and my encouragement of supervisees' exploration of the felt experience of their own style of relating to clients.

The literature on the multiple benefits of using mindfulness approaches with clients is vast, ranging from mindfulness-based stress reduction, mindfulness-based cognitive therapy, acceptance and commitment therapy, dialectical behavior therapy, and mindfulness-based relationship enhancement (see Baer, 2006 for review of treatment approaches). In addition to an explosion of research on mindfulness-based psychotherapies, the notion that psychotherapists should engage in mindfulness meditation for the purposes of self-care and self-efficacy is gaining popularity (Epstein, 1995; Germer, Siegel, & Fulton, 2005; Mikulus, 2002; Welwood, 2002). However, how does the research on mindfulness meditation relate to clinical supervision?

What is Mindfulness?

Mindfulness is both a process (i.e., mindfulness practice) and an outcome (i.e., awareness) (Shapiro & Carlson, 2009). For purposes of this paper, mindfulness is defined as the awareness developed through "intentionally attending in an open, accepting, and discerning way to whatever is arising in the present moment" (Shapiro & Carlson, 2009, p. 555). While several practices can foster mindfulness such as yoga, qigong, and tai chi (Siegel, 2007b), the bulk of theory and research investigates mindfulness cultivated from mindfulness meditation practice. Mindfulness meditation, also known as Vipassana or insight meditation, is a form of meditation practice that derives from Theravada Buddhism (Gunaratna, 2002). Mindfulness meditation involves the intentional practice of bringing one's attention moment to moment to one's thoughts, body sensations and the surrounding environment (Bodhi, 2000; Germer, 2005; Germer et al., 2005, Gunaratana, 2002; Wallace, 2001).

Supervisory Relationship

The supervisory working alliance model proposed by Bordin (1983) has been one of the most utilized conceptualizations of the supervisory relationship in research (Cooper & Ng, 2009). Bordin (1983) defines the supervisory working alliance as a collaborative relationship involving a mutual understanding and agreement on the goals and tasks of supervision and an emotional bond between supervisor and supervisee. It has been theorized that the supervisory

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working alliance has utility for a wide variety of supervision settings, including supervision in a university psychotherapy environment, due to the model's transtheoretical approach, compatibility with other models of supervision, usefulness in evaluation, and ability to enable and support multicultural competency in supervision (Wood, 2005).

Bordin (1983) theorized that the quality of the supervisory working alliance plays a crucial role in trainee outcome. It has been proposed that supervisors who focus on building the supervisory alliance in supervision help teach trainees how to build the therapeutic alliance with their clients (Gard & Lewis, 2008) and model helping relationships (Shulman, 2006). This notion is supported by research that found that psychotherapist trainees' perception of the supervisory working alliance was significantly correlated to their clients' perceptions of the psychotherapy working alliance (Patton & Kivlighan, 1997).

From his review of current brain research, Siegel (2007b) proposes that mindfulness meditation develops internal self-awareness and attunement, which in turn fosters empathy for oneself and others. Thus, as one's level of mindfulness increases, the ability to internally attune increases, as does the ability to empathize and self-regulate (Siegel, 2007b). Practically speaking, this translates to potentially more intimate relationships with self and others.

What does this proposition mean for the supervisory alliance? The implication is that if supervisors practice mindfulness meditation and/or encourage supervisees to engage in mindfulness practices, then stronger emotional bonds will form within supervisory relationships and within supervisees' therapeutic relationships.

Mindfulness meditation elicits more positive emotions, decreased anxiety and decreased negative emotions (Siegel, 2007b), and contributes to more effective emotion regulation in the brain (Corcoran, Farb, Anderson, & Segal, 2010; Farb et al., 2007; Siegel, 2007b). In addition, evidence supports that mindfulness meditation practice contributes to decreased reactivity (Cahn & Polich, 2009; Siegel, 2007a, 2007b), increased cognitive flexibility (Moore & Malinowski, 2009; Siegel, 2007a, 2007b), increased processing speed (Moore & Malinowski, 2009), decreased task effort (Lutz et al., 2009), increased ability to sustain attention, increased ability to suppress distractions (Lutz et al., 2009; Moore & Malinowski, 2009) or thoughts unrelated to the task at hand (Cahn & Polich, 2009; Lutz et al., 2009), decreased psychological distress (Coffey & Hartman, 2008; Ostafin et al., 2006), decreased psychological symptoms, (Carmody & Baer, 2008), decreased perceived stress, decreased rumination (Shapiro, Oman, Thoeresen, Plante, & Flinders, 2008), improved well-being (Carmody & Baer, 2008), and strengthened immune system functioning (see Lutz, Dunne, & Davidson, 2007 for a review of physical health benefits).

Theoretically, decreased reactivity, decreased anxiety, more effective emotion regulation and increased cognitive flexibility fostered by mindfulness meditation could enable both supervisors and trainees to effectively manage trainee anxiety and issues related to supervisor-supervisee transference and countertransference. Managing trainee anxiety and supervisor-supervisee transference and countertransference issues are known to be common components of clinical supervision (Borders & Brown, 2005) that can affect the supervisory relationship (Muse-Burke, Ladany & Deck, 2001).

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In addition, Lutz et al. (2009)'s research implies that psychotherapists who practice mindfulness meditation may have an increased ability to effectively manage distractions and be more present to their clients. Research suggests that these attentional skills should become effortless with meditation practice over time (Farb et al., 2007; Siegel, 2007a, 2007b). In practice, this implies that psychotherapists who practice mindfulness meditation may have an increased ability to be truly present to their supervisees and clients.

Theoretically, these attentional skills could not only benefit the supervisory alliance and the therapeutic relationship, but could also potentially impact supervisors' and trainees' present moment awareness of when parallel process occurs in supervision. Parallel process, when supervisees unconsciously mimic the relational processes between themselves and their clients in the supervisory relationship (Searles, 1955), is considered to be a common component of clinical supervision (Borders & Brown, 2005; Mothersole, 1999) that can affect the supervisory relationship (Muse-Burke, et al. 2001).

Integrating Mindfulness into Supervision

In considering integrating mindfulness approaches to clinical supervision, Dubin (1991) argues that while supervisees' ability to know what 'to do' with clients is essential, their ability to know how 'to be' with clients is equally important. Applying mindfulness approaches to supervision models may help supervisees learn what Dubin (1991) refers to as the "inner subtle qualities of relatedness," including facilitating the development of supervisees' ability to center themselves in the role of being a therapist, stay balanced, work through resistance, tolerate ambiguity, and effectively establish rapport with clients (p. 65). Currently Dubin's (1991) proposal of ways to integrate mindfulness into supervision is the only such mindful approach to date. Future research investigating mindfulness meditation's impact in clinical supervision is needed.

Psychotherapists Who Meditate

The old adage that people can only guide another in a practice as far as they themselves have ventured also applies to psychotherapists integrating mindfulness into supervision. Introducing mindfulness into supervision necessitates engaging in a mindful practice ourselves as psychotherapists. In addition, psychotherapists supervising trainees who implement mindfulness-based approaches with their clients should have some familiarity, if not personal experience, with mindfulness meditation.

Neurological research now explains how states experienced during mindfulness meditation ultimately become effortless traits of meditators over time (Farb et al., 2007; Siegel, 2007a). Neuroplasticity, the re-wiring in the brain that occurs due to experience, now demonstrates how regular mindfulness meditation practice literally changes both the functioning and the physical structure of the brain (Davidson et al., 2003; Lazar et al., 2005; Siegel, 2007a; Vestergaard-Poulsen et al., 2009).

Consistently studies have shown that psychotherapists who regularly practice mindfulness meditation over time report that their meditation practice increases their empathy and ability to be present in their clinical work (Aiken, 2006; Dreifuss, 1990; Fredenberg, 2002; Vinca, 2009; Wang, 2007). Psychotherapists also report increased levels of nonjudgmental acceptance, compassion (Wang, 2007), self-insight (Dreifuss, 1990), gratitude, patience, intentionality, sense of connectedness, and body awareness (Rothaupt & Morgan, 2007),

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and increased ability to support clients in putting words to feelings and body sensations (Aiken, 2006).

Research shows promising results for including mindfulness meditation interventions in psychotherapy training including trainees reporting being more comfortable with silence, feeling more attuned with oneself and clients, being more attentive to the therapy process (Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008), and feeling more self-compassion, experiencing decreased rumination, and reporting lower levels of perceived stress and trait anxiety (Shapiro, Brown, & Biegel, 2007). A recent pilot study using interpersonal mindfulness training with psychotherapist trainees suggested that such training positively affects emotional intelligence, perceived stress, anxiety, and social connectedness (Cohen & Miller, 2009).

These findings are consistent with research on mindfulness-based stress reduction (MBSR) interventions for health care students and professionals, which has shown that compared with a control group, MBSR decreases anxiety and depression symptoms, increases self-reports of empathy in health care students (Shapiro, Schwartz, & Bonner, 1998), decreases perceived stress and increases self-compassion and quality of life in health care professionals (Shapiro, Astin, Bishop, & Cordova, 2005), and decreases self-reports scores on total mood disturbance measures in medical students including fatigue, anxiety and stress (Rosenzweig, Reibel, Greeson, Brainard, & Hojat, 2003). MBSR has been linked to decreases in psychological symptoms and increases in quality of life in nursing students (Bruce, Young, Turner, Vander Wal, & Linden, 2002). Thus far, one study has examined the relationship between mindfulness and counseling self-efficacy. Greason & Cashwell (2009) found that mindfulness in masters-level interns and doctoral counseling students significantly predicted counseling self-efficacy.

Angus and Kagan (2007) have proposed that novice supervisees' openness to new learning, empathic self-attunement (Rogers, 1975), and awareness that is self-reflexive are qualities theorized to contribute to supervisees' personal agency (Bandura, 2006), effective learning, and successful supervisory relationships. Given that the above research suggests that mindfulness meditation cultivates increased attention, self-awareness, empathy, and attunement in trainees, it seems plausible that mindfulness meditation may enhance trainee's ability to successfully grow in and use supervision.

Client Outcomes

While research suggests that mindfulness interventions are beneficial to psychotherapists and trainees, do these benefits translate to client outcomes? In one study, clients of psychotherapist trainees who practiced Zen meditation in a group immediately before their sessions scored higher on standardized assessments of well being, had greater overall symptom reduction, greater rate of change, and perceived the results of their treatment to be better than clients whose psychotherapists did not meditate (Grepmair, et al., 2007; Grepmair, Mitterlehrner, Wolfhardt, & Nickel, 2006).

While these findings seem promising, three independent studies imply an unclear relationship between psychotherapists' mindfulness and client outcomes. To date, research has shown that psychotherapist trainees' trait mindfulness has been inversely correlated with client outcomes (Bruce, 2006; Stanley et al., 2006; Vinca & Hayes, 2007), or found not to predict client outcomes (Stratton,

2006). The data from these studies suggest problems with the validity of self-report measures of trait mindfulness; a long-standing issue which has been suggested in other research on mindfulness (see Grossman, 2008 for summary). It is important to emphasize, however, that these studies assessed trait mindfulness among presumably non-meditating psychotherapists. Thus, research on client outcomes of psychotherapists who meditate is inconclusive and needs further investigation.

Implications

So, should psychotherapists run out and join their local mindfulness meditation sitting group? Given the strong empirical support of the numerous benefits of mindfulness, I would answer that question with a "yes". As a meditator and as a psychotherapist, it has been thrilling to have research help explain the "intended outcomes" of mindfulness meditation. These are what Buddhism refers to as the four immeasurables: loving kindness, empathetic joy, compassion, and equanimity (Bein, 2008; Wallace, 2001).

Since mindfulness meditation may facilitate the development of skills that contribute to empirically supported relationship skills (Germer, 2005) and common factors of the therapeutic alliance (Fulton, 2005), psychotherapists who supervise trainees may benefit from practicing mindfulness meditation to further enhance their ability to model transferable relational skills to their supervisees (Lambert & Simon, 2005). Based on the research previously reviewed, I speculate that perhaps mindfulness meditation can enhance psychotherapists' empathy and quality of being present to their supervisees and increase their attentiveness in components of supervision, such as the supervisory relationship, managing supervisees' anxiety, transference-countertransference issues, and parallel process issues.

In addition, it has been recommended that supervisees would benefit from training in preparation for clinical supervision on the supervisory relationship (Berger & Buchholz, 1993), how to best use supervision (Pearson, 2004), and on behaviors that demonstrate effectively using supervision (Vespia, Heckman-Stone, & Delworth, 2002). I propose that mindfulness meditation may serve as an adjunct in training to help develop relational skills in trainees that could help their relationships with supervisors and clients.

Given that mindfulness has been proposed as a common factor in psychotherapy (Martin, 1997), and has been called a necessary component of psychotherapy training since it is a metacognitive skill (Fauth, Gates, Vinca, Boles & Hayes, 2007), mindfulness is a meaningful construct for clinical supervision and a construct that is not going away any time soon. Future research on the utility of mindfulness meditation practice in clinical supervision is needed.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

Supervision from a Psychotherapy Integration Perspective

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Introduction

An increasing number of therapists' perspectives have become more integrative (Norcross, Hedges, & Prochaska, 2002), yet without a unanimous definition of what integration exactly means, in particular related to training (Walder, 1993). This trend, although possibly more accentuated as the experience of therapists grows, begins early: In a poll (undertaken for this article) of 78 trainees in a convenience sample of participants in postgraduate CBT training in Switzerland and Germany, a majority reported that their supervisors also proposed non-CBT-*concepts, and* even more frequently that they proposed non-CBT *interventions*. When the *supervisees* brought in such concepts/interventions they felt strongly supported by their supervisors. The trainees reported furthermore that the inclusion of non-CBT elements was useful for the individual therapies, and they reported with overwhelming clarity that this inclusion increased their therapeutic expertise.

The ongoing development of psychotherapy impacts how supervision can and should be done; a current discussion of constraints and possibilities seems necessary, and we hope to contribute to such a discussion.

Manualized Treatments

The partially inverse trend of developing and using manualized treatments (Chambless & Hollon, 1998) has received much attention and discussion (e.g. Elliott, 1998). This approach demands, as a guarantee for the quality of delivered therapies, that the characteristics of patients in treatment correspond sufficiently to those selected in the randomized trials, and that the procedures be sufficiently similar to the procedures in the studies. The supervisor's role from this perspective is to monitor the therapist's adherence to the manual and to ensure that patients sufficiently match those in the studies. If one acknowledges that empirical evidence cannot be applied directly and that evidence based medicine (or psychotherapy) is the integration by a clinician of the best available evidence with information on the individual case (Sackett et al., 1996), then understanding and guiding such integration becomes a crucial part of supervision.

If one further assumes that empirically supported treatments can be applied directly to only a relatively small percentage of real-world patients (Beutler et al., 2004) and that every patient requires a unique combination of concepts and interventions to best fit and treat the case, things become more complex—and possibly more integrative. This has implications for the supervisor's tasks: S/he also needs to supervise the selection and use of these concepts and interventions. Castonguay (2000) recommends that a deliberate decision be made as to whether a supervisee wishes to stay within a single therapeutic approach, or to take an integrative perspective. If supervisee and supervisor decide on an integrative stance, concepts and interventions may be chosen from a wide menu.

Increasing the chance of fit with the patient and the supervisee

Widening the perspective and the toolbox, and breaking free from the limitations of one single approach is supposed

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to increase the a priori chance of finding the optimal view and procedure in the sense of maximal desired main and positive side effects, accompanied by minimal negative side effects. All possible procedures have negative side effects, sometimes relatively harmless, but often more severe. The more flexibility, the higher the chance to succeed with an optimal main/side effects balance - unless the therapist fails in mastering the complexity. The supervisor's task depends on the therapist: It may be to convey concepts a less knowledgeable therapist is unfamiliar with, or it may be to help a therapist overwhelmed by the range of possibilities to sort out, decide, and manage complexity in order to maintain the capacity to act.

To open up in an integrative sense also increases the a priori chance of finding procedures that optimally fit the *therapist*. A good supervisor helps a therapist take the issue of fit between therapist and procedure seriously, and then to deliberate. This is not a trivial task, as it may be difficult to decide whether the view and procedure a therapist decides on is completely appropriate and in the interest of a patient, or whether the therapist imposes his or her own preferences on a patient at the disadvantage of the latter. An example is the discrepancy between the proven efficacy of exposure with anxiety patients and the (low) frequency with which therapists actually engage in such procedures outside a research context. This discrepancy may be due to practical obstacles or personal anxieties of the therapists. Here the decision as to whether and how a therapist could and should enlarge his or her range of possibilities even touches issues of personal therapy and illustrates how far the responsibility of a supervisor may go, at least in some supervision cases.

In any case, the supervisor should also reflect with the therapist on the extent to which the use of an integrative stance is actually advantageous in comparison with a pure approach (Walder (1993). In spite of a general preference for flexibility expressed here, it is important that before integrative approach is chosen, it must be better for each patient and situation.

Opening up in the process of developing professional abilities

There are several phase models for the professional development of therapists. A non-clinical model of high relevance from an integration perspective, stems from Dreyfus and Dreyfus (1986). These authors assume that in an initial phase, professionals stick to clear, simple whenthen rules, and to relatively simple models. This simplicity is considered to be appropriate for their beginning level of development, but the results are at the same time considered to be suboptimal. This very experience with individual tasks/cases is seen as the driving force behind a process of enlarging perspectives as well as concrete procedures. According to this model, the subjective confidence first *decreases* instead of increasing as the therapist gains experience. This is due to the awareness that multiple perspectives are possible, and that the responsibility of the therapist is not only to use rules properly, but also to decide on the right perspective or combination of concepts.

Only when arriving in the later stages of professional experience do psychotherapists develop an ease and efficiency in the form of a good combination of rationally and intuitively knowing what is right, a process which is expected to take about 10 years (Ericsson, Krampe & Tesch-Römer, 1993).

Psychotherapy integration provides models and interventions in the process of opening up. The task of the supervisor is manifold: To help the therapist acknowledge trainee development, to encourage and guide the search for

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appropriate concepts and procedures, to give support in tolerating ambiguity and complexity, to give feedback and guidance with case formulations, to help with procedures the therapist had not originally learned, including role playing with the therapist to teach a technique, to stabilize the therapist when s/he becomes temporarily desperate, but also to challenge when a supervisee avoids relevant interventions due to personal anxieties.

Halgin (1985) has formulated this beautifully: "Supervisors play a critical role in escorting beginners through their experiences of artificial security, subsequent confusion, and onward to a process of integration. The supervisor who pushes a beginner into an inappropriate affiliation with a singular model is really colluding with the beginner's simplistic notion that there might indeed be only one correct way of doing therapy. Such a supervisor is not likely to be sensitive to the struggles of the beginner who is trying to make sense of an overwhelming number of theories and techniques. This beginning period in an individual's professional development provides an excellent opportunity for communicating the importance of developing integrated methodologies, for it is during this period that the individual is most malleable" (p. 560).

The role of concepts and theory

What is the role of theory in such a process? There are several levels on which psychotherapy integration can take place (Goldfried, 1980). The lowest, technical level does not require theories: They may even appear as obstacles. The highest level is that of theoretical integration. Wolfe (2000) states about the Society for the Exploration of Psychotherapy Integration: "In fact, only a minority of SEPI members believes it is even possible to develop an integrative psychotherapy theory. Even if it were possible, such a theory would not be a great idea, some argue, because it would have a chilling effect on therapeutic creativity" (p. 234). Most colleagues would, while acknowledging the importance of guidance coming from theoretical concepts, agree that none of the existing theories satisfies all needs and preferences (Walder, 1993).

The intermediate level of principles may be based on evidence for the efficacy of these principles (Castonguay & Beutler, 2005). Castonguay (2000) proposes a common factors perspective and states that "any attempt to train therapists from a common factors perspective will force one to decide which common factors should be the focus of training and what level or dimensions of the therapeutic intervention should be emphasized.... For instance, knowing that a therapeutic alliance is an important catalyst of change across different forms of therapy is not particularly illuminating when one is trying to create the most suitable intervention for a client's needs (How helpful would it be for a trainee if his/her supervisor would simply tell him/her: ''Well, now go and create a good alliance?!'')" (p. 264). He continues by emphasizing the importance of a good case conceptualization.

It can be assumed that most integrative efforts made by practicing therapists take place at the intermediate level. As far as the role of concepts and theory is concerned, the role of a supervisor would then be to insist that case formulations be not purely inductive, based on common sense, but to suggest that theories can be helpful, and can and should be used and made explicit. Their role would further be to lead the supervisee's attention to concepts considered useful. For this task, Peake, Nussbaum, and Tindell (2002) emphasize the importance of not forcing supervisees into procedures or theoretical concepts not suitable for them. In addition, the super-

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visor would need to monitor the extent to which the therapist is overly theory driven vs. inductive/pragmatic.

The supervisor's role of temporarily complementing the therapist

A model we use to think about the construction of therapeutic action in the individual situation may help to illustrate an additional aspect already implicit in the points made above: The role of temporarily assuming tasks the therapist is not able to do. It is a "multiple constraint satisfaction" model which depicts what experienced therapists do anyway, and which can serve as a prescriptive model also for novices:

Fig. 1: Multiple constraint satisfaction model for therapist action

The point in this model (which is not explained in detail here; see Caspar 1995; 2007) is that, unless one abstracts and overemphasizes, for example, the diagnosis, or the technique, all these aspects (and possibly more) are explicitly or implicitly taken into account and have an impact not only on what a concrete intervention or procedure looks like, but also whether or not it is successful. There are always many alternative ways, points in time, and other circumstances in which a therapist can formulate, behave nonverbally, and proceed technically. For some easier patients, the range of possible and effective interventions may be large, and it may be less crucial which alternatives are chosen. For many other patients, whether they begin a therapy, stay in therapy, and eventually change or not, depends on crucial details. Not all aspects are of equal importance all the time. Some patients demand little of the therapeutic relationship, for some patients systemic aspects are relatively unimportant, and some correspond precisely to those for whom a specific procedure has been developed, manualized, and evaluated. But we need to reflect on whether an aspect is relevant or not. This may look complicated, but as stated above, we believe that experienced therapists construct their behavior in such a way anyway. They do it efficiently because these checks and the multiply determined construction of a resulting therapist behavior run largely in an effortless and at least partially automated way.

Where does this leave the novice? Colleagues have often suspected that beginners must be overwhelmed by the demands assumed in an integrated model. They say that one needs to master one approach first before engaging in integration (Stricker, 1988; Walder, 1993). This seems plausible. Our experience over many years of training is nevertheless positive: We are convinced that it is better to offer a realistic integrative model from the outset instead of simplifying.

What about too great a complexity and information overload? It is a supervisory task to monitor whether the therapist, at times at the edge of his or her capacities, neglects one aspect or another, and to take responsibility and fill in an unostentatious way where necessary. It may also be useful to take different perspectives sequentially. With this kind of training, for instance with an emphasis on CBT, but integrative from the outset, novices bring about effect sizes even with difficult patients, which are very close to the ones of (effective!) experienced therapists at our outpatient clinic.

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We believe that Assimilative Integration (Messer, 1992; Castonguay, 2000) is a valuable alternative, according to which a therapist learns one approach first and later integrates, step by step. The use of a model which is integrative from the outset is nevertheless feasible. In addition, it has the advantage of not binding the therapist to a necessarily limited model for too long. But it can only work if a good supervisor spares the therapist overload. This is not to favor what Grawe once called an "integrative super therapist," who knows and can do *everything*, but *nothing right*. A concentration on some views and interventions may be necessary, but not sufficient.

A supervisor following an analogous multiple constraint satisfaction model tries to do justice to the possibilities and limitations of each supervisee. This corresponds nicely with the postulates of Norcross (1988; Stricker, 1988) of adapting to the supervised therapists.

The importance of quality control

The idea of guaranteeing the quality of psychotherapy services by referring to an empirically supported procedure is popular. We have argued that sticking too narrowly to a manualized procedure may in many cases, if not most, be suboptimal for patients. When a supervisor cannot refer to such procedures and monitor adherence, how can s/he be sure that the therapy resulting from a procedure with more degrees of freedom is actually favorable? Although an experienced clinical evaluation of process and outcome has its value, the less we can refer to 1:1 application of ESTs, the more we need an independent monitoring of progress and outcome. It is not the aim of this article to elaborate this notion in detail, but it would be incomplete without at least mentioning the importance of a qualified monitoring system including feedback to the therapist (Lambert et al., 2005).

The supervisor's needs and weaknesses

Emphasizing some aspects/approaches and neglecting others may have to do with the supervisor's needs: A supervisor may emphasize techniques, as s/he feels most comfortable with this clear, simple part of psychotherapy, and this reduces his/her own anxieties (Halgin, 1985). Doing so, s/he will limit the supervisee. If more narcissistic, a supervisor may show off with the large range of concepts s/he knows, thus confusing a supervisee in a stage where s/he would have needed more simple advice or support. Or s/he may recommend exaggerated confrontation in order to impress a trainee with a heroic flair. A supervisor who tends to be overzealous for new concepts s/he has just learned or encountered may not sufficiently reflect what would help a supervisee most. The two latter examples may be facilitated in a negative sense by an integrative stance whereas strict adherence to one model would limit such a being determined by supervisor rather than supervisee needs.

Overall, the supervision of therapists engaged in a process of psychotherapy integration includes some special demands. This article has endeavored to identify some of them, and to draw attention to the need of being aware of them while engaging in integrative supervision.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

ETHICS IN PSYCHOTHERAPY

Psychotherapy with LGBTQ Clients: Essentials for Ethical Practice

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Psychotherapists provide clinical services to a wide range of clients. In addition to being competent in utilizing specific psychotherapy techniques and treatment modalities to assist clients with a variety of presenting problems and diagnoses, it is essential that psychotherapists be competent to work with and assist clients with a wide range of individual differences (Barnett, Doll, Younggren, & Rubin, 2007). In their cube model of competence, Rodolfa, Bent, Eisman, Nelson, Rehm, and Ritchie (2005) include *individual-cultural diversity* as part of "The foundational competency domains, the building blocks of what psychologists do…" (p. 350). They further describe *individual-cultural diversity* as "Awareness and sensitivity in working professionally with diverse individuals, groups, and communities who represent various cultural and personal backgrounds and characteristics" (p. 351). The integration of attention to individual backgrounds and characteristics into all aspects of competent professional services by psychologists is also consistent with the Institute of Medicine's definition of evidence-based practice, which includes "the integration of best research evidence with clinical expertise and patient values" (Sackert, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 147).

Sensitivity to, and competently addressing and integrating diversity factors into every psychologist's clinical work is essential to effective clinical practice. In fact, Barnett (2009) states that "the complete practitioner … values diversity in all of its forms and actively attends to it in all aspects of professional work" (p. 797). This view is consistent with the guidance provided to psychologists in the Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code; APA, 2002) which states in Principle E: Respect for People's Rights and Dignity:

> Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (p. 1063)

This focus on diversity should occur with every psychotherapy client regardless of their appearance or how they present clinically. Additionally, psychologists need to focus on the multiple identities and aspects of diversity pos-

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sessed by every individual. As Comas-Diaz and Caldwell-Colbert (2006) stated:

> Cultural competence can be applied to ALL individuals, because human interaction is anchored in a cultural context. Indeed, everyone has a culture and is part of several subcultures, including those related to age, ethnicity, gender, sexual orientation, race, socioeconomic class, religion/spirituality, national origin, socioeconomic status, language preference, ideology, geographic region, neighborhood, physical ability/disability, and others. (p. 1)

Standards in the APA Ethics Code specifically relevant to work with diverse clients include:

- **Competence:** only providing services with populations with whom we possess the needed competence.
- **Bases for Scientific and Professional Judgments:** Basing assessment, diagnosis, and treatment decisions on "established scientific and professional knowledge" (p. 1064)
- **Unfair Discrimination:** Not engaging in unfair discrimination based on any aspects of diversity or individual differences.
- **Other Harassment:** Not engaging in harassing or demeaning behavior toward clients based on any aspects of diversity or individual differences
- **Avoiding Harm:** Actively taking steps to avoid harm to clients and to minimize it "where it is foreseeable and unavoidable" (p. 1065).
- **Conflict of Interest:** Not engaging in professional relationships where personal or other factors could impair the psychologist's "objectivity, competence, or effectiveness" or that could lead to "harm or exploitation" of the client (p. 1065).

Guidance on Ethical Psychotherapy with LGBTQ Clients

As is clearly highlighted above, in addition to, and in combination with, other aspects of diversity, the gender identity and sexual orientation and identity of all clients should be considered by psychotherapists. Failure to do so can result in harm to clients, can be perceived by them as demeaning, and could violate their right to self-determination. It is clear from the guidance above that sexual orientation and identity and gender identity are essential aspects of the broader context of diversity that is an important ethical focus for psychotherapists. Accordingly, possessing the competencies to ethically and appropriately assess and treat Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) clients is essential for ethical practice.

In addition to being knowledgeable of the relevant literature, psychotherapists should be familiar with the details of APA's "Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients" (LBG Guidelines; APA, 2000), the Resolution on the Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998), and the Report of the APA Task Force on the Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009). Additional relevant guidance can be found in several additional APA guidelines to include "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2002), "Guidelines for Psychological Practice with Girls and Women" (APA, 2007), and "Guidelines for Psychological Practice With Older Adults" (APA, 2004). Each is an important resource for providing ethical and effective clinical services to LGBTQ clients and each merits a detailed examination by all psychotherapists. They are readily accessible online at http://www.apa.org/practice/prof.html.

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LGBTQ clients are a very diverse group of individuals. Knowledge of how homosexuality is viewed in different cultural groups is essential for understanding each client's clinical needs. Each aspect of their diversity should be addressed and it is important not to assume that sexual orientation or identity is the client's presenting problems (Greene, 2007). While experience in providing psychotherapy to LGBTQ clients is important, it clearly is not sufficient. For example, competence in work with gay men does not equate with competence with lesbian women. Formal education and training should include attention to issues such as common stressors for LGBTQ individuals, appropriate treatment strategies and techniques, and a comprehensive knowledge of the relevant professional literature.

The Relevance of the LGB Guidelines for Psychotherapists

APA's LBG Guidelines (APA, 2000) comprise 16 specific guidelines that taken together, provide a coherent framework to guide the provision of clinical services to LGBTQ clients. While each of these guidelines could be discussed in detail in its own article, they are briefly summarized here in the hope that psychotherapists will increase their awareness of these guidelines. It is further hoped that this brief review will encourage psychotherapists to read the actual guidelines, to pursue increased competence in clinical work with LGBTQ clients by reading the relevant literature and through obtaining advanced training and supervised clinical experience, and to promote increased self-reflection and self-awareness regarding the issues raised.

Attitudes Toward Homosexuality and Bisexuality

- Guideline 1. Awareness that homosexuality and bisexuality do not imply mental illness.
- Guideline 2. Awareness of how our attitudes and knowledge about LGB issues impact assessment, treatment, consultation, and referral issues.
- Guideline 3. Awareness of how social stigmatization poses risks to the mental health and well-being of LGB clients.
- Guideline 4. Awareness of how inaccurate or prejudicial views may impact the LGB client's presentation and the treatment process.

Relationships and Families

- Guideline 5. Being knowledgeable about and respecting the importance of LGB relationships.
- Guideline 6. Understanding challenges faced by LGB parents.
- Guideline 7. Understanding the nature and composition of LGB families.
- Guideline 8. Awareness of how LGB clients' sexual orientation may impact their family of origin and the relationship to it.

Issues of Diversity

- Guideline 9. Awareness of the multiple and often conflicting norms, values, and beliefs LGB minorities may face.
- Guideline 10. Awareness of the particular challenges bisexual individuals may face.
- Guideline 11. Awareness of the special problems and risks that exist for LGB youth.
- Guideline 12. Awareness of generational differences and challenges faced by LGB older adults.
- Guideline 13. Awareness of challenges faced by LGB individuals with physical, sensory, and cognitive-emotional disabilities.

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Education

- Guideline 14. Promoting professional education and training on LGB issues.
- Guideline 15. Increasing our knowledge and understanding of LGB issues through lifelong learning activities.
- Guideline 16. Being familiar with relevant LGB mental health, educational, and community resources.

What's in a Name?

Psychotherapists working with LGBTQ clients should be cognizant of the impact they will have on clients. Making derogatory statements when discussing an individual's beliefs or behaviors, using dismissive terms, or even referring to a client as "transsexual" when they identify as "transgender" are likely to indicate to clients the absence of an accepting environment in which they can work on the issues that led them to seek treatment. Rather, it is recommended that psychotherapists work to provide what colleagues such as Eubanks-Carter, Burckell, and Goldfried (2005) describe as gay-affirmative psychotherapy. These authors further share that psychotherapists with an understanding of the gay experience, who can share their experiences of working with LGBTQ clients, who do not pathologize homosexuality or try to modify a client's beliefs, values, or lifestyle but who support and assist clients in their exploration of these issues are described as most effective. Each psychotherapist must develop and maintain the needed competencies to provide ethical and effective psychotherapy services to LGBTQ clients. Further, with regard to names used and how homosexuality or the gay lifestyle is addressed in treatment, psychotherapists must be careful not to "reinforce social devaluation of homosexuality and bisexuality" (Haldeman, 2002, p. 260). An additional important step in this regard is for each psychotherapist to be aware of negative biases, stereotypes, and homophobic views they may possess (Pachankis & Goldfried, 2004).

Acceptance and Assistance

At times psychotherapists will receive requests to modify a client's sexual orientation. Often, these requests will come from parents with regard to their adolescent children. Many of these requests are motivated by strongly held religious beliefs that are inconsistent with homosexuality. When addressing such a request it may seem appropriate to be respectful of others' beliefs and values (c.f. the APA Resolution on Religion-Based and Religion-Derived Prejudice, 2008), and the request to modify the client's sexual orientation may be presented as something that will be beneficial for him or her. But, competent psychotherapists will act in accordance with the most current scientific information which clearly indicates that no scientific data exist that support efforts to alter an individual's sexual orientation or that such attempts would ever be successful (APA, 1998; 2009). Despite the presence of an extensive body of literature that makes this clear, there are still those who support 'conversion therapy' and who will ask psychotherapists to provide this 'treatment' (Haldeman, 2002).

One way psychotherapists can assist families with strong religious beliefs who make such requests (in addition to educating them while attempting to respect their beliefs and values) is to refer them to support groups and programs that are gay-affirmative, yet speak to their religious background. Numerous such resources exist that can easily be found on the Internet. Examples include The Gay Christian Network, and God and Gays.org, which provide information, resources, and support for Christian gays and their families. Parents of LGBTQ clients who are struggling with

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reconciling their religious beliefs with their child's sexual orientation may find support and assistance in these groups. Other support groups available in many communities, that don't have a religious focus, include Parents, Families, and Friends of Lesbians and Gays (PFLAG) which also promotes acceptance and support, provides education, and advocates for respect, dignity, and equality. For adolescents, referral to a local chapter of the Gay Straight Alliance can provide the young person with needed support, understanding, and acceptance. It is a student-run club in a high school or middle school that "brings together LGB and straight students to support each other, provide a safe place to socialize, and create a platform for activism to fight homophobia and transphobia" (GSA Network, para 1), something so vital during an important period of development for LGBTQ teens.

Clarifying Obligations

It is hoped that through a comprehensive informed consent process psychotherapists will share all needed information with clients (and family members as is appropriate) so that they can make the most informed decisions possible about participating in treatment. This is especially important when working with adolescents who may be brought to treatment by parents (at times occurring when young people are exploring, experimenting with, or questioning their sexual orientation). Psychotherapists must be cautious about working as agents for parents' objectives or agendas. It is essential that all obligations, responsibilities, and agreements be discussed prior to treatment being provided. In these situations, where different agendas and expectations may exist, it is important to clarify our obligations to each party. As Fisher (2009) highlights, in such situations we may have multiple 'clients' and need to clarify what our obligations are to each individual. Since these obligations may not all be mutually consistent, endeavoring to act in the LGBTQ client's best interests is paramount, regardless of who is paying for or initiating treatment. These may be challenging situations, but ethical and competent psychotherapists will endeavor to resolve these issues up front and not provide treatment that is contradictory with the minor client's best interests.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

Author Notes:
Madeline Barnett is a student in the Honors Humanities program at the University of Maryland College Park where she is pursuing a double major in Government and Politics as well as in LBGTQ Studies.

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- Please include a title page as part of a separate attached MS-Word or PDF document so that the papers can be judged "blind." This page can include authors' names and academic affiliations.
- Also include a cover letter as part of a separate attached MS-Word or PDF document. The cover letter should state that the paper is based on work that the first author conducted while in graduate school. It should also include your mailing address, telephone number, and e-mail address.

E-mail your paper and address your questions to:

Sheena Demery, M.A.
Chair, Student Development Committee, Division of Psychotherapy
E-mail: Sheena.Demery@fedexkinkos.com

Deadline is April 30, 2010

EDUCATION AND TRAINING

Trends in Psychotherapy Research and Education

Michael J. Murphy, Ph.D.
Department of Psychology, Indiana State University

The new decade offers a good opportunity to examine the major trends in psychotherapy research and education that have emerged in the past ten years and to reflect on how they will continue to affect training in professional psychotherapy in the future. The major trend in psychotherapy research has been the focus on evidence-based practice. Competency-based training has been a leading development in professional education. Explication of these trends deserves greater consideration than can be given here so the goal is to briefly highlight each trend as they affect education and training in psychotherapy.

Psychotherapy Research

The publication of the Division12 Task Force report, *Training and Dissemination of Empirically Valid Treatment: Report and Recommendations* (1995), introduced a passionate and contentious discussion that was a defining element of 1990's psychotherapy literature. In the course of the debate, concepts shifted from validated treatments to empirically supported treatments and Division 29 widened the discourse when it published the report of its task force on empirically supported relationships (Norcross, 2001). Close to that time the literature began to shift to evidence-based practice that offered an approach to integrating research findings into psychological practice in general and psychotherapy in particular.

The publication of the report of the APA Presidential Task Force on Evidence-Based Practice (2006) articulated a position that practice should be based on the best available research evidence, clinical expertise, patient characteristics, culture, and preferences. The balanced and inclusive approach offered by evidence-based practice has been well received. However, issues have been raised about the report's underlying epistemological assumptions (Wendt & Slife, 2007); the need to emphasize the role of clinical expertise (Hunsberger, 2007); and its failure to operationalize evidence, address iatrogenic treatments, and highlight the use of objective criteria for the ongoing evaluations of all cases (Stuart & Lilienfeld, 2007).

Given the range and conflicting perspectives that the authors cited above in regard to the Task Force's report, it appears that the Task Force on Evidence-Based Practice achieved a reasonably balanced position between proponents of methodological rigor, clinical experience and knowledge, and alternative epistemological approaches. Overall the last decade ended with a reasonable direction for pursuing research-informed practice that provides a mechanism for including the findings and perspectives of those who adopt different stands as to what constitutes acceptable evidence and how to accommodate individual patient characteristics and cultural backgrounds. This allows for a range of methods to inform research on the complex factors that are integral to psychotherapy and fosters an approach that integrates different perspectives.

Last year the Summit on the Future of Practice called for the development of

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treatment guideline as one of its recommendations. In following-up on the Summit, APA President Carol Goodhart announced in her column in the February *Monitor* that the APA will pursue development of treatment guidelines. President Goodheart stated that development of treatment guidelines is necessary because other groups will move into the vacuum created by APA inaction. Her announcement was in anticipation the APA Council of Representatives approval of a proposed treatment guidelines initiative at its February meeting. The decision to develop guidelines is a significant change in APA policy related to treatment guidelines that has been circumscribed to providing guidance to members for the review of guidelines developed by other groups. The development of guidelines represents a major undertaking and development of guidelines will likely be a major focus of psychotherapy education, research, and practice in the coming years.

Competency-Based Training

Competency-based training has been a central focus of education and training in professional psychology. The developments in this area have significantly advanced in the past decade and will undoubtedly continue to be a significant foundation for professional education and training in psychology (see Rubin et al., 2007 and Leigh et al., , et al., 2007). The Competency Conference: Future Directions in Education and Credentialing in Professional Psychology, held in 2002, brought together representatives of all major stakeholder groups in the education and training community. The Conference focused upon the identification of competencies for professional practice of psychology and the implications training and the evaluation of outcomes at all levels of training.

A Cube Model for Competency Development (Rodolfa, Bent et al., 2005) was developed at the Conference. The model identifies a foundational competency domain and functional competency domain, and identifies stages of professional development that are characterized by different levels of attainment. Foundational competency domains are "the building block of what psychologists do" and include reflective-practice-self assessment, scientific knowledge-methods, relationships, ethical-legal standards-policies, individual-cultural diversity, and fundamental systems. Foundational competencies form the basis for development of functional competencies that are the primary focus of professional training. Functional competencies include assessment-diagnosis-case conceptualization, intervention, consultation, research-evaluation, supervision–teaching, and management-administration. The Cube Model articulates stages of professional development (graduate education, internship, post-doctoral training-residency, and continuing competency).

The Cube Model has provided the armature on which workgroups have articulated benchmarks (Fouad, Grus et al., (2009) for competencies across the levels of training and a "toolkit" (Kaslow, Grus et al., 2009) designed to offer resources for best practices for assessment of student and practitioner competence. The Cube Model, benchmarks, and toolkit have been well received by training communities because of the flexibility of the system that accommodates diverse theoretical orientations and applications.

The competency-based model of training and professional evaluation is a robust movement that provides the conceptual and procedural tools that can be applied across models of training, specialties, and diverse orientations. It provides the foundation for the development of systems of assessment across a

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variety of approaches to training and will be a significant force in training in the future.

Directions for the New Decade

Evidence-based practice, competency-based training, and the development of treatment guidelines are trends that will have significant impact on training over the next ten years. These trends reflect processes that foster integration of differing conceptual, methodological, and technical approaches as a means of articulating best practices in treatment and training. The approach to best practices does not pursue resolutions of conflict among groups employing different methods or standards for evidence or practice but seeks to balance perspectives in order to give guidance to practitioners and educators as they seek to provide the best care and training. When you thing about it, the process is a lot like psychotherapy.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

CHARLES J. GELSO, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Brief Statement about the Grant

The annual Charles J. Gelso, Ph.D., Psychotherapy Research Grant provides $2,000 toward the advancement of research on psychotherapy process or psychotherapy outcome.

Eligibility: In alternating years, graduate students/predoctoral interns or doctoral level psychologists/postdoctoral fellows will be eligible for the Charles J. Gelso Grant. In 2010, graduate students in psychology and predoctoral interns who are in good standing at an accredited university will be eligible. In 2011, doctoral level psychologists, including postdoctoral fellows, will be eligible. The grant will rotate biannually between graduate students/predoctoral interns and doctoral level psychologists/postdoctoral fellows, such that nominations will be accepted in even number years for the former group and odd number years for the latter group.

Deadline: March 15, 2010

Request for Proposals

Description

This program awards grants for research projects in the area of psychotherapy process and/or outcome. In alternating years the grant is awarded to graduate students or doctoral level psychologists.

Program Goals

- Advance understanding of psychotherapy process and psychotherapy outcome through support of empirical research in these areas
- Encourage talented graduate students towards careers in psychotherapy research
- Support psychologists engaged in psychotherapy research

Funding Specifics: One annual grant of $2,000

Eligibility Requirements

- In alternating years, graduate students/pre-doctoral interns (even-numbered years) or psychologists/postdoctoral fellows (odd-numbered years) will be eligible
- In 2010, graduate students in psychology and pre-doctoral interns who are in good standing at an accredited university will be eligible
- In 2011, doctoral level psychologists and postdoctoral fellows will be eligible
- Demonstrated or burgeoning competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The same project/lab may not receive funding two years in a row

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals

- Description of the proposed project to include goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans
- CV of the principal investigator
- Format: not to exceed 3 pages (1 inch margins, no smaller than 11-point font)
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted). The budget should clearly indicate how the grant funds would be spent.
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows
- Graduate students, predoctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.

Additional Proposal Requirements for Graduate Students, Predoctoral Interns, and Postdoctoral Fellows:

- Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work
- Graduate students and pre-doctoral interns must also submit 2 letters of recommendation, one from the mentor who will be providing guidance during the completion of the project and this letter must indicate the nature of the mentoring relationship
- Postdoctoral fellows must submit 1 letter of recommendation from the mentor who will be providing guidance during the completion of the project and this letter should indicate the nature of the mentoring relationship

Additional Information

- After the project is complete, a report on how the money was spent must be submitted
- Grant funds that are not spent on the project within two years must be returned
- When the resulting research is published, the grant should be acknowledged

Submission Process and Deadline

Submit a CV and all required materials for proposal (see above for proposal requirements) to: Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net

If the grant is to be used to support a thesis or dissertation, the thesis/dissertation proposal must be approved by the thesis/dissertation committee (this should be noted in the letter of recommendation from the mentor)

Deadline: March 15, 2010

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Susan Woodhouse at ssw10@psu.edu), or the Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Norman Abeles at abeles@msu.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net

DIVERSITY

Cultural Diversity in Psychotherapy

Keith Wood, Ph.D.
Emory University School of Medicine, Atlanta, Georgia

I was asked to write a reflective article on cultural diversity in psychotherapy. I suppose the request came because I am classified as an African American male clinical psychologist who has been "treating" individuals from a variety of environmental backgrounds and racial make-ups for over thirty years. My assumed "expertise" (a presumptuous descriptor for me in this area) warranting my written words on this topic is clearly more experiential than scientific. I believe it is more about the phenomenological trait factors of what I look like, what the people I see look like, and my continued use of some form of office-based, one-on-one therapeutic interactions than a true study of cultural diversity and psychotherapy. With this as my foundation, which is the foundation of most of us in venturing into this area, I begin my reflections.

For me the psychotherapeutic process begins with establishing a relationship through which "the talking work" can be done. In spite of my efforts to minimize me from the beginning and throughout the course of the therapeutic relationship, I have had to realize I am a central figure. In most cases the therapeutic relationship would not exist without me! So I have to recognize who I am and who I am perceived to be from the very beginning. Usually I don't start off thinking that I am African American, male or a psychologist with gray hair, even though I recognize those may be the primary perceived factors by many I see (or better stated, who see me). Instead, I begin noting differences and similarities I have with the other person such as physical characteristics, historical family and life experiences, current living, learning and social environments, language and communication styles, abilities, interests, thoughts, perceptions, beliefs, moods, and so on. At the same time, I also realize that the other person is, at some level, doing the same different and similarity assessments with me. During this early phase, I am trying to hear and understand the other person through my lenses and communicate that I do hear and understand what he or she is verbally and nonverbally saying. Understanding what is being said and communicating that understanding to the other person is essential in building needed trust in relationships. I realize I best understand individuals with whom I have many similarities (there is a reason we therapists tend to be most effective with individuals with whom we most share in-common characteristics. There is a reason the best candidates for therapy tend to be people who are most like the therapists). Additionally, I realize I and the therapeutic relationship could be significantly disadvantaged with major dissimilarities and differences between who is delivering and receiving therapy.

Realizing the importance of the match between my personal appearance, experiences, world-view, social/interactive network, language and mannerisms, learning and exposure… way of life, and that of the other person in the relationship, is daunting. I'd prefer not thinking a great deal about it. The thought that my effectiveness in developing and utilizing a therapeutic relationship is impacted by things like my hair and furniture style, my clothing and office

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accessories, my religious and political beliefs, and my eye and social contacts, is almost paralyzing. There are limitations to this matching process: I can't lighten my skin and straighten my hair for a 9:00 am appointment and don my dashiki and bump knuckles at 10. Fortunately, we can't be exact matches (it is through the differences we grow and expand), but in our attempt at a synchronized therapeutic swim we need to be minimally in the same pool and preferably using the same strokes. I, as a therapist working with a diverse population presenting with a variety of issues, needed to do my part in bridging the diversity gap. Getting to the place where we can see, experience and build on our similarities and "appreciate and celebrate" our differences requires special effort and direction by the therapist.

The process of bridging the diversity gap begins with a personal look in the mirror. My focus on the uniqueness of the other person in the therapeutic room (usually an office) requires that I bring to my awareness my unique characteristics as well. While the two of us share some range of common appearances, traits, backgrounds, beliefs, and behaviors, we clearly have differences in the way we look, in our personalities, in our experiences, in the way we understand the world and in the way we act. For me to recognize our similarities and appreciate our differences, I have to see who I am. This personal reflection assessment can be challenging, especially for therapists like me who like to avoid labels. Coming to grips with racial, financial, educational, experiential, relational, religious/political, philosophical/world view, value, and style/presentation identities is not an easy task, and in some areas, not a stagnant one. But it is necessary in recognizing and addressing cultural diversity in the psychotherapeutic relationship.

Once I identify my identities I am prepared to look at and begin addressing diversity in the therapeutic relationship. I begin identifying the identities of the other person in the relationship (at some level he or she is doing the same identity classification process with me). I compare and contrast these identity findings with my personal reflective assessments, and I use these comparisons to determine the level of cultural diversity needing to be addressed in the therapeutic relationship (there is diversity in all relationships. Most of our issues are around areas where there are significant identity differences; things like race, gender, nationality, income, type of illness, legal status, and source of payment). The challenge is being able to successfully work with individuals culturally significantly different from ourselves. This doesn't just happen. We don't grow into perceiving and understanding significant cultural differences by doing "therapy" and ignoring or minimizing the differences. When we fail to address the diversity issues (the differences that have so much potential for growth), we significantly limit our ability to be therapeutic with people who are significantly different than we are.

To a large extent it is my ability to match on key cultural characteristics that most determines the outcome of the therapeutic relationship. We so often fail at this, especially with individuals coming from world perceptions that are significantly different than ours. We are guilty of wanting them to be, understand, behave and enjoy the things we do. When that isn't happening we either fail at the therapeutic relationship or shift to a less relationship based intervention style. We are much more effective teaching individuals who are different from us; teaching them to become more like us. It is not mere coincidence that the primary group of people providing and receiving psychotherapy today are culturally quite homogenous: females, white, mid-

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dle-class. It is not by chance that we minimize the role of the therapeutic relationship with individuals significantly different from ourselves (those seriously mentally ill individuals need skills training, not therapy, even though we are learning about the power of peer relationships). The purpose for identifying the culturally diverse world of similarities and differences is for us to use it constructively in the therapeutic process, not to select those most like us and weed out the others.

We need to be able to see through more eyes than our own. Realizing I am significantly different than the other person in a relationship does not prevent me from growing that relationship. My job is to listen, observe and understand that person, and in the process develop a relationship which, along with techniques and procedures, I will use to help that person function better. The interventions I use need to be compatible with the other person's cultural realm (the emphasis being on adherence to a therapeutic approach, not compliance within my limited range) and the improved functioning needs to be within their worldview and within their primary social environment. My communicating this understanding is essential in building needed trust in the relationship. Bridging the separating cultural differences is essential in maximizing the benefit of psychotherapy. It is in how I address the differences that I am most vulnerable to loosening my grip on the relationship or increasing my ability on making the greatest impact on the person's life.

I have found the use of the therapeutic relationship is the most powerful and effective means of improving individuals' lives we have. That special relationship is the platform upon which we can facilitate the greatest amount of growth. To have this relationship with individuals significantly different or diverse from ourselves requires us to grow and become more diverse ourselves, intellectually in our knowledge and understanding and experientially in our interactions and lives. This is challenging. It requires our shifting away from our separating mindsets to diagnose and treat the problem, to understanding and appreciating the world in which the other person functions; their cultural milieu. My psychological gray hair has taught me that this process is fun with its challenges. My literal gray hair has placed me in a cultural group that is able to give such aged musings.

NOTICE TO READERS

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

EARLY CAREER PSYCHOLOGIST

Life After Training: Challenges of an Early Career Psychologist

Patricia Gready, Psy.D.
MedOptions, Inc., Connecticut

Some people begin their graduate training in clinical psychology knowing exactly where they want to be in 8 to 10 years: a psychologist working with children with trauma/abuse histories, working in a private practice seeing couples, doing forensic assessments, teaching and conducting research in academia, and so on. Others have a plan, but are open to seeing where their experiences lead them. On careful reflection, although I knew I would be in practice, I still believe that I fell into the latter group. As I grow professionally in my now early career years, I've recently paused to consider how my identity as a practicing psychologist is evolving. This exploration has left me with perhaps more questions than answers, but I suspect that is all part of the process. Many of my previous supervisors impressed upon me how becoming (and being) a psychotherapist is a process, something that occurs over time, and now as I look back over several years of experience, I begin to see the experiences that challenged me in ways that created a better therapist or a better teacher. I can take this information about myself and use it to move forward, deciding "where to next?"

When I think about the development of a psychologist, Erikson's (1963) developmental stages come to mind, with the early career striking me as the time of identity formation somewhat parallel to late adolescence and early adulthood in his model. The task, according to Erikson, is to explore different roles in order to develop an identity. This seems akin to the post-doc and early career years, as one develops knowledge and gains additional responsibilities in their work. Trying on different roles during the process of developing a professional identity begins during graduate school training, but continues in these early career years as more and more opportunities become available. It is a task that requires careful self-reflection, openness to feedback, and an occasional willingness to challenge oneself beyond one's 'comfort zone.'

Many of us in clinical practice are still making decisions about our career paths even in our first so-called "independent" years. Although we make many decisions in graduate school, internship and post-doc that impact our early careers, much growth and development remains as a psychologist and as a psychotherapist in particular. These training years set the foundation of theory and technique, but our early years of practice help us build upon this foundation by refining our understanding of theory, strategy, and considerations such as timing and patience. Additionally, many of us are also considering how many different roles (researcher, psychotherapist, teacher, supervisor, administrator, etc) we want to comprise our professional lives. For some, having only one or two roles will be quite fulfilling, while others will thrive on having many different tasks to balance.

My own career path has been unclear at times, but each of my professional expe-

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riences in community mental heath settings, medical settings, teaching, and supervising has provided an opportunity for me to learn about what fits me and how I can continue to develop my strengths as a psychologist and address my weaknesses. Some of my greatest challenges were with teaching and supervising while I was working on an inpatient unit affiliated with a medical school. Fresh out of post-doc myself, I now needed to train psychiatry residents about psychotherapy. I had to find a way to clearly articulate those thought processes that guide us through sessions with clients. I repeatedly found myself stuck in thinking that I barely knew how to be a psychotherapist myself; thus, how could I possibly teach someone else these skills? Adding the role of supervisor to my professional repertoire and identity pushed me to grow in teaching to others, as well as helping me to continue to refine my own therapy skills. It is not a role that I necessarily would have pursued at that point in my career, but taking the risk proved very rewarding.

My current position providing psychotherapy and assessment in skilled nursing/ rehabilitation facilities challenges my need for being part of a cohesive team. I prefer working with others on a team and being integrated into a system, but consulting in several different facilities often leaves me on the periphery in each of them. To address this challenge, I've begun to consider ways to increase my connection to these sites as well as to develop more professional connections since I work very independently most days. I've discovered that at previous jobs, I took the team, support, and resulting learning opportunities for granted. It had not occurred to me that future jobs might not necessarily have this treatment team approach. Reflecting on all of these experiences can help me explore ways to redefine my career path and to consider what might be next.

Our development as psychologists does not happen in a vacuum, but rather in the rich context of our personal lives. Personal challenges and events like marriages, children, aging parents, death, financial worries, and illness all happen while we are trying to navigate these new professional roles. Early career psychologists often navigate multiple life changes at the same time that they are "trying on" these professional roles, and these personal events often impact our career choices. This past June I gave birth to my first child, and this event challenges my previous ideas about my career. It challenges them in complex ways that I am only beginning to understand, raising question like: How much time do I want to be working? What aspects of being a psychologist (psychotherapist, teacher, supervisor, researcher) are most important to me if my time is limited? What do I want my child to see and understand about being a psychologist?

Jeffrey Barnett recently asserted (Barnett, 2009) that the choices we make at one stage in our career do not restrict us, because we always have opportunity to make changes as our interests evolve over time. Yet when I consider how to combine meaningful professional experiences with the needs and demands of family life, there are times when this assertion does not seem to be the case. I know that this occasional uncertainty is normal, and part of the process of considering what is next. I know that my training and education have prepared me for many options, and identifying a way to shape this knowledge and experience into a satisfying career is up to me. At its core, this challenge is what being an early career psychologist is all about.

I also have to consider a critical factor in helping the continued process of profes-

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sional identity development: support. Support can come in many forms such as informal peer discussions, peer supervision groups, or a mentor. Support can also be found within larger organizations such as APA, APA divisions, and state psychological associations. Professional development support is often built into training programs, but then suddenly disappears when training ends. Early career psychologists are still working through many of the same issues, but professional support resources often seem limited beyond the post-doc years. Being part of smaller organizations, such as Division 29 or state/regional groups, can be a key support resource for early career psychologists to reflect on our experiences, and find ways to connect and create opportunities that will benefit ourselves and others on this journey of identity development. This step of focusing on the development of professional relationships as a way to avoid professional isolation, and moving towards continued growth and contribution in the next career phase, also seems to parallel Erikson's next developmental stages (Erikson, 1963). As we settle into roles and organizations many of us will start to see new and exciting ways to contribute to the field and to grow in our careers. Reflecting on possibilities of the future can feel like a ray of light at the end of the tunnel during the challenging times in the early career years.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

CALL FOR NOMINATIONS

Editor of Psychotherapy Bulletin

The Publication Board of the APA Division of Psychotherapy is seeking nominations (including self-nominations) for the position of Editor of the *Psychotherapy Bulletin*. Candidates should be available to assume the title of Incoming Editor January 1, 2011, for a three-year term. During the first year of the term, the incoming editor will work with the incumbent editor.

The *Psychotherapy Bulletin* is an official publication of the Division of Psychotherapy. It serves as the primary communication with Division 29 members and publishes archival material and official notices from the Division of Psychotherapy. The *Bulletin* also serves as an outlet for timely information and discussions on theory, practice, training, and research in psychotherapy.

Prerequisites:

- Be a member or fellow of the APA Division of Psychotherapy
- An earned doctoral degree in psychology
- Support the mission of the APA Division of Psychotherapy

Responsibilities: The editor of the *Psychotherapy Bulletin* is responsible for its content and production. Since the editor will work in collaboration with the Internet editor, a strong background in the use of technology and a vision for expanding the Bulletin's presence in the online environment are important. The editor maintains regular communication with the Division's Central Office, Board of Directors, and contributing editors. The editor is responsible for managing the page ceiling and for providing reports to the Publication Board as requested. The editor must be a conscientious manager, determine budgets, and administer funds for his or her office. As an *ex officio* member of the Publication Board, the editor attends the scheduled meetings and conference calls of the Division's Publications Board. An editorial term is three years.

Oversight:
The Editor of the *Psychotherapy Bulletin* reports to the Division of Psychotherapy's Board of Directors through the Publication Board.

Search Committee: Nominations should be submitted to Jean Carter, PhD.

Nominations:
To be considered for the position, please send a letter of interest and a copy of your curriculum vitae no later than April 15, 2010 to: Jean Carter, PhD, Publications Board, c/o Washington Psychological Center, PC, 5225 Wisconsin Avenue, NW, Suite 513, Washington DC 20015 or electronically to jcarterphd@gmail.com. Inquiries about the position should be addressed to Dr. Jean Carter (202 244-3505 or jcarterphd@gmail.com) and/or to the incumbent editor, Dr. Jennifer Cornish (303 871-4734 or jcornish@du.edu).

FEATURE

Psychotherapy's New Interactive Online Presence

Christopher Overtree, Ph.D.

When I went to college, all students were required to have a voicemail account, enabling college administrators to send campus wide messages. Voicemail served an important social purpose too; we checked hourly to see whether we would be enjoying burritos at the Wa Wa or foot-longs at Hoagie Haven. But, we had a choice about whether we wanted email, and without realizing what I was doing, I selected one. Thus begins my story of the race for information, constant availability, and the battle for privacy amidst a world of transparency. Sometimes I wish I had that choice back.

But there was no one to email back then, unless I wanted to shoot some computer jock a note about "how cool this is" or a message to Steve Jobs reserving a *Newton*. Now I am plugged in, and my suspicion is that you are too. If not, you are probably told you are hard to reach, asked for your email rather than your name, or have been told that your family's photos are on *Facebook* rather than in an album. It's been a bumpy ride.

For psychotherapists, this has created unique challenges. Our profession understands the role that self-disclosure can play in therapy. But in the Internet age, self-disclosure happens *to* us as information is gradually absorbed by the searchable Internet. We used to think we could opt out, but now realize that it is often better to manage our information than to keep it hidden. In my view the question is not *whether* psychotherapists should embrace technology, but rather, *how* should this be done. Our economy frequently asks what jobs and services can be moved to the Internet. My plumber recently ordered parts for my washing machine on his *Blackberry*. But what about psychotherapy?

As this question brings positive and negative associations to your mind, ponder additionally where discussions about our field are taking place. Where is the dialogue about modern psychotherapy happening? Where do early career psychologists and psychology students find their information, their mentors, and their outlets for dialogue? Where do critics post their harangues? Where is the role of psychotherapy, its utility, its billability, and its very livelihood being discussed? Why the Internet of course! Shouldn't the Division of Psychotherapy have a loud voice amidst the cacophony? Our own www.divisionofpsychotherapy.org is this opportunity.

Taking over as the Internet Editor for the Division of Psychotherapy was like knocking down the top floor of a skyscraper and rebuilding the penthouse. Obviously, any discussion of the future of our website begins with gratitude to Abe Wolf, past President and first Internet Editor who built things from the ground up and gave the Division such an outstanding online presence. New changes are not referendums on how things used to be done, but rather opportunities for the evolution of ideas and possibilities. But rebuilding the penthouse is no small task, and requires us to ponder its design, its selling points, and how it will stand out in the very crowded web.

The New Web

The new web is not a place where paper documents are scanned and stored. It is

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not a redundant back-up of printed content, nor is it a secondary source of information. The new web is a primary source, the place where more and more original content is created, displayed and made searchable. Printed documents have become secondary sources because their information is anchored to their publication date. Sad, but true, your morning Times is already out-of-date when it arrives at your doorstep.

The new web is also extremely interactive, not static. It is an interconnected network of information that evolves in response to its users. In essence, the web is a *wiki*, which represents the collective wisdom (and interests) of the global online community. A website that does not adapt to user interactions, or update its content in real time, comes to resemble the dusty leaves of a silk plant; attractive maybe, but certainly not alive.

In 2004, *Google* began an experiment in which flu-related search terms were used to map flu activity in different regions of the United States. By aggregating the data, essentially a collection of users searching flu symptoms and remedies, *Google* was able to map flu outbreaks roughly two weeks before the CDC. The power of their algorithm was in the interactions between users and the web, not in the web itself (see www.google.org/flutrends). This success reminds us that the web is a primary source, an interactive endeavor, and one that relies on its users to establish its relevance.

Division 29's growth and influence in the field of psychotherapy is intimately tied to its web presence, perhaps as much as its publications and activities. Our website is a portal for our members, but also for the public, policy makers, our critics and supporters. Our website has the opportunity to play a valuable role in the dissemination of information about psychotherapy, establishing Division 29's leadership in the field.

If you google the word, "psychotherapy," our website comes up third in the hit list (*Wikipedia* is number one). However, if you google the phrase, "psychotherapy bylaws," we shoot to the number one spot. This says a lot about how our website has been used in the past, but also gives us a clear picture of our future direction. A focus on documenting Division activities can shift to one that plays a vital role in the exchange of information about psychotherapy. It can be a resource for early career psychologists and students seeking colleagues and information. It can be a tool for leadership.

Our New Website

Our new website looks very different from the old, and is built on a different set of design principles which bring unique strengths and weaknesses. The website was built using *WordPress* (www.wordpress.org), an Open Source, self-hosting blogging tool used by millions of sites to display everything from pictures of puppies engaging in humorous antics to international corporations reporting news and earnings. Our site has a custom-built exterior, backed by a powerful infrastructure that is very stable and feature-rich. For those of you not familiar with the Open Source movement (www.opensource.org), it is based on the notion of collectively authored software platforms with code made available to the public for editing, troubleshooting, and the incorporation of new features. Open Source software is often more stable, adaptable, and typically faster than commercial platforms, and in case you still need to be convinced, is available free. Our choice of *WordPress* thus represents a shrewd financial decision as well as a statement of support for Internet freedom and transparency. It also brings some excellent features.

Now first and foremost, forget what you know about "blogging," as our site does

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not operate like some of the blogs you may have come to enjoy or despise. A blog-style website simply means a design that highlights and organizes new material as "posts," placed at center stage to get the viewer's attention. Posts can be articles, commentaries, announcements, book reviews, or even pictures from social events. Each post is optimized for keyword search, grouped into categories for easy sorting, and also "tagged" with specific keywords that tell readers which topics occur most often (check out the *Tag Cloud* on the homepage which graphically represents hot topics). So new posts get highlighted on the homepage, categorized and tagged. As a post ages, it fades into the background, but is always ready to be called up by a targeted keyword or category search. A post can be authored by anyone, and readers can respond with comments that are monitored to prevent spam.

Our homepage does lots of other things too. Using *widgets*, we can display many other items including reminders, hyperlinks, *Really Simple Syndication* (RSS) feeds to display content from other sites, slideshows and much more. Currently, we are highlighting the Division's 40th Anniversary celebration, Jeffrey Magnavita's "Re-envisioning the Division" slide show, an events calendar, and an RSS feed coming right from our Psychotherapy Journal showing the latest articles.

Across the top of every page is a selection of static pages, where the informational content of a traditional website is located. These pages are updated less frequently, and are designed to contain information regarding governance activities. New and emerging content will always be showcased on the homepage, but the backbone of the Division's structure is contained in these permanent pages.

One of the best features of the new website is the ability to add users with different privileges, enabling them to create their own content, manage their own posts, and make changes to the site. One excellent example of this is Jeffrey Barnett's *Ask the Ethicist* column, which accepts questions on ethics in psychotherapy, and receives responses directly from Dr. Barnett. Whenever Dr. Barnett responds to a question, readers see a new post highlighted on the homepage. A description of the *Ask the Ethicist* column, a place to post your own questions, and a link to view the archives can be found under the *Continuing Education* tab. We hope that other Division 29 members will author their own columns, and there are currently plans for an Early Career Psychologist mentoring column, a Technology column, and a column for student members.

What is Different About the New Website

One of the major changes for the new website is its focus. As was mentioned above, much of the previous content was "Division-only" business and paperwork. While the new website still attempts to document these activities, it is not quite as useful for archiving documents given its focus on emerging content. While members will still be able to find these documents, users will find this material well organized, but in the background. There will be fewer PDF files, and more content is viewable directly on the page to improve access.

One of the other shifts our website is making is to be more attractive to websurfers, particularly members of the public, policy makers, students and non-members with an interest in psychotherapy. We hope to increase membership by expanding our reach throughout the Internet and by providing content that is useful to anyone interested in learning more about our field.

A Few Other Division 29 Internet Resources

For a while there, we watched, wallets

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in hand, as companies fought the format battle. Vinyl to 8-track to cassettes to CD's to MP3's and back to vinyl. VHS to DVD to Blueray to 3D ESPN. But the ubiquitous role of information and the ability of computer code to adapt to any device has slowed these battles, and allowed us to focus on the point of all these formats and devices, the enjoyment and sharing of content. Our online presence is also designed to be adaptable to emerging communication trends. Rather than a one-size-fits all approach, we hope that our Division can be flexible, garnering followers in different venues or devices. Can you believe I can edit our Division's website from my *iPhone*? Actually, I could if my fingers were smaller, but I promise you it *is* possible!

One such example is the Division's new *Facebook* Page (www.facebook.com/psychotherapy29). *Facebook* makes room for businesses and educational organizations, allowing them to post information and relying on *fans* to propagate this information by forwarding or reposting items of interest. On our own homepage, you will see an invitation to become a *Fan* of the Division's *Facebook* page. New posts on the Division website are automatically reposted on *Facebook*, connecting them to the vast social network of our *fans*. For those of you who are not *Facebook* users yet (or will never be), it is important to understand that developing a web presence means adaptability. Our *Facebook* page reaches an entirely different type of user, one that is generally younger and more apt to follow web trends. Our *Facebook* page also helps us to benefit from the logarithmic effect of passing information socially as posts are automatically shared with friends once, twice and thrice removed. *Facebook* is also a great place for members of the Division to share interesting pieces of information that would not necessarily warrant rent space on our own homepage. Shrewd followers of Division 29 will *Find Us On Facebook*! At press time, we have 47 fans, with a hope that when article hits mailboxes, we will see a spike. I'll be watching.

You may also notice that the electronic version of our Psychotherapy Bulletin is viewable directly on our website, as well as available for download as a PDF file. This is made possible by a document-hosting site, known as *Scribd* (pronounced *scribe-d;* www.scribd.com/division29). *Scribd* focuses primarily on complete documents and online publications, but also has a social networking component. *Scribd* users can choose to *subscribe* to our publications, receiving notifications when new ones arrive.

Finally, if you saw the photos from the 40th Anniversary celebration on the website, these were hosted on our *Picasa* page (http://picasaweb.google.com/PsychotherapyDivision29) which displays photos for public, private, or by-invitation-only viewing. This is a popular photo-sharing site, making it easy to upload photos from events, or to establish an archive of our Division's history.

The Role of Online Publishing

I read an analysis recently on the environmental impact of manufacturing and delivering an *Amazon Kindle* (http://earth2tech.com/2009/08/19/why-the-kindle-is-good-for-the-planet). The conclusion was that the deleterious environmental consequences of purchasing a *Kindle* were outweighed in a single year by the reduction in paper use and waste in the print industry. This is an impressive triumph for a new electronic device, which typically places increased pressure on the environment. The proliferation of information devices such as the *Kindle, iPhone and Blackberry,* and new generation tablet computers such as the *iPad* tell us to expect considerably more growth in the online readership of our *Psychotherapy Journal* and *Psychotherapy Bulletin*.

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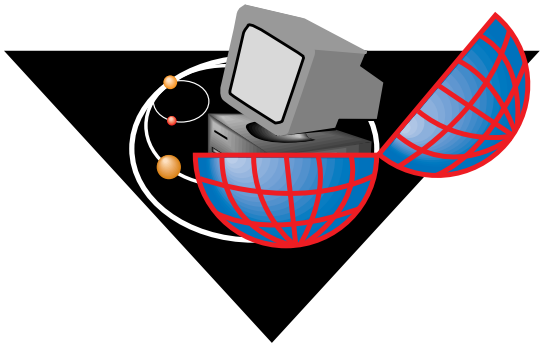
As such, it makes sense that we discuss the optimal means for adapting publications to the online environment, and that we encourage members to select electronic versions instead of print. As is the case with our website, it is the *content* that is most important. Our strategy is to promote broad appeal, across many devices and formats. We hope that future publications will be compelling enough and improved enough by electronic dissemination, that members will choose to view documents electronically. More importantly, choosing to reduce paper use and publication cost is an opportunity for us to *Go Green*, bringing the Division more inline with modern conservation standards for educational and business organizations. As if the above were not enough, we also hope members will choose to opt-out of receiving print documents in order to free up financial resources for improving the benefits of membership in new and exciting ways.

Future Possibilities

There are innumerable opportunities provided by the Internet to strengthen the Division of Psychotherapy. Future growth may see the development of a presence on *YouTube* or possibly other areas more specifically geared to the field of psychotherapy. As the Internet is a highly interactive environment, wholly dependent on the contributions of its users for growth, I hope the Division of Psychotherapy's website will be equally participatory and members will feel comfortable coming forward with new ideas for content or strategies for broader dissemination. I will be placing an electronic, hyperlinked copy of this article on our website with a place for comments, questions or suggestions (www.divisionofpsychotherapy.org/overtree-2010). I hope readers of this article will share their reactions and ideas for the growth of Division 29's online presence.



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

WANTED: CLINICIANS' FEEDBACK ON TREATING PANIC DISORDER

Once a drug has been approved by the Federal Drug Administration (FDA) as a result of clinical trials, practitioners have the opportunity to offer feedback to the FDA on any shortcomings in the use of the drug in clinical practice. The Society of Clinical Psychology, Division 12 of the American Psychological Association, is in the process of establishing a mechanism whereby practicing psychotherapists can report their clinical experiences using empirically supported treatments (ESTs).

This is not only an opportunity for clinicians to share their experiences with other therapists, but also can offer information that can encourage researchers to investigate ways of overcoming these limitations. We are starting with the treatment of panic disorder, but will extend our efforts to the treatment of other problems at a later time.

Our Web site provides the opportunity for therapists using cognitive-behavior therapy (CBT) in treating panic to share their clinical experiences about those variables they have found to *limit the successful reduction of symptomotology*. Although research is underway to determine if other therapies can successfully treat panic, CBT is the only approach at present that is an EST. However, in order for the field to move from an EST to an evidence-based treatment that works well in practice settings, we need to know more about the clinical experience of therapists who make use of these interventions in actual clinical practice. By identifying the *obstacles to successful treatment, we can then take steps to overcome these shortcomings.*

Your responses, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 Web site at a later time. The results of the feedback we receive from clinicians will be provided to researchers, in the hope they can investigate ways of overcoming these obstacles.

The survey, which should take 10 minutes, can be found at:
www.div12.org/panic

FEATURE

Training in Supervision during the Pre-Doctoral Internship Year: Experiences and Recommendations

Shelly Smith-Acuna, Ph.D., Courtney Hergenrother, M.A., Casey Cassler, M.A., Tim Doty, M.S., Lisa Fuchs, M.A., Kirsten Ging, M.A., Shaayestah Merchant, M.A., Kim Pfaff, M.A., Millie Riss, M.A., Rob Rosenthal, M.A., Kym Thompson, M.A., Brenna Tindall, M.A., Olga Wartenberg , M.A.
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An integral part of becoming a well-rounded psychologist involves receiving training in supervision. In the past two decades, an emerging body of literature has focused on the stages of development of supervisor and supervisee (Nelson, Oliver, & Capps, 2006; Henry, Hart & Nance, 2004; Rau, 2002; Watkins, 2001; Stoltenberg, 1984). Several organizations within the American Psychological Association (APA) have listed supervision as a core competency area in the training of psychologists (Falender et al., 2004). As such, many graduate programs offer coursework in supervision, and information is available regarding the experiences of graduate students learning to be supervisors (Hill et al., 2007). Current studies indicate that there are many benefits to providing hands-on experience in supervision during graduate school, such as the opportunity to integrate coursework and practical experience. At this point, however, little attention has been paid to the exceptional challenges and benefits of receiving training in supervision during the pre-doctoral internship year. While the APA does not require supervision experience in accredited pre-doctoral internships, an informal review of programs suggests that the practice of providing supervision training is common, with 68% of a random sample of Association of Psychology Postdoctoral Programs and Internship Centers (APPIC) internships providing at least a minor emphasis in supervision (APPIC, 2009). The intensive training opportunities and unique

professional role provided by the pre-doctoral internship makes this setting particularly relevant for a focus on training in supervision.

Given the lack of literature in the area, a group of twelve pre-doctoral interns sought to examine and report on our experiences in receiving supervisory training during the internship year. The Graduate School of Professional Psychology (GSPP) Internship Consortium at the University of Denver is comprised of seven training sites, including a large medical facility, two university counseling centers, and several community mental health clinics and forensic agencies. While the population and clinical experience vary by site, all twelve interns are required to supervise a graduate student trainee at the home site. In addition to receiving individual clinical

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supervision, all interns are also supervised on their supervision by licensed psychologists. These supervisors differ in supervision style, length of experience as supervisors, and theoretical orientation. Depending on the site, supervision of supervision occurs in either a group or individual format.

In light of the fact that as interns we had such rich experiences in becoming supervisors, our group used part of our experiential research seminar to explore the issue of supervisor development. We first convened a group discussion related to our experiences in more depth, highlighting both the challenges that we faced and the knowledge that we gained in this area. After summarizing this discussion, we reviewed the literature to compare our experiences with current practices. We were pleased to discover that recent literature describes the process of supervisory training as distinct from training in psychotherapy, but we were disappointed to note the absence of an examination of supervisory training during the internship year. We then conducted another discussion group, exploring ways that our experiences could add to the current literature. We transcribed our ideas and examined the transcript to identify key themes in the areas of benefits, challenges, and recommendations for providing supervisory training during the internship year.

An overarching conclusion when looking at the internship year is that we found ourselves in a uniquely triadic and sometimes confusing role of student intern, supervisee, and supervisor. As interns, we were not considered full employees of our training site, nor were we considered psychologists. As supervisees, all of our work was overseen by a psychologist, and yet as supervisors ourselves we bore at least some of the responsibility for the work of our graduate student trainee. The confusion in these roles was evident as we were writing this paper, when struggling to use the appropriate term for each intern role. For the scope of this paper, *intern* refers to the pre-doctoral intern, whether they are serving as supervisor or supervisee. The term *student* refers to the practicum supervisee, and the term *psychologist* refers to the licensed clinical supervisor.

One of the major benefits of supervising during our internship year was that the structure of our sites already provided training resources that were useful for teaching supervision. First, we were provided with the opportunity to be supervised by licensed psychologists and we received this supervision in an individual or group format. Group supervision of supervision, in particular, allowed us to receive feedback from licensed psychologists *and* our peers. In this capacity, we vicariously learned from our fellow interns about the difficulties they experienced, and in this way, we felt more prepared to face similar struggles as they presented themselves. Additionally, supervision of supervision, both group and individual, allowed us to engage in extensive consultation. We received substantial support especially during crisis situations, including ethical challenges that most professionals face. For example, group supervision proved especially helpful for one intern when her supervisee faced an ethical dilemma about a potential dual relationship with a client. Her peers and the licensed psychologist helped her navigate additional challenges, identifying other potential conflicts of interest that were not apparent. Through the supervision process, the intern felt validated in addressing the conflict directly with her student, knowing that she was not overreacting in her concerns. Further, the group was able to brainstorm potential solutions to the problem, which the intern was able to share with the student. As a result, the group supervision of supervision process helped her decide how to proceed through a very anxiety-provoking situation.

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A second advantage of supervision training was that our triadic roles, as intern, supervisor, and supervisee helped to solidify our identities as psychologists. We felt that we received two levels of clinical supervision, first as our own clinical work was supervised and second, when we learned about the psychologist's ideas about our students' cases. This process enhanced our clinical work by allowing us to simultaneously evaluate our own performance, our clinical interventions and conceptualization abilities, and then compare it to our supervisee's progress in all of these areas. Similarly, we could examine the process of supervision from two experiences at the same time while also being in supervision with our own supervisors. We concurrently incorporated positive supervisory experiences from our current supervision into the work we would provide to our own supervisees. In addition, this training approach provided us the ability to differentiate between therapy and supervision and to identify parallel processes between the two dyads of supervisee and supervisor. Finally, many interns said that they gained confidence and competence as both a supervisor and therapist by being in this triadic role.

Third, our recent graduate education and supervisory experiences aided our development as new supervisors. Several programs, including the GSPP, require coursework specific to supervision methods and theory, a factor that can be advantageous to the development of a new supervisor. Recent exposure to supervision coursework kept the material current, and we were easily able to apply the knowledge from the classroom to our work with our supervisees. As such, we effectively conceptualized our interactions with our supervisees and their clinical work. Therefore, another advantage of supervising during the internship year is the ability to apply recently acquired knowledge to our real-world clinical work, with no lapse in time. If we were not afforded this unique opportunity, realistically it would likely have taken two years before we could apply the knowledge learned in the classroom to professional supervision as licensed psychologists.

While our overall experiences as supervisors were positive, we noted that as beginning supervisors, we faced many challenges unique to our triadic role. First, many of us felt undermined by our students, licensed supervisors, and senior colleagues on at least one occasion. Due to the unique hierarchical structure of internship, we sometimes felt challenged from those in positions above us and below us at the same time. Some of our students viewed us as peer consultants, rather than as professionals who could offer guidance and evaluate their work. Many of us found that our students initially disregarded our input and referred to us by nick-names in overly-informal ways, such as calling one of us "honey." We believe that their behavior may have stemmed their knowing that we were not the ultimate authority regarding their clinical work, the closeness between us in age and experience, and the fact that we ourselves were also in the midst of the training process. Some of us also tended to be overly accommodating and indirect with feedback, which may have interfered with our ability to provide competent supervision. At times some of us also felt undermined when our supervisors or senior colleagues would second-guess our supervisory decisions. For example, after discussing a demanding case with his licensed supervisor, one of us encouraged his student to gradually set in motion a transfer to another clinician, but was required by another senior colleague to encourage the student to transfer the case immediately. Such situations and relationship dynamics led several of us to feel ineffectual in our supervisory roles.

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Second, several of us felt awkward in our roles as gatekeepers because models of supervision do not provide examples regarding how to offer challenging feedback. We define the role of gatekeeper as a person who provides input about the student's progress (or lack thereof) towards becoming a psychologist, in an effort to protect the public and the profession (Bernard & Goodyear, 2009). One intern found herself in a trying situation in which she felt pushed to voice several colleagues' concerns about a student's suitability to become a psychologist. While she shared her colleagues' concerns about this student's ability to convey empathy for his clients, she felt uncertain about how to provide clear and direct feedback to this student.

Lastly, with regards to the vast cultural differences in the clients we treat, one intern was frustrated that her supervisor seemed somewhat unaware of the importance of multicultural issues. As such this intern avoided discussions with her supervisor about how she approached multiculturally competent treatment with her student. Had this supervisor been more open to supporting the intern in bringing training issues into the supervisory process, the intern would have felt less conflict in carrying out her triadic role.

Given some of the special challenges found in learning supervision during the internship year, our interns developed the following recommendations for pre-doctoral psychology interns in order to help them maximize the experience.

Recommendation 1—Focus on the Training aspects of supervision

- Utilize supervision of supervision in order to enhance your own training experiences and benefits the training given by your supervisor.
- Integrate supervisory didactics into your training by participating in either a supervision class or a venue where you may receive consultation regarding supervisory issues.

Recommendation 2—Ask for clear guidelines, policies, and procedures to clarify the role of the intern supervisor

- Discuss guidelines, goals, expectations and prepare for upcoming evaluations with your supervisee at the outset of the supervisory relationship.
- Maintain constant awareness of ethical dilemmas and appropriately address these with your supervisee. It is possible that your trainee may not have had any previous training in ethical issues
- Utilize a theory that will provide a basis for understanding and explaining the supervisory role. Given that this may be a first supervisory experience for you and for your student, a focus on theory can help structure and guide your process.
- Develop and maintain the individual roles between your own supervisor, yourself, and your supervisee. Of particular importance highlight the flow of information, decision making, and power structure.

Recommendation 3—Discuss and process the challenges of being in the gatekeeper/ evaluator role

- Be mindful of your role as a gatekeeper when helping your supervisee to move forward in the field of psychology.
- Utilize supervision to discuss evaluating and giving feedback to your supervisee.

Of course, this list can also be shared with internship directors and supervisors as they seek to incorporate supervision into the internship training program. It is our hope that other training programs will benefit from our experiences, and they will add this valuable component to their training program design.

REFERENCES FOR THIS ARTICLE MAY BE FOUND ON-LINE AT www.divisionofpsychotherapy.org

WASHINGTON SCENE

The Maturation of the Profession

Pat DeLeon, Ph.D.
Former APA President

From the first days of his Administration, President Obama has made clear his personal commitment to the enactment of comprehensive health care reform. His Inaugural Address: "We will… wield technology's wonders to raise health care's quality and lower its costs…." At September's Joint Session of Congress: "(T)onight, I return to speak to all of you about an issue that is central to that future – and that is the issue of health care. I am not the first President to take up this cause, but I am determined to be the last. It has been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way…. We are the only advanced democracy on Earth—the only wealthy nation—that allows such hardships for millions of its people…. (T)he problem that plagues the health care system is not just a problem of the uninsured. Those who do have insurance have never had less security and stability than they do today…. The plan I'm announcing tonight would meet three basic goals: It will provide more security and stability to those who have health insurance. It will provide insurance to those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government."

Some interesting facts: in 2001, 48 percent of all bankruptcies were attributable to medical costs, and by 2007, that number had risen to 62 percent. Organized medicine's insistent call for tort reform may provide cost savings, but it risks harming patients. The Congressional Budget Office (CBO) noted that a 10 percent reduction in medical malpractice liability costs could increase the nation's mortality rate by 0.2 percent—representing an additional 4,853 Americans killed every year by malpractice. Annually, between 44,000 and 98,000 Americans die as a result of preventable medical errors within our nation's hospitals. Less than 40 cents on the dollar collected in premiums by medical malpractice insurers is currently used to pay out claims. This would perhaps suggest a different approach than placing patients at risk. By 2010, more than 30 million Americans could not get health insurance coverage, with 14,000 losing their coverage daily. This is a significant national problem. And yet, the shocking election results to fill the seat of the late Senator Edward Kennedy brought home for many healthcare reform supporters how fragile their evolving legislation really was.

From A Health Policy Perspective: This year, the Institute of Medicine (IOM) released its report, Redesigning Continuing Education in the Health Professions, with the active participation of psychologist Nancy Adler of the University of California, San Francisco and several APA staff members. The IOM: "Continuing education (CE) is the process by which health professionals keep up to date with the latest knowledge and advances in health care. However, the CE 'system,' as it is structured today, is so deeply flawed that it cannot properly support the development of health

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professionals." In the fall of 2003, the media reported: "Each year, more than 57,000 people die because they do not receive the care that the medical profession and health care community agrees they need…. (T)his is not a measure of medical errors or an analysis of patient access to health care. It is an accounting of the simpler but perhaps more sobering fact that, despite record per-capita spending on health care, the quality of U.S. medical practice badly trails the state of medical knowledge. Effective treatments for many conditions are available… but many patients are not receiving them." Unfortunately, there is little reason to believe that this situation has gotten better during the intervening years. The IOM: "CE is one of many strategies to strengthen and retool the health care workforce and just one of many pieces necessary to improve health care quality and patient safety. Yet it is a critical piece—one that has been overlooked for too long.

"A workforce of knowledgeable health professionals is critical to the discovery and application of health care practices to prevent disease and promote well being. Today in the United States, the professional health workforce is not consistently prepared to provide high quality health care and assure patient safety, even as the nation spends more per capita on health care than any other country. The absence of a comprehensive and well-integrated system of continuing education (CE) in the health professions is an important contributing factor to knowledge and performance deficiencies at the individual and system level [IOM]." All would agree that at every stage of a health professional's career he or she must continue learning about advances in research and treatment in their field or specialty. The IOM reports that on average, about 17 years are required for new knowledge generated by randomized controlled trials to be incorporated into practice and even then application is highly uneven. CE serves two fundamental functions: maintenance of current practice and translation of knowledge into practice. Interestingly, CE is reported to have begun with Florence Nightingale; the first recorded continuing nursing education course dating back to 1894.

Today, health professionals (including psychologists) tend to focus on meeting regulatory requirements rather than identifying personal knowledge gaps and finding programs to address them. The current approach to CE is most often characterized by didactic learning methods, such as lectures and seminars; traditional settings, such as auditoriums and classrooms; specific intervals (frequently mandated); and teacher-driven content that may or may not be relevant to the clinical setting. CE is operated separately in each profession or specialty, with responsibility dispersed among multiple stakeholders within each of these communities. The scientific literature offers guidance about general principles for CE but provides little specific information about how best to support learning. In some fields (e.g., medicine and pharmacy) pharmaceutical and medical device companies have taken a lead role in financing the provision of and research on CE—raising significant "conflict of interest" concerns. Regulations vary widely by specialty and by State, as State boards are generally responsible for determining the number of CE credits required for profession-specific licensure. Today, CE requirements are frequently based on credit hours rather than critical outcomes, which is an approach that is fundamentally not conductive to teaching and maintaining core competencies aimed at providing quality care. In medicine, 76 percent of CME instruction hours are delivered through lectures and conferences which typically limit in-

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teractive exchanges. The IOM urges consideration of embracing the underlying concept of continuing professional development (CPD), which would include components of CE but has a broader focus, including teaching how to identify problems and apply solutions and which allows individual health professionals to tailor the learning process, setting, and curriculum to their unique personal needs. Systematic feedback is a key component.

From the beginning, the Obama Administration has been supportive of an increasing federal presence in a wide range of areas, many of which would traditionally be considered the responsibility of state government or the private sector. Accordingly, the underlying IOM recommendations, including its call for the development of national CE/CPD standards, should be of considerable interest to psychology's practitioners, educators, and state association leaders. "The Secretary of the Department of Health and Human Services should, as soon as practical, commission a planning committee to develop a public-private institute for continuing health professional development. The resulting institute should coordinate and guide efforts to align approaches in the areas of: a) Content and knowledge of CPD among health professions, b) Regulation across states and national CPD providers, c) Financing of CPD for the purpose of improving professional performance and patient outcomes, and d) Development and strengthening of a scientific basis for the practice of CPD." This proposed new organization could catalyze participation of a broad set of stakeholders in improving health care quality and patient safety and of considerable significance, would be accountable to the federal government.

Stated more directly, rather than serving as an exciting and key catalyst for necessary change within the nation's healthcare environment, the current CE systems are viewed as professionally isolated with their highly "silo" orientations and thus fundamentally ineffective in providing consistently high quality CE experiences for practitioners of any discipline. From a health policy perspective, if one focuses upon the potential long term benefit of quality CE for patient welfare, it would be most reasonable to actively encourage interdisciplinary CE, especially that capitalizing upon advances in health information technology and utilizing emerging electronic health databases as a means of providing feedback on provider performance. This would include interaction with CD-ROMs, webinars, and videoconferences. Increasingly, CE should be delivered within the context of care (practice-based learning and point-of-care learning), not in comfortable lecture hall formats. Health professionals from any discipline should be able to earn required CE credits for attending a relevant activity offered by another profession, especially where the content overlaps with their clinical interests and the resulting relationships would foster collaborative practice. Psychology and nursing, for example, could learn a considerable amount from clinical pharmacy, especially as their prescriptive authority agendas mature. CE represents a major healthcare investment, the estimated cost in 2007 for medicine alone was $2.54 billion.

From The Front Line: [Ray Folen] — "This Fall, thirty minutes before Pat left Honolulu to return to Washington, DC, I was on a plane at an adjacent gate preparing to fly to Okinawa to set up behavioral telehealth services between Tripler Army Medical Center, located on Oahu, and the U.S. Army Torii Station in the Nakagami District of Okinawa. The plan was to use webcam videoconferencing to provide 'real-time' assessment and follow-up treatment services to the

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soldiers in Okinawa, where a shortage of providers existed. My trip to set things up there occurred within two weeks of receiving the request for assistance, and within a month clinical services were being provided three days a week. We have since expanded the program to provide psychological services to other military installations on the island.

"Tripler's area of responsibility extends over 50 percent of the earth's surface, much of which is water. By necessity, we were one of the early adopters of telehealth technologies to extend our ability to provide services to remote areas. I recall one day in the late '90s, where my schedule for the day included a 10 a.m. face-to-face patient in Honolulu, followed by telehealth patients on Maui (11 a.m.), Korea (1 p.m.), Japan (2 p.m.), and Guam (3 p.m.). Program outcome evaluations since that time have consistently supported the continued use and expansion of 'behavioral telehealth' services for the provision of psychological care. We found, for instance, that the recipients of psychological services rated their comfort and satisfaction with behavioral telehealth very high. While one might speculate that younger individuals would have a greater affinity for telehealth than older individuals, we did not find this to be the case. We also found, surprisingly, that recipients of care were more willing to disclose information of concern via videoconference than in a face-to-face interview, suggesting that telehealth is more than just a 'second best' alternative and in some ways may be superior to the traditional psychological face-to-face session.

"While patients easily embrace telehealth, we have found that some providers, at least initially, are more reluctant to do so. This appears to be due to a lack of familiarity with the medium and the expectation (based on years of watching TV) that the video used in these sessions must be of broadcast quality. Fortunately, though, I have found that providers do adapt fairly quickly to 'webcam-quality video' and are able to gather the verbal and nonverbal information needed to appropriately diagnose and treat. I have observed that, while variable video quality can be tolerated, both clinicians and patients cannot tolerate a decrement in audio quality. As a result, we now have telephones readily available on each end as a backup should audio quality suffer over the internet.

"Patient care using this medium has some unique requirements. Webcam security is a concern that requires full disclosure of the limits of confidentiality. Fortunately, encryption programs have been developed that now add additional levels of security. Licensure in the State where the patient is being seen is often a requirement, as are clinical privileges at the remote facility. Emergency procedures must also be in place at the remote site, so the clinician can engage these support services should, for example, there be a power outage that leaves the patient at the remote site in the dark, or should an imminently suicidal patient abruptly leave the clinical session.

"To be effective, clinicians must also be aware that many behaviors—appropriate in a face-to-face encounter—may be experienced very differently through the camera. Recently, during a review of a telehealth clinical interview, we observed a clinician who routinely took notes on his computer while talking with his patients. In the telehealth encounter—where the clinician's computer was outside of the patient's camera view—the patient interpreted the clinician's looking away (to type a note) as an expression of a lack of interest in what the patient was saying. Similarly, clinicians have a tendency to speak louder when talking to a patient via telehealth, which may be interpreted by the patient as being strident or argu-

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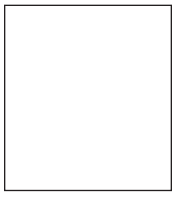
mentative. It is also important for clinicians to move as little as possible when on camera, as frequent movement causes pixilation of the video image being viewed by the patient. Thus, clinician training (e.g., having the clinician tell the patient that they will be looking away to type a note, or advising the patient at the beginning of the session to adjust the volume to a pleasant level) is needed in order to maximize clinician and patient comfort with the process.

"In both military and civilian environments, telehealth increases our ability to provide care that may otherwise be difficult or impossible to access. In the very near future, I will likely hire a number of psychologists and other behavioral health professionals to provide care via behavioral telehealth to service members and families located throughout the world. Given the many time zones that will be crossed, I'll be looking for people who don't mind a flexible work schedule…. [Folen@hawaii.edu]."

Aloha,

Pat DeLeon, former APA President

Armond R. Cerbone, Ph.D.



Psychotherapy is at the heart of my long career; so I have been a member of Division 29 for almost as long as I have been a member of APA. I have long valued the contributions psychotherapy makes to the health and growth of countless people and, in particular, the science that makes it possible. I have been a Fellow of 29 for almost ten years.

I was fortunate to serve as secretary of this division for four years working with other division officers to revitalize our mission, to map our new directions, and to expand our governing structure, effectively bringing more members into leadership. Now I ask you to support my hopes to be your next President-elect.

I bring over 35 years of leadership to the Division as:

- a psychotherapist in independent practice;
- a director of behavioral health in a community health center;
- a faculty member in a doctoral training program;
- chair of several APA boards, committees, caucuses of Council, and APA presidential task forces;
- a state association (IL) and division (44: LGBT psychology) president; and
- a member-at-large of the APA Board of Directors.

In addition, I have co-authored the APA's *Guidelines for psychotherapy with lesbian, gay, and bisexual guidelines* and chaired the working group that drafted APA's policies on same-sex marriage and families, published several book chapters and reviews, and presented close to a hundred papers and invited addresses. These many years and varied positions have tested and deepened my grasp of the challenges psychology and psychotherapy face in a changing world. They have also demonstrated my effectiveness as a leader. They evidence also my considerable knowledge of both the workings of our association and the meaning of our work for people.

Two divisions (12 and 44) and two state associations (Georgia and Illinois) have cited my work with awards for distinguished contributions to our profession and for advancing the welfare of diverse and marginalized groups. Most recently, Division 12 (Clinical Psychology) selected me for the *Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology*. I also hold the American Board of Professional Psychology Diplomate in Clinical Psychology.

Besides proven experience and demonstrated leadership, a president must have vision. My vision for our Division begins with coordinating our mission with the newly adopted APA strategic plan. It includes examining how our empirical methodologies contribute to effective treatments for people. It also seeks to explore the role of psychotherapy in understanding human sexuality and intimate relationships. My vision entails exploring our core values and shaping our agenda around those values. Finally, my vision is to encourage the visions of each board member and committee chair to increase member involvement and benefits, particularly at convention.

This is an important division in APA, the only one committed entirely to the research, training, and practice of psychotherapy. Its members and leaders have added richly to the growth and excellence of our profession. With your trust and help I hope to build on those achievements.

Marvin R. Goldfried, Ph.D., ABPP

I consider myself a scientist-practitioner. My struggle to implement this role began in graduate school, and it has been a long-term effort over the years. Not only has it involved the attempt to live the role in my own professional life as a therapist, but also to make it work in my teaching, supervision and research. And while it may not be possible for all professionals to function as scientist-practitioners, I do believe that it is possible to close the gap that exists between practice and research.

The reality is that clinicians and researchers live in different worlds. As clinicians, our lives are about getting referrals and convincing insurance companies to support ongoing therapy sessions. As researchers, our lives are about publishing and convincing granting agencies to support our work. I live in both these worlds. In my role as Distinguished Professor of Psychology at Stony Brook University, I have been actively involved in therapy research and teaching. I have also experienced the clinical world through a part-time therapy practice and my supervision of graduate students. Indeed, I feel deeply honored to have received recognition for my practice, mentoring, and research efforts from APA, Division 29, Division 12, the Society for Psychotherapy Research (SPR), and the Association for Advancement of Behavior Therapy (AABT).

Much of my professional efforts have been devoted to encouraging collaborative communication among therapists of different theoretical orientations, inclding co-founding the Society for the Exploration of Psychotherapy Integration (SEPI) in 1983. I am currently devoting my efforts to the integration of practice and research in conjunction with my being President of Division 12. These efforts have been described in last year's Division 29 newsletter [Goldfried, M. R. (2009), Making evidence-based practice work: The future of psychotherapy integration, *Psychotherapy Bulletin, 44,* 25-28].

At present, psychotherapy is confronted with pressures for accountability (e.g., pay for performance, quality insurance, practice guidelines), with evidence-based practice likely to be the driving force for how therapy is conducted in the future. I firmly believe for it to be implemented in an empirically and clinically sophisticated way, the collaborative efforts of researchers and practitioners are essential. More than ever before, this collaboration needs to become the organizing theme for psychotherapy integration.

Moreover, this integration needs to consist of a two-way bridge, where practice and research informs the other. In 1995, I founded the journal *In Session*, which includes research reviews written specifically for the practicing therapist. As president of Division 29, I will work toward developing a way in which practicing therapists can provide feedback on their successes and failures in using empirically supported treatments in their clinical practice. Not only will this being a way of offering clinically relevant research questions to the therapy researcher, but will also be a way for practitioners to see how their experiences compare to those of their colleagues. If elected President of Division 29, I will do all I can to make this happen.

Shane P. Davis, Ph.D.

I am delighted to be nominated for the Diversity Domain Representative seat. I bring to this position a variety of diversity experiences. During post-doctoral fellowship, I conducted research on interventions designed to prevent suicidal behavior in abused African-American women. After post-doctoral training, I continued my clinical and research interests in this area by providing psychotherapy services, publishing research on the usefulness of providing culturally-informed group interventions for this population, and serving an editor for a special issue on intimate partner violence for *Professional Psychology: Research and Practice*. As a public health scientist, the focus of my work in diversity is on health-related tobacco disparities including documenting the prevalence of smoking among adults with mental illness and understanding the effects of menthol cigarette consumption and its potential contributions to health disparities among African American smokers.

As I reflect on this position in D29, it reminds me of this quote: "Diversity is the one true thing we have in common. So let's celebrate it!" It is exciting to see that D29 is committed to addressing diversity as it plays out in its board's activities, division priorities, and membership efforts. It is my belief that D29 cannot be one of APA's most attractive and relevant divisions unless it becomes more diverse in its membership and represents "diversity" in all of its activities.

If elected to serve, my goals as Domain Representative would be to 1) recognize current members who promote diversity in their practice, agency, community, or scholarly activities, 2) ensure all members feel valued for their culture, skills and traits, and know they can contribute to the success of this division, 3) make provisions that members from diverse backgrounds represent all aspects of D29, and 4) ensure that the issue of diversity pervades all D29's communications and resources relevant to psychotherapy.

Caryn Rodgers, Ph.D.

I am honored to have been nominated for Diversity Domain Representative for Division 29. Diversity is recognizing and supporting the promotion of commonalities as well as embracing the importance and value of differences and creating a space for the multiplicity of voices to be heard. As the inaugural Diversity Domain Representative, I have focused on developing the role of the representative, identifying the needs of the division as it relates to diversity, and led the initiative for the development of the Strategic Plan for Diversity. If elected, I would focus on implementing the strategic plan, and supporting the division in its efforts to incorporate attention to diversity in both its breadth and depth. I will work with the board to ensure integration of diversity in all domains, as well as make resources available for members. I think that the continuity of the divisions work on diversity through my continued service would greatly strengthen and solidify the divisions work and initiatives around diversity.

I am invested in the role of diversity as it relates to the research, practice and training of psychotherapy. As a faculty member at the Albert Einstein College of Medicine, much of my time is devoted to understanding the limited access of mental health services to adolescents of color in low-income urban communities. Limited access to mental health services continues to burden a large part of the population; there are also challenges around the representation of diverse groups in our research, and in education and training. These are areas that are pertinent to the continued growth and development of the profession of psychotherapy, and drive my passion and enthusiasm. Serving Division 29 has been a tremendously fulfilling experience. I would greatly value the opportunity to continue to serve. I appreciate your consideration and look to earn your vote.

CANDIDATE STATEMENTS — Science and Scholarship Domain Representative

Norm Abeles, Ph.D.

I have been active in our Division for a number of years and have done process and outcome research As well as research on treatment options for older persons. I am particularly interested in demonstrating that our Division is involved in contributions to Science. scholarship and the Public Interest. I f you plan to attend the APA meeting in San Diego this summer, please come and hear my presentation on how Division 29 can optimally contribute to science, scholarship and the Public interest. I would also hope you will vote for me for this elective office. Feel free to email me at abeles@msu.edu

Michael J. Constantino, Ph.D.

I am honored to be a nominee for the Science and Scholarship Domain Representative to the Division 29 Board, of which I am Fellow. As an Associate Professor at the University of Massachusetts, I direct my Psychotherapy Research Lab, teach psychotherapy courses, and supervise clinicians-in-training. Across these roles, I am deeply committed to integrating rigorous science with quality practice and training. This commitment is exemplified by my research productivity, as well as my active involvement in Division 29, Division 12, and the Society for Psychotherapy Research.

My participation in Division 29 began as a member of the Student Development Committee. I subsequently served as Chair of the Continuing Education Committee, and I am currently the Early Career Domain Representative. I also serve on the Editorial Board of *Psychotherapy*, and I am a Contributing Editor to *Psychotherapy Bulletin*. I owe the Division and its leaders much gratitude for the positive influence they have had on my early career development. Furthermore, I am grateful for having been awarded the 2007 APF/Division 29 Early Career Award, and for having had the opportunity to carry out my Early Career Domain initiatives.

I am excited by the prospect of implementing new Science Domain initiatives. If elected, I would enthusiastically focus on maintaining and even amplifying the Division's commitment to and support of psychotherapy research and evidence-based practice. I am eager to continue to serve the Division with such initiatives as on-line and convention-based research mentoring, a web-based brown bag series on psychotherapy science translation/dissemination, practice-research network involvement, and the use of new technologies for mapping psychotherapy techniques and change principles. My hope is that such work products will build on my leadership track record in a way that fosters Division 29's important voice in psychotherapy theory, research, practice, and training. I appreciate your consideration.

CANDIDATE STATEMENTS — Early Careeer Domain Representative

Erin E. Howard, Ph.D.

I am pleased and honored to be nominated as a candidate for Early Career Domain Representative for Division 29. My name is Erin Howard, and I earned my doctorate in Counseling Psychology from Lehigh University in 2008. Since then, I completed my postdoctoral fellowship in clinical psychology with UC Davis Medical Center, passed the required exams to become licensed, and began working as a clinical psychologist with the Department of Veterans Affairs. As my career begins to take shape, and I settle into roles as a therapist, supervisor, and writer, I look forward to continued involvement with Division 29 as an ECP.

Early career psychologists are growing in number and diversity, and bring new ways of thinking and learning into the field of psychotherapy. I might add that for many new psychotherapists, the 'early career' period is marked by transition and challenges; after years of practicing how to soak up wisdom from training faculty and consult with supervisors when uncertain, embarking on and shaping a professional career can be both exciting and nerve-wracking. There are numerous opportunities for new professionals to become involved with specialty divisions within the APA, and I value the emphasis Division 29 places on understanding and enhancing the development of veteran, new, and future psychologists. As a graduate student, I enjoyed having opportunities to interact, consult, and collaborate with professionals in the field, including by serving as a member of our Division's Student Development Committee and writing articles for Psychotherapy Bulletin.

I view the role of the Early Career Domain Representative within Division 29 as one that can, ideally, provide a voice for those transitioning into this new and important role among our seasoned teachers, supervisors, and mentors. I would be honored and enthusiastic to be elected into this role.

Susan S. Woodhouse, Ph.D.

I am honored to be nominated to run for Early Career Domain Representative. I received my doctorate in Counseling Psychology in 2003 from the University of Maryland, College Park, and I am an assistant professor at Penn State University. I am currently in my second year of serving Division 29 as the Chair of the Research Committee. There are a number of reasons I would like to serve as the Early Career Domain Representative. First, I am involved in psychotherapy research, including research on psychotherapy for college students and research on preventive interventions for families with young children. Also, Division 29 serves as one of my intellectual "homes." I want to provide a way for the next generation of psychotherapists and psychotherapy researchers to have a voice in Division 29, facilitate involvement of early career psychologists in Division activities, and help early career psychologists tap into the support that is available through Division 29. I think it is very important to attend to the unique needs of ECPs. For

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Linda Campbell, Ph.D.

I am honored to be nominated by our Division of Psychotherapy for a Council of Representatives seat. Thinking about writing this statement sent me back to the day when I interviewed to become the Editor of our cherished *Psychotherapy Bulletin* and was asked by Carol Goodheart, who was a member of the Publications Board, why I was interested in the editor's position. I instinctively replied, "Because psychotherapy is the heart and soul of psychology." My wonderful experiences in our Division 29 and also in the profession generally have confirmed that belief many times over. My service as the *Psychotherapy Bulletin* editor was a most meaningful and rewarding position because I saw the dedication and commitment our membership has to psychotherapy and to the role that psychotherapy can have in changing people's lives forever in a way that no other means of change can do.

I served as your president in 2004 and undertook multiple focus groups of trainers, practitioners, researchers and students to identify how we can ensure that psychotherapy remains both foundational and central in psychology going forward. Our Division 29 is the only entity in the entire APA structure with the mission of advancing psychotherapy in training, research, and practice. This is not a small thing. This role carries monumental importance and responsibility.

There has never been a more important time than now for us to promote and advance psychotherapy. Some of the areas of challenge for us include:

- Continued role in the developing relationship between science and practice
- Taking a major role in standards of practice for evolving technology including telehealth and the practice of psychotherapy electronically
- Promoting federal funding for psychotherapy research
- Ensuring a presence for psychotherapy in model licensure acts
- Protecting and promoting psychotherapy as reimbursed services
- Promoting awareness of the established effectiveness of psychotherapy
- Ensuring the presence of psychotherapy in the evolving training and practice of prescribing psychologists.

These are but a few of the areas of scope of practice, research, and training. Our division has a very special place in the leadership of the profession, but we also have a special responsibility to advance psychotherapy. I pledge to you our membership that I will do my very best to represent you and our Division of Psychotherapy.

Alice Rubenstein, Ph.D.

I am both pleased and honored to be nominated to serve the Division of Psychotherapy as APA Council Representative. What drew me to this division more than twenty-five years ago was the opportunity to work with practitioners, researchers, and educators who understand the critical importance of integrating research, practice, and education in order to advance psychotherapy.

Today, more than ever before, our division must take a strong leadership role in the APA Council of Representatives to ensure that health care reform bill includes psychology and psychotherapists as heath care providers. We need the respect and support of other health care providers and the public. We need to find more ways to fund services to the poor and the disenfranchised. We need to focus more energy on interdisciplinary health care. We must demonstrate the effectiveness of psychotherapy in prevention and we must be able to translate, demonstrate, and communicate our effectiveness to legislative leaders in Washington. We can play a central role in bringing down the cost of health care and improving the quality of life for millions of Americans. We must emphasize prevention as well as treatment.

Veterans returning from two wars have increasing rates of suicide. Treatment for PTSD has been far from adequate. The spouses and children of veterans have significant and serious mental health needs. The devastating earthquake in Haiti has traumatized an entire nation. The Division of Psychotherapy must represent the critically important role of psychology and psychotherapy in treating those impacted by war and disaster to the APA Council of Representatives.

I have been a member of the Division of Psychotherapy for more than twenty-five years. I have served on numerous committees and task forces and had the honor of serving as Division 29 President. I have served on the editorial boards of both *Psychotherapy* and *The Journal of Clinical Psychology: In Session.* I have been honored to be elected as a Division of Psychotherapy Fellow and to receive the Division of Psychotherapy Distinguished Psychologist Award (1996).

I am a practitioner who has been a member of the Society for Psychotherapy Research for more than ten years. I believe that researchers and practitioners must respect and inform the other if we are going to design studies that translate into effective evidence based practices. I ask for your vote for Division 29 Representative to APA Council.

Susan S. Woodhouse, Ph.D., continued from page 57

example, during my time as Chair of the Research Committee I helped to develop an Orientation Manual to help new members of the governance of Division 29 quickly understand how governance works and how to have a voice in the process of governance. As an ECP myself, I personally understand some of the issues that are of concern to ECPs—and I am also aware of the many talents that ECPs can bring to Division 29. I would like to advocate for new investigators and find ways for students and ECPs to become more involved. I would also like to advocate for ongoing attention to issues of diversity, broadly defined, so as to continue to welcome ECPs of diverse backgrounds to contribute their talents and energy to the Division.

John C. Norcross, Ph.D., ABPP

I am honored to be nominated for another term as your APA Council Representative for the Division of Psychotherapy. Division 29 is my natural professional home in that my daily responsibilities entail practicing, teaching, supervising, and researching psychotherapy as a university professor and as an independent practitioner.

My service to the Division traverses a variety of activities and a number of years. I have served as President (2000), Council Representative (2002-2007), and chair of our Publications Committee. I have edited several special issues of *Psychotherapy*, contributed regularly to our *Psychotherapy Bulletin*, and conducted comprehensive studies of the Division 29 membership. In addition, with Drs. Don Freedheim and Gary VandenBos, I codeveloped the APA Psychotherapy Videotape Series and coedited the second edition of *History of Psychotherapy*.

Recent books include *Psychotherapy Relationships That Work*, *Leaving It at the Office: Psychotherapist Self-Care* (with Jim Guy), *Systems of Psychotherapy: A Transtheoretical Analysis* (with Jim Prochaska), *Psychologists' Desk Reference* (with Gerry Koocher and Sam Hill), and the *Handbook of Psychotherapy Integration* (with Marv Goldfried). I also edit the *Journal of Clinical Psychology: In Session*. All of this is to say that my primary commitment is to advance psychology and psychotherapy.

Succinctly stated, my priorities as your Council Representative will be to: maintain the quality and integrity of psychotherapy in the face of health care industrialization; enhance the integration of practice and research in psychotherapy; advocate for the centrality of psychological treatment in daily life; and expand services for the Division 29 membership. Perhaps most importantly, I will strive for an open mind, a responsive ear, and an active stance toward the interests of the membership.

I welcome your continued support and collaboration.

Abe Wolf, Ph.D.

I am honored to be nominated as Council Representative for the Division of Psychotherapy. I am deeply committed to building bridges between psychotherapy practitioners and researchers and will work to give our field a strong voice in a body that represents the entire field of psychology.

As a psychologist practicing psychotherapy for 30 years at a major metropolitan country hospital, I have firsthand experience with the disparities in our health care system. As a Professor of Psychology at the Case Western Reserve University School of Medicine with over 50 published articles in psychotherapy and health psychology, I am aware of the challenges of translating research into practice.

I have served on the board of the Division of Psychotherapy for the past 15 years. As the 2006 President, I established the *Online Psychotherapy Academy,* a collaborative effort with the APA Education Directorate to provide Internet based material on psychotherapy for continuing education. As founding Internet editor of our Division, I understand the importance of this medium and how we can to use it to further the mission of our organization.

My service to the Division includes terms as Secretary, Chair of the Student Development Committee, Publication Board member, Member-at-Large, Mid-Winter Convention coordinator, editorial consultant to the journal *Psychotherapy,* and Publication Coordinator for the Division 29 Brochure Project. In 1996, I was honored by the Division with the Jack Krasner Early Career Award. In 2003, I edited a special issue of our journal, *Psychotherapy,* that focused on the impact of computers and the Internet on the practice of psychotherapy.

The field of psychotherapy needs strong representation. I will strive to provide that representation on the APA Council.

JOIN THE DIVISION OF PSYCHOTHERAPY
ON-LINE!

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

www.divisionofpsychotherapy.org

SPR

Society for Psychotherapy Research

An international, multidisciplinary, scientific organization

Dear colleagues and students,

I would like to invite you to join the Society for Psychotherapy Research (SPR). Dedicated to the advancement of scientific knowledge about psychotherapy and behavioral change, SPR brings together researchers, clinicians, and students from a variety of theoretical orientations (e.g., cognitive-behavioral, humanistic, integrative/eclectic, interpersonal, psychodynamic, systemic) and professional backgrounds (e.g., psychiatry, psychology, social work).

Research conducted by SPR members involves a rich diversity of quantitative and qualitative methodologies (within individual case analyses, randomized clinical trials, large naturalistic studies) and spans a variety of treatment modalities (individual, couple, family, and group therapies), client populations (children, adolescents, adults, older adults), and clinical problems: Anxiety disorders, mood disorders, conduct disorders, eating disorders, personality disorders, substance use disorders, marital discord, grief and bereavement, and suicide—just to name a few.

The primary mission of SPR is to foster the development and dissemination of scientifically rigorous and clinically relevant studies related to the outcome of psychological interventions, the process of change, and the characteristics of clients and therapists. Among the many therapeutic factors and issues that have been investigated at SPR are the therapist's techniques and competence, therapeutic alliance, empathy, emotional expression, transference and counter-transference, expectations, interpersonal problems, therapist's effect, client's feedback, dose-effect relationships and patterns of change during treatment, inpatient psychotherapy, behavioral medicine, computerized treatments, psychopathology, attachment, development, neuroscience, culture, diversity, spirituality, gender, assessment and case formulation, prevention, supervision, and training.

For more than 40 years, SPR has provided an ideal forum to address questions such as: Does psychotherapy work? Is there a type of psychotherapy that is superior to all others? Are there forms of therapy that are particularly indicated for specific clients? Can we predict who will benefit from therapy, who will terminate treatment prematurely, and who might get worse during psychotherapy? Is client-therapist cultural-matching beneficial? Are there therapeutic factors that cut across different types of treatment? If so, how important are these common factors for the client's improvement? What is more important for change to take place: a good therapeutic relationship, the use of powerful techniques,

or the complex interaction between them and client's characteristics? Do expert therapists do what they say they do?

SPR has also fostered discussion among leaders of the field about controversial issues such as, the link between research and practice, the pros and cons of treatment manuals and empirically-supported treatments, empirically-supported therapeutic relationships, and the strengths and limitations of efficacy and effectiveness research.

Every year, researchers and clinicians from around the world attend SPR's international meetings. Regional chapters (Europe, Latin America, North America, UK) also meet regularly, as do local SPR organizations (e.g., Mid-Atlantic, Ohio, Taiwan). All of these meetings are very friendly, interactive, and welcoming to newcomers. In addition, SPR has it own official journal: *Psychotherapy Research.* Published by Taylor & Francis, this highly respected peer-reviewed journal features exciting and influential articles aimed at improving our understanding of change and the beneficial effects of psychotherapy.

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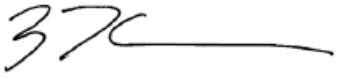
I hope you will join us soon!



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