# Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.divisionofpsychotherapy.org

BULLETIN

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Convention Issue!

APA 118th Annual Convention August 12–15 SAN DIEGO 2010

2010 VOLUME 45 NO. 2

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**PSYCHOTHERAPY BULLETIN**

Published by the
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# PSYCHOTHERAPY BULLETIN

*Official Publication of Division 29 of the American Psychological Association*

**2010 Volume 45, Number 2**

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## PRESIDENT'S COLUMN

*Jeffrey J. Magnavita, Ph.D.*
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In 1957 Hans Eysenck published what was then considered a highly controversial paper titled *The Effects of Psychotherapy: An Evaluation*, in which he declared that the results of psychotherapy are likely due to spontaneous remission and have nothing to do with psychotherapy. This was seen by many as an assault on the field of psychotherapy because of the major implications if indeed valid. Fortunately, later research studies failed to support his contention and instead showed psychotherapy to be effective. The field of psychotherapy has come a long way since that time and the Division of Psychotherapy has been a vital force in advancing science, practice, scholarship, and training. Eysenck's research was a wake-up call to psychotherapists who had become complacent with the belief that psychotherapy was beneficial. Psychoanalysis was the dominant school at the time and very influential, attracting many highly qualified individuals to enter lengthy and expensive training programs. Practitioners of psychoanalysis, as well as other schools of psychotherapy, had become complacent and did not actively seek to use the tools of science, instead relying on reification of theory, charisma of major figures, and tradition. Of course, there were exceptions, such as Carl Rogers and others, who believed in the value of research. The situation has changed dramatically since then, in part, thanks to Eysenck's challenge to the field. He unwittingly spawned a burgeoning psychotherapy research field that continues to inform clinical practice, and provide valuable evidence about effectiveness. We have witnessed many advances in psychotherapy in practice and science that have beyond reasonable doubt established psychotherapy as an effective treatment for psychological disorders, with a greater effect size than most medical procedures, and one which is readily accessible in most parts of the western world.

It appears that the field of psychotherapy over the last four decades, after enduring assaults on many fronts, has been in a phase of resurgence and growth. New sophisticated research studies that illuminate many of the components, principles, and processes of psychotherapy are being published with increasing numbers. Our journal, *Psychotherapy*, a leading publication, features just a portion of this burgeoning research and offers readers the most up to date findings. We are also witnessing a change from primarily a biological-medical model that has held ascendance during the last few decades to a much more integrative, biopsychosocial model that values sophisticated theory about mental functions and processes, as well as multiple theoretical perspectives. Findings from neuroscience illuminate and provide support for many of the observations of early clinical pioneers showing many are indeed valid while allowing others to fall by the wayside. Psychopharmacological treatment while showing promise for alleviating emotional suffering is proving to be insufficient by itself. Pharmaceutical companies have tremendous resources to advertise their products, resulting in many suffering people to request medication that may have questionable effectiveness. On the other hand, psy-

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chotherapy is driven by forces other than marketing and advertising and is fueled by consumer satisfaction, recognition of evidence-base, and word of mouth reports about its value from friends and relatives who have experienced the benefit.

A recent article in the *New York Times Magazine* entitled *Mind over Meds* caught my attention. Daniel Carlat, an associate clinical professor of psychiatry at Tufts University School of Medicine describes his experience first majoring in psychology then "laboring through medical school's rites of passage in order to qualify for a psychiatric residency." Dr. Carlat describes the transformation of psychiatry "from a profession in which we talk to people and help them understand their problems into one I which we diagnose disorders and medicate them." Carlat describes his "split treatment" practice where during 15-20 minute medication visits he adjusts and changes medication, referring to "professionals lower in the mental-health hierarchy, like a social worker or a psychologist to do the therapy. The unspoken implication is that therapy is menial work—tedious and poorly paid." Naturally I found this perspective compelling for a variety of reasons and it got me thinking and examining my feelings about what I do every day in my office. It is interesting that psychotherapy is viewed as menial by some psychiatrists. Many of the wonderful psychiatrists that I work with, and are my close friends, have expressed a certain envy of my ability to practice psychotherapy and get paid out of network for what I do primarily based on client satisfaction with outcome. I realize many psychologist-psychotherapists don't have this option because of serving in rural areas or because of other factors. Many psychiatrists don't have this option because of the way the health care system reimburses at a higher rate for psychopharmacological treatment making it financial burden to practice psychotherapy. In my experience I haven't really encountered the view that psychotherapy is menial or done by those of us lower in the hierarchy. In fact, the trend that I have witnessed is that more medical professionals are seeking out qualified psychotherapists because they have read the research and have had friends for whom psychotherapy has been effective. My interpretation of these observations and others is that psychotherapy has been established as an effective and efficacious treatment for psychological disorders, and that the public values psychotherapy.

Although stigma is still associated with mental health treatment there seems to be much less than in previous decades. When I did my dissertation in 1980, my findings suggested that perceived stigma toward mental health services led to premature termination of psychotherapy. I think Tony Soprano and other television and movie characters have had a significant impact on how seeing a "shrink" is viewed. There is evidence to show that most psychotherapists are regular consumers and seek out psychotherapy during our lives at different stages. I have been an advocate of personal psychotherapy and at various times have engaged in different approaches to help me function better in my complicated life.

So what does this mean for psychotherapy practitioners, researchers, and educators? One thing that is abundantly clear is that psychologists still maintain a keen interest in attaining the competencies necessary to provide this service to members of our community. Although psychotherapy is still not highly valued by many insurance companies, the general public continues to seek qualified practitioners and encourage

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their family and friends to seek treatment. Psychotherapy is a highly complex and multi-faceted skill that cannot be mastered in a short period of time and is not something that can be practiced without solid grounding in psychological and clinical science. Training psychotherapists to an adequate level of competence takes time and high quality training. Most of us know that there are certain individuals who seem naturally gifted and can provide a healing experience to others, but mastering any complex endeavor probably must meet the 10,000-hour rule of focused and consistent practice.

The *Task Force on Psychologist Psychotherapists* (TOPPs) under the able leadership of Dr. Jeff Barnett is beginning to gather the relevant extant literature that we can use to guide further research and policy. It is imperative that we take a leading role in disseminating valid information to the pubic about the benefits and potential hazards of seeking out unqualified practitioners. The American Psychological Association (APA) is in the process of developing a task force to begin the invaluable work of developing practice guidelines that are solidly based on psychological principles and the most relevant evidence. The Division of Psychotherapy has been invited to send a representative to the sixth annual science leadership conference and we are pleased that Dr. Susan Woodhouse has agreed to represent us and ensure that the scientific basis of psychotherapy and clinical research is recognized. The theme of the 2010 conference is *Strengthening Our Science: Enhancing the Status of Psychology as a STEM Discipline* (science-technology-engineering-mathematics).

Dr. Michael Constantino is spearheading a new feature on our Website that will summarize current research with important implications for practitioners. Dr. Jeff Barnett welcomes questions to the ethicist where you can get expert advice from one of the leading figures in ethics. Our domain representatives are in the process of developing interactive content for their web pages. Please visit our site and stay connected with what is happening.

Our Division remains on the forefront in representing psychotherapy to the world. Our Website, Psychotherapy Bulletin, and journal (*Psychotherapy*) allow information to be disseminated to our members and interested psychotherapists from all disciplines. Under the able leadership of Dr. Jean Carter and our excellent publications board we continue to thrive and produce the highest quality publications. Our Journal of Psychotherapy has gained prestige and increased the quality and number of submission under Dr. Charlie Gelso's expert editorial direction. Dr. Mark Hilsenroth is now transitioning to Editor-in-Chief and is already initiating and planning many innovations. Dr. Jenny Cornish has ensured that the quality of the Psychotherapy Bulletin you are reading is of the highest caliber. Every piece in this and every edition has undergone careful review and editing to ensure the highest quality. Dr. Christopher Overtree is a creative force who has done a yeoman's job in his new role as Internet Editor building on the work of Dr. Abe Wolf to keep the division in the forefront of digital publishing and technology. Dr. Stephen Sobelman, who also serves as our division treasurer and has made sure that we are financially sound, has tirelessly guided the *Task Force on Advancing Technology*. Our Division under the direction of Dr. Jack Anchin, our program chair, has put together a phenomenal program for our convention in San Diego this summer. These are all labors of love by devoted individuals and committees who work behind the scenes for all our benefit.

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APA is hosting a number of excellent practice, science, and education plenary sessions that should be very exciting and informative. I hope that many of you can attend. We are in the process of developing suite programming so that small groups can get together to learn, interact, socialize and network. I remember a few years ago sponsoring a suite program with Dr. Abe Wolf who was president of the division. Abe and I had an amazing hour-long discussion that was the highlight of my convention experience with Dr. David Barlow one of the most prominent psychologists of our era. Later Dr. Frank Farley entertained a small group of us with his hilarious comic routine. Drop in and you may get to have an intimate conversation with some of the leaders in our field. Please look for our suite programming in the next issue. Our Early Career Committee will be hosting a Lunch with the Masters for the third year. This had been a very successful program and I hope that you will alert your students and early career psychologists.

I am truly privileged to be working with an amazingly talented and dedicated group of individuals working not only to re-envision our division but also to make us continue to be relevant and at the cutting-edge of emerging trends.

## ROSALEE G. WEISS LECTURE ON OUTSTANDING LEADERS IN PYSCHOLOGY

Division 42 is proud to announce the ROSALEE G. WEISS LECTURE ON OUTSTANDING LEADERS IN PYSCHOLOGY by JOHN DOVIDIO, PH.D.

WHEN: Saturday August 14, 2010, from 5:00-5:50 PM
WHERE: San Diego Convention Center, Room 31C

## Tailoring Social Skills Training to Treat Aggressive Behaviors in Inner city African American Youth

*Courtney Thomas, Psy.D., Columbus State University*
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The epidemic of violence in our communities continues to impact lives at an alarming rate. According to the Bureau of Justice Statistics (2007), the age of those affected by violent crimes has changed significantly since 1994, shifting from adults to teenagers. The National Crime Victimization Survey (Bureau of Justice Statistics, 1994) indicated that juveniles between the ages of 12 and 17 were three times more likely than adults to be victims of a violent crime. Between 1985 and 1991, annual homicide rates among males 15 to19 years old increased 154%, surpassing the rates of those in the 25 to 29 and 30 to 34 year age groups (Snyder & Sickmund, 1995). This pattern has continued as data indicates that from 2002 to 2007, the number of homicides involving African American male juveniles as victims rose by 31%, and as perpetrators by 43% (U.S. Department of Justice, 2007).

While these trends are essentially consistent across most demographic variables, both race and socioeconomic status appear to have a significant relationship with rates of violent behavior. Homicide remains the second leading cause of death of youths aged 15 to 24 overall, and specifically is the leading cause of death for African Americans in this age group (Snyder & Sickmund, 1995). While African Americans only accounted for 28% of the juvenile population in 1995, they accounted for 49% of the juveniles murdered and 54% of the juveniles incarcerated in the U.S. (Sickmund, Snyder, & Poe-Yamagata, 1997). Additional evidence (e.g., FBI, 1997) suggests that aggressive behaviors are more likely to be displayed in certain environments; notably, inner city environments. The Federal Bureau of Investigations annually publishes a Supplementary Homicide Report (1997) which indicated that one-third of all juvenile murders occurred in 10 counties throughout the United States. These 10 counties were all inner city environments, with mainly African American and Latino populations, and high levels of poverty. Urban areas have a greater population density, and therefore, increased opportunities for interpersonal conflict, a heightened sense of insecurity, and higher levels of social disadvantages (Chu, Rivera, & Loftin, 2000). Options are significantly limited in these inner–city neighborhoods, where a larger number of people compete for a finite number of resources. These communities are often defined by their lack of adequate health services, limited educational opportunities, and financial insecurity. A highly competitive playing field is established, where people learn to survive at the expense of others. Fear of crime and violence is a serious individual, community, and societal problem that impacts lives across many domains and influences how people interact with their environment (Liska, Sanchirico, & Reed, 1988; Taylor & Shumaker, 1990).

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For many African American youth, the predatory nature of the inner city is an inescapable context, in which the child must nevertheless learn to flourish and grow. Children are thrust into an environment in which they are routinely recruited by gangs, propositioned by drug dealers, and unfairly profiled by police. Children who are unable to adapt to the dangers in their community are at a distinct disadvantage to those children who learn to operate in this unpredictable and volatile environment. Several studies (e.g., Watt, Howells, & Delfabbro, 2004; McCarthy-Tucker, Gold, & Garcia III, 1999) have understood aggressive behavior as the primary response when a youth does not have the problem solving skills necessary for coping with situations in another way. In many instances, aggression is the only response to problematic situations. This is of particular importance in high crime, low safety environments, where adversarial interpersonal interactions are commonplace. The aggressive behavioral responses of an inner city adolescent are often rewarded by the reinforcer of increased personal safety. The lesson learned is that one's own safety is assured by jeopardizing the safety of others. This strategy becomes increasingly problematic when the aggression generalizes to other situations (like home and school contexts) where the behavior elicits an unexpected aversive outcome.

Zamel (2004) suggests that hypermasculinity is an important, adaptive identity factor among African American males in urban environments and that "invulnerability training" is part of the socialization process for African American youth. Internalized stereotypes that violence and aggression are "typical" behaviors for African Americans may also be reinforcers for aggressive behavior among this population (Bailey, Chung, Williams & Singh, 2006).

Any effort at therapeutic intervention with African American inner city youth must acknowledge that violence is often an adaptive behavior that allows these youths to function in their particular environment. A child who has learned to keep him or herself from being a victim of violence by perpetrating violence against others, has essentially learned to prioritize his or her own personal safety at the expense of developing other interpersonal relationship skills. These individuals will have fewer tools available to get their needs met when faced with adversity. As a result of their underdeveloped problem solving and conflict resolution skills, they rely upon violent behavior patterns and lessen their chance of developing and maintaining healthy social interactions. An appropriately designed intervention would teach strategies to increase individual safety, while promoting the development of a more comprehensive set of interpersonal relationship skills.

Hawkins and Weis (1985) suggest that there may be an inverse relationship between social skills and aggressive behavior in adolescents. The importance of developing children's social skills is well documented by the number of programs designed to teach pro-social behaviors to children with behavior problems. Unfortunately, many social skills training programs ignore specific deficits and broadly apply similar approaches across all children (Gresham, 1998). They also lump all "aggressive behaviors" together (Tremblay, 2010) and ignore differences in motivations and reinforcements among behaviors such as bullying, gang-related violence, sexual violence or forcible theft. As such, the goal of generalizing and maintaining social skills learned in social skills therapy modules, is often unmet (Gresham, 1985). The tendency for a social skills

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training module to focus on predetermined behavioral targets poses a definite risk to the social validity of the intervention. Behaviors that may lead to successful social interactions between inner city youth may differ significantly from the predetermined behavioral targets found to be effective in other populations. The proposed outcomes of many social skills training interventions are largely cognitive with the assumption that changes in thinking will translate into changes in behavior (Gresham, 1985). It appears to be critical that a social skills intervention should be culturally appropriate and effectively target relevant behaviors for the children being treated (Dygdon, 1998). For example "successful behavioral outcomes" for many social skills training interventions include peer acceptance, improved scholastic performance, positive parent reports and other social outcomes that are valued by society but do not necessarily serve as primary reinforcers for the youth in question. More research should be done on social skills training with African American inner city youth, a population who is at high-risk to be both the victims and perpetrators of aggressive patterns.

While some interventions have found success in addressing the behavioral and emotional problems encountered by children, they have not demonstrated effectiveness across all populations (Evans, Axelrod, & Sapia, 2000). The literature available suggests that not all social skills interventions are alike in their ability to target the appropriate behaviors and address specific deficits. Studies such as Evans, et al. (2000) and Kavale & Forness, (1996) have shown low effect sizes for many social skills programs that include participants with diagnosed emotional or behavioral problems. Research also indicates that behaviors learned in one environment do not necessarily translate into other environments (e.g., Gresham, 1998). An aggressive child can learn a suitable response to inappropriate behavior in the classroom, but that same response may not be socially or culturally desirable in that child's neighborhood. Socially acceptable behavior is often culturally defined and varies across racial, economic, and religious lines. The most significant effects of social skills therapy have been found when the lessons reflect the unique needs and social mores of the children being serviced (Lewis & Sugai, 1998).

Effective social skills intervention with African American, inner city youth exhibiting aggressive behaviors must not rely on a predetermined hierarchy of behavioral targets. An alternative to restricting children to focus only on a specified list of skills, is to let the youth participate in the identification of social behaviors that are effective in their environments (Dygdon, 1998). Social skills interventions should be tailored to meet the unique needs of African-American, inner city children. The literature available suggests that a disproportionate number of African-American children from urban neighborhoods use aggressive behavior to accomplish many goals. However, there is growing evidence that many of those same goals can be accomplished through the development of culturally relevant, pro-social skills training. African-American children equipped with a full repertoire of social skills, should no longer be limited to using aggressive behavior as the only means to accomplish objectives and overcome obstacles in high-risk environments.

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

# Conceptual skills needed for evidence-based practice of psychotherapy: A few recommendations

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*"Evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." APA Presidential Task Force on Evidence-Based Practice (2006, p. 273)

An advanced graduate student therapy trainee recently expressed concern about treatment of a difficult case seen in one of her placements. She was frustrated with a supervisor and torn between utilizing knowledge of the patient's treatment history and family patterns versus following a different path suggested by a particular treatment manual. The frustration had been stirred up in context of a group discussion about tailoring treatments to fit individual patients, and using the empirical literature to do so. She asked: "But doesn't the research literature say that fidelity to treatment will bring the best effects? A patient I'm seeing now doesn't like the approach for specific reasons, and it also hasn't worked for her in the past. But, how can I respond to my patient's needs and still be evidence-based? Isn't it unethical to deviate from the manual if it is empirically supported?" Her plan before this discussion was simply to comply with supervisory input to follow the manual, but without much hope for its success with this patient.

The questions asked by this psychotherapist-in-training points to several challenges we face as educators and supervisors in the age of evidence-based practice. On the one hand, we need to provide specific training for empirically supported interventions. On the other hand, we need to help therapists develop the conceptual tools necessary to continue integrating research findings into their clinical work, and apply all these skills in a manner that takes into account individual client needs, preferences, and unique context (APA, 2006).

Reflecting our field's current emphasis, the trainee mentioned above has been taught that empirically supported treatment packages (ESTs) represent the most ethical approach to treatment because of their proven track record in research (cf. Chambless & Crits-Christoph, 2006). She has even been told to steer clear of "non-EST" approaches by some faculty advisors. Given these directives, plus the constraints of time around provision of therapy in graduate training, she has focused almost exclusively on learning ESTs. As a result, she has considerable skill implementing a number of treatment packages for specific disorders, and can cite their empirical basis in randomized control trials (RCTs) with accuracy.

Her skill set as a psychotherapist is still quite limited, however. While she is gaining skill with a few interventions developed for discrete diagnoses, she has received little encouragement to be aware of (much less think integratively about) the broader empirical literature or identify principles that could help her more flexibly generalize and tailor her

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interventions (e.g., Castonguay & Beutler, 2006). When faced with clients whose needs do not easily fit the molds the models she knows, she is at a loss.

As educators, we should not be pleased with this result. Without additional input, this young psychotherapist will go out into practice with a relatively rigid skill set of limited applicability. The frustration she already feels suggests she is at risk for eventual "burn out" as a practitioner.

**Old and new views of evidence based practice**

Our trainee's problems reflect tensions in our field over how best to weigh and apply research evidence. The primary view that has guided this young therapist's education has held sway for roughly a decade and places emphasis on developing, testing, and disseminating treatment packages for discrete disorders (e.g., Gotham, 2006; McHugh & Barlow, 2010; Kazak et al, 2010). A treatment qualifies as an EST based on successfully replicated, randomized control trial (RCT) studies (multiple single-case studies with strong research controls may also qualify for EST status; Chambless & Hollon, 1998). Lists of ESTs were initially compiled in an attempt to demonstrate that psychosocial treatments produced effects comparable to pharmacological interventions and should therefore receive research funding, training, and reimbursement in the era of managed care (APA Division of Clinical Psychology, 1995). An RCT study answers a single question about psychotherapy very well: "Does therapy X have an effect on disorder Y, if all other factors are controlled?" The information provided by an RCT directly addresses the needs of an administrator overseeing a large system of care who wishes to ensure that "on average" there will be a positive effect if a particular approach is implemented. In an RCT, treatments are usually applied to a single category of disorder by clinicians trained to a high level of adherence. Randomization is used to distribute pretreatment characteristics such as personality type, age, gender, motivation, and prior treatment experience evenly across groups so that they are unlikely to be responsible for any group differences in outcome. Dissemination of an EST tends to flow logically from the same research design: psychotherapists are trained to adhere to the EST manual and apply it with patients having a particular disorder (McHugh & Barlow, 2010; Kazak et al, 2010), just as in the case of our frustrated trainee.

By contrast, "evidence-based practice of psychology" (EBPP) has been defined by an APA Presidential Task Force (2006) as invoking all available research methodologies and focusing treatment on individual clients:

"*It is important to clarify the relation between EBPP and empirically supported treatments (ESTs). EBPP is the more comprehensive concept. ESTs start with a treatment and ask whether it works for a certain disorder or problem under specified circumstances. EBPP starts with the patient and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome. In addition, ESTs are specific psychological treatments that have been shown to be efficacious in controlled clinical trials, whereas EBPP encompasses a broader range of clinical activities (e.g., psychological assessment, case formulation, therapy relationships). As such, EBPP articulates a decision-making process for integrating multiple streams of research evidence—including but not limited to RCTs—into the intervention process.*" (p. 273)

Ultimately, the APA application of EBPP requires a higher standard from therapists and educators, and is likely to be worth the effort if it allows therapists

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like our trainee to effectively answer the questions she poses and meet the needs of her client. In addition to training with discrete treatment packages and intervention "tool kits," the most successful therapists will also be prepared with sufficient background and conceptual skills to integrate what is known from across the research literature, combine it with clinical expertise, and apply it in ways that are flexible and responsive to client characteristics.

**Skills needed for successful EBPP**

The "competencies movement" in psychology seeks to identify the skills and attitudes that need to be acquired for professional development (Fouad et al, 2009; Kaslow et al, 2009). Its focus is comprehensive and sees psychotherapy skill acquisition as unfolding across levels of graduate training and professional practice. Competencies are divided into two broad classes, those that are "functional," reflecting discrete domains of professional activity (assessment, intervention, consultation, supervision, research/evaluation, supervision, teaching, administration, and advocacy), and those that are "foundational," cutting across functional domains (professionalism, reflective practice, knowledge of scientific methods and findings, relationship skills, sensitivity to individual differences and cultural diversity, attention to ethical and legal standards and policies, and ability to interface with interdisciplinary systems). We wish to draw particular attention to foundational competencies that involve scientific method and recommend a particular kind of scientifically-minded thinking style vital for evidence based practice.

**Scientific-mindedness**

By scientific-mindedness, we refer to a clinician's willingness to engage in a process of inquiry that should involve not just consideration of the empirical literature, but also evidence available directly from clients. Ideally, the process begins with careful assessment that results in an individual case formulation, that is, a set of hypotheses about the sources and maintaining factors associated with an individual's problems. Interventions are then selected in light of the relevant literature, and in consultation with the patient about his or her needs and preferences. Ongoing evaluation of therapeutic impact then provides data about the effects of the intervention and can lead to flexible modification or a change in course as needed, and in collaboration with the client. Lambert and colleagues (e.g., Slade, Lambert, Harmon, Smart, & Bailey, 2008) provide evidence that feedback from formal, ongoing monitoring of symptom states can improve outcome. To extend this logic, depending on the individual formulation of a client, relevant outcome data may also involve clients' patterns of thinking, feeling, or relating with others, motivation for change, quality of the in-session relationship, and more. To summarize, the proposition here is that psychotherapists be trained in a manner that leads to primary identity as a clinical scientist whose work places emphasis on generating and testing individual-level hypotheses about change, in a context of collaboration with clients and consultation with the empirical literature.

**Critical thinking and integration**

Critical thinking involves evaluating logic and weighing evidence. As applied to psychotherapy, it involves the ability to understand and evaluate published research results as well as to accurately assess the circumstances and experiences of individual clients. The complement to critical thinking is *integrative ability*, which involves being able to pull together different studies, different strands of data, and synthesize them into a specific hypothesis with associated plans of action. Examples of inte-

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grative thinking would include pulling assessment data together into a case formulation with clear implications for treatment, detecting areas of overlap and convergence between multiple treatment methods, and using clinical experience to inform treatment decisions. With critical thinking, clinicians learn how to break problems into separate parts, evaluate and analyze underlying logic. Then, using integrative abilities they shuttle in the opposite direction, synthesizing information, generating new hypotheses and possible solutions that respond to unique circumstances. Both skills are needed.

Supervisors and educators can model these thinking skills and invite the same from trainees in concrete ways. For example, problems presented by an individual client could be used to demonstrate and directly apply principles of evidence-based practice. Students could be assigned to scour the empirical database about some aspect of the client's presentation. The contents of EST manuals and other relevant material would be reviewed with an eye toward finding specific interventions of relevance. Once this review has occurred, the underlying logic and evidentiary base for treatment would be taken into consideration, as would areas of potential convergence across multiple studies or schools of thought. A mindful, collaborative, application of what has been learned would then be applied with the specific case. Optimally, supervisor and trainee would become engaged in an active, collaborative, evidence-based endeavor involving careful assessment, consultation with the empirical literature, hypothesis formation about useful interventions, and systematic evaluation of their impact for an individual case. Three key elements of EBPP are present in the foregoing suggestion: primary focus on the individual through use of case conceptualization methods, active use of the existing evidence-base, and exercise of EBPP as a process of decision-making and empirical inquiry. At first, the training model would be slow and resource intensive, with a great deal of time spent focused on individual cases. With time and practice, the process can be abbreviated and tailored to training needs as clinical skills are effectively practiced and internalized.

**Relationship skills and EBPP**

One of the more consistent findings in psychotherapy research studies with many different treatments and disorders is that a positive therapeutic relationship correlates with improved outcome (Horvath & Bedi, 2001; Wampold, 2001). Resources are increasingly available to summarize empirical work on the alliance and provide specific training recommendations (e.g., Muran & Barber, 2010; Norcross, 2002). The most studied aspect of the therapeutic relationship is the alliance, which consists of the affective bond between a patient and therapist, as well as their agreement about goals and therapeutic tasks for reaching them. Evidence-based practice may be particularly well-suited to enhance collaboration to the degree that it begins with focus on the individual client, thereby planting the seeds for a strong alliance.

**Final comments**

The approach outlined here suggests that the curriculum for psychology training needs to include greater emphasis on "foundational" competencies so that skilled intervention is learned and applied in broader context of EBPP. Scientific-mindedness, critical thinking, integrative capacity and relational skills all must be modeled and practiced across the curriculum so that they become part of the language and culture of evidence-based professional practice. We believe that a basic introduction to evidence-

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based practice should occur from the earliest phases of psychotherapy training, rather than being treated as an 'advanced topic' to be learned only after diagnosis-specific interventions and ESTs have been mastered. Perhaps the easiest place to start implementing EBPP in training settings is simply to introduce the APAs definition of evidence-based practice and encourage critical thought and discussion about its elements and implications, as recommended by Levant and Hasan (2008). An edited volume by Norcross, Beutler, and Levant (2006) also provides a related, excellent overview of the issues and challenges our field faces integrating science and practice as the empirical database continues to grow.

Ultimately, our hope for future trainees is that they will continue to push and expand boundaries of our current knowledge, improving client outcomes through a process of active engagement with the evidence-base.

**Note: The authors invite comments on this article in the Education and Training area of the Division of Psychotherapy website (www.divisionofpsychotherapy.org). Pull down the menu titled 'Domains' and select "education/training" to find the relevant area of the site.**

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# You might think that it is cold, but it has been hot since the beginning and it is only getting hotter: The therapeutic relationship in CBT

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Cognitive-behavioral therapy (CBT) has had a long and complex relationship with, well, the relationship. It seems that there are few topics as popular for discussion among psychotherapists and psychotherapy researchers than what role therapeutic orientation and therapeutic relationship play in treatment, and few misunderstandings more pronounced than how cognitive-behavioral therapies regard the role of the relationship.

For instance, the first author recently attended a talk by a senior clinician who informed the audience that he has a colleague who "combines CBT with a warm and friendly approach in a really neat way." Similarly, when the first author informed a fellow psychotherapist-in-training that he was writing a piece on the working alliance in cognitive-behavioral therapy, the student (who happens to be primarily psychodynamically-oriented) playfully replied, "Oh, is there one?"

These brief anecdotes illustrate what seems to be a fairly common belief among psychotherapists: that practicing CBT is somehow at odds with being a warm and friendly person, and that in CBT the relationship is not a crucial factor. However, the history of research on these issues is much less clear than many people assume. In fact, the literature suggests that CBT has always required a warm relationship. In this paper we will address the issues of whether the therapeutic relationship in CBT is best characterized as "cold," whether CBT assumes the relationship to be an unimportant factor in change, and finally, specific ways cognitive-behavioral therapists have used the relationship as part of the therapy process.

**Is the relationship in CBT cold?**

From our standpoint this question is raised with surprising frequency, particularly given CBT's long history of endorsing warmth, empathy, and collaborative affiliation in theory, practice, and research. Going back to the pioneers of behavioral, cognitive, and then cognitive-behavioral therapies, experts have long encouraged practitioners to adopt a warm and engaging interpersonal style in order to improve the relationship.

For example, one of the early behavior therapists who made important technique and theoretical contributions to behavior therapy, Wolpe, noted that when clients seemed to like him, they showed signs of improvement even before the specific application of his therapeutic interventions (Wolpe, 1958). Similarly, in their classic application and expansion of behavior therapy, Goldfried and Davison (1976), said "the truly

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skillful behavior therapist…interacts in a warm and empathic manner with his client" (p. 56). It should also be noted that these authors also gave a strongly worded warning of clinical and research import: "Any behavior therapist who maintains that principles of learning and social influence are all one needs to know in order to bring about behavior change is out of contact with clinical reality" (p. 55). A more clear statement regarding the quality and value of a strong relationship in cognitive-behavioral therapy is hard to imagine.

Far from being a small minority, many other prominent researchers and clinicians were coming to similar conclusions around this time. Beck, Rush, Shaw, and Emery (1979), for instance, suggested that their approach was not so different from other practitioners at the time: "Cognitive and behavior therapies probably require the same subtle therapeutic atmosphere that has been described explicitly in the context of psychodynamic therapy" (p. 50). Further, they went on to discuss warmth, accurate empathy, and genuineness as important characteristics of cognitive and behavioral therapists. Known as an early and prominent figure of behavior therapy, Brady stated that all psychotherapists should seek to be perceived as an "honest, trustworthy, and decent human being with good social and ethical values" (Brady, Davison, Dewald, Egan, Fadiman, et al., 1980).

The emphasis on basic qualities of the therapeutic relationship has not disappeared with the energy that has been invested by many CBTs in the development of therapy manuals and empirically supported therapies (Castonguay & Grosse Holtforth, 2005). As one example, Hembree, Rauch, & Foa (2003) have noted that trust is an absolutely essential element of the therapeutic relationship in prolonged exposure therapy, because of the difficult and sometimes distressing nature of the process of exposure therapy with trauma victims. The "trust" that these authors identify as essential is not only reminiscent of the "basic trust" identified by Beck, Rush, Saw & Emery (1979), a client's belief that the therapist is working in the client's best interest – but it is also a suitable paraphrase of the construct of agreement on goals of therapy, an important component of the working alliance (Bordin, 1979).

Given all of this theoretical writing on the CBT relationship, one might wonder how CBT has acquired such an infamous reputation. We propose that there are primarily two reasons for this. The first is that the therapeutic relationship *is* different in CBT, at least theoretically, than in some other orientations of psychotherapy. A second reason is that historically, cognitive-behavioral therapies have emphasized therapeutic interventions (techniques) as the primary causes of therapeutic change while other therapies have placed more emphasis on the therapeutic value of working with the relationship. This first point will be addressed next, while the second requires more space and will be addressed after.

The particular qualities of the CBT relationship that have emerged over the years can be summarized by a term coined by Beck and colleagues (1979): collaborative empiricism. While, as we mentioned above, these authors were not the first in the CBT literature to note the importance of the relationship, this term has become widely used and might just as pithily reflect the entire CBT approach to treatment as it does describe the relationship that takes place within it. "Collaborative empiricism" at once captures a relationship that is highly interactive, democratic, task-oriented, and based on the exploration of reality as best defined by the knowledge of the senses. This has also been described as a sense of teamwork that is necessary in

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CBT, perhaps as a function of CBT's fairly directive stance (Raue & Goldfried, 1994). "Collaborative empiricism" has become a common term used to describe cognitive, behavioral, and cognitive-behavioral psychotherapies (e.g., Dimidjian, Martell, Addis, & Herman-Dunn, 2008; Fairburn, Cooper, Shafran, & Wilson, 2008; Turk, Heimberg, & Magee, 2008; Young, Rygh, Weinberger, & Beck, 2008).

Do not mistake us for saying that cognitive and behavioral therapists are typically collaborative while therapists of other orientations lack this quality entirely. Collaboration is no doubt important in other therapies as well, and a strong and explicit "dose" of it is likely to be particularly needed for the successful implementation of any kind of directive treatment. When the psychotherapist seeks to engage the client in planned activities or tasks, whether they are cognitive (e.g., Socratic dialogue in the service of cognitive restructuring), behavioral (e.g., exposure), experiential (e.g., a one-chair technique aimed at assisting the client to identify his or her experience), interpersonal (e.g., taking an extensive history of interpersonal relationships), or any other type, the process is made much more difficult by the absence of a collaborative relationship. Nevertheless, cognitive and behavior therapists deserve some credit for pioneering and popularizing this attitude. The pioneers of Gestalt therapy, for instance, were not so collaborative, though quite directive, when they described their interactions with clients as "arguments" (see, e.g., Perls, Hefferline & Goodman, 1977).

There is also substantial empirical evidence to suggest that CBT therapists are not cold with clients, and this literature extends back nearly as far as behavior therapy itself. One of the more well-known examples is the study by Sloane, Staples, Cristol, Yorkston, and Whipple (1975), who found that behavior therapists displayed significantly more empathy, genuineness, and interpersonal contact, as well as comparable warmth, than did psychoanalysts. Though this may not be surprising to some of us now, at the time this was an unexpected finding. A similar study conducted by Brunink and Schroeder (1979) compared verbal utterances of expert therapists in psychoanalytic, Gestalt, and behavior therapies in levels of empathy, rapport, or structure of the session. While orientations did not predict any difference in these variables, behavior therapists were found to provide more supportive statements than the other therapists.

More recently, evidence from empirical studies (e.g., Krupnick et al., 1996; Marmar, Gaston, Gallagher, & Thompson, 1989; Raue, Putterman, Goldfried, & Wolitzky, 1995; Salvio, Beutler, Wood & Engle, 1992) and meta-analyses (e.g., Horvath & Symonds, 1991) suggests that while the alliance in CBT is not unequivocally stronger than the alliance in other orientations, there is ample evidence to suggest that it is not at all weaker. While we have only described a small piece of the literature on this subject (for more comprehensive reviews, see Lejuez, Hopko, Levine, Gholkar, & Collins, 2006; Morris & Magrath, 1983; Raue & Goldfried, 1994; Waddington, 2002; Wright & Davis, 1994), we hope that the reader is convinced that CBT is not characteristically cold, as some of our colleagues have insinuated. We now turn to the role CBT ascribes to the relationship in the change process.

**Does CBT assume that the working alliance is an unimportant factor in treatment outcome?**

Given that behavior therapy was based on principles of learning and conditioning that originated in experimental laboratories, and has developed specific techniques to capitalize on the experimentally-demonstrated causes of behav-

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ior change, this may suggest that claiming a CBT orientation means that one believes that the relationship is not a significant part of the change process. We would like to suggest, however, that while the early proponents of CBT may have under-emphasized the importance of the relationship in the change process, it seems that the current state of the literature is much more receptive to the idea of the relationship or alliance, as a contributor to therapeutic gains.

One of the early behavioral attitudes towards the relationship is that of Wolpe & Lazarus' (1966) belief in a positive relationship providing "nonspecific reciprocal inhibition." By this, the authors indicated that a strong relationship helps to reduce clients' anxiety in general when in the presence of the therapist, and this decreased arousal could be helpful when applied to the clients' specific presenting problems. Thus, this perspective essentially takes the therapeutic relationship as useful only insofar as it provides a productive context for working on the identified psychopathological issue for therapy. For instance, Raue & Goldfried (1994) provide an excellent analogy in stating that the alliance is to therapy what the anesthesia is to surgery. While this analogy does not ascribe any therapeutic benefits directly to the "anesthetic," it does highlight the central importance of the alliance in setting the stage for change. Similarly, Linehan (1993) has written, "Not much in DBT can be done before [a strong] relationship is developed" (p. 98), echoing this sentiment in a modern primarily CBT-oriented therapy.

However, it may well be that this notion of the alliance as anesthetic, which has certainly been a main trend in the CBT literature, undervalues the mutative power of a strong therapeutic relationship. This may have less to do with the clinical importance of the relationship as CBT is implemented, rather than being a consequence of its historical roots in experimental psychology and learning theory. Consistent with their empirical approach to therapy, CBT scholars and researchers have frequently separated therapeutic components into two distinct categories: specific and nonspecific variables. Specific variables are those that are identified by a particular theory as the primary cause of change. They can be defined operationally and are assumed to be unique to a specific approach. In contrast, nonspecific factors are assumed to be present in all orientations and perceived as being difficult to measure. For many CBT scholars, nonspecific variables have been viewed, scientifically, as variables to be controlled (in order to establish the causal effect of specific factors) and, clinically, as factors that are auxiliary to the primary means of change (see Castonguay, 1993, for a more extensive discussion on specific and nonspecific factors). And for most of its history, CBT has viewed the techniques based on learning principles (e.g., systemic desensitization) as specific variable *par excellence* and the therapeutic relationship an archetypal nonspecific variable.

As noted elsewhere (Castonguay, 1993; Castonguay, Constantino, Grosse Holtforth, 2006; Castonguay & Grosse Holtforth, 2005), however, the construct of the alliance has been clearly defined and several instruments have been able to measure it reliably and validly. In fact, to the authors' knowledge, the alliance is the most frequently investigated process of change. In addition, even though there are notable exceptions (e.g., DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999), the empirical evidence as a whole suggests that the working alliance is a correlate of outcome in CBT (see Waddington, 2002).

The fact that it has been defined operationally and that it is predictive of

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clients' change (although there is still controversy about it causal impact), indicate that therapists, including CBT therapists, should not consider the alliance and other relationship variables (see Castonguay & Beutler, 2005; Norcross, 2002) as a nonspecific (unspecified) factors that are merely auxiliary to the prescribed techniques. While there is clear evidence that CBT-specific techniques (such as the assignment and completion of regular homework and the emphasis on psychoeducation) are sometimes good predictors of psychotherapy outcome (e.g., Burns & Spangler, 2000; DeRubeis & Feeley, 1990), there is reason to trust that aspects of the relationship, such as the perceived therapist warmth and empathy are facilitative of therapeutic gains as well (e.g., Burns & Auerbach, 1996;).

Consistent with the view that the therapeutic relationship is a potential mechanism of change to be fostered and used, clinicians and researchers have developed (or assimilated) theory and techniques designed to enhance this element within a CBT treatment. The next section focuses exactly on this subject.

**How do CBT therapists use the relationship?**

One way that cognitive and behavioral therapies have progressed over the recent past is by assimilating techniques and theory from outside sources. In the case of the therapeutic relationship, several CBT writers have borrowed from psychodynamic-interpersonal and humanistic approaches to therapy. These developments in CBT have largely moved in two distinct but related directions: first, in reassessing the role of the alliance as a theoretically corrective part of therapy, and second, in adopting new techniques designed to resolve problems with the alliance.

Several contemporary researchers and theoreticians have proposed uses of the therapy relationship in CBT, sometimes in ways that may seem very unexpected to those unfamiliar with this literature. For instance, Young (1999) suggested that therapists treating clients with personality disorders use the therapy relationship to more effectively activate schemata, and explicitly highlights how similar this is to the use of transference in other orientations (p. 34). Kohlenberg and colleagues have also developed a CBT-oriented treatment that relies on the use of the therapeutic relationship and *in vivo* interpersonal interventions, which often directly address the relationship (Kohlenberg & Tsai, 1991). Hayes and his colleagues who have developed their approach to CBT (Acceptance and Commitment Therapy; Hayes, Strosahl, & Wilson, 1999) have similarly said that the relationship may not be the end purpose of therapy, but that it may be curative if it provides an example of a loving, accepting relationship (Hayes, Strosahl, & Wilson, 1999, p. 279). These authors have clearly worked to show that psychotherapists can, and should, address the therapeutic relationship in CBT because doing so provides a pathway to change.

However, it is important to note that CBT writing on how to work with the therapeutic relationship to directly bring change is not new in and of itself. Arnkoff (1981), for one, made the point that the relationship in cognitive therapy can be as fruitful a source of information and therapeutic focus as in a transference-focused psychodynamic treatment. Goldfried (1985), in an almost radical stance, suggested that not only are relationship-focused interventions (therefore including, most famously, transference interpretations) fully appropriate within cognitive and behavioral therapy, but should be considered *in vivo* interventions which may possess more power than imaginal interven-

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tions. Using such *in vivo* interventions, a psychotherapist may not only begin to address some complex interpersonal patterns and issues arising within the therapy relationship, but use the relationship to perhaps provide corrective experiences for any maladaptive relationship expectations. Thus, he essentially suggested that client improvement can be directly fostered by working with the relationship itself.

There have also been other scholars who have studied the way that CBT therapists can better address, or indeed, utilize any naturally occurring difficulties in the therapy relationship (e.g., Leahy, 2001; Newman, 1994; 1997; Persons, 1989; Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996; Young, 1999). Burns (1989), for example, described what he called "listening skills," which can help cognitive therapists address problems such as client resistance to treatment or a disagreement regarding treatment. This set of skills, briefly, include inviting clients to express their subjective state, responding empathically to the client's response, and finally the "disarming" technique, which means to explicitly validate the criticism or negative emotion, and find something true about it to agree with. Burns argued that by employing these tools, CBT therapists might find success in deescalating conflicts in the relationship.

In a program of research regarding alliance ruptures and repairs, Safran and colleagues have described productive ways to treat alliance ruptures in several types of psychotherapy, including cognitive therapy (e.g., Muran et al., 2009; Safran et al., 1990; Safran & Muran, 2000; Safran, Muran, Samstag, & Stevens, 2002; Safran & Segal, 1990). Based on a series of empirical studies, these authors suggest that therapists, when confronted with any alliance rupture, would do well to explicitly recognize their own contribution to the alliance rupture. In doing this, Safran and colleagues have suggested that the goal of such an intervention is to induce the client to discuss his or her own contribution to the conflict in the therapy relationship, and potentially as well their own contribution to extra-therapy interpersonal problems.

These and other interventions have received some empirical support as useful skills for cognitive and behavioral therapists. For instance, research from Safran, Muran, and their colleagues suggests that directly exploring rupture experiences within sessions can help resolve the alliance rupture and may contribute to psychotherapy outcome (Muran et al., 1990; Safran & Muran, 1996; Safran et al., 1990). Relying on the contributions of Burns as well as Safran and Muran, Castonguay et al. (2004) developed a treatment protocol called Integrative Cognitive Therapy (ICT) that assimilates techniques to repair alliance ruptures into cognitive therapy for depression. ICT has demonstrated promise both as compared to a wait-list control group in an initial study (Castonguay et al., 2004) and compared to a standard cognitive therapy for depression (Constantino et al., 2008). In sum, there is evidence, albeit preliminary, supporting the assertion that cognitive and behavioral therapists can treat problems in the relationship not only as obstacles to therapeutic gains but also as possible opportunities to promote therapeutic growth.

**Conclusion**

In this paper, we have considered the questions "Is the relationship in CBT cold?" "Does CBT assume that the working alliance is an unimportant factor in treatment outcome?" and "How do CBT therapists use the relationship?" In examination, it seems clear that the relationship in CBT has never been de-

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fined by even the slightest coolness, and that while CBT has often emphasized learning and behavior change as the central mechanisms of change, there is evidence to support the hypothesis that the relationship itself may have positive effects within a CBT treatment. Moreover, it seems that within the last several years many CBT researchers have begun to conceive the relationship in new, more encouraging light, and have even developed specific interventions designed to promote the alliance within CBT. It seems that the time for considering CBT a cold, dispassionate application of technique, has long passed: it is hotter than many people think it is.

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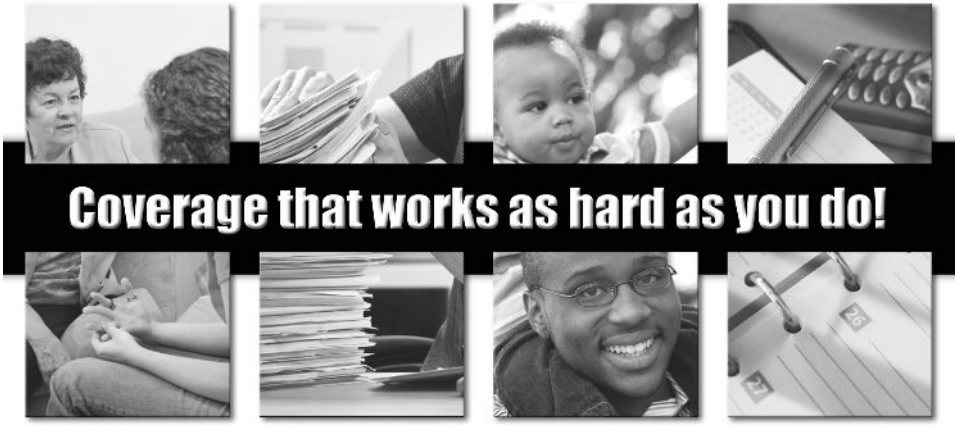


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## Lessons Learned in the Path to Academia

*Amy Przeworski, Case Western Reserve University*

My path to academia began during an undergraduate seminar for which we wrote a journal style paper each week reviewing assigned articles, identifying a gap in the literature, and designing a study that addressed that gap. This intense course represented the first time in my schooling that I was not a passive recipient of psychological knowledge, but instead, an active participant—critiquing the literature and creating my own hypotheses about the field, being scientifically curious and continuously asking why things are the way that they are. To this day, I still think of the instructor and how she shaped the entire trajectory of my career with that one course. I also thank her each day for doing so.

What she inspired in me was the desire to know the answers to questions—why does this therapy work, for whom does it work, why does trauma devastate some and leave others largely unscathed, why do some develop psychopathology and others don't? In the years since my transformative undergraduate seminar, each question that has crossed my mind when reading an article or seeing a client (and pondering how the client ended up where he or she is) has excited me and left me yearning to find answers. Each data point brings me closer to such answers, and that is what academia is all about for me—the inception of a hypothesis and the moment where you learn if what you expected is actually supported by the data. It is that moment that makes academia the most wonderfully fulfilling career, and that keeps brings researchers back to the drawing board to design a new study, write a new grant, and refine or develop a scientific method.

As an empiricist and a behaviorist, I would like to say that my path to academia was based on hard work, perseverance, and most of all, the data. And it was; however, it was also about luck, happenstance, and fortuitous circumstances. After my undergraduate training, I was lucky enough to obtain a research assistant position in one of the best anxiety clinics in the world. I have also been fortunate enough to work with some of the most brilliant scientists in the field throughout graduate school and my postdoctoral fellowship. The many years of schooling, theses, comprehensive exams, and training all taught me the skills on which I continue to rely now.

I had expected that I would be entirely prepared for academia—after all, it is what I had been doing as a trainee for so many years. And yet, somewhere along the 10+ years of training, there were still many things that I had not learned—such as how to start up your own lab, how to set up your own clinic, and how to form a network of referrals when you are starting in a new place and entirely from scratch. When I walked into my office on my first day as an academician, I realized that I was not as prepared as I expected. I walked into a room that was entirely bare—there were four walls, a carpet, and a telephone and that was it. I had never started from scratch before and had little idea where to begin. There was no structure, no one else to teach me

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what to do, and I found myself feeling entirely unprepared. In my first year as an academician, I found myself floundering far more than I expected. From the large questions of how to start up my own anxiety clinic with absolutely no structure in place, to the most basic questions of how to get a desk chair. I have learned many lessons in my short time in academia and happily have a fully functioning office and lab now.

***Lessons learned***

*Don't rush through grad school.* Graduate school is the time when you truly learn what it takes to succeed in academics. Therefore, it is important to take in every lesson that you can learn in graduate school and to ensure that you are gaining the training and experience for which you were looking. This cannot be done by rushing through a program or by doing the bare minimum in any of the various spheres of training—research, teaching, and clinical work. Most academic environments are looking for individuals who are well rounded, so take your time to do research, gain extra clinical experience and teaching experience, present at conferences, and network.

*Do a post doc.* Do I need to do a post doc? This is the question that I asked the most throughout graduate school and rarely got a satisfactory answer. As a cautious individual, I decided that more training must be better than less training and I decided to do a post doc. That was perhaps one of the best career decisions that I have made to date.

Post doc is your last opportunity for training before you are off on your own. Although you can take workshops to learn a new therapy or courses to learn a new statistical method, the training that you receive will never be as exhaustive (and without most other student or professional responsibilities) as that of post doc. The majority of my training throughout graduate school consisted of work with adults; however, I wanted to work with individuals with anxiety disorders across the lifespan. On post doc, I had the opportunity to immerse myself in pediatric psychology research and clinical work. This opened my eyes to new areas of interest—obesity, sleep disorders, and siblings of children with chronic illness. I also learned that there were many skills that I didn't have and that are necessary for a successful academic career, such as grantsmanship, how to write a job talk, and how to get licensed. Post doc is an excellent time to learn those skills and many postdoctoral programs have seminars that cover those topics.

Post doc is also a wonderful time to try out new settings. Most of us attended graduate school in a psychology department in a university, which is often the only academic setting with which we are familiar. Post doc can be an opportunity to expand your horizons and work in various settings, such as a VA hospital, private hospital, or medical school. My postdoc included clinical rotations at a children's hospital and research in a medical school setting. I learned of the unique challenges that are present in "soft-money" positions, but also the advantages to working in a position that consists primarily of conducting research, writing grants, and seeing clients. Postdoctoral positions may also provide the opportunity to supervise research assistants and interns engaging in clinical work.

*Choose the position that works best for you.* Academic positions come in various flavors; therefore, it is important to go into the application process being fully aware of the advantages and disadvantages of each. Having worked as a research assistant in a medical school setting before graduate school and then

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being in a psychology department at a large university for graduate school, I had been exposed to the different environments and challenges faced by faculty in each setting. Each comes with its own uncertainty—for faculty members in most medical schools, the majority of their salary comes from grant funding, with supplemental funding for seeing clients, and involvement in training and administration. For faculty members in most university psychology departments, the majority of their salary comes from teaching, with supplemental funding from grants, seeing clients, and involvement in training. Faculty in medical schools often feel secure in their positions as long as they have a grant, with increased uncertainty as a grant expiration date looms. The stress is therefore dispersed over time and often occurs when a grant will be expiring. For faculty in university psychology departments, the stress and uncertainty occurs mainly for the first several years of the academic position—the pre-tenure phase. There is less emphasis on grant funding and more emphasis on publishing. However, in a medical school position, a faculty member is paid a 12 month salary and in a university psychology department, the faculty member is paid only a 9 or 10 month salary. It is important to identify which academic position will provide the opportunities and lifestyle that makes an individual happy—another reason why it is so important to have had the opportunity to work in both settings.

*There is no magic formula.* I spent much of the months when I was applying for academic positions wondering what was enough—did I have enough publications, enough clinical experience, teaching experience, and grant-writing experience? But what I have learned since then is that there is no magic number or formula. Each faculty member in my department has had a different path to academia and entered our department with different degrees of productivity and experience. What is most important is the fit with the institution to which an applicant is applying and the position that the institution wants to fill. Each institution has entirely different criteria for tenure, different emphases, and different compositions of specialty areas. Therefore, each institution has different criteria for applicants for tenure track positions and the goal is to find a position that best matches the individual.

*Have lunch.* In the orientation for new faculty at our university we were told that we should spend our first year just having lunch with people. I laughed at the time, being unable to remember a time when I did not each lunch at my desk either between appointments or while prepping for the next meeting. However, I quickly realized the importance of this advice once I decided that I wanted to write a grant on a particular topic and realized that it really does take a village! I searched the internet for a potential collaborator in the area who had expertise that complemented mine. Once I found this collaborator, she opened the door to connections with many other individuals at local institutions and hospitals, as well as recruitment avenues. This process is necessary for success in many research studies and grant applications, as well as in order to maximize the enjoyment of conducting a research study through a team approach. Connections are essential for finding collaborators, referrals, and statistical consultation, as well as for brainstorming new ideas and conducting translational research. So take time for a leisurely lunch with a colleague or potential collaborator and you will reap the benefits.

*Consult with senior faculty mentors and previous mentors.* One of the most useful

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programs in my current institution is a mentorship program in which tenured faculty meet with untenured faculty to provide guidance. This mentorship has helped me to navigate the infrastructure at my university, has provided me guidance in the tenure process, and has assisted me in adjusting to academic life. I have also consulted many times with mentors from graduate school and other training experiences and have found their advice to be invaluable.

*Realize that it is a process.* The first year of being a faculty member felt much like my first year of graduate school—acclimating to a new experience, struggling with the imposter complex, many logistic issues, and wondering if I would ever have the time or connections to do what I actually wanted to do—research. I was finally finished with training and had achieved what I wanted to achieve. I expected to feel confident, secure, and a sense of achievement. Instead, I felt quite lost and unsettled as I realized that there was a whole new set of expectations for me (and now my job depended on me meeting those expectations!). As usual, when faced with uncertainty, I jumped head long into work—trying to set up my lab, design my courses, submit numerous IRB proposals, and work on publications at a frantic pace. Each day brought new frustrations, as I was unfamiliar with the infrastructure at the university and therefore new and unexpected hurdles kept appearing. At the time, I was focused almost exclusively on where I wanted to get, not the process of getting there or the present moment. I had to continuously remind myself of things that I had learned as a therapist and a process researcher—that what is important is not always about achieving a goal or reaching an endpoint, but about the process of getting there and enjoying each moment of that journey. Once I did that, things clicked into place. Most departments hire a faculty member because they have confidence that the individual will get tenure. The important thing is to remember to enjoy each moment of that pursuit instead of focusing on the ticking of the tenure clock.

Academia truly is one of the most fulfilling, intellectually stimulating, and enjoyable careers. In one day an academician may help a client to overcome their symptoms, finish a grant application that will advance the therapeutic work of future clinical psychologists, analyze data providing new information about the etiology of a disorder, and/or inspire a new student to major in psychology (as I once was). Few careers afford so many opportunities to impact individuals in such far reaching and diverse ways or the opportunity to spend each day asking that favorite childhood question of "why?" Although the path to academia is long, it is worth every moment of the journey.

## 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 July 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).

# Psychotherapists and the Ethics of Scholarship: An Introduction

*Jeffrey E. Barnett, Psy.D., ABPP and*
*Arianna E A. Perra, M.S.*
*Loyola University Maryland*

Psychotherapists participate in a wide range of scholarship activities. These may include conducting research, providing workshops and other presentations, and professional writing. These scholarship activities are essential for the ongoing growth and development of the psychotherapy field. Psychotherapy researchers and theoreticians provide the foundation for all clinical work by psychotherapists. As such, psychotherapists must be able to count on the fact that the highest standards of scholarship are maintained. The APA Ethics Code (APA, 2002) and the APA Publication Manual (APA, 2010) provide psychotherapy researchers and scholars with clear guidance for their conduct in two very important aspects of their work. First, specific standards are provided for the ethical conduct of research. These standards include such issues as informed consent, the use of deception, debriefing procedures, the use of incentives, recording of research participants, and others. Additionally, a number of standards specifically address the ethics of scholarship: how research results and other scholarly contributions are shared. These standards include conflicts of interest, publication credit, reporting research results, plagiarism, duplicate publication of data, sharing research data for verification, the use of confidential information for didactic or other purposes, and serving as a reviewer. This article provides a brief overview of these issues relevant to the ethics of scholarship. Subsequent articles may address them individually in greater detail.

Psychotherapy researchers may be under a number of pressures that can influence the decisions they make and if unwary, might lead to impaired judgment and decision making. At times, the pressure to 'publish or perish' may, alone or in combination with other pressures, result in lapses in ethical judgment. Those with grant funding at stake may feel pressure to report certain findings. Researchers who receive funding from industry sources or who have paid consultantships may be especially vulnerable to ethical lapses. Personal issues such as ego and the need for status may also influence ethical judgment and decision making. Additionally, those not adequately trained in ethical practices may inadvertently violate ethical standards.

One can easily question if such issues are really relevant to psychotherapy researchers, especially if violations of ethical standards in scholarship are only rarely violated. Martinson, Anderson, and de Vries (2005) conducted a survey of early- and mid-career researchers and asked them to report on unethical behaviors in which they had participated. Results include the following:

15.5%—Changing the design, methodology or results of a study under pressure from a funding source.

15.3%—Dropping data from analysis

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based on a gut feeling.

12.5%—Overlooking others' use of flawed or questionably interpreted data.

10.8%—Withholding details of methodology or results in papers or proposals.

10.0%—Inappropriately assigning authorship credit.

6.0%—Failing to present data that contradicts one's own previous research.

4.7%—Publishing the same data or results in two or more publications.

1.7%—Unauthorized use of confidential information.

1.4%—Using another's ideas without permission or giving credit.

1.4%—Questionable relationships with students, subjects, or clients.

0.3%—Not properly disclosing involvement with firms whose products are based on one's own research.

0.3%—Falsifying or "cooking" research data.

A number of researchers have examined the frequency of scientific misconduct in its various forms and the underlying causes and motivations that contribute to their occurrence (Fanelli, 2009; Geelhoed et al., 2007; Martinson et al., 2005). In a meta-analysis of the published research on reports of scientist misconduct, Fanelli found that up to a third of scientists admitted to a number of the questionable research practices described above. Geelhoed et al. explored the reasons given by researchers for engaging in such misconduct and found them to include "sense of loyalty or obligation" (p. 111), failure to utilize any formal guidelines when making authorship decisions, "publish or perish pressures" (p. 112), and "power differentials" (p. 112). Similarly, Walter and Bloch (2001) report the "'publish or perish' ethos" … "an expectation to generate 'positive' data, the declining status of replication studies (which might uncover fraud), and linking of publication output with academic self-esteem, tenure, promotion and securing of grants" (p. 31) each contribute to misconduct in scholarship and publishing. When looking at authorship decisions in particular (the assignment of authorship credit), Sandler and Russell (2005) found that 27.3% of their sample felt they had been involved in an unethical incident. Similarly, Geelhoed and colleagues also surveyed authors in the psychology literature about authorship decisions. They found that 27% of their sample acknowledged experiencing unethical authorship decisions. In an international study, Pignatelli, Maisonneuve, and Chapuis (2005) found that 59% of those surveyed acknowledged violating prevailing authorship standards despite being familiar with them. Several researchers maintain that some ethical regulations, such as those pertaining to self-plagiarism and duplicate publication, oppress the free dissemination of scientific knowledge (Roig, 2008). Yet, other authors have found that a lack of training in the ethics of scholarship can be a contributing factor to perceived unethical behaviors such as plagiarism (e.g., Roig, 1999; Walker, 2008).

**Conflicts of Interest**

Conflicts of interest may be present due to pressures from external funding sources, personal ambition and employment pressures, and the like. Standard 3.06, Conflicts of Interest, of the APA Ethics Code (APA, 2002) makes it clear that psychologists should be alert to "personal, scientific, professional, legal, financial, or other interest or relationships" (p. 1065) that may adversely impact their objectivity and judgment in decision making. Pachter, Fox, Zimbardo, and Antonuccio (2007) have writ-

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ten a prescient and highly cautionary article about the potential impact of the pharmaceutical industry and other corporate interests on psychologists' decision making with regard to research and scholarship. Each psychotherapy researcher and scholar should be vigilant about potential conflicts of interest that may impact them in their work.

**Publication Credit**

The assignment of authorship order is an important one for all psychologists. Each scholar needs to be appropriately recognized for their contributions to a publication. Numerous authors have studied the challenges of publication credit and some have offered strategies for resolving the dilemmas involved. For example, Fine and Kurdek (1993) recommend the use of verbal and written agreements prior to beginning the project similar to an informed consent agreement. Winston (1985) recommends the use of a formal rating scheme wherein various types of contributions carry different point values; at the completion of the project authorship order is assigned by decreasing point values based on each author's contributions. Standard 8.12, Publication Credit, of the APA Ethics Code (APA, 2002) provides additional specific guidance.

**Reporting Research Results**

Standard 8.10, Reporting Research Results (APA, 2002) addresses one of the most serious aspects of scientific integrity, the fabrication of data. This fraudulent activity may be influenced by the conflicts of interest described above, and is a serious breach of ethics. Other researchers base their research on previously published data, faculty share these results with their students, and practicing psychotherapists utilize these data to directly inform the treatments they provide to clients. The very integrity of our profession rests on the accurate and complete reporting of research findings.

**Plagiarism**

An additional breach of integrity and professional ethics is that of plagiarism, which is addressed in Standard 8.11, Plagiarism, of the APA Ethics Code (APA, 2002). This standard refers both to the previously published or presented words of another as well as the ideas of another. Failure to give credit to others for their words and ideas results in a violation of this important standard. Plagiarism may be intentional and the result of the various influences described earlier, or it may be inadvertent or unintentional. Several researchers have found that inadequately trained professionals are more likely to engage in unintentional plagiarism (Roig, 1999; 2008). Those who are careless may also plagiarize without intending to do so. Self-plagiarism is a closely related issue that involves using one's own previously published or presented work without citing it appropriately. This may occur due to carelessness, but may also be the result of pressures to publish as many publications at possible, such as for career advancement, promotion, tenure, and even status seeking and feelings of competition with one's peers.

**Duplicate Publication of Data**

If properly cited and referenced, psychologists may publish material they have previously published, but they may not do so in a manner that implies original data or an original publication. This is stated clearly in Standard 8.13, Duplicate Publication of Data of the APA Ethics Code (APA, 2002). This standard also applies to splitting one study up into multiple smaller manuscripts in an effort to have as many publications as possible. This practice has been referred to by Holaday and Yost (1995) as

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# 2010 SAN DIEGO CONVENTION

The Division of Psychotherapy is pleased to offer an exciting convention program this year in San Diego! We want to thank everyone for their fine submissions and let you know that we very much appreciate the time and effort that goes into these. Unfortunately, because of limitations of program hours (based on the number of members in our Division who attend the APA Convention), we are unable to accept all the quality submissions that we would like. Our blind raters work very hard at rating each program and there are many submissions that we hope to see again next year. This year's program will be exciting and inspiring for both our younger and later career members. Many of the leaders in the field will present their latest thinking, research, and clinical strategies for us to take back to our offices and institutions. We were also able to participate in planning the plenary sessions that APA sponsors, which will be very relevant to psychotherapy.

We are conducting suite programming this year and hope that you will all drop by when you have a few minutes or more to share your experience, to network, and to share some nourishment. We are very excited this year to offer "Brunch with Barnett," a suite program on psychotherapists' self-care and life balance on Saturday morning with Dr. Jeff Barnett. Please check back to our website for greater details and information on registering. We will keep you posted about further suite programming as we go.

Please carefully review our program and highlight those sessions that you want to attend. Don't forget to encourage early career psychologists and students to attend our "Lunch with the Masters" where there will be copious food and a very popular book raffle. This year, our masters include Drs. Jeffrey Magnavita Judith Beck, Louise Silverstein, Florence Kaslow, and others.

We think there is an abundance of riches here and (unfortunately!) deciding what to attend will be a challenge.

See you all in San Diego!

*Jack C. Anchin, Program Chair*

*Jeffrey J. Magnavita, President*

# DIVISION OF PSYCHOTHERAPY
# 2010 CONVENTION PROGRAM

## THURSDAY, AUGUST 12th

***Symposium:***
***Evidence-Based Decision Making in a University Counseling Setting***
8:00 AM – 8:50 AM • San Diego Convention Center – Room 29A
Chair: Dallas Jensen PhD
Participant/1stAuthor:
Stevan Nielsen PhD
Sasha Mondragon BS
Tyler Pedersen PhD

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****Symposium: Client Factors in Psychotherapy—***
***Attachment Motivation and Culture***
*This symposium will be offered for CE credit*
9:00 AM – 9:50 AM • San Diego Convention Center – Room 5A
Chair: Chia-Chih D.C. Wang PhD
Participant/1stAuthor:
Chia-Chih D.C. Wang PhD
Changming Duan PhD
Wei-Su Hsu PhD

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***Symposium: Interventions for Suicidal Abused***
***African American Women—External Therapeutic Factors***
10:00 AM – 11:50 AM • San Diego Convention Center – Room 3
Co-chair: Meghna Patel PhD & Nadine J. Kaslow PhD
Participant/1stAuthor:
Shane Davis PhD
Noelle Santorelli MA
Tara Samples MS
Meghna Patel PhD
Amit Shahane PhD
Nicole Azores-Gococo
Discussant: Nadine J. Kaslow PhD

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***Symposium: Positive Psychological Interventions for Clinicians***
1:00 PM – 1:50 PM • San Diego Convention Center – Room 7B
Chair: Jeana L. Magyar-Moe PhD MS
Participant/1stAuthor: Jeana L. Magyar-Moe PhD MS
Participant/1stAuthor: Michael B. Frisch PhD
Participant/1stAuthor: Acacia Parks-Sheiner PhD
Participant/1stAuthor: Collie W. Conoley PhD
Discussant: Shane J. Lopez PhD

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****Workshop: Using Social Psychology to Enhance***
***Clinical Relationships and Process Outcomes***
*This workshop will be offered for CE credit*
2:00 PM – 3:50 PM • San Diego Convention Center – Ballroom 6D
Chair: Dan N. Short PhD

***Symposium: REBT As a Clinical Intervention—***
***Current Status and Future Directions***
8:00 AM – 8:50 AM • San Diego Convention Center – Ballroom 6E
Chair: Mark D. Terjesen PhD
Participant/1stAuthor:
Mark D. Terjesen PhD
Raymond A. DiGiuseppe PhD
Daniel David PhD
Discussant: Kristene A. Doyle PhD

***Symposium: Attachment and Treatment Outcomes***
9:00 AM – 9:50 AM • San Diego Convention Center – Room 26B
Chair: Susan S. Woodhouse PhD
Participant/1stAuthor:
Susan S. Woodhouse PhD
Jessica R. Mason MA
Karina P.M. Zorzella BA
Discussant: Joseph H. Obegi PsyD

***Poster Session***
12:00 PM – 12:50 PM • San Diego Convention Center – Exhibit Hall ABC
Participant/1stAuthor:
Kevin Keenan PhD
Timothy P. Baardseth MS
Mary M. Brant PhD
KC K.L. Collins MS BA
James Hansell PhD
Charles A. Waehler PhD
Cathy Morrow
Rachel E. Crook-Lyon PhD
John M. Poston MS
Jessie L. Breyer MA
Kathleen L. Niegocki BA
Melissa E. Gonska MA
Eleni M. Romano MA
Shaina I. Bernardi BA
Jamie D. Bedics PhD
Gina L. Fedock MSW
Changming Duan PhD
Cara A. Treatman MS
Allen K. Hess PhD
Howard Kassinove PhD
Ryan P. Douglas MEd
Sally M. Hage PhD
Bethany L. Fiebelkorn BA
Ann M. Hummel MS
Robert J. Reese PhD
Robert J. Reese PhD
Lisa A. Firestone PhD
Al Carlozzi EdD

****Symposium: Clinical Lessons That Eminent Researchers***
***Have Learned From Their Work***
*This symposium will be offered for CE credit*
2:00 PM – 3:50 PM • San Diego Convention Center – Ballroom 6F
Chair: Louis G. Castonguay PhD
Participant/1stAuthor:
Lorna Benjamin PhD
Marvin R. Goldfried PhD
Leslie S. Greenberg PhD
Larry E. Beutler PhD
Discussant: Jeffrey A. Hayes PhD

***Symposium: Unified Psychotherapy Project—Mapping the Methods and Techniques of Psychotherapy***
4:00 PM – 5:50 PM • San Diego Convention Center – Ballroom 6E
Co-chairs: Jeffrey J. Magnavita PhD & Jack C. Anchin PhD
Participant/1stAuthor:
Jack C. Anchin PhD
Jeffrey J. Magnavita PhD
Kenneth L. Critchfield PhD
Jay L. Lebow PhD
Steven A. Sobelman PhD
Discussant: Katherine C. Nordal PhD

***Business Meeting: Awards Ceremony***
6:00 PM – 6:50 PM • Manchester Grand Hyatt Hotel – Mohsen Room

***Social Hour***
7:00 PM – 7:50 PM • Manchester Grand Hyatt Hotel – Ford Room B and C

## SATURDAY, AUGUST 14th

****Symposium: Studying Clinical Wisdom Research on Therapists' and Clients' Wisdom-Related Processes***
*This symposium will be offered for CE credit*
8:00 AM – 8:50 AM • San Diego Convention Center – Ballroom 6D
Chair: Heidi M. Levitt PhD
Participant/1stAuthor:
Elizabeth Piazza-Bonin BA
Cynthia Baum-Baicker PhD
Arthur C. Bohart PhD

***Symposium: Solution-Focused Therapy and Research—Contributions to Strength-Based Psychology***
9:00 AM – 9:50 AM • San Diego Convention Center – Ballroom 6D
Chair: Barbara M. Vollmer PhD
Participant/1stAuthor:
Janet B. Bavelas PhD
Stephen Langer PhD
Christopher J. Richmond PhD
Ellen K. Quick PhD

***Conversation Hour: Lunch With the Masters for Graduate Students and Early Career Psychologists***
8/14 Sat: 12:00 PM - 1:50 PM Manchester Grand Hyatt Hotel
Elizabeth Ballroom A

## SUNDAY, AUGUST 15th

***Workshop: Enlightened Therapy— Facilitating the Meditative Process***
*This workshop will be offered for CE credit*
9:00 AM – 10:50 AM • San Diego Convention Center – Room 9
Co-chairs: Annellen M. Simpkins PhD & C. Alexander Simpkins PhD
Participant/1stAuthor:
C. Alexander Simpkins PhD
Annellen M. Simpkins PhD

***Symposium: Eminent Psychotherapists Revealed— Audiovisual Presentation of Principles of Psychotherapy***
12:00 PM – 1:50 PM • San Diego Convention Center – Room 10
Chair: Jeffrey J. Magnavita PhD
Participant/1stAuthor:
Jeffrey J. Magnavita PhD
Leslie S. Greenberg PhD
Hanna Levenson PhD
Judith S. Beck PhD
Discussant: Nadine J. Kaslow PhD

## CO-SPONSORED PROGRAMMING

***Symposium: Immigration—Impact on Demographics, Mental Health, Education, and Sexual Identity***
**8/13 Fri**: 4:00 PM – 5:50 PM • San Diego Convention Center – Room 31A
Division/Sponsor: 27 - Community

***Symposium: Mental Illness, Self-Assessment, and Insight Among Psychologists—Ethical Challenges in Self-Care***
**8/13 Fri**: 12:00 PM – 1:50 PM • San Diego Convention Center – Room 4
Division/Sponsor: ETHICS - APA Ethics Committee

preparing manuscripts in the "least publishable unit" (p. 25) and contradicts both Standard 8.13 of the APA Ethics Code (APA, 2002) and in Section 1.09, Duplicate and Piecemeal Publication of Data, of the APA Publication Manual (APA, 2010).

**Sharing Research Data for Verification**
As Walter and Bloch (2001) highlight above, replication studies help reduce scientific fraud as well as lend support for significant findings of research. Thus, in keeping with Standard 8.14, Sharing Research Data for Verification (APA, 2002), researchers make their data available to "other competent professionals who seek to verify the substantive claims through reanalysis and who intent to use such data only for that purpose….(p . 1071). Compliance with this standard adds to the credibility of research findings.

**Use of Confidential Information for Didactic or Other Purposes**
Standard 4.07 of the APA Ethics Code (APA, 2002), Use of Confidential Information for Didactic or Other Purposes, makes it clear that each psychotherapy client's confidentiality must be respected and preserved. While researchers may wish to use client information in publications, this may only be done with clients' specific written permission. Otherwise, their identifying information must be sufficiently disguised so that others will not be able to identify them. Should this limit the effectiveness or appropriateness of the use of client information, representative cases created by authors may be used with a note that no actual clients are being described.

**Serving as a Reviewer**
Service as a reviewer of submitted manuscripts for journals is an important aspect of scholarship in the profession of psychology. It helps to ensure the high quality of manuscripts that are published. Standard 8.15, Reviewers, of the APA Ethics Code (APA, 2002) makes it clear that reviewers have an obligation to treat all manuscripts they review as confidential documents. Reviewers should not utilize data or ideas in manuscripts they review in their own scholarship. Further, if a reviewer can not be objective in conducting a review s/he should withdraw from the process (see Standard 3.06, Conflict of Interest).

**Summary and Conclusions**
This brief overview of issues relevant to the ethics of scholarship provides important information to all psychotherapy researchers. It is hoped that psychotherapy scholars will familiarize themselves with the relevant standards of the APA Ethics Code as well as the relevant sections of the APA Publication Manual. Additionally, it is hoped that faculty and supervisors will instruct their students and supervisees on the details of these standards, will model ethical conduct as scholars, and will instill the underlying values of ethical conduct in them.

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

# ATTENTION GRADUATE STUDENTS AND EARLY CAREER PROFESSIONALS

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No RSVP needed, but please feel free to contact Dr. Rachel Smook at Rachel@birchtreepsychology for additional information.

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

# Integrating Attachment Theory and Research into Psychotherapy: Attachment and Interpersonal Behavior

*Jennifer A. Hardy, The Pennsylvania State University*

When I was first taught about attachment theory, it made intuitive sense to me. At the same time, I found myself struggling to identify attachment behaviors in adult interactions and to understand how to integrate attachment theory into my work as a psychotherapist. In essence, it was difficult to see how attachment behaviors were enacted in session, both in terms of client interpersonal functioning and the interpersonal process of psychotherapy. In this article, I provide an overview of attachment theory and explore the literature on attachment and interpersonal functioning. Then, discussion will shift to understanding psychotherapy as an attachment-activating environment both for clients and psychotherapists, including how the various attachment styles may be exhibited in session.

Bowlby (1973) theorized that humans, like their animal counterparts, possess an evolutionary drive to maintain relationships with individuals who can offer protection and security. Among infants and children, this predisposition for attachment-related behaviors is critical for survival. Four features characterize attachment behaviors: proximity maintenance, separation distress, safe haven, and secure base. In other words, children seek to stay within close proximity of their caregiver and will become distressed when this proximity is disrupted. Further, the caregiver is a secure base from which to explore the environment as well as a safe haven to return to when sick, tired, injured or afraid. Over time, children form relatively stable expectations regarding how caregivers will respond to their distress. When caregivers are consistently available and emotionally responsive to the concerns of their offspring, children develop a sense of security toward their attachment figures. In contrast, attachment insecurity emerges when caregivers are inconsistently available during distress and/or respond in manners that are incongruent with the child's distress. These early relationship patterns are internalized as working models, or mental representations of the self and of relationships (Bowlby, 1982, 1988). These internal working models continue into adulthood, so that attachment continues to be important even in adulthood (Bowlby, 1979, 1988; Simpson & Rholes, 1998). Research has shown that adult attachment plays a role in relationships important in adulthood such as romantic relationships (e.g., Hazan & Shaver, 1987) and the psychotherapy relationship (e.g., Black, Hardy, Turpin, & Parry, 2005).

Currently, general adult attachment is conceptualized as containing varying degrees of two dimensions of insecurity: attachment anxiety and attachment avoidance (Fraley & Shaver, 2000). Attachment anxiety is the degree to which an individual desires excessive interpersonal closeness while also fearing rejection or abandonment. Attachment avoidance is the extent to which individuals deny the importance of interpersonal relationships, feel uncomfortable depending on others emotionally, and

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prefer to maintain emotional distance. Individuals internalize varying degrees of these two attachment dimensions, with low degrees of both dimensions representing attachment security. In other words, attachment security is present when an individual is comfortable with intimacy and relying on others for care. These individuals also tend to adapt to stressors in their environment in a healthy, productive way, as described below.

**Attachment and Interpersonal Functioning**

Substantial research has been conducted exploring the relations between the attachment dimensions and various aspects of interpersonal functioning. This section will summarize major themes from the literature (for a more extensive review, see Mikulincer & Shaver, 2007).

Individuals high in attachment anxiety tend to report higher degrees of psychological distress, lower self-esteem, less differentiation of self, and increased affect intensity and expressiveness when compared with individuals who have minimal attachment anxiety (Horowitz, Rosenberg, & Bartholomew, 1993; Pietromonaco & Barrett, 1997). Individuals who are high in attachment anxiety also describe themselves as sensitive to rejection from others (Downey & Feldman, 1996; Taubman-Ben-Ari, Findler, & Mikulincer, 2002), and actively seeking to avoid rejection (Vorauer, Cameron, Holmes, & Pearce, 2003). Attachment anxiety has also been related to feelings of loneliness (Wei, Russell, & Zakalik, 2005) and difficulties with assertiveness (for a review, see Mikulincer & Shaver, 2007). Thus, individuals high in attachment anxiety often display an ambivalence that stems from an internal conflict of seeking help from others who they also fear will abandon them, eliciting behaviors that seemingly contradict one another (Mikulincer & Shaver).

Attachment avoidance has also been related to loneliness (for a review, see Mikulincer & Shaver, 2007) as well as low relationship satisfaction and describing oneself as hostile and cold (Pietromonaco & Barrett, 1997; Horowitz, Rosenberg, & Bartholomew, 1993). Individuals high in attachment avoidance have been found to minimize the meaning of interpersonal closeness (Collins, Guichard, Ford, & Feeney, 2004; Mikulincer & Selinger, 2001), preferring dominance and control in social interactions (Mikulincer, 1998). It is thought that this preference stems from an overall discomfort with intimacy (Doi & Thelen, 1993; Greenfield & Thelen, 1997). Further, individuals high in attachment avoidance have been found to prefer to be alone and have noted that this preference was not necessarily because of shyness (Cyranowski et al., 2002; Duggan & Brennan, 1994; Griffin & Bartholomew, 1994). Finally, attachment avoidance has been linked to restricted emotional expression (Collins & Read, 1990; Tucker & Anders, 1999; Wei, Russell, & Zahalik, 2005) and emotional control (for a review, see Mikulincer & Shaver). In sum, the research literature suggests that attachment avoidance is associated with interpersonal distance in part because of discomfort with intimacy as well as perceiving oneself as cold, hostile, and controlling.

**Psychotherapy as an Attachment-Activating Environment**

In his book, *A Secure Base*, Bowlby (1988) conceptualized the psychotherapy relationship as an attachment-activating environment for several reasons. First, an attachment system becomes activated when an individual is distressed. Since most individuals enter psychotherapy with some degree of distress, clients are typically therefore in an attachment-acti-

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vating situation and respond to their psychotherapists in manners consistent with their attachment style. Clients look to psychotherapists as sources of help, comfort, and support during distress. Also, the relationship is of an asymmetrical nature, in which the psychotherapist is expected to provide care whereas the client receives care. Finally, Bowlby theorized that the consistent emotional availability of the psychotherapist can provide a corrective attachment experience that helps to shift internal working models toward increased attachment security.

In outlining the central tasks of psychotherapy, Bowlby (1988) contended that the first task of psychotherapy was to establish the psychotherapist as a secure base and safe haven for the client in preparation for the difficult work of exploring painful past experiences. Subsequent tasks involve understanding current ways of relating with others, examining how these patterns are exhibited in the psychotherapy relationship through transference reactions, exploring the roots of their working models of self and others, and recognizing that their models are no longer adaptive to their current environment. Thus, the psychotherapy dyad is working toward more realistic internal working models in the context of current relationships. For example, clients high in attachment avoidance would feel more at ease allowing significant others to be emotionally close with them and would become more comfortable relying on trusted others. In contrast, the shift in working models for clients high in attachment anxiety is to become more confident in managing their own distress and to connect with others while also maintaining a degree of autonomy in their relationships.

Of note, psychotherapy is also thought to be influenced by psychotherapist attachment because attachment impacts the degree of comfort experienced when in a caregiving role (Bowlby, 1988). It is theorized that when psychotherapists possess attachment security, they can focus on client needs without becoming distracted by attempts to meet their own personal needs (as with attachment anxiety) or experiencing discomfort with the intimacy of the psychotherapy relationship (as with attachment avoidance; Mikulincer & Shaver, 2007). In fact, research has shown that caregiving behavior is linked to caregiver attachment both in parenting (see Mikulincer & Shaver, for a review) and psychotherapy (Rubino, Barker, Roth, & Fearon, 2000).

**Psychotherapy with the Highly Attachment Anxious Client**

A growing body of research has explored the influence of attachment anxiety on psychotherapy process and outcome. First, clients high in attachment anxiety have been found to self-report higher degrees of distress than when others report such for them (Dozier & Lee, 1995; Pianta, Egeland, & Adam, 1996). Working alliance ratings have been found to decrease as clients endorse higher degrees of attachment anxiety (Bruck, Winston, Aderholt, & Muran, 2006; Eames & Roth, 2000; Mallinckrodt, Coble, & Gantt, 1995). Psychotherapists describe themselves as acting in less autonomous and in more enmeshed ways in early psychotherapy sessions as client attachment anxiety increases (Hardy, 2010). It seems as though, at least initially, psychotherapists are pulled to respond to client desires for closeness when clients are high in attachment anxiety.

In terms of the working alliance trajectory over the course of treatment, psychotherapy relationships with clients high in attachment anxiety will likely experience a decrease in working alliance toward the middle of psychother-

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apy, though working alliance ratings increase sharply toward treatment's end (Kanninen, Salo, & Punamaki, 2000). Research suggests that a reduction in attachment anxiety is a positive and possible outcome of psychotherapy, associated with notably less psychological distress and significantly higher functioning when compared to clients who did not see a positive shift in their attachment style (Levy et al., 2006; McBride et al., 2006; Tasca, Balfour, Ritchie, & Bissada, 2007; Travis, Binder, Bliwise, & Horne-Moyer, 2001). Slade theorized that possible countertransference reactions toward clients high in attachment anxiety include feeling "swamped, angry, helpless, confused, and dysregulated" (1999, p. 588). Further, she suggested that these countertransference reactions likely stem out of the client's emotionally intense presentation and desire for extreme closeness. In sum, both theory and research suggest that psychotherapy relationships with clients high in attachment anxiety may pose difficulties for psychotherapists as they attempt to maintain appropriate boundaries and assist these clients with affect regulation; however, research also demonstrates that meaningful positive changes in attachment anxiety are attainable in psychotherapy.

**Psychotherapy with the Highly Attachment Avoidant Client**

Because the hallmarks of attachment avoidance are dismissing the importance of relationships and discomfort with intimacy, it is unlikely that many clients high in attachment avoidance will self-refer to psychotherapy unless they also possess a modest amount of attachment anxiety as well. As could be expected, client attachment avoidance has been negatively related to working alliance ratings, with clients described as rejecting of treatment (Dolan, Arnkoff, & Glass, 1993; Kivlighan, Patton, & Foote, 1998; Mallinckrodt, Coble, & Gantt, 1995; Parish & Eagle, 2003; Satterfield & Lyddon, 1995, 1998). Further, Kanninen, Salo, and Punumaki (2000) found that attachment avoidance was found to be associated with working alliance deterioration toward the end of psychotherapy. In addition, client attachment avoidance has been linked to avoidant-fearful attachment to the psychotherapist, a type of attachment to the psychotherapist in which the client perceives the psychotherapist as rejecting and disapproving of them (Mallinckrodt, Porter, & Kivlighan, 2005; Hardy, 2010). Slade (1999) theorized that psychotherapists may experience countertransference reactions like feeling "intrusive, melodramatic, helpless, ridiculous, and excluded" as they make active efforts to connect with a client who is well-defended against emotional intimacy and connection (p. 588).

**What about Us? Psychotherapist Attachment in the Psychotherapy Relationship**

As mentioned previously, the psychotherapy relationship is theorized to activate psychotherapist attachment and initial research is beginning to confirm these ideas. Just as client attachment insecurity is associated with reduced working alliance ratings, psychotherapist attachment anxiety has been related to lower working alliance scores, decreased session smoothness, and increased problems identified in psychotherapy (Black et al., 2005; Bruck et al., 2006; Rozov, 2002; Sauer, Lopez, & Gormley, 2003). In addition, psychotherapists high in attachment anxiety also describe their in-session behaviors early in psychotherapy as less autonomous when compared to psychotherapists low in attachment anxiety, suggesting that psychotherapists who are drawn toward interpersonal closeness actually end up experiencing their psychotherapy sessions as such (Hardy, 2010). The more attachment

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avoidance is endorsed by psychotherapists, the more likely they are to describe their client as hostile early in the psychotherapy relationship, suggesting that they feel rejected or negatively evaluated by their clients (Hardy, 2010).

Research has explored the interactions between psychotherapist and client attachment, with interesting findings. First, psychotherapists high in attachment avoidance have been found to be more likely to enact hostile and distancing countertransference with clients high in attachment anxiety in comparison to clients high in attachment avoidance (Mohr, Gelso, & Hill, 2005). Thus, it appears that psychotherapists who strive to maintain interpersonal distance struggle to manage their countertransference with clients who seek excessive closeness. In contrast, hostile countertransference was exhibited by psychotherapists high in attachment anxiety when working with clients high in attachment avoidance (Mohr et al., 2005). It seems as though these psychotherapists may be frustrated by unsuccessful attempts at interpersonal closeness with clients who are uncomfortable with intimacy.

Although limited, the research that has explored the influence of psychotherapist attachment on the psychotherapy process suggests that psychotherapists with attachment insecurity may struggle to develop a cohesive, supportive working relationship with their clients, particularly if these clients have an attachment style that has opposing interpersonal tendencies (e.g., a psychotherapist high in attachment anxiety who struggles to feel connected to a client high in attachment avoidance). Because of the relationship between attachment insecurity and both hostile countertransference and lower working alliance ratings, psychotherapists who identify a degree of attachment insecurity in themselves may consider using their own psychotherapy to shift their own relational patterns and expectancies. Likewise, supervisors involved in training new psychotherapists may be on the lookout for manifestations of attachment in the interpersonal behavior of both clients and psychotherapists in training.

**Final Thoughts**

Bowlby hoped to assist clinicians by developing a theory that "*informs* rather than *defines* intervention and clinical theory" (1988; Slade, 1999, p. 577). The research generated from his theory paints interesting pictures demonstrating how early experiences with caregivers play out in current interpersonal relationships and even within the psychotherapy relationship. Further, the research suggests that we should be attending not only to the attachment style of our clients but also our own internal working models of self and others because both influence the psychotherapy process.

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# PUBLIC POLICY AND SOCIAL JUSTICE

## Social Justice and Public Policy Domain

*Rosemary Adam-Terem*

As we were all preparing to set off for our Winter board meeting in Washington, D.C. on January 12, news broke: A 7.0-magnitude earthquake near Port-au-Prince, Haiti, devastated the city and surrounding areas. About one third of the population of Haiti, some 3 million people, were affected, and Port-au-Prince's three largest medical centers were severely damaged along with most government buildings, and housing units. Haiti, already the poorest nation in the Western hemisphere, was terribly hard-hit. In the days to follow, the news was grimmer and grimmer. Approximately 200,000 people were killed.

The Executive Committee immediately voted to donate $500 from the Division's budget towards relief efforts, and the whole board responded with additional personal donations amounting to well over $1000.

We selected two organizations among the many active in the relief efforts: Doctors without Borders/Medecins sans Frontieres (doctorswithoutborders.org) and Partners in Health (pih.org). Both have had two decades or more of experience working in Haiti. Doctors without Borders, winners of the Nobel Prize in 1999, ran three emergency hospital units in Port-au-Prince and provided emergency assistance to poor Haitians in the capital for 19 years. Impressively, 87% of their income goes directly to programs, 12% to fund-raising, and only 1% to administration. Partners in Health has a 25 year history of working to serve the medical needs of the poor in Haiti. They run health centers in very poor rural areas and are deeply connected in the community. Their work and the life of founder Paul Farmer, M.D. are described in Pulitzer Prize winner Tracy Kidder's book Mountains beyond Mountains: Kidder, T. (2004) *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World*. New York: Random House.

**NOTICE TO READERS**

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

## State Leadership Conference 2010: More Exciting Times on Capitol Hill

*Report of Federal Advocacy Coordinator for Division 29*

*Bonita G. Cade, Ph.D., J.D.*

As FAC for Division 29 it was my pleasure to attend my second State Leadership Conference on your behalf in Washington D. C. this past March 6-9. The political climate fueled by our historic presidential campaign and the intensity of debate related to health care made the theme *The Power of Advocacy* timely.

I was amazed by the amount of information and thought provoking presentations that there were offered this year. For me the presentation of the Healthy Workplace Awards and the address delivered by Congressman Patrick Kennedy were most memorable. That being said, there so many aspects of this year's SLC that are worth sharing and that have significant implications for how we responsibly fulfill our roles in our communities as social scientists and mental health care providers.

In her keynote address, Dr. Nordal reminded us of our tendency as professionals to avoid the political arena. We tend to be more comfortable in our roles in academia, clinical environments and human service organizations. It is in these places that we have traditionally acted to effect change that benefits those we serve and to further the values that we support. She reminded us of the many instances in which we have made important differences when we have stepped out of our comfort zone to advocate. We were reminded in a powerful way that this is not a time for complacency or apathy because others depend on us and the concerns, knowledge and expertise that we bring to health care in this country.

There were many enlightening and informative speakers and workshops that brought us up to date in just how we psychologists can utilize many tools in advocacy that did not even exist in the recent past. We can make a positive difference. I invite you to visit the SLC website where many of the materials that reflect the presentations are available to you. Go to http://www.apapracicecentral.org/advocacy/state/slc.aspx, and enjoy!

I continue to be inspired by the extent to which some organization go to recognize their employees needs in the work environment and the philosophies that underlie and promote healthy workplace environments.

Another highlight was Congressman Patrick Kennedy's address. He was humorous, forthright and realistic in his appraisal of the strides that have been made on the healthcare front and those that need to made. We were all touched at the beginning of his visit by a tribute to father the late Senator Edward Kennedy who was a champion for so many and certainly a crusader on the issues so many of us cares about in our field.

Our concluding activity was of course a visit to lawmakers on Capitol Hill. There we again emphasized the need for psychologists to be recognized as qualified primary care professionals who bring

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crucial research findings, experience and expertise to the discussions, delivery and decisions pertaining to both general health care and mental health care.

At the conclusion of this year's SLC it was clear that our commitment and our advocacy must continue throughout the year. As I receive information and updates in my capacity as FAC I will keep you informed and request your help. One of the things that we learned was that legislators are more likely to be impressed by the personal genuine story and request for action than "form" letters. This is something that is important to remember. Although it may be easier to send a form letter your own experience, in your practice, with your clients, may be more effective in the long run. Something to think about.

Finally it would be both helpful and effective if those of you who might have a personal connection with a particular lawmaker would volunteer to act as "key" contacts on our behalf when issues arise that are relevant to the practice of psychotherapy. This personal contact can be as close as a distant relative or that your legislator visits the same salon as you, when they are in town. It can be a very small world indeed. If you are willing to be one of these key contacts please let me know!

In the future I will be contacting members of the division about relevant issues. On occasion I will elicit your help in contacting your government officials. Again, many of you may have already developed relationships with particular lawmakers and are therefore strategically positioned to "make our case" to the benefit of those we serve. Please feel free to contact me at drbcade@gmail.com or bcade@rwu.edu.

Please check out the website and feel free to share your thoughts with me!

# Teaching Culturally Competent Psychotherapy: A Year-Long Four-Course Approach

*Fernand Lubuguin, Ph.D.*
*University of Denver Graduate School of Professional Psychology*

As the demographic diversity in the United States continues to increase, the training of clinical psychology graduate students requires more than the traditional pedagogy of teaching foundational theories and skills. Rather, the training must include the development of cultural competency in order for psychotherapists to provide effective services to an increasingly diverse population. For clarification, *cultural competence* refers to the practice of psychotherapy in ways that comprehensively attend to the various aspects of a person's identity, including but not limited to: the person's race, ethnicity, language, disability, spiritual/religious orientation, sexual orientation, gender, national origin, and socioeconomic status (American Psychological Association, 2003). Since these aspects of a person's identity vary in unlimited combinations and degrees of complexity, the attainment of cultural competence is clearly aspirational, as a therapist cannot achieve ultimate cultural competence. As such, the essential pedagogical goal cannot be to train students to become proficient in cultural competence, but rather to establish the requisite foundation upon which cultural competence can begin and continue to develop throughout their careers.

Sue & Sue (2008) operationalized cultural competence in terms of three essential dimensions. The first dimension is *awareness*, wherein the culturally competent psychotherapist strives to become aware of his/her own assumptions, values, and biases. The second dimension is *knowledge*, in which the culturally competent psychotherapist strives to understand the worldview of culturally diverse clients. The final dimension is *skills*, such that the culturally competent psychotherapist strives to develop appropriate interventions, strategies, and techniques. Within each dimension, there are several specific goals. (For a detailed description of the specific goals, please review Sue & Sue, 2008, pg. 47).

These guidelines provide the pedagogical foundation for the cultural competence training curriculum in the Doctor of Psychology clinical training program at the University of Denver, Graduate School of Professional Psychology (GSPP). Customarily, the majority of clinical training programs in the U.S. provide this training through one or two courses, while few provide three or more courses. At the GSPP, this training is provided through a required year-long four-course sequence. Specifically, the courses are entitled "Racial/Ethnic Identity Development," "The Social Psychology of Racism and Oppression," "Gay, Lesbian, Bisexual, Transgender Issues," and "Culturally Competent Psychotherapy." In the following section, the content and pedagogical strategies for each course will be described in ways that reflect the cultural competence guidelines specified by Sue & Sue.

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**Year-Long Course Sequence Racial/ Ethnic Identity Development**

As the introduction to the sequence, this course primarily focuses on the awareness dimension of cultural competence. The class explicates the concept of racial/ethnic identification and the processes by which this central aspect of a person's overall identity develops. In order to sensitize students to the complexities and nuances inherent in multiculturalism and diversity, it behooves the students to first learn about themselves as racial, ethnic, and cultural persons. Accordingly, this course promotes self-exploration and self-understanding for the students in these particular aspects, in addition to exploring and understanding the racial/ethnic/cultural identities of the predominant racial groups in the U.S. Specifically, this course studies African Americans, Asian Americans, Latinos/as, American Indians, White Americans, and multiracial Americans.

Pedagogically, the preceding course objectives are realized through didactic and experiential learning experiences. As the introductory course in the sequence, one of the fundamental aims of this course is to set the tone for the entire year. Typically, students begin this course sequence with feelings of apprehension, anxiety, and heightened self consciousness. These concerns are directly addressed in the first class.

Regarding specific didactic methods and processes, students are initially taught a set of fundamental concepts that provide a common point of reference for this course, if not the entire year. For each of the racial groups, invited guest panelists describe the development of their own racial/ethnic identity. By doing so, the instructor intends to bring the theories and models to life as they are manifested in real individuals. The panel presentations are followed by a class discussion, a question and answer period, and finally small group discussions that promote their critical thinking skills, self awareness, and cultural sensitivity.

With regard to written assignments, students are assigned a midterm paper that requires them to articulate their own racial/ethnic identity and its development by applying the concepts introduced in this course. The provided structure and guidelines for this paper are intended to promote the realization and understanding of themselves as having an ethnic and racial identity. For many students, especially those who belong to the racial and cultural majority, the dynamics and implications of White Privilege have previously prevented them from even considering these aspects of themselves.

Additional written assignments include weekly critique papers that consist of a critical thinking section, and two sections that promote self reflection and self awareness. The last written assignment is the final research paper. The intent of this paper is to provide the opportunity for the student to elaborate or expand on either a topic already covered in the course, or a directly related topic of personal interest that is not covered. The student conducts research to pursue an area of particular interest.

Regarding experiential exercises that promote self awareness, several techniques and strategies are utilized. Students are instructed to complete an Implicit Association Test to explore their conscious and unconscious attitudes and biases. They are also assigned to interview their relatives to gain some understanding and appreciation of their cultural heritage. During the first class, they are asked to respond to questions that elicit their personal biases, prejudices, and fears about culturally different others. Their re-

*continued on page 48*

sponses constitute a "pre-test" that is followed up on in the last class. Finally, they are also instructed to engage in four cultural activities in the community, over the course of the year, that provide them with direct contact with culturally different groups.

**The Social Psychology of Racism and Oppression**

The second course in the sequence focuses on the broad dimension of knowledge within the cultural competence guidelines. Specifically, this course examines the sociopolitical system's operation in the United States with respect to its treatment of marginalized groups in society, as well as the institutional barriers that prevent some diverse clients from using mental health services. The meaning and implications of specific aspects of personal identity for people of color are explored—i.e., race, gender, and social class. The course objectives also include furthering the development of self awareness regarding biases, attitudes, and beliefs as they relate to these particular aspects of personal identity. Finally, this course also focuses on developing the awareness and understanding of the experiences of marginalized others within U.S. society.

As in the first course, this class employs both didactic and experiential l methods. In addition to the standard utilization of textbooks and journal articles, videos are utilized that depict the following critical topics: (a) the distinction between overt old-fashioned racism versus covert modern racism, (b) the experiences and voices of diverse women, and (c) the experiences and voices of diverse men. For the final paper, students are instructed to select a particular marginalized group with whom they expect to work professionally. This assignment guides the students to examine the following: (a) the historical foundation of Anglo-Saxon racism and oppression of this group, (b) the adaptation and coping strategies of this oppressed group, (c) the current dynamics of difference operating between the dominant culture and this oppressed group, and (d) the clinical implications of the above.

The experiential teaching strategies for promoting understanding and self exploration are multimodal. During the initial class session, the instructor directs the students to play "Barnga" which is a card game that simulates and illustrates cross cultural interactions by having participants engage in a game that has different rules depending on the particular group of players. This game highlights the phenomenon of groups of people ostensibly engaging in the same institutional social behaviors of daily life (e.g., participating in commerce, acquiring an education, raising children, or engaging in psychotherapy), but doing so without being aware of different "rules." Various class exercises are utilized over the course of the term in order to elicit the students' perspectives on race, racism and privilege. Finally, personal journals are assigned to evoke their emotional reactions to the readings and class session, their observations of themselves and the class dynamics, the insights they acquire, and the personal actions or potential actions that these experiences evoke in them.

**Gay, Lesbian, Bisexual, Transgender Issues**

The third course in the sequence focuses on the personal identity aspect of sexual orientation. The broad objective of this course is to increase awareness and understanding of the central social and psychological issues that affect persons who belong to sexual minority groups and are gender variant. Broadly speaking, this course primarily addresses the awareness and knowledge dimensions

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of cultural competence as they pertain to sexual minorities. As central aspects of a person's identity that cross racial, ethnic, and cultural domains, sexual orientation and gender identity merit close examination and acquiring knowledge.

This course provides a survey of the central topic areas pertaining to these groups. Initially, the meanings and distinctions of the following key concepts are clarified: (a) gender, (b) gender identity, (c) gender expression, and (d) sexual orientation—i.e., gay, lesbian, and bisexual. Given the varying perspectives and values regarding homosexuality, the topic of conversion and reparative treatment is addressed early in the course to elicit personal exploration and awareness among the students. By critically examining and clarifying one's own perspective and values regarding homosexuality, the student is in a better position to meaningfully engage in the rest of the class.

Exploring the access to and treatment of sexual minorities within the mental health system sensitizes students to the adversity that members of these sexual minorities often face. Adequately understanding a person's current experience and perspective ordinarily calls for an appreciation of that person's early development. In the case of sexual minorities, the coming out process is a particularly significant period and aspect of that development. The similarities and differences regarding the dynamics of couples relationships, parenting, and families between heterosexuals and sexual minorities are essential to understand. Without an adequate understanding of the similarities and differences, clinicians are susceptible to unconsciously act on their assumptions, biases, and attitudes.

Problems that are particularly salient to these populations are addressed in the course syllabus, including substance abuse, violence, sexually risky behaviors, HIV and AIDS. Finally, the complexities of multiple minority statuses are considered. Specifically, the personal and clinical implications of the intersection between race/ethnicity and sexual orientation are examined.

Consistent with the preceding two courses, this course also utilizes experiential teaching strategies to supplement the traditional didactic methods of assigning readings and facilitating class discussions. As an exercise intended to promote sensitivity to being a sexual minority, students are instructed to purchase either Curve Magazine (the nation's best-selling lesbian magazine) or Out (the best-selling gay men's magazine), and then to read it in public for at least 30 minutes. Afterwards, students are instructed to write about their experience. A second experiential exercise involves watching a television show or film from a list provided by the instructor. These videos depict various aspects and perspectives regarding GLBT communities. Students are then expected to write about their reactions to these videos.

Assignments that promote self exploration include writing a paper that describes the development of the student's own sexual orientation. For most heterosexuals, this process is one that is taken for granted and typically not explored, since they are in the majority. Additionally, students are also instructed to write a paper that explores their own gender identity and gender expression, which may or may not be consistent. This assignment is intended to sensitize students to the concept of gender and the range through which gender can be expressed, both publicly and privately.

**Culturally Competent Psychotherapy**

As the fourth and final course in the year-long sequence, the overarching

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goal of this class is to integrate and synthesize the theoretical knowledge presented in the preceding three courses, and to explicate their psychotherapeutic implications among the groups that have been the focus for the entire year. In principle, the preceding three courses emphasize foundational concepts and knowledge about these groups. These courses also focused primarily on the first two dimensions of cultural competence, namely awareness and knowledge. The final class, in turn, focuses on the final dimension of skills.

As core abilities, this course aims to promote the development of the necessary sensitivity and judgment required to practice culturally competent psychotherapy. The heightened awareness and acquisition of knowledge provide the essential basis for developing sensitivity to the relevant cultural dynamics in therapy. A person cannot be sensitive to matters to which a person lacks awareness, knowledge or understanding. In turn, sound judgment is required to know the effective ways to intervene and respond to those cultural dynamics. Mere awareness, knowledge and understanding are insufficient for their effective implementation. The development of this sort of sensitivity and judgment is predicated on having the relevant practice and experience.

The primary course objectives include the following: (a) to understand what constitutes multicultural psychotherapy, (b) to understand the process of acquiring cultural competence, and (c) to generate an accurate self-appraisal of their current level of competency and develop a clear and feasible plan for further development. Understanding multicultural psychotherapy requires distinguishing it from other kinds of therapy, which in turn, requires a critical analysis of the basic premises of conventional psychotherapies. This critical analysis involves an examination of the generic characteristics of psychotherapy, and the cultural values and norms upon which those generic characteristics are based.

The realization of the third course objective described above is primarily achieved through the midterm paper. Students are instructed to follow the cultural competence guidelines and conduct a self appraisal of their current level of proficiency on each of the goals within all three broad dimensions (i.e., awareness, knowledge, and skills). This self appraisal includes utilizing a rating scale in order to quantify their current competence level. The most important aspect of this assignment is the development of a clear, specific, and feasible plan to develop each of the goals. This plan is intended to serve as a guide for their professional development in this domain.

Pedagogically, a multi-modal approach to training is utilized for this course. Specifically, the course is structured so that students first read about the skills involved, then observe how these skills can be implemented, and finally practice these skills. Readings are assigned from a set of textbooks and other scholarly sources. A particular class session is devoted to each of the major groups covered by the course sequence. For each group, a guest speaker who is an expert in that group is invited to class. The guest speaker and the instructor conduct a role play in which the instructor plays the culturally diverse client, and the guest speaker plays the role of therapist. The instructor and guest speaker attempt to highlight and demonstrate the key concepts and skills that are described in the readings. Following the role play, a class discussion is conducted to promote the integration of the readings with the role play.

To provide the students with the opportunity to actually practice these skills, role

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plays are structured. The class is divided into groups of three, with each group having three roles – i.e., therapist, client, and observer. The therapist practices the skills that s/he has just read about and observed. In order for a student to conduct a realistic portrayal of the diverse client, the student must have a nuanced understanding of the culture, history, values, and common personal characteristics of the particular group. Without these abilities, the portrayal of the client is at risk of being merely stereotypical. Finally, the observer provides constructive feedback to the therapist. The three students in each group rotate until all of them have played all roles.

Additional experiential exercises include conducting a "post-test" of the exercise that they completed during the first class of the entire year. Specifically, this exercise elicits their personal biases, prejudices, stereotypes and fears regarding culturally different groups and individuals. After responding to the two questions again, they are instructed to compare their responses during the first class to their responses at the fourth class. The students are then encouraged to openly discuss their thoughts, feelings and reactions to this exercise. Typically, this exercise is especially powerful as it highlights the discomfort associated with these painful realizations, and the difficulty involved in changing our biases and attitudes.

**Further Development**

Although this year-long four-course sequence is comparatively extensive relative to the norm among doctoral-level clinical training programs, by no means is the training comprehensive. The principles and values of inclusivity call for the integration of other important aspects of personal identities. Specifically, the sequence does not adequately address spirituality and religion as critical aspects of a person's worldview, way of life, values and identity. Furthermore, persons with disabilities are not directly addressed in this course sequence, although this status is addressed to some extent in other courses regarding health psychology. Socioeconomic status and level of education are other impactful aspects of a person's experience in the world. Based on sociopolitical considerations, the inclusion of Arab Americans and Jewish Americans would also be important. Other important demographic characteristics such as age, gender, and U.S. residency status (i.e., immigrant or refugee) have great psychological impact. Finally, due to the demographic characteristics of the current generation of doctoral students, these courses are primarily aimed at White females, who comprise the majority of students. However, addressing the distinct dynamics for minority therapists working with minority clients would be important to do.

In addition to expanding the content, this course sequence can also be enhanced by conducting outcome studies regarding the effectiveness of the training. Broadly speaking, does completing this year-long education actually improve the students' practice of culturally competent psychotherapy? If not, then what aspects of cultural competence are deficient? What modifications are required to compensate for these deficits? Although ultimate cultural competence is aspirational, minimal cultural competence is essential.

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

## Summertime, and the Livin' is Easy

*Pat DeLeon, Ph.D.*
*Former APA President*

**Exciting Times Ahead:** In her inspirational keynote address at this year's Practice Directorate State Leadership conference (SLC), The Power of Advocacy, Executive Director Katherine Nordal provided those in attendance with an exciting vision for how each of us can help shape the future of our profession. "An abiding commitment to advocacy must be part of our identity as psychology's leaders. Each of us has a responsibility to help others understand what psychologists do and the many contributions we make to health and well being. Advocacy is an ongoing process of educating and assisting decision makers, whether they are legislators, other policy makers, or individuals making choices about health care professionals for family members. When we psychologists serve as advocates we represent not only the interests of the profession, but, more importantly, the interests of our patients and other consumers of psychological services…. (T)he system ultimately will have to be changed. We need an integrated health care delivery system, and psychologists must be part of the health care teams in that system. We cannot afford to watch from a distance as a new health care delivery system is crafted… one that is unlikely to value what psychologists can bring to the table if we sit on the sidelines…. But if we do not change the advocacy behaviors of many psychologists that is exactly what will happen!"

As an outgrowth of discussions at SLC by those pursuing prescriptive authority (RxP) legislation, Deborah Baker developed an overview of the APA Designation System for training: "In 2006, a joint task force was established by CAPP (Committee for the Advancement of Professional Practice) and the Board of Educational Affairs (BEA) to review and revise the APA model psychopharmacology curricula and related policies. Among the revisions proposed by the joint task force included the recommendation that APA develop a designation system for education and training programs in psychopharmacology as a means for assuring minimal standards of program quality. Because those task force members agreed that development of such a designation program was beyond its charge and expertise, a second joint task force was established to develop the designation system for education and training programs in psychopharmacology. In August 2009, the APA Council of Representatives approved as APA policy the proposed APA designation system, as well as the revised Recommended Postdoctoral Education and Training Program in Psychopharmacology for Prescriptive Authority ('Model Curriculum') and the related Model Legislation for Prescriptive Authority.

"The APA designation system outlines the minimal standards of program quality for psychopharmacology education and training programs. The system does not designate individuals; it designates programs preparing psychologists for prescriptive authority through a voluntary application process. The APA Model Curriculum is the published

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criteria for the designation system. The review is a threshold assessment through documentation that assures that the education and training experience is sufficient to prepare students to be eligible for credentialing in that domain. Those programs identified as meeting these criteria would be referred to as an APA designated program in psychopharmacology for prescriptive authority. The designation system will be implemented by a 6-person committee, which will be overseen jointly by CAPP and BEA. Since the APA Board of Directors recently approved the committee nominations, it is anticipated that the committee will be prepared to begin receiving designation applications by the end of this year."

**Unlimited Opportunities For Those With Vision:** Stephen Lally's report on the Spring CAPP meeting for his colleagues in the National Council of Schools and Programs in Professional Psychology (NCSPP): "One area of focus at the meeting that may be of interest to NCSPP schools is CAPP and BPA (Board of Professional Affairs) holding a joint retreat to address telepractice issues. This has been an area of increased focus and the practice directorate has been meeting with ASPPB (Association of State and Provincial Psychology Boards) about this issue. It was noted that the new Model Licensing Act (MLA) does not clearly define this area of practice." From a health policy perspective, it is increasingly clear that advances in the communications and technology fields will ultimately have an unprecedented impact upon our nation's health care environment and thus psychological practice.

The 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009. The U.S. Senate Committee on Indian Affairs, chaired by Senator Dorgan, recently recommended the enactment of S.1635, Establishing An Indian Youth Telemental Health Demonstration Project. This legislation would "enhance the provision of mental health services to Indian youth" and "encourage Indian tribes, tribal organizations, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns." The underlying objective of this bill is to provide Indian youth suicide prevention programs with greater authorization and flexibility to meet the federal government's trust responsibility to provide health care to Native Americans. It would streamline the Substance Abuse and Mental Health Services Administration (SAMHSA) grant process for Indian youth suicide prevention and authorize tribal use of predoctoral psychology and psychiatry interns for health care services to increase the availability of mental health services and to recruit mental health providers to Indian country. It would also authorize an Indian youth telemental health demonstration project for Native American communities in order to capitalize upon the use of technology to enhance mental health care and prevent youth suicides. The underlying goal is to increase the early identification of, and provide intervention services for, at-risk Indian youth, as well as serve as a recruitment tool for psychologists and psychiatrists throughout Indian country.

Testimony presented before the Committee indicated that the incidence of suicide among Native Americans is 1.9 times higher than the national average and even higher among Native American youth. Native American youth experience the highest rate of suicide of any population group in the U.S. Between the ages of 15 and 24, Native American youth have a suicide rate 3.5 times higher than their peers of other races. The incidence of suicide for Native

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American male youth is especially extreme, with a rate four times higher than males in other racial groups. Suicide is the second leading cause of death among Native American youth. Clearly this is an area in which psychology, and especially Native American psychologists, can make a real difference.

Experts testified that there are many risk behaviors and contributing factors for youth suicide. The Centers for Disease Control and Prevention (CDC) lists the following risk factors for youth suicide: history of previous suicide attempts, family history of suicide, symptoms of depression or other mental illness, alcohol or drug abuse, stressful life event or loss, easy access to lethal methods, exposure to the suicidal behavior of others, and incarceration. Several of these factors are overrepresented among Native American communities and thus may contribute to the high rate of suicide experienced.

The situation is further compounded by the overall scarcity of mental health services available to Native American youth. Reportedly, in the U.S., ninety percent of all teens who die of suicide suffer from a diagnosable mental illness at the time of death and over half are never seen by a mental health provider. This lack of access to mental health professionals is especially problematic for Native American youth, with the Indian Health Service (IHS) consistently experiencing severe mental health professional shortages. Furthermore, when tribes do seek federal assistance for suicide prevention programs, such as grants, they often lack the resources and infrastructure to successfully access federal funding. The remote nature of reservations may hinder the tribe's ability to develop the telecommunication and epidemiological infrastructure to effectively compete. The bill is named from the belief in Indian Country that you should consider the impact of your decisions on the seventh generation yet to come. The hope for the 7th Generation Promise is to enhance the mental health services and suicide prevention resources available to Native Americans, particularly youth.

**Unprecedented Change Is Definitely Coming:** The Institute of Medicine (IOM) was established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. Its expertise is expressly noted in President Obama's Health Care Reform legislation, the Patient Protection and Affordable Care Act (P.L. 111-148). The IOM has requested nominations for experts in the scientific, technical, and medical professions for a study committee titled "A Learning Healthcare System in America." The charge for this body will be to: Review information related to the nature and sources of ineffective, inefficient, and wasteful factors that reduce the value from health care delivered in the United States. Based on that assessment: 1) to characterize qualitatively and quantitatively, to the extent possible, the primary targets of opportunity for improving value from health care; 2) to estimate the value and efficiency—improved health outcomes with lower costs—that ought to be achievable within ten years if the necessary changes were made; 3) to identify the areas, activities, strategies, and system changes with the greatest potential to drive achievement of the ten year target; 4) to author a series of reports that review the key opportunities and priorities for the respective priority areas, and provide technical and policy recommendations on matters important for progress; and 5) to synthesize the finding of each report and develop a policy framework and implementation

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strategy that takes best advantage of existing health system infrastructure and provides incentives for care of greater value. The membership of the committee will have expertise in the fields of health economics, health policy, healthcare delivery, industry, insurers, employers, consumers, clinicians, information technology, research, education, and system engineering.

It is often informative to reflect upon earlier health policy documents as they frequently provide the template for future evolutions. In November 2008, Senator Baucus, Chairman of the Senate Finance Committee, laid out his vision for healthcare reform. "The link between health care costs and the economy is undeniable. Reforming the health care system is essential to restoring America's overall economy and the financial security of our working families…. A high-performing health care system would guarantee all Americans affordable, quality coverage no matter their age, health status, or medical history. Today, the costs of care for the uninsured are largely borne by those with insurance…. Requiring all Americans to have health insurance will help end the shifting of costs from the uninsured to the insured…. Improving Health Care Quality and Value. Recognizing that any attempt to cover the uninsured and reduce health care spending must address the perverse incentives fostered by current payment systems, the Baucus plan includes delivery system reforms that would improve quality and, over time, lower costs. The plan strengthens the role of primary care and chronic care management. Primary care is the keystone of a high-performing health care system. Increasing the supply and availability of primary care practitioners by improving the value placed on their work is a necessary step towards meaningful reform. The plan would refocus payment incentives toward quality and value. Today's payment systems reward providers for delivering more care rather than better care. A redefined health system would realign payment incentives toward improving the quality of care delivered to patients…. To facilitate the proposed delivery system reforms, the Baucus plan would improve the health care infrastructure by investing in new comparative effectiveness research and health information technology (IT). Health IT is needed for quality reporting and improvement and to give providers ready access to better evidence and other clinical decision-support tools. Reinvesting in the training of a twenty-first century health care workforce is necessary for many delivery system goals to be realized…. The U.S. spends $2.3 trillion per year on health care…. According to the Congressional Budget Office, up to one-third of that spending—more than $700 billion—does not improve Americans' health outcomes." Without question, Chairman Baucus was a major player in the recent National Healthcare Reform deliberations.

During her testimony before the U.S. Senate Appropriations Committee on the Department of Health and Human Services (HHS) Fiscal Year 2011 budget, Secretary Kathleen Sebelius: "Investing in Prevention. Reducing the burden of chronic disease, collecting and using health data to inform decision-making and research, and building an interdisciplinary public health workforce are critical components to successful prevention efforts…. Improving Quality of and Access to Health Care. At HHS, we continue to find ways to better serve the American public, especially those citizens least able to help themselves. We are working to improve the quality of and access to health care for all Americans by supporting programs intended to enhance the health care workforce

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and the quality of health care information and treatments through the advancement of health information technology (IT) and the modernization of the health care system…. The Budget includes an increase of $290 million to ensure better access to health centers through further expansions of health center services and integration of behavioral health into health centers' primary care system…. The Budget advances the President's health IT initiative by accelerating health IT adoption and electronic health records (EHR) utilization – essential tools for modernizing the health care system… During FY 2011, HHS will also begin providing an estimated $25 billion over 10 years of Recovery Act Medicare and Medicaid incentive payments primarily to physicians and hospitals who demonstrate meaningful use of certified EHRs, which will improve the reporting of clinical quality measures and promote health care quality, efficiency, and patient safety." Major change is rapidly approaching. Will psychology actively participate in this (r)evolution, or will we be passive observers? As Katherine passionately noted at SLC: "When we fail to become involved in advocacy, we give others the power over our future as health care providers." So hush little baby. Don't you cry. Aloha,

Pat DeLeon

# CONGRATULATIONS TO DIVISION 29 AWARD WINNERS!

**Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy**:
The Distinguished Psychologist Award is based on significance of contributions to the practice, research, and/ or training in psychotherapy. The 2010 award is presented jointly to Jeff Barnett, Psy.D. and Judith Jordan, Ph.D., in recognition of their outstanding accomplishments and significant lifetime contributions to the field of psychotherapy

**American Psychological Foundation Division of Psychotherapy Early Career Award** is presented to Tami Jo De Coteau, Ph.D. for distinguished early career contributions to the field of psychotherapy and the Division of Psychotherapy.

**The Division of Psychotherapy Award for Distinguished Contributions to Teaching and Mentoring,** which is presented in 2010 to Louis Castonguay, Ph.D. in recognition of his significant contributions to the field of psychotherapy through his impact on the lives of developing psychologists in their careers as psychotherapists

**The Distinguished Publication of Psychotherapy Research Award (co-sponsored by John Wiley Publishing) for 2010** is awarded to Antonio Pascual-Leone's (2009) article as the winner of the Division 29 Distinguished Publication of Psychotherapy Research Award for 2010:

Pascual-Leone, A. (2009). Dynamic emotional processing in experiential therapy: Two steps forward, one step back. *Journal of Consulting and Clinical Psychology, 77*, 113-126.

Join us as we honor our award winners at the Division 29 Awards Ceremony scheduled for Friday August 13th at 6:00 pm, Manchester Grand Hyatt Hotel, Mohsen Room. The Social Hour will be immediately following in the Ford Room B &C.

# DIVISION 29
# 2010 DISTINGUISHED PSYCHOLOGISTS

**Jeffrey E. Barnett, Psy.D., ABPP**

Jeff Barnett is a licensed psychologist with an independent psychotherapy practice in Annapolis, Maryland and he is a Professor in the Department of Psychology at Loyola University Maryland. He is board certified in Clinical Psychology and in Clinical Child and Adolescent Psychology by the American Board of Professional Psychology and he is a Distinguished Practitioner of Psychology in the National Academies of Practice. Jeff is a past president of the Division of Psychotherapy as well as of two other APA divisions and his state psychological association. He has also served in numerous other governance positions in his state and in APA to include two terms on APA Council, Chair of the APA Board of Convention Affairs and the APA Ethics Committee. Presently, he is the Vice Chair of the APA Fellows Committee, the Coordinator of the Karl F. Heiser APA Presidential Awards for Advocacy, and he serves on the Maryland Board of Examiners of Psychologists. Additionally, he is an Associate Editor of the APA journal Professional Psychology: Research and Practice.

Jeff is a prolific author and presenter, specializing in ethics and professional practice issues for psychologists and trainees. He is an active mentor who regularly publishes and presents with his students. He recently led a five-year effort in Maryland that led to the successful change in the sequence of training component of the state's licensing law. He has repeatedly been recognized for his contributions to the profession of psychology to include receiving the 2009 APA Award for Distinguished Contributions to the Independent Practice of Psychology. In 2010 he received the Outstanding Mentor Award from the Maryland Psychological Association of Graduate Students.

**Judith Jordan, Ph.D.**

In addition to her position at WCW, Judy is an assistant professor of psychiatry at Harvard Medical School. After graduating phi beta kappa and magna cum laude from Brown University, she earned her Ph.D. in clinical psychology at Harvard University where she received commendation for outstanding academic performance. She was the director of Psychology Training as well as the director of the Women's Studies program at McLean Hospital. For the past 20 years she has worked with her colleagues, the late Jean Baker Miller, the late Irene Stiver, and Jan Surrey on the development of what has come to be known as the relational-cultural model of women's development.

Judy co-authored the book *Women's Growth in Connection* and edited *Women's Growth in Diversity* and *The Complexity of Connection*. She has published over forty original reports (many as works in progress at the Stone Center) and twenty-five chapters, and been co-author for three books. She is the recipient of the Massachusetts Psychology Association's Career Achievement Award for Outstanding Contributions to the Advancement of Psychology as a Science and a Profession. She was also selected as the Mary Margaret Voorhees Distinguished Professor at the Menninger School of Psychiatry and Mental Health Science in the Spring of 1999. She received the annual psychiatric resident's "outstanding teacher of the year" award at McLean Hospital and is included in Who's Who in America. She was awarded an honorary Doctor of Humane Letters from New England College (2001) with "utmost admiration for her contribution to science and the

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practice of psychology." Dr. Jordan also received a Special Award from the Feminist Therapy Institute "in recognition of outstanding contributions to the development of feminist psychology" (2002). She is on the editorial board of the *Journal of Clinical Psychology: In Session* and the *Journal of Creativity and Mental Health*. She has written, lectured, and conducted workshops nationally and internationally on the subjects of women's psychological development, gender differences, mothers and daughters, mothers and sons, empathy, psychotherapy, marginality, diversity, mutuality, courage, competence and connection, women's sexuality, gender issues in the workplace, relational practice in the workplace, new models of leadership, traumatic disconnections, conflict and competition, and a relational model of self.

## DIVISION 29 2010 AWARDEE FOR DISTINGUISHED CONTRIBUTIONS TO TEACHING AND MENTORING

**Louis G. Castonguay, Ph.D.**

Louis G. Castonguay, Ph.D. completed his doctorate in Clinical Psychology at SUNY Stony Brook, a clinical internship at U.C. Berkeley, and a Postdoctorate at Stanford University. He is currently a Professor at the Department of Psychology at Penn State University. His research focuses on the process and outcome of psychotherapy for depression, anxiety disorders, and eating disorders. Based on his dissertation research, he won the Graduate Student Paper Competition awarded by the Division of Psychotherapy of the American Psychological Association (APA). He has also received the Early Career Contribution Award from the International Society of Psychotherapy Research, the Jack D. Krasner Memorial Award from the Division of Psychotherapy of APA, as well as the David Shakow Award from the Division of Clinical Psychology of APA. With Thomas Borkovec and Stephen Ragusea, he has also received the Pennsylvania Psychological Association Presidential Award for their work on a state-wide Practice-Research Network. In addition, he has recently received the Distinguished Psychologist Award from the APA Division of Psychotherapy. He currently is President of the international Society for Psychotherapy Research (SPR) and serves on the Steering Committee of the Society for the Exploration of Psychotherapy Integration (SEPI). He also served as President of The North American Society for Psychotherapy Research (NASPR) and co-chaired (with Larry Beutler) the APA Division of Clinical Psychology and NASPR Task Force on Empirically Based Principles of Therapeutic Change.

## APF/DIVISION 29 EARLY CAREER AWARD

**Tami Jo De Coteau, Ph.D.**

American Psychological Foundation and The Division of Psychotherapy (Division 29) recognize Tami Jo De Coteau, PhD, for her work with providing appropriate practice techniques for Native American patients, and with developing training programs in rural, under-served areas, particularly in treating anxiety disorders with the **Division 29 Early Career Award**.

Dr. De Coteau is the Training Director of the Psychology Internship Training Pro-

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gram at the Standing Rock Service Unit of the Indian Health Service. She serves as a Regional Coordinator for Federal Education Advocacy for the American Psychological Association, where she has been an effective advocate for Congressional funding for programs to train Native American in Psychology, as well as the provision of mental health services to Native Americans.

The American Psychological Foundation Division of Psychotherapy Early Career Award is presented for distinguished early career (seven years or less post doctorate) contributions to the field of psychotherapy and the Division of Psychotherapy.

## CORANN OKORODUDU AWARD RECIPIENT

**Louise Evans, Ph.D., ABPP** is the recipient of the Corann Okorodudu International Women's Advocacy Award of 2009, given by the Society for the Psychology of Women (Division 35) of the American Psychological Association's annual convention. Dr. Evans is a Fellow of APA Division 29 as well as Divisions 12, 13, 35, and 52.

# CALL FOR NOMINATIONS

## CHAIR, STUDENT DEVELOPMENT COMMITTEE
## APA DIVISION OF PSYCHOTHERAPY (29)

This is a call to nominate a new Chairperson of the Student Development Committee for a two-year term beginning January 1, 2011, and ending December 31, 2012. The duties of the chair include:

- Serving as a voting member of the Division's Board of Directors and attending two meetings of the Board of Directors annually (Division pays meeting and travel expenses in accordance with its reimbursement policies). You may also be required to participate in periodic conference calls throughout the year.
- Coordinating the student award process for the Division's three student paper awards.
- Facilitating recruitment of students to write an article for each issue of the division's quarterly publication Psychotherapy Bulletin.
- Collaborating with APAGS to coordinate division and APA student initiatives.
- Chairing and coordinating the activities of the Student Development Committee.

The Division of Psychotherapy (29) of APA is committed to the exchange of ideas, policies and resources for members pertaining to the practice, science, education and theory of psychotherapy and has a commitment to diversity in all of its activities. The Student Development Committee provides a unique student voice in the Division, promoting the interests of students in programs and activities sponsored by the Division. The chair has opportunities to form personal relationships with leading psychotherapists and to become better acquainted with APA governance and the activities of professional organizations.

Nominees for chair must be student members of the division, but need not have prior experience working within the APA. Self-nominations are welcome. All applications should include a cover letter, CV, and a biographical statement limited to 200 words that will be published on-line prior to the election. All nominations must be received by June 30, 2010. This year's voting will be conducted on-line and the on-line voting system will be active in July.

Send all nominations to the Division 29 Central Office, c/o the Nominations and Elections Committee, 6557 E. Riverdale St., Mesa, AZ 85215.

For more information, please contact the current Student Development Chair, Sheena Demery, at Sheena.Demery@fedexkinkos.com.

**DEADLINE FOR NOMINATIONS IS JULY 15, 2010.**

## NOMINATION BALLOT

Nominees for Student Development Committee Chair

_____

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_____

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

Name (Printed) _____

Signature _____

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

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# CHARLES GELSO, PH.D., GRANT FOR PSYCHOTHERAPY RESEARCH

## Awarded to Stephanie Budge

Stephanie Budge has been awarded the first Charles J. Gelso, Ph.D., grant. She is a doctoral candidate in Counseling Psychology at the University of Wisconsin—Madison and her project mentor is Dr. Bruce Wampold. The project title is "Determining Treatment and Cost-Effectiveness of Psychotherapies for Personality Disorders Using Treatment-as-Usual and Bona-Fide Treatments."

The Charles J. Gelso, Ph.D. Grant program awards an annual grant of $2000 for research projects in the area of psychotherapy process and/or outcome. The goals of the grant program are to 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, and support psychologists engaged in psychotherapy research. In alternating years graduate students or doctoral level psychologists are eligible to apply for the grant. In 2010, graduate students were eligible. In 2011, doctoral level psychologists (including postdoctoral fellows) will be eligible to apply. The due date for next year's Charles Gelso, Ph.D., Grant proposals will be April 1, 2011. Details for applying for next year's competition will be available on the Division 29 website in the fall.

# 2010 DIVISION 29 DISTINGUISHED PUBLICATION OF PSYCHOTHERAPY RESEARCH AWARD

We are delighted to announce that the winner of the Division 29 Distinguished Publication of Psychotherapy Research Award for 2010 is Antonio Pascual-Leone of the University of Windsor. He is the author of the winning article, which is

Pascual-Leone, A. (2009). Dynamic emotional processing in experiential therapy: Two steps forward, one step back. *Journal of Consulting and Clinical Psychology, 77,* 113-126.

Division 29 is very grateful to the Wiley for sponsoring the $500 cash award that accompanies the Division 29 Distinguished Publication of Psychotherapy Research Award.

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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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