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BULLETIN

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PSYCHOTHERAPY BULLETIN

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EDITORS' COLUMN

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

Once again, the *Psychotherapy Bulletin* editors are privileged to offer a wonderful array of excellent articles in this issue. There are three papers authored (or co-authored) by students on important topics including perspectives on diversity, preventing distress and impairment, and the ethics of working with suicidal clients. We know you will also want to read the Early Career submission reflecting on the issues involved in transitioning from early to mid career. The article on health care disparities is fascinating, as is the paper introducing an integrative attachment-based model of sexual and loving feelings in psychotherapy. The Research submission on strengthening our science and enhancing the status of psychology as a STEM discipline is also compelling. There is an interesting feature on telepsychology, and of course, the Washington Scene again provides us with unique political insight.

In this issue you will find President Jeffrey Magnavita's final column, with a helpful overview of Division 29's recent initiatives and accomplishments, and several useful recommendations. Please express your gratitude to him for his outstanding tenure. This issue of the *Bulletin* is also Jenny's last as editor. We are excited to announce that our associate editor, Lavita Nadkarni, will assume the role of editor as of the first issue in 2011.

Jenny wishes to thank all the outstanding contributing editors and authors who have submitted a wide range of articles with incredibly breadth and depth. These three years have seen such amazing contributions to the field, and Jenny feels very honored to have been a small part in bringing these papers to the *Bulletin* readers. In addition, she is particularly pleased to have been the first editor to offer the *Bulletin* in electronic-only format.

In fact, just a reminder that you may choose the green option of receiving your *Bulletin* by visiting www.divisionofpsychotherapy.org/members/go green/ and filling out a brief form. Thereafter, you will receive an email with a link to the online *Bulletin* as soon as it is available. Of course, you may still download and print out the *Bulletin* (or any specific articles) if you want to read anything in hard copy.

To our knowledge, Lavita is the first person of color to edit the *Bulletin*. We are both greatly excited with her new role, and know that she will do a great job. She has enjoyed working with Jenny to ensure that Division 29 members receive current information on theory, practice, training, and research in psychotherapy. As someone who wears multiple hats and has a passion for the training of students and mentorship of early career psychologists, and is also actively engaged in practice and research, she is delighted to promote the D29 domain structure in the Bulletin. She is a clinical and forensic psychologist, and an Associate Professor at the University of

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Denver's Graduate School of Professional Psychology. Lavita is invested in diversity issues on a local and national level, and will strive to continue the *Bulletin's* tradition of creating *space* for the expression of diverse voices.

As usual, please contact us with your ideas, suggestions, criticisms, and comments.

Wishing everyone a healthy and happy holiday season, and a wonderful new year in 2011.

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CALL FOR NOMINATIONS

APF Rosalee G. Weiss Lecture for Outstanding Leaders

The American Psychological Foundation's Rosalee G. Weiss Lecture honors an outstanding leader in psychology or a leader in the arts or sciences whose work and activities has had an effect on psychology. The lecture is delivered at the annual APA convention; the 2011 Convention will be held in Washington, DC. The APA Divisions of Psychotherapy (29) and Independent Practice (42), administer the lectureship in alternate years. The lecture was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee G. Weiss, Ph.D. The lecturer receives a $1,000 honorarium.

Eligibility Criteria:
The nominee must be an:
- Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology; or,
- Outstanding leader in any of the special areas within the sphere of psychology.

Nomination Materials:
Self-nominations are welcomed. Letters of nomination should outline the nominee's credentials and contribution. Nomination letters and a brief CV ***should be submitted electronically*** to the Division 29 2011 Awards Chair:

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Deadline: January 1, 2011

PRESIDENT'S COLUMN

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

It is with great excitement and some sadness that I am writing my last official column as President of the Division of Psychotherapy. Having just completed my final board meeting during my presidential year, I am very gratified to have had the opportunity to work over the year to advance the mission of the division. Many people have asked me what it has been like serving as President and I can truly say that it has been a great pleasure and honor for which I will always be grateful. It has required time and energy, but the rewards have been great, adding to the abundance in my life with new relationships, projects, and challenges. The Division of Psychotherapy serves as a premier organization for the advancement of psychotherapy. Our division keeps the fire of psychotherapy burning brightly and leads the way to the future.

I remember many years before the fall of communism hearing how psychotherapists in the USSR would meet clandestinely in tents in the woods to try to keep their tradition alive. Psychotherapy was apparently viewed as a Western indulgence for which the communist party had little regard, and even posed a danger to those who practiced psychotherapy surreptitiously. During our current era, the field of psychotherapy has been challenged and eroded on many fronts, yet our division remains steadfast in preserving and expanding what we have to offer to those who suffer and seek out expert psychologist-psychotherapists for assistance.

I can tell you that the people who serve our division in their various roles are quite remarkable for their passion, intellect, scholarship, and devotion. Our division represents those of us who continue to value the importance of psychotherapy in the amelioration of human suffering and seek to advance our understanding through accumulation of a robust evidence-base. This truly represents a holistic vision, which does not limit itself but honors the importance of relationship, techniques, patient characteristics, cultural influences, converging lines of evidence, scientific rigor and humanism.

Some of the initiatives that we have undertaken are immensely rewarding to me and I hope will continue to establish our division as a premier organization where one can find the latest information, be stimulated with relevant content, receive continuing education credits, find fellowship in being connected to other devoted psychotherapists, and participate in shaping our future. In my last column, I wrote about the Presidential Task Force that I established to investigate the issue of efficacy of psychologist-psychotherapists, which under the able leadership of Dr. Jeff Barnett has completed their report and submitted it to the division with recommendations. You will find the full report, including an excellent summary of much of the extant research on psychotherapy effectiveness organized topically and presented in a summary form. It is a wonderful working document that can be used as a resource and is available on our website (**www.divisionofpsychotherapy.org/*), along with the recommendations.

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One of the recommendations of the *Task Force on Psychologist-Psychotherapists* (TOPPs) is that we establish a research grant specifically for those who want to pursue research on factors related to psychotherapy effectiveness. The grant will be awarded to the psychotherapy research proposal that holds the most promise for advancing the field of psychotherapy research in the area of psychotherapist factors that may impact treatment effectiveness and outcomes, to include type and amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcome. What I am really thrilled about is that the Board of Directors overwhelmingly approved $20,000 to be awarded yearly for someone whose research will focus on this topic. I appreciate the fact that we were challenged to be good stewards of our resources and "put what we have to good" use by Dr. Jeff Younggren our secretary and future President-elect of our sister Division 42,*The community for Psychologists in Independent Practice*. I am pleased to tell you that this award has been named to honor one of our leading members, Dr. Norine Johnson, who was a past president of APA and most recently served our division as a Council Representative. Norine spearheaded many initiatives including one to have the word "psychotherapy" endorsed by APA as the official description of what our members do, instead of the more generally used term "therapy." Norine has always been a passionate protector and spokesperson for our field and we are truly pleased to be able to offer this substantial grant in honor of her life long contribution to psychology and psychotherapy. I had the honor to step into her role until our new Council Representative Dr. John Norcross begins his term in January. You can read about my experience on council later in this issue. I want to thank Dr. Linda Campbell, our experienced and savvy representative, for shepherding me and showing me the ropes.

I can also say that we have made great strides in advancing our agenda to use technology effectively and give us all the advantages that we can reasonably have to be connected with one another and the latest information in the various domains that represent our varied interests in psychotherapy. I would like to thank Dr. Chris Overtree who worked diligently over the past year to bring our website up to date. He showed great devotion and creativity, working with the *Technology Task Force* under the leadership of Dr. Steve Sobelman to create a wonderful portal for all of us to access the latest publications, resources, and advances, as well as be socially connected. New features continue to be added to the popular ones such as *Ask the Ethicist* led by Dr. Jeff Barnett and *Research Updates* by Dr. Mike Constantino. In the near future you will be able to find a new feature called *Psychotherapists: Face-to-Face,* which is an interview series that I am producing and will feature some of our leading psychotherapists. We (Aniko Safran-videographer, Tracey Martin, and Cedric Wood, volunteer on camera) completed four of these interviews at the APA convention this past summer with Drs. Lorna Smith Benjamin, Laura Brown, Leslie Greenberg, and Hanna Levenson,. I think you will find them excellent resources for students, as well as wonderful compliments to the APA psychotherapy video series that has featured their work.

During our very productive board meeting we, our President-elect Dr. Libby Nutt Williams and I, appointed a *Presidential Task Force on Telepsychotherapy* that will be chaired by Dr. Annie Judge and was inspired by the article and encour-

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agement of Dr. Norm Abeles, which can be read in this issue. Telehealth, telepsychology, and telepsychotherapy are evolving so rapidly that psychotherapists are often unsure about what is a reasonable standard of care and informed practice. Norm, who will serve on the committee, felt that we should not wait and move on this issue. He also suggested that we use the term telepsychotherapy to distinguish us from telehealth, which is used by medicine. Also serving on this committee are Drs. Jeff Younggren and Shane Davis. We look forward to your input and the committee would like to hear about your experiences with telepsychotherapy.

Thanks to wonderful financial stewardship over the years and income from our flagship journal *Psychotherapy* (the new name starting in January, 2011), we are enjoying a time of abundance, which is very remarkable given the global and national economic downturn we are experiencing. We are able to use our resources in a manner that will add to the field of psychotherapy and underscore our commitment to advancing the field of psychotherapy. I am also eager to see us begin to consider how we can better serve the underserved and address the mental health needs of people with limited access to care. I am hoping that future leaders will take up this call.

We had an amazing convention in San Diego where we resumed our suite programming and I enjoyed meeting with many of you. Our convention program was of a high caliber thanks to all your wonderful submissions and Dr. Jack Anchin's excellent work as Program Chair. We had a very nice balance of research and practice oriented symposia as well as many other topical areas of interest to our membership. Our awards ceremony is becoming a major event with new awards and grants being added yearly to our roster. Our social hour, coordinated by our wonderful administrator Tracey Martin, was a lively and exciting time to reconnect with old friends and talk about our achievements. We plan to continue our suite programming next year in Washington, DC so please make a note of this and drop in for some awesome programming and socializing. You may even run into some of our famous psychologists who you can meet in person.

As I begin to wind down my Presidential term and hand over the reigns to our able President-elect Dr. Libby Nutt Williams, I remain devoted to serving the division in the capacity of awards committee chair and producer of our new video series *Psychotherapists: Face-to-Face*, which I hope you will enjoy as much as I did making this exciting series. I am also committed to making this a smooth transition and am looking forward to Libby's initiatives. We are all very happy to have Dr. Marvin Goldfried join us as President-elect in January. Marv has always been a staunch advocate of psychotherapy and with whom I have been working on a joint project while he served as President of Division 12 this year.

I want to personally and publicly thank Dr. Nadine Kaslow who is finishing her term as Past President and has done a remarkable job over her three years of service in the presidential term. Nadine has been an amazing mentor to me, as well as many others. She has the capacity to inspire people and draw them into participate. I don't know of anyone who has brought so much new talent to our division. I remember when I was heading the nominating committee and was running out of names how Nadine would pull out our phone and say call this person, many who are now serving on our board or committees. Nadine's

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influence spans the globe. Unfortunately, because she was called to collaborate with the *World Health Organization* she was in Switzerland and missed her last meeting so the board was not able to personally thank her but thank her we do! We will see her next summer in Washington, DC at our awards ceremony to properly thank her. I asked her to reserve this time because her schedule is probably already being filled. Please join us to honor her for her service and then afterwards for a celebration at our social hour.

We have some of the most remarkable people in our division. I have met many of you over the past number of years and am always struck by your integrity, commitment toward education and training, as well as willingness to serve those suffering. I have enjoyed many presentations, dinners and social events around the country and experienced your hospitality and fellowship. I want to thank each and every one of you for this opportunity to lead this wonderful division and hope that I have made a difference. I look forward to meeting the rest of you in the coming years. I truly feel privileged in having had the chance to serve and hope that you too will consider joining our movement!

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

Unique Perspective on Diversity: Experiencing Intersecting Roles of Students in Clinical Training

Sharlet Anderson, Meena Khowaja, Alvina Rosales, Elizabeth Schroth, Jalika Street
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Graduate students in clinical psychology, as clinicians in training, offer a unique perspective on not only how matters of diversity are approached within the therapy relationship, but also how they are experienced by the student clinicians themselves. The challenge of negotiating the demands from the perspective of having multiple roles as therapist, supervisee, researcher, and student can be difficult, particularly as they relate to matters of diversity. Upon entering clinical training, students bring with them past experiences of discussing or not discussing race and ethnicity among peers, which can serve as fodder for rich development if the necessary supports are in place.

In 2005, graduate students in the clinical psychology program at Georgia State University came together to mobilize a mission to value the differences and similarities among individuals and to respect all facets of our therapy clients. The students, with the support and membership of clinical faculty and staff supervisors, formed the Clinic Diversity Committee to respond to the changing demography of our country, the increasing need for mental health services for diverse populations (Bernal & Castro, 1994), and potential systemic barriers to creating a sense of safety for the diverse client population our clinic serves. The committee took action initiating such changes as displaying artwork in the clinic that is inclusive of a wide range of diversity and petitioning to have automatic door openers installed on the restroom doors near the clinic to increase accessibility for our clients with varying degrees of physical ability. These and other actions were part of a larger goal of increasing effort to develop more understanding of life experiences of persons of color (Sue & Sue, 1999), critical in the therapeutic relationship. However, changes in the clinic's physical environment were not enough.

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The Clinic Diversity Committee members questioned whether or not matters of diversity were being discussed in supervision groups such that the needs of our clients could be respected and addressed appropriately and sensitively. A survey assessing the frequency of missed opportunities to discuss matters of diversity in supervision, and possible contributing factors was administered to student clinicians. The results indicated that students in the program had indeed experienced missed opportunities and themes of creating more of a sense of safety emerged. In response, the committee organized continuing education workshops, for student clinicians and supervisors, specifically focused on addressing diversity within supervisory relationships. The committee members acknowledged that discussing potentially emotionally salient matters relating to diversity openly and frankly in supervision can be a difficult experience due to a cultural gap, if supervisors have not received diversity training themselves (Constantine 1997, 2001). This poses a dilemma for not only student clinicians of color but also those of the majority cultural group, due to the power differential and evaluative nature of the supervisor-supervisee relationship in vertical models of clinician training at the doctoral level. The complex relationship among culture, intrapsychic and interpersonal processes, and client symptomatology affects the supervisory process and therefore the quality of treatment. Failure to acknowledge that supervision involves multiple cultural interactions can lead to mutual avoidance of discussion of cultural issues and may prevent therapists and clients from fully immersing into relevant material, such as clients' individual experience of discrimination and oppression (Leary, 2000). Differing cultural worldviews of the client, therapist, and supervisor and the ability to adequately address issues of race and culture can be critical to change in the treatment and lead to development of increased self-esteem for student clinicians. This phenomenon is not limited to work with ethnic minority clients, therapists, and supervisors, but is a point of general clinical competence for all therapists and supervisors, according to the American Psychological Association's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (2002).

Student clinicians have noted that initiating exploration of diversity-related topics may be affected by their own experience of stereotype threat or discrimination. Those who identify with marginalized groups may feel that the onus to bring up issues of racism and oppression, is on them, rather than on the supervisor. These feelings may be intertwined with concerns regarding the supervisor's evaluation of the student's performance or potential scrutiny of student peers in the supervisory group, building pressure that can result in a silent crescendo. As the committee heard from the student clinicians, supervision must strive to create a sense of safety that is actively maintained.

In therapy supervision, differences in racial or ethnic identity between therapists and clients are common points of discussion regarding diversity. However, when the therapist and client personally identify with similar groups, intra-ethnic differences have the potential to be omitted in the supervision discussion. This omission is particularly salient when there is an unspoken assumption that a student clinician of color is versed in multiculturalism and comfortable in openly discussing their experience of it. Individuals in same ethnicity client-therapist dyads are not immune to the very biases or assumptions that are thoughtfully brought into awareness in didactic diversity training.

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For example, student therapists and clients from very similar ethnic or racial backgrounds can differ greatly in their family's immigration status and history, level of and attitudes toward acculturation, religion or religiosity, socioeconomic status, or any number of experiences. These differences may seem nuanced to supervision group members, though may be experienced as particularly salient within the therapist-client dyad. If these differences are missed or avoided, student clinicians may feel responsible to raise others' awareness of them lest they allow erroneous assumptions to persist, and yet have difficulty formulating an approach to do so while being evaluated.

The experience of graduate-level diversity training specific to clinicians challenges students to explore multiple aspects of identity beyond race and ethnicity, and how they can impact values, thoughts, and behaviors. This challenge may also arise for the client during the course of therapy. Understanding the intersections and interactions among different aspects of the therapist and client identity as well as the fluidity thereof can be crucial in fostering the development of a responsive and solid therapeutic relationship, particularly for individuals of color. Open discussion about these complexities in supervision groups precludes anonymity on the part of the student clinician. The Clinic Diversity Committee survey revealed the opportunities for these discussions were being missed. Through the process of negotiating these factors, the student clinicians at Georgia State University have taken note of the need to address this socio-cultural phenomenon of diversity in therapy relationships as it is experienced by the clinician in training. And thus, there was another call to action.

Similar to how a sense of community can be created though peer consultation among seasoned clinicians, a sense of safety can grow roots among students' peers discussing their unique, shared experience as clinicians in training exploring matters of diversity, and may bolster the supervision experience to benefit both supervisor and student, but most of all, the client. Individual members of the committee presented the possibility of a forum, a non-evaluative environment, a discussion among peers, to support one another as clinicians in training. Discovering allies among peers can facilitate student therapists' growth in being forthcoming in supervision and sensitive in therapy as matters of diversity arise. To date, the Clinic Peer Support Group has met once, but the hope and momentum are already palpable. The number of attendees across year levels in the program was higher than anticipated by the student founders, and several suggestions for how to structure the group were made. We have set forth a list of mutually agreed upon guidelines, aimed at creating and maintaining safety in the group. These guidelines will be amended in response to the maturation of the group, as necessary. There is no designated leader of the group— only participants who volunteer to keep track of time and materials for that month's meeting—as it is acknowledged that we are all new to the experience of how the roles of therapist, student, and supervisee intersect and impact our experience of diversity. We commit to use this ongoing conversation about our personal experience to augment our supervision experience and utilize our privileged positions to foster positive change in our clients.

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

ETHICS IN PSYCHOTHERAPY

Psychotherapy and the Suicidal Client: A Brief Introduction

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Perhaps no other clinical situation is more challenging or more anxiety arousing for psychotherapists than that of the suicidal client. Integrating knowledge about risk factors, warning signs, prevention, assessment, and treatment of the suicidal client is essential for every psychotherapist. Additionally, in our efforts to provide competent and ethical services to all clients, psychotherapists must actively stay informed of ongoing clinical developments and research findings to be able to provide the most current evidence-based clinical services possible.

Available data indicate that approximately 32,000 individuals die as a result of suicide each year in the United States (Hoyert, Heron, Murphy, & Kung 2006). Further, as Rudd and colleagues (2009) point out, over one half of these individuals are involved in some type of mental health treatment at the time of their suicide and close to 90% of those who commit suicide suffer from a diagnosable mental disorder. Of further relevance for psychotherapists is the fact that over 20% of practicing psychotherapists will treat a potentially suicidal client at some point in their career (DeAngelis, 2000) although those working in inpatient settings and with certain high risk populations will face an even greater likelihood.

Competence

In accordance with the aspirational General Principles of the Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code; APA, 2002) as well as with enforceable standards to include Standard 2.01, Boundaries of Competence, it is vital that psychotherapists are competent to provide needed services to those with whom they work. This includes having a clear understanding of the current research that informs ethical assessment and treatment with suicidal clients and the ability to implement it appropriately and effectively.

Clinical competence is essential for psychotherapists in their work with all clients. Due to the likelihood of meeting with clients with the potential for suicide risk, comprehensive knowledge of suicidology is a must for every practicing psychotherapist. While much of clinical competence originates during graduate training and pre- and post-doctoral internships, a large amount of competence can be gained and maintained through continuing education, continued clinical work, and consultation with colleagues (Jobes, Rudd, Overholser, & Joiner, 2008). This brief article provides psychotherapists with relevant information to play a small part in the development and maintenance of ongoing competence regarding the treatment and assessment of suicidal clients.

Informed Consent

Informed consent, a fundamental element of all ethical psychotherapy practice, is an essential component of how treatment begins for potentially suicidal clients. Until recently, research showed that informed consent with high-risk

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clients must cover limits of confidentiality and a plan for coping mechanisms to employ should suicidal ideation arise. More recently, however, specialists in suicidology recommend that psychotherapists include discussion of the risks of suicide and suicide attempts in the informed consent process. Addressing these components at the very beginning of the therapeutic relationship has been shown to enhance treatment compliance, encourage individual responsibility and the involvement of family or other social supports, and open a direct and honest exchange between the psychotherapist and the high-risk client about the likely risks involved and to ensure a realistic understanding of what treatment will require of the client (Rudd et al., 2009).

Additionally, for clients with current suicidal ideation or a history of suicide attempts, psychotherapists should use informed consent processes that are common in Dialectical Behavior Therapy (DBT) and Cognitive Therapy (CT), as these are the two treatments with proven efficacy with suicidal clients (Althaus & Hegert, 2003; Tarrier, Taylor, & Gooding, 2008) . The informed consent process from these perspectives involves a collaborative approach to goal setting, a direct statement of expectations of the client and the psychotherapist, and a primary goal of preventing a suicide attempt (Rudd et al., 2009). Current research suggests that high-risk clients need a more structured form of treatment; a structured treatment begins with informed consent (Jobes, Rudd, Overholser, & Joiner, 2008).

Rudd, Mandrusiak, and Joiner (2006) recommend using what they have termed a Commitment to Treatment Statement (CTS) to address in the first session the client's motivation and commitment to his or her treatment; CTS was developed from the CBT theory. A typical CTS consists of an agreement that the client will attend and actively participate in psychotherapy sessions, set goals honestly and realistically with the psychotherapist, complete any homework assignments, take all prescribed medications, and employ a crisis response plan when necessary. Research encourages that a CTS is signed by the client and by a witness, who should be a significant other or a family member. With family involvement, a client is more likely to remain committed to his or her psychotherapy work and to improving his or her life.

The Role of Assessment

While informed consent is the primary focus of a first psychotherapy session(s) with a suicidal client, it is not the only component. An objective quantitative risk assessment should be administered during the first session and all subsequent sessions thereafter to measure current feelings of hopelessness, worthlessness, changes in social supports, and current stressors or potential triggers. Simply asking a client about ideation, intent, and plan on one occasion is not sufficient; however, allowing clients to verbally express their own feelings has been found to aid in treatment outcomes. For this reason, Jobes et al. (2004) recently reconstructed his Suicide Status Form, a qualitative measure, so that clients have the opportunity to express in their own words their current experiences. As suggested by Berman, Jobes, and Silverman (2006), any qualitative or quantitative assessments given must at a minimum address four factors including predisposed vulnerabilities, any triggering events that caused a loss of something valued, current mental status, and any protective factors possessed by the client.

Generally speaking, most psychothera-

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pists agree on the use of objective assessments to monitor either active or passive suicidal clients; however, current research builds on this conclusion by recommending that the results of these assessments be updated every few days if a client is in crisis. Ethically, clinicians must be aware that due to the constantly changing mental status of a person with active suicidal ideation, assessments are only valid for one to three days (Simon & Gutheil, 2009). Therefore, when treating an actively suicidal client, psychotherapists should consider offering more frequent assessment and treatment sessions, and other contacts. Some research also recommends that during an initial meeting with any new client, even one with little to no history of suicidal ideation, a psychotherapist should administer a relevant screening tool in order to identify if the person is at any risk for suicide (Bryan, Corso, Neal-Walden, & Rudd, 2009). Giving a brief screening measure will ensure that necessary further assessments can be completed and appropriate treatment plans are created.

Evidence-Based Interventions

In addition to the use of weekly or bi-weekly formal objective assessment, clients who are actively or passively suicidal require extra treatment supports, often including family involvement, crisis response plans, or possibly hospitalization. Current research suggests that significant others or family members should be involved in the treatment of high-risk clients from day one (Rudd et al., 2009). With appropriate consent, psychotherapists should be sure to speak to as many involved family members or loved ones as possible because often, they will have important data that the client might not disclose (Simon & Gutheil, 2009). Additionally, if the psychotherapist builds relationships with members of the client's support network, the clinician will be more able to engage them in serving as effective resources for the client when he or she is outside of psychotherapy sessions. Only several years ago, psychotherapists believed that above all else, confidentiality must be upheld. However, now it is recommended that psychotherapists seek consent from high-risk clients to communicate with family members and others as needed.

Involving the family in a suicidal client's treatment also aids in preventing hospitalization and more recently, evidence shows that hospitalization is not necessarily beneficial for clients who threaten or gesture suicide. According to Marsha Linehan, the creator of DBT, hospitalization of Borderline Personality Disorder patients in response to suicide gestures or ideation may prove harmful. She and her colleagues further explain that hospitalization can reinforce the attention-seeking behavior by way of attention from the nursing staff and colluding social interactions with other patients; DBT trains clinicians to help the client use other resources and coping mechanisms to avoid hospitalization unless it is an absolute emergency (Miller, Rathus, & Linehan, 2007). With that, clinicians are encouraged to use all members of a client's family to provide support and attention before resorting to hospitalization. As well, some psychiatric inpatient stays can be negative, overwhelming, non-therapeutic experiences that will not aid in recovery and may in fact make it more likely that the client completes suicide. For this reason as well, recent literature recommends that clinicians should utilize all other possibilities prior to hospitalizing a potentially suicidal client. Furthermore, practicing clinicians should be aware of the bimodal peaks for suicide risk when hospitalizing a suicidal client; the client

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is most at risk during the first week after admission and the first week after discharge. With this, if a clinician hospitalizes a client, he or she should ensure that the client is well prepared for the inpatient experience and is connected to immediate outpatient care following discharge (Qin & Nordentoft, 2005).

No-suicide contracts were once the most commonly recommended short-term treatment method for actively suicidal clients; however, these contracts are no longer recommended, as they did not aid in preventing suicide (Rudd, Mandrusiak, & Joiner, 2006). Rather, Crisis Response Plans (CRP) are the newest tools suggested for use by psychotherapists who are treating actively suicidal clients. Typically, a CRP should be outlined and agreed upon collaboratively between the psychotherapist and the client during the first session, as it is included in the CTS discussed earlier in this article. A CRP involves individualized steps for the client to pass through when feeling that he or she is at high-risk for suicidal gestures or attempts. The first part of the CRP involves internal intervention, how to utilize oneself to alleviate symptoms, and the second part of the CRP involves external management, addressing who or what the client should contact in case his or her self-management skills fail. Research recommends that psychotherapists role play enacting the CRP with the client so that the pair can work collaboratively to build the skills necessary for effectively carrying out the CRP (Rudd, Mandrusiak, & Joiner, 2006).

Risk Management and Effective Clinical Practice

The recommendations iterated above focus on how to ethically assess and treat suicidal clients so as to prevent a future attempt or suicide and to protect the client. While all of these suggestions are fundamental to sound psychotherapeutic work, it is also important to consider how psychotherapists should ethically protect themselves while providing suicidal clients with ethical and competent care. When working with an active or passive suicidal client or even an individual who has a history of suicide attempts or gestures, psychotherapists should be sure to document the date, time, and content of each contact with the client, including in-person, telephone, and e-mail contacts; psychotherapists should do the same for contacts with clients' family members and significant others.

Timely and thoughtful documentation should also include all assessments and their results, recommendations made, and interventions implemented. Further, the psychotherapist's decision making process is important to document as well. This should include options and alternatives considered, how treatment decisions were made, and why certain options were rejected. Any consultation with colleagues or others involved in the client's care and review of previous treatment records should be documented as well (Barnett, 1999). This way, should one's care of a client be challenged, the treatment record would provide a tangible record of the psychotherapist's reasonable good faith efforts to meet the standards of care of our profession.

Conclusions

Even with the incorporation of the previously discussed recommendations into clinical practice, psychotherapists can never ensure the safety of each client. The information shared and discussed in this article is simply a summary of several of the more important aspects of providing psychotherapy to suicidal and potentially suicidal clients.

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These include clinical competence, informed consent, and assessment and treatment based on the most recent empirical findings. However, this article should only be considered a brief introduction to the subject.

As was discussed earlier, clinical competence is at the heart of psychotherapy with suicidal clients and therefore, psychotherapists should continuously self-assess, seek ongoing continuing professional development, and consult with experienced colleagues. Since decisions made about suicidal clients truly can be life or death matters, careful consideration of one's ability to meet each client's treatment needs should be a regular occurrence. When the above mentioned steps prove insufficient, referring clients to expert colleagues is an important action to take. Consistent with the recommendations of Jobes, Rudd, Overholser, and Joiner (2008) it is hoped that the information presented in this brief article will help to promote improved clinical practices with suicidal clients by all psychotherapists.

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

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APA'S DIVISION OF PSYCHOTHERAPY IS PLEASED TO ANNOUNCE:

The Distinguished Publication of Psychotherapy Research Award for 2011

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

We ask members of the Division to nominate articles for consideration by **April 1**. Nominations should include the complete citation for the article, and should be emailed to the Chair of the Research Committee, Dr. Jim Fauth, at jfauth@antioch.edu.

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

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

The criteria for the award appear below.

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

The Distinguished Publication of Psychotherapy Research Award is accompanied by a $500 cash award sponsored by Wiley and Sons.

Personal Therapy for Graduate Trainees in Professional Psychology

Eric Everson, M.A., Marquette University

Because of the rigorous academic and personal demands (i.e., self-exploration, personal development) of graduate training in professional psychology, trainees are also challenged to care for themselves throughout their education. Additionally, this self-care must continue beyond the training experience, as the counseling profession presents stressors different from other fields of study (e.g., working with clients who are suicidal). The ability to balance one's personal and professional well-being thus remains important throughout the career, making self-care a vital component in maintaining stability. One method of such self-care is attending psychotherapy, which can enable professionals and trainees alike to address a range of concerns.

While personal therapy is commonly mentioned as a beneficial method of self-care for graduate trainees in professional psychology, the topic has only recently received attention in the empirical literature (Guy, Stark, & Poelstra, 1988; Holzman, Searight, & Hughes, 1996). Psychotherapy as part of the graduate training experience has historical support, as graduate programs once traditionally required psychotherapy for trainees (Garfield & Kurtz, 1976), particularly in psychoanalytic training institutes. While it is no longer typical for therapy to be a requirement of graduate training, nearly all APA-accredited doctoral programs and internships do report instances of faculty recommending professional counseling or therapy for trainees (Huprich & Rudd, 2004). Most of the literature exploring the use of psychotherapy for those in the mental health field, however, focuses on established professionals as opposed to trainees (Dearing et al., 2005; Holzman et al., 1996). Thus, while personal therapy for the trainee has been traditionally viewed as beneficial (Coleman, 2002; Williams, Coyle, & Lyons, 1999), there is actually little existing empirical literature to support such an assertion, nor to demonstrate the actual effects, if any, of such therapy. The profession would benefit, then, from greater attention to the impact of psychotherapy on professional psychology trainees. In an effort to stimulate such attention, I first examine the inevitable stressors of the graduate training experience, stressors that may spur the use of personal therapy.

The Graduate Training Experience

Inherent to training in professional psychology are challenges involving both personal and professional growth. Research in the area of graduate training has identified a number of stressors that are common across disciplines, as well as those unique to psychology, all of which might contribute to trainees seeking psychotherapy.

Practical issues (e.g., finances, time) have been found particularly problematic for the graduate trainee, as well as stressors that were viewed as an "intrinsic part of postgraduate professional studies: academic pressure and professional socialization" (Kumary & Baker, 2008, p. 22). Graduate trainees may also struggle to develop a new support sys-

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tem (Cushway, 1997), for they might be required to move away from family or friends to begin graduate training, potentially adding stressors on top of those associated with their program of study. It is also possible that trainees may experience difficulty in personal relationships, as emotional and cognitive resources can be limited during especially difficult periods of graduate training (Cushway, 1992, 1997).

Psychology graduate trainees are also required to simultaneously expand, maintain, and communicate knowledge in a given area of expertise, while also developing skills used in a clinical setting (e.g., active listening, facilitation of insight). Graduate training in professional psychology is thus a growth-oriented process that, in research focusing on trainee and professional perspectives on therapy for trainees, was found to be significantly stressful for the trainee (Kaslow & Friedman, 1984). It may come as no surprise, then, that many graduate trainees in professional psychology experience a relatively high rate of psychological distress (Cushway, 1992).

Developing self-awareness is also a large part of the professional psychology training experience, one also not without difficulties (Cushway, 1997). For instance, trainees may struggle with personal reactions to incidents that occur in academic or clinical settings, or in their personal lives (Howard, Inman, & Altman, 2006; Skovholt & Ronnestad, 2003). Attending psychotherapy, perhaps in an effort to address such reactions, has been found "critical in their development as counselors" (Furr & Carroll, 2003, p. 487), particularly with regard to gaining insight into the counseling process as well as achieving personal growth. Sank and Prout (1978), noting that empirical evidence focusing on personal therapy for graduate trainees in professional psychology was lacking, nevertheless stated that psychotherapy was "supportive and reassuring, and therefore of great use while first undergoing the demands of the role of therapist" (p. 643). Other research has also underlined the importance of psychotherapy for providing the opportunity for self-exploration personally and professionally (Woodside, Oberman, Cole, & Carruth, 2007).

In some cases, therapy for the graduate trainee in professional psychology might be recommended for remediation of noted difficulties. For example, Prodicano, Busch-Rossnagel, Reznikoff, and Geisinger (1995) found that 29% of programs surveyed recommended that students seek psychotherapy for remediation of deficiencies, and reported that "follow-up on the efficacy of this approach seems warranted" (p. 432). In some instances, psychotherapy was required for the trainee, and in others a more informal recommendation of therapy was made. Programs also varied in their level of involvement in the trainee's psychotherapy, which was largely mediated by factors including the perceived severity of the trainee's impairment and the program's familiarity with the treating therapist (Elman & Forrest, 2004). Research on the professional psychology training experience thus illuminates the range of stressors and concerns experienced by trainees, as well as the potential for trainee impairment, impairment that may be ameliorated by seeking psychotherapy.

Professionals' Use of Personal Psychotherapy

As noted above, the bulk of the empirical literature on psychotherapy for those in the mental health field has focused on post-training professionals. Among the areas investigated are the frequency with which professionals seek therapy and the presenting con-

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cerns they report (Deacon, Kirkpatrick, Wetchler, & Niedner, 1999; Deutsch, 1985; Gilroy, Carroll, & Murra, 2002; Mahoney, 1997; Neukrug & Williams, 1993; Norcross & Guy, 2005; Pope & Tabachnick, 1994), the process and outcomes of such treatment (Bike, Norcross, & Schatz, 2009; Norcross, Strausser-Kirtland, & Missar, 1988), and the impact of psychotherapy on practice (Lucock, Hall, & Noble, 2006; Macran, Stiles, & Smith, 1999; Rizq & Target, 2008; Wiseman & Shefler, 2001) and on awareness of self and others (Coleman, 2002).

Early inquiry into the topic of psychotherapy for practicing professionals revealed that approximately 60% of psychologists sought personal therapy at some point during their career (Garfield & Kurtz, 1976). Subsequent research has yielded somewhat similar results, with anywhere from 54% to 84% of surveyed psychologists reporting that they have attended psychotherapy at some point in their career (Deutsch, 1985; Neukrug & Williams, 1993; Pope & Tabachnick, 1994). Among the most common presenting concerns were relationship conflicts, work-related stressors, depression, anxiety, self-confidence, career issues (Deutsch, 1985; Pope & Tabachnick, 1994), personal growth, grief, and childhood issues (Deacon et al., 1999; Mahoney, 1997).

Mental health professionals generally agree that psychotherapy for individuals in the field is a valuable experience with a range of personal and professional effects, including positive impacts on therapist verbal interactions with clients and skill development (Bellows, 2007). Intriguingly, however, both Clark (1986) and Macran and Shapiro (1998) reported that professionals with previous personal therapy were no more effective than those who had no such experience, with Clark also noting that client outcomes were more related to the experience level of the treating professional than to whether or not the professional had sought psychotherapy. In contrast, other research on the processes and outcomes of professionals' personal treatment has found overwhelmingly positive effects, with respondents reporting improvement in behaviors, insight, or emotions (Bike, Norcross, & Schatz, 2009; Norcross et al., 1988; Williams et al., 1999). Qualitative inquiry into this topic has also found noteworthy effects, with participants reporting increased awareness of their role in the therapy process, an increased level of authenticity in treating clients, higher levels of creating a collaborative experience with clients, better recognition of the need to give clients space in counseling, and affirmations of the importance of listening to understand clients on a deeper level (Coleman, 2002; Macran et al., 1999; Rizq & Target, 2008; Wiseman & Shefler, 2001).

Thus, attending psychotherapy is a relatively common experience for established mental health professionals, and those who have attended therapy report largely positive effects. The majority of professionals with experience in psychotherapy count it as a beneficial influence on their personal and professional development.

Trainees' Use of Personal Psychotherapy

In contrast to the relatively substantial literature base on professionals' use of psychotherapy, few empirical studies have examined professional psychology trainees' experiences of therapy. Those that do exist have largely focused on the rates of trainees' use of therapy, their presenting concerns (Dearing, Maddux, & Tangney, 2005; Guy et al. 1988; Holzman et al., 1996; McEwan & Duncan,

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1993), and the impact of therapy on training and clinical experiences (Garfield & Bergin, 1971; Gold & Hilsenroth, 2009; Kaslow & Friedman, 1984; Sandell et al., 2006).

A recent survey of clinical and counseling psychology graduate students found that a clear majority of participants (70%) reported that they had attended psychotherapy at some point in their lives, and 47% to 54% of those respondents initiated therapy during their graduate training (Dearing et al., 2005). This rate of attending counseling differs somewhat from earlier findings by Holzman et al. (1996), who found that 74% of respondents reported seeking psychotherapy.

Research on trainees' use of personal therapy has also examined the reasons that trainees enter psychotherapy and the factors that might influence this decision. Among those who did seek personal therapy, personal growth (70%) and the desire for professional improvement (65%) were the most common reasons for doing so, with 56% endorsing adjustment issues, and 38% seeking treatment for depression (Dearing et al., 2005). Trainees have also reported entering treatment primarily for personal (i.e., emotional well-being) as opposed to professional (i.e., learning about the counseling process) reasons (Kaslow & Friedman, 1984).

Trainees have also reported inconsistent departmental views regarding attending psychotherapy as having an influence on their decision (Bruss & Kopala, 1993; Kaslow & Friedman, 1984), with some participants reporting support for personal therapy and others reporting ambivalence or negative perceptions from faculty as affecting their decision not only to seek therapy, but also whether or not to disclose their therapy. If the program's culture seems not to support trainees seeking psychotherapy, trainees may well worry about disclosing their decision to seek treatment (Dearing et al., 2005; Holzman et al., 1996). Furthermore, peer relationships also contributed to trainees' decision to attend psychotherapy, as participants reported conflicted feelings about disclosing their treatment to others, particularly in instances in which the therapist was known to peers (Holzman et al., 1996). When asking specifically about risks that trainees perceived with regard to seeking psychotherapy while in training, McEwan and Duncan (1993) found that the majority of risks focused on confidentiality and ethical dilemmas related to the decision to seek therapy.

Early research highlighted a correlation between trainees' engaging in therapy and their efficacy in clinical practice. Strupp (1958), for instance, found that inexperienced therapists with previous personal treatment had lower levels of empathy than their colleagues with no previous treatment. Garfield & Bergin (1971) identified less positive change in clients whose primary therapists were practicum students with high levels of experience receiving psychotherapy vs. those with little or no experience receiving therapy. Later research focused on the trainee perspective of the impact of psychotherapy, with participants reporting both positive (e.g., increased empathy, personal insight) and negative (e.g., overidentification with the patient role) impacts (Kaslow & Friedman, 1984).

In more recent research, Grimmer and Tribe (2001) reported that trainees mandated to attend psychotherapy developed increased insight into the process of therapy and experienced both validation and normalization during their

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help-seeking experience. In other research, trainees and faculty rated an increase in self-awareness as the highest potential benefit, with faculty rating the role of the therapist as a model for the trainee as of secondary importance, while trainees rated the opportunity to deal with their personal issues as the second most important potential benefit (Strozier & Stacey, 2001). A later study by Murphy (2005) reported somewhat similar results, with findings suggesting that trainees experienced a number of effects, ranging from personal growth to realizing the potential impact of the psychotherapy experience. Studies have also emphasized the need for continued exploration of this area, with Murphy (2005) stating that trainees are "being asked to undergo personal therapy without supporting evidence explaining the benefits" (p. 31).

Thus, research in the area of psychotherapy for trainees in professional psychology has yielded information regarding rates of attendance and presenting concerns, as well as initial findings regarding the potential benefits and impact of such therapy. Few studies, however, have focused on the trainee perspective in-depth to illuminate how psychotherapy is experienced during training and how trainees view its potential impact.

Conclusions: Focusing on the Experience and Impact of Psychotherapy for Trainees

Furthering the profession's understanding of the trainee experience of psychotherapy would provide valuable information about the help-seeking behaviors and experiences of trainees, for effective coping strategies developed during training can provide a solid foundation for self-care later in one's career (Dearing et al., 2005). As noted above, the literature focusing on trainees' use of personal therapy does provide some initial information regarding the rates with which they seek psychotherapy (Deacon et al. 2005), the concerns they bring to the personal therapy process (Holzman et al. 1996), the influence of the graduate school setting on trainees' decisions to pursue treatment, and the impact that psychotherapy can have on the trainee's functioning (Kaslow & Friedman, 1984), with results from trainees largely paralleling those from professionals (Grimmer & Tribe, 2001; Murphy, 2005; Strozier & Stacey, 2001). Continued research in this area could expand upon existing findings by exploring trainees' perspectives on the whole of the psychotherapy experience; that is, not focusing solely on presenting concerns or potential effects on clinical work, but rather on the trainee view of the interplay between their academic, clinical, and personal development while in psychotherapy. We do not yet have a well-developed understanding of this focus, which could provide useful information for trainees, for the faculty and staff responsible for delivering the training experience, and for the professionals providing such treatment for the trainees.

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

CALL FOR FELLOWSHIP APPLICATIONS DIVISION 29—PSYCHOTHERAPY

Clara E. Hill, Chair, Fellows Committee

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

The minimum standards for Fellowship under APA Bylaws are:

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

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

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

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

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

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

DEADLINE FOR SUBMISSION. The deadline for submission to be considered for 2011 is **December 15, 2010**. The initial nominee must enclose a *Uniform Fellow Application*, self-nominating letter, three or more letters of endorsement, updated CV, along with a cover letter, and three copies of all the original materials. Incomplete submission packets after the deadline will not be considered for this year. Those who are current Fellows of APA who want to become a Fellow of Division 29 need to send a letter attesting to your qualifications and a current CV.

Completed Applications should be forwarded to:

Clara E. Hill
Chair, Division 29 Fellows Committee
Department of Psychology
University of Maryland
College Park, MD 20742
Email: hill@psyc.umd.edu
Phone: 301-405-5791

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

Preventing Distress and Impairment: The Importance of Self-Care Education and Utilization During Graduate Training in Clinical Psychology

Ian Goncher, M.S.
Loyola University, Maryland

Freud (1905/1933) stated, "No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed" (p. 184). This declaration demonstrates the possible toll that providing psychotherapy can take on the practicing psychologist and underscores the need for increased education and emphasis of self-care within graduate training of future psychotherapists.

The implementation of self-care strategies has been referred to as an ethical imperative in the practice of professional psychology (Barnett, Johnston, & Hillard, 2006). However, data suggest that many psychologists refrain from utilizing self-care services despite the observed negative impact distress and subsequent impairment have on their ability to function, according to established professional standards (e.g., Guy, Poelstra, & Stark, 1989; Pope, Tabachnick, & Keith-Spiegel,1987; Sherman, 1996). This occurrence is tremendously concerning given the rates of distress and impairment reported by psychologists, (Gilroy, Carroll, and Murra, 2002; Guy, Poelstra, & Stark, 1989; Thoreson, Miller, & Krauskopf, 1989). In a study of the prevalence of distress and its impact on effective professional functioning, Guy, Poelstra, and Stark (1989) found that approximately 75% of those surveyed acknowledged distress in the previous three years. Although the experience of distress is an expected part of life and by itself should not necessarily be a cause for significant concern, these authors also found that 36.7% of those surveyed reported an awareness that their distress resulted in a reduction of the quality of care provided to clients.

The practice of psychology can be a very stressful enterprise by virtue of the profession (Laliotis & Grayson, 1985), which includes the potential for deterioration of personal and professional functioning related to symptoms of burnout (Maslach, 1976; Pines & Maslach, 1978; Raquepaw & Miller, 1989; Truchot, Keirsebilck, & Meyer, 2000) and secondary traumatization (Figley, 1995; Kassam-Adams, 1995; Munroe, 1995). Additionally, the job setting of independent practitioners may also be a contributing factor regarding the development of symptoms of distress and impairment. For example, long work hours, administrative "red tape," sizable caseloads, third party payers, and budgeting concerns could be job setting factors that contribute to the development of symptoms of burnout (Vrendenburgh, Carlozzi, & Stein, 1999). Furthermore, Raquepaw and Miller (1989) suggest that the potentially isolative nature of independent practice may contribute to symptoms of burnout.

Although stressful life experiences are not a unique phenomenon specific to in-

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dividuals practicing psychotherapy, Kilburg (1991) posits that psychotherapists are likely to feel more responsibility and emotional distress than the average individual due to their specific knowledge and skills. Psychologists have reported their most distressing personal events to include marital difficulties (Katsavadakis et al., 2004; Pope & Tabachnik, 1994; Sherman & Thelen, 1998), depression (Pope & Tabachnik, 1994; Sherman & Thelen, 1998; Thoreson et al., 1989), suicidal ideation (Katsavadakis et al., 2004), death of family member and personal illness (Sherman & Thelen, 1998; Thoreson et al., 1989), and financial or legal trouble (Freudenberger, 1990; Sherman & Thelen, 1998; Thoreson et al., 1989).

The aforementioned literature highlights a very real and concerning dilemma within the practice of psychology. In particular, this evidence suggests that the training of future professional psychologists in the development and utilization of positive and empirically validated self-care strategies is of critical importance. However, the American Psychological Association Advisory Committee on Colleague Assistance (ACCA, 2006) surveyed 500 graduate students recruited from the American Psychological Association of Graduate Students (APAGS) and found 82.8% of students said their training program did not offer written material on the issue of self-care and stress, 63.4% said their training program did not sponsor activities promoting self-care, and 59.3% said their training program did not informally promote an atmosphere of self-care. Schwebel and Coster (1998) concluded, "to summarize planned efforts, it is fair to say that in most instances, little is offered to all students with the express purpose of preventing mental health problems" (p. 288).

Currently, there is a paucity of research examining the influence of faculty and programmatic emphasis of self-care on graduate students' self-care practices. However, in a recent study, Dearing, Maddux, and Tagney (2005) found that faculty attitudes toward seeking personal psychotherapy directly and indirectly predicted student attitudes toward help-seeking. Additionally, surveying 264 doctoral-level trainees in clinical psychology, Goncher (2010) found positive correlations between the perceived emphasis placed on self-care within each graduate trainee's clinical psychology program, the use of self-care strategies by each graduate trainee, and graduate trainee quality of life. Furthermore, Goncher (2010) found a positive correlation between programmatic self-care emphasis and self-care strategy utilization. These data suggest that self-care education and emphasis of self-care importance within doctoral level training programs in clinical psychology results in increased use of self-care strategies and enhanced functioning. Furthermore, by intervening at the early stages of the graduate trainees' educational journey it is more likely that the graduate trainee will employ these strategies as they progress in their training (Sussman, 1995).

Although the extant literature does not possess a universal definition of self-care, research has provided several models. Baker (2003) describes self-care as being comprised of three interrelated factors: self-awareness, self-regulation, and balance. Baker (2003) suggests that psychologists endeavor to take care of themselves psychologically, physically, and spiritually. According to Baker (2003), to take care of oneself psychologically, one must examine and understand one's psychological development, which includes scrutinizing influences that contribute to current psychological functioning and one's motivation to enter the

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field, understanding one's own needs and how to fulfill them, optimizing coping strategies and limiting stress, finding meaning and purpose in personal and professional endeavors, engaging in activities such as relaxation, personal therapy, and leisure activities, and creating meaningful interpersonal connections. For optimal physical health, Baker (2003) suggests getting adequate rest, engaging in physical exercise, good nutrition, general medical care, cautioning against the use of substances, and healthy sexuality. Additionally, Baker (2003) asserts that we must take care of ourselves spiritually through finding our own spirituality and developing spiritual practice. Norcross (2000) provides a ten point model comprised of practitioner-tested, research-informed strategies that eloquently encapsulate the multifaceted nature of practicing self-care as a psychologist. These strategies include recognizing the hazards of psychological practice, thinking strategies as opposed to techniques or methods, beginning with self-awareness and self-liberation, embracing multiple strategies traditionally associated with diverse theoretical orientations, employing stimulus control and counter-conditioning when possible, emphasizing the human element, avoiding wishful thinking and self-blame, diversifying professional activities, appreciating the rewards of a career in psychotherapy, and using personal therapy. The use of personal therapy by psychologists has been shown as effective in the alleviation of distress and provides many personal and professional benefits (Bellows, 2007; Orlinsky & Ronnestad, 2005). Furthermore, participation in personal therapy has been suggested as an essential and ethically imperative aspect of graduate training and the independent practice of psychotherapy (Barnett & Goncher, 2008; Norcross, 2005).

This, among many other self-care models and activities, should be an essential aspect of training in psychological practice. Thus, as we train and educate future psychologists it is necessary to begin to intervene at the primary prevention stage of development (Caplan, 1964). We must not implement self-care strategies as strictly reactive measures against distress and impairment, but become proactive in the prevention of debilitating physical, psychological, interpersonal, and spiritual distress that may result in impairment and subsequent harm to our clients.

One way to achieve this goal is by incorporating education on models of self-care within the mandatory curriculum of each accredited clinical psychology program. The future of psychology hinges not only on the refinement of diagnostic instruments and use of empirically supported therapeutic interventions, but also on the physical, psychological, and spiritual health of those who represent the future of psychology.

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

The Psychotherapy Bulletin is Going Green:

Click on
www.divisionofpsychotherapy.org/members/gogreen/

CALL FOR NOMINATIONS

Distinguished Psychologist Award

The APA Division of Psychotherapy invites nominations for its 2011 *Distinguished Psychologist Award,* which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

Letters of nomination outlining the nominee's credentials and contributions should be forwarded to the Division 29 2011 Awards Chair:

Jeffrey J. Magnavita, Ph.D., ABPP
Glastonbury Medical Arts Center
300 Hebron Ave. Suite 215
Glastonbury, CT 06033
E-mail: magnapsych@aol.com

The applicant's CV would also be helpful. Self-nominations are welcomed.
Deadline is January 1, 2011

CALL FOR NOMINATIONS

Division 29 Award for Distinguished Contributions to Teaching and Mentoring

Each year, Division 29 honors a psychologist who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists by presenting the Division 29 Award for Distinguished Contributions to Teaching and Mentoring. This award is given annually to a member of Division 29 who exerted a significant impact on the development of students and/or early career psychologists in their careers as psychotherapists.

Both self-nominations and nominations of others will be considered. The nomination packet should include:

1) a letter of nomination, sent electronically, describing the individual's impact, role, and activities as a mentor;
2) a vitae of the nominee; and,
3) letters of reference for the mentor, written by students, former students, and/or colleagues who are early career psychologists. Letters of reference for the award should describe the nature of the mentoring relationship (when, where, level of training), and an explanation of the role played by the mentor in facilitating the student or colleague's development as a psychotherapist. Letters of reference may include, but are not limited to, discussion of the following behaviors that characterize successful mentoring:
   - helping students to select and work toward appropriate goals
   - providing critical feedback on individual work
   - providing support at all times, especially encouragement and assistance in the face of difficulties
   - assisting students in applying for awards, grants, and other funding

- assisting students in building social network connections, both with individuals and within organizations that are important in the field
- serving as a role model and leader for teaching, research, and academic and public service in psychology
- offering general advice with respect to professional development (e.g., graduate school, postdoctoral study, faculty positions), awards, and publications
- treating student/colleagues with respect, spending time with them, providing open communication lines, and gradually moving the student into the role of colleague.

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

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

The letter of nomination must be emailed to the Chair of the Professional Awards Committee. Deadline is January 1, 2011**.** ***All items must be sent electronically***. The Award is to be presented at the APA annual convention and we encourage all award winners to attend this ceremony. Division 29 2011 Awards Chair:

Jeffrey J. Magnavita, D29 Awards Chair
Glastonbury Medical Arts Center
300 Hebron Ave. Suite 215
Glastonbury, CT 06033
E-mail: magnapsych@aol.com

NOTICE TO READERS

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

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Is it Really Ending? Some Reflections on the Transition from Early to Mid-career

Michael J. Constantino, Ph.D.
University of Massachusetts Amherst

I am a tenured, Associate Professor. I am a *tenured*, *Associate* Professor. I really did need to write it twice to believe it! These labels, while associated with tremendous pride (and a lot of work!), also clearly indicate that I am no longer in my *early* career. Although I often still feel junior, I cannot ignore the overwhelming number of signs that tell me that I am now entering my mid-career. Thus, it is appropriate, although also somewhat sad, that as of December 31, 2010, I will rotate out of my position as Early Career Domain Representative to the Division 29 Board of Directors. As I leave this position after three and a half years, I would like to (a) share some reflections on my early career, as well as this inevitable transition out of it, and (b) offer several recommendations for those who are entering or will soon enter the early stages of a career in academia.

Reflections

Like each stage of training, early career goes by quickly. And the transition to mid-career reflects another one of those imaginary lines that one crosses whether they are psychologically ready or not. When I first obtained my faculty position, it was clear, whether or not I believed it, that I was crossing a line into the realm of "expert." I was reminded of that in many ways. Numerous manuscript review requests came rolling in even before I got settled into my new office! Both undergraduate and graduate students began looking to me for wisdom and direction. I became uncomfortably aware that soon I would be personally responsible for a student's training and professional development. I had indeed crossed a line. As it turns out, I was well trained and prepared for this step, but the notion of when I suddenly became an "expert" was still murky in my mind. And now, as I leave early career behind, I am crossing another one of those invisible lines into "experienced expert," whatever that means! And, again, despite history telling me that I will be prepared for it (or at least that I will survive it), the crossing is a bit uncomfortable. But it will happen no matter what, so I am trying to embrace the loss of my "newbie-ness."

As I reflect back, I also recall several salient early career experiences. Starting a research lab was challenging; however, it was also fun. Part of the fun was the ability to use start-up funds to make the space mine (and ultimately that of my graduate students). I was also fortunate that the Chair of my search committee was kind enough to review my start up request and to suggest that I double it. It worked—I received the doubled amount! Such guidance was crucial in what was uncharted territory for me. Of course, as I move into mid-career, I am bummed that my start-up is all gone. Like early career (and all stages before that), it went quickly! But, hey, that's what grants are for, right?

I also recall that I networked a lot (even more so than when in graduate school).

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I worked hard to build connections both within my University and across the profession. Running for a Division 29 Board position was a perfect example, and it was one of the most rewarding decisions that I made in my early career. Connection and collaboration are crucial in academia (and many other professions), which reminds me how much I said "yes" to things early on. Although I still say "yes" to a lot of things, it is interesting that one of my biggest goals as I enter mid-career is to learn how to politely decline certain invitations in order to preserve my own sanity! I have to say, my current, and very first, sabbatical has helped in this regard.

I also learned that getting involved in relevant professional associations sometimes means accepting the less glamorous role. For example, I served as the Continuing Education Coordinator for a research society for several years. Although the work was not glamorous, and even occasionally tedious, the benefits to the development of my professional network were immense. In fact, I would say that such benefits were directly associated with my even being in the conversation for more "glamour" roles (e.g., I was recently nominated and subsequently elected as President-Elect in the same research society). Paying one's dues really does matter!

I suppose that my most central reflection as I look back on early career is that there were countless times when I either initiated (e.g., my first solo grant application) or was assigned (e.g., to be a search committee chair) something that seemed somewhat beyond my felt readiness. However, in most cases, I surprised myself. And in the cases where the outcomes were less positive, I realized that this career is a marathon, which will *safely* involve some trial, error, revision, adaptation, and adjustment. And at the font-end of my mid-career, I can honestly say, "I am doing okay." I might not always feel it, but I trust it.

Recommendations

Although I am sure with time I could think of numerous others, here are a few quick recommendations that I would confidently share to an early career, tenure-track faculty member at a research-oriented institution.

Accept two graduate students in your first year of recruitment. It will help to create a lab environment more quickly for both you and your students. Furthermore, although it will involve some additional work, this will be a time when your energy is at its highest level! Thus, it will feel more enjoyable than straining. I have to admit that I am simply passing this recommendation on from my graduate advisor with whom I consulted on this very issue. Speaking of which…

Stay in touch with your former advisors. They have much wisdom to continue to offer, and they will be interested in (and proud of) your development and accomplishments. *However,* you should also continue to foster your independence, and do so at an even more advanced pace than during internship and postdoc. Part of this will simply involve trusting your judgment. Of course I mean "simple" in theory, but not always practice!

Humility is good, but self-confidence is good too. Strive for a nice blend, as this will invite (more often than not) collegiality, friendship, *and* respect. These will in turn promote mental well-being!

It is fine, and often necessary, to have a "publish or perish" mentality and even competitive spirit on your way to tenure. However, this should not fully

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translate into a "publish or perish" *existence*! I know it is cliché, but maintain your life and your personality outside of academia, i.e., still be you, and enjoy it. For example, grants are incredible, but so are sports, movies, music, friends (perhaps especially those who have very different careers than you!), etc. So, despite the many demands with seemingly impossible deadlines, also say "yes" to starting that softball team! Find a local pub that has the NFL Ticket so that you can continue to follow your team. Tailgate a local football game. This is a wonderful collegiate tradition for which you are never too old (not even at mid- or late-career!). Of course I am leaking here some of *my* things, but you get the idea.

Appreciation

To reiterate, I cannot believe how quickly my early career has passed. It is a bit frightening to shed the protective "junior" label. However, it is also an exciting challenge—a challenge in part made possible by my involvement in important and inspiring endeavors such as my term on the Division 29 Board. I appreciate all that the Board has done for me, as well as all of the hard work of its members (including those directly tied to Early Career initiatives). I also look forward to continued mid-career involvement with this Division. I will remain connected!

PSYCHOLOGY DAY AT UN

For the past few years the APA–NGO delegation has sponsored a Psychology Day at the United Nations. Next year Psychology Day will be held on April 14, 2011. Florence Kaslow, Ph.D., ABPP, a former President of Division 43(Family) and 46 (Media), a former member of the APA Council, and a member Division 29 who hosted one of our tables at our recent luncheon for graduate students, has been invited to be one of the presenters. The theme for the day is Universal Access to Education: Barriers and Innovations. Florrie will speak about The Pivotal Role of the Family in their Child's Learning.

Florrie is currently a member of CIRP—the Committee on International Relations in Psychology and will serve as Committee Co-chair in 2011. CIRP works closely with the APA-NGO delegation.

At the recent APA Convention in San Diego, she received the Russell Bent Award for Distinguished Contribution to ABPP at the ABPP Convocation. A number of those Board Certified in Couple and Family Psychology were present to help celebrate this honor.

DIVISION 29 2010 AWARDS CEREMONY

APA Annual Convention—San Diego California

Division 29 President Jeffrey Magnavita, Past President and Awards Chair Nadine Kaslow, and Psychotherapy Journal Editor Charles Gelso

Past President and Awards Chair Nadine Kaslow, Division 29 Distinguished Psychologist Award recipient Jeff Barnett, and President Jeffrey Magnavita

Jeffrey Magnavita, Nadine Kaslow, Distinguished Publication of Psychotherapy Research Article Award recipient Antonio Pascual-Leone, and Research Committee Chair Susan Woodhosue

Nadine Kaslow, APF/Division 29 Early Career Award recipient Tami Jo De Coteau, and Jeffrey Magnavita

Jeffrey Magnavita and Mathilda B. Canter Education and Training Student Paper Award recipient Samuel Nordberg

Nadine Kaslow, Distinguished Contributions to Teaching and Mentoring Award recipient Louis Castonguay, and Jeffrey Magnavita

CALL FOR NOMINATIONS

DIVISION 29 EARLY CAREER AWARD

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

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

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

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

Funding Specifics
One $2,500 award presented annually

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

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

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

Submission Process and Deadline
Submit a completed application online at **http://forms.apa.org/apf/grants/** by **January 1, 2011**.

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

Division of Psychotherapy (29)
American Psychological Association

Enter the Annual Division of Psychotherapy Student Competitions

The APA Division of Psychotherapy offers four student paper competitions:

- The Donald K. Freedheim Student Development Award for the best paper on psychotherapy theory, practice or research.
- The DiversityAward for the best paper on racial/ethnic gender, and cultural issues in psychotherapy.
- The Mathilda B. Canter Education and Training Award for the best paper on education, supervision or training of psychotherapists.
- The Jeffrey E. Barnett Psychotherapy Research paper Award for the best paper that addresses psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role of psychotherapists' personal characteristics.

What are the benefits to you?

- Cash prize of $250 for the winner of each contest.
- Enhance your curriculum vitae and gain national recognition.
- Plaque and check presented at the Division 29 Awards Ceremony at the annual meeting of the American Psychological Association (August 4-7, 2011)
- Abstract will be published in the Psychotherapy Bulletin, the official publication of the Division of Psychotherapy.

What are the requirements?

- Papers must be based on work conducted by the first author during his/her graduate studies. Papers can be based on (but are not restricted to) a masters thesis or a doctoral dissertation.
- Papers should be in APA style, not to exceed 25 pages in length (including tables, figures, and references) and should not list the authors' names or academic affiliations.
- Please include a title page as part of a separate attached MS-Word or PDF document so that the papers can be judged "blind." This page can include authors' names and academic affiliations.
- Also include a cover letter as part of a separate attached MS-Word or PDF document. The cover letter should attest that the paper is based on work that the first author conducted while in graduate school. It should also include the first author's mailing address, telephone number, and e-mail address.

Submissions should be emailed to:

Doug Wilson
Chair, Student Development Committee, Division of Psychotherapy
E-mail: dougcwilson@msn.com

Deadline is April 1, 2011

2011 NOMINATIONS BALLOT

Dear Division 29 Colleague:

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

NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN THE DIVISION OF PSYCHOTHERAPY.

THE OFFICES OPEN FOR ELECTION IN 2011 ARE:

- President-elect
- Secretary
- Domain Representative for Public Interest and Social Justice

All persons elected will begin their terms on January 2, 2012

A Domain Representative is a voting member of the Board of Directors. The open position wil be responsible for creative initiatives and oversight of the Division's portfolio in Public Interest and Social Justice. Candidates should have demonstrated interest and investment in the area of their Domain.

The Division's eligibility criteria for all positions are:

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

Return the attached nomination ballot in the mail. The deadline for receipt of all nominations ballots is December 31, 2010. We cannot accept faxed copies. Original signatures must accompany ballot.

EXERCISE YOUR CHOICE NOW!

If you would like to discuss your own interest or any recommendations for identifying talent in our division, please feel free to contact the division's Chair of Nominations and Elections, Dr. Marvin Goldfried at (631) 632-7823 or by Email at marvin.goldfried@sunysb.edu

Sincerely,

Jeffrey J. Magnavita, Ph.D.	*Elizabeth Nutt Williams, Ph.D.*	*Marvin Goldfried, Ph.D.*
President	President-elect	Chair, Nominations & Elections

NOMINATION BALLOT

President-elect

_____

_____

_____

Secretary

_____

_____

_____

Domain Representative for Public Interest and Social Justice

_____

_____

_____

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 _____

FOLD THIS FLAP IN.

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

Fold Here.

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

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

Eligibility: In alternating years, graduate students/predoctoral interns or doctoral level psychologists/postdoctoral fellows will be eligible for the Charles J. Gelso Grant. In 2011, doctoral level psychologists, including postdoctoral fellows, will be eligible. In 2012, graduate students in psychology and predoctoral interns who are in good standing at an accredited university will be eligible. The grant will rotate biannually between graduate students/predoctoral interns and doctoral level psychologists/postdoctoral fellows, such that nominations will be accepted in even number years for the former group and odd number years for the latter group.

Deadline: April 1, 2011

REQUEST FOR PROPOSALS
Description
This program awards grants for research projects in the area of psychotherapy process and/or outcome. In alternating years the grant is awarded to graduate students (even-numbered years) or doctoral level psychologists (odd-numbered years).

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

Funding Specifics
One annual grant of $2,000

Eligibility Requirements
- In alternating years, graduate students/pre-doctoral interns (even-numbered years) or psychologists/postdoctoral fellows (odd-numbered years) will be eligible.
- In 2011, doctoral level psychologists and postdoctoral fellows will be eligible.
- In 2012, graduate students in psychology and pre-doctoral interns who are in good standing at an accredited university will be eligible .
- Demonstrated or burgeoning competence in the area of proposed work.
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved.
- The same project/lab may not receive funding two years in a row.

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

Proposal Requirements for All Proposals
- Description of the proposed project to include goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans
- CV of the principal investigator
- Format: not to exceed 3 pages (1 inch margins, no smaller than 11-point font)

- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted). The budget should clearly indicate how the grant funds would be spent.
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows
- Graduate students, predoctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.

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

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

Additional Information

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

Submission Process and Deadline

- Submit a CV and all required materials for proposal (see above for proposal requirements) to: Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net
- If the grant is to be used to support a thesis or dissertation, the thesis/dissertation proposal must be approved by the thesis/dissertation committee (this should be noted in the letter of recommendation from the mentor)
- Deadline: April 1, 2011
- Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Jim Fauth at jfauth@antioch.edu), or the Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Norman Abeles at abeles@msu.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net

PERSPECTIVES ON PSYCHOTHERAPY INTEGRATION

Introduction To An Integrative Attachment-Based Model of Sexual and Loving Feelings in Psychotherapy

Alan Nathan, Psy.D.
Argosy University, Washington, D.C.

This paper provides an introduction to an integrative attachment-based model of sexual and loving feelings within the psychotherapy relationship. I posit a three dimensional model for understanding and responding to sexual and loving feelings that includes: (a) normalization of psychotherapist sexual and loving feelings that includes provision of a supportive professional community; (b) an attachment-based conceptualization of sexual and loving feelings in psychotherapy; and (c) an integrated formulation of effective intervention that centers on psychotherapist reflective function within a secure therapist-patient attachment relationship, the transformation of sexual and loving feelings into clinical observations, and cultivation of a therapeutic form of love. Due to space limitations the model is briefly presented along with a clinical vignette. The overarching goal is to contribute to the development of a more inclusive discourse on this enormously challenging topic within the psychotherapy profession. I attempt to address the therapeutic challenges by first normalizing psychotherapist experience of sexual and loving feelings and the anxiety and avoidance they can provoke (Dallenberg, 2000; Gutheil & Gabbard, 1992; Ladany et al., 1997; Paxton, Lovett, & Riggs, 2001; Pope, Keith-Spiegel, & Tabachnick, 1986; Pope, Sonne, & Greene, 2006; Pope, Sonne, & Holroyd, 1993; Rodolfa et al., 1994). It is my hope to widen the space between exploitative and unethical sexual acting out and the forbidden zone to which loving and sexual feelings within the psychotherapy relationship are often cast and to broaden the application of effective intervention strategies across theoretical orientations. A final introductory note is that sexual and loving feelings in psychotherapy result from complex processes in which both patient and therapist make contributions. While it is beyond the scope of this paper to present a comprehensive typology of this phenomenon, the assumption of co-creation of experience within the psychotherapy relationship serves as a subtext for this discussion.

Psychotherapist Sexual and Loving Feelings as Normative

There is now a well established body of evidence in the form of large scale psychotherapist survey studies that have confirmed that the experience of sexual and romantic attraction toward patients is a common but not frequent occurrence for psychotherapists, acknowledged by 78 to 90 percent of respondents (Paxton et al., 2001; Pope et al., 1986; Pope & Tabachnick, 1993; Pope, Tabachnick, & Keith-Spiegel, 1987; Rodolfa et al., 1994; Stake & Oliver, 1991). While such feelings are typically not acted upon by therapists in an explicit way there is a small proportion (approximately 7%) of psychotherapists who engage in sexual relations with their patients. The harm that comes to

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patients, their families, to the profession, and to the public's view of the profession has been well documented (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983; Brown, 1988; Parsons & Wincze, 1995; Pope, 1988, 1990, 2001). Regardless of theoretical orientation we can all agree that therapist-patient sexual activity is a disaster that every psychotherapist must be responsible for guarding against as part of the commitment to do no harm (American Psychological Association, 2002).

That said, loving and sexual feelings can potentially disrupt the course of psychotherapy even when the therapist refrains from sexual involvement with the patient. Psychotherapists report powerful anxiety laden reactions to sexual attraction to patients that may contribute to confusion and distraction from the clinical work, difficulty managing therapeutic boundaries effectively, premature termination, and negative treatment impact particularly if the patient is believed to be aware of the therapist's feelings (Ladany et al., 1997; Pope et al., 1987; Rodolfa et al., 1994; Stake & Oliver, 1991).

Psychotherapists have reported that sexual and loving feelings arise in the following forms: (a) in-session sexual arousal, (b) between session sexual or romantic fantasy, and (c) noticing patient as physically attractive (Pope et al., 1986; Pope et al., 1987; Pope & Tabachnick, 1993; Rodolfa et al., 1994). The most common form of sexual feeling is noticing the patient as physically attractive with a 96% endorsement rate and approximately three quarters of therapists reporting that they notice up to fifty percent of their patients as physically attractive. Overall 58% reported sexual arousal while in the presence of a patient at least with 1-2% of patients and most no more than with 20% of patients (Pope & Tabachnick, 1993). Approximately one fourth of therapists acknowledge sexual fantasies about patients during sexual activity with others (Rodolfa et al., 1994; Pope et al., 1986). When therapist respondents are asked more generally about between session sexual fantasies involving patients 46.3% endorse this item as a rare experience and 22.4% endorse this item as a sometimes experience (Pope et al., 1987).

Dalenberg (2000) in an analogue study and a post-treatment interview study obtained patient and therapist ratings of therapist responses to patient expressed sexual attraction to the therapist. Severe anxiety and angry feelings were reported by more than half of the therapists in the analogue study and patients rated over 70% of therapist responses as harmful including those described as punitive and avoidant. In the patient interview study two thirds of patients reported that issues related to patient sexual attraction were left unresolved and of those patients one third felt that their therapist avoided the issue. There is no direct evidence that the therapists in these studies experienced sexual or loving feelings. That said, patient expression of sexual material and behavior has been found to be associated with therapist sexual attraction in several of the above survey studies (Ladany et al., 1997; Pope et al., 1986; Rodolfa et al., 1994) and two studies of therapists who became sexually involved with their patients (Gabbard, 1994c; Gutheil, 1989).

Clearly when sexuality enters the psychotherapy space anxiety and struggle follow. Yet the vast majority of therapists manage to refrain from sexual activity with patients including under these anxiety provoking circumstances. It is noteworthy that perceived negative treatment impact is correlated with belief in patient awareness of therapist sexual attraction. It can feel nearly im-

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possible to maintain an objective and neutral therapeutic frame when the therapist believes that the patient can see her most intimate and vulnerable states of desire. The tendency to equate sexual feeling with sexual action along with the sometimes shaming responses to therapist sexual feelings within the professional community can lead any therapist toward avoidance when the patient is believed to know (Gutheil & Gabbard, 1992; Pope, Sonne, & Greene, 2006; Pope, Sonne, & Holroyd, 1993).

That potential sexual and loving feelings can provide for deeper understanding of the patient, creative and effective intervention, and positive treatment outcome is noted via therapist report in the above survey studies (Ladany et al., 1997; Pope et al., 1987; Rodolfa et al., 1994). Factors that contribute to the formulation of useful clinical observations include therapist acceptance of such feelings as normative, therapist confidence that he will not act upon those feelings, and the availability of trusted professional resources including supervision, peer consultation, and personal psychotherapy (Ladany et al., 1997; Paxton et al., 2001; Pope et al., 1986; Rodolfa et al., 1994).

When therapists do not have the necessary preparation and support to work with sexual and loving feelings reflectively it can be easy for them to feel that their only option is to inhibit such feelings and avoid the topic with their patients. Survey studies show that at least half of psychotherapist respondents described their graduate training as inadequate, insufficient, or absent in this regard (Paxton et al., 2001; Pope et al., 1986; Pope & Tabachnick, 1993; Rodolfa et al., 1994). Between 27% and 43% of psychotherapist respondents did not seek any form of assistance when faced with sexual or loving feelings toward the patient (Paxton et al., 2001; Pope et al., 1986; Rodolfa et al., 1994). Reasons given for remaining silent on the issue included fear of negative reactions from professional peers and supervisors. On the other hand when psychotherapists did seek professional assistance or consultation the following factors were most influential: (a) safe training environment that included normalization of sexual and loving feelings, (b) supportive relationship with a supervisor, and (c) provision of specific guidelines for management of sexual and loving feelings (Ladany et al., 1997; Paxton et al., 2001).

It is interesting to compare these factors to those described by Dalenberg's (2000) patient participants in relation to effective therapist response to sexual feelings: (a) provision of reassurance to the patient that therapeutic boundaries would not be violated, (b) acceptance of patient's sexual feelings and willingness to help the patient to understand the feelings, (c) willingness to help the patient to understand the therapist's feelings and the nature of the psychotherapy relationship, and (d) avoidance of transference interpretation that dismisses and pathologizes the patient's feelings. Thus sexual and loving feelings can be understood as clinical data and can effectively enter the therapeutic dialogue. It might be said that patients can benefit from a therapeutic experience in which this distinction between sexual and loving feeling, dialogue about those feelings, and acting on those feelings is clarified and internalized. The next section works to further articulate these ideas.

An Attachment Based Conceptualization of Psychotherapist Sexual and Loving Feelings

This section examines the psychotherapy relationship as an attachment relationship by nature in which powerful emotional, physiological, and visceral levels of experience are generated for

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the therapist and patient alike. Publications that conceptualize the psychotherapy relationship as an attachment relationship in which therapist reflective function is a key feature are accumulating (Bateman & Fonagy, 2004, 2009; Eagle, 2003, 2007; Fonagy, Gergely, Jurist, & Target, 2004; Fosha, 2009; Mikulincer & Shaver, 2007; Parrish & Eagle, 2003; Weinstein, 2007).

Briefly, the attachment system is designed to engage distress signaling behaviors that activate protective behaviors in a caregiver or person who assumes a caregiver role such as a psychotherapist. Attachment security can be thought of as the smooth transition from distress that activates the attachment system to distress relief that deactivates the attachment system and allows for exploratory and bonding modes of interaction where reflective function can thrive (Bowlby, 1969/1982; Fonagy et al., 2004; Meins, Fernyhough, Fradley, & Tuckey, 2001; Sroufe, Egeland, Carlson, & Collins, 2005).

Reflective function is a concept that has emerged within the psychoanalytic and attachment literature and refers to the capacity to recognize and process complex implicitly communicated intentional states within oneself and others (Diamond & Yeomans, 2007; Fonagy et al., 2004). It is also thought to be important in affective regulation and the establishment and maintenance of secure attachment including within the psychotherapy relationship (Eagle, 2007; Fonagy et al., 2004; Mikulincer & Shaver, 2007; Weinstein, 2007). In addition, the discovery of *mirror neurons* has contributed to the understanding of the mechanisms involved in empathy and reflective function as well as the communication of implicit body-based representations of intimate relational experiences (Gallese, 2009; Gallese, Rochat, Cossu, & Sinigaglia, 2009; Ginot, 2009; Kerr, 2008). Mirror neurons are located in the motor cortex and contain complex synaptic ties to the emotional centers of the brain. They are activated through observation of emotionally charged goal directed movements including those displayed during the course of intimate interaction. Thus, it appears that human beings are hardwired to represent the internal experience of others in a physical modality that creates a sense of being touched, moved, or as if the observed other has taken up residence inside of the observer.

Mirror neurons alone can explain why psychotherapists would experience a range of sexual and loving feelings in response to patient communication of sexual material. Returning to the psychotherapist survey studies, patient vulnerability is noted as one of the most common patient characteristics that contribute to therapist sexual attraction (Ladany et al., 1997; Pope et al., 1986; Rodolfa et al., 1994). Sometimes the distinction between tender feelings related to the desire to nurture and protect and sexual desire can be ambiguous. Thus, the act of empathizing with a patient's emotional vulnerability can produce a sexual response even when the patient's communications are not directly sexual in nature. Further support for this claim is derived from experimental studies of attachment, sexual desire, and romantic attraction in which tracking of their neurobiological and experiential correlates have produced evidence that they can be understood as separate and interdependent systems of emotionally charged intentional states (Eagle, 2007; Fisher, 2000; Mikulincer & Shaver, 2007; Weinstein, 2007). Common to both sexual and romantic attraction mental states is the deactivation of reflective function (Diamond & Yeomans, 2007; Fisher, 2000; Mikulincer & Shaver, 2007). Romantic attraction is associated with a mental

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state marked by emotional elation, rumination and fantasizing about the love object, idealization of the love object, and alterations in behavior designed to make oneself available to and attractive to the love object. Sensitivity to signs of rejection or separation from the love object increases so that emotional elation can easily shift to anxiety and frantic efforts to reunite or to despair when those efforts fail (Fisher, 2000).

This conceptualization can be utilized by psychotherapists to both normalize experiences of sexual and loving feelings and to help make the distinction between such feelings as clinical observations and as signals that the therapeutic frame maybe in danger. Distinguishing features may include sustained intensity of psychophysiological and emotional arousal and inhibited reflective thought versus the activation of reflective function accompanied by modulated forms of psychophysiological and emotional arousal. Experientially the difference can be characterized as ruminative or wistful thought upon a love object versus reflective thought about a patient. For instance, a therapist who experiences a sexual fantasy about a patient and reflects upon that fantasy resulting in enhanced clinical understanding and new ideas for intervention is on different ground than a therapist who experiences such a fantasy and lingers upon it in a manner that provides temporary relief of distress followed by shame and guilt. In the latter case such experiences can signal the therapist to reflect upon ways in which his or her attachment and sexual needs might be blurring therapeutic boundaries and to seek professional assistance toward the reactivation of reflective function and therapeutic availability to the patient.

An Integrative Intervention

Next, I briefly introduce the central constructs of the proposed integrative approach to intervention. Informing this model are three forms of psychotherapy that rely upon the psychotherapy relationship as the primary change agent and that are informed by attachment theory. Exposure is another way to conceive of this process in which the patient is helped to experience the presenting problem within the psychotherapy relationship in a way that allows for extinction of intimacy fear and avoidance and the development of new relational experiences and behaviors. Relational psychoanalysis (RP) refers to this process as *enactment* (Benjamin, 1994; Davies, 1994a, 1994b, 1998, 2001; Gabbard, 1994a, 1994b, 1996; Ginot, 2009; Hirsch, 1994; Tansey, 1994). Fears and desires concerning intimate contact with others are thought to be registered in implicit nonverbal form and accessible via the interpersonal interaction. The analyst attends to the bodily rhythms and related emotional states evoked within the interaction, recognizes and processes how she has implicitly participated in the therapeutic interaction in ways that reflect the patient's primary relational problems, and works to transform the nonverbal pattern into verbal material that can enter the therapeutic dialogue.

Functional analytic psychotherapy (FAP) has been applied to treat adult survivors of chronic childhood interpersonal trauma (Kohlenberg & Tsai, 1998). It utilizes the psychotherapy relationship as an in vivo exposure field. The therapist attends to *clinically relevant behaviors* which are defined as subtle intimacy approach and avoidance behaviors. The therapist is required to respond authentically to the patient's fear of intimacy and expressed desire for intimacy in a way that requires him to cultivate a state of mind similar to that of a parent figure. As articulated by Kohlenberg and Tsai, "FAP theory indicates that, in general, the therapeutic process is facil-

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itated by a caring, genuine, sensitive, and emotional client-therapist relationship" (p. 312). Technical forms of reinforcement are thought to be ineffective and referred to as *contrived reinforcement.* Contrived reinforcement is thought to lead the patient to comply with the therapist's agenda while intimacy avoidant behaviors are maintained.

Accelerated experiential dynamic psychotherapy (AEDP) requires the therapist to act as an emotion regulating attachment figure in which her authentic emotional responses to the patient in real time are the central focus. Diana Fosha is one of the lead authors of this process-experiential form of psychotherapy (Fosha, 2009). A central premise is that emotion itself is adaptive and if allowed to emerge fully into awareness previously foreclosed needs and adaptive behaviors designed to meet those needs will follow. Physiological and visceral sensations are carefully attended as patient and therapist alike allow themselves to be taken by the momentum of the experience. It is common for patient and therapist to express feelings of warmth and excitement in relation to each other and the therapeutic work. Fosha quoted one AEDP therapist who reported that a patient said that her therapist's empathy felt like "warm liquid honey down her esophagus" (Fosha, 2009, p. 181). Such intimate physically registered experiences are common both to attachment bonding and romantic bonding. The distinction again lies in the therapist's reflective state of mind directed toward the patient's emotional growth interests.

Each of the above psychotherapies describe a form of therapeutic love that allows for an integrated understanding of the distinction between intimacy in the psychotherapy relationship and intimacy in other forms of relationship. RP uses the concept of *potential space* to describe an intersubjective process in which patient and analyst transform frightening relational experiences that have previously signaled traumatic boundary violation and invalidation into manageable relational experiences that signal reflection and communication (Davies 1994a, 1994b, 1998, 2001; Winnicott, 1971). It is like an intersubjective living space for self and other where the warmth of security, jubilation of pleasure, and vitality of love can be experienced in a way that allows for the fantastical without losing sight of the limits of the real. It allows for the psychotherapist to metaphorically touch her patient without literal touching. It is a love of the creative and intrinsically relational human mind.

FAP focuses upon parental love while at the same time recognizing that the therapy relationship cannot literally take the form of a parental relationship. To quote Kohlenberg and Tsai, "Because the therapist-client relationship captures many essential elements of the parent-child relationship, it has great potential for both harm and healing" (1998, p. 319). It is the therapist's focus upon utilization of clinical theory and skill in a way that becomes an authentic living experience for patient and therapist alike that signifies a form of therapeutic love. At the same time the therapist's reflective attention to observable and mutually verifiable behaviors allows for the distinction between the therapeutic and the personal to be monitored and developed. It can be thought of as a love of knowledge that heals.

AEDP brings the concept of *transformance* which describes the process of change itself as it occurs within the therapeutic interaction (Fosha, 2009). It oc-

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curs in the moments after exposure in which the patient and therapist explore and put into words the emotional states triggered by relief from fear and anxiety and the emergence of new experience. This process can be thought of as a love for the process of growth.

Clinical Vignette

A young female patient of mine had made substantial progress by the end of a yearlong treatment. She had suffered repeated emotional abuse, including sexual boundary violations that left her deeply ashamed of her sexual and attachment needs. One of her central presenting issues was her fear that expressing her desires would be perceived as hostility and responded to with retaliation or shaming rejection. In addition, she was rarely able to trust that others who did fulfill her desires were doing so because they cared about her. Relationships typically ended with her feeling used and discarded.

At our planned last session she announced that she could only stay for twenty minutes, because she had a date. I initially felt rejected and disappointed, a response I had come to be familiar with in our work. Fortunately I was in a supervision at the time that supported me in identifying the sources of my countertransference responses in a way that normalized the responses and made the work of sorting out what was personal from what was clinical observation exciting and secure. That security was with me in the moment of my initial response and allowed me to maintain a reflective state of mind. I knew that there was a part of me that wanted the patient to see me as desirable and that felt jealous that she found someone else. I also knew that in that moment we had entered the very relational conflict that had contributed to so much exploitation and suffering for the patient in the past. Her father and other men in her life required her to bolster their self-esteem and to submit to their sexual and romantic desires. Efforts on her part to obtain recognition and acceptance of her budding sense of feminine identity were sexualized and met with seduction or shaming rejection. It would have been easy to avoid my own feelings in this moment and to interpret her effort to end the psychotherapy in her own way as avoidance or hostility. That would have been a traumatic repetition and a missed opportunity to recognize her growth. She had withdrawn from the dating scene and most other socializing for over a year, spending most of her time alone in painful rumination and self recrimination.

With the above clinical understanding coming to mind my emotional state and attitude toward her rapidly shifted. I noticed how radiant and excited the patient appeared and realized what an important moment this was for her. I felt like a father seeing his daughter off to the prom. I decided to simply accept her request to leave the session early and asked her with excited interest to say more about her date. I shared with a proud smile, "You look radiant and excited like a part of you that has been asleep for a long time has awakened". The patient smiled and continued to talk excitedly about her date and hopes for the future. Within this interchange the enactment, potential space, and love of the human mind can be seen in the therapist's ability to welcome painful personal experiences in the process of understanding the patient. Attention to the patient's intimacy approach behaviors in the form of her excitement about her date was also helpful to the process. And transformance can be seen as therapist and patient let go of technical interventions and enjoyed the process of growth that was emerging.

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Discussion and Future Directions

Reacting effectively to sexual and loving feelings begins with a distinction that can be made between how sexual and loving feelings are typically experienced within the context of psychotherapy and how they are experienced within the context of sexual and romantic relationships. Such a distinction can solidify the ground between feeling and action that is required in order for effective understanding and intervention to take place. The attachment state of mind cultivated by the therapist opens her to receive and respond empathically to the patient's communicated attachment, sexual, and intimacy related needs and anxieties. The reflective state of mind cultivated by the therapist modulates this responsiveness and allows for the transformation of sexual and loving feelings to clinical observations. This transformation shapes the therapeutic frame so that therapist and patient alike establish an implicit sense of the distinction between the therapeutic relationship and sexual and romantic relationships. As in the above clinical vignette the therapist's state of mind helps in creating an implicit relational experience in which the therapist can be authentically responsive to the patient in a situation where technical interventions are likely to foreclose the opportunity to rework problematic attachment and sexual communication patterns in real time.

Sexual and loving feelings are too volatile and fraught with risk for any single psychotherapist to attempt to handle alone. In addition, I posit that no single school of thought can go it alone either. The ways in which we address each other within the literature around this topic are crucial to developing a sense of working together and being held together in a united purpose even if our methods are at odds. The more we are able to heal the splitting and accusations that often mark discussions about sex and love in psychotherapy the more we will create a sense of safety and guidance for all psychotherapists and patients.

I have provided an outline for an integrative model for understanding and working with sexual and loving feelings in psychotherapy. It might be the case that it is trauma work in which patients often suffer from confusion between attachment and sexual desire that these issues are most relevant. It might also be argued that short term technical forms of psychotherapy do not require such intimate forms of relating within the psychotherapy relationship. Even if both of these arguments are true it is well worth our efforts to examine how we can effectively help the patient to discover that intimacy can be safe and vitalizing in multiple forms. Additional issues to be explored include self-disclosure of sexual and loving feelings and the form such disclosure should take if at all. Further research is needed that elicits feedback from patients as was done in the Dallenberg studies.

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

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Brief Statement about the Grant:

The annual Norine Johnson, Ph.D., Psychotherapy Research Grant provides $20,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Eligibility: Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: April 1, 2011

Request for Proposals

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Description
This program awards grants for research projects in the area of research on psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Program Goals
- Advance understanding of psychotherapist factors that may impact treatment effectiveness and outcomes through support of empirical research areas to include: type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.
- Encourage researchers with a successful record of publication to undertake research in these areas.

Funding Specifics
One annual grant of $20,000

Eligibility Requirements
- Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
- The selection committee may choose not to award the grant in years when no suitable nominations are received

Evaluation Criteria

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

Proposal Requirements for All Proposals

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

Additional Information

- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion.
- Grant funds that are not spent on the project within two years of receipt must be returned.
- When the resulting research is published, the grant must be acknowledged by footnote in the publication.

Submission Process and Deadline

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

Deadline: April 1, 2011

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

Disparities in Health and the Potential Impact of Increased Access to Healthcare

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Recently, the editors of *Health Psychology* announced a special series on health disparities. The themes for 2011 are infectious diseases and cancer. Examples provided by the editors of relevant topics associated with infectious diseases include social determinants of infection prevalence/ incidence, predictors of protective behaviors, and biopsychosocial mechanisms relevant to infectious disease susceptibility. Examples provided by the editors of relevant topics associated with cancer include randomized clinical trials designed to impact prevention or treatment behavior, methods to facilitate recruitment to and participation in cancer treatment clinical trials, and factors related to obtaining informed consent for use of biospecimens among diverse groups.

For psychotherapists, the issue of health disparities is timely and salient with the extension during the past year of access to health insurance, and therefore to healthcare, to millions more Americans. While the extension may give more people the opportunity to access healthcare and to subsequently experience fewer health disparities, *Unequal treatment: Confronting racial and ethnic disparities in health care* (2002) has pointed out:

> The historical evolution of healthcare for persons of color, the current financial and organizational structures of health systems, the settings in which care is delivered, and the nature of the workforce providing care may, both independently and jointly, influence the quality of care that minorities receive. (p. 80)

Disturbing examples of the insidious side of the history of healthcare for racial and ethnic minorities are the Tuskegee syphilis "biomedical research study" with impoverished black males and the "biomedical experiments" on Jewish concentration camp prisoners, which poignantly make clear that racial and ethnic minorities have had good reason historically to distrust healthcare providers (e.g., Thomas & Hersen, 2003). This distrust, in turn, has quite likely created a disparity in the willingness of at least some persons of color to access healthcare and, therefore, a disparity in their subsequent health.

Similarly, the history of mental health providers categorizing same sex sexual orientation as a mental illness, the current structure of employer-provided healthcare insurance which denies access for many LGBT individuals to health insurance through their partners, the sometimes-non-affirming settings in which mental healthcare is delivered, and the nature of the workforce providing care may influence the quality of care that sexual minorities receive. For example, even in the best of circumstances, there may be too few LGBT-identified psychotherapists, and many LGBT individuals express a preference for a similarly identified therapist (e.g., McDermott, Tyndall, & Lichtenberg,

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1989). Furthermore, even though there may be an adequate number of heterosexual psychotherapists willing to provide gay affirming therapy, they may be ill-equipped to do so. For example, Lyons (2010) asserted that, "Generally, psychologists' level of training in LGB issues and populations may be inadequate. Murphy, Rawlings, and Howe (2002) reported that 28% of the psychologists they surveyed reported no formal training in clinical work with LGB clients." (p. 425) More disturbing, there are therapists willing to use "treatments" that have no legitimate empirical support to try to change the sexual orientation of individuals with internalized homophobia. As Cass (1979) noted, internalized homophobia is the most significant impediment to a positive gay identity—arguably a significant impediment to mental health.

The phenomenon of health disparities, sometimes due to healthcare disparities, can be found among many populations who have, at least in the past, experienced no care, incompetent care, and/or iatrogenic care. For example, prior to deinstitutionalization, developmentally delayed individuals were warehoused in government institutions, with behavior modification the treatment of choice. Prior to recent advances in geropsychology, institutionalized elderly patients simply received behavior management rather than affirming approaches, such as life review.

In short, there are instances in which psychologists who could have offered rich, population-specific interventions may have missed these opportunities and, consequently, inadvertently contributed to healthcare disparities and subsequent health disparities. There have been calls (e.g., Bieschke & Dendy, 2010; Lyons, 2010; Worthington, 2010) for increased competency in working with underserved (and sometimes, badly served) communities through both formal training and supervised experience. Psychotherapists with such training and experience are more proficient at identifying the mental health disparities characteristic of these communities, their etiologies, and the appropriate treatment.

To provide ethical psychotherapy that does not contribute to health disparities requires that psychotherapists are adequately trained in evidence-based treatments appropriate for the population to which those symptoms are applied and for the symptoms that they are intended to treat with an understanding of the systemic variables that may be the etiology of the problem or at least, exacerbating the problem. To vilify oppressed individuals and then characterize their reaction to oppression as a disorder requiring treatment is not only cynical and cruel, it is a misuse of the science of psychology to assess, conceptualize, and treat individual clients for what are systemic problems or at least, systemic contributors to individual problems. In this era of increased access to healthcare for previously underserved populations, psychotherapists have an ethical obligation to be particularly aware of the potential systemic etiologies of the presenting symptoms of diverse populations, the evidence-based treatments for symptoms when treatment of the individual is appropriate, and the responsibility to advocate for the elimination of systemic sources of healthcare disparities and health disparities for these populations.

PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

Strengthening Our Science and Enhancing the Status of Psychology as a STEM Discipline: The Theme of the Science Leadership Conference in 2010

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

This month, as the Research Committee Chair, I will represent Division 29 at the annual APA Science Leadership Conference to be held in Washington, DC, on November 11–14, 2010. The theme for this year's Science Leadership conference is "Strengthening Our Science: Enhancing the Status of Psychology as a STEM Discipline."

Psychology as a STEM Discipline

The term *STEM discipline* refers to areas pertaining to science, technology, engineering, and mathematics. Psychology is officially a STEM discipline, but it is often treated as if it were not actually a STEM discipline—i.e., not a science. For example, some funding that is officially available for research, education, and training in the STEM disciplines is rarely awarded for psychological research. This is a problem that needs to be addressed because psychological research has many important contributions to make. Without a better understanding of human behavior, the benefits of science and technology will be limited.

In June of this year the APA 2009 Presidential Task Force on the Future of Psychology as a STEM Discipline published a report entitled *Psychology as a Core Science, Technology, Engineering and Mathematics (STEM) Discipline*. You can view a copy of this report at http://www.apa.org/pubs/info/reports/stem-discipline.aspx . This report documents important examples of the ways in which a scientific understanding of human behavior has advanced public health, public safety, education and learning, and national security—as well as examples of technological solutions that should have worked well but actually did not work well because of a lack of understanding about human factors. The report also give a number of recommendations for promoting the role of psychological science in solving national and local problems (e.g., health and mental health disparities), promoting the teaching of psychological science, increasing a public recognition of psychology as a science, and enhance training in the science of psychology.

As a part of preparing to represent Division 29 at the APA Science Leadership Conference I have read this report, and also learned a bit about the APA Science Directorate, the Board of Scientific Affairs (BSA), and the history of the Science Leadership Conference. In addition, I have been doing some thinking about psychology as a STEM discipline, how the public views psychology, and how we might be involved in advocacy for psychological research in general and research on psychotherapy specifically. My goal here is to share some of what I have learned and also share some of my initial reflections as I prepare to attend this conference.

As a psychologist who is still relatively early in my own career, I know that I find it very helpful when others talk about the work they are doing, particu-

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larly if it is not something I might otherwise have been aware of. It struck me that the Science Leadership Conference may be one of the areas that others may not be aware of. In January, I will begin my term as the Early Career Domain Representative in Division 29, so I thought a discussion about these issues of science advocacy would be a meaningful way to mark my personal transition from Research Committee Chair to Early Career Domain Representative. Because I had not heard about the annual APA Science Leadership Conference prior to being asked to represent Division 29 at the conference, I thought that perhaps others in Division 29, particularly Early Career psychologists, may not have heard about it either. Thus, I thought it might be a useful topic. It may be that others could become interested in playing a role in ensuring that those interested in psychological and psychotherapy research have a place at the table in setting the national agenda.

The ways in which psychology is perceived by the public and by agencies that fund research in psychology are ultimately very important to all of us. If psychological research, including research on psychotherapeutic interventions, is valued and seen as important then we can make richer contributions to building healthier communities. I think that it is crucially important that we who understand the value of psychotherapeutic interventions, as well as the value of psychotherapy research, have a voice in helping to shape the national research agenda and policy about research.

The APA Science Leadership Conference

Interestingly, members of the Board of Division 29 recently expressed to me that this is the first year that Division 29 has been represented at the APA Science Leadership Conference. I am pleased to be able to represent the Division and so help to ensure that the voice of researchers concerned with psychotherapy research is a part of the dialogue in this national forum.

The APA Science Leadership Conference (SciLC) has been an annual event since 2005. Each year's conference has had a different theme. Pervious topics included the public face of psychological science (2005), supporting and advancing the careers of scientists (2006), getting involved in advocacy and training civic scientists (2007), innovations in methods for dissemination of knowledge for psychological science (2008), and enhancing the nation's health through psychological science (2009). Information about the documents that have emerged from each of the previous SciLCs are provided at http://www.apa.org/science/programs/conference/index.aspx .

Given this list of topics, it does seem important that Division 29 have a voice in the SciLC because many of these topics are of crucial importance to our membership. Clearly, we are very interested in promoting the nation's health, which was the topic for the 2009 conference. The 2009 conference focused on advocating for "increased federal funding for basic and translational psychological research to contribute to the development and evaluation of empirically-based interventions." This is clearly at the core of what we do.

Science Directorate of APA. The SciLC is jointly sponsored by the Board of Scientific Affairs (BSA) and the Science Directorate. Many might be familiar with the Science Directorate of APA. The goals of the Science Directorate are to facilitate and promote psychological sci-

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ence, and to represent the science of psychology to the public. You can get more information about the Science Directorate and the programs they offer through their website: http://www.apa.org/science/index.aspx . Although many may have heard of the Science Directorate, many may be unaware of the many services and programs offered through the Science Directorate. I know that I certainly had not been aware of them. The Science Directorate has a number of publications on its website that focus on how psychological science has made a difference in people's lives (http://www.apa.org/science/about/publications/index.aspx). Some of these publications are very appealing and have very interesting examples that could be very useful for educators who are trying to convey the importance of psychology in every day life. The Science Directorate has a number of programs (http:// www.apa.org/vscience/programs/index.aspx), including programs related to training and careers (http://www.apa.org/science/resources/index.aspx). There are a number of training programs, for example, for advanced training in statistics for undergraduates, graduate students, postdocs, and faculty at all stages of their careers. There is also a Career Workshop program that is designed to introduce graduate students and postdocs to careers in academia, and help them through the practicalities of the hiring process. There is also a series on non-academic careers available to psychological scientists that may be of interest. I had not realized that these programs were available through the Science Directorate.

Board of Scientific Affairs

The Board of Scientific Affairs (BSA; http://www.apa.org/science/leadership/bsa/index.aspx) is a co-sponsor of the SciLC. The BSA is an advisory body to the APA Science Directorate, and focuses on psychology as a science. One of the roles of the BSA is to serve as a liaison with agencies that fund scientific research. The BSA also has a number of awards recognizing scientific achievements. They try to figure out how APA can support psychological science and they also oversee the scientific programming at the annual APA convention.

It has been interesting to me to learn about these aspects of APA that I had not really known about in the past. My own research agenda focuses on basic research aimed at helping us develop better preventive and psychotherapeutic interventions for underserved families with infants and young children, as well as testing new interventions for these families. So for me, it is heartening to know that APA is concerned about helping psychological science to be included in the national research agenda. I am very excited that this year Division 29 will have representation at the SciLC, and I hope that representation will continue into the future.

This year the focus of the SciLC is to generate ideas about how to enhance the status of psychology as a STEM discipline. I think it is important that the public be aware that there is an empirical basis for the treatments we offer, and likewise, it is beneficial to society as a whole that funding for research to continue to improve psychotherapy interventions.

To give you a picture of the kinds of things that will be discussed at the SciLC, I thought it might be helpful to walk you through the agenda. Registration will occur in the evening of Thursday, November 11. On Friday, November 12, conference attendees will hear a talk based on the results of an APA-sponsored survey about how the

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public views psychological science, as well as an overview of the APA STEM Task Force Report mentioned earlier. We will then hear about what APA and its partners have been doing to advocate for psychological science as a STEM discipline and hear from the National Science Foundation (NSF) about how psychology is viewed at NSF. There will be a talk by Congressman Brian Baird of Washington, who worked for many years as a clinical psychologist before becoming a politician. We will then go into breakout groups to discuss the public's understanding of psychological science, federal legislation and funding agency policies, and research and academic infrastructure. We will generate recommendations in each of these areas and then discuss and prioritize those recommendations.

The focus on Friday, November 12, will be on issues of psychological science in education at the elementary school, high school, and undergraduate levels. One interesting issue that I learned about in preparing for the conference is that President Obama's Council of Advisors on Science and Technology recommended that the social and behavioral sciences, including psychology, not be considered STEM fields at the K-12 level. This group also made a recommendation that teaching the behavioral sciences will not help children be better prepared for STEM fields in the future. This group admits that psychology is a STEM field at the undergraduate and graduate levels, but that psychology is not taught as a science at the K-12 level. Essentially, they are recommending that psychology not be taught in K-12 because it is not taught in a scientific manner. It seems to me that a better approach might be to include psychology and to do so in a way that is rooted in the empirical basis for what we do. If the goal is to prepare young people to be ready to help to solve society's challenges, then we should be inspiring more young people, not fewer, to understand the science of psychology and how understanding human behavior is relevant to a variety of issues. There will be a talk on interdisciplinary research and training. Later we will go into our breakout groups to discuss K-12 psychology education, undergraduate education, and interdisciplinary research and training. Personally, I am very interested in interdisciplinary research and training because much of my intervention research brings together teams of collaborators across diverse fields. I think an ability to work in an interdisciplinary fashion can help to strengthen the kinds of research we do and help lead to greater funding opportunities for psychotherapy-related research. Perhaps there is more we could do to educate our students to be ready for this kind of interdisciplinary work. The conference will end with a discussion of the recommendations that emerge and work to prioritize the recommendations.

Division 29 and Research

Division 29 has been very committed to supporting research activity in the area of psychotherapy, and has become increasingly involved in directly supporting psychotherapy research. Last year Division 29 created the annual Charles J. Gelso, Ph.D., Psychotherapy Research Grant. This grant provides $2,000 annually toward the advancement of research on psychotherapy process or psychotherapy outcome. This year Division 29 established the Norine Johnson, Ph.D., Psychotherapy Research Grant. This annual grant program provides $20,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree

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or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes. Additional information about both of these grant programs offered through Division 29 are available at the Division 29 website (http://www.divisionofpsychotherapy.org/).

I am very excited that this year Division 29 will be represented at the SciLC for the first time. I think that Division 29 has much to offer to the discussion of how to help the public and policy makers better understand what psychological science has to offer, not only this year but into the future. I hope that others in Division 29 will become involved in these efforts. I have greatly enjoyed my two years as Chair of the Research Committee in Division 29 and I will look forward to serving Division 29 next year in my role on the Board as the Early Career Representative. My hope is that others in the Division, particularly those early in their careers, may get interested in the exciting opportunities becoming available to advocate for the science we do, and help others become aware of how the research we do is relevant for solving a variety of the issues we face as a society.

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TIRED OF 9 MILLION HITS THAT DON'T ANSWER YOUR PRACTICE QUESTION? TRY PSYCLINK INSTEAD!

Clinicians now have an interactive, online forum where they can find, share and discuss resources and useful web sites like practice management tools, anxiety, dementia, postpartum depression, and other topics relevant to their practices. Part social networking site, part community bulletin board, PsycLINK is a wiki platform "by psychologists, for psychologists." Psychologists can also use PsycLINK to pose questions, get answers to their clinical issues, and receive e-mail updates when members add new content.

APA's Presidential Task Force on Advancing Practice developed the new tool, and the Task Force believes PsycLINK will grow over time and increase in value as practitioners add to the content. We also see it evolving as a way for clinicians to easily get pertinent clinical and patient related references and information, interact with colleagues, and have discussions that one can participate in as desired. It is an online product, and while one can get notified of postings, it is not email intensive in the slightest.

As an APA member, you can benefit from this incredible resource by signing in to my.apa.org, click on PsycLINK.apa.org and create your profile. Sign up for e-mail updates, add materials and share resources, and comment on current materials. The more psychologists that sign up, the more the Wiki will grow and evolve into a premiere resource for practitioners, educators and researchers.

FEATURE

Should Division 29 Develop Telepsychology Guidelines?

Norman Abeles, Ph.D., Michigan State University

Let us first look at the definition of telehealth. According to APA, telehealth services include all interactions that are not in person between health care professionals and their patients. It should be noted, however, that regulators and insurers use more narrow definitions. APA notes that there is no universal definition of telehealth services (APA, 2010). In this paper I include the terms telepsychology, telehealth, telemental health, telecare, and email therapy within the APA definition of such non face-to-face communications between mental health providers and recipients be they individuals or groups. However, the major focus should probably be on videoconferencing and telephone therapy as the prime examples of telepsychology.

About 10 years ago, Koocher and Morray (2000) surveyed the regulation of telepsychology by contacting all State Attorney Generals. They noted that licensing requirements of ten states serve as obstacles to telepsychology. At that time, four states had regulated the practice of psychotherapy by electronic means, and nineteen states provided regulatory authority over out of state practitioners who offer psychological services via the internet, telephone, or other electronic means. Ohio (2007) appears to be one of the pioneers for telepsychology guidelines. In its most recent version, the Ohio Psychological Association Guidelines note that telepsychology is practiced by many psychologists around the world and psychologists may be at risk for personal harm due to the lack of clear and defined guidelines (p1). The Guidelines point out that the APA Ethics Code fails to provide sufficient guidance in the use of telepsychology when psychological services are provided. While the Ethics Code considers confidentiality and competence, there is no provision concerning disclosure of information to the client when there is no face to face contact. Some state laws require that informed consent be given prior to teletherapy, but specifics are not clearly described. There are also continuing concerns about limitations regarding the practice of telepsychology across state lines. Some state licensing boards have insisted that practitioners be licensed in the states where they practice, but this is not clearly enunciated by many, if not most state licensing boards.

Selected research findings concerning telepsychology effectiveness:

The lead article in the Journal of the American Medical Association on July 14, 2010 deals with the effects of telecare management on pain and depression in patients with cancer (Kroenke, et al, 2010). The authors hypothesized that telecare management would be superior to usual care in reducing pain and depression for geographically dispersed patients in various oncology practices. According to their prediction, the authors found that significant improvements were reported for both pain and depression. The article noted that telecare was superior to usual care in improving outcomes. The trial also demonstrated that telephone-based centralized

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symptom management was feasible for dispersed practices in urban as well as rural areas. In addition, there did not appear to be any differential rates of health care use.

A somewhat different approach was recently reported in the American Psychiatric Association's publication of Psychiatric Services (Yellowlees, et al., 2010). Here, a non-psychiatrist research physician interviewed adults for 20-30 minutes. The adults were referred by their primary physicians for non-emergency psychiatric problems. These recorded interviews were conveyed to psychiatrists who diagnosed the patients and recommended additional tests and medication changes. In addition, they recommended psychotherapies and made recommendations for long-term treatment. Most diagnoses included depression, anxiety or substance use disorders. Many patients also had co-occurring problems.

In a study using teletherapy for PTSD, Stephanie Guay (2010) from the University of Montreal, reported that patients in the experimental group (teletherapy) benefited from therapy as much as patients in the control group (face to face therapy). 75-80% showed significant decrease in stress, depression, and anxiety symptoms. Earlier studies (Swinson, Cox and Wickwire, 1995) found teletherapy to be an effective treatment for agoraphobics living in rural areas where specialized treatments for anxiety were not available. 'Phone delivered therapy was as effective as face to face therapy in alleviating symptoms. Pat DeLeon (2010), former Division 29 and past APA President, recently reported that some studies indicated no differences between telemental health and face to face delivery in the perception of the therapeutic relationship, post session mood or general satisfaction with services.(Morgan, Patrick & Magaletta (2008).

More on guidelines, regulatory efforts, and assessment studies:

In recent actions, the Board of Directors of the American Psychological Association received a petition to establish national Guidelines for telepsychology. APA's President-elect, Melba Vasquez, stated that expanded technologies and increasing use of telecommunication devices have presented new venues requiring refined guidelines (Bradshaw, 2010). In the latest issue of "Good Practice" (APA, 2010) there is a discussion on legal issues for psychologists involved in telehealth. It is pointed out that some states prefer that psychologists should be specially credentialed or licensed in order to provide telehealth services. The article notes that both California and Kentucky do have teletherapy definitions in their laws, though California excludes telephone conversations and email between patients and providers (p4).Vermont uses a broader definition and does not exclude any telepsychology services. The American Telemedicine Association (2009) has a telemental health standards and guidelines working group which has sections on telepsychological assessment which includes the administration of diagnostic instruments and scales, personality assessment, and neuropsychological assessment. The paper notes that telepsychology opinions for the treatment of patients in underserved areas have been widely used though not many reliability or validity studies are reported. It is reported that two studies using the SCID (Structured Clinical Interviews) with the DSM IIIR did show high reliability. No examination of the use of telemedicine in personality assessment is reported (p11). With regard to Neuropsychological Assessments, feasibility has been demonstrated, but there are few formal studies. While studies have argued for comparability between remote and face to face assess-

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ments, other studies have noted differences on test scores (p11). The authors recommend that new norms be developed to compare results with face to face administration. Though neuropsychological assessment via telemedicine is often valid with regard to ongoing mental health care, the authors review psycho-education, individual psychotherapy, and group therapy efforts via telemedicine. Case reports and clinical trials of individual therapies via telemedicine have been reported and it is concluded that group psychotherapy appears to be amenable to the video conferencing telepsychology health effort.

With regard to group therapies, it is recommended that standard practice guidelines should guide videoconferencing (p12). The authors note that marital and family therapies could be considered as specialized types of group therapy (p13). The paper goes on to discuss populations for special focus such as work with older adults, as well as telepsychology with children and adolescents.

For older adults, further studies need to be done to provide reliable evidence (p15). For adolescents and children, it is suggested that the same guidelines used for adults could be considered but with modifications that include the developmental status of youths (e.g. motor functioning, speech and language capabilities, and relatedness). In a personal communication from Sarah Knox, PhD, our Division 29 Domain Representative from Education and Training, she noted the telesupervision requirements at Marquette University's (Milwaukee) Department of Counselor Education. Their telesupervision guidelines are used only when in-person supervision is not available, and only trainees who have completed at least two semesters of master's level practicum/internship training can be considered for telesupervision. Only clinics that have been properly certified for the use of telehealth are utilized. Those clinics must use HIPAA compliant technology. For doctoral programs, telesupervision may account for no more than 50% of the total supervision at a given practicum site. In addition, off –site supervisors maintain full professional responsibility for of our members.

I have presented a variety of efforts concerning telepsychology guidelines, regulatory efforts and some research findings. Division 29 could be involved in a more comprehensive effort detailed below.

Why our division should establish telepsychology guidelines:

a. Division 29 is the oldest and most respected division when it comes to the practice of psychotherapy, so it is more likely that our colleagues will pay attention to guidelines we might develop.
b. While there is a business item before APA council to develop guidelines, knowing about the governance process leads me to believe it will take several years before such efforts will be fully implemented.
c. Our division clearly needs products (such as guidelines) that will focus attention to practitioners and researchers engaged in psychotherapy practice.
d. I believe we can develop preliminary and credible guidelines in 6 months or less by using a small, dedicated task force of both junior and senior members of our division. Initial guidelines should be limited to telephone and videoconferencing therapy.
e. Initially our guidelines could be as simple as asking our members to be familiar with APA's 50 state review of telehealth by consulting www.apa-

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practicecentral.org/advocacy/state/telehealth-slides.pdf.

f. Further, we could ask our members to be familiar with the recently adopted inter-jurisdictional practice certificate by the Association for State and Provincial Psychology Boards (ASPPB). These two resources area discussed in the recent APA (2010) Good Practice document. Of course this would have to be adopted by state licensing boards. It might be wise to check state regulations on the availability of temporary practice provisions. In addition, the National Register of Health Service Providers in psychology may also have relevant materials on this topic. The National Register has a listing of states that utilize National Register credential as an aid in facilitating licensure for practitioners.
g. Guidelines could provide appropriate and helpful services to psycho-therapy practitioners and inform them of potential areas of concern when practicing telepsychology within their state and outside of state boundaries.
h. It is at least possible that any guidelines we develop may be helpful at a later date for the development of APA wide guidelines.
i. Our guidelines might also serve as an impetus for states and licensing boards to proceed more quickly in establishing guidelines or even adopting portions of our guidelines. Furthermore we could focus on guidelines that are specific to the work done by psychotherapists. At the recent meeting of the Division 29 board meeting in Washington, D.C., the topic of telepsychology guidelines for psychotherapists was discussed. The president of our division, Jeff Magnavita, PhD, appointed a Presidential Task Force whose job it will be to make recommendations at the February 2011 board Meeting. The task force is chaired by Annie Judge, PhD. In the meantime if you have comments please feel free to contact me at abeles@msu.edu.

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The Importance of Visionary Leaders

Pat DeLeon, Ph.D.
Former APA President

International: Last year the Institute of Medicine (IOM) released its report The U.S. Commitment to Global Health. "Global health is the goal of improving health for all nations by promoting wellness and eliminating avoidable disease, disability, and death. It can be attained by combining population-based health promotion and disease prevention measures with individual-level clinical care. This ambitious endeavor calls for an understanding of health determinants, practices, and solutions, as well as basic and applied research on risk factors, disease, and disability.... The U.S. government, along with U.S.-based foundations, nongovernmental organizations, universities, and commercial entities, can take immediate concrete action to accelerate progress on the urgent task of improving health globally by working with partners around the world to scale up existing interventions, generate and share knowledge, build human and institutional capacity, increase and fulfill financial commitments, and establish respectful partnerships. U.S. leadership in global health reflects many motives: the national interest of protecting U.S. residents from threats to their health; the humanitarian obligation to enable healthy individuals, families, and communities everywhere to live more productive and fulfilling lives; and the broader mission of U.S. foreign policy to reduce poverty, build stronger economics, promote peace, increase national security, and strengthen the image of the United States in the world. As has often been said: 'When you're up to your neck in alligators, it's hard to focus on draining the swamp.' However, as we evolve into the 21st century and President Obama's vision for implementing his landmark Patient Protection and Affordable Care Act (PPACA) takes hold, psychology (and the other health professions) must accept their societal responsibility for providing visionary leadership in addressing our nation's and world's most pressing needs. This is especially true for our professional schools. The alternative is to become obsolete, if not irrelevant. Protecting the status quo is not a viable option."

The IOM emphasized that health is inextricably connected to the broader goals of hastening development and reducing poverty. Significant progress has been made in the last 50 years with life expectancy increasing more than in the preceding 5,000 years. The creation, dissemination, and adoption of knowledge has been one of the main drivers of these health gains, delivering marked improvements in low- and middle-income countries that have invested in sustainable and equitable systems to deliver proven, cost-effective interventions. Our nation has an unprecedented opportunity to improve global health. The promise of potential solutions has captured the interest of a new generation of philanthropists, students, scientists, healthcare professionals, private sector leaders, and citizens B all eager to make a difference in this interconnected world.

The IOM identified five areas for action:

- Scale up existing interventions to achieve significant health gains;

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- Generate and share knowledge to address health problems endemic to the global poor;
- Invest in people, institutions, and capacity building with global partners;
- Increase U.S. financial commitments to global health; and,
- Set the example of engaging in respectful partnerships.

The global health community has reached a critical juncture. The knowledge, innovative technologies, and proven tools to help millions of people in need are within reach. Yet even with demonstrated success in tackling certain health issues, a wide gap remains between what can be done with existing knowledge, and what is actually being done. Existing interventions are not widely used even though many are inexpensive and easy to administer. As the advocates for PPACA constantly pointed out, even within our own modern day health care delivery system, the lag between the discovery of more efficacious forms of treatment and their incorporation into routine patient care is unnecessarily long, in the range of about 15 to 20 years. The timeless health problems associated with poverty are now coupled with new challenges. Infectious diseases are emerging at the historically unprecedented rate of one per year. With airlines carrying more than 2 billion passengers annually, and systems of trade more interconnected than in any time in human history, the opportunities for the rapid international spread of infectious agents and their vectors have vastly increased. The rising tide of chronic diseases and injuries in low- and middle-income countries, where 80 percent of the world's deaths from chronic, non-infectious diseases now occur, cannot be ignored.

One of the greatest contributions we can offer to the global campaign to improve health is to share America's traditional strength, "the creation of knowledge" for the benefit of the global poor. Not surprisingly, Americans traditionally focus upon conditions that affect people within our own borders and as a result, we often ignore or significantly neglect diseases or conditions that are overwhelmingly or exclusively incident in low- and middle-income countries. For example, globally more than 2 billion people are at risk of malaria each year. Despite dramatic reductions in malaria incidence and mortality in many parts of the world, approximately 500 million people still contract the disease, resulting in 1 million deaths annually. The IOM expressly noted that global health would greatly benefit from developing and disseminating a variety of novel behavioral and biomedical prevention strategies to combat infectious diseases. Focusing upon two disease entities for which the behavioral sciences clearly have particular expertise: Obesity is escalating worldwide at an alarming pace, along with rates of type 2 diabetes, hypertension, and lipid abnormalities associated with obesity. More than 1 billion adults are overweight; 300 million are clinically obese. Mental disorders affect millions worldwide; about 14 percent of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders and psychosis.

Margy Heldring's vision of establishing a senior-scientist/practitioner U.S. Public Health Service Corps is most timely. As she points out, many of our colleagues are entering the twilight years of their careers. They want to make a difference and are not yet ready to fully retire. How can their considerable expertise be effectively utilized? The vision expressed by President Lyndon Johnson at the University of Michigan

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comes to mind: "The challenge of the next half century is whether we have the wisdom to use that wealth to enrich and elevate our national life, and to advance the quality of our American civilization.... This is the place where the Peace Corps was started.... Will you join in the battle to build the Great Society, to prove that our material progress is only the foundation on which we will build a richer life of mind and spirit? There are those timid souls who say this battle cannot be won; that we are condemned to a soulless wealth. I do not agree. We have the power to shape the civilization that we want.... Those who came to this land sought to build more than just a new country. They sought a new world." The following year Medicare became the law of the land.

Unlike the United States, in low- and middle-income countries, universities, science academics, and the research community are often absent from public policy engagement. Our government, which is the largest funder of many international organizations and a significant donor of bilateral aid, carries considerable influence in shaping the global health environment and thus possesses the opportunity to be a good steward for health at both the national and global levels. "Health is a highly valued, visible, and concrete investment that has the power to both save lives and enhance the image of the United States in the eyes of the world.... Working with partners around the world and building on previous commitments, the United States has the responsibility and chance to save and improve the lives of millions; this is an opportunity that the [IOM] committee hopes the United States will seize."

Integrated/Co-located Care: Retired Rear Admiral Chris Bruzek-Kohler recently shared her vision for the health care environment of the 21st century. "One place to look to as an encouraging story of health care delivery transformation and a way forward for civilian mental health professionals is the Navy. Navy Medicine has successfully implemented two programs providing mental health care in non-traditional settings: on the battlefield with Marines and in primary care practice. A primary component of the Navy's promotion of a 'Culture of Fitness' is mental health. Recognizing their responsibility to effectively prevent, identify, and treat all psychological health conditions and the ill effects of war, Navy Medicine mental health stationed with the Marines developed Operational Stress Control and Readiness (OSCAR) Teams, which embed psychologists, psychiatrists, psychiatric nurse practitioners and psychiatric technicians as organic assets in operational units. The goal of the OSCAR teams is to be as far forward and to spend as much time as possible with the Marines to build the trust, cohesion, and understanding necessary to break the stigma of mental health care with military patients.

"The concept of OSCAR is to demystify the whole process of psychiatric treatment. The Marines often call the mental health provider 'the wizard." The origins of this term were not only because the mental health provider could make people disappear, i.e., suddenly remove them from their units without warning, but it also provoked the image of the mysterious Wizard of Oz pulling the smoke levers behind the mirror. This is not the case with OSCAR. The mental health provider interacts with the Marines in the normal routine of the day. In this way the mental health provider becomes a real person that the Marines can trust and get to know. Being a full member of the Marine Corps unit, the Marines are more likely to ask questions about minor issues

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without the stigma of being seen as patients and before the minor issue becomes something major. The OSCAR provider is also highly effective when they are a trusted advisor to mid-level leaders who can gain perspective from the provider, thereby helping them to become better leaders. There is a heightened sense of trust and awareness on both sides and a profound improvement in communication among the warfighters, their leaders, and medical.

"The power of having providers embedded is unmistakable. Retired Navy Medical Corps Officer, Captain William P. Nash: 'OSCAR builds a bridge across the cultural gap between the warfighter and the mental health professional the only way a bridge can be built: by drawing the mental health professional as fully as possible into the culture and life of the military unit to be supported.' OSCAR's success is evident in the enthusiasm surrounding the program in the Marine Corps and the desire of military commanders outside of the regimental level to expand it to air wings, logistics groups, and reserve forces for the benefit of their service members."

Navy Medicine is also utilizing mental health professionals in innovative ways on the home front. To improve quality and access to care, Navy Medicine has created integrated Medical Home Teams within its Internal Medicine and Primary Care clinics to provide personalized, coordinated, and proactive care to patients. The Medical Home initiative is unique because it is an integrated care model where primary care services and behavioral health assets are together in the same clinic space. The embedded behavioral health consultant provides health assessment and intervention expertise to primary care managers and their patients. Clinical Psychologists are ideally suited for the Navy's Medical Home Team model.

A report from a 2007 DoD Task Force on Mental Health suggested that the integration of mental health providers within the Medical Home would improve access and decrease stigma by maximizing the number of interventions that can be conducted in a primary care setting. "Research supports the Task Force's assertion and provides evidence of significant improvement in clinical outcomes and reduced psychological stress among service members served by behavioral health providers in primary care settings. The Medical Home Model with integrated behavioral health specialists was first implemented at National Naval Medical Center (NNMC) in Bethesda, Maryland in 2008, followed by Naval Medical Center in San Diego and Naval Hospital Pensacola. Building on early successes, the Navy will roll out the Medical Home Model at all remaining treatment sites this summer."

Innovative Practices: One of the more visionary provisions contained in the President's Health Care Reform legislation (PPACA) authorized demonstration programs to train or employ alternative dental health providers in order to increase access to dental health care services in rural and other underserved communities. This Fall, the W. K. Kellogg Foundation released its report on the Alaska Dental Therapists program, which was strongly opposed by organized dentistry essentially proffering that these providers would be "public health hazards," affirmatively harming their patients if allowed to practice. The Kellogg Foundation found that: "dental therapists practicing in Alaska provide safe, competent and appropriate dental care. The two-year, intensive evaluation is the first independent evaluation of its scale to assess care provided by dental therapists practicing in the United States. It confirms for us what numerous

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prior studies of dental therapists practicing in other countries have already shown: that dental therapists provide safe care for underserved populations."

Dental therapists have been providing preventive and basic dental care to children and families in remote Alaska Native villages since 2006. Although new to the U.S., dental therapy has been well-established for decades in more than 50 countries, including those with advanced dental care systems similar to ours. The evaluation assessed the work of dental therapists in five communities, as well as the experience of hundreds of patients. They were directly observed performing sealant placement, composite and amalgam preparations, stainless steel crown placement, and oral health instruction. The evaluation relied on examination standards used for assessing clinical competency for board certification of U.S. dental school graduates. Alaskan dental therapists are technically competent to perform the procedures within their scope of work and do so safely and appropriately. After graduating and completing a 400-hour externship under the direct supervision of a dentist, dental therapists are certified to provide a limited scope of dental services under the general supervision of a dentist. They successfully treat cavities and help to relieve pain for people who often had to wait months or travel hours to seek treatment; patient satisfaction with their care is very high; and, they are will-accepted in tribal villages. The report further noted that severe shortages of dentists disproportionately affect low-income communities and communities of color; that lack of affordable dental care is putting sorely needed dental services out of reach for nearly 50 million Americans, particularly those in rural and underserved areas. Hawaii's federally qualified community health centers have been particularly supportive of this (r)evolution as access to dental care and/or behavioral health care has continued to be their top priorities over the past decade. The dental therapists are well respected in their communities. Because many dental therapists return to practice in their home communities, they typically have the cultural skills and language fluency needed to educate and motivate people towards behavioral change. As role models they serve as important oral health advocates. "Simply training more dentists will not solve this problem. The Alaska model is a community-driven solution that can work in communities across the country." Aloha,

Pat DeLeon,
former APA President, Division 29

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AMERICAN PSYCHOLOGICAL ASSOCIATION DIVISION 1: THE SOCIETY FOR GENERAL PSYCHOLOGY

Call for Nominations 2011 Awards The Society for General Psychology, Division One of the American Psychological Association is conducting its Year 2011 awards competition, including the **William James Book Award** for a recent book that serves to integrate material across psychological subfields or to provide coherence to the diverse subject matter of psychology, the **Ernest R. Hilgard Award** for a Career Contribution to General Psychology, the **George A. Miller Award** for an Outstanding Recent Article in General Psychology, and the **Arthur W. Staats Lecture for Unifying Psychology**, which is an American Psychological Foundation Award managed by the Society. In addition, there is an award for graduate students: **The Anne Anastasi General Psychology Graduate Student Award** (see below for details).

All nominations and supporting materials for each award mus**t be received on or before February 15, 2011. With the exception of the William James Award, you are encouraged to submit your materials electronically.**

There are no restrictions on nominees, and self-nominations as well as nominations by others are encouraged for these awards.

The Society for General Psychology encourages the integration of knowledge across the subfields of psychology and the incorporation of contributions from other disciplines. The Society is looking for creative synthesis, the building of novel conceptual approaches, and a reach for new, integrated wholes. A match between the goals of the Society and the nominated work or person will be an important evaluation criterion. Consequently, for all of these awards, the focus is on the quality of the contribution and the linkages made between diverse fields of psychological theory and research.

Winners will be announced at the annual convention of the American Psychological Association the year of submission. The awardees for the first four awards will be expected to give an invited address at the subsequent APA convention and also to provide a copy of the award presentation for inclusion in the newsletter of the Society (*The General Psychologist*). These Awardees will receive a certificate and a cash prize of $1000 to help defray travel expenses for that convention.

For the **William James Book Award,** nominations materials should include three copies of the book (dated post-2006 and available in print); the vitae of the author(s) and a one-page statement that explains the strengths of the submission as an integrative work and how it meets criteria established by the Society. The award criteria can be found at www.apa.org/div1/awards. Textbooks, analytic reviews, biographies, and examples of applications are generally discouraged. Nomination letters and supporting materials should be sent to Dean Keith Simonton, PhD, Department of Psychology, One Shields Avenue, University of California, Davis 95616-8686; dksimonton@ucdavis.edu..

For the **Ernest R. Hilgard Award**, nominations packets should include the candidate's vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award and supporting letters from others who en-

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dorse the nomination. Nomination letters and supporting materials should be sent electronically to John D. Hogan, PhD, Psychology Department, St. John's University, 8000 Utopia Parkway, Jamaica, NY 11439 (hoganjohn@aol.com).

For the **George A. Miller Award**, nominations packets should include four copies of the article being considered (which can be of any length but must be in print and have a post-2006 publication date), vitae of the author(s), and a statement detailing the strength of the candidate article as an outstanding contribution to General Psychology. Nomination letters and supporting materials should be sent electronically to Nancy Felipe Russo, PhD, Department of Psychology, Box 871104, Arizona State University, Tempe, AZ 85287-1104 NANCY.RUSSO@asu.edu.

The **2012 Arthur W. Staats Lecture for Unifying Psychology** is to be awarded in 2011 and given at APA's 2012 annual convention. Nominations materials should include the candidate's vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award including evidence that the nominee would give a good lecture. They should be sent electronically to Donald Dewsbury, PhD, Department of Psychology, University of Florida, Gainesville, FL 32611 (dewsbury@ufl.edu).

The **Anne Anastasi General Psychology Graduate Student Award** is in its second year and some changes are being introduced. This nomination must be submitted electronically to Harold Takooshian, PhD, Psychology-916, Fordham University, New York NY 10023, takoosh@aol.com.

Please send the Following Cover Sheet:

Candidates for the Anne Anastasi General Psychology Graduate Student Award should submit the following:

1. There are 2 levels of the Anastasi Award: Students with 2 years or less of graduate study and those with more than 2 years of graduate study. Circle the one that best applies to you:

   a. Two years or less of study beyond the baccalaureate.
   b. More than two years beyond the baccalaureate.

2. I completed my masters' degree in year: _____; or did not complete _____.

1. Include:
   a. Name + email:
   b. Institution:
   c. A mentor + email:
   d. Focus of research, title:

II. Send the next three as attachments:

1. Research statement on your past/present/future work (2-3 pages, with limited number of important citations)
2. Your Curriculum Vitae

e. upporting letter from one mentor, either attached or sent separately

These materials should be sent electronically to the 2011 Chair of the committee, Harold Takooshian, PhD, Psychology-916, Fordham University, New York NY 10023, takoosh@aol.com.

Each of two recipients of this award will receive $300 and a certificate in 2011. The winner will be decided based on the student's vitae and research plan, plus a supporting letter from the student's advisor.

Requests for further information about Division One Awards may be directed to MaryLou Cheal, PhD, Awards Coordinator, Society for General Psychology, 127 E. Loma Vista Drive, Tempe, AZ 85282 (cheal@asu.edu).

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