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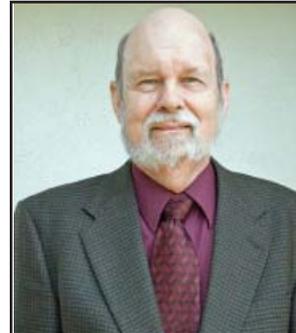
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President's Column



Christopher Ebbe, Ph.D, ABPP

Greetings, AACCP Fellows! I am honored to have been selected by the Board to serve as its President for 2009-2010, and I will do all I can to further the interests of Board Certified Clinical Psychologists.

The biggest concern of the Board (and of the American Board of Clinical Psychology, which devises and administers the examinations) is increasing our numbers (currently 580 Fellows, out of 1400 or so Board Certified Clinical Psychologists who pay ABPP dues), since for several years we have been losing more members through retirement, etc., than we are adding. The current pay differentials for diplomates offered by the military and the VA will help to stabilize those numbers or increase them slightly, but only until all VA and military psychologists who wish to obtain Board Certification have done so (and only as long as those pay differentials continue to exist). In addition, the new early application option (for starting the process during graduate school) may produce more applicants in years to come. There will always be a certain number of psychologists who wish to reach the profession's highest measured level of competence, but it is not clear where our membership numbers would level off in the future.

In response to declining membership, your Board has worked hard to revise its operations to stay within a reasonable budget (under the leadership of Larry Schoenfeld). Clinical is the largest ABPP group, so we are in no great danger at the moment, but some other ABPP specialties are examining so few applicants that they are on a schedule to increase their numbers or face being subsumed by other ABPP boards! (Forensic and Clinical Neuropsychology, on the other hand, are going great guns!)

Continued on pg 14.

Notes From Your Editors: We Want To Hear From You



Rafael Art. Javier, Ph.D., ABPP

Dear Colleagues,

In our last communication, as we introduced our first electronic Bulletin, we challenged Academy members to help us establish a dynamic, professional forum through our Bulletin where our members can share their thoughts and contribute their views. The Bulletin provides an opportunity to communicate ideas about issues affecting our profession, including treatment challenges that clinical psychologists face in their practice, recent treatment innovations for specific disorders, perspectives about research findings, current challenges and crises in clinical psychology and ways to overcome these as we move forward into the future, intersection with other disciplines and what we can learn from them to inform our clinical practice, and other topics of interest to clinical psychologists. As evident in the contents of this issue, our members responded to the challenge.

The current issue features remarks from our new president, Dr. Christopher Ebbe, whose involvement and leadership in our Academy are well known over the years. We are looking forward to working closely with him during what we anticipate to be an exciting and productive year. The issue also features two position papers representing two different perspectives regarding the role and impact of Evidence-Based approaches in psychological training and practice. In his article, "Integrating all Components in the Training of Evidence-Based Practice in Psychology," Joshua Swift recommends that EBPP be taught in an integrative fashion to avoid the pitfalls of training interventions in isolation of clinical expertise from the patient context. In the second special feature, "The Challenge for Psychoanalysis in the Area of Evidenced-Based Practice," William Herron explores the controversy generated by the emphasis of EBPP as a preferred treatment approach and the economic forces behind its promulgation. What is missing, according to Dr. Herron, is a more serious look at research-supported treatment effectiveness that



George Kapalka, Ph.D., ABPP

is based in comprehensive theory and technique. We are now inviting our members to offer their own reactions and perspectives in response to these features and the challenges they identify. These are important topics in need of serious discussion and we intend to print many of your responses in our future issues.

We hope that you enjoy this issue of the Bulletin and that you help us maintain an active, dynamic dialogue by submitting your contributions about important issues affecting our discipline.

Again, thank you and we are waiting to hear from you!

Errata

The editors regret the following errors:

Social Constructionism, Scientific Realism, and "g"

In the last edition, this article gave credit to one author, James M. Stedman, Ph.D, ABPP. We also should have given credit to the following co-authors: Brendan Sweetman, Ph.D. and Curtis Hancock, Ph.D. of the Department of Philosophy, Rockhurst University.

President's Column

Dr. Bob Yufit's name was inadvertently left off of the heading of the recent President's letter. He is in charge of mentoring and is still a valued member of our Board!

Special Features

Integrating All Components in the Training of Evidence-Based Practice of Psychology

Joshua K. Swift

Oklahoma State University

Jennifer L. Callahan and Frank L. Collins, Jr.

University of North Texas

Evidence-based practice in psychology (EBPP) has been defined by the American Psychological Association (APA) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 273). EBPP may thus be likened unto a three-legged stool, with each of the three parts of the EBPP definition (i.e., research, expertise, context) being essential to stability and balance. The current emphasis in training on the use of *empirically supported treatments* (ESTs) fosters development of competencies in integrating the best available research with practice (Chambless et al. 1996, 1998). However, EST studies typically systematically constrain both patient and therapist variables to examine the relationship between the intervention and treatment outcomes (King et al., 2005; Krause & Lutz, 2009). The debate concerning the usefulness and limitations of ESTs has a long history (see Norcross, Beutler, & Levant, 2006) and is beyond the scope of this paper. However, we highlight the routine constraint of therapist and patient variables to underscore a contemporary challenge facing trainers: adequately developing clinical expertise (a therapist variable) within the context of patient variables (including characteristics, culture, and preferences). In this brief position paper we seek to bring attention to this challenge, stimulate discussion, and tentatively identify some ways in which attending to therapist and patient variables may foster balanced training in EBPP.

Training in the Development of Clinical Expertise

Clinical expertise involves “the ability to integrate

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Of special note, given the topic, the first author is a doctoral student in training.

knowledge, experience, technical and relational skills, critical thinking, prediction, decision-making, and self-assessment within a fluid situation that often is uncertain and ambiguous” (Goodheart, 2006). In other words, clinical experts are able to utilize their knowledge of the research and previous experience in treating a unique and individual patient. APA’s policy statement on EBPP further indicates that clinical expertise involves competencies such as the ability to develop appropriate diagnostic judgments, formulate and implement treatment plans based on an accurate case conceptualization, make appropriate clinical decisions while implementing treatments, and monitor patient progress, among others.

Gaining experience and developing a solid knowledge of the research are valuable methods that can be used to develop clinical expertise; however, a number of other methods exist that can also be useful in training. For example, a competency-based approach as outlined by Kaslow (2004) and Spruill et al. (2004) recommends skill-based training methods that can be utilized both in and out of the classroom. These skill-based methods may include modeling by experts, role playing, exposure to case vignettes, in-vivo practice, review of one’s own clinical work, supervised practice, and consultation with others, to name a few. Thus, it is clear that there are diverse training options for improving expertise.

Usage of patient-focused research [characterized by Howard, Moras, Brill, Martinovich, and Lutz (1996) as monitoring patient progress through objective outcome and process measures] also has a number of applications for helping trainees further develop their clinical expertise. More specifically, feedback from objective outcome and process measures could help trainee development. For example, regularly administering a therapeutic alliance measure could signal to a trainee when a subtle rupture in the alliance has taken place and foster the development of competency in identifying future ruptures within session using clinical judgment. In addition, feedback from routinely administered measures allows trainees to progressively develop appreciation of the strengths and limitations of their own clinical judgments and decisions. As just one example, a trainee may identify a given problem as being cen-

tral to the patient's symptoms and inadvertently initiate an intervention that is not well suited to that particular patient. Routine outcome tracking could identify that the client is not responding, or even deteriorating, and prompt the trainee to re-evaluate the judgments they relied on in creating the treatment plan. This final example brings to light the other area of training that we consider a challenge: adequately attending to fostering an appreciation of the patient context in EBPP.

Training in the Recognition of Patient Characteristics, Culture, and Preferences

Patient characteristics include the numerous factors that make each patient a unique individual. These characteristics can be related to the patient's presenting problems (e.g., variations in disorders, etiology, symptoms, behavior), the patient's views of treatment (e.g., readiness to change, preferences, expectations), socio-cultural and familial factors (e.g., gender, ethnicity, race, social class, religion, values, beliefs), environmental factors (e.g., unemployment, major life events), and other factors such as age or developmental level (APA, 2006). Research has indicated that patient characteristics play an important role in determining treatment outcomes (see Clarkin & Levy, 2004; Zane, Sue, Young, Nunez, & Hall, 2004), and should be incorporated in EBPP (Ford, Schofield, & Hope, 2003).

Similar to training in clinical expertise, a number of different methods can be used in teaching future clinical psychologists to recognize and include patient characteristics as part of EBPP. Encouraging practicum experience with a variety of patients may assist in helping trainees learn to recognize that patients are unique individuals with backgrounds, characteristics, values, and preferences that may be different from their own. A second way to encourage trainees to recognize patient characteristics, specifically preferences and values for treatment, is to teach a shared decision-making model to clinical practice (Adams & Drake, 2006). A shared decision-making model emphasizes a collaborative interaction between the therapist and the patient, with both parties having an investment in the treatment decision (Charles, Gafni, & Whelan, 1999; Ford et al., 2003). This model includes four components: (1) two parties are involved, (2) both share information, (3) both discuss preferences with regards to treatments, and (4) an agreement is reached as to the implementation of treatment (Charles, Whelan, Gafni, Willan, &

Farrell, 2003). The key in using this model as part of EBPP training is to teach trainees to routinely discuss treatment preferences, goals, plans, progress, etc. with their patients.

Recommendations

First, it is important that those involved in the supervision of future psychologists teach trainees how to integrate all components of EBPP and avoid the pitfall of training interventions in isolation of clinical expertise and the patient context. Mere adherence and treatment fidelity to an intervention does not ensure competent EBPP. Although fostering integrated training can be a challenge, given the current spotlighting in the field on ESTs, it is imperative that training also focus on the growth of clinical expertise and the inclusion of patient characteristics, culture, and preferences, too, if true EBPP training is to be achieved.

Second, advancing evidence-based practice is, in part, dependent upon developing evidence-based training. To borrow liberally from Paul's (1969) suggestion for needed directions in psychotherapy research, it is clear that to achieve the goal of evidence-based training we must empirically identify "what training experiences, under which set of circumstances, are most effective in developing competencies within a particular [trainee] with specific goals and via what processes" (Collins, Callahan, & Klonoff, 2007, p. 268). What should such research look like?

McCabe (2004) suggested that research evidence exists on a strength continuum, taking into account the validity and reliability of the finding(s), the strength of inference offered by the research design, the generalizability to a population of interest, and the size of the effect in both statistical and clinical terms. With these considerations in mind, McCabe (2004) offers a hierarchical arrangement of benchmarks on this continuum (i.e., randomized clinical trials, quasi-experimental designs, expert consensus, qualitative literature reviews, and expert advice or single case experiences). The most widely cited evidence supporting the methods used in training reflects, at best, expert consensus and, more often, only expert advice. Therefore, *a significant challenge facing training in EBPP is the limited research pertaining to training itself.*

In conclusion, training of future psychologists is, fun-

damentally, an intervention. The outcomes of this intervention are distal, but not to be dismissed. Quality training—or lack of—ultimately contributes to the outcomes of hundreds, likely thousands, of patients over the course of a single career. It is of paramount importance that training become evidence-based and meet, or exceed, the rigorous standards presently demanded of psychological interventions. We strongly recommend a commitment to integrating all components in evidence-based training as a means of improving evidence-based practice in psychology.

References

- Adams, J. R., & Drake, R. E. (2006). Shared decision-making and evidence-based practice. *Community Mental Health, 42*, 87-105.
- American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271-285.
- Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L., Calhoun, K. S., Crits-Christoph, P., et al. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist, 51*, 3-16.
- Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett Johnson, S., Pope, K. S., Crits-Cristoph, P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5-18.
- Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Social Science & Medicine, 49*, 651-661.
- Charles, C. A., Whelan, T., Gafni, A., Willan, A., & Farrell, S. (2003). Shared treatment decision making: What does it mean to physicians? *Journal of Clinical Oncology, 21*, 932-936.
- Clarkin, J. F., & Levy, K. N. (2004). The influence of patient variables on psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 194-226). New York: Wiley.
- Collins, F.L., Callahan, J.L., & Klonoff, E.A. (2007). A scientist-practitioner perspective of the internship match imbalance: The Stairway to competence. *Training and Education in Professional Psychology, 1*, 267-275.
- Ford, S., Schofield, T., & Hope, T. (2003). What are the ingredients for a successful evidence-based patient choice consultation?: A qualitative study. *Social Science & Medicine, 56*, 589-602.
- Goodheart, C. D. (2006). Evidence, endeavor, and expertise in psychology practice. In C.D. Goodheart, A.E. Kazdin, & R.J. Sternbert (Eds.), *Evidence-based psychotherapy: Where practice and research meet*. (pp. 37 – 61). Washington, DC: American Psychological Association.
- Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*, 1059-1064.
- Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist, 59*, 774-781.
- King, M., Nazareth, I., Lampe, F., Bower, P., Chandler, M., Morou, M., et al. (2005). Impact of participant and physician intervention preferences on randomized trials: A systematic review. *Journal of the American Medical Association, 293*, 1089-1099.
- Krause, M. S., & Lutz, W. (2009). Process transforms inputs to determine outcomes: Therapists are responsible for managing process. *Clinical Psychology: Science and Practice, 16*, 73-81.
- McCabe, O. L. (2004). Crossing the quality chasm in behavioral health care: The role of evidence-based practice. *Professional Psychology: Research & Practice, 35*, 571.
- Norcross, J. C., Beutler, L. E., & Levant, R. F. (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association.

The Challenge for Psychoanalysis in the Era of Evidenced Based Practice

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Psychoanalysis is being increasingly marginalized to the point that its future viability as a treatment modality is in doubt. The fact that it continues to survive is not predictive of its ability to thrive. Given the economic downturn pervading the world, a bet against psychoanalysis as a desired consumer product seems a likely winner. Considering the historical role of psychoanalysis as well as the pervasive conceptual influence on all psychotherapies, this appears as quite an unfortunate possibility, potentially disruptive to the mental health of society as well as the economic well-being of the psychoanalytic profession. However, if consumers continue to retreat from the product a tipping point will be reached where psychoanalytic training institutes, already limping in terms of both quantity and quality of candidates, will indeed be training people who cannot sustain practices. The maintenance of a psychoanalytic practice is already a precarious undertaking, with many if not most analysts providing psychoanalytic psychotherapy rather than psychoanalysis in order to survive. If that possibility also continues to diminish based on reduced consumer demand, which appears likely given the economic support for treatments of choice to be brief behavioral therapies and medications, institutes will have such a limited supply of trainees that many will cease to operate.

Commenting on this bleak picture, McWilliams (2008, pp.2-3) states, "We need to keep doing what we believe in while the evidence accumulates, as it has been doing, that psychoanalytic concepts and treatments are valid and effective."

That is a good idea, but does not go far enough. For psychoanalysis to be viable it has to appeal to a sufficient number of people. Even empirical support will not ensure that unless there is evidence of unique benefits that will be seen as worth the investment. This point was made by Greenberg (2001, p. 133), "I believe that

analysis is unique as a treatment modality and that if it is to be viable in the intellectual or the economic marketplace, it must have unique goals."

Greenberg does not insist that these goals, and their achievement, be better than those of other therapies, but they must. Just being different will not work. In fairness to Greenberg, and to McWilliams, both experienced analysts, there is no doubt that they believe in psychoanalysis as Freud (1937, p. 157) stated, "As a method of treatment it is one among many, though to be sure, *primes inter pares*." If psychoanalysis wishes to remain viable, it is time to redeploy that idea with some force. However, before considering that possibility in specific terms, it is necessary to consider how psychoanalysis went from being the theory and treatment of choice for so many people to a niche product that could soon become extinct.

Pathways to Insignificance

Time and the cost of that time are major factors in the unraveling of patients' choice of psychoanalysis. The treatment modality is designed to be long-term because analysts believe, based on experience, that a significant amount of time, namely years, is required to make the most successful use of the transference, countertransference, and resistance generated in the patient-analyst relationship. It is certainly possible for analysts to achieve short-term goals, and in turn to reduce the time and cost involved. However, that is psychoanalytic or psychodynamic psychotherapy, not psychoanalysis. Short-term work has traditionally been practiced when for a variety of reasons patients were not suited to the longer, more intensive and comprehensive process. Doing something was and is considered more helpful than no therapy.

At the same time, over the years insurance coverage broadened to cover more providers from different disciplines, who in turn brought their fees in line with what insurance carriers had previously viewed as appropriate when physicians were classified as their only legitimate therapists. Essentially that translated into an overall rise in fees for psychoanalysts, although patients did not experience this as a significant increase because health insurance was primarily funded by employers.

As employers became more concerned about total

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health-care costs, managed care took hold. Although the cost of mental health care is small relative to other health-care costs, it was an easy target for reduction. Mental disorders are not cured, but alleviated, regardless of the type of treatment, nor do they generally result in death if they are left untreated or get limited treatment. The result is that there is a lot of room for different opinions about what is medically necessary. Insurance carriers used this opening to establish short-term therapy as the norm, and behavior therapists stepped in as willing providers (Herron, 1997; Herron & Javier, 1998).

Psychoanalysis was shoved aside, but for some time analysts did not realize the impact of the shove. At first analysts were able to sidestep the insurance issue by having patients pay directly and then the patients decided to what degree they needed to use insurance. Many continued even if insurance payments ceased because the patients believed in the value of an analysis. However, managed care was armed not only with the inducements of brevity and lower cost, but also with a philosophy of what constituted necessary treatment that was akin to their concept of reasonable fees. Lengthier treatment was viewed with suspicion, implying inept practice. Also, networks were formed which were theoretically designed to offset fee reductions for practitioners with high volume. For some therapists, that was an empty promise, while others had to work more hours to achieve previous income levels. Nonetheless, enough therapists participated, viewing network inclusion as a necessity for survival as an increasing number of patients insisted on the subsidized treatment.

The result was a decreasing chance for analysts, largely missing from networks either by exclusion or choice, to attempt to educate consumers to the value of psychoanalysis as well as the dubious motives of both employers and insurance managers. In addition, the threat to analysis was “misunderestimated.” This was based on analysts’ impression that the philosophy of managed care as applied to mental health services was a transparent deception about quality that consumers would easily see. Some did, but too many accepted the logic, and the threat became a significant reality. McWilliams (2008, p.2) makes the point in reference to her experience with current psychology graduate students; “... they have been thoroughly indoctrinated

in the belief that there is no place for psychoanalytic treatment in the contemporary health scene.”

While the practice of psychoanalysis in a traditional form of many sessions per week over many years has been significantly curtailed, analysts have continued to practice using psychoanalytic principles in psychodynamic therapies. These are briefer, more focused on presenting problems, and can produce results matching competitors, as behavior therapies. However, this approach is also at risk from a movement termed Evidence-Based Practice or Therapy (EBP or EBT). The logic for this approach appears to be more compelling and the methods are more deftly misleading.

EBP is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (American Psychological Association, 2006, p. 273). The main ingredient of EBP is research evidence of effectiveness, replacing opinions of effectiveness which are generally offered by proponents of a form of therapy as evidence of its value. The activation of EBP is gaining conceptually based on the logic of using therapies that are empirically proven to be effective as delineated in research-derived guidelines. Subjective views of therapeutic benefits are considered less substantial because they are seen as more likely to be tainted by personal bias. Although research has limited objectivity as well, EBP considers it more objective than clinical experience.

Given that EBP appears to respect the relativity of its central theme and is cognizant of the limitations of available evidence of therapeutic effects regardless of the source (Norcross, Hogan, & Koocher, 2008), it would seem that any psychotherapy backed by solid research evidence of effectiveness would be on most EBT lists, but this is not the case. For example, and overview of two major texts on EBT, namely *Practitioner’s Guide to Evidence-Based Psychotherapies* edited by Fisher and O’Donohue (2006) and *Handbook of Evidence-Based Psychotherapies* edited by Freeman and Power (2007), strongly suggest that EBT is restricted to short-term, primarily behavioral therapies. Psychoanalytic therapies either go unmentioned or are dismissed. The implication is that psychoanalytic therapies either have no research foundation or no validation. Such a presentation suggests clear bias in

light of considerable contrary research evidence demonstrating its effectiveness (Fonagy, Roth, & Higgitt, 2005; Leichsenring, 2005; Leichsenring & Roburg, 2008; Luborsky, 1996). EBT appears to be aligned with managed care by supporting brief, behavioral therapies to the exclusion of psychodynamic therapies, long or short. In so doing, they may be unwittingly or more consciously violating one of the most fundamental scientific principles in our discipline, intellectual integrity and the importance of maintaining an objective appraisal of evidence (Hayes, Follette, Dawes, & Grady, 2007).

The EBT concept plays to mixed reviews within the psychoanalytic community. For example, Aisenstein (2007) states, "I am among those who think that no theory of therapeutic action can be proved, which is why I remain skeptical about research in the field of psychoanalysis that passes itself off as 'empirical'." In contrast, McWilliams (2008) cites the value of empirical research supporting the efficacy of psychodynamic therapy, as well as the pivotal role of psychoanalytic elements contained in non-psychodynamic therapies.

EBT may not be seen as an immediate issue by some because it has not been seen as that attractive in practice to most therapists. For example, Norcross, Hogan, and Koocher (2008, p.272) state, "The studies uniformly find that practitioners continue to rely on the traditional (i.e., non-EBP) information sources."

However, the tepid overall response of psychotherapists is not indicative of how the major organizations, e.g., the two APAs, are responding, because both have compiled EBT lists for their members to use. In addition, insurance providers like the conceptual framework and are at work developing their own outcome measures. In so doing they are likely to make use of any evidence they can interpret to support the least expensive treatments. These trends are unlikely to aid psychoanalytic practice. As a result the visibility of psychoanalysis may well rest on paying more attention to Evidence-Based Practice lest it turn into Economics-Based Practice.

The same can be said of the possibility of national mental health care. Medicare is a likely model for this. Medicare providers receive less reimbursement for their services than providers of other health services, and the allowed charge for services is less now than it was three

years ago. Every year there is the threat of deeper cuts in provider fees, based on Medicare's funding formula. This further makes the point that now is the time for psychoanalysts to pay attention to developing mental health policy, particularly such issues as defining effective treatment and setting reasonable fees.

Repositioning Psychoanalysis

The ideal therapeutic effects that can be accomplished by psychoanalysis, namely sweeping and enduring changes in a person's life, need time to be accomplished as well as skilled practitioners who, in accord with the philosophy of our society, deserve to be appropriately compensated. Psychoanalysis is in many ways an education, limited by the skills of the participants of course, but also limited by practical matters that ultimately set the time limit for the analytic work. The paper by Freud (1937), *Analysis Terminable and Interminable*, makes it clear that analysis could be interminable in terms of learning and changing, but will not turn out that way. An expedient end will occur and be accepted by participants, but satisfaction will depend on sufficient time having been spent to accomplish a great deal. Over the decades patients have become less willing to spend that time, so the number of people being analyzed has decreased. The effect on society is unknown, but from the point of view of the value of exploring the inner life of the population, the decrease cannot be considered positive. As Greenberg (2002) has noted, psychoanalysis offers people the opportunity for self-reflection leading to the possibility of a better life. In turn, this offers the possibility of a better society. However, it appears that more people are accepting less self-knowledge as sufficient, thereby eviscerating psychoanalysis as a treatment modality.

At the same time the philosophy of translating some type of insight into effective action underpins contemporary psychotherapeutic treatments of mental disorders. For analysts this means that psychoanalytic theory and technique are primarily at work now in psychoanalytically-oriented therapies that are less extensive and less ambitious in their therapeutic effects. This is now what the marketplace expects, and in most instances, all it will accept. Furthermore, there is intense competition, particularly from cognitive-behavioral therapies that place little emphasis on self-exploration, self-understanding, and the duration and intensity of the therapist-patient relationship as an essential component of

the therapeutic intervention. The alternatives to psychoanalytic work incorporate the principles of managed care and EBT in keeping their work brief, structured, and targeted, using etiological explanations such as disordered thought patterns or a disease model congruent with drug therapy. Policy support for such an approach is popular while the possibility of expediency fostering subsequent emotional impoverishment is generally dismissed. Knowledge of what else is possible is also quite limited for consumers, so increasing numbers of people take what appears to be their only choice, accepting that it will be good enough.

For psychoanalytic therapy to be a successful competitor in such an environment it needs to establish that it is a better offering. It has to do more than the alternatives. This begins with fostering a conviction in patients that this can be a more productive experience, which indeed is why it will take longer and cost more. This is a formidable task because despite a considerable amount of outcome research, differential effectiveness is limited, at the same time that all therapies cannot be considered equally effective (Freeman & Power, 2007). In terms of funding policy, these results have been spun in the direction of the differential being insignificant so that the best therapies are those that are brief and inexpensive. Aside from the fact that all psychotherapies share the value of a broadly defined therapeutic relationship, the quality of the experience, particularly the breadth and depth, is discounted. Alternatives to psychoanalysis have been successful in taking components of analysis, as learning, cognition, dialectics, meaning, agency, or relating as major examples, and built a theory and procedure on one of them. They have also been able to create sufficient conviction about the validity of such an approach that these therapies now dominate the marketplace. However, even these therapies are at risk because the next cost-cutting move could be the replacement of verbal psychotherapy with drug therapy. Clearly this too is an issue for psychoanalysts.

The task for psychoanalytic therapy is to distinguish itself sufficiently from the alternatives as a better value because of its comprehensive exploration of the many facets of human behavior. Also, this needs to be accomplished within a time frame that is reasonably competitive with the other therapies.

For example, interpersonal therapy (IPT), a psychody-

namically-derived therapy that eschews psychodynamics for a medical disease model (Weissman, Markowitz, & Klerman, 2000), highlights what is in effect “dropped out” of the treatment. This includes the past, childhood experiences, self-understanding, character alteration, conflict, transference, and dream interpretation. IPT is also time-limited and targeted, and classified as an EBT, meaning it has some research support.

So there is the challenge. Is the “left-out stuff” of psychoanalysis that is integral to its structure and technique, worth it to the consumer? Furthermore, can analysts successfully utilize transference, countertransference, and resistance in patients’ self-explorations within a relatively limited time frame in order to lead to beneficial change? They should be able to, and in fact will have to or the current cultural surround will have no room for them as practitioners. This is not an ideal situation from the psychoanalysts’ viewpoint, nor should it be from the patients’, but such a structure has become necessary for continued viability. Now is the time for the “selling” of psychoanalysis because it no longer sells itself. It is also a time for analysts to be proactive, to educate consumers and policymakers to the potential value for society of psychotherapeutic work that is not increasingly restricted in quality and is carried out by analysts who are appropriately valued for their skill. This contention needs to be supported by both solid research evidence as well as personal experience.

References

- Aisenstein, M. (2007). On therapeutic action. *Psychoanalytic Quarterly*, 76, 1443-1462.
- APA Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271-285.
- Fisher, J. E., & O’Donohue, W.T. (Eds.) (2006). *Practitioner’s guide to evidence-based psychotherapies*. New York: Springer.
- Fonagy, P., Roth, A., & Higgitt, A. (2005). Psychodynamic therapies, evidence based practice and clinical wisdom. *Bulletin of the Menninger Clinic*, 69, 1-58.
- Freeman, C., & Power, M. (Eds.) (2007). *Handbook of evidence-based Psychotherapies*. West Sussex, England: Wiley.
- Freud, S. (1937). Analysis terminable and interminable. *Standard Edition*, 23, 209-253.
- Greenberg, J. (2002). Psychoanalytic goals,

- therapeutic action, and the analyst's tension
Psychoanalytic Quarterly, 71, 651-678.
- Greenberg, J. (2001). Thinking, talking, playing: The peculiar goals of psychoanalysis. *Psychoanalytic Quarterly*, 70, 131-148.
- Hayes, S. C., Follette, V. M., Dawes, R. M. & Grady, K... E. (2007). *Scientist standards of psychological practice: Issues and recommendations*. Reno Nevada: Context Press.
- Herron, W.G. (1997). Restructuring managed mental health care. In R.M. Alperin & D. G. Phillips (Eds.), *The impact of managed care on the practice of psychotherapy* (pp.217-233). New York : Brunner/Mazel.
- Herron, W. G. & Javier, R. A. (1998). *Mental disorder and its treatment: Social and political implications*. In R. A. Javier & W.G. Herron (Eds.) *Personality development and psychotherapy in our diverse society* (pp. 657-678). Northvale, NJ: Aronson.
- Leichsenring, F. (2005). Are psychoanalytic and psychodynamic therapies effective? A review of empirical data. *International Journal of Psychoanalysis*, 86, 841-868.
- Leichsenring, F., & Roburg, S. (2008). Effectiveness of long-term psychodynamic Psychotherapy: A meta-analysis. *Journal of the American Medical Association*, 300, 1557-1565.
- Luborsky, L. (1996). Theories of cure in psychoanalysis and the evidence for them. *Psychoanalytic Inquiry*, 16, 257-264.
- McWilliams, N. (2008). Psychoanalysis: The next generation. *Psychologist-Psychoanalyst*, 28, 1-4.
- Norcross, J. C., Hogan, T. P., & Koocher, G. P. (2008). *Clinicians guide to evidence-based practices*. New York: Oxford University Press.
- Norcross, J. C., Hogan, T. P., & Koocher, G. P. (2008). Evidence-based practices in psychology. *The Register Report*, 34, 8-15.
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.

Attachment, Play, and Authenticity: A Winnicott Primer

By Steven Tuber



Book Review

David A. Crenshaw, Ph.D., ABPP

Steven Tuber is Professor of Psychology and Past Director, Doctoral Program in Clinical Psychology of the City University of New York at City College. His new book on Winnicott's work will be of great interest to play therapists. Of particular interest is his Chapter 8, "The Meaning and Power of Play." Tuber states on page 119, that Winnicott "believes that the ability to play is the benchmark for the entrance into a life of health and vitality." He explains Winnicott's notion of the duality of play by stating, "It is the milieu in which the baby discovers her True and hence utterly private self and yet the means by which she engages others and develops support" (p.122). Another important Winnicott concept of play is, "Playing thereby allows the child to consistently work on the boundary between illusory omnipotence and helplessness and thus has at its essence the quest for mastery over the inner and outer chaotic (that is, not yet understood) aspects of its experience" (p. 123).

Tuber cites essential characteristics of play in general emphasized by Winnicott, but in play therapy this quest for mastery over the inner and outer worlds, creating cohesive play and later verbal narratives out of the bewildering experiences of a young child, is a quintessential task. Tuber also explains that play is about repetition; play themes are endlessly repeated. This redundancy is most valuable to the play therapist because if we miss something the first or second time around, chances are it will come around again.

This same redundancy, however, poses a challenge to the parent, especially the mother who is typically the primary caretaker because she must attempt

to maintain a "good enough" connection with the child in the face of boring, repetitions of play themes that may after a point become mind-numbing. Ending these play sequences often as a result of necessity involves as Tuber explains the "good-enough" mother learning to help the child make a difficult transition. Among many clinically astute and remarkable insights expressed by Tuber in this outstanding book is his comparison to the role of a child therapist in ending a play session. He states, "It makes me think immediately of what it is like to be a child therapist when the patient doesn't want to leave at the end of the session. These moments speak to how difficult it is to end the magic of play, to end the magic of relating, and for children who have had parents who have been experienced as unreliable, how frightening and/or depriving it is to end the therapy session. These children expect that the ending of the session will also not be reliably done, such that they won't get back to the pleasure of playing and the pleasure of relating" (p.124). Tuber goes on to explain that not wanting to end the session is a sign of hope in child therapy because it represents a wish in Winnicott's term of continuing the "good object" and a fear that the "good object" will not come back. Although the "good object" is viewed as unreliable there nevertheless is implied both the wish and capacity for relatedness.

Tuber beautifully expands on Winnicott's concept of a holding environment and its crucial importance in the creation of the True self. But the very process of creating a true and separate self presents the young human with the ever present prospect of aloneness. Tuber eloquently elaborates on this point, "The capacity to be alone thus implies the need for relatedness. To the extent that the baby can evoke treasured people in its play, and use the play to engage imaginatively with these people in interactions that explore every type of affect the baby knows, then the baby can tolerate the aloneness and indeed come to thrive despite—actually because of—its awareness. We can also say that the capacity to create symbols allows the child to cognitively "hold" her parent more easily; creating a salve to combat aloneness" (p.127).

The above examples represent the richness of insight and creative clinical process that this beautifully written book offers to my colleagues in play therapy.

General Announcements

AACP Website

Christopher Ebbe, Ph.D., ABPP, FAACP

If you have not visited or used our Academy website, we hope you will take a look at it. The website (www.aacpsy.org) serves as a source of information about the Academy for potential diplomates and for the general public, and it includes several resources for members. (1) The member directory can be used by the public to locate a Board Certified psychologist and used by Fellows to locate colleagues and referrals in other areas. (2) The AACP tri-fold brochure can be printed out and used in Fellows' offices, for public education, and in advocacy with third-party payers. (3) Continuing education opportunities, with APA CE credits, (see elsewhere in the newsletter for details) are located at Resources/Continuing Education. (4) Guidelines are posted for mentors who may be assisting applicants through the application and examination processes. (5) The member and academy news bulletin board keeps you up to date on AACP business and on member news. (6) Recent Academy Bulletins are posted, as are (7) minutes of the Academy's Executive Board.

The bulletin board can be used to network and to share helpful information that can aid us in our quest to provide excellent (or at least "high quality") services and to continue in our career-long professional development. We can post address and phone number changes; awards received, elected offices, and other professional achievements; and anecdotal or research-based tips on practice specifics (a little known treatment method for trichotillomania; a particularly useful line of questioning in dynamic therapy; a new study on psychotherapy with schizophrenia; etc.). Please send your announcements, news, tips, and suggestions for how to make the website more useful to me at cebbe@alum.mit.edu.

Continuing Education

Christopher Ebbe, Ph.D., ABPP, FAACP

The Academy is offering home study continuing education opportunities on our website (under "Resources" on www.aacpsy.org). Each course consists of reading a listed journal article and taking a brief learning test on the article. APA CE credits will be issued for passing scores (generally 70 percent). Due to copyright issues and the fact that few publishers, including APA, will allow us to post articles without sizeable reprint charges, we are unable to provide the actual articles to you online or by mail, so take a look at the articles' sources to see if you have ready access. Most are from APA journals, and APA members can obtain reprints of all of those articles for \$11.95 each. (See the Continuing Education page on the website for APA on-line ordering information.) Courses are for one or two credits each (and so are useful for filling in a small gap in one's state-required number of credits for license renewal). Credits are free (members) or \$20 (non-members).

There are currently eleven articles posted, and we are adding more as we can. The Continuing Education Committee selects only articles that seem as if they would be potentially useful for Board Certified-level practitioners.

Obituaries

David R. Cox, Ph.D., ABPP writes:

I am deeply saddened to bring the news of the death of our good friend and colleague, **Dr. Russell Bent**. As you all know, Russ was Executive Officer of ABPP for several years until his retirement in 2006. He was a mentor and friend to many of us in psychology, and brought much to the effort to advance quality and competence in professional psychology. We will honor Dr. Bent more formally in our next newsletter. Russ will be greatly missed. Below is the obituary of his death, as published in the *Atlanta Journal-Constitution*.

Russell Julian Bent, age 79, passed away peacefully after a long illness on August 22, 2008 at his home in Roswell, Ga. He was surrounded by family and friends. He attended St. Peter's College and received his Ph.D. in clinical psychology from Fordham University in 1961. He was awarded an honorary D.Sc. degree from the University of Indianapolis and an honorary Psy.D. degree from Forest Institute of Professional Psychology in 2002. His professional career included a faculty position at Emory University and was Deputy Superintendent at Georgia Mental Health Institute. He was a leader in the American Psychological Association national quality of care and credentialing activities. Russ was a faculty member and, later, Dean of the School of Professional Psychology at Wright State University from 1978 until he retired in 1994. After his retirement, he worked as a private consultant and became the Executive Officer of the American Board of Professional Psychology until he retired in 2006. Throughout his life, Russ was an avid and accomplished golfer, skier, magician, and photographer. He is survived by his wife, Ann Bent; daughter, Pamela LeBey Wilson and son, Daniel LeBey, both from a previous marriage; son-in-law, Randy Wilson, and grandsons, Nicholas and David Wilson. A memorial celebration will be held Sunday August 31, from 3pm to 5pm at the family's home in Roswell, Ga. In lieu of flowers, donations may be made to the American Cancer Society or Hospice Atlanta. Arrangements by Cremation Society of the SOUTH in Marietta, 770-420-5557.

Nancy McDonald writes:

Jacqueline Goldman, Ph.D., ABPP recently passed. The funeral was at The B'nai Israel Congregation in Gainesville, Florida. Dr. Goldman was a Professor Emeritus in the Department of Clinical and Health Psychology at UF. She had a distinguished career authoring three textbooks (including "On Becoming a Psychotherapist") and many honors. She had in the past served on ABPP Board of Trustees. In lieu of flowers donations may be made to Hopsice or to any of the many organizations she supported: Altrusa Club, Maimonides Society of the Jewish Council of North Central Florida, the Humane Society, the Democratic Party, the Harn Museum of Art. She established the Jacqueline R. Goldman Scholarship in Developmental Psychology and made a generous donation to APA to establish a congressional fellowship for psychologists to impact child-related legislation. Dr. Goldman was known as an excellent teacher and mentor.

President's Column con't.

After years of establishing its procedures and its turf and trying to find an appropriate identity for the Academy, your Board is turning more attention to member benefits. Working to promote Board Certification may be a sufficient reason for AACP to exist, but surely we can do some things for members as well, besides the lower malpractice insurance rate negotiated with American Professional Agency. We plan to pay for pop-up ads on Google search pages, inviting searchers to visit the AACP website and use our directory. We also will try to organize Fellows in major metropolitan areas to place a large ad for Board Certification (with Fellows' names listed) in local newspapers. We have decided to reinstitute providing AACP certificates to Fellows (for wall display). If you have other ideas about how AACP could serve you, please let me (or other Board members) know.

The Board will be discussing some ways that Fellows could benefit from interacting more with each other. Establishing subspecialty groups might be of value (with sharing via a listserv, perhaps). A structure for making consultations and referrals among diplomates possible could also be useful. We will also look into more formal ties with Division 12 of APA. If anyone would like to spearhead a way for diplomates to interact more, let us know.

Relations between the various specialty academies and their examining boards are in the process of revision. It appears that the academy and board of each specialty will together have one representative on the ABPP Board of Trustees. Discussions will begin soon about how to organize this for clinical. If any of you have insights about how this might best be done, please let me know.

Board meeting minutes are on the website (www.aacpsy.org). We value your membership and your opinions. Let us know what you think (cebbe@alum.mit.edu)!