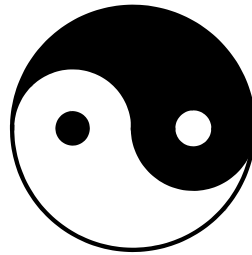


Behavioral Emergencies Update



President's Column

It May Be Slow, But We're Making Progress...

*M. David Rudd, PhD
Texas Tech University*

In looking back on the past year (and decade for that matter), I'd say one phrase captures the essence of our section, *we're making progress*. It may be slow, but it's steady and recognizable. And that progress is evident on a number of fronts; scientific, practical and political.

A quick review of our statement of purpose provides some context. It emphasizes the following elements with respect to behavioral emergencies:

- The development and improvement of clinical assessment, treatment and management approaches.
- Promotion of the scientific understanding of behavioral emergencies.
- Advocacy for graduate education and professional training.
- Improving our understanding of the professional, forensic and ethical issues surrounding behavioral emergencies.

A snapshot of the rapidly growing literature in this area reveals considerable progress. At last count there were over 50 (I counted 54 just this past week) clinical trials targeting suicidality. Although that's a tragically small number in comparison to other areas of the treatment literature, it's doubled in the past seven years, with 27 trials since the year 2000. As was mentioned in a previous column, core competencies have been identified and endorsed by the American Psychiatric Association (2003), the American Association for Suicidology and the Suicide Prevention Resource Center. Similarly, the Substance Abuse and

IN THIS ISSUE:

President's Column:
Pgs. 1-2

Spousal Support and
PTSD: Pgs 3-4

Professional Identity
of Clinical
Psychologists: Pgs
4-5

Combat Related
PTSD: Pgs 5-6

Election results: P. 7

APA Photos: Pg. 8-9

Moving Toward
Patient-Centered
Care: Pg. 10-11

Continued on the next page.

Continued from previous page.

Mental Health Services Administration have embraced the idea of *suicide warning signs* and will publish very soon a treatment improvement protocol targeting the identification and management of suicide risk for substance abuse counselors. Despite these (and other) political gains, federal research funding continues to lag terribly. In 2004, suicide resulted in 32,439 deaths, more than doubling the number of deaths secondary to HIV/AIDS (13,063). Federal research funding in fiscal year 2008 was only \$31 million, in contrast to the more than \$2.8 billion allocated for HIV/AIDS. Although we're making progress, much remains to be done. Without adequate funding, the small gains made over the last decade will undoubtedly be lost.

A quick look at our recent APA program also reveals progress. We honored the work of Aaron T. Beck with the lifetime achievement award. Dr. Beck's work clearly evidences not only exceptional scientific rigor, but also promotion, education and advocacy consistent with our purpose. The section hosted an excellent panel entitled "Current Directions in Understanding and Responding to Non-Suicidal Self-Injurious Behavior", featuring the work of Matthew Nock, Jennifer Muehlenkamp, and Dave Jobes. The panel provided some insights into the exciting and cutting edge work of each of the panelists. Over the past decade, some truly exciting science has emerged in this area. There is much to be optimistic about. I would also encourage you to review latest addition to our webpage, a fact sheet on *violence and victimization among ethnic minorities in the U.S.* It was prepared by our student representative, Liliana Cordero.

Let me close in thanking Alec Miller for his exceptional service to our section as past-president and welcome Jim Rogers to his new term as president. We're making slow and steady progress.

Section Members in Press



Have a book or article coming out that you would like to let other members know about? Make sure you send that information to be included.

All submissions should be sent to Dr. Jennifer Hartstein.

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Spousal Support and PTSD: Implications for Interventions

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More than 240,000 troops have experienced deployment to Afghanistan or Iraq since June 2007 (Department of Defense [DoD], 2007). These returning troops have an increased risk of developing PTSD as a result of their exposure to combat. There is a large body of research that has examined the risk factors, protective factors, and treatment of PTSD. However, little investigation has been made into the specific effects PTSD has on spousal relationships or how strengthening these relationships and preparing caregivers for the return of their spouses may serve as protective factors for both the veteran with PTSD and his/her spouse.

This important area of research has been overlooked even though it has been argued that those closest to victims of PTSD suffer the most (Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough, & Weiss, 1992). Generally, families with members suffering from PTSD have been shown to have decreased family cohesion and expressiveness, increased family violence, higher incidences of alcohol abuse, increased marital problems, and decreased life satisfaction (Jordan et al., 1992; Gimbel & Booth, 1994). Specifically, spouses of veterans with PTSD report increased caregiver burden, increased physical and psychological hostility toward their spouses, increased presence of depression, increased health complaints, and a loss of independence (Calhoun, Beckham, & Bosworth, 2002; Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Gold, Taft, Keehn, King & King et al, 2007).

In a qualitative study examining the perceptions of nine wives living with veterans diagnosed with PTSD (Dekel et al., 2005), the wives expressed consistent sentiments throughout their interviews. For example, wives reported feeling an overwhelming sense of burden tainted by their sense of duty and commitment to their husbands. Additionally, they described their experience in marriage as dominated by a constant fear due to their husbands' suicidal inclinations, and expressed a sense of loss over the relationship as it existed prior to their husband's deployment (Dekel et al.). Gradually these women experienced symptoms similar to those of their husbands including depression and anxiety coupled with guilt over wanting to leave their husbands while at the same time feeling a sense of duty or obligation to stay in the relationship.

A second study echoed similar findings that wives of veterans with PTSD reported lower levels of happiness and life satisfaction, increases in stress resulting from efforts to cope with their spouses' symptoms, and 50% of these wives reported being battered (Jordan et al., 1992). In addition, it was found that a higher proportion of spouses of veterans with PTSD committed some act of violence against their spouse (Jordan). Gold et al. (2007) also examined female Vietnam veterans suffering from PTSD and their spousal relationships. Their research indicated that male spouses are affected in much the same way as female spouses. One difference this study found was that male veterans with PTSD tended to be more physically aggressive while female veterans with PTSD were more psychologically aggressive with their spouses.

PTSD is highly associated with an increase in the risk of suicide. This risk is even greater when there are unstable marital relationships and divorce (Ben-Ya'acov & Amir, 2004; Jones, Kennedy, & Hourani, 2006). There is overwhelming evidence to support the approach of treating both the troops suffering with PTSD and to also prepare, educate and support their spouses. A thorough consideration of this research suggests that interventions should be employed that involve educating spouses about what living with a partner with PTSD may involve as well as empowering them by providing strategies and support for dealing with the upcoming changes in their lives. Because spouses serve as the primary caregivers for veterans with PTSD and because keeping the marriage intact is a protective factor against suicide as a possible outcome, it is critical to arm spouses with the resources and the skills necessary to effectively cope with their partner's PTSD (Ben-Ya'acov & Amir, 2004; Dekel et al, 2005).

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The professional identity of clinical psychologists: Where does Division 12 stand?

Marc Hillbrand, Ph.D.

Connecticut Valley Hospital and Yale University

In September 2007 I had the good fortune of representing Section VII at the Board meeting of Division 12 under the sunny Arizonan skies. Having inherited the position of Section VII representative a few months earlier, I approached the meeting with a mixture of excitement and mild trepidation. I have been a member of D12 for more than two decades but my involvement in Divisional activities is largely limited to reading divisional journals, attending D12-sponsored programs at the APA conventions and casting 10 votes for D12 every year and encouraging my wife to do the same. I thus wondered whether I was sufficiently informed about the Division to participate meaningfully. The purpose of this column is to share with you what I have learned, in the spirit of promoting knowledge about and participation in D12.

The meeting was chaired by Marsha Linehan, Ph.D., D12 president and attended by past D12 presidents Drs. Gerald Davison, Nadine Kaslow and Linda Sobell (the latter two are also council representatives), president-elect Irving Weiner, Ph.D., and Drs. Knaus (secretary), Klepac (treasurer), Brodsky, Hong, (council representatives) King, Gottsegen, Caldwell-Colbert, Brown, Austria, Weinnad (representing Sections I through X), Mr. Sullivan (student representative, Section X), and Ms. Peterson (administrative officer).

One topic on the agenda was professional identity. This topic is important to D12 as it loses about 50 members a year. About 100 new members join, and 150 leave, and even applications for D12 Fellow status have become rare. The membership attrition is of concern for many reasons including financial ones. The Board voted

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to raise D12 fees by \$1 a year for the next 5 years to produce balanced budgets. The plan was to review the findings and recommendations of the Identify Task Force Report submitted by Drs. Sobell and Hong. However, the discussion rapidly moved to the topic of the mission of D12.

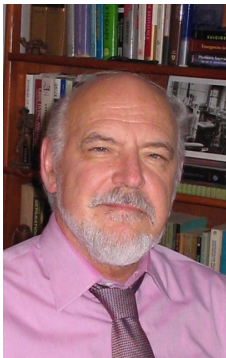
In discussing what the mission statement should be, two positions emerged. One emphasizes the integration of science and practice as the core value of clinical psychology. The most ardent proponents of this position argued that “you are either for the integration of science and practice or you are not welcome in D12”. The other school of thought stresses the value of integrating science and practice alongside other foci such as education, public service, advocacy, diversity, etc. Advocates of that position made statements such as: “There are many ways to be a clinical psychologist”. Although the objectively hottest moment of my trip was when I stepped out of the car in the middle of the magnificent Organ Pipe Cactus National Monument (it was 115 degrees), the only time I really sweated was in response to the vehemence of this discussion. Two drafts of the mission statement were generated. The Board will vote on these at the next meeting after further discussion.

With respect to public service, the Board will make PROFNET available to all D12 Sections. PROFNET is a web-based platform that catalogues the names of psychologists and their areas of expertise. The listings are then made available to media outlets when they request experts on various topics.

Regarding education, the Board encourages the Sections to advertise their educational offerings in the News & Events section of the D12 website. Also, field testers are needed for nine new D12-sponsored books.

D12 gives a number of awards every year at the APA Convention, including three Student Awards: one for service, one for research, one for practice. Nominations for these have become rare. The Board requested that each Section nominate at least one candidate per student award. The nominations require two supporting letters and the candidate’s c.v. Your recommendations are welcome for the next cycle of awards. New ideas are sought on how to make the Awards Ceremony at the Convention less formulaic and more meaningful. A new award has been created to recognize a psychologist who has distinguished him/herself in Interventions for Communities of Color.

The next Board meeting is in Austin in January 2008. I look forward to reporting on it in an upcoming column.



Combat-Related PTSD and Suicide Revisited

Phil Kleespies, PhD

VA Boston Healthcare System

In my column on combat-related PTSD and suicide in the Spring/Summer 2007 issue of this newsletter, I cited a large register linkage study of Vietnam veterans (on the Agent Orange Registry) which indicated that veterans who had PTSD (n=4247) were 4 times more likely to die by suicide than combat veterans who had no psychiatric diagnosis (n=12,010) (Bullman and Kang, 1994). In this same study, it was also found that those combat veterans with PTSD and another concurrent psychiatric diagnosis (e.g., depression, anxiety, substance abuse) were 10 times more likely to die by suicide than those who had no psychiatric diagnosis.

A recently published study by Zivin, et al., (2007), however, has raised questions about whether combat-related PTSD is a significant risk factor for suicide, at least in a population of veterans who have a primary diagnosis of depression. Their findings seem to call for an examination of the differing findings in these studies.

Zivin, et al., conducted a very large record linkage study in which they collected data from the VA’s National Registry for Depression (NARDEP) and linked it to the National Death Index, a registry that provides information on all causes of death including suicide. They found that the suicide rate in the VA treatment population with depression (88.25 per 100,000) was 7-8 higher than the suicide rate for those in the general U.S. population of the same age group. Since depression is the diagnosis most frequently associated with suicide, this finding does not seem surprising. They also found that those veterans who had co-morbid diagnoses of depression and substance abuse had a suicide rate that was significantly higher than those veterans who only had a diagnosis of depression. This finding is also consistent with previous findings (Cornelius, 1995; Murphy, 1992). Surprisingly, however, they found that veterans with

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co-morbid diagnoses of depression and PTSD had a significantly lower rate of suicide than those veterans who were depressed but did not have a diagnosis of PTSD.

How can the findings of Bullman and Kang be reconciled with the findings of Zivin, et al. ? A re-examination of the study by Bullman and Kang reveals that 23% of those veterans with PTSD had diagnoses for an additional mental disorder. Of those with PTSD and a co-morbid diagnosis, however, only 10% had a diagnosis of depression while 56% had a diagnosis of alcohol and/or drug dependency. Thus, it would seem that co-morbid alcohol and/or drug dependency may have had a far greater influence than depression on the finding in the Bullman and Kang study that PTSD plus another mental disorder increased the risk of suicide. Such an explanation, of course, requires further study, but should it prove true, it would increase the specificity of our thinking about veterans with PTSD who are at high risk for suicide. We would see veterans with combat-related PTSD and alcohol or drug dependency as at a more elevated risk, while those with PTSD and depression might be of lesser concern (as suggested by Zivin, et al.). Why this should be the case would be a matter for empirical inquiry.

Of course, there are other possible explanations for the differences between the findings of Bullman and Kang and Zivin, et al. For one, there may have been population differences. The veterans in the Bullman and Kang study were exclusively Vietnam War veterans who had been exposed to Agent Orange; while the veterans in the study by Zivin, et al., were veterans of several different wars. There could be factors specific to the Vietnam combat experience that increased the risk of suicide in those with PTSD. Moreover, as Bullman and Kang noted, the proportion of Vietnam veterans with PTSD in their study who had co-morbid diagnoses was much smaller than what was reported in other studies. Concurrent diagnoses (such as depression) may have been under-reported on the Agent Orange Registry. So, too, with a registry like the NARDEP which has a primary focus on depression, secondary diagnoses like PTSD may have been under-reported. Under-reporting of secondary diagnoses will reduce the likelihood that they will be detected as risk factors for suicide.

The study by Zivin, et al., raises interesting questions about PTSD as a risk factor for suicide. For the reasons noted above, it does not seem that one can take the findings and conclude that combat-related PTSD is not a risk factor for suicide. In addition to the study by Bullman and Kang, other studies such as those by Kramer, et al., (1994) and Hyer, et al., (1990) clearly suggest otherwise. Hopefully, the findings of Zivin, et al., will be clarified by further research.

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Section VII Election Results

The Section VII election results are in. The President-Elect for 2008 is Anthony Spirito, Ph.D., and the Treasurer for 2008-2010 is Jennifer Muehlenkamp, Ph.D.

Anthony Spirito, PhD, ABPP, is Professor of Psychiatry and Human Behavior at Brown Medical School, Director of the Clinical Psychology Training Consortium, and Associate Director of the Brown University Center for Alcohol and Addiction Studies. He has conducted a number of studies in emergency departments, with both adolescents who have attempted suicide and adolescents presenting due to excessive alcohol use. Currently, he is examining the effectiveness of a family-based motivational interview for alcohol positive adolescents seen in the emergency department. Dr. Spirito also has a mid career award from NIMH to mentor junior faculty in developing interventions for adolescents with comorbid substance use and suicidal behavior.

Dr. Spirito is Past President of the Society for Pediatric Psychology, Division 54 of the American Psychological Association. In the recent years he has been an invited participant to workshops sponsored by NIMH and NIAAA, and was appointed to the Scientific Advisory Council of the American Foundation for Suicide Prevention and the NIMH Data and Safety Monitoring Board.

Jennifer Muehlenkamp, Ph.D., is a licensed clinical psychologist and an assistant professor of psychology at the University of North Dakota. Dr. Muehlenkamp completed her degree at Northern Illinois University in 2005, where she focused on an emphasis in understanding and preventing suicidal and non-suicidal self-injurious behaviors in youth and young adults. In addition to her faculty appointment, Dr. Muehlenkamp maintains a small private practice where she continues to treat adolescents and young adults who engage in self-injurious behaviors. She has published a number of articles and book chapters on non-suicidal self-injury and suicidal behavior. Dr. Muehlenkamp's research contributions have been recognized by an award from the American Association of Suicidology and the North Dakota Psychological Association. Dr. Muehlenkamp is currently acting in the role of project evaluator on a Garrett Lee Smith Grant submitted by the Department of Rural Health at the University of North Dakota. She is a member of the North Dakota State Suicide Prevention Coalition and is assisting the state with implementing their Garrett Lee Smith SAMHSA grant. Dr. Muehlenkamp is acting chair of the Research Division on the Council of Delegates for the American Association of Suicidology and has previously held positions as the Student Representative for both the American Association of Suicidology and Section VII of Division 12 of the American Psychological Association.

We welcome them to the Section VII board and look forward to working closely with them in the upcoming years.



Section VII at the APA Conference

Section VII president David Rudd presenting the Section VII Career Achievement Award to Dr. Aaron T. Beck for his seminal contributions to the study and understanding of suicide.

Jennifer Muehlenkamp, Ph.D., presenting at the Section VII symposium entitled "Current Directions in Understanding and Responding to Nonsuicidal Self-Injurious Behavior" as co-presenter Matthew Nock, Ph.D. and Chair, David Rudd, Ph.D., listen



Section VII at the APA Conference



At the Section VII annual business meeting: President David Rudd presents a Section VII certificate of appreciation to Past President Alec Miller for his service to the Section. From left to right, Phil Kleespies (Treasurer), Dale McNiel (a past President of the Section), James Rogers (President-Elect), Alec Miller, and David Rudd.

Have articles, news or photos you would like included in the newsletter?
Submissions are welcome anytime.

Please email any items of interest to Dr. Jennifer Hartstein
drhartstein@gmail.com

NEXT DEADLINE: May 15, 2008

Moving towards patient-centered care in forensic practice

*Marc Hillbrand, Ph.D.,
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Patient-centered care is a collaborative model of service delivery that emphasizes active collaboration between clinicians and empowered service consumers (Institute of Medicine, 2001; Kopelowicz, Liberman, & Zarate, 2006; US Psychiatric Rehabilitation Association; Young et al., 2005). This model represents an ideological shift away from the traditional model of mental health service delivery. It envisions clinicians as individuals who collaborate with patients in their rehabilitation and recovery rather than traditional clinicians focused on assessing and treating deficits such as psychopathology, cognitive impairment, and disordered behavior.

Nowhere is this paradigm shift felt more strongly than in forensic hospitals. Forensic hospitals house individuals with severe mental illnesses who have committed violent offenses. The culture of forensic hospitals contains elements of coercion and control. Mission statements of forensic hospitals often mention balancing treatment and safety needs, with safety often trumping treatment. Forensic clinicians often view themselves as agents of social control whose responsibility is public safety (Howe, Hillbrand, & Bennett, 2005). As such, tools at their disposal include the creation and enforcement of numerous and occasionally arbitrary rules and the use of coercive means such as seclusion and restraints. This identity and these tools clash with the humanistic values of person-centered care. Moving towards the new model therefore requires altering this mindset by encouraging forensic clinicians to forge new identities as healthcare workers promoting health.

In our experience, this shift in institutional culture cannot be accomplished by administrative fiat alone. Though the head of a hospital can proclaim the dawning of a new area of person-centered care, direct-care staff is unlikely to give up well-established and oft-reinforced patterns of professional behavior. The typical forensic culture is also Hydra-like: Challenging one of its components, such as over-reliance on restraints, often results in the emergence of a new problem, such as excessive laxity and non-interventionism when responding to aggressive incidents. We describe our experience of developing and implementing a novel staff training methodology that has shown positive effect in altering staff identities and behavior.

Inspired by the movie "Blue eyes, brown eyes", based on the work of famed social activist Jane Elliott, we designed a role-play exercise in which forensic staff adopts for 90 minutes the role of forensic patients in a structured learning environment. For added realism, we worked with a group of forensic inpatients in a focus group format to identify specific staff-patient interactions that exemplify the inpatient maximum-security experience. Patients listed numerous examples such as "Can't you see I'm busy", "You can't have that, that's a safety issue", and "Come back later"; they also suggested scenarios that would allow training participants to experience the parts of institutional life that are unintentionally oppressive and harmful to hospitalized individuals (e.g., privacy restrictions, crowding, seclusion).

The training consisted of three major components: a role-play exercise, watching a video on racial discrimination, and a panel discussion with several "ex-patients", i.e., past residents of the hospital. The role-play consisted of an introduction, the simulation itself, and debriefing exercises. The head of the hospital welcomed all trainees. Trainees were assigned the role of high- or low-status patients and participated in a 1.5 hour simulation on an empty hospital ward during which they acted the assigned patient roles. Trainees were then debriefed and given group exercises that promoted discussions of their experience. They then watched and later discussed the movie "Blue eyes, brown eyes", a film on racial discrimination. The movie was chosen because it describes eloquently and movingly how the members of one group come to treat

badly the members of another. A lunch followed, with continued dialog among trainees, trainers, and hospital leadership. The afternoon consisted of a 1 hour panel discussion with 5 ex-patients who were invited to describe their hospital experience and comment on its positive and negative aspects, followed by group exercises mixing ex-patients and staff.

Feedback from all who were involved in the training was very positive. Trainees reported greater closeness to patients, as well as pride and joy about their improvement. Patient panel participants also viewed the experience as positive and empowering. They recognized particularly meritorious staff and denounced harmful practices such as restraints. The experiences were joyful and humanizing for all involved and illustrate the benefits of encouraging consumers of psychiatric services to share their experiences (Weingarten et al, 2000).

Promoting service users' strengths, autonomy, power, and connections with others, along with their hopes, dreams, interests, talents, and skills, is a central focus of client-centered care (CT DMHAS, 2004; Davidson et al., 1999). This requires empathy for the plight of patients. A mechanism that appears to have been activated in the present training is the instillation of hope. Numerous participants mentioned hope in the feedback, as did several of the panel members. Alongside strengthening competencies, instilling hope is a fundamental value of client-centered care (Davidson et al., 1999), one that can only be promulgated in an experiential fashion. The important ingredients of the present intervention appear to have been the leadership support, the multi-faceted nature of the training, and the small group interactions. The many small group activities stressed the fact that all opinions are important. As one attendee said: "*The opinions of staff and patients were equally as meaningful.*"

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