16 CONTEMPORARY CHALLENGES AND CONTROVERSIES

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The other chapters in this book show psychotherapy's fascinating diversity. Therapists come from a variety of disciplines—psychology, psychiatry, social work, and counseling, to name just a few—and apply different principles from different perspectives in their work with people who come to them for help.

Yet for all the diversity, every therapist who shows up for work in a private office, clinic, community center, hospital, or elsewhere faces an array of contemporary challenges and controversies. This chapter takes a look at nine of them:

1. The mental health workforce
2. Physicians, medications, and psychotherapy
3. Empirically supported therapies
4. Phones, computers, and the Internet
5. Therapists' sexual involvement with patients, nonsexual physical touch, and sexual feelings
6. Nonsexual multiple relationships and boundary issues
7. Accessibility and people with disabilities
8. Detainee interrogations
9. Cultures

THE MENTAL HEALTH WORKFORCE

You and your partner have just moved to a new state. After a week, your partner tells you, "I've been feeling a little depressed and anxious since we moved. It's not one of those things I can pull myself out of. I think I need some help. We don't know anyone here, so there's no one we trust to ask for a recommendation, but I've looked in the phone book and here are the people who are available: a counselor, a life coach, a marriage and family therapist, a psychiatrist, a psychologist, and a social worker. The phone book doesn't give anything more than the title. Which do you think I should choose?" How do you respond to your partner?

Defining the mental health workforce with any precision presents complex challenges, especially in light of the fact that many therapists work part-time and many identify with more than one mental health profession (for example, a therapist may be both a social worker *and* a marriage and family therapist). However, we know that for every 100,000 U.S. citizens, there are about 6.5 psychiatric nurses, 11.4 school psychologists, 13.7 psychiatrists, 16.7 marriage and family therapists, 31.1 psychologists, 35.3 social workers, and 49.4 counselors (Robiner, 2006). Mental health services are also delivered by other health professionals, including rehabilitation counselors, pastoral counselors, substance abuse counselors, and general practice physicians and nurses (Wedding, DeLeon, & Olson, 2006). Whatever their professional identification, the majority of these individuals practice *technical eclecticism* (described in Chapter 14) and use a variety of methods, most of which are derived from the therapies described in *Current Psychotherapies.*

In recent years, psychologists and social workers have come closer to achieving the status of medical therapists, especially in the areas of insurance reimbursement, participation in federal health programs, and admission to psychoanalytic training. In many states, psychologists also have gained hospital admitting privileges, and some states enacted laws requiring hospitals that offer psychology services to allow psychologists to directly admit their patients. Other groups that practice counseling or psychotherapy are making rapid strides toward achieving those privileges now available to psychologists and social workers.

The accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) influence the hiring practices and staffing decisions made by administrators of hospitals, community mental health centers, and other settings where psychotherapy services are delivered. These administrators, confronted with fiscal limitations and budget constraints, are acutely aware that there is tremendous variation in the base salaries expected by therapists who may have different professional backgrounds but who deliver essentially comparable services.

Nearly all states classify psychotherapy as a legitimate part of medical practice without any requirement that its use be restricted to psychiatrists. However, psychiatrists now devote the majority of their time to medication management, and far fewer psychiatrists are being trained to provide psychotherapy to their patients (Luhrmann, 2000; Moran, 2009). This trend results in part from the fact that approximately half of new psychiatrists licensed in the United States are International Medical Graduates (IMGs), and these physicians are more likely to be trained in biological psychiatry. Bernard Beitman and other psychiatrists have decried the abdication of psychotherapy training by psychiatry residency programs and have developed time-limited, modular approaches to training that can be adapted to fit psychiatry residency curricula (Beitman & Yue, 1999).

In 2009, psychologists, psychiatric nurse practitioners, and social workers in all 50 states were required to be licensed or certified, and professional counselors had to be licensed or certified in almost all states. A growing number of states also require marriage/family and substance abuse counselors to be licensed or certified.

Licensing is more meaningful than certification because *licensure* restricts the practice of a profession, whereas *certification* restricts the use of a profession's name. These distinctions are difficult to apply to psychotherapy because it is virtually impossible to restrict the practice of a profession that includes such a varied range of activities. Certain professional activities may be state regulated, however. Psychological testing may be restricted to psychologists, for example, and the authority to prescribe medication may be granted only to physicians, dentists, and other health care practitioners such as advanced practice nurses, nurse practitioners, physicians' assistants, optometrists, and podiatrists. Regulatory authority is usually invested in a state board appointed by the governor and composed of professionals and members of the public. Frequently, state boards will use *reciprocity* to license professionals who hold a license to practice in other states.

It is difficult to decide who should have the right to practice psychotherapy because there are few unambiguous practice guidelines to define what is appropriate professional care for patients with mental and emotional disorders. A psychoanalyst and a behavior therapist may provide dramatically different treatment for a patient with an anxiety disorder, for example. Yet both will claim—and genuinely believe—that their mode of treatment is appropriate, and both will expect payment for their services.

PHYSICIANS, MEDICATIONS, AND PSYCHOTHERAPY

You are a psychologist practicing in a small town. You and a psychiatrist, who is also in solo practice, provide the town's only mental health services. Over the years, you have noticed that whenever one of your therapy patients needs to be evaluated for medications and you refer him or her to the psychiatrist, the patient soon stops seeing you. It's one of those small towns where there are few secrets, so you discover that the psychiatrist encourages your patients to discontinue seeing you so that they can consolidate their care and receive both medication and psychotherapy from the same person, even though many of them are subsequently treated only with medication. Rosa Gonzales, for example, had been seeing you in connection with her work-related depression. Her employer was exploitive, abusive, and disrespectful. She'd been working on developing the confidence and courage to change jobs. However, once she went to the psychiatrist for a medication consult, she stopped coming to therapy. When you happen to see her in the grocery store several months later, she looks at the floor and comments, "The medications made me feel better and the job doesn't seem so bad now." What are your reactions to your experiences with the psychiatrist? And how do you think you'd respond to your former patient's comment?

No therapist works in isolation. All therapists must cope with frequently changing rules about the allocation and delivery of clinical services. The patterns that reflect which people receive—and which people fail to receive—clinical services, in what forms, for what problems, and from whom continue to evolve. Therapists must decide how they want to respond to these shifting patterns and what role, if any, they want to play in changing them.

What are the major trends? Many studies document that treatment consisting solely of psychotherapy is becoming less common. Wang, Demler, Olfson, Pincus, Wells, and Kessler (2006), for example, found that a

> mental-health-specialty-only profile, representing possible use of psychotherapy alone, had been the most popular profile in the NCS [National Comorbidity Survey] but declined significantly in the past decade. This finding is consistent with a significant decrease in psychotherapy visits during the 1990s. . . . It could reflect new restrictions on the number of psychotherapy sessions, increased patient cost sharing, and reduced provider reimbursements for psychotherapy visits imposed by many third-party payers. . . . It could also reflect changes in the popularity of

> therapeutic modalities, particularly patients' growing preferences for psychotropic medications. (p. 1195)

Those findings echo an earlier study by Olfson, Marcus, Druss, Elinson, Tanielian, and Pincus (2002) that found that

> Significant growth occurred in the number of Americans who received treatment for depression during the past decade, and at the same time the treatments they received underwent a profound transformation. Antidepressant medications became established as a mainstay, psychotherapy sessions became less common and fewer among those receiving treatment, and physicians assumed a more prominent role. (pp. 206–207)

These data suggest that people seeking help for problems such as depression are turning more to physicians and less to psychologists. Olfson and his colleagues reported that

> there was a significant increase in the proportion of patients whose treatment of depression involved visits to a physician. . . . By 1997, more than 8 (87.3%) of 10 patients who received outpatient treatment of depression were treated by a physician, compared with 68.9% in 1987. Conversely, the percentage who received treatment from psychologists declined (29.8% vs. 19.1%). Treatment of depression by social workers remained little changed and relatively uncommon. (p. 206)

Interestingly, this shift to seeking help from physicians, particularly primary care physicians, involves obtaining not only medications but also psychotherapy from those primary care physicians. Wang and his colleagues note that

> The general medical-only profile experienced the largest growth over the past decade and is now the most common profile. This increased use of general medical providers without specialists may be because primary care physicians now act as "gatekeepers" for nearly one-half of patients. . . . The development and heavy promotion of new antidepressants and other psychotropic medications with improved safety profiles have further spurred care of mental disorders exclusively in general medical settings. . . . There has also been a growing tendency for some primary care physicians to deliver psychotherapies themselves. (Wang et al., 2006, p. 1194)

Although some mental health practitioners may be concerned about competition with physicians, there is a growing national trend toward collaborative practice and integrated care (Bluestein & Cubic, 2009; Ruddy, Borresen, & Gunn, 2008). This model involves co-location of mental health practitioners with physicians and nurses, joint training, and shared continuing education opportunities. The model facilitates respect between different professional groups and supports the "curbside consults" and "hallway hand-offs" that are so critical to continuity of care (Wedding & Mengel, 2004).

Several studies also suggest a shift away from longer-term psychotherapies. Olfson, Marcus, Druss, and Pincus (2002) examined changes that occurred between 1987 and 1997. In 1987, about 16% of the outpatients had more than 20 sessions of psychotherapy. Ten years later, only about 10% had more than 20 sessions. In both years, about one third of the patients reported only one or two therapy sessions. In 1987, about 48% of the therapy sessions were conducted by physicians, about 32% by psychologists, about 7% by social workers, and about 23% by others. By 1997, the percentage of physicians conducting therapy sessions had increased to about 65%, psychologist-led therapy sessions had increased to around 35%, social worker-led therapy had almost doubled to 13%, and sessions conducted by others had decreased to around 15%.

In some cases, the focus on medication may mean that patients receive little monitoring or other help of any kind. A study of 84,514 adult and pediatric patients found that "during the first 4 weeks of treatment with antidepressants, only 55.0% of the patients saw a healthcare provider for any purpose, and only 17.7% saw a provider for mental healthcare" (Stettin, Yao, Verbrugge, & Aubert, 2006, p. 453).

The increased use of medications to treat psychological disorders was one factor that led psychologists to seek prescription privileges. The issue soon erupted in controversy, with thoughtful arguments made on each side. Would prescription privileges enable psychologists to provide a more comprehensive array of clinical services to clients? Would psychologists' ability to prescribe enable them to provide services in geographic areas of critical need that lacked psychiatrists? Would psychologists betray their professional identity and values, shifting toward a medical model in which medication is often an initial intervention? If psychologists were not going to add a year or two to their doctoral training, what part of their current curriculum and training would have to be abandoned to make room for training in psychopharmacology? Those interested in reviewing the proposed standards and reading a broader and more detailed discussion of the arguments for and against psychologists' prescription privileges should review publications by the American Psychological Association (2007a), Ax, Bigelow, Harowski, Meredith, Nussbuam, and Taylor (2008), Fagan, Ax, Liss, Resnick, & Moody (2007), and Rae, Jensen-Doss, Bowden, Mendoza, and Banda (2008).

As this chapter is written, only New Mexico, Louisiana, and the U.S. Territory of Guam have laws providing limited prescription privileges to psychologists with special training, and slightly more than 1,500 psychologists have completed Level 3 Clinical Pharmacotherapy training (Ax, Fagan, & Resnick, 2009). The New Mexico law authorizing prescription privileges for psychologists is online at the New Mexico Board of Psychologist Examiners Web site (www.rld.state.nm.us/Psychology/ruleslaw.html). The Louisiana law authorizing prescription privileges for psychologists is online at the Louisiana State Board of Examiners of Psychologists Web site (www.lsbep.org). Hawaii passed legislation authorizing prescription privileges for psychologists, but the governor vetoed the bill.

EMPIRICALLY SUPPORTED THERAPIES

It is your first week as executive director of a community mental health clinic. The clinic offers individual therapy, group therapy, and family therapy, as well as a suicide hotline and a walk-in crisis clinic. At the end of the week, the Board of Directors informs you that because they want to be sure that money is spent wisely and effectively, they have adopted a new policy for you to implement: The clinic will offer only services that have been empirically supported through well-designed scientific research. If research has not demonstrated that an intervention is both safe and effective, it is prohibited. Would you agree with this policy? If required to implement it, what steps would you take?

The push to put therapy on sound scientific footing led to the concept of *empirically supported therapies* (ESTs). Proponents of ESTs believed that each form of therapy needs to be tested in carefully controlled experimental research. The results would show which therapies actually worked and which, though well intended, did nothing to help the patient or, worse, were harmful.

Eager to stop wasting money on worthless interventions, managed care companies and other third-party payment sources rushed to embrace the concept. ESTs held the promise of allowing insurance companies to restrict payments to those therapies that well-designed experiments had demonstrated to be the most effective and efficient.

The concept of empirically supported therapy, appealing to so many in theory, has turned out to be difficult and controversial to put into practice. Drew Westen and Rebekah Bradley (2005) note that

> evidence-based practice is a construct (i.e., an idea, abstraction, or theoretical entity) and thus must be operationalized (i.e., turned into some concrete form that comes to define it). The way it is operationalized is not incidental to whether its net effects turn out to be positive, negative, or mixed. (p. 226; see also Westen, Novotny, & Thompson-Brenner, 2004)

One challenge is that a therapy cannot be described simply as "effective" any more than a psychological test can be described simply as "valid" or "reliable." The validity and reliability of psychological tests do not exist in the abstract. They must be established for a specific purpose (e.g., identifying malingering), for a specific setting (e.g., forensic), and for a specific population (e.g., adults who can read and write English at a seventh-grade or more advanced level). Gordon Paul acknowledged this complexity in 1967 when many were searching for therapies that were "effective." Paul wrote that both therapists and researchers must confront the question "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" (p. 111).

David Barlow reviewed research showing the importance of these complex sets of variables. He notes, for example, that studies show "that therapist variables such as experience contribute to successful outcome. . . . But this research on therapist variables occurs in the context of considering, first and foremost, the presenting pathology of the patient" (2004, p. 874). He concludes that

> there are three overriding principles in evaluating the robustness of [psychotherapies]. . . . First, it is important to match the psychological intervention to the psychological or physical disorder or problem. . . . Second, it is important to match the treatment to patient and therapist characteristics. . . . Finally, the evaluation of treatments must be considered in the context of the actual settings in which the treatments are provided. (p. 874)

Another challenge is that it is difficult to define with precision exactly what variables are significant in a specific situation. Imagine, for example, that a series of experiments had evaluated the effectiveness and efficiency of different treatments for a specific psychological syndrome, perhaps one of those found in DSM-IV. As Robert Sternberg points out,

> If every client was a textbook-pure case of a particular syndrome, then it might be possible to comfortably generalize the results of many and even most . . . [random assignment studies] . . . to clinical settings. [But] the degree of fidelity is, at best, variable. . . . [E]cological validity is a matter of degree, and as the universe of therapy situations to which one wishes to generalize expands, one has to be increasingly cautious in interpreting the results of RAS designs. Will the treatment work in other cultures? Will it work for people with comorbid diagnoses? Will it work for people on a particular combination of drugs? How will it work for people who are highly resistant to psychotherapy? In the end, one must ask just how general the results of any given study or set of studies can be. (2006, p. 269)

The daunting complexity of the research needed to investigate a particular psychological therapy adequately stands in stark contrast with the sheer number of available therapies. Kazdin (2008b; see also 2008a), for example, notes that there are more than 550 psychological interventions for children and adolescents but that only a relatively small minority have been subjected to research.

Trying to determine whether a set of studies can be validly generalized to other individuals, other cultures, and other situations is difficult enough, but Alan Kazdin (2006) takes the challenge to a deeper level: In light of the kinds of measures used in most therapy research, do we have logical, empirical, or other scientific proof that the individuals in the research studies themselves are being helped? A fundamental scientific and clinical question, according to Kazdin, "is whether our findings 'generalize' to patient functioning. Stated more empirically, what exactly is the evidence that EBTs [Evidence Based Therapies] help patients? I believe it is possible to delineate an EBT . . . that improves the life of no one" (p. 46). Furthermore, he says,

> In most therapy studies, measures are not linked to specific referents in everyday life and are arbitrary metrics. Fancy data transformations, creation of new metrics, and

> statistical razzle-dazzle can be very useful (and worked with my dissertation committee, even if only for the first hour of my six-hour root-canal-like oral defense). However, these statistical strategies do not alter the arbitrariness of the metric, and in the case of psychotherapy research, they say little to nothing about whether patients have changed in ways that make a difference. (p. 46)

Carol Goodheart (2006) identified a challenge on yet another level:

> Psychotherapy is first and foremost a human endeavor. It is messy. It is not solely a scientific endeavor, nor can it be reduced meaningfully to a technical mechanistic enterprise. . . . Psychotherapy is a fluid, mutual, interactive process. Each participant shapes and is shaped by the other. They are masters of tact and timing, of when to push and when to be patient. They know the spectrum of disruptions that can occur in a working alliance and are versatile and empathetic in their reparative responses. They are creative in finding paths to understanding, in matching an intervention to a need. (pp. 42–42)

Despite such challenges, the APA 2005 Presidential Task Force on Evidence-Based Practice reached an optimistic conclusion about evidence-based practice, defining it as

> the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. . . . Many strategies for working with patients have emerged and been refined through the kinds of trial and error and clinical hypothesis generation and testing that constitute the most scientific aspect of clinical practice. Yet clinical hypothesis testing has its limits, hence the need to integrate clinical expertise with the best available research.
>
> Perhaps the central message of this task force report—and one of the most heartening aspects of the process that led to it—is the consensus achieved among a diverse group of scientists, clinicians, and scientist–clinicians from multiple perspectives that [evidence-based psychology practice] requires an appreciation of the value of multiple sources of scientific evidence. In a given clinical circumstance, psychologists of good faith and good judgment may disagree about how best to weigh different forms of evidence; over time, we presume that systematic and broad empirical inquiry—in the laboratory and in the clinic—will point the way toward best practice in integrating best evidence. What this document reflects, however, is a reassertion of what psychologists have known for a century: The scientific method is a way of thinking and observing systematically, and it is the best tool we have for learning about what works for whom. (p. 282)

Despite the widespread optimism and enthusiasm among some, controversies remain. Goodheart and Kazdin (2006), for example, in their introduction to the APA-published book *Evidence-Based Psychotherapy: Where Practice and Research Meet,* wrote:

> It is not clear whether the EBP movement is good for clients. . . . There is agreement on the interest and priority of improving client care. There is disagreement on the extent to which conclusions from research ought to be applied to and constrain clinical practice and the extent to which practitioners can genuinely identify client needs and apply the best or more appropriate combination of treatments based on that evaluation. (pp. 7–8)

The debate about evidence-based practice is not limited to the mental health professions; the absence of clear guidelines characterizes much of medical practice. The United States government has attempted to deal with this lack of uniform standards by establishing the Agency for Healthcare Research and Quality (AHRQ). This agency and

a number of professional organizations have developed explicit treatment guidelines for behavioral problems such as depression and anxiety, but the use of practice guidelines in mental health remains controversial. Proponents of practice guidelines argue that they bring much-needed standardization to a field that has suffered greatly from extensive but unnecessary variance in practice (largely as the result of a lack of standardized training in the mental health professions). Critics of the guidelines, on the other hand, argue that every clinical case is unique and adamantly reject any attempt to apply standardized treatment protocols, algorithms, or "cookbooks." Moreover, Terrence Shaneyfelt and Robert Centor (2009) argue that "too many current guidelines have become marketing and opinion-based pieces, delivering directive rather than assistive statements" and that "Most current articles called 'guidelines' are actually expert consensus reports" (p. 868). They wrote:

> The overreliance on expert opinion in guidelines is problematic. All guideline committees begin with implicit biases and values, which affects the recommendations they make. However, bias may occur subconsciously and, therefore, go unrecognized. Converting data into recommendations requires subjective judgments; the value structure of the panel members molds those judgments. (p. 868)

In a similar vein, John Kraemer and Laurence Gostin (2009) caution against the "politization of professional practice guidelines."

Anyone interested in reviewing the large number of existing guidelines for treating behavioral disorders should visit the *AHRQ Guideline Clearinghouse* (www.guidelines.gov).

The other chapters in this book illustrate the great diversity of approaches to psychotherapy. In light of that diversity, and the diversity of human nature itself, perhaps it should not be surprising that there is no general agreement about the definition, methodology, or value of evidence-based psychotherapy. Diverse views and a lack of general agreement among therapists about basic definitions, methodology, and the like have deep historical roots. APA president Carl Rogers set in motion an organized effort to define psychotherapy when he appointed David Shakow to chair a special committee. The APA convention of 1947 adopted the Shakow committee report, which led to the Boulder Conference in 1949. The Boulder Conference recorder summarized the result of this massive effort to define psychotherapy in a memorable passage: Psychotherapy is "an undefined technique which is applied to unspecified problems with a nonpredictable outcome. For this technique we recommend rigorous training" (Lehner, 1952, p. 547).

PHONES, COMPUTERS, AND THE INTERNET

You have established a busy practice, and you schedule eight 1-hour sessions each day. You use your computer both for billing and for record keeping, and all of your client files are maintained on your office computer. You also use e-mail extensively as a way to follow up and check on your patients. Because so much of your work depends on access to your computer, it is especially frustrating when your hard drive crashes, and you realize that you have not backed up your files in months. When you frantically call a local computer repair company, you are told that your data can probably be recovered but that a technician will need access to your computer for an entire day. You can bring your computer into the shop for repair, or the technician can visit your clinic to do the work on site. A colleague is on vacation, and you will be able to use her office to see your patients, so you tell the computer repair company to send somebody out the next day. What ethical dilemmas does this vignette present? Is it reasonable to expect a therapist to cancel eight patients in order to simply sit and watch someone work on her computer for 8 hours? Is it sufficient to simply "check in" on the technician between patients?

Scenario One

The digital age makes it possible for psychotherapy to occur without therapist and patient ever meeting face to face or even being in the same country. Consider this scenario:

Someone seeking therapy begins the search on the Internet, examining a number of therapists' Web sites. One site offers just what the prospective patient is looking for. The site provides a list of available times for initial sessions, one of which is convenient. The soon-to-be patient reads a series of passages describing the nature and ground rules of the therapy, the exceptions to confidentiality, the responsibilities of both therapist and patient, and so on. After reading each passage, the individual indicates "agree" or "disagree" as part of the informed-consent process.

Once the basics are covered, the soon-to-be patient answers a series of open-ended questions about personal history, demographics, health status, the reasons for seeking therapy, and so on. The therapist offers an initial session at half price—therapist and prospective patient will get to know a little about each other and decide whether they both want to work together. The prospective patient must pay the fee in advance, by credit card, to reserve the time for the initial session.

Therapist and patient meet on the Internet once a week for 45-minute sessions for a total of 12 weeks. They focus on the patient's depression, which they trace to the patient's unsatisfying career. They discuss the barriers—both internal and external—that have kept the patient from finding a new line of work. When the patient decides it is time to end the therapy after 3 months, the depression is no longer constant and debilitating. The patient has started to implement a plan to change careers.

Scenario Two

The therapist and patient in this scenario live more than 300 miles from each other. They communicate only by computer. The words of both therapist and patient appear on their computer monitors.

The patient in this scenario is particularly appreciative of this mode of therapy. Not only was she able to find a therapist whose skills and personal approach were what she was looking for—the kind of therapist who was simply not available in her own small, remote community—but this patient is in the advanced stages of a neuromuscular disease that makes it very difficult for her to leave home. No longer able to speak, she communicates with others via assistive technology on her computer that enables her to control the computer using a "sip and puff" switch. Her words are displayed on a monitor.

Technologies enabling therapist and client to work together without meeting each other face to face, without living in the same state or even in the same country, and without either of them leaving home have brought many benefits. Patients, especially those living in small or remote communities, are more likely to find a therapist with particular qualities, values, approaches, skills, or experience. Therapists specializing in a very rare disorder can reach patients with this disorder living across a wide range of states, provinces, and other locales. Many patients—for example, those in the final stages of terminal diseases; those whose physical conditions limit their mobility, and those with highly contagious diseases—can choose among a great variety of therapeutic approaches, even though any attempted travel outside their home is arduous, painful, risky, and perhaps impossible. Some patients whose fears, anxieties, or conditions (such as agoraphobia) might discourage them from trying more traditional modes of therapy may find that therapy by computer or telephone seems safe as an initial intervention. Therapists whose physical condition makes it impractical for them to travel to and from a job site or to spend extended time in an office can work from home, hospital, or hospice.

Scenario Three

These forms of long-distance therapy have also brought challenges and controversy. For example, imagine a scenario in which a therapist begins work traditionally, working with the client in an office setting. However, the company for which the client works transfers the client to another state. Both client and therapist believe that it would be in the client's interest to continue working with the same therapist rather than starting over in the new state with a new therapist. Therapist and client continue to work for the next 2 years, holding sessions by phone and computer. However, the client becomes profoundly depressed and confesses to the therapist that he has been sexually abusing children in his new neighborhood. Then the client becomes acutely suicidal and takes his life. The client's family subsequently sues the therapist for malpractice.

During the extended litigation, a number of issues arise:

- Was the therapist practicing without a license in the state to which the client had moved? If a therapist and patient are in different jurisdictions during therapy sessions, must the therapist maintain appropriate licensing status in both jurisdictions? If a therapist lives in Missouri and is licensed only in Missouri, what authority, if any, does the state licensing board in Missouri have over the therapist's work via telephone or Internet with a client living in Illinois? What authority, if any, does the licensing board in Illinois have to regulate the work of the therapist who lives in Missouri? Does it make any difference if the patient and therapist live only minutes apart, but on different sides of the Mississippi river?
- What are the standards of care regarding basic competence when therapy is conducted by telephone or Internet? What education, training, or supervised experience in telephone therapy or Internet therapy establishes that therapists are not working outside their areas of competence?
- Do the laws regarding privacy, confidentiality, privilege, mandatory reporting (of child abuse or elder abuse, for example), and duty to protect third parties that prevail in the state where the therapist lives apply, or do such laws of the state in which the client lives apply, or do both sets of laws apply? What happens if the laws in the therapist's state conflict with the laws in the client's state? For example, what if the laws in one state require that certain information be kept confidential, whereas the laws of the other state require that the information be reported?
- What information about telephone therapy or Internet therapy must a therapist be sure that a client understands and consents to as part of the process of informed consent and informed refusal?
- Under what conditions is telephone therapy or Internet therapy covered—or not covered—under different professional liability policies?

One useful source of guidance in considering these issues is Gerry Koocher and Elizabeth Morray's (2000) article "Regulation of Telepsychology: A Survey of State Attorneys General." In closing their review, Koocher and Morray offer seven maxims:

1. Before engaging in the remote delivery of mental health services via electronic means, practitioners should carefully assess their competence to offer the particular services and should consider the limitations of efficacy and effectiveness that may be a function of remote delivery.
2. Practitioners should consult with their professional liability insurance carrier to ascertain whether the planned services will be covered. Ideally, a written confirmation from a representative of the carrier should be obtained.

3. Practitioners are advised to seek consultation from colleagues and to provide all clients with clear, written guidelines regarding planned emergency practices (e.g., suicide risk situations).
4. Because no uniform standards of practice exist at this time, thoughtful written plans that reflect careful consultation with colleagues may suffice to document thoughtful professionalism in the event of an adverse incident.
5. A careful statement on limitations of confidentiality should be developed and provided to clients at the start of the professional relationship. The statement should inform clients of the standard limitations on confidentiality (e.g., child abuse reporting mandates), any state-specific requirements, and cautions about privacy problems with broadcast conversations (e.g., overheard wireless phone conversations or captured Internet transmissions).
6. Clinicians should thoroughly inform clients of what they can expect in terms of services offered, unavailable services (e.g., emergency or psychopharmacology coverage), access to the practitioner, emergency coverage, and similar issues.
7. If third parties are billed for services offered via electronic means, practitioners must clearly indicate that fact on billing forms. If a third-party payer who is unsupportive of electronic service delivery is wrongly led to believe that the services took place in person rather than online, fraud charges may ultimately be filed.

Formal guidelines relevant to therapy provided by telephone or Internet, as well as discussion of the other topics included in this chapter, can be found on the Web page *Ethics Codes & Practice Guidelines for Assessment, Therapy, Counseling, & Forensic Practice* (http://kspope.com/ethcodes/index.php), which provides links to more than 100 formal sets of guidelines and codes, including the National Board for Certified Counselors' "The Practice of Internet Counseling" and the APA's "American Psychological Association: Statement on Services by Telephone, Teleconferencing, & Internet."

The continuing evolution of the digital revolution has great potential for transforming the relationship between clinicians and patients. In "Take Two Aspirin and Tweet Me in the Morning: How Twitter, Facebook, and Other Social Media Are Reshaping Health Care," Carleen Hawn (2009) describes the ways in which "new media tools like weblogs, instant messaging platforms, video chat, and social networks are reengineering the way doctors and patients interact" (p. 361).

Digital technology has created changes and challenges for therapists in another area of practice: the storage and transmission of records. Even though the widely hailed "paperless office" has not come to pass for most therapists, many therapists use computers to handle clinical data. Some may use computers to administer, score, or interpret psychological tests and other assessment instruments. Many use computers for recording information about their clients and notes on psychotherapy sessions. Spreadsheets and specialized software handle billing, track accounts receivable, and provide documentation to insurance companies and other third-party payment sources.

How can therapists make sure that this confidential information is restricted to those authorized to see it? It may seem a reasonably easy challenge, but therapists and patients have been stunned by instances in which supposedly secure information fell into the wrong hands. Here are some of the things that can happen:

- A desktop or laptop computer containing confidential patient information is stolen from an office.
- A car is vandalized, and a laptop stored in the trunk is stolen.
- Someone hacks into a computer that is connected to the Internet and steals the information stored on the computer's hard drive.

- A virus, worm, Trojan, or other malware infects a computer and sends confidential files to a hacker, uploads confidential files to a Web site where anyone can read them, and sends confidential files to everyone listed in the computer's address book. This includes all the Internet discussion groups to which the therapist belongs and all addresses in the computer's memory.
- A hacker makes subtle and undetected changes in a therapist's files (such as adding numbers randomly to billing records or changing the dates in the records of therapy sessions).
- Someone sits down at an unattended computer that is not password-protected or whose password is easy to find (in the desk drawer, under the keyboard, or on a Post-it note nearby) or easy to guess (the person's name, the word "password") and reads, downloads, or transmits confidential data to unauthorized sources.
- Someone reads a monitor—and obtains confidential information—by standing near the monitor or sitting next to a laptop user in an airport, on a flight, or in some other public setting.
- A therapist and client discuss extremely sensitive information, unaware that because one of them is using a cordless phone, the conversation can be overheard by someone using a cordless phone close by.
- A therapist e-mails a message containing confidential information to a colleague who is authorized to have it, but accidentally uses the wrong e-mail address.
- A therapist e-mails a message containing confidential information to a colleague who is authorized to have it, but the recipient shares his or her computer with someone else who opens the e-mail message.
- A therapist faxes confidential information, but the recipient's fax machine is shared with others.
- A therapist keeps clinical and financial records on a computer, unaware that spyware has been installed on the computer.
- A therapist faxes confidential information but, by mistake, punches in the wrong fax number.
- A therapist sells a computer, forgetting that confidential information, thought "erased" from the hard drive, is still recoverable because a more thorough form of "scrubbing" the hard drive was not used.

Computers and other electronic devices for storing information and communicating with others offer obvious benefits. However, the mental health community has been slow to recognize their potential pitfalls and the need for creativity and care in their use. Therapists have extensive education, training, and supervised experience in working with people. For most of us in this field, however, working with computers and other digital devices is not our strong suit. When we use digital devices to handle the most sensitive and private information about our clients, we must remember to live up to an ancient precept: First, do no harm.

Therapists—and all students learning to be therapists—should also realize that most clients will "Google" their therapist's name either before or immediately after the first session. This can be particularly problematic when a therapist's Facebook page or a similar social networking site (e.g., a dating service) contains highly personal information that one would not want to have shared with one's clients. Admissions committees for professional training programs are currently grappling with the issue of whether or not highly personal information (e.g., nude photos) obtained from an Internet search is appropriate data to be shared with other members of the committee and used in making decisions about admission to professional training programs.

THERAPISTS' SEXUAL INVOLVEMENT WITH PATIENTS, NONSEXUAL PHYSICAL TOUCH, AND SEXUAL FEELINGS

You are a therapist in a hospital and mental health center seeing your last client of the day. She is dressed in a short skirt and t-shirt, and she has for several sessions hinted at some secret that she is too embarrassed to talk about. You find her very attractive and enjoy spending time with her. She begins by saying that she had an intense dream that may have given her the courage to work on her secret in therapy. She tells you the dream in detail. It is an erotic dream, and you find yourself becoming intensely aroused. She says that all the graphic sexual activity in the dream is related to her secret, which is that she has always been ashamed that her breasts were so small and that she had wanted to ask you if you thought so. She immediately pulls her t-shirt off. What do you think you would do if you were this therapist? What, if anything, would you tell your supervisor about it? What, if anything, would you write in the client's chart? If you imagine the same scenario adapted to a male patient who is concerned about the size of his penis and suddenly pulls down his pants, are your responses to these questions different in any way?

Sex is the focus of one of the most ancient rules of working with patients, is a cause of discomfort and confusion for many therapists, and is a contemporary challenge for the profession.

Therapist-Patient Sexual Involvement

No circumstances or rationale justify sexual involvement with a patient. This basic rule has ancient roots. Annette Brodsky's (1989) research led to her discovery that the prohibition is older than the Hippocratic Oath, which included it. In fact, she found that this prohibition was set forth centuries earlier in the Nigerian Code of the Healing Arts.

The prohibition continues to be fundamental to the profession for many reasons, including the issue of harm to patients. In the landmark 1976 case of *Roy v. Hartogs,* for example, New York Supreme Court Presiding Justice Markowitz wrote, "Thus from [Freud] to the modern practitioner we have common agreement of the harmful effects of sensual intimacies between patient and therapist" (*Roy v. Hartogs*, 1976, p. 590).

Studies of the effects of therapist–patient sexual involvement have looked at both patients who never returned to therapy and those who worked with a subsequent therapist; have compared those who engaged in sex with a therapist with matched groups of those who engaged in sex with a nontherapist physician and of those who did not engage in sex with a health care professional; and have evaluated the effects of sexual involvement between patients and therapists using an array of measures including standardized psychological tests, clinical interview by subsequent therapists and by independent clinicians, behavioral observation, and self-report (Pope, 1994). Reading first-person accounts of therapist–patient sexual involvement—its course of development and its aftermath—can deepen the understanding provided by research-based findings. Client accounts include those by Bates and Brodsky (1989), Freeman and Roy (1976), Noel and Waterson (1992), Plaisil (1985), and Walker and Young (1986).

The effects of therapist–patient sexual involvement on clients often seem to cluster into 10 very general areas: (1) ambivalence, (2) guilt, (3) emptiness and isolation, (4) sexual confusion, (5) impaired ability to trust, (6) confused roles and boundaries, (7) emotional liability, (8) suppressed rage, (9) increased suicidal risk, and (10) cognitive dysfunction, frequently in the areas of concentration and memory and often involving flashbacks, intrusive thoughts, unbidden images, and nightmares (Pope, 1988, 1994; Pope & Vasquez, 2007).

In light of the harm associated with sexual boundary violations, almost half the states have determined that the civil legislation and case law prohibiting sex with patients were insufficient and have added criminal penalties that can be applied in some situations.

Despite the harm that therapist–patient sexual involvement can cause to patients, despite the longstanding professional prohibition, and despite civil and even criminal penalties, a small minority of therapists sexually exploit their patients. A study of the combined data from the first eight national, anonymous self-report surveys that appeared in peer-reviewed journals found that 4.4% of the 5,148 therapists surveyed reported having engaged in sex with at least one patient (Pope & Vasquez, 2007).

Statistical analysis found no significant differences among the three professions surveyed in these studies: Social workers, psychiatrists, and psychologists report becoming sexually involved with their patients at roughly the same rates.

These studies do, however, reveal significant gender differences. Male therapists reported engaging in sex with their patients at much higher rates (6.8%) than did female therapists (1.6%). By far the most common pairing is a male therapist with a female patient, accounting for about 88–95% of the instances of therapist–patient sex in large-scale peer-reviewed studies that report gender data.

Gender is a significant factor in a variety of other sexual dual or multiple relationships and boundary issues (e.g., supervisor–supervisee, professor–student)—even when the base rates of gender in each role are taken into account—and in other nonsexual dual or multiple relationship situations. An early national study of sex between therapists and patients, supervisors and supervisees, and professors and their students noted that

> When sexual contact occurs in the context of psychology training or psychotherapy, the predominant pattern is quite clear and simple: An older higher status man becomes sexually active with a younger, subordinate woman. In each of the higher status professional roles (teacher, supervisor, administrator, therapist), a much higher percentage of men than women engage in sex with those students or clients for whom they have assumed professional responsibility. In the lower status role of student, a far greater proportion of women than men are sexually active with their teachers, administrators, and clinical supervisors. (Pope, Levenson, & Schover, 1979, p. 687; see also Pope, 1994; Pope & Vasquez, 2007)

Therapists usually become sexually involved with their patients through a variety of common scenarios. Pope and Bouhoutsos (1986, p. 4) presented 10 of the scenarios that seem to occur most often (see Table 16.1).

Nonsexual Physical Touch

It is important to distinguish therapist–patient sexual involvement from two very different phenomena. First, nonsexual physical touch is clearly different from sexual involvement. Pope, Sonne, and Holroyd (1993) documented the ways in which nonsexual physical touch within therapy had acquired a "guilt by association" with sexual touch. Their review of the research and other professional literature found no harm from nonsexual touch per se, although context, culture, and meaning should always be considered before touching a patient. When consistent with the patient's clinical needs and the therapist's approach, nonsexual touch can be comforting, reassuring, grounding, caring, and an important part of the healing process. When discordant with clinical needs, context, competence, or consent, even the most well-intentioned nonsexual

TABLE 16.1 **Ten Common Scenarios**

Scenario	Description
Role Trading	Therapist becomes the "patient" and the wants and needs of the therapist become the focus
Sex Therapy	Therapist fraudulently presents therapist–patient sex as valid treatment for sexual or related difficulties
As If . . .	Therapist treats positive transference as if it were not the result of the therapeutic situation
Svengali	Therapist creates and exploits the dependence of the patient
Drugs	Therapist uses cocaine, alcohol, or other drugs as part of the seduction
Rape	Therapist uses physical force, threats, and/or intimidation
True Love	Therapist uses rationalizations that attempt to discount the clinical/professional nature of the professional relationship and its duties
It Just Got Out of Hand	Therapist fails to treat the emotional closeness that develops in therapy with sufficient attention, care, and respect
Time Out	Therapist fails to acknowledge and take account of the fact that the therapeutic relationship does not cease to exist between scheduled sessions or outside the therapist's office
Hold Me	Therapist exploits patient's desire for nonerotic physical contact and [patient's] possible confusion between erotic and nonerotic contact

physical contact may be experienced as aggressive, frightening, intimidating, demeaning, arrogant, unwanted, insensitive, threatening, or intrusive.

Sexual Attraction to Patients

Like nonsexual touch, sexual feelings about patients seem to have acquired a guilt by association with therapist–patient sex. National studies indicate that *simply experiencing sexual attraction to a client*—without acting on it and without necessarily even feeling tempted to act on it—makes a majority of both social workers and psychologists feel guilty, anxious, and confused (see Pope & Vasquez, 2007). Although a large majority of therapists report feeling sexually attracted to one or more clients, and most also report discomfort with the feelings, these studies also suggest that adequate training in this area is relatively rare. A majority reported no training in the area, and only around 10% of social workers and psychologists reported adequate training in their graduate programs and internships. Gerry Koocher, the 2006 president of the American Psychological Association, asked, "How can the extant population of psychotherapists be expected to adequately address [these issues] if we pay so little attention to training in these matters?" (1994, p. viii).

Pope, Sonne, and Greene (2006) discuss the seemingly taboo nature of sexual feelings about clients as reflecting one of several basic myths about therapists that interfere with training and effective therapy. The myth is

> that *good* therapists (those who don't sexually exploit their patients) never have sexual feelings about their patients, don't become sexually aroused during therapy

> sessions, don't vicariously enjoy the (sometimes) guilty pleasures of their patients' sexual experiences, don't have sexual fantasies or dreams about their patients. (p. 28)

Because of the widespread discomfort with sexual feelings about clients and the inadequacy of training in this area, it is not surprising that many professional books do not focus on this topic.

> In light of the multitude of books in the areas of human sexuality, sexual dynamics, sex therapies, unethical therapist–patient sexual contact, management of the therapist's or patient's sexual behaviors, and so on, it is curious that sexual attraction to patients per se has not served as the primary focus of a wide range of texts. The professor, supervisor, or librarian seeking books that turn their *primary* attention to exploring the therapist's *feelings* in this regard would be hard pressed to assemble a selection from which to choose an appropriate course text. If someone unfamiliar with psychotherapy were to judge the prevalence and significance of therapists' sexual feelings on the basis of the books that focus exclusively on that topic, he or she might conclude that the phenomenon is neither widespread nor important. (Pope, Sonne, & Holroyd, 1993, p. 23)

There may be a circular process at work here: The discomfort about sexual feelings may have fostered a relative absence of books and a lack of adequate training in this area. The relative dearth of books and training may have, in turn, led to further discomfort with the topic.

NONSEXUAL MULTIPLE RELATIONSHIPS AND BOUNDARY ISSUES

You are a social worker providing weekly psychotherapy sessions to an extremely rich and successful CEO, Ms. Chin. Your client is struggling with how to implement her decision to acquire a medium-sized company. When she makes the public announcement that she is buying the company, should she immediately announce the planned lay-offs at the new company or should she take time to try to cushion the blow? It is about this time that you decide to buy some stock in her company. Ms. Chin is so appreciative of your help in sorting through her difficult issues that she asks you if you will attend a special event at her home, a celebration of her installation as the new president of the company. You accept the invitation and, during the all-day celebration, wind up playing tennis with her and some of her friends in the business community, leading to new referrals to your practice and to a weekly tennis game on the courts of her estate. As your practice and the value of your stock holdings grow, you reflect on your choices. Your buying the stock harmed no one, did not disclose confidential information, was not based on illegally obtained information, and, as you think about it, was something you had planned to do all along, even before you heard that Ms. Chen's investment group would be buying a new company. Your weekly visits to Ms. Chen's estate allow you to see her in another setting and interacting with other people—and this provides invaluable information that helps you understand and treat your client. The visits enable you to bond with your client more deeply and in more varied ways, strengthening your working relationship with her and giving you a better basis for your therapy. It is all very proper, and everyone benefits. As you imagine yourself as the therapist in this vignette, do you have any second thoughts?

Sound judgments about nonsexual boundaries always depend on context.

Nonsexual boundary crossings can enrich therapy, serve the treatment plan, and strengthen the therapist–client working relationship. They can also undermine the

> therapy, sever the therapist–patient alliance, and cause immediate or long-term harm to the client. Choices about whether to cross a boundary confront us daily, are often subtle and complex, and can sometimes influence whether therapy progresses, stalls, or ends. (Pope & Keith-Spiegel, 2008, p. 638)

In the 1980s and the early and mid-1990s, the full, often daunting complexity of boundary issues made itself known to the profession through clinical experimentation, research, articles challenging virtually every aspect of the status quo, and open discussion from diverse points of view. A vigorous, wide-ranging, and healthy controversy over therapists' nonsexual multiple relationships and other boundary excursions blossomed. Was it good practice for a therapist to enter into dual professional roles with a client, serving both as a client's therapist and as that client's employer? What about multiple social roles? Is it helpful, hurtful, or completely irrelevant for a therapist to provide therapy to a close friend, spouse, or stepchild? Are there any potential benefits or risks to social outings with a client (meeting for dinner, going to a movie, playing golf, or heading off for a weekend of sightseeing), so long as there is no sexual or romantic involvement? Are financial relationships (say, the therapist borrowing a large sum from a client to buy a new house or car, or inviting a client to invest in the therapist's new business venture) compatible with the therapeutic relationship? What about lending a client money to help pay the rent or buy food and medications, or driving a patient home after a session because she doesn't have a car and can't afford cab fare? Under what circumstances should a therapist accept bartered services or products as payment for therapy sessions?

The 15 years or so from the early 1980s to the mid-1990s saw these and other questions about multiple relationships and boundaries discussed—and often argued—from virtually every point of view, every discipline, and every theoretical orientation. In 1981, for example, Samuel Roll and Leverett Millen presented "A Guide to Violating an Injunction in Psychotherapy: On Seeing Acquaintances as Patients." In her 1988 article on "Dual Role Relationships," ethicist Karen Kitchener provided systematic guidance to readers on the kinds of "counselor–client relationships that are likely to lead to harm and those that are not likely to be harmful" (p. 217). According to Kitchener, the kinds of dual relationships that were most likely to be problematic were those in which there were "(1) incompatibility of expectations between roles; (2) diverging obligations associated with different roles, which increases the potential for loss of objectivity; and (3) increased power and prestige between professionals and consumers, which increases the potential for exploitation" (p. 217). Similarly, in the 1985 edition of their widely used textbook *Ethics in Psychology: Professional Standards and Cases,* Patricia Keith-Spiegel and Gerald Koocher discussed ways in which boundary crossings may be unavoidable in good clinical practice and presented ways to think through the ethical implications of specific dual relationships or other boundary issues. Patrusksa Clarkson, who wrote "In Recognition of Dual Relationships," discussed the "mythical, single relationship" and wrote that "it is impossible for most psychotherapists to avoid all situations in which conflicting interests or multiple roles might exist"(1994, p. 32).

Vincent Rinella and Alvin Gerstein argued that "the underlying moral and ethical rationale for prohibiting dual relationships (DRs) is no longer tenable" (1994, p. 225). Similarly, Robert Ryder and Jeri Hepworth (1990) set forth thoughtful arguments that the AAMFT ethics code should not prohibit dual relationships. Jeanne Adleman and Susan Barrett (1990) took a fresh and creative look, from a feminist perspective, at how to make careful decisions about dual relationships and boundary issues. Laura Brown (1989; see also 1994) examined the implications of boundary decisions from another perspective in "Beyond Thou Shalt Not: Thinking about Ethics in the Lesbian Therapy Community." Ellen Bader (1994) urged that the focus on the duality of roles be replaced by an examination of whether each instance did or did not involve exploitation.

Elisabeth Horst (1989) and Amy Stockman (1990) were among those who explored issues of dual relationships and boundaries in rural settings. Melanie Geyer (1994) examined some of the decision-making principles that had evolved for evaluating multiple relationships and boundary issues in rural settings and adapted them for some of the unique challenges faced by Christian counselors (and counselors for whom other religious faiths are a focus of practice). *Ethics & Behavior* was one of many journals in the 1980s and early 1990s that spotlighted the richness of creative thinking in this area. In 1994, it published a special section in which nine prominent authorities debated sharp disagreements about the issue of boundaries in therapy and explored their contrasting approaches.

The care with which these diverse articles and books in the 1980s and first half of the 1990s examined a diverse array of contextual issues such as the nature of the community (e.g., rural or small town) and the therapist's theoretical orientation, in thinking through whether a specific multiple relationship or boundary crossing was likely to be healing or hurtful, helped develop a more complex appreciation for both the potential benefits and the risks in this area. In 1989, a survey (return rate = 49%) of 1,600 psychiatrists, 1,600 psychologists, and 1,600 social workers found that therapists' behaviors and beliefs about a wide range of dual relationships and other boundary issues tended to be significantly associated with factors such as

1. Therapist's gender
2. Therapist's profession (psychiatrist, psychologist, social worker)
3. Therapist's age
4. Therapist's experience
5. Therapist's marital status
6. Therapist's region of residence
7. Client's gender
8. Practice setting (such as solo or group private practice or outpatient clinic)
9. Practice locale (size of the community)
10. Therapist's theoretical orientation (Borys & Pope, 1989; see also Baer & Murdock, 1995; Gutheil & Brodsky, 2008; Lamb & Catanzaro, 1998; Lamb, Catanzaro, & Moorman, 2004)

Research Leading to a Call for a Change in the APA Ethics Code

The first ethics code of the American Psychological Association was empirically based. APA members responded to a survey asking them what ethical dilemmas they encountered in their day-to-day work. A replication of that survey, performed 50 years after the original, led to a call for a change in the APA ethics code regarding dual relationships.

The second most often reported ethical dilemma that psychologists reported was in the area of blurred, dual, or conflictual relationships. These responses from such a wide range of psychologists led the investigators, Pope and Vetter (1992), to include in their report a call for changes to the APA ethics code in the areas of dual relationships, multiple relationships, and boundary issues so that the ethics code would, for example,

1. define dual relationships more carefully and specify clearly conditions under which they might be therapeutically indicated or acceptable;
2. address clearly and realistically the situations of those who practice in small towns, rural communities, remote locales, and similar contexts (emphasizing that neither

the current code in place at the time nor the draft revision under consideration at that time fully acknowledged or adequately addressed such contexts); and

3. distinguish between dual relationships and accidental or incidental extratherapeutic contacts (e.g., running into a patient at the grocery market or unexpectedly seeing a client at a party) . . . [in order] to address realistically the awkward entanglements into which even the most careful therapist can fall.

The following section from the *American Psychologist* report of the study presents the relevant findings, examples, specific suggestions for changes, and reasoning.

Blurred, Dual, or Conflictual Relationships

The second most frequently described incidents involved maintaining clear, reasonable, and therapeutic boundaries around the professional relationship with a client. In some cases, respondents were troubled by such instances as serving as both "therapist and supervisor for hours for [patient/supervisee's] MFCC [marriage, family, and child counselor] license" or when "an agency hires one of its own clients." In other cases, respondents found dual relationships to be useful "to provide role modeling, nurturing and a giving quality to therapy"; one respondent, for example, believed that providing therapy to couples with whom he has social relationships and who are members of his small church makes sense because he is "able to see how these people interact in group context." In still other cases, respondents reported that it was sometimes difficult to know what constitutes a dual relationship or conflict of interest; for example, "I have employees/supervisees who were former clients and wonder if this is a dual relationship." Similarly, another respondent felt a conflict between his own romantic attraction to a patient's mother and responsibilities to the child who had developed a positive relationship with him:

> I was conducting therapy with a child and soon became aware that there was a mutual attraction between myself and the child's mother. The strategies I had used and my rapport with the child had been positive. Nonetheless, I felt it necessary to refer to avoid a dual relationship (at the cost of the gains that had been made).

Taken as a whole, the incidents suggest, first, that the ethical principles need to define dual relationships more carefully and to note with clarity if and when they are ever therapeutically indicated or acceptable. For example, a statement such as "Minimal or remote relationships are unlikely to violate this standard" ("Draft," 1991, p. 32) may be too vague and ambiguous to be helpful. A psychologist's relationship to a very casual acquaintance whom she or he meets for lunch a few times a year, to an accountant who only does very routine work in filling out her or his tax forms once a year (all such business being conducted by mail), to her or his employer's husband (who has no involvement in the business and with whom the psychologist never socializes), and to a travel agent (who books perhaps one or two flights a year for the psychologist) may constitute relatively minimal or remote relationships. However, will a formal code's assurance that minimal or remote relationships are unlikely to violate the standard provide a clear, practical, valid, and useful basis for ethical deliberation to the psychologist who serves as therapist to all four individuals? Research and the professional literature focusing on nonsexual dual relationships underscores the importance and implications of decisions to enter into or refrain from such activities (e.g., Borys & Pope, 1989; Ethics Committee, 1988; Keith-Spiegel & Koocher, 1985; Pope & Vasquez, 2007; Stromberg et al., 1988).

Second, the principles must address clearly and realistically the situations of those who practice in small towns, rural communities, and other remote locales. Neither the current code nor the current draft revision explicitly acknowledges and adequately addresses such geographic contexts. Forty-one of the dual relationship incidents involved such locales. Many respondents implicitly or explicitly complained that the principles seem to ignore the special conditions in small, self-contained communities. For example,

> I live and maintain a . . . private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that "conventional" people can also feel confidence in. Clients often come to me because they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation, healing, and change. The stricture against dual relationships helps me to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations, but doesn't give me any help in working with the actual circumstances of my practice. I hope revised principles will address these concerns!

Third, the principles need to distinguish between dual relationships and accidental or incidental extratherapeutic contacts (e.g., running into a patient at the grocery market or unexpectedly seeing a client at a party) and to address realistically the awkward entanglements into which even the most careful therapist can fall. For example, a therapist sought to file a formal complaint against some very noisy tenants of a neighboring house. When he did so, he was surprised to discover "that his patient was the owner–landlord." As another example, a respondent reported,

> Six months ago a patient I had been working with for 3 years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along, and continue to do so. Currently they are living together and I referred the patient (who was furious that I did this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I'm currently trying to figure out if we can ever resume our friendship and under what conditions.

The latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients. Although it is impossible to anticipate every pattern of multiple relationship or to account for all the vicissitudes and complexities of life, psychologists need and deserve formal principles that provide lucid, useful, and practical guidance as an aid to professional judgment. (Pope & Vetter, 1992, pp. 400–401)

It is worth emphasizing that the complexity of both therapy itself and specifically of boundary issues can never obscure, erode, or minimize the clinician's inescapable responsibility to maintain boundaries that protect and serve the patient's safety and the goals of therapy. Robert Simon and Daniel Shuman (2007) wrote:

> It is always the therapist's responsibility to maintain appropriate boundaries, no matter how difficult or boundary testing the patient may be. . . . The conduct of

> psychotherapy is an impossible task because there are no perfect therapists and no perfect therapies. Knowing one's boundaries, however, makes the impossible task easier. (p. 212; see also Appelbaum & Gutheil, 2007; Gutheil & Brodsky, 2008)

Some Helpful Guidelines

The topic of multiple relationships and boundary issues is complex and rich with multiple points of view from diverse perspectives. Fortunately for therapists and counselors, there is no shortage of well-informed, thoughtful, practical guides to this area. For those in search of decision-making help as they think through the various issues, here are six highly respected and widely used sets of guidelines:

1. Gottlieb's 1993 guide in "Avoiding Exploitive Dual Relationships: A Decision-Making Model" (*Note:* This set of guidelines is on the Web at http://kspope.com/dual/index.php.)
2. Faulkner and Faulkner's 1997 guide for practice in rural settings in "Managing multiple relationships in rural communities: Neutrality and boundary violations"
3. Lamb and Catanzaro's 1998 model in "Sexual and Nonsexual Boundary Violations Involving Psychologists, Clients, Supervisees, and Students: Implications for Professional Practice"
4. Younggren's 2002 model in "Ethical Decision-Making and Dual Relationships" (*Note:* This set of guidelines is on the web at http://kspope.com/dual/index.php; see also Younggren & Gottlieb, 2004.)
5. Campbell and Gordon's 2003 five-step approach for considering multiple relationships in rural communities in "Acknowledging the Inevitable: Understanding Multiple Relationships in Rural Practice"
6. Sonne's 2006 "Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians" (*Note:* This set of guidelines is on the web at http://kspope.com/dual/index.php.)

For those seeking guidance in internship settings, Burian and Slimp (2000) wrote a helpful article titled "Social Dual-Role Relationships during Internship: A Decision-making Model" (see also Slimp & Burian, 1994).

Finally, published articles, standards, research studies, some of the widely used guides mentioned above, and other resources in the area of multiple relationships and other boundary issues are online at http://kspope.com/dual/index.php.

On Not Overlooking How Difficult This Topic Tends to Be for Us

In closing this section, it's worth noting what a vexing challenge this area is for mental health practitioners. Part of the problem is the difficulty of psychotherapy itself. We can never go on automatic pilot, never let the formal standards and guidelines do our thinking for us, and never let the general principles obscure the uniqueness of every therapeutic encounter.

> Awareness of the ethics codes is crucial to competence in the area of ethics, but the formal standards are not a substitute for an active, deliberative, and creative approach to fulfilling our ethical responsibilities. They prompt, guide, and inform

> our ethical consideration; they do not preclude or serve as a substitute for it. There is no way that the codes and principles can be effectively followed or applied in a rote, thoughtless manner. Each new client, whatever his or her similarities to previous clients, is a unique individual. Each situation also is unique and is likely to change significantly over time. The explicit codes and principles may designate many possible approaches as clearly unethical. They may identify with greater or lesser degrees of clarity the types of ethical concerns that are likely to be especially significant, but they cannot tell us how these concerns will manifest themselves in a particular clinical situation. They may set forth essential tasks that we must fulfill, but they cannot tell us how we can accomplish these tasks with a unique client facing unique problems. . . . There is no legitimate way to avoid these struggles. (Pope & Vasquez, 1998)

But another part of the difficulty is the topic itself, how often we jump to conclusions, rely on stereotypes, or fail to consider carefully what is actually occurring rather than what seems to be happening. Former APA president Gerry Koocher (2006) provides a vivid example of how others tend to react when he tells them about crossing time boundaries (i.e., letting a session run far beyond its schedule), financial boundaries (i.e., not charging), and other boundaries with one of his clients.

> On occasion I tell my students and professional audiences that I once spent an entire psychotherapy session holding hands with a 26-year-old woman together in a quiet darkened room. That disclosure usually elicits more than a few gasps and grimaces. When I add that I could not bring myself to end the session after 50 minutes and stayed with the young woman holding hands for another half hour, and when I add the fact that I never billed for the extra time, eyes roll.
>
> Then, I explain that the young woman had cystic fibrosis with severe pulmonary disease and panic-inducing air hunger. She had to struggle through three breaths on an oxygen line before she could speak a sentence. I had come into her room, sat down by her bedside, and asked how I might help her. She grabbed my hand and said, "Don't let go." When the time came for another appointment, I called a nurse to take my place. By this point in my story most listeners, who had felt critical of or offended by the "hand holding," have moved from an assumption of sexualized impropriety to one of empathy and compassion. The real message of the anecdote, however, lies in the fact that I never learned this behavior in a classroom. No description of such an intervention exists in any treatment manual or tome on empirically based psychotherapy. (p. xxii)

Setting appropriate boundaries and limits presents vexing dilemmas for all therapists. Consider the following situations and discuss how you would respond:

- Several of your clients ask to follow you on Twitter and to be listed as a friend on Facebook.
- A longtime client dies, and her sister asks you to say a few words at your client's funeral.
- Your client, a travel agent, offers you a free upgrade to first class when you are only paying for an economy-class seat.

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- A patient you have seen for many years commits suicide, and the patient's sister—a trial attorney who has been paying the bills for therapy for many years—asks to have a private session to "get closure on David's death."
- A client reveals that she is in fact "Maria," a woman you have been flirting with on an Internet dating site for the past 2 months.
- A state trooper—who also happens to be one of your clients—stops you for speeding, but tells you he is only going to give you a warning ticket because you've helped him so much in therapy.

ACCESSIBILITY AND PEOPLE WITH DISABILITIES

You are a therapist with a thriving practice in a large city. You see clients in a large suite atop a high-rise office building, with a magnificent view of the city. There is a new client who will be showing up that evening for an initial session. The office building closes and locks its doors at 5 p.m. each day, but both heating in winter and air conditioning in summer remain on until 10 p.m., and at the top of the front steps is a call-box system allowing people outside to call the phone in any of the offices to ask to be buzzed in. The new client never shows up at your office. It is only the next day that you learn that the client is blind. Finding the front door locked, he was unable to locate a way to enter the building. There were no instructions in Braille or any other indications of how to gain access to the building that would be perceived by someone who was blind or had any form of severely impaired vision. As you consider this situation, the phone rings. It is someone whose initial appointment is scheduled to begin 5 minutes from now. She is calling with her cell phone. She is outside your building but does not know how to enter. She uses a wheelchair for mobility and is unable to use the front steps that lead up to your building's front door. What are your feelings as you imagine yourself the therapist in this vignette? What do you think you would say to these two people? What, if anything, do you wish you had done differently?

This vignette illustrates two of the many ways in which psychotherapists and their offices may be blocked off from people with disabilities. These physical barriers may shut out many people. Psychologist Martha Banks noted that

> Approximately one-fifth of U.S. citizens have disabilities. The percentage is slightly higher among women and girls (21.3%) than among men and boys (19.8%). Among women, Native American women and African American women have the highest percentages of disabilities. . . . As a result of limited access to funds, more than one-third of women with work disabilities and more than 40% of those with severe work disabilities are living in poverty . . . (2003, p. xxiii)

Individual therapists and the profession as a whole face the challenge of identifying the barriers that screen out people with disabilities or that make it unnecessarily difficult for them to become therapists or to find appropriate therapeutic services. Think back to the classrooms, lecture halls, and therapy offices you have seen. Would a person using a wheelchair or walker find reasonable access to those places? Would a person who is blind or has severe visual impairment experience unnecessary hardships in navigating those buildings? For additional information and strategies to identify and address issues of physical access, see Pope (2005), Chapter 4, in *How to Survive and Thrive as a Therapist: Information, Ideas, and Resources for Psychologists* (Pope & Vasquez, 2005), and the Web site *Accessibility & Disability Information & Resources in Psychology Training & Practice* at http://kpope.com.

In addition to the challenge of identifying and addressing physical barriers is the challenge of providing adequate training. A survey of American Psychological Association members by Irene Leigh and her colleagues found reports of problems resulting from lack of adequate training.

> "A deaf woman [was] diagnosed as having schizophrenia by a mental health agency because she flailed her arms around; she was signing." Another respondent indicated that a child with hearing impairment had been misdiagnosed with mental retardation. With regard to test interpretation, a respondent reported that a provider administered a short version of the Minnesota Multiphasic Personality Inventory and did not take into consideration how disability might affect some responses such as "I have difficulty standing or walking." Other examples . . . included providers not using an interpreter and provider refusal to treat persons with disabilities. (Leigh, Powers, Vash, & Nettles, 2004)

Similarly, in "Impact of Professional Training on Case Conceptualization of Clients with a Disability," Nancy Kemp and Brent Mallinckrodt (1996) reported the results of their study:

> Therapists gave different priorities to treatment themes depending on whether the client had a disability and whether they, the therapists, had received any training in disability issues. Untrained therapists were more likely to focus on extraneous issues and less likely to focus on appropriate themes for a sexual abuse survivor with a disability (p. 378).

Among the findings were that "even a small amount of training on issues of disability may be associated with significantly less bias in case conceptualization and treatment planning" (p. 383).

Unfortunately, studies of how therapists are trained suggest that we have a long way to go in meeting these challenges. In "ADA Accommodation of Therapists with Disabilities in Clinical Training," Hendrika Kemp and her colleagues noted that

> Despite the obvious need . . . disability is not a standard part of clinical training. . . . We found that of the 618 internship sites recently listed on the APPIC web-site, only 81 listed a disabilities rotation. . . . The picture is even bleaker when we examine how training sites accommodate clinicians with disabilities. (Kemp, Chen, Erickson, & Friesen, 2003)

DETAINEE INTERROGATIONS

Scenario One

You are a therapist in independent practice. Several government officials arrive at your office to explain that one of your clients has been placed in a high-security center for questioning. The Department of Homeland Security has reason to believe that your client has knowledge of a terrorist network planning a massive attack. An interrogation team hopes to obtain enough information from your client, who has so far refused to discuss the topic, in time to prevent the attack. Emphasizing that lives are at stake and there is not a moment to waste, the officials ask for your client's evaluation and treatment records so that they can be faxed immediately to the interrogation team. They ask you to accompany them to the holding center so that the interrogation team can consult with you about the strategies most likely to gain the client's trust and persuade him to cooperate. They also ask you to talk with your client because he trusts you. When you hesitate, they stress that the attack

may be only a matter of hours away, that surely you would not want to be the one person who could have prevented the attack and whose delay or refusal to help resulted in widespread death and destruction.

What ethical issues does this scenario raise? What reasons would you give for cooperating fully, cooperating in some ways but not in others, or refusing to cooperate with the government officials?

Scenario Two

You are a military psychologist transferred to a detention center holding those suspected of being enemy combatants, unlawful combatants, and others who pose a threat to national security. You are ordered to use interviews and other appropriate methods to prepare psychological profiles of several detainees so that they may be interrogated effectively.

What ethical issues, if any, does this scenario present? Would you have concerns about any aspects of your participation?

Should psychologists, psychiatrists, and other mental health care specialists participate in the planning or implementation of detainee interrogations? Does this kind of work compromise the profession's ethical values, or do the special skills, training, and values of health care professionals help to ensure that interrogations are safe, effective, and ethical? Are the consequences of undertaking this work foreseeable and clear, or are there unexpected complications and unintended consequences?

Such questions confronted the professions with a striking urgency when, in the aftermath of 9/11, reports began to surface that some interrogators were using methods characterized as enhanced or extreme. Professional organizations created formal policies endorsing or prohibiting members' participation in detainee interrogations.

In 2005, the president of the American Psychological Association appointed a Presidential Task Force on Psychological Ethics and National Security [PENS]. The PENS Task Force Report (APA, 2005) did not prohibit psychologists from involvement in detainee interrogations but specified various limits. For example, psychologists could use medical records in some ways but not others for detainee interrogations:

> Psychologists who serve in the role of supporting an interrogation do not use health care related information from an individual's medical record to the detriment of the individual's safety and well-being. While information from a medical record may be helpful or necessary to ensure that an interrogation process remains safe, psychologists do not use such information to the detriment of an individual's safety and well-being. (APA, 2005, p. 4)

The PENS Report left several issues open because members were unable to reach consensus. For example, although it permitted psychologists not to disclose what they are doing or why, there was no agreement about prohibiting how far a psychologist could go in disguising his or her role in interrogations:

> While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly. (APA, 2005, p. 9)

The American Psychological Association took the position that psychologists were playing a key role in detainee interrogations because the interrogations were inherently a psychological process requiring psychological expertise. The "Statement of the

American Psychological Association on Psychology and Interrogations Submitted to the United States Senate Select Committee on Intelligence" stated:

> Conducting an interrogation is inherently a psychological endeavor. . . . Psychology is central to this process because an understanding of an individual's belief systems, desires, motivations, culture and religion likely will be essential in assessing how best to form a connection and facilitate educing accurate, reliable and actionable intelligence. Psychologists have expertise in human behavior, motivations and relationships. . . . Psychologists have valuable contributions to make toward . . . protecting our nation's security through interrogation processes. (APA, 2007b)

Psychologists' special expertise sets them apart, according to the American Psychological Association, from psychiatrists and other physicians. The Director of the APA Ethics Office wrote: "This difference, which stems from psychologists' unique competencies, represents an important distinction between what role psychologists and physicians may take in interrogations" (Behnke, 2006, p. 66).

Adopting a starkly different policy, the American Psychiatric Association's Board of Trustees and the Assembly of District Branches approved a clear prohibition:

> No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees (American Psychiatric Association, 2006).

Similarly, the American Medical Association prohibited participation in detainee interrogations to such a degree that they banned even monitoring an interrogation with an intent to intervene (Moran, 2006; Ray, 2006).

Why did the American Psychiatric Association and the American Medical Association adopt an approach to involvement in detainee interrogations that differed so sharply from the American Psychological Association's policy? As noted earlier, the American Psychological Association presented the difference as one of "unique competencies." The American Psychiatric Association, however, viewed the difference as one of ethical values. Discussing psychiatrists' "core values," American Psychiatric Association president Steven Sharfstein (2006) wrote:

> I told the generals that psychiatrists will not participate in the interrogation of persons held in custody. Psychologists, by contrast, had issued a position statement allowing consultations in interrogations. If you were ever wondering what makes us different from psychologists, here it is. This is a paramount challenge to our ethics and our Hippocratic training. Judging from the record of the actual treatment of detainees, it is the thinnest of thin lines that separates such consultation from involvement in facilitating deception and cruel and degrading treatment. Innocent people being released from Guantanamo—people who never were our enemies and had no useful information in the War on Terror—are returning to their homes and families bearing terrible internal scars. Our profession is lost if we play any role in inflicting these wounds. (p. 1713)

The American Psychiatric Association's stance distancing itself from the detainee interrogations at Guantanamo and prohibiting members from participation, in contrast to the American Psychological Association's emphasis on its unique competencies in interrogation and the value of its contributions to the interrogations, led the Pentagon to adopt a new policy in 2006 that focused solely on psychologists, rather than including

psychiatrists, for help in developing strategies for interrogating detainees. *The New York Times* reported:

> Pentagon officials said Tuesday they would try to use only psychologists, not psychiatrists, to help interrogators devise strategies to get information from detainees at places like Guantánamo Bay, Cuba. The new policy follows by little more than two weeks an overwhelming vote by the American Psychiatric Association discouraging its members from participating in those efforts. Stephen Behnke, director of ethics for the counterpart group for psychologists, the American Psychological Association, said psychologists knew not to participate in activities that harmed detainees. But he also said the group believed that helping military interrogators made a valuable contribution . . . (Lewis, 2006)

What were the effects of psychologists' participation in detainee interrogations? The American Psychological Association emphasized important benefits such as psychologists' knowing "not to participate in activities that harmed detainees" and their "valuable contributions" toward "protecting our nation's security through interrogation processes." In 2007, the president of the American Psychological Association wrote: "The Association's position is rooted in our belief that having psychologists consult with interrogation teams makes an important contribution toward keeping interrogations safe and ethical."

It is worth noting, however, that some reports suggested that the effects of psychologists' involvement were not all positive. Eban (2007; see also Goodman, 2007), for example, documented ways in which "psychologists weren't merely complicit in America's aggressive new interrogation regime. Psychologists, working in secrecy, had actually designed the tactics and trained interrogators in them . . ." According to the Associated Press, "Military psychologists were enlisted to help develop more aggressive interrogation methods, including snarling dogs, forced nudity and long periods of standing, against terrorism suspects, according to a Senate investigation." Mayer (2008) reported: "[General] Dunlavey soon drafted military psychologists to play direct roles in breaking detainees down. The psychologists were both treating the detainees clinically and advising interrogators on how to manipulate them and exploit their phobias . . ." After publishing a series of investigative reports, the *Boston Globe* (2008) stated: "From the moment US military and civilian officials began detaining and interrogating Guantanamo Bay prisoners with methods that the Red Cross has called tantamount to torture, they have had the assistance of psychologists."

The sharp disagreements over interpretations of the effects of psychologists' participation in detainee interrogations is exemplified by the contrasting reactions to a set of government documents obtained by the American Civil Liberties Union (ACLU). The ACLU released the documents under the heading: "Newly Unredacted Report Confirms Psychologists Supported Illegal Interrogations in Iraq and Afghanistan." The ACLU disagreed with the view that the Director of the APA Ethics Office had expressed:

> We do not, however, agree with your conclusion that documents recently obtained by the ACLU through its Freedom of Information Act Litigation demonstrate that the APA's 'policy of engagement served the intended purpose'. . . . Rather, we are deeply concerned by the fact that, viewed in context, these documents warrant the opposite conclusion. (Romero, 2008)

APA's controversial policies attracted sharp criticism. The editor of *British Medical Journal* wrote that APA's approach was shocking (Goddlee, 2009). Amnesty International, Physicians for Human Rights, and 11 other organizations (2009) sent an open letter to APA describing necessary steps to acknowledge and confront "the terrible stain on . . . American psychology."

Here is an excerpt:

> Any meaningful approach to this issue must start by acknowledging the fact that psychologists were absolutely integral. . . . When the Bush administration decided to engage in torture, they turned to psychologists. . . . American Psychological Association] leadership has much work ahead to begin to repair the harm they have caused to the profession, the country, former and current detainees and their families.

The American Psychological Association has not yet reached a final or complete resolution of the complex and difficult issues underlying psychologists' participation in detainee interrogations. In 2008, the APA membership formally approved a petition that prohibited psychologists from working in some settings. APA's press release stated:

> The petition resolution stating that psychologists may not work in settings where "persons are held outside of, or in violation of, either International Law (e.g., the UN Convention Against Torture and the Geneva Conventions) or the US Constitution (where appropriate), unless they are working directly for the persons being detained or for an independent third party working to protect human rights" was approved by a vote of the APA membership. (APA, 2008a)

APA had previously stated that this new resolution would not be enforceable. Prior to the vote, the APA Office of Public Affairs had issued a fact sheet in the form of a Q & A: "Petition on Psychologists' Work Settings: Questions and Answers." APA's response to the question "If adopted would the petition be enforceable by APA?" included the following clarification: "As explained above, the petition would not become part of the APA Ethics Code nor be enforceable as are prohibitions set forth in the Ethics Code" (APA 2008b).

Working our way through these difficult issues, to which there are no easy answers, will require a careful review of the available documents, evidence, and arguments; critical thinking coupled with a willingness to consider contrary views; and open discussion. Some works presenting basic information, reviews, and/or analysis include APA (2005, 2007b, 2008a, 2008b), Levine (2007), Pope & Gutheil (2009a, 2009b), and Soldz (2009). A comprehensive online archive of more than 320 citations of articles, chapters, and books representing the full range of views of the controversy over psychologists, psychiatrists, and other health care professionals participating in the planning or implementation of detainee interrogations is available at http://kspope.com/interrogation/index.php.

CULTURES

You are a marriage and family counselor who works in a large mental health clinic. One client immigrated to the United States from another country and has learned enough English to communicate adequately during therapy. During the fourth session, the client says, "As you know, I come from another culture and I was wondering: Do you think that your own culture and the culture of this clinic have any effects on me and my therapy? For example, I notice that all the therapists and administrators in this clinic seem to be of the same race, while the people who clean the building and take care of the grounds all seem to be of a different race. Why do you think that is and do you think it has any effects on what happens between us in my therapy?"

How do you think you would respond to the client? What are your thoughts about how a therapist's culture and a mental health organization's culture might affect individual clients and the therapeutic process? How would you design a research study to explore the possible effects of culture on therapy, therapists, and clients? What hypotheses would you

advance? When you imagined this situation, what country did you imagine the client emigrated from? What race was the client? The therapist? The cleaning staff? Why did these particular images come to mind?

The United States is a diverse nation enriched by the presence of many different cultures. However, cultural differences between therapist and client can sometimes pose significant challenges to everyone involved. One of the most obvious challenges occurs when the cultures speak different languages. In "Language Barriers to Health Care in the United States," Glen Flores (2006) writes,

> Some 49.6 million Americans (18.7 percent of U.S. residents) speak a language other than English at home; 22.3 million (8.4 percent) have limited English proficiency, speaking English less than "very well," according to self-ratings. Between 1990 and 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million (a 47 percent increase), and the number with limited English proficiency grew by 7.3 million (a 53 percent increase . . .). The numbers are particularly high in some places: in 2000, 40 percent of Californians and 75 percent of Miami residents spoke a language other than English at home, and 20 percent of Californians and 47 percent of Miami residents had limited English proficiency. (pp. 229–230)

Even when therapist and patient both speak the same language (Spanish or Chinese, for example), each language may have many dialects that can prevent clear communication. And furthermore, "variations in language barriers experienced by immigrant groups are often reflective of differences in the local migration histories and socioeconomic status of these groups" (Kretsedemas, 2005, p. 109).

In addition to language challenges are the challenges imposed when the research studies that inform our understanding overlook potentially significant cultural and other group differences. For example, Beverly Greene (1997) notes:

> A preponderance of the empirical research on or with lesbians and gay men has been conducted with overwhelmingly white, middle-class respondents. . . . Similarly, research on members of ethnic minority groups rarely acknowledges differences in sexual orientation among group members. Hence there has been little exploration of the complex interaction between sexual orientation and ethnic identity development, nor have the realistic social tasks and stressors that are a component of gay and lesbian identity formation in conjunction with ethnic identity formation been taken into account. Discussion of the vicissitudes of racism and ethnic identity in intra- and interracial couples of the same gender and their effects on these couples' relationships has also been neglected in the narrow focus on heterosexual relationships found in the literature on ethnic minority clients. There has been an equally narrow focus on predominantly white couples in the gay and lesbian literature. (pp. 216–217)

Research that does take into account cultural complexity suggests that culture may sometimes play a significant role in the development of psychological disorders. Jeanne Miranda (2006) wrote,

> Rates of depression and substance abuse disorders are low among Mexican Americans born in Mexico (Vega et al., 1998), and immigrant Mexican American women have a lifetime rate of depression of 8%, similar to the rates of nonimmigrant Mexicans (Vega et al., 1998). However, after 13 years in the United States, rates of depression for those women who immigrated to the U.S. rise precipitously. U.S.-born women of Mexican heritage experience lifetime rates of depression similar to those of the White population in the United States, nearly twice the rate of immigrants. These findings are mirrored in other indicators of health. . . . Despite high rates of

> poverty, Mexican American immigrant women have low rates of physical and mental health problems (Vega et al., 1998), Chinese American immigrant women have a lifetime rate of major depression near 7%, approximately half that of White women (Takeuchi et al., 1998). These results suggest that some aspects of culture protect against depression. (pp. 115–116)

Shankar Vedantam (2005) provides other examples of how culture and other group differences may influence mental health:

- Patients with schizophrenia, a disease characterized by hallucinations and disorganized thinking, recover sooner and function better in poor countries with strong extended family ties than in the United States, two long-running studies by the World Health Organization have shown.
- People of Mexican descent born in the United States have twice the risk of disorders such as depression and anxiety, and four times the risk of drug abuse, compared with recent immigrants from Mexico. This finding is part of a growing body of literature that indicates that the newly arrived are more resilient to mental disorders, and that assimilation is associated with higher rates of psychiatric diagnoses.
- Black and Hispanic patients are more than three times as likely to be diagnosed with schizophrenia as White patients—even though studies indicate that the rate of the disorder is the same in all groups.
- White women in the United States are three times as likely to commit suicide as Black and Hispanic women—a difference that experts attribute in part to the relative strengths of different social networks.
- A host of small studies suggest that the effects of psychiatric drugs vary widely across different ethnic groups. There are even differences in the effect with dummy pills.

It is crucial to remember that even though any names and descriptions we might use to identify cultures, groups, and similar characteristics relevant to a client may help us understand the client's words, experiences, and behavior, they are *not* a substitute for learning directly from and about this unique individual. Individual differences within a group may overwhelm between-group differences, and an individual within a group may not reflect group characteristics. Any attempt to view, describe, or understand a person as the sum of a fixed set of descriptors oversimplifies in ways that are misleading. The descriptors themselves may not be as clear as some of the research seems to assume. As Connie Chan (1997) puts it,

> Although identity is a fluid concept in psychological and sociological terms, we tend to speak of identities in fixed terms. In particular, those aspects of identity that characterize observable physical characteristics, such as race or gender, are perceived as unchanging ascribed identities. Examples of these would include identifications such as *Chinese woman,* or *Korean American woman,* or even broader terms such as *woman of color,* which are ways of grouping together individuals who are not of the hegemonic "white" race in the United States. We base these constructions of identity upon physical appearance and an individual's declaration of identity. However, even these seemingly clear distinctions are not definitive. For example, I, as a woman of Asian racial background, may declare myself a woman of color because I see myself as belonging to a group of ethnic/racial minorities. However, my (biological) sister could insist that she is not a woman of color because she does not feel an affiliation with our group goals, even though she is a person of Chinese ancestry. Does her nonaffiliation take her out of the group of people of color? Or does she remain in regardless of her own self-identification because of her obvious physical characteristics? Generally, in the context of identities based upon racial and physical characteristics,

> ascribed identities will, rightly or wrongly, continue to be attributed to individuals by others. It is left up to individuals themselves to assert their identities and demonstrate to others that they are or are *not* what they might appear to be upon first notice. (pp. 240–241; see also Wyatt, 1997)

It is also crucial that therapists be aware not only of the client's culture but also of the therapist's own culture and how it influences the therapist's values, frameworks, theoretical orientation, understanding, and decisions. An exceptional book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (Fadiman, 1997) documents in vivid detail the efforts of health care professionals at a California hospital and a refugee family from Laos to help a Hmong child whom the health care professionals had determined was experiencing epileptic seizures. Despite the great expertise and dedication of the girl's physicians, the failure to take culture into account had disastrous consequences. Medical anthropologist Arthur Kleinman is quoted in the book:

> As powerful an influence as the culture of the Hmong patient and her family is on this case, the culture of biomedicine is equally powerful. If you can't see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture? (p. 261)

Kleinman addresses the effects of culture, such as the culture of biomedicine, in more detail in an article (2004) in the *New England Journal of Medicine:*

> The culture of biomedicine is also responsible for some of the uncertainty surrounding depression. Symptoms that represent a depressive disorder for the practitioner (say, sadness and hopelessness in a patient dying from cancer) may not denote a medical problem to the patient, his or her family, or their clergy, for whom depression may be a sign of the moral experience of suffering. What is seen by a particular social network as a normal emotional response—say, grief lasting for years—may count as a depressive disorder for the psychiatrist, since the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV), defines normal bereavement as lasting for two months. In this area, the professional culture, driven by the political economy of the pharmaceutical industry, may represent the leading edge of a worldwide shift in norms.
>
> Yet many people with clinical depression—at least 50 percent among immigrants and minority groups in the United States—still receive neither a diagnosis nor treatment from a biomedical practitioner. Lack of access to appropriate services is a major reason for this failure, but cultural causes of misdiagnosis also contribute. Culture confounds diagnosis and management by influencing not only the experience of depression, but also the seeking of help, patient–practitioner communication, and professional practice. Culture also affects the interaction of risk factors with social supports and protective psychological factors that contribute to depression in the first place. Culture may even turn out to create distinctive environments for gene expression and physiological reaction, resulting in a local biology of depression: research already shows that persons from various ethnic backgrounds metabolize antidepressant drugs in distinct ways. (pp. 951–952)

Melba Vasquez (2007; see also Comas-Diaz, 2006; Sue & Sue, 2007; Sue et al., 2006) provides an evidence-based analysis of the ways in which cultural differences can affect the therapeutic alliance specifically and therapy more generally. Lillian Comas-Dias explores the relationship between culture and psychotherapy more fully in Chapter 15 of this book.

The same question arises here as with the other challenges and controversies noted in this chapter: Are we addressing these issues adequately in our training programs? Research conducted by Nancy Hansen and her colleagues (2006) suggests that we may need to pay more attention to issues of culture in our graduate programs, practica, internships, and other educational settings to develop competencies in this area and the ability to follow through. Hansen and colleagues' "Do We Practice What We Preach?" provides the results of a survey that found that "Overall and for 86% of the individual items, participants did not practice what they preached" (p. 66) in terms of what they endorsed as the need for multicultural competencies. Hansen and her colleagues concluded that

> psychotherapists need to recognize their vulnerability to not following through with what they know to be competent practice, and they need, in advance, to problem solve creative solutions. It would be helpful to identify your personal barriers in this regard: Are you anxious about raising certain issues with racially/ethnically different clients? Are you uncertain about how best to intervene? Do you fear you will "get in over your head" exploring these issues? What will it take to work through (or around) these barriers to become more racially/ethnically responsive in your psychotherapy work? (Hansen et al., 2006, p. 72)

Taking seriously the reality that *every* therapist is influenced by culture and *every* client is influenced by culture saves us from the misleading stereotype that multicultural counseling is something you need to know about only if you happen to find yourself working with someone from a different country, say, or someone of a different ethnicity who speaks a different language. As Pedersen, Draguns, Lonner, and Trimble (1989, p. 1) remind us in *Counseling Across Cultures:* "Multicultural counseling is not an exotic topic that applies to remote regions, but is the heart and core of good counseling with any client."

GLOSSARY

The following abbreviations are used to indicate primary associations: (AD) Adlerian Psychotherapy; (AP) Analytical Psychotherapy; (BT) Behavior Therapy; (CC) Client-Centered Therapy; (CN) Contemplative Psychotherapy; (CT) Cognitive Therapy; (EX) Existential Therapy; (FT) Family Therapy; (GT) Gestalt Therapy; (INT) Integrative Therapy; (IPT) Interpersonal Psychotherapy; (MC) Multicultural Psychotherapy; (PA) Psychoanalysis; (REBT) Rational Emotive Behavior Therapy.

Abreaction (PA) The reliving or recovery of painful, repressed emotional experiences in psychotherapy, accompanied by a discharge of affect or intense feelings. *See also* Catharsis.

Acceptance and Commitment Therapy (BT) A form of behavior therapy developed by Steven Hayes that focuses on experiential avoidance and cognitive fusion as key determinants of psychopathology and commitment as one component of therapeutic success.

Active Imagination (AP) A form of reflection through which people activate and follow their imaginative reveries in a purposive way.

Activity Scheduling (CT, BT) Setting up routine activity in order to offset inertia.

Actualizing Tendency (CC) An innate human predisposition toward growth and fulfilling one's potential.

Agape Unconditional love for humanity (literally, "love between friends").

Aggression (GT) The basic biological movement of energy extending out from the organism to the environment. Aggression is required for assimilation, love, assertion, creativity, hunger, humor, discrimination, warmth, etc.

Agoraphobia An excessive fear of open spaces and/or leaving one's own home.

Aha! (GT) Awareness of a situation in which a number of separate elements come together to form a meaningful whole; sudden insight into the solution to a problem or the structure of a situation.

Albert Ellis Institute (REBT) An organization founded by Albert Ellis in 1959. There was considerable controversy in psychotherapy circles in 2005 when the Institute removed Albert Ellis from the Board.

Albert Ellis Foundation (REBT) An organization established in 2006 to support the work and legacy of Albert Ellis.

Anal Phase (PA) Freud's second phase of psychosexual development, extending roughly from 18 months to 3 years of age, in which most libidinal pleasure is derived from retaining and expelling feces.

Anima (AP) A feminine archetypal image that serves as a bridge to the unconscious in both men and women, but is most often expressed as the feminine part of a man. *See also* Animus.

Animus (AP) A masculine archetypal image that serves as a bridge to the unconscious in both men and women, but is most often expressed as the masculine part of a woman. *See also* Anima.

Anorectic A person engaging in self-starving behavior.

Antisuggestion (AD) *See* Paradoxical Intervention.

Aphasia An organic speech deficit involving difficulty understanding or using language.

Applied Behavior Analysis (BT) A form of behavior therapy, closely tied to Skinner's philosophy of radical behaviorism, that stresses observable behavior rather than private events and uses single-subject experimental design to determine the relationship between behavior and its antecedents and consequences.

Arbitrary Inference (CT) Drawing conclusions without supporting evidence or despite evidence to the contrary.

Archetype (AP) An innate universal pattern or organizing principle similar to an instinct. It has no specific form but can be seen through archetypal images observable in the common motifs present in myths, fairy tales, legends, and dreams across cultures and times. Examples include the Earth Mother, the Wise Old Man, the Hero's Quest, the Shadow, and the Trickster.

Armamentarium The complete range of psychotherapeutic methods and techniques used by a therapist.

Assertion Training (BT) A treatment procedure designed to teach clients to openly and effectively express both positive and negative feelings.

Assimilation (GT) The process of breaking something into component parts so that these parts can be accepted and made part of the person, rejected, or modified into suitable form.

Assimilative Integration (INT) An approach to psychotherapy integration that entails a firm grounding in one system of psychotherapy, but with a willingness to selectively incorporate (assimilate) practices and views from other systems.

Attachment Theory (FT, IPT) A theory developed by John Bowlby, who proposed that all humans have an innate tendency to develop strong affectional

bonds and that threat to these bonds resulted in psychopathology.

Authentic Mode (EX) A way of being described by Heidegger in which one understands and appreciates the fragility of being while acknowledging responsibility for one's own life. Also referred to as the *Ontological Mode*.

Autoeroticism (PA) Obtaining gratification from self-stimulating a sensual area of the body.

Automatic Thought (CT) A personal notion or idea triggered by particular stimuli that lead to an emotional response.

Autonomy A personality dimension based on needs to be independent, to be self-determining, and to attain one's goals.

Auxiliary A person who aids a therapist or client in enacting a particular scene.

Aversive Racism (MC) A theory proposed by Gaertner & Dovidio that maintains that Whites can sincerely endorse egalitarian values while at the same time being racist and harboring unacknowledged negative attitudes toward racial/ethnic out-groups.

Awfulizing (REBT) Seeing something inconvenient or obnoxious as awful, horrible, or terrible.

Basic Encounter (CC) One member of a group's responding with empathy to another member's being genuine and real.

Basic Mistake (AD) Myth used to organize and shape one's life. Examples include overgeneralizations, a desperate need for security, misperceptions of life's demands, denial of one's worth, and faulty values.

Behavioral Experiment (CT, REBT) Testing distorted beliefs or fears scientifically in a real-life situation (e.g., having a shy person initiate a conversation to see what actually happens).

Behavioral Medicine (BT) Applying learning theory techniques to prevent or treat physical problems (e.g., pain reduction, weight loss).

Behavioral Rehearsal (CT, BT) Practicing an emotionally charged event and one's response to it prior to its actual occurrence.

Belonging (AD, BT) An innate need, drive, and source of human behavior. It leads people to seek relationship and involvement with other human beings.

Boundary (FT) A barrier between parts of a system, as in a family, in which rules establish who may participate and in what manner.

Catastrophizing (REBT, CT) Exaggerating the consequences of an unfortunate event.

Catharsis The expression and discharge of repressed emotions; sometimes used as a synonym for *abreaction*.

Cathexis (PA) Investment of mental or emotional (libidinal) energy into a person, object, or idea.

Circular Causality (FT) The feedback model of a network of interacting loops that views any causal event as the effect of a prior cause, as in family interactions.

Circular Questioning (FT) An interviewing technique directed at eliciting differences in perceptions about events or relationships from different family members, especially regarding those points in the family life cycle when significant coalition shifts occur.

Classical Conditioning (BT) A form of learning in which existing responses are attached to new stimuli by pairing those stimuli with those that naturally elicit the response; also referred to as *respondent conditioning*.

Closed System (FT) A self-contained system that has impermeable boundaries and thus is resistant to new information and change.

Cognitive Behavior Modification (BT) A recent extension of behavior therapy that treats thoughts and cognition as behaviors amenable to behavioral procedures. Cognitive behavior modification is most closely associated with the work of Aaron Beck, Albert Ellis, and Donald Meichenbaum.

Cognitive Distortion (CT) Pervasive and systematic errors in reasoning.

Cognitive Restructuring (AD, BT, REBT) An active attempt to alter maladaptive thought patterns and replace them with more adaptive cognitions.

Cognitive Shift (CT) A systematic and biased interpretation of life experiences.

Cognitive Triad (CT) Negative views of the self, the world, and the future that characterize depression.

Cognitive Vulnerability (CT) Individual ways of thinking that predispose one to particular psychological distress.

Collaborative Empiricism (CT) A strategy of seeing the patient as a scientist capable of objective interpretation.

Collective Unconscious (AP) The part of the unconscious that is universal in humans, in contrast to the personal unconscious belonging to individual experience. The contents of the collective unconscious come into consciousness through archetypal images or basic motifs common to all people. *See also* Personal Unconscious.

Common Factors Approach (INT) An approach that seeks to determine and apply the core ingredients different therapies share, predicated on the assumption that commonalities across therapies account for more of the variance in therapeutic success than do unique factors. Common factors include the therapeutic alliance, catharsis, acquisition of new behaviors, and positive expectations.

Complex (AP) An energy-filled cluster of emotions and ideas circling a specific subject. A complex has an archetypal core but expresses aspects of the personal unconscious. Jung's discovery and explanation of the complex lent validity to Freud's belief in the personal unconscious.

Conditional Assumption (CT) An erroneous "if then" interpretation of events that leads to an erroneous conclusion (e.g., "*If* one person dislikes me, *then* I am not likable").

Confluence (GT) A state in which the contact boundary becomes so thin, flexible, and permeable that the distinction between self and environment is lost. In confluence, one does not experience self as distinct but merges self into the beliefs, attitudes, and feelings of others. Confluence can be healthy or unhealthy.

Congruence (CC) Agreement between the feelings and attitudes a therapist is experiencing and his or her professional demeanor; one of Rogers's necessary and sufficient conditions for therapeutic change. *See also* Genuineness.

Conscientization (MC) An educational concept, also known as critical consciousness, that was developed by Paulo Freire. Conscientization involves learning to perceive the social, political, and economic contradictions associated with oppression.

Consensus Trance (CN) View of the normal waking state as dreamlike, lacking real awareness, and shared consensually by most people.

Conjoint Session (FT) Psychotherapy in which two or more patients are treated together.

Constructivism (FT) The view that emphasizes the subjective ways in which each individual creates a perception of reality.

Contact (GT) Basic unit of relationship involving an experience of the boundary between "me" and "not me"; feeling a connection with the "not-me" while maintaining a separation from it.

Convenient Fiction A philosophy of science phase signifying concepts that are imaginary and unreal, but that may be helpful in conceptualization.

Conviction Conclusion based on personal experience and perceptions, usually biased because each person's perspective is unique.

Core Conditions (CC) According to Carl Rogers, the core conditions for growth in therapy are congruence, unconditional positive regard, and empathy. Other theorists such as Albert Ellis have argued that these three conditions are neither necessary nor sufficient for therapeutic growth.

Core Conflictual Relationship Theme Method (PA) A supportive-expressive psychotherapy method used to examine the inner workings of a patient's relationship patterns; an operational version of transference. Each CCRT pattern has three elements: wish, response of others, and response of self.

Counterconditioning (BT) Replacing a particular behavior by conditioning a new response incompatible with the maladaptive behavior. Counterconditioning is one of the explanations for the effectiveness of systematic desensitization.

Countertransference (PA, AP) The activation of unconscious wishes and fantasies on the part of the therapist toward the patient. It can either be elicited by and indicative of the patient's projections or come from the therapist's tendency to respond to patients as though they were significant others in the life, history, or fantasy of the therapist.

Courage (AD) Willingness to take risks without being sure of the consequences; necessary for effective living.

Cultural Competency (MC) The set of knowledge, behaviors, attitudes, skills, and policies that enables a practitioner to work effectively in a multicultural situation. Cultural competence requires congruent behaviors, attitudes, and policies that reflect an understanding of how cultural and sociopolitical influences shape individuals' worldviews and related health behaviors.

Cultural Genogram (MC) A therapeutic tool that emphasizes the role of culture and context in the lives of individuals and their families.

Cybernetic Epistemology (FT) A framework for conceptualizing and analyzing what is being observed in terms of the flow of information through a system.

Cybernetic System (FT) The study of methods of feedback control within a system.

Decatastrophizing (CT, REBT) A "what if" technique designed to explore actual rather than feared events and consequences.

Decentering (CT) Moving the supposed focus of attention away from oneself.

Deconstructionism A theory of literary criticism that challenges many of the prevailing assumptions of psychotherapy. Therapists influenced by deconstructionism attempt to "deconstruct" the ideological biases and traditional assumptions that shape the practice of psychotherapy. Like postmodernism, deconstructionism rejects all claims of ultimate truth.

Defense Mechanism (PA) Method mobilized by the ego in response to its danger signal of anxiety as protection from inner and outer threat. Examples include repression, denial, and projection.

Deflection (GT) A means of blunting the impact of contact and awareness by not giving or receiving feelings or thoughts directly. Vagueness, verbosity, and understatement are forms of deflection.

Dehypnosis (CN) Awakening from a hypnotic trance, especially the enculturated consensus trance shared by most people. This involves disidentifying from mental phenomena such as thoughts and fantasies rather than assuming them to be "real."

Demandingness (REBT) The belief of some clients that they must get what they want in life and that it is a terrible tragedy if this does not occur.

Dementia Praecox An obsolete term for schizophrenia.

Denial (PA) A basic defense through which aspects of experienced reality are treated as if they did not exist; often directed against personal existential death anxieties.

Dereflection (CN) Directing one's attention away from the self.

Determinism The assumption that every mental event is causally tied to earlier psychological experience.

Dialectical Behavior Therapy (BT) A therapy developed by Marsha Linehan for use with patients with borderline personality disorders. DBT balances the need to change with acceptance of the way things are; this is the central dialectic of psychotherapy. Mindfulness is a central component of DBT.

Dialogue (EXT, GT) Genuine, equal, and honest communication between two people; the "I—Thou" relationship.

Dichotomous Thinking (CT, REBT) Categorizing experiences or people in black-and-white or extreme terms only (e.g., all good vs. all bad), with no middle ground.

Dichotomy (GT) A split in which a field is experienced as comprising competing and unrelated forces that cannot be meaningfully integrated into a whole.

Differentiation of Self (FT) Psychological separation by a family member, increasing resistance to being overwhelmed by the emotional reactivity of the family.

Discriminative Stimulus (BT) A stimulus signifying that reinforcement will (or will not) occur.

Disengaged Family (FT) A family whose members are psychologically isolated from one another because of overly rigid boundaries between the participants.

Disorientation Inability to correctly identify time and place (e.g., dates and locations).

Disturbances at the Boundary (GT) A disturbance in the ongoing movement between connection and withdrawal. Blocking connection results in *isolation*; blocking withdrawal results in *confluence*.

Double The auxiliary role that involves playing the protagonist's inner self or what the protagonist might be feeling or thinking but not expressing outwardly. *See also* Auxiliary.

Double Bind (FT) Conflict created in a person who receives contradictory messages in an important relationship but is forbidden to leave or escape from the relationship or to comment on the discrepancy.

Drama Therapy Use of theater techniques to gain self-awareness or increase self-expression in groups.

Dramaturgical Metaphor Framing situations as if they were scenes in a play, which helps to include and more effectively describe vividly the range of psychosocial phenomena that are difficult to describe in more prosaic or abstract terms.

Dual-Instinct Theory (PA) The notion that humans operate primarily in terms of pervasive and innate drives toward both love and aggression. *See also* Eros, Thanatos.

Dyadic (FT) Pertaining to a relationship between two persons.

Dynamics (PA) Interactions, usually conflicted, between one's basic drives or id and the ego's defenses. *See also* Psychodynamics.

Dysarthria Speech deficit involving difficulty with the mechanical production of language.

Early Maladaptive Schemas (CT) Broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime; dysfunctional to a significant degree.

Early Recollection (AD) Salient memory of a single incident from childhood; used as a projective technique by Adlerian therapists.

Eclecticism The practice of drawing from multiple and diverse sources in formulating client problems and devising treatment plans. Multimodal therapists are technical eclectics (e.g., they employ multiple methods without necessarily endorsing the theoretical positions from which they were derived).

Effectiveness Study Less well-controlled studies that do not typically use treatment manuals or specific training for the therapists involved in the study. Effectiveness research tends to be conducted in community settings under conditions that approximate day-to-day clinical practice. Contrast with *Efficacy Study*.

Efficacy Study A controlled study that typically uses random assignment of patients to treatments, treatment manuals, carefully trained therapists, and rigorous assessment of outcome by impartial evaluators. This is the type of research typically conducted in universities. Contrast with *Effectiveness Study*.

Ego (PA) The central controlling core of the personality mediating between the *id* (primitive, instinctive needs) and the *superego* (civilized, moralistic elements of the mind).

Eigenwelt (EX) One level of the ways each individual relates to the world. *Eigenwelt* literally means "own world" and refers to the way each of us relates to self.

Electra Complex (PA) Erotic attraction of the female child for her father, with accompanying hostility for her mother; the female equivalent of the Oedipus complex. *See also* Oedipus Complex.

Elegant Solution (REBT) Solution that helps clients make a profound philosophical change that goes beyond mere symptom removal.

Emotional Cognition (PA) The means by which, both consciously and unconsciously, we perceive and process emotionally charged information and meaning in the service of adaptation.

Emotive Techniques (REBT) Therapy techniques that are vigorous, vivid, and dramatic.

Empathic Understanding (CC) The ability to appreciate a person's phenomenological position and to accompany the person's progress in therapy; one of the necessary conditions for therapeutic change.

Empathy (CC) Accurately and deeply feeling someone else's expressed emotions, concerns, or situation.

Empirically Supported Treatments Therapies that have been shown to be effective in scientific studies that meet rigid criteria (e.g., randomized clinical trials). For a treatment to be empirically supported, patients receiving the treatment must have been shown to be better off than patients who receive no treatment, and outcomes must be at least equal to those obtained by alternative therapies that have been documented to be beneficial.

Empty Chair (GT) A chair whose inhabitant is imagined by a client, with all the client's projected attitudes. The imaginary occupant might be a significant person in the client's life, a figure from a dream, a part of the client's body or mind, or even the therapist. The chair is usually used along with role reversal, and the term "shuttling" is used to describe the client's moving back and forth between the chairs as the two parts engage in an encounter. *See also* Encounter, Role Reversal.

Enactment Showing (rather than verbalizing) a situation that deserves to be explored.

Encounter (GT) A dialogue between two persons, or two aspects of the same person, either in reality or with one part played by someone else.

Encounter Group A small number of people who meet (sometimes only once, sometimes on a weekly basis for a specified time) to truly know and accept themselves and others.

Enmeshed Family (FT) Family in which individual members are overly involved in each other's lives, making individual autonomy impossible.

Eros (PA) The life instinct, fueled by libidinal energy and opposed by Thanatos, the death instinct. *See also* Libido, Thanatos.

Epistemology The study of the origin, nature, methods, and limits of knowledge.

Ethicality (CN) Internally based emphasis on moral or principled behavior.

Ethnocentrism (MC) The belief that one's worldview is inherently superior and desirable to others.

Existential Isolation (EX) Fundamental and inevitable separation of each individual from others and the world; it can be reduced but never completely eliminated.

Existentialism (EX) A philosophical movement that stresses the importance of actual existence, one's responsibility for and determination of one's own psychological existence, authenticity in human relations, the primacy of the here and now, and the use of experience in the search for knowledge.

Existential Neurosis (EX) Feelings of emptiness, worthlessness, despair, and anxiety resulting from inauthenticity, abdication of responsibility, failure to make choices, and a lack of direction or purpose in life.

Experiencing (CC) Sensing or awareness of self and the world, whether narrowly and rigidly or openly and flexibly. Experience is unique for each person.

Experiential Family Therapist (FT) A therapist who reveals himself or herself as a real person and uses that self in interacting with families.

Extinction (BT) In classical conditioning, the result of repeated presentation of a conditioned stimulus without the unconditioned stimulus and the resulting gradual diminution of the conditioned response. In operant conditioning, extinction (no response) occurs when reinforcement is withheld following performance of a previously reinforced response.

Facilitator An individual who aids a group in going the direction they choose and accomplishing their chosen goals without doing harm to any member.

Factors of Enlightenment (CN) Seven mental qualities identified by Buddhist psychology as important for psychological well-being and maturation: mindfulness, effort, investigation, rapture, concentration, calm, and equanimity.

Family Constellation (AD) The number, sequencing, and characteristics of the members of a family. The family constellation is an important determinant of life-style.

Family Sculpting (FT, PD) A nonverbal technique to be used by individual family members for physically arranging other family members in space to represent the arranger's symbolic view of family relationships.

Feedback The process by which a system makes adjustments in itself; can be negative (reestablishing equilibrium) or positive (leading to change).

Field Theory (GT) A theory about the nature of reality and our relationship to reality in which our experiences are understood within a specific context. A field is composed of mutually interdependent elements, and changes in the field influence how a person experiences reality. No one can transcend embeddedness in a field, and therefore no one can have an objective perspective on reality.

First-Order Change (FT) Change within a system that does not alter the basic organization of the system itself.

Formative Tendency (CC) An overall inclination toward greater order, complexity, and interrelatedness common to all nature, including human beings.

Free Association (PA) A basic technique of psychoanalysis in which analysands are asked to report, without structure or censure, whatever thoughts come to mind.

Functionally Specific States (CN) States of consciousness in which particular abilities such as introspection are increased, while others are reduced.

Fusion (EXT, FT) In existential therapy, the giving up of oneself to become part of another person or a group; a particular attempt to reduce one's sense of isolation. In family therapy, a blurring of boundaries between family members with the resultant loss of a separate sense of self by each member.

Future Projection Demonstration of what one sees going on in life at some specified time in the future.

Gemeinschaftsgefühl (AD) A combination of concern for others and appreciation of one's role in a larger social order; usually translated as "social interest."

Generalization (BT) The occurrence of behavior in situations that resemble but are different from the stimulus environment in which the behavior was learned.

Genital Stage (PA) The final stage in psychosexual development, also termed the oedipal phase, in which heterosexual relations are achieved. Its roots are formed at ages 5 to 6, and it is said to be the basis for the mature personality.

Genogram (FT, MC) A schematic diagram of a family's relationship system that is used to trace recurring family patterns over generations.

Genuineness (CC) The characteristic of being real and true to oneself; lack of pretense, social facade, or refusal to allow certain aspects of one's self into awareness. See *congruence*.

Gestalt (GT) A word with no literal English translation, referring to a perceptual whole or a unified configuration of experience.

Givens of Human Existence (EX) Psychiatrist Irvin Yalom defines these as death, freedom, isolation, and meaninglessness. The courage with which we meet the givens of human existence defines our life.

Graded-Task Assignment (CT, BT) Starting with a simple activity and increasing the level of complexity or difficulty in a step-by-step fashion.

Guided Discovery A series of questions to assist the client to uncover relevant information out of his or her current awareness, examine his or her interpretations of events and discover alternative meanings.

Hidden Agenda The actual goal of an interaction between people (as in a game), which is different from what superficially appears to be the goal.

Higher States (CN) States of consciousness containing normal mental capacities plus additional, heightened ones.

Holism (AD) Studying individuals in their entirety, including how they proceed through life, rather than trying to separate out certain aspects or parts, such as studying the mind apart from the body.

Homeostasis A balanced and steady state of equilibrium.

Homework (REBT, BT) Specific activities to be done between therapy sessions.

Hot Cognition (CT) A powerful and highly meaningful idea that produces strong emotional reactions.

Hysteria An early term for conversion reaction, a disorder in which psychological disturbance takes a physical form (e.g., paralysis in the absence of organic disturbance). Many of Freud's theories grew out of his experience in treating hysterical patients.

Id (PA) The reservoir of the biological, instinctual drives with innate and developmental components. *See also* Ego, Superego.

Identification (PA) A mental mechanism, used unconsciously in normal interactions and as a psychic defense, through which one person absorbs and takes on the traits, values, and defenses of another person.

Identified Patient (FT) The person who seeks treatment or for whom treatment is sought.

Inauthentic Mode (EX) Heidegger believed the inauthentic mode of being was characterized by mindless responding and a failure to take responsibility for becoming one's true self.

Inclusion (GT) Putting oneself as completely as possible into another's experience without judging or evaluating, while still maintaining a separate sense of self.

Individual Psychology (AD) An approach to understanding human behavior that sees each person as a unique, whole entity who is constantly becoming rather than being and one whose development can only be understood within a social context.

Individuation (AP) The process by which an individual becomes an indivisible and integrated whole person responsibly embodying his or her individual strengths and limitations.

Inferiority Complex (AD) An exaggeration of feelings of inadequacy and insecurity resulting in defensiveness and neurotic behavior. It is usually, but not always, abnormal.

Inferiority Feeling (AD) Seeing oneself as inadequate or incompetent in comparison with others, with one's ideal self, or with personal values; considered universal and normal. *Contrast with* Inferiority Complex.

Integration Organized and harmonious relationships among personality components.

Intensive Group (CC) A small number of people who come together for a brief but condensed period (e.g., a weekend) to engage in special interpersonal experiences that are designed to expand awareness of self and others.

Interlocking Pathologies (FT) Multiple forms of dysfunction within a family that are interdependent in the way they are expressed and maintained.

Interlocking Triangles (FT) Basic units of family relationships consisting of a series of three-person sets of interactions (e.g., father—mother—child; grandparent—parent—child).

Internal Frame of Reference (CC) A view or perception of both the world and self as seen by the individual, as distinguished from the viewpoint of an observer, psychotherapist, or other person.

Interpersonal Problem Areas (IPT) Grief, interpersonal disputes, role transitions, and interpersonal deficits. These four problem areas serve as the triggers for depressive episodes.

Intrapsychic Within the mind or psyche of the individual.

Introject (FT) Internalized object from one's past that affects current relationships.

Introjection (PA, GT) In psychoanalysis, an unconscious process of identifying with other persons, real or imagined, by incorporating attributes of these others into oneself. In Gestalt therapy, accepting information or values from the outside without evaluation; not necessarily psychologically unhealthy.

Irrational Belief (REBT) Unreasonable conviction that produces emotional upset (for example, insisting that the world should or must be different from what it actually is).

Isolation (GT) A state in which the contact boundary is so thick, rigid, and impermeable that the psychological connection between self and environment is lost, and the person does not allow access from or to the outside. Isolation can be healthy or unhealthy. *Contrast with* Withdrawal.

Latency Period (PA) A relatively inactive period of psychosexual development said to begin around age 6 and end around age 11.

Leaning Tower of Pisa Approach (FT) A variation of paradoxical intention in which a therapist intentionally makes a problem worse until it falls of its own weight and is thereby resolved.

Libido (PA) The basic driving force of personality in Freud's system. It includes sexual energy but is not restricted to it.

Life-style (AD) One's characteristic way of living and pursuing long-term goals.

Life Tasks (AD) The basic challenges and obligations of life: society, work, and sex. The additional tasks of spiritual growth and self-identity are included by Rudolf Dreikurs and Harold Mosak.

Linear Causality (FT) The view that one event causes the other, not vice versa.

Locus of Evaluation (CC) The place of a judgment's origin, its source; whether the appraisal of an experience comes more from within the individual (internal) or from outside sources (external).

Logotherapy (EX) A therapeutic approach developed by Viktor Frankl emphasizing value and meaning as prerequisites for mental health and personal growth.

Lucid Dreaming (CN) A sleep state in which people know they are dreaming.

Magnification (CT) Exaggerating something's significance.

Manual-Based Treatments (BT) The use of standardized, manual-based treatments is advocated by most proponents of evidence-based treatment because manuals increase the likelihood of treatment fidelity. Critics of manualized treatment argue that the use of manuals represents a Procrustean approach that ignores individual differences in patients and problems.

Marital Schism (FT) A disturbed family arrangement characterized by disharmony, undermining of the spouse, and frequent threats of divorce. *See also* Marital Skew.

Marital Skew (FT) A disturbed family arrangement in which one person dominates to an extreme degree, and in which the marriage is maintained through the distortion of reality. *See also* Marital Schism.

Maya (CN) An illusory and encompassing distortion of one's perception and experience that is not recognized as such.

Mediational Stimulus-Response Model (BT) A behavioral model that posits internal events, such as thoughts and images, as links between perceiving a stimulus and making a response.

Medical Model (IPT) An approach that is used to allow depressed individuals to adopt a "sick role" and understand that it is a treatable medical problem like diabetes.

Meditation (CN) Practices designed to train attention and bring various mental processes under greater voluntary control.

Microaggressions (MC) Psychological assaults that individuals receive on a regular basis solely because of their race, color, or ethnicity.

Mindfulness (CN) Clear objective awareness of experience.

Mindfulness-Based Cognitive Therapy (CT) An approach to cognitive therapy that uses acceptance and meditation strategies to promote resiliency and prevent recurrences of depressive episodes.

Minimization (CT) Making an event far less important than it actually is.

Mirror Person who imitates a client's behavior and demeanor so that the client can more clearly see him- or herself in action.

Mitwelt (EX) The way in which each individual relates to the world, socially and through being with others; the age we live in, our age, our own times, the present generation, our contemporaries.

Mode (CT) Network of cognitive, affective, motivational, and behavioral schemas that composes personality and interprets ongoing situations.

Monadic (FT) Based on the characteristics or traits of a single person.

Monodrama (PD, GT) One client's playing both parts in a scene by alternating between them.

Morita (CN) A Japanese therapy for treating anxiety by redirecting one's attention away from the self.

Multigenerational Transmission Process (FT) The passing on of psychological problems over generations as a result of immature persons marrying others with similar low levels of separateness from their families.

Multiple Psychotherapy (AD) A technique in which several therapists simultaneously treat a single patient.

Musturbation (REBT) A term coined by Albert Ellis to characterize the behavior of clients who are absolutistic and inflexible in their thinking, maintaining that they *must* not fail, *must* be exceptional, *must* be successful, and so on.

Mystification (FT) The deliberate distortion of another person's experience by misinterpreting or mislabeling it.

Naikan (CN) Japanese therapy using intensive reflection on past relationships to increase social and interpersonal contributions.

Narcissism (PA) Self-absorption, self-concern, and self-love arising from psychic energy directed at the self; the term currently is used to include tension regulation, self-image, and self-esteem.

Narrative Therapy (FT) An approach to family therapy built on the belief that reality is constructed, organized, and maintained through the stories we create. Associated with Australian therapist Michael White and others.

Negative Feedback (FT) The flow of output information back into a system to correct too great a deviation from normal and return the system to its steady state.

Negative Reinforcement (BT) Any behavior that increases the probability of a response by terminating or withdrawing an unpleasant stimulus. Negative reinforcement increases the likelihood of future occurrence of the behavior it follows.

Neurosis (PA) A term first used by Freud to include all but the most severe psychological syndromes; currently narrowly defined as an emotional disorder in which psychic functioning is relatively intact and contact with reality is sound.

Neurotic Anxiety (EX) A state of fear or apprehension out of proportion to an actual threat. Neurotic anxiety is destructive or paralyzing and cannot be used constructively. *Compare with* Normal Anxiety.

Nondirective Attitude (CC) Valuing the client's inherent capacity for and right to self-determination.

Normal Anxiety (EX) A sense of apprehension appropriate to a given threatening situation, which can be faced, dealt with, and used creatively. *Compare with* Neurotic Anxiety.

Object Relations Theory (PA, FT) The view that the basic human motive is the search for satisfying object (person) relationships. Associated with the writings of W. Ronald Fairbairn.

Oedipus Complex (PA) Erotic attraction of the male child for his mother, accompanied by hostility toward the father. *See also* Electra Complex.

Ontological (EX) Concerned with the science of being or existence.

Open System (FT) A system with relatively permeable boundaries permitting the exchange of information with its environment.

Operant Conditioning (BT) A type of learning in which responses are modified by their consequences. Reinforcement increases the likelihood of future occurrences of the reinforced response; punishment and extinction decrease the likelihood of future occurrences of the responses they follow.

Oral Phase (PA) The earliest phase of psychosexual development, extending from birth to approximately 18 months, in which most libidinal gratification occurs through biting, sucking, and oral contact.

Organ Inferiority (AD) Perceived or actual congenital defects in organ systems believed by Alfred Adler to result in compensatory striving to overcome these deficits.

Organismic Valuing Process (CC) Making individual judgments or assessments of the desirability of an action or choice on the basis of one's own sensory evidence and life experience.

Overgeneralization (CT, REBT) Constructing a general rule from isolated incidents and applying it too broadly.

Panacea A remedy for all diseases and difficulties; a cure-all.

Paradigm A set of assumptions limiting an area to be investigated scientifically and specifying the methods used to collect and interpret the forthcoming data.

Paradigm Shift A significant and widespread change in the concepts, values, perceptions, and practices that define a community or a structured activity (e.g., psychotherapy).

Paradoxical Intervention (FT) A therapeutic technique whereby the patient is directed to continue the symptomatic behavior. To comply is to admit voluntary control over the symptom; to rebel is to give up the symptom.

Paradoxical Theory of Change (GT) A theory of change that is based on a paradox: The more one tries to be who one is not, the more one stays the same; the more one tries to stay the same in a changing world, the more one changes relative to the world. When a person knows and accepts himself or herself, maximum growth can occur. When one rejects oneself, e.g., by forcing oneself beyond one's support, growth is hindered by internal conflict.

Paraphilias Unusual or atypical sexual behaviors that are thought to have clinical relevance. The major paraphilias include exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism.

Persona (AP) A mask or way of appearing that is appropriate to a specific role or social setting. It both shields an individual and reveals suitable aspects of the personality, but is often at variance with the personality as a whole.

Personal Unconscious (AP) An individual unconscious layer of the personality containing undeveloped parts of the personality, repressed ideas, experiences, emotions, and subliminal perceptions. *See also* Collective Unconscious.

Personalization (CT) Taking personal responsibility for negative events without supporting evidence of personal involvement.

Phallic Phase (PA) A psychosexual phase in boys of ages 3 to 5 in which penile experiences and fantasies of thrusting and exhibiting are predominant. The comparable phase in girls is termed the vaginal phase. *See also* Vaginal Phase.

Phases of Dynamic Psychotherapy (PA) Opening; working through; termination.

Phenomenology (AD, EXT, GT) A method of exploration that primarily uses human experience as the source of data and attempts to include all human experience without bias (external observation, emotions, thoughts, and so on). Subjects are taught to distinguish between current experience and the biases brought to the situation. Phenomenology is the basic method of most existentialists.

Placebo In medicine, placebos are inert substances given to patients in place of bona fide medications. In psychotherapy, placebos are most often sham treatments used in research to control for the nonspecific effects of attention.

Pleasure Principle (PA) The basic human tendency to avoid pain and seek pleasure, especially salient in the first years of life. *Contrast with* Reality Principle.

Positive Feedback (FT) The flow of output information back into the system in order to amplify deviation from a steady state, thus leading to instability and change.

Positive Reinforcement (BT) Any stimulus that follows a behavior and increases the likelihood of the occurrence of the behavior that it follows.

Postmodern Therapies (GT) Any approach to therapy that recognizes the validity and assumptions of multiple realities while rejecting the primacy of the worldview of the therapist. Postmodern therapies stress the importance of culture in determining reality and emphasize the influence of language and power relationships in shaping and defining psychopathology.

Primary Process Thinking (PA) Nonlogical thinking such as is found in dreams, creativity, and the operation of the unconscious. Freud believed primary process thinking characterized the operations of the Id. Contrast with *Secondary Process Thinking.*

Principled Nondirectiveness (CC) An unwavering attitude of respect adopted by the client centered therapist to provide an optimal environment in which clients can change. Ususally contrasted with instrumental nondirectiveness in which the therapist's empathic responding is goal directed.

Projection (PA, AP) Attributing to others unacceptable personal thoughts, feelings, or behaviors.

Projective Identification (PA) An interactional form of projection, used both normally and as a defense, through which one person places into another person his or her inner state and defenses.

Protagonist In psychodrama, the term used for the client whose situation is being explored, who is also usually the main player in the role-playing process.

Pseudohostility (FT) Superficial bickering that allows one to avoid dealing with deeper, more genuine, and more intimate feelings.

Pseudomutuality (FT) A facade of family harmony that gives the appearance of an open and satisfying relationship that does not truly exist.

Psychodrama A method of psychotherapy developed by J. L. Moreno in the mid-1930s in which clients role-play their problems.

Psychodynamic Diagnostic Manual (PA) A psychodynamic alternative to the *Diagnostic and Statistical Manual (or DSM).* The *Psychodynamic Diagnostic Manual* is based on a psychoanalytic model of human functioning and addresses the subjective experiences associated with various diagnoses.

Psychodynamic Psychotherapy (PA) A general term for a variety of therapies that evolved from psychoanalysis. Dynamic psychothcrapists generally see their clients once or twice each week and the client is sitting up.

Psychodynamics (PA) A term similar to dynamics that refers to mental interactions and conflict, usually formulated in terms of ego, id, and superego. *See also* Dynamics.

Psychological Masquerade Apparent psychological symptoms actually caused by physical or organic conditions.

Punishment (BT) An aversive event likely to terminate any behavior that it follows.

Randomized controlled trial (IPT; BT) A prospective experiment in which investigators randomly assign patients to one or more treatment groups; considered the gold standard in evidence-based therapy. Most widely used in interpersonal psychotherapy and behavior therapy. (Also known as **randomized clinical trial.**)

Rapture(CN) Somatically experienced ecstasy that accompanies clear awareness in advanced meditation.

Reality An individual's private world, but more generally, a group of perceptions or "facts" with substantial consensus about their meaning.

Reality Principle (PA) The guiding principle of the ego, which permits postponement of gratification to meet the demands of the environment or secure greater pleasure at a later time. *Contrast with* Pleasure Principle.

Reattribution (CT) Assigning alternative causes to events; reinterpreting one's symptoms.

Redundancy Principle (FT) Repetitive behavioral sequences between participants, as within a family.

Re-evaluation Counseling (MC) An empowering co-counseling approach in which two or more individuals take turns listening to each other without interruption in order to recover from the effects of racism, classism, sexism, and other types of oppression.

Reframing (FT) Relabeling behavior by putting it into a new, more positive perspective.

Regression (PA) Variously defined as an active or passive slipping back to more immature levels of defense or functioning, or seeking gratification from earlier phases of development.

Reinforcement (BT) The presentation of a reward or the removal of an aversive stimulus following

a response. Reinforcement always increases the future probability of the reinforced response.

Replay (PD, BT) A psychodramatic technique, often used in behavior therapy and other approaches, in which the client repeats a previous scene. It is often applied in the mastery of interpersonal skills.

Repression (PA) A major defense mechanism in which distressing thoughts are barred from conscious expression.

Resistance (PA, GT) In psychoanalysis, any obstacle, pathological or nonpathological, to the progress of an analysis or therapy, usually involving a modification of a ground rule of treatment and based on unconscious sources within both patient and analyst (i.e., interactionally determined). In Gestalt therapy, the reluctance of people to know, show, or own aspects of themselves. Resistance can be healthy or unhealthy.

Respondent Conditioning (BT) *See* Classical Conditioning.

Retroflection (GT) A contact boundary disturbance in which a person substitutes self for the environment and does to self what he or she originally did or tried to do to others. Retroflection is the chief mechanism of isolation and is not necessarily unhealthy.

Role Playing Acting the part of oneself or someone else under therapeutic guidance. (Originally used in psychodrama, the term has now come to be used also as a way of problem exploration in many other therapies, as well as in education and business.)

Role Reversal In psychodrama, the dropping of the point of view of one's own role and taking on the attitudes and physical position and perspective of the other person in an interaction. A plays B and B plays A. Or sometimes, if the actual other person isn't present, A takes the role of whoever he imagines B to be, using an empty chair, thus opening his mind to a deeper level of empathy. *See also* Empty Chair.

Samadhi (CN) Yogic state of consciousness marked by deep calm and concentration.

Scapegoating (FT) Casting a person in a role that unfairly exposes him or her to criticism, blame, or punishment.

Schema (CT) Strategy or way of thinking comprising core beliefs and basic assumptions about how the world operates.

Schema Therapy (CT) A strategy developed by Jeffrey Young that elaborates on classic cognitive therapy by incorporating techniques drawn from psychodynamic theory and other systems. Schema therapy specifically focuses on childhood experiences believed to be associated with anxiety and depression.

Secondary Process Thinking (PA) Linear, logical, and verbal thinking, associated with the operations of the ego. Contrast with *Primary Process Thinking.*

Second-Order Change (FT) Fundamental change in a system's organization and function.

Selective Abstraction (CT) Basing a conclusion on a detail taken out of context and ignoring other information.

Self-Actualization A basic human drive toward growth, completeness, and fulfillment.

Self-Concept One's own definition of who one is, including one's attributes, emotions, abilities, character, faults, and so on.

Self-Instructional Training (BT) A technique, described most completely by Donald Meichenbaum, for replacing self-defeating thoughts with self-enhancing cognitions.

Self Psychology (PA) A psychoanalytic approach associated with the work and writings of Heinz Kohut. Self psychology stresses empathy, mirroring, and support for positive esteem.

Self-Regard (CC) That aspect of the self-concept that develops from the esteem or respect accorded oneself.

Sensate Focus (BT) A series of exercises used in sex therapy designed to reintroduce clients to receiving and giving sensual pleasure.

Shadow (AP) Unconscious, unaccepted, or unrecognized parts of the personality that are most often, but not always, negative.

Sharing The third phase of a psychodramatic enactment in which other group members in the audience and even auxiliaries share how that role playing may have touched on similar or related events in their own lives—in contrast to giving advice, interpretations, or analysis.

Social Interest (AD) The feeling of being part of a social whole; the need and willingness to contribute to the general social good. *See also* Gemeinschaftsgefühl.

Social Learning Theory (BT) A system that combines operant and classical conditioning with cognitive mediational processes (e.g., vicarious learning and symbolic activity) to account for the development, maintenance, and modification of behavior.

Sociometry A method in which groups give feedback about their interpersonal preferences (e.g., attraction or repulsion).

Sociotrophy (CT) A personality dimension characterized by dependency on interpersonal relationships and needs for closeness and nurturance.

Socratic Dialogue (CT) A series of questions designed to arrive at logical answers to and conclusions about a hypothesis.

Splitting (PA, GT) In psychoanalysis, a primitive defense through which persons are classified as all-good or all-bad individuals, making it impossible to have a full and balanced picture of other people. In Gestalt therapy, a situation in which a person splits off part of him- or herself as a polar opposite. The individual is aware of one pole and oblivious to the other. For example, an individual may split into competent and incompetent selves and vacillate between these roles. A split is one form of a dichotomy.

Spontaneity A frame of mind enabling one to address situations afresh, often with a significant measure of improvisation.

Stages of Change (INT) A model developed by Prochaska and DiClemente and used to match therapeutic approaches to a client's readiness to change. The model posits five stages: Precontemplation, contemplation, preparation, and action. See Table 1 in Chapter 14.

Stimulus Control (BT) Arranging the environment in such a way that a given response is either more likely or less likely to occur (e.g., buying only one pack of cigarettes per day in order to decrease the likelihood of smoking).

Strategic Intervention Therapy (FT) An approach to family therapy employing specific strategies, plans, and tactics to force changes in behavior.

Structuralism (FT) An approach to family therapy, associated with Salvador Minuchin, that emphasizes the importance of the nuclear family and seeks to change pathological alliances and splits in the family.

Structuralist (FT) A therapist who emphasizes changing or realigning a family's organizational structure to improve its transactional patterns.

Structural Theory or Hypothesis (PA) Freud's second model of the mind. The model postulates three agencies of the mind—ego, superego, and id—each with conscious and unconscious components. *See also* Id, Ego, *and* Superego.

Stuck-Togetherness (FT) A situation observed in schizophrenic families in which roles and boundaries are blurred and no family member has an identity distinct from the family.

Subjective Reasoning (CT) Believing that feelings are the same as, or equivalent to, facts.

Subsystem (FT) An organized component within an overall system, such as a family.

Superego (PA) A structure of the mind, developed from innate tendencies and early parental interactions and identifications, that embraces moral and other standards and regulates psychic tensions, self-image, self-esteem, and drive-discharge. *See also* Ego, Id.

Support (GT) To provide the psychological, physiological, social, or material aid needed to initiate, terminate, regulate, and maintain contact or withdrawal as needed by the person or the environment. People are self-supporting to the degree that they are the chief agents in initiating, terminating, regulating, and maintaining contact/withdrawal and do so based on self-identification.

Surplus Reality Psychological experiences involving other than physical reality (e.g., spiritual events, a relationship with a significant deceased other).

Survival An innate need, drive, and source of human behavior. It leads human beings to seek health, nutrition, and protection from physical danger.

Symbiosis (FT) A relationship in which two people, often a mother and her child, become so intertwined that it is impossible to find a boundary between them.

Symbolization (CC) A process of allowing a life event or experience into one's consciousness or awareness and interpreting it in terms of the self-concept; it may be straightforward, distorted, or prohibited altogether.

Symptom—Context Method (PA) A way to decode the meanings of symptoms; used in supportive–expressive psychotherapy for both research and therapy purposes.

Syncretism (INT) A pejorative term referring to the uncritical and unsystematic combination of various therapeutic approaches.

Synthesis Making a whole from elements or parts; constructing the overall meaning of a situation from many different aspects of it.

System A complete unit made up of interconnected and interdependent parts operating in a stable way over time.

Systematic Desensitization (BT) A step-by-step procedure for replacing anxiety with relaxation while gradually increasing exposure to an anxiety-producing situation or object.

Systematic Eclecticism (INT) An approach advocated by Norcross and Beutler (Chapter 14) in which the various approaches to eclecticism (e.g., technical eclecticism, theoretical integration, common factors, and assimilative integration) are blended to meet the unique needs of each individual patient. Also referred to as *systematic treatment selection (STS).*

Technical Eclecticism (INT) An integrative approach in which therapists use multiple procedures drawn from various therapeutic systems without particular concern about the theories from which they came.

Thanatos (PA) An instinct toward death and self-destruction posited by Freud to oppose and balance Eros, the life instinct.

Theoretical Integration (INT) The integration of two or more therapies with an emphasis on integrating the underlying theories associated with each therapeutic system.

Therapeutic Alliance The partnership between therapist and client that develops as the two work together to reach the goals of therapy.

Third-Party Payer Financial intermediary that controls payment to therapists. In therapy, third-party payers are usually insurance companies or government agencies.

Third Wave of Behavior Therapy (BT) The first wave of behavior therapy focused on modifying overt behavior. The second wave addressed cognitions (e.g., cognitive behavior therapy). The third wave addresses mindfulness and self-awareness and includes dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT).

Token Economy (BT) A program that provides people with short-term reinforcement for specific behaviors by allotting tokens (poker chips or points) that are accumulated and later exchanged for privileges or desired objects.

Topographic Theory (PA) Freud's first model of the mind in which access to awareness of contents and functions was the defining criterion. The model had interactional elements but was eventually replaced by Freud's structural model. *See also* Unconscious.

Trait Theory The belief in stable and enduring personality characteristics.

Transference (PA, AP) The therapy situation in which the patient responds to the therapist as though he or she were a significant figure in the patient's past, usually a parent. *See also* Countertransference.

Triadic (FT) Pertaining to a relationship involving the interaction of three or more persons.

Trust (CC) Basic faith in oneself and others as being growth-directed and positively oriented.

Two-chair Technique (GT) An affective, experiential procedure in which the client engages in dialogue with another person (or with another part of the self) symbolically represented by an empty chair. The client may assume different roles by switching from one chair to the other.

Umwelt (EX) A way of relating to the world through its biological and physical aspects; one's relationship with nature and the surrounding world.

Unconditional Positive Regard (CC) A nonpossessive caring and acceptance of the client as a human being, irrespective of the therapist's own values. One of Rogers's necessary and sufficient conditions for therapeutic change.

Unconscious (PA, AP) A division of the psyche; the repository of psychological material of which the individual is unaware.

Vaginal Phase (PA) The phase in girls that corresponds to boys' phallic phase, ages 3 to 5, during which vaginal sensations and incorporative imagery predominate.

Vicarious Learning (BT) Learning through observation and imitation; a synonym for *modeling*.

Voluntary Simplicity (CN) Self-motivated choice to live more simply and to de-emphasize material goods.

Warming Up The process of becoming more spontaneous, often associated with a relaxation of self-consciousness and anxiety, a higher level of trust, and an increasing degree of involvement in the task at hand.

Warmth (CC) Positive and real feelings of acceptance toward another person.

Will to Power (AD) Individual striving for superiority and dominance in order to overcome feelings of inadequacy and inferiority.

Withdrawal (GT) Temporary withdrawing from contact while maintaining a permeable contact boundary. Withdrawal can be healthy or unhealthy. *Contrast with* Isolation.

Work (GT) The process of exploring by phenomenological focusing in order to increase awareness. One can work in any setting and can focus on any theme (here-and-now contact, life problems, developmental themes, spiritual concerns, creativity and emotional expansion, dreams, belief systems, etc.)

Worldview (MC) Those ideas and beliefs, shaped by one's culture, that influence the way an individual interprets the world and interacts with it. Associated with the writings of Harry Triandis.

Yoga (CN) Disciplines dealing with ethics, lifestyle, body postures, breath control, intellectual study, and meditation.

Zeitgeist The spirit of the times; the prevailing cultural climate.