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

THEME NTAL HEALTH WO RK E Q R C E

You and your partner have just moved to a new state. After a week, your partnertells you, "I've been feeling a little depressed and anxious since we moved.It's not one ofthose things I can -pull 形フself out of.Ithink I need some help. We don't know anyone here, so there's no one we trustto ask for a recommendation, butI've looked in the -phone hook 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フガ How do you respond to your partner?

Defining the mental health workforce with any precision presents complex challenges, especially in light ofthe factthat 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 thatfor 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).Whatevertheir professionalidentification,the majority ofthese individuals practice technical eclecticism (described in Chapter14) and use a variety of methods, most of IVトich are derived from the therapies described in Current Psychotherapies.

In recent years, psychologists and social workers have come closerto achieving the status of medicaltherapists, especially in the areas ofinsurance 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 admittheir 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 ofthe 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 thatthere is tremendous variation in the base salaries expected by therapists WIIo may have different professional backgrounds but WトO deliver essentially comparable services.

Nearly all states classify psychotherapy as a legitimate part of medical practice without any requirementthatits use be restricted to psychiatrists. However, psychiatrists now devote the majority oftheirtime to medication management, and farfewer psychiatrists are being trained to provide psychotherapy to their patients (Luhrmann, 2000; Moran, 2009). This trend results in partfrom the factthat 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 & YIIe,1999).

In 2009. psychologists, psychiatric nurse practitioners, and social workers in all 50 states WCre 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 meaningfulthan certification because licensure restricts the practice of a profession, whereas certification restricts the use of a profession's name. These distinctions are difficultto apply to psychotherapy because itis virtually impossible to restrictthe practice of a profession thatincludes such a varied range of activities. Certain professional activities may be state regulated, however. Psychologicaltesting 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 ofthe public. Frequently, state boards will use reciprocity to license professionals who hold a license to practice in other states.

Itis difficultto decide who should have the rightto practice psychotherapy because there are few unambiguous practice guidelines to define whatis appropriate professional care for patients with mental and emotional disorders. A psychoanalyst and a behaviortherapist may provide dramatically differenttreatmentfor a patient with an anxiety disorder,for example. YCt both will claim@and genuinely be|ieve@ thattheir mode oftreatmentis appropriate, and both will expect paymentfortheir services

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You are a psychologist practicing in a smalltown. You and a psychiatrist, who is also in solo practice, provide the town's only mental health services. Overthe years, you have noticed that whenever one of yourtherapy patients needs to be evaluated for medications and you refer him or herto the psychiatrist,the patient soon stops seeing you.It's one ofthose small towns where there are few secrets, so you discoverthatthe psychiatrist encourages your patients to discontinue seeing you so thatthey can consolidate their care and receive both medication and psychotherapy from the same person, even though many ofthem are subsequently treated only with medication. Rosa Gomales,for example, had been seeing you in connection with her work-related depression. Her employer was exploitive, abusive, and disrespectful. Shed been working on developing the confidence and courage to change jobs. however, once she wentto the psychiatristfor a medication consult, she stopped coming to therapy. When you happen to see hピグ附 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 yourreactions to your experiences with the psychiatrist? And how do you think you'd respond to yourformer patient's comment? 」一ソ

No therapist works in isolation. Alltherapists must cope with frequently changing rules aboutthe allocation and delivery of clinical services. The patterns thatreflect which people receivC@and which people failto receive@clinical services,in whatforms,for what problems, and from whom continue to evolve. Therapists must decide how they wantto respond to these shifting patterns and whatrole,if any,they wantto play in changing them.

What are the majortrends? Many studies documentthattreatment consisting solely of psychotherapy is becoming less common. VIぉng, Demler, Olfson, Pincus, VHClls, 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 nCW restrictions on the number of psychotherapy sessions,increased patient cost sharing, and reduced providerreimbursements 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)thatfound that

> Significant growth occurred in the number of Americans TEL ト o received treatmentfor depression during the past decade, and atthe same time the treatments they received underwent a profound transformation. Aユddepressant medications became established as a mainstay, psychotherapy sessions became less common and fewer among those receiving treatment, and physicians assumed a more prominentrole.(pp. 206-207)

These data suggestthat people seeking help for problems such as depression are t ing more to physicians and less to psychologists. Olfson and his colleagues reported tha

> there was a significantincrease in the proportion of patients W ト ose treatment of depression involved visits to a physician.... By 1997. more than 8 (87.3 %) of10 patien who received outpatienttreatment of depression were treated by a physician, compared with 68.9% in 1987. Conversely,the percentage W ト o received treatmentfrom psychologists declined (29.8% vs.19.1%). Treatment of depression by social WOrkers remained litde changed and relatively uncommon,(p. 206)

Interestingly,this shiftto seeking help from physicians, particularly primary car 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 overthe 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 nCW 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 nationaltrend toward collaborative practice and integrated care (Bluestein & Cubic, 2009; RIIddy, Borresen, & Gunn, 2008). This model involves co-location of mental health practitioners with physicians and nurses,joint training, and shared continuing education opportunities. The modelfacilitates respect between different professional groups and supports the "curbside consults" and "hallway hand-offs" that are so criticalto continuity of care (Wedding & Mengel, 2004).

Several studies also suggest a shift away from longer-teE山 psychotherapies. Olf Marcus, Druss, and Pincus (2002) examined changes that occurred between 1987 and 1997.In 1987. about16% ofthe outpatients had more than 20 sessions of psychotherapy. Ten years later, only about10% had more than 20 sessions.In both years, about one third ofthe patients reported only one ortwo therapy sessions.In 1987. about 48% of the therapy sessions WCre 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 oftreatment with antidepressants, only 55.0% ofthe patients saw a healthcare providerfor any purpose, and only 17.7% sれW a providerfor mental healthcare" (Stettin, Yao, Verbrugge, & A廿bert, 2006. p. 453).

The increased use of medications to treat psychological disorders was one factor thatled 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 thCμμ to provide services in geographic areas of critical need thatlacked psychiatrists? Would psychologists betray their professionalidentity and values, shifting toward a medical modelin Wトich medication is often an initialintervention? If psychologists were not going to add a year ortwo to their doctoraltraining, VIIat part oftheir current curriculum and training would have to be abandoned to make room fortraining 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 reviCV publications by the American Psychological Association (2007a), Ax, Bigelow, Harowski, Meredith, Nussbuam, and Taylor(2008), Fagan, Ax, Liss, RCsnick, & Moody (2007), and Rae, Jensen-Doss, Bowden, Mendoza, and Banda (2008).

As this chapteris written, only New Mexico, Louisiana, and the U.S. Territory of Gu8cm 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, & RCsnick, 2009). The New Mexico law authorizing prescription privileges for psychologists is online atthe NCW 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 atthe Louisiana State Board of Examiners of Psychologists Web site (www.lsbep.org). Hawaii passed legislation authorizing prescription privileges for psychologists, butthe governor vetoed the bill.

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evidence-based practice is a construct(i.e., an idea, abstraction, ortheoretical entity) and thus must be operationalized (i.e.,turned into some concrete form that comes to define it). The Wれy itis operationalized is notincidentalto WIIetherits net effects turn outto 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 mo than a psychologicaltest can be described simply as "valid" or "reliable." The validity reliability of psychologicaltests do not existin the abstract. They must be established a specific purpose (e.g.,identifying malingering),for a specific setting (e.g.,forensic) for a specific population (e.g., adults WHo can read and write English at a seventh-gra or more advanced level). Gordon Paul acknowledged this complexity in 1967 WHen many were searching fortherapies that IVCre "effective." Paul wrote that both therapists and searchers must confrontthe question "Whattreatment, by WHom,is most effective forthis individual with that specific problCIJ, and under WHich set of circumstances?" (p.111).

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

> there are three overriding principles in evaluating the robustness of[psychotherapies].... First,itis importantto match the psychologicalintervention to the psychological or physical disorder or problem.... Second,itis importantto match the treatmentto patient and therapist characteristics.... Finally,the evaluation of treatments must be considered in the context ofthe actual settings in IVHich the treatments are provided,(p. 874)

Another challenge is thatitis difficultto define with precision exactly WHat va are significantin a specific situation.Imagine,for example,that a series of experiments evaluated the effectiveness and efficiency of differenttreatments for a specific psychol cal syndrome, perhaps one ofthose 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 offidelity is, at best, variable....[E] cological validity is a matter of degree, and as the universe oftherapy situations to WHich one wishes to generalize expands, one has to be increasingly cautious in interpreting the results of RAS designs. WIllthe treatment WOrk in other cultures? WIllit WOrk for people with comorbid diagnoses? VIIllit WOrk for people on a particular combination of drugs? HOW willit work for people WLo are highly resistantto psychotherapy? In the end, one must ask just hOW generalthe results of any given study or set of studies can be.(2006. p. 269)

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

Trying to determine WHether a set of studies can be validly generalized to other viduals, other cultures, and other situations is difficult enough, but Alan Kazdin (2006 takes the challenge to a deeperlevel:In light ofthe kinds of measures used in most therapy research, do WC have logical, empirical, or other scientific proofthatthe indivi uals in the research studies themselves are being helped? A fundamental scientific and clinical question, according to Kazdin, "is WLether ourfindings 'generalize'to patient functioning. Stated more empirically, WHat exactly is the evidence that EBTs [Evidence Based Therapies] help patients? I believe itis possible to delineate an EBT ...thatimproves the life of no one" (p. 46). Furthermore, he says,

> In mosttherapy studies, measures are notlinked to specific referents in everyday life and are arbitrary metrics. Fancy data transformations, creation of nCW metrics, and

> statisticalrazzle-dazzle can be very useful(and WOrked with my dissertation committee, even if only forthe first hour of my six-hourroot-canal-like oral defense). However,these statistical strategies do not alterthe arbitrariness ofthe metric, and in the case of psychotherapy research,they say little to nothing about WヽetherIVatients have changed in IVれys that make a difference,(p. 46)

Carol Goodheart(2006)identified a challenge on yet anotherlevel

> Psychotherapy is first and foremost a human endeavor.Itis messy.Itis 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 oftact and timing, of WヽenIVto push and IVヽen to be patient. They know the spectrum of disruptions that can occurin a working alliance and are versatile and empathetic in theirreparative 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 practise, defining it as

> the integration ofthe 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 oftrial 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.
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> Perhaps the central message ofthis task force report@and one ofthe most heartening aspects ofthe process thatled 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 ofthe value of multiple sources of scientific evidence.In a given clinical circumstance, psychologists of good faith and good judgment may disagree about how bestto weigh differentforms of evidence; overtime, WC presume that systematic and broad empiricalinquiry@ヒn the laboratory and in the clinic@will pointthe way toward best practice in integrating best evidence. Whatthis documentreflects, however,is a reassertion of WLat psychologists have known for a century: The scientific method is a way ofthinking and observing systematically, and itis the besttool WC have for learning about WIIat WOrks for WヽOm.(p. 282)

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

> Itis not clear WヽetherthE EBP movementis good for clients.... There is agreement on the interest and priority ofimproving client care. There is disagreement on the extentto WヽIich conclusions from research oughtto be applied to and constrain clinical practice and the extentto WヽIich practitioners can genuinely identify client needs and apply the best or more appropriate combination oftreatments based on that evaluation,(pp. 7-8)

The debate about evidence-based practice is notlimited 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 explicittreatment guidelines for behavioral problems such as depression and anxiety, butthe use of practice guidelines in mental health remains controversial. Proponents of practice guidelines argue thatthey bring much-needed standardization to a field that has suffered greatly from extensive bu unnecessary variance in practice (largely as the result of a lack of standardized traini in the mental health professions). Critics ofthe guidelines, on the other hand, argue th every clinical case is unique and adamantly reject any attemptto apply standardized trea ment protocols, algorithms, or "cookbooks." Moreoverfe1Terrence Shaneyfelt and Robert Centor(2009) argue that "too many current guidelines have become marketing and opinion-based pieces, delivering directive ratherthan assistive statements" and that "Most curre articles called 'guidelines' are actually expert consensus reports" (p. 868). They wrote

> The overreliance on expert opinion in guidelines is problematic. All guideline co mittees begin with implicit biases and values, Wヽich affects the recommendations they make. However, bias may occur subconsciously and,therefore, go unrecog-nized. Converting data into recommendations requires subjective judgments;the value structure ofthe panel members molds those judgments,(p. 868)

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

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

The other chapters in this book illustrate the great diversity of approaches to p chotherapy.In light ofthat diversity, and the diversity of human nature itself, perhaps should not be surprising thatthere is no general agreement aboutthe definition, meth-odology, 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 historicalroots. APA president Carl ROgers setin motion an organized effortto define psychotherapy TELHen he appointed David ShakOW to chair a special committee. The APA convention of1947 adopted the Shakow committee report, Wヽich led to the Boulder Conference in 1949. The Boulder Conference recorder summarized the result ofthis massive effortto define psychotherapy in a memorable passage: Psychotherapy is "an undefined technique IVヽich is applied to unspecified problems with a nonpredictable outcome. Forthis technique WC recommend rigorous training" (Lehner,1952. p. 547).

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You have established a busy practice, and you schedule eight1-hour sessions each day. YOu use your computer both for billing and forrecord keeping, and all of your clientfiles are maintained on your office computer. TOu 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,itis especially frustrating when your hard drive crashes, and you realize that you have not backed up yourfiles in months. When you frantically call a local computerrepair company, you are told that your data can probably be recovered butthat a technician will need access to your computerfor an entire day. YOu can bring your computerinto the shop forrepair, orthe technician can visit your clinic to do the work on site. A colleague is on vacation, めれメ you will be able toofficeher office to see your patients, so you tellthe com-puterrepair company to send somebody outthe next day. What ethical dilemmas does this vignette present? Is itreasonable to expect a therapistto cancel eight patients in orderto simply sit and watch someone work on her computerfor 8 hours? Is it sufficientto simply "check in" on the technician between patients?

Scenario One

The digital age makes it possible for psychotherapy to occur withouttherapist and patient ever meeting face to face or even being in the same country. Considerthis scenario:

Someone seeking therapy begins the search on the Internet, examining a number of therapists Web sites. One site offers just whatthe prospective patientis looking for. The site provides a list of available times forinitial sessions, one of which is convenient. The soon-to-be patientreads a series of passages describing the nature and ground rules ofthe therapy, the exceptions to confidentiality,the responsibilities of both therapist and patient, and so on. Afterreading each passage,the individualindicates <(agree" or "disagree" as part ofthe 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 getto know a little about each other and decide whetherthey both want to work together. The prospective patient must pay the fee in advance, by credit card,to reserve the time forthe initial session.

Therapist and patient meet on the Internet once a week for 45-minute sessions for a total of12 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 patientfrom finding a new line of work. When the patient decides itis 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 patientin 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 patientin this scenario is particularly appreciative ofthis mode oftherapy. Not only was she able to find a therapist whose skills and personal approach were what she was looking for@the kindoftherapist who was simply not available in her own small,remote community@butthis patientis in the advanced stages of a neuromuscular disease that makes it very difficultfor herto leave home. No longer able to speak, she communicates with others via assistive technology on her computerthat enables herto controlthe computer using a "sip-and-puff switch. Her words are displayed on a monitor.

Technologies enabling therapist and clientto work together without meeting each otherface to face, withoutliving in the same state or even in the same country, and without either ofthem leaving home have brought many benefits. Patients, especially those living in small orremote 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 disorderliving across a wide range of states, provinces, and otherlocales. Many patients@for example,those in the final stages ofterminal diseases;those Whose physical conditions limittheir mobility, and those with highly contagious diseases@can choose among a great variety oftherapeutic 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 thattherapy by computer ortelephone seems safe as an initialintervention. Therapists Whose physical condition makes itimpracticalforthem to travelto and from a job site orto spend extended time in an office can work from home, hospital, or hospice.

Scenario Three

These forms oflong-distance therapy have also brought challenges and controversy. For example,imagine a scenario in which a therapist begins work traditionally, working with the clientin anoffice setting. However,the company for which the client works transfers the clientto another state. Both client and therapist believe thatit would be in the client's interestto continue working with the same therapistratherthan starting overin the new state with a new therapist. Therapist and client continue to work forthe next 2 years, holding sessions by phone and computer. However,the client becomes profoundly depressed and confesses to the therapistthat 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 therapistfor malpractice.

During the extended litigation, a number ofissues arise:

- Was the therapist practicing without a license in the state to IVhich the client ha moved? If a therapist and patient are in differentjurisdictions during therapy se sions, mustthe therapist maintain appropriate licensing status in both jurisdicti If a therapistlives in Missouri and is licensed only in Missouri, WLat authority, any, does the state licensing board in Missouri have overthe therapist's WOrk via telephone orInternet with a clientliving in Illinois? What authority,if any, does the licensing board in Illinois have to regulate the WOrk ofthe therapist Who li Missouri? Does it make any difference ifthe patient and therapistlive only minute apart, but on different sides ofthe Mississippiriver?
- What are the standards of care regarding basic competence WHen therapy is conducted by telephone orInternet? What education,training, or supervised experience in telephone therapy orInternettherapy establishes thattherapists 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 protectthird parties that prevailin the state Where the therapistlives apply, or do such laws ofthe state in Which the clientlives apply, or do both sets oflaws apply? What happens if the laws in the therapist's state conflict with the laws in the client's state? F example, IVIIatifthe laws in one state require that certain information be kept confidential, whereas the laws ofthe other state require thatthe information be reported?
- Whatinformation abouttelephone therapy orInternettherapy must a therapist be sure that a client understands and consents to as part ofthe process ofinformed consent and informed refusal?

Under WLat conditions is telephone therapy orInternettherapy covered or not covered@under different professionalliability 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 theirreviCW, 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 offerthe particular services and should considerthe limitations of efficacy and effectiveness that may be a function ofremote delivery.
2. Practitioners should consult with their professionalliability insurance carrierto ascertain Whetherthe planned services will be covered.Ideally, a written confirmation from a representative ofthe 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 atthis time,thoughtful written plans thatreflect careful consultation with colleagues may suffice to documentthoughtful professionalism in the event of an adverse incident.

5 A careful statement on limitations of confidentiality should be developed and provided to clients atthe start ofthe professionalrelationship. The statement should info[illegible] clients ofthe 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 Internettransmissions).

6 Clinicians should thoroughly infoF[illegible] clients of W[illegible]atthey can expectin terms of services offered, unavailable services (e.g., emergency or psychopharmacology coverage), access to the practitioner, emergency coverage, and similarissues.

7 Ifthird parties are billed for services offered via electronic means, practitioners must clearly indicate thatfact on billing forms.If a third-party payer who is unsupportive of electronic service delivery is wrongly led to believe thatthe services took place in person ratherthan online,fraud charges may ultimately be filed.

Formal guidelines relevantto therapy provided by telephone orInternet, as IVCll as discussion ofthe othertopics included in this chapter, can be found on the Web page Ethics Codes (S- Practice G[illegible]idelines 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 ofInternet Counseling" and the APA's "American Psychological Association: Statement on Services by Telephone, Teleconferencing, & Internet."

The continuing evolution ofthe digitalrevolution has great potentialfortransfo[illegible]ing 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 W[illegible]ich "nCW media tools like weblogs,instant messaging platforms, video chat, and social networks are reengineering the W[illegible]y doctors and patients interact" (p. 361).

Digitaltechnology has created changes and challenges fortherapists in another area of practice:the storage and transmission ofrecords. Even though the widely hailed "paperless office" has not come to pass for mosttherapists, many therapists use computers to handle clinical data. Some may use computers to administer, score, orinterpret psychologicaltests and other assessmentinstruments. Many use computers forrecording information abouttheir clients and notes on psychotherapy sessions. Spreadsheets and specialized software handle billing,track accounts receivable, and provide documentation to insurance companies and otherthird-party payment sources.

How can therapists make sure thatthis confidentialinformation is restricted to those authorized to see it? It may seem a reasonably easy challenge, buttherapists and patients have been stunned by instances in W[illegible]ich supposedly secure information fell into the wrong hands. Here are some ofthe things that can happen:

- A desktop orlaptop computer containing confidential patientinformation is stolen from an office.
- A caris vandalized, and a laptop stored in the trunk is stolen
- Someone hacks into a computerthatis connected to the Internet and steals the information stored on the computer s hard drive.

A virus, WOてIIJ, Trojan, or other malware infects a computer and sends confidential files to a hacker, uploads confidentialfiles to a Web site WトIere anyone can read thCIIII, and sends confidentialfiles to everyone listed in the computer s address book. This includes allthe Internet discussion groups to WトIich 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 oftherapy sessions).

Someone sits down at an unattended computerthatis not password-protected or whose password is easy to find (in the desk drawer, underthe keyboard, or on a Post-it note nearby) or easy to guess (the person's name,the word "password") and reads, downloads, ortransmits confidential data to unauthorized sources.

Someone reads a monitor@and obtains confidentialinformation@by standing near the monitor or sitting nextto a laptop userin an airport, on a flight, orin some other public setting.

A therapist and client discuss extremely sensitive information, unaware that because one ofthem 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 confidentialinformation to a colleague who is authorized to have it, but accidentally uses the WFong e-mail address.

A therapist e-mails a message containing confidentialinformation to a colleague WHo is authorized to have it, butthe recipient shares his or her computer with someone else WトO opens the e-mail message.

A therapistfaxes confidentialinformation, butthe recipient s fax machine is shared with others.

A therapist keeps clinical and financialrecords on a computer, unaware that spyware has been installed on the computer.

A therapistfaxes confidentialinformation but, by mistake, punches in the wrong fax number.

A therapist sells a computer,forgetting that confidentialinformation,thought "erased" from the hard drive,is stillrecoverable because a more thorough foてIIII 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 IVOrking with people. For most of us in this field, however, IVOrking with computers and othe digital devices is not our strong suit. When we use digital devices to handle the most sensitive and private information about our clients, we mustrememberto live up to an ancient precept: First, do no haてIIJ.

Therapists@and all students learning to be therapists@should also realize that most clients will "Google" theirtherapist's name either before orimmediately afterthe first session. This can be particularly problematic WトIen a therapist's Facebook page or a similar social networking site (e.g., a dating service) contains highly personalinform tion that one IVOuld not wantto have shared with one's clients. Admissions committees for professionaltraining programs are currently grappling with the issue of WトIether or not highly personalinformation (e.g., nude photos) obtained from an Internet search is appropriate data to be shared with other members ofthe committee and used in making decisions about admission to professionaltraining programs.

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

You are a therapistin a hospital and mental health center seeing yourlast client ofthe day. She is dressed in a short skirt and t-shirt, and shehas for several sessions hinted at some secretthat 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 dre切形 that may have given herthe courage to work on her secretin therapy. She tells you the dre切形 in detail.It is an erotic dre夕彬, and you find yourself becoming intensely aroused. She says that allthe 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 hert-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 aboutthe size of his penis and suddenly pulls down his pants, are yourresponses to these questions different in any way?

Sex is the focus of one ofthe most ancientrules of WOrking with patients,is a cause of discomfort and confusion for many therapists, and is a contemporary challenge for the profession.

Sexual Involvement

No circumstances orrationale justify sexualinvolvement with a patient. This basic rule has ancientroots. Annette Brodsky's (1989)research led to her discovery thatthe prohibition is olderthan the Hippocratic Oath, WHich included it.In fact, she found thatthis prohibition Was setforth centuries earlierin the Nigerian Code ofthe Healing Arts.

The prohibition continues to be fundamentalto the profession for many reasons, including the issue of harm to patients.In the landmark 1976 case otRoy v. Hartogs, for example, NCIV YOrk Supreme Court Presiding Justice Markowitz Wrote, "Thus from [Freud]to the modern practitioner WC have common agreement ofthe harmful effects of sensualintimacies between patient and therapist" (Roy v. Harfogs,1976. p. 590).

Studies ofthe effects oftherapist-patient sexualinvolvement have looked at both patients VIIo neverreturned to therapy and those VIIo WOrked with a subsequenttherapist; have compared those WHo engaged in sex with a therapist with matched groups ofthose WHo engaged in sex with a nontherapist physician and ofthose Who did not engage in sex with a health care professional; and have evaluated the effects of sexualinvolvement between patients and therapists using an array of measures including standardized psychologicaltests, clinicalinterview by subsequenttherapists and by independent clinicians, behavioral observation, and self-report(Pope,1994). Reading first-person accounts oftherapist-patient sexualinvolvement@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 oftherapist-patient sexualinvolvement on clients often seem to clusterinto lo 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) emotionalliability,(8) suppressed rage,(9)increased suicidalrisk, and (lo) 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 ofthe harm associated with sexual boundary violations, almost halfthe states have determined thatthe civillegislation and case law prohibiting sex with patients WCre insufficient and have added criminal penalties that can be applied in some situations.

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

Statistical analysis found no significant differences among the three professions veyed in these studies: Social IVOrkers, psychiatrists, and psychologists report becomin sexually involved with their patients atroughly the same rates.

These studies do, however,reveal significant gender differences. Male therapists reported engaging in sex with their patients at much higherrates (6.8%)than did female therapists (1.6%). By farthe most common pairing is a male therapist with a female patient, accounting for about 88-95% ofthe instances oftherapist-patient sex in large-scale peer-reviewed studies thatreport gender data.

Genderis a significantfactorin a variety of other sexual dual or multiple relationships and boundary issues (e.g., supervisor-supervisee, professor-student)@even when the base rates of genderin each role are taken into account@and in other non-sexual 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 ofthe higher status professionalroles (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 professionalresponsibility 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 common scenarios. Pope and Bouhoutsos (1986. p. 4) presented lo ofthe scenarios that seCIЦ to occur most often (see Table 16.1).

Nonsexual Physical Touch

Itis importantto distinguish therapist-patient sexualinvolvementfrom two very different phenomena. First, nonsexual physicaltouch is clearly differentfrom sexual involvement. Pope, Sonne, and Holroyd (1993) documented the ways in WЬich nonsexual physicaltouch within therapy had acquired a "guilt by association" with sexual touch. Theirreview ofthe research and other professionalliterature found no harm from nonsexualtouch 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, nonsexualtouch can be comforting,reassuring, grounding, caring, and an important part ofthe 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 therapist become the focus
Sex Therapy	Therapist fraudulently presents therapist–patient se treatment for sexual or related difficulties
As If . . .	Therapist treats positive transference as if it were nc of the therapeutic situation
Svengali	Therapist creates and exploits the dependence of th
Drugs	Therapist uses cocaine, alcohol, or other drugs as pa seduction
Rape	Therapist uses physical force, threats, and/or intimi
True Love	Therapist uses rationalizations that attempt to disco clinical/professional nature of the professional relati and its duties
It Just Got Out of Hand	Therapist fails to treat the emotional closeness that therapy with sufficient attention, care, and respect
Time Out	Therapist fails to acknowledge and take account of t the therapeutic relationship does not cease to exist b scheduled sessions or outside the therapist's office

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

Sexual Attraction to Patients

Like nonsexualtouch, sexualfeelings about patients seem to have acquired a guilt by association with therapist-patient sex. National studies indicate that simply experiencing sexual attraction to a clienお@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 oftherapists reportfeeling sexually attracted to one or more clients, and most also report discomfort with the feelings,these studies also suggestthat adequate training in this area is relatively rare. A majority reported no training in the area, and only around lo% of social workers and psychologists reported adequate training in their graduate programs and internships. Gerry Koocher,the 2006 president ofthe 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 sexualfeelings about clients as reflecting one of several basic myths abouttherapists thatinterfere with training and effective therapy The myth is

> that good therapists (those WHo don't sexually exploittheir patients) never have sexualfeelings abouttheir patients, don't become sexually aroused during therapy

sessions, don't vicariously enjoy the (sometimes) guilty pleasures oftheir patients5 sexual experiences, don't have sexualfantasies or dreams abouttheir patients,(p. 28)

Because ofthe widespread discomfort with sexualfeelings about clients and the inadequacy oftraining in this area,itis not surprising that many professional books do notfocus on this topic.

In light ofthe multitude of books in the areas of human sexuality, sexual dynamics, sex therapies, unethicaltherapist-patient sexual contact, management ofthe therapist's or patient's sexual behaviors, and so on,itis curious that sexual attraction t patients per se has not served as the primary focus of a wide range oftexts. The professor, supervisor, orlibrarian seeking books thatturn their primary attention to exploring the therapist s feelings in this regard would be hard pressed to assemble a selection from W卜ich to choose an appropriate course text.If someone unfamiliar with psychotherapy VCre to judge the prevalence and significance oftherapists' sexualfeelings on the basis ofthe books thatfocus exclusively on thattopic, he or she might conclude thatthe phenomenon is neither widespread norimportant.(Pope, Sonne, & Holroyd,1993. p. 23)

There may be a circular process at WOrk here: The discomfort about sexualfeelings 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 AN D B O U N DARY I S S U E S

You are a social worker providing weekly psychotherapy sessions to an extremely rich and successful CEO, Ms. Chin. YOur clientis struggling with how to implement her decision to acquire a medium-sized company. When she makes the public announcementthat she is buying the company, should she immediately announce the planned lay-offs atthe new company or should she take time to try to cushion the blow? Itis aboutthis time that you decide to buy some stock in her company. Ms. Chin is so appreciative of your help in sorting through her difficultissues that she asks you if you will attend a special event at her home, a celebration of herinstallation as the nピ功 president ofthe company. アOu acceptthe invitation and, during the all-day celebration, wind up playing tennis with her and some of herfriends 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 confidentialinformation, was not based on illegally obtained information, and, as you think aboutit, was something you had planned to do all along, even before you heard that Ms. C万en's investment group would be buying a new company. YOur weekly visits to Ms. C万en's estate allow you to see herin 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.Itis all very proper, and everyone benefits. As you imagine yourself as the therapistin 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, severthe therapist-patient alliance, and cause immediate orlong-term harm to the client. Choices about WHetherto cross a boundary confront us daily, are often subtle and complex, and can sometimes influence VLethertherapy 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 ofthe status quo, and open discussion frOIIIL diverse points of viCW. A vigorous, wide-ranging, and healthy controversy over therapists' nonsexual multiple relationships and other boundary excursions blossomed. Was it good practice for a therapistto enterinto dual professionalroles with a client, serving both as a client s therapist and as that client's employer? What about multiple socialroles? Is it helpful, hurtful, or completely irrelevantfor a therapistto provide therapy to a close friend, spouse, or stepchild? Are there any potential benefits orrisks to social outings with a client(meeting for dinner, going to a movie, playing golf, or heading off for a WCekend of sightseeing), so long as there is no sexual orromantic involvement? Are financialrelationships (say,the therapist borrowing a large sum from a clientto buy a new house or car, orinviting a clientto investin the therapist's new business venture) compatible with the therapeutic relationship? What aboutlending 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 TELhat circumstances should a therapist accept bartered services or products as paymentfortherapy 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 her1988 article on "Dual ROle Relationships," ethicist Karen Kitchener provided systematic guidance to readers on the kinds of "counselor-clientrelationships that are likely to lead to harm and those that are notlikely to be harmful" (p. 217). According to Kitchener,the kinds of dualrelationships that were mostlikely to be problematic WCre those in WhIch there were "(I)incompatibility of expectations between roles;(2) diverging obligations associated with differentroles, WhIch increases the potentialforloss of objectivity; and (3)increased power and prestige between professionals and consumers, WLich increases the potentialfor exploitation" (p. 217). Similarly,in the 1985 edition oftheir widely used textbook Ethics in Psychology: Professional Standards and Cases, Patricia Keith-Spiegel and Gerald Koocher discussed ways in WIIich boundary crossings may be unavoidable in good clinical practice and presented ways to think through the ethicalimplications of specific dualrelationships or other boundary issues. Patrusksa Clarkson, IVLo wrote "In Recognition of Dual Relationships," discussed the "mythical, single relationship" and wrote that "itis impossible for most psychotherapists to avoid all situations in WLich 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 dualrelationships (DRs)is no longertenable" (1994. p. 225). Similarly, RObert Ryder andjeri Hepworth (1990) setforth thoughtful arguments thatthe AAMFT ethics code should not prohibit dualrelationships. Jeanne Adieman and Susan Barrett(1990)took a fresh and creative look,from a feminist perspective, at hOW to make careful decisions about dualrelationships 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 thatthe focus on the duality ofroles be replaced by an examination of WhIether each instance did or did notinvolve exploitation.

Elisabeth Horst,(1989) and Amy Stockman (1990) WCre among those WHo explored issues of dualrelationships and boundaries in rural settings. Melanie Geyer(1994) examined some ofthe decision-making principles that had evolved for evaluating multiple relationships and boundary issues in rural settings and adapted them for some ofthe unique challenges faced by Christian counselors (and counselors for VLom otherreligious faiths are a focus of practice). Ethics &- Behavior was one of many journals in th 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 aboutthe issue of boundaries in therapy and explored their contrasting approaches.

The care with WHich these diverse articles and books in the 1980s and first hal the 1990s examined a diverse array of contextualissues such as the nature ofthe community (e.g.,rural or smalltown) and the therapist's theoretical orientation,in thinking through IVIIether 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%) of1,600 psychiatrists,1,600 psychologists, and 1,600 social WOrkers found thattherapists' behaviors and beliefs about a wide range of dualrelationships and other boundary issues tended to be significantly associated with factors such as

- Therapist's gender
- Therapist's profession (psychiatrist, psychologist, social WOrker)
- Therapist's age
- Therapist's marital status
- Therapist's region ofresidence
- Client's gender
- Practice setting (such as solo or group private practice or outpatient clinic)
- Practice locale (size ofthe community)
- 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 Callfor a Change in the APA Ethics Code

The first ethics code ofthe 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 ofthat survey, performed 50 years afterthe original,led to a callfor a change in the APA ethics code regarding dualrelationships.

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

- define dualrelationships more carefully and specify clearly conditions under WHich they might be therapeutically indicated or acceptable;
- address clearly and realistically the situations ofthose WHo practice in smalltowns, rural communities,remote locales, and similar contexts (emphasizing that neither

the current code in place atthe time northe draftrevision under consideration at thattime fully acknowledged or adequately addressed such contexts); and

distinguish between dualrelationships and accidental orincidental extratherapeutic contacts (e.g.,running into a patient atthe grocery market or unexpectedly seeing a client at a party)...[in order]to address realistically the awkward entanglements into VHich even the most carefultherapist can fall.

The following section from the American Psychologistreport ofthe study presents the relevantfindings, examples, specific suggestions for changes, and reasoning.

Blurred, Dual, or Conflictual Relationships

The second mostfrequently described incidents involved maintaining clear,reasonable, and therapeutic boundaries around the professionalrelationship with a client. In some cases,respondents were troubled by such instances as serving as both "therapist and supervisorfor hours for[patient/supervisee's] MFCC [marriage, family, and child counselor]license" or WLen "an agency hires one ofits own clients." In other cases,respondents found dualrelationships 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 socialrelationships and WHo are members of his small church makes sense because he is "able to see how these people interactin group context." In still other cases,respondents reported thatit was sometimes difficultto knOW WHat constitutes a dualrelationship or conflict ofinterest;for example, "I have employees/supervisees VIIo WCre former clients and WOnderifthis is a dualrelationship." Similarly, anotherrespondentfelt 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 thatthere 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,Ifeltit necessary to referto avoid a dualrelationship (atthe cost ofthe gains that had been made).

Taken as a WHole,the incidents suggest,first,thatthe ethical principles need to define dualrelationships more carefully and to note with clarity if and WHen they are evertherapeutically indicated or acceptable. For example, a statement such as "Minimal orremote 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 WIIom she or he meets forlunch a few times a year,to an accountant IVHo 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 involvementin the business and with WIIom the psychologist never socializes), and to a travel agent(who books perhaps one ortwo flights a yearforthe psychologist) may constitute relatively minimal orremote relationships. However, will a formal code's assurance that minimal orremote relationships are unlikely to violate the standard provide a clear, practical, valid, and useful basis for ethical deliberation to the psychologist VIIo serves as therapistto allfour individuals? Research and the professionalliterature focusing on nonsexual dual relationships underscores the importance and implications of decisions to enterinto orrefrain 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 smalltowns,rural communities, and otherremote locales. Neitherthe current code northe current draftrevision explicitly acknowledges and adequately addresses such geographic contexts. Forty-one ofthe dualrelationship incidents involved such locales. Many respondents implicitly or explicitly complained thatthe principles seem to ignore the special conditions in small, self-contained communities. For example,

> Ilive and maintain a ... private practice in a rural area.I am also a member of a spiritual community based here. There are very few othertherapists in the immediate vicinity WHO work with transformational, holistic, and feminist principles in the context of good clinicaltraining 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 wantto WOrk with someone WHO understands their spiritual practice and can incorporate its principles and practices into the process oftransformation, healing, and change. The stricture against dualrelationships 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 dualrelationships and accidental orincidental extratherapeutic contacts (e.g.,running into a patient atthe grocery market or unexpectedly seeing a client at a party) and to address realistically the awkward entanglements into WHich even the most carefultherapist can fall. For example, a therapist soughtto 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 respondentreported,

> Six months ago a patientI had been working with for 3 years became romantically involved with my best and longestfriend.I could write no less than a book on the complications ofthis fact!I have been getting legal and therapeutic consultations all along, and continue to do so. Currently they are living together and Ireferred the patient(who was furious thatI did this and felt abandoned). I worked with the other psychologistfor several months to provide a bridge for the patient.Itold MY friend soon afterIfound outthatI WOuld have to suspend our contact.I'm currently trying to figure outif we can everresume ourfriendship 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 oftheir patients. Although itis impossible to anticipate every pattern of multiple relationship orto accountfor allthe vicissitudes and complexities oflife, 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)

Itis WOrth emphasizing thatthe 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 oftherapy. RObert Simon and Daniel Shuman (2007) wrote:

> Itis 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 perfecttherapists and no perfecttherapies. 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 viCW from diverse perspectives. Fortunately fortherapists and counselors, there is no shortage of WCll-informed,thoughtful, practical guides to this area. Forthose 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 settings in "Managing multiple relationships in rural communities: Neutrality and boundary violations"
3. Lamb and Catanzaro's 1998 modelin "Sexual and Nonsexual Boundary Violations Involving Psychologists, Clients, Supervisees, and Students:Implications for Professional Practice"
4. Younggren's 2002 modelin "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 Modelfor Clinicians" (Note: This set of guidelines is on the web at http://kspope.com/dual/index.php.)

Forthose 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 ofthe widely used guides mentioned above, and otherresources in the area of multiple relationships and other boundary issues are online at http://kspope.com/dual/index.php.

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

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.

hallenge this area is for mental
y of psychotherapy itself. WC
ards and guidelines do oui
re the uniqueness of every
therapeutic encounter.

Awareness ofthe ethics codes is crucialto competence in the area of ethics, but the formal standards are not a substitute for an active, deliberative, and creative approach to fulfilling our ethicalresponsibilities. 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)

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however, lies in the fact that I never learned this behavior in a
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cally based psychotherapy. (p. xxii)

Setting appropriate boundaries and limits presents vexing dilemmas
Consider the following situations and discuss how you would respon

- Several of your clients ask to follow you on Twitter and to be list

(continued)

- A patient you have seen for many years commits suicide, and the p
  a trial attorney who has been paying the bills for therapy for many
  have a private session to "get closure on David's death."
- A client reveals that she is in fact "Maria," a woman you have be
  on an Internet dating site for the past 2 months.
- A state trooper—who also happens to be one of your clients—stop

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 front steps is a call-box system allowing people outside to call the phone in 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 cellphone. 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 buildings 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 ofidentifying and addressing physical barriers is th 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." Anotherrespondentindicated that a child with hearing impairment had been misdiagnosed with mentalretardation. W士th regard to testinterpretation, a respondentreported that a provider administered a short version ofthe Minnesota Multiphasic Personality Inventory and did nottake 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 providerrefusalto treat persons with disabilities. (Leigh, Powers, Vash, & Nettles, 2004)

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

> Therapists gave different priorities to treatmentthemes depending on WLetherthe client had a disability and W卜etherthey,the therapists, had received any training in disability issues. Untrained therapists WCre more likely to focus on extraneous issue and less likely to focus on appropriate themes for a sexual abuse survivor with a disability (p. 378).

Among the findings IVCre that "even a small amount oftraining on issues of disabi ity may be associated with significantly less bias in case conceptualization and treatme planning" (p. 383).

Unfortunately, studies of hOW therapists are trained suggestthat we have a long w 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 clinicaltraining... We found that ofthe 618 internship sites recently listed on the APPIC web-site, only 81listed a disabilities rotation.... The picture is even bleaker WHen we examine how training sites accommodate clinicians with disabilities.(Kemp, Chen, Erickson, & Friesen, 2003)

DETAIN EE INT-ERRO GAT IONS

Scenario One

You are a therapistin independent practice. Several government officials arrive at your office to explain that one of your clients has been placed in a high-security centerfor 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 farrefused to discuss the topic, in time to preventthe attack. Emphasising thatlives are at stake and there is not a moment to waste,theofficials ask for your client's evaluation and treatmentrecords so thatthey can be faxed immediately to the interrogation team. They ask you to accompany them to the holding center so thatthe interrogation team can consult with you aboutthe strategies mostlikely to gain the client's trust and persuade hえ形 to cooperate. They also ask you to talk with your client because he trusts you. When you hesitate,they stress thatthe 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 centralto this process because an understanding of an individual's belief systems, desires, motivations, culture and religion likely will be essentialin assessing how bestto 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 thCμ apart, according to the American Psychological Association,from psychiatrists and other physicians. The Director ofthe APA Ethics Office wrote: "This difference, WHich stems from psychologists' unique competencies,represents an important distinction between VLatrole 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 orlaw enforcement authorities, VLether in the United States or elsewhere. Direct participation includes being presentin the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques ofinterrogation with particular detainees (American Psychiatric Association, 2006).

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

Why did the American Psychiatric Association and the American Medical Association adopt an approach to involvementin 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) WFote:

> Itold 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 IVLat makes us differentfrom psychologists, here itis. This is a paramount challenge to our ethics and our Hippocratic training. Judging from the record ofthe actualtreatment of detainees,itis the thinnest ofthin lines that separates such consultation from involvementin facilitating deception and cruel and degrading treatment.Innocent people being released from Guantanamo@people WIIo never WCre our enemies and had no usefulinformation in the War on Terror@are returning to their homes and families bearing terrible internal scars. Our profession is lostif we play any role in inflicting these WOunds,(p.1713)

The American Psychiatric Association's stance distancing itselffrom 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 ofits contributions to the interrogations,led the Pentagon to adopt a nCW policy in 2006 thatfocused solely on psychologists,ratherthan including

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

> Pentagon officials said Tuesday they IVOuld try to use only psychologists, not psychiatrists,to help interrogators devise strategies to getinformation from detainees at places like Guantanamo Bay, Cuba. The nCIV 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 forthe counterpart group for psychologists,the American Psychological Association, said psychologists knCW notto 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 "notto participate in activities that harmed detainees" and their "valuable contributions" toward "protecting our nation's security through interrogation processes." In 2007.the president ofthe American Psychological Association wrote: "The Association's position is rooted in our beliefthat having psychologists consult with interrogation teams makes an important contribution toward keeping interrogations safe and ethical."

Itis worth noting, however,that some reports suggested thatthe effects of psychologists'involvement were not all positive. Eban (2007; see also Goodman, 2007), for example, documented ways in V]-ich "psychologists weren't merely complicitin 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 WCre enlisted to help develop more aggressive interrogation methods,including snarling dogs,forced nudity and long periods of standing, againstterrorism suspects, according to a Senate investigation." Mayer(2008) reported: " [General] Dunlavey soon drafted military psychologists to play directroles in breaking detainees down. The psychologists were both treating the detainees clinically and advising interrogators on how to manipulate them and exploittheir phobias ..." After publishing a series ofinvestigative reports,the Boston Globe (2008) stated: "From the moment US military and civilian officials began detaining and interrogating Guantanamo Bay prisoners with methods thatthe Red Cross has called tantamountto torture,they have had the assistance of psychologists."

The sharp disagreements overinterpretations ofthe 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 underthe heading: "Newly Unredacted Report Confirms Psychologists Supported IllegalInterrogations in Iraq and Afghanistan." The ACLU disagreed with the viCW thatthe Director ofthe APA Ethics Office had expressed:

> We do not, however, agree with your conclusion that documents recently obtained by the ACLU through its Freedom ofInformation Act Litigation demonstrate that the APA's 'policy of engagement served the intended purpose'.... Rather, we are deeply concerned by the factthat, viewed in context,these documents warrantthe 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 letterto 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 factthat psychologists WCre 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 repairthe ha[illegible] they have caused to the profession,the country,former and current detainees and theirfamilies.

The American Psychological Association has not yetreached a final or complete resolution ofthe complex and difficultissues 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 W[illegible]ere "persons are held outside of, orin violation of, eitherInternational Law (e.g.,the UN Convention Against Torture and the Geneva Conventions) orthe US Constitution (where appropriate), unless they are working directly forthe persons being detained orfor an independentthird party WOrking to protect human rights" was approved by a vote ofthe APA membership.(APA, 2008a)

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

Working our way through these difficultissues,to WLich there are no easy answers, willrequire a carefulreview ofthe available documents, evidence, and arguments; criticalthinking 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 fullrange of views ofthe controversy over psychologists, psychiatrists, and other health care professionals participating in the planning orimplementation of detainee interrogations is available at http://kspope.com/interrogation/index, php.

R-, は九TU・R
ES

You are a marriage and family counselor who works in a large mental health clinic. One [illegible]ugh E乃-
index.php. client says,
that your
own culture and the culture ofthis clinic have any effects on me and 形ツ therapy? For

RES

be of a differentrace. Why do you think thatis and do you think it has any effects on what

You are a marriage and family counselor who works in a large mental
client immigrated to the United States from another country and has l
glish to communicate adequately during therapy. During the fourth sess
"As you know, I come from another culture and I was wondering: Do

W.

advance? When you imagined this situation, what country did you imagine the client emigrated from? Whatrace was the client? The therapist? The cleaning staff? Why did these particularimages 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 ofthe most obvious challenges occurs when the cultures speak differentlanguages.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 otherthan 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 V ⊦o spoke a language otherthan English at home grew by 15.1 million (a 47 percentincrease), and the number with limited English proficiency grew by 7.3 million (a 53 percentincrease ...). The numbers are particularly high in some places:in 2000. 40 percent of Californians and 75 percent of Miamiresidents spoke a language otherthan English at home, and 20 percent of Californians and 47 percent of Miamiresidents had limited English proficiency (pp. 229-230)

Even W ⊦en 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 ofthese groups" (Kretsedemas, 2005. p.109).

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

> A preponderance ofthe empiricalresearch 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 socialtasks and stressors that are a component of gay and lesbian identity formation in conjunction with ethnic identity formation been taken into account. Discussion ofthe vicissitudes ofracism and ethnic identity in intra- and interracial couples ofthe same gender and their effects on these couples'relationships has also been neglected in the narrow focus on heterosexualrelationships found in the literature on ethnic minority clients. There has been an equally narrOV focus on predominantly VHite 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 significantrole in the development of psychological disorders. Jeanne Miranda (2006) wrote,

> Rates of depression and substance abuse disorders are lOV among Mexican Americans born in Mexico (Vega et al.,1998), and immigrant Mexican American WOmen have a lifetime rate of depression of 8%, similarto the rates of nonimmigrant Mexicans (Vega et al.,1998). However, after13 years in the United States,rates of depression forthose WOmen V ⊦o immigrated to the U.S.rise precipitously U.S.-born women of Mexican heritage experience lifetime rates of depression similarto those ofthe White population in the United States, nearly twice the rate ofimmigrants. These findings are mirrored in otherindicators 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 halfthat of White women (Takeuchi et al.,1998). These results suggestthat 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 betterin 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 fourtimes the risk of drug abuse, compared with recentimmigrants from Mexico. This finding is part of a growing body ofliterature thatindicates thatthe newly arrived are more resilientto mental disorders, and that assimilation is associated with higherrates 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 thatthe rate of the disorderis 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 partto the relative strengths of different social networks.
>
> A host of small studies suggestthatthe effects of psychiatric drugs vary widely acros different ethnic groups. There are even differences in the effect with dummy pills.

Itis crucialto rememberthat even though any names and descriptions we might use to identify cultures, groups, and similar characteristics relevantto a client may he us understand the client's WOrds, experiences, and behavior,they are not a substitute fo learning directly from and aboutthis unique individual.Individual differences within a group may overwhelm between-group differences, and an individual within a group may notreflect group characteristics. Any attemptto 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 ofthe research seems to assume. As Connie Chan (1997) puts it,

> Although identity is a fluid conceptin psychological and sociologicalterms, WC tend to speak ofidentities in fixed terms.In particular,those aspects ofidentity that characterize observable physical characteristics, such as race or gender, are perceived as unchanging ascribed identities. Examples ofthese WOuld include identifications such as Chinese woman, or ん Orean American woman, or even broaderterms such as woman of color, WIIich are ways of grouping togetherindividuals V ト o are not ofthe hegemonic "white" race in the United States. We base these constructions ofidentity upon physical appearance and an individual's declaration ofidentity. However, even these seemingly clear distinctions are not definitive. For example,I, as a V Oman 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 insistthat she is not a WOman of color because she does notfeel an affiliation with our group goals, even though she is a person of Chinese ancestry. Does her nonaffiliation take her out ofthe group of people of color? Or does she remain in regard less of her own self-identification because of her obvious physical characteristics? Generally,in the context ofidentities based upon racial and physical characteristics,

> ascribed identities will,rightly or IVτongly, continue to be attributed to individuals by others.Itis left up to individuals themselves to asserttheiridentities and demonstrate to others thatthey are or are not WЬatthey might appearto be upon first notice,(pp. 240-241; see also Wyatt,1997)

Itis also crucialthattherapists be aware not only ofthe client's culture but also ofthe therapist's own culture and how itinfluences the therapist's values,frameworks, theoretical orientation, understanding, and decisions. An exceptional book, The Spirit Catches You and 7Ou Tall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures (Fadiman,1997) documents in vivid detailthe efforts of health care professionals at a California hospital and a refugee family from Laos to help a Hmong child WЬom the health care professionals had determined was experiencing epileptic seizures. Despite the great expertise and dedication ofthe 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 ofthe Hmong patient and herfamily is on this case,the culture of biomedicine is equally powerful.If you can't see that your own culture has its own set ofinterests, 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 detailin an article (2004)in the New England Journal of Medicine:

> The culture of biomedicine is also responsible for some ofthe uncertainty surrounding depression. Symptoms thatrepresent a depressive disorderforthe practitioner (say, sadness and hopelessness in a patient dying from cancer) may not denote a medical problCíll to the patient, his or herfamily, ortheir clergy,for WЬom depression may be a sign ofthe moral experience of suffering. Whatis seen by a particular social network as a normal emotionalresponse@say, grieflasting for years@may count as a depressive disorderforthe psychiatrist, since the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), defines normal bereavement as lasting fortwo months.In this area,the professional culture, driven by the political economy ofthe pharmaceuticalindustry, may representthe leading edge of a worldwide shiftin norms.
>
> Yet many people with clinical depression@atleast 50 percent among immigrants and minority groups in the United States@stillreceive neither a diagnosis nortreatmentfrom a biomedical practitioner. Lack of access to appropriate services is a majorreason forthis 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 ofrisk factors with social supports and protective psychologicalfactors that contribute to depression in the first place. Culture may even turn outto create distinctive environments for gene expression and physiologicalreaction,resulting in a local biology of depression:research already shows that persons from various ethnic backgrounds metabolize antidepressant drugs in distinct WЬys.(pp. 951-952)

Melba Vasquez (2007; see also Comas-Diaz, 2006; Sue & Sue, 2007; Sue et al., 2006) provides an evidence-based analysis ofthe 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 Chapter15 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 ourtraining 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 thatfound that "Overall and for 86% ofthe individual items, participants did not practice WhatthEy preached" (p. 66)in terms of VhatthEy endorsed as the need for multicultural competencies. Hansen and her colleagues concluded that

> psychotherapists need to recognize their vulnerability to notfollowing through with whatthey knOW to be competent practice, and they need,in advance,to problem solve creative solutions.It WOuld be helpfulto identify your personal barriers in thi regard: Are you anxious aboutraising certain issues with racially/ethnically different clients? Are you uncertain about how bestto intervene? Do you fear you will "getin over your head" exploring these issues? What willittake 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 therapistis influenced by culture and ev is influenced by culture saves us from the misleading stereotype that multicultural couns ing 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 differentlanguage. As Pedersen, Draguns, Lonner, and Trimble (1989. p.1)remind us in Counseling Across Cultures: "Multicultural counseling is not an exotic topic that applie remote regions, butis 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.

Anoractic 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 thatthreatto these bonds resulted in psychopathology.

Authentic Mode (EX) A way of being described by Heideggerin 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 ofthe body.

Automatic Thought(CT) A personal notion orideation triggered by particular stimulithatlead to an emotionalresponse.

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 clientin 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, orterrible.

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 oflife's demands, denial of one's worth, and faulty values.

Behavioral Experiment(CT, REBT) Testing distorted beliefs orfears 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 ortreat physical problems (e.g., pain reduction, weightloss).

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.Itleads people to seek relationship and involvement with other humanbeings.

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 ahreaction.

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

Circular Causality (FT) The feedback model of a network ofinteracting 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 orrelationships from differentfamily members, especially regarding those points in the family life cycle when significant coalition shifts occur.

Classical Conditioning (BT) A form oflearning in which existing responses are attached to nCW stimuli by pairing those stimuli with those that naturally elicitthe response; also referred to as respondent conditioning.

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

Cognitive Behavior Modification (BT) A recent extension of behaviortherapy thattreats 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 attemptto alter maladaptive thought patterns and replace them with more adaptive cognitions.

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

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

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

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

Collective Unconscious (AP) The part ofthe unconscious thatis universalin humans,in contrastto the personal unconscious belonging to individual experience. The contents ofthe 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 differenttherapies share, predicated on the assumption that commonalities across therapies accountfor more ofthe 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 ofthe personal unconscious. Jung's discovery and explanation ofthe complex lent validity to Freud's beliefin the personal unconscious.

Conditional Assumption (CT) An erroneous "if then" interpretation of events thatleads to a erroneous conclusion (e.g., "I/one person dislikes me, then I am notlikable").

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

Congruence (CC) Agreement between the feelings and attitudes a therapistis experiencing and his or her professional demeanor; one of Rogers's necessary and sufficient conditions fortherapeutic 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 ofthe 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 ofreality.

Contact(GT) Basic unit ofrelationship involving an experience ofthe 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 phrase signifying concepts that are imaginary and unreal, but that may be helpfulin 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 thatthese three conditions are neither necessary nor sufficient fortherapeutic 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 ofthe explanations forthe effectiveness of systematic desensitization.

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

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

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

Cultural Genogram (MC) A therapeutic toolthat emphasizes the role of culture and contextin the lives of individuals and theirfamilies.

Cybernetic Epistemology (FT) A framework for conceptualizing and analyzing whatis being observed in terms ofthe flow ofinformation through a system.

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

Decatastrophizing (CT, REBT) A "whatif" technique designed to explore actualratherthan feared events and consequences.

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

Deconstructionism A theory ofliterary criticism that challenges many ofthe prevailing assumptions of psychotherapy Therapists influenced by deconstructionism attemptto "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 outerthreat. Examples include repression, denial, and projection.

Deflection (GT) A means of blunting the impact of contact and awareness by not giving orreceiving feelings orthoughts directly. Vagueness, verbosity, and indirectstatement 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 ratherthan assuming them to be "real."

Demandingness (REBT) The belief of some clients thatthey must get whatthey wantin life and thatitis a terrible tragedy ifthis does not occur.

Dementia Praecox An obsolete term for schizophrenia.

Denial(PA) A basic defense through which aspects of experienced reality are treated as ifthey 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 either-or 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 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.

Elektra 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 discern, 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 meetrigid criteria (e.g.,randomized clinical trials). For a treatmentto be empirically supported, patients receiving the treatment must have been shown to be better offthan patients WLo receive no treatment, and outcomes must be atleast equalto those obtained by alternative therapies that have been documented to be beneficial.

Empty Chair(GT) A chair WI-ose inhabitantis imagined by a client, with allthe client's projected attitudes. The imaginary occupant might be a significant person in the client's life, a figure from a dream, a part ofthe client's body or mind, or even the therapist. The chairis 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 (ratherthan verbalizing) a situation that deserves to be explored.

Encounter(GT) A dialogue between two persons, ortwo aspects ofthe same person, eitherin 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 ofthe origin, nature, methods, and limits of knowledge.

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

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

ExistentialIsolation (EX) Fundamental and inevitable separation of each individualfrom 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 ofthe 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 ofresponsibility, 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 selfin interacting with families.

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

Facilitator An individual who aids a group in going in 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 ofthe members of a family. The family constellation is an important determinant of life-style.

Family Sculpting (FT, PD) A nonverbaltechnique to be used by individualfamily members for physically arranging otherfamily members in space to represent the arranger's symbolic view offamily 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 aboutthe nature of reality and ourrelationship to reality in which our experiencees 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 alterthe basic organization ofthe system itself.

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

Free Association (PA) A basic technique of psychoanalysis in WIIich analysands are asked to report, without structure or censure, whateverthoughts 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 existentialtherapy,the giving up ofoneselfto become part of another person or a group, a particular attemptto reduce one's sense of isolation.In family therapy, a blurring of boundaries between family members with the resultantloss 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.

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

Generalization (BT) The occurrence of behavior in situations thatresemble but are different from the stimulus environmentin which the behaviorwas learned.

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

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

Genuineness (CC) The characteristic of being real and true to oneself;lack of pretense, socialfacade, orrefusalto 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 ourlife.

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 clientto uncoverrelevantinformation out of his or her current awareness, examine his or herinterpretations 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 apartfrom 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 meaningfulidea that produces strong emotionalreactions.

Hysteria An early term for conversion reaction disorderin which psychological disturbance takes a physicalform (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 ofthe biological,instinctual drives with innate and developmental components. See also Ego, Superego.

Identification (PA) A mental mechanism, used unconsciously in normalinteractions 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 orfor whom treatmentis sought.

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

Inclusion (GT) Putting oneself as completely as possible into another's experience withoutjudging or evaluating, while still maintaining a separate sense of self.

Individual Psychology (AD) An approach to understanding human behaviorthat 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 herindividual strengths and limitations.

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

Inferiority Feeling (AD) Seeing oneself as inadequate orincompetentin 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 togetherfor a brief but condensed period (e.g., a weekend)to engage in specialinterpersonal experiences that are designed to expand awareness of self and others.

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

Interlocking Triangles (FT) Basic units offamily relationships consisting of a series ofthree-person sets ofinteractions (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 ofthe individual.

Introject(FT)Internalized objectfrom one's past that affects currentrelationships.

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 origin of judgments, 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 to 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

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 (PD) Person who imitates a client's behavior and demeanor so that the client can more clearly see himself/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 (MC) 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 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 pastrelationships 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 tendencies regulation, self-image, and self-esteem.

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

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

Negative Reinforcement(BT) Any behaviorthatincreases the probability of a response by terminating or withdrawing an unpleasant stimulus. Negative reinforcementincreases the likelihood offuture occurrence ofthe behavioritfollows.

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

Neurotic Anxiety (EX) A state offear or apprehension out of proportion to an actualthreat. 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 rightto 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 thatthe basic human motive is the search for satisfying object (person)relationships. Associated with the writings of W. Ronald Fairbairn.

Oedipus Complex (PA) Erotic attraction ofthe 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 ofinformation with its environment.

Operant Conditioning (BT) A type oflearning in which responses are modified by their consequences. Reinforcementincreases the likelihood offuture occurrences ofthe reinforced response; punishment and extinction decrease the likelihood offuture occurrences ofthe responses they follow.

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

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

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

Overgeneralization (CT, REBT) Constructing a generalrule 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 interpretthe 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).

ParadoxicalIntervention (FT) A therapeutic technique whereby the patientis directed to continue the symptomatic behavior. To comply is to admit voluntary control overthe symptom;to rebelis to give up the symptom.

Paradoxical Theory of Change (GT) A theory of change thatis 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 thoughtto have clinicalrelevance. The major paraphilias include exhibitionism,fetishism,frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism.

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

Personal Unconscious (AP) An individual unconscious layer ofthe personality containing undeveloped partsofthe personality,repressed ideas, experiences, emotions, and subliminal perceptions. See also Collective IJnconscious-

Personalization (CT) Taking personalresponsibility for negative events without supporting evidence of personalinvolvement.

Phallic Phase (PA) A psychosexual phase in boys of ages 3 to 5 in which penile experiences and fantasies ofthrusting 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 experience without bias (external observations, intuitions, 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. Usually contrasted with instrumental nondirectiveness in which the therapist attempts to make 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 psychotherapists 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.

Reformulation Counseling (MC) An empowering 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) RClabeling behavior by putting it into a nCW, 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 ofthe reinforced response.

Replay (PD, BT) A psychodramatic technique, often used in behaviortherapy and other approaches, in which the clientrepeats a previous scene.Itis often applied in the mastery ofinterpersonal 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 ofan analysis ortherapy, usually involving a modification of a ground rule oftreatment and based on unconscious sources within both patient and analyst(i.e., interactionally determined).In Gestalttherapy,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 selfforthe environment and does to self what he or she originally did ortried to do to others. Retroflection is the chief mechanism ofisolation and is not necessarily unhealthy.

Role Playing Acting the part of oneself or someone else undertherapeutic 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 ReversalIn psychodrama,the dropping of the point of view of one's own role and taking on the attitudes and physical position and perspective ofthe other person in an interaction. A plays B and B plays A. Or sometimes,ifthe 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 deeperlevel 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 herto criticism, blame, or punishment.

Schema (CT) Strategy or way ofthinking 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 verbalthinking, 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 detailtaken 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, actions and so on.

Self-Instructional Training (BT) A technique, described most completely by Donald Meichenbaum, forreplacing 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 supportfor positive esteem.

Self-Regard (CC) That aspect ofthe self-concept that develops from the esteem orrespect 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 ofthe personality that are most often, but not always, negative.

Sharing The third phase of a psychodramatic enactment,in WIIich other group members in the audience and even auxiliaries share how thatrole playing may have touched on similar orrelated events in their own lives@工n contrastto 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 Gemeinschaftsgefuhl.

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

Sociometry A method in WLich groups give feedback aboutheirinterpersonal preferences (e.g., attraction orrepulsion).

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

Socratic Dialogue (CT) A series of questions designed to arrive atlogical 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 itimpossible 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 splitinto competent and incompetent selves and vacillate between these roles. A splitis 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 1in 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 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 organization or 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, usually 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 reinforcementfor 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 beliefin stable and enduring personality characteristics.

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

Triadic (FT) Pertaining to a relationship involving the interaction ofthree 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 differentroles by switching from one chairto the other.

Umwelt(EX) A way ofrelating 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 ofthe client as a human being,irrespective ofthe therapist's own values. One of Rogers's necessary and sufficient conditions for therapeutic change.

Unconscious (PA, AP) A division ofthe psyche,the repository of psychological material of which the individualis 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 higherlevel oftrust, and an increasing degree ofinvolvementin the task at hand.

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

Will to Power(AD)Individual striving for superiority and dominance in orderto 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 orderto 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,thatinfluence 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 ofthe times;the prevailing cultural climate.