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The Ethical Practice of Psychology in Small Unified Communities

The Rapidly Changing Health Care Environment

An Introduction to Psychotherapy Integration

Mindfulness Techniques in Your Private Practice Setting

Therapy Groups that Work: A Scientist-Practitioner Approach to Social Skills Training for Children

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Bulletin of Psychologists in Independent Practice

A Division of the American Psychological Association

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About the Independent Practitioner

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Submissions:

All submissions (including references) should be formatted in APA style and e-mailed as an attached Word file to the Editor and Associate Editor. If you do not have attached file capabilities, mail the disc to the Editor. Hard copies are not needed. Please write two sentences about yourself for placement at the end of the article and provide contact information you would like published (e.g., address, phone, E-mail, web page). Photos are appreciated and should be sent directly to the Central Office. Please limit submissions to 2,500 words, equivalent to 6 double-spaced pages.

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President's Column

Division 42 and the Psychological Sense of Community

— Steven Walfish

In his writings, Yale University Professor Seymour Sarason (1974) coined the phrase, "Psychological Sense of Community" (PSC). He defined PSC as "the perception of similarity to others, an acknowledged interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, and the feeling that one is part of a larger dependable and stable structure" (1974, p. 157).

It is because of the PSC that I have found my professional home in Division 42. Until 2008 I actively avoided becoming involved in APA except for paying my dues. When I was ready to test the waters, I sought the counsel of my friend Jeff Barnett. He suggested that I apply for the vacant position of Associate Editor of the IP as a way to get started in the Division. Working with the Editor Frank Froman, I started to get to know members of 42 who were writing articles or who I contacted to request that they consider making a submission. I also attended the 42 Board meetings where I felt: (a) privileged to be included, and (b) in awe of the people who sat around the table. While quite accomplished, I never sensed an ounce of arrogance in the group. I was a "newbie" but felt both professionally and personally welcomed.

McMillan and Chavis (1986) identified four elements of PSC. In the next few paragraphs I describe these elements as they apply to my involvement in 42. These elements are, membership, influence, integration and fulfillment of needs, and shared emotional connection.

Two components of membership, according to McMillan and Chavis (1986), include a "sense of belonging" and "personal investment." I have never felt quite so at home with "like-minded" people as I have with my 42 community. While I have occasionally met people who were interested in the "business of practice," 42 has exposed me to people who not only think about the business of practice, but many members: (a) have been at the forefront in defining the business of practice, and (b) have perfected the business of practice. We have an amazing community of talent. Read about what members are doing in the IP, listen to their advice on the listserv, participate in a Virtual Learning Hour, or attend workshops at APA or our Fast Forward or Forensic conferences, and just be dazzled with the wide array of talent that speaks our language. We have shared goals of: (a) being clinically and programmatically astute, and (b) financially successful. I have been willing to personally invest in 42 because so many members of 42 have shown they want to invest in me.

I am a solo practitioner and not a big-time university academic. I never dreamed that I could come to a Board meeting and sit in the room with former APA Presidents, former Division Presidents and leaders in our field and that these people would want to hear what I had to say. A significant early moment for me in 42 came after I expressed an opinion about psychologists needing to develop practice activities outside of traditional psychotherapy. The next speaker was Bob Resnick, a former APA President and the person who championed parity laws for psychology thru the courts. He said, "I agree with Steve." Yes, indeed this solo practitioner learned early that he can have influence in shaping the operations and future directions of 42. All I had to do was make the choice to get involved.

As a small business owner and private practitioner I have needs for information, instrumental support, and emotional support. For the integration and fulfillment of needs 42 has been there for me "in spades!" The Community for Psychologists in Independent Practice (the tag line for our Division) has been there to support me in my work. Need a business question answered? Post to the listserv. Need to find a book for a client? Post to the listserv. As is true with all of us, I have been faced with a few ethical dilemmas in my practice in the past few years. In those instances where I wanted to "talk it out" I have gotten on the phone with a few of the "ethics gurus" in the Division and received sage advice and direction. In the past 5 years, 42 has been there for me and I hope I have been equally as supportive to our community as well.

I learned from my mother the importance of relationships. She was about relationships. The shared emotional connection that I have had with my brothers and sisters of 42 has been nothing short of amazing to me. Come to a Board meeting and it is hugs abound. When my parents passed, an outpouring of support. I have not only developed close working relationships, but several close personal friendships that never would

have happened if I did not get involved in 42. These relationships will last long past my direct involvement in 42.

My psychology hero, Seymour Sarason, had it right when he wrote about the importance of the psychological sense of community. I would encourage you to increase your sense of community by becoming more involved in 42. It has been a blessing in my life. If you haven't posted or responded to the list serve please do so. If you have an idea to write an article for the IP, contact our Editor, Lawrence Riso, and run it by him. If you have a special skill or expertise that you would like to share or highlight, contact Pauline Wallin to see if you can lead a Virtual Learning Hour. Become involved in 42 and watch your PSC grow exponentially.

Mi casa su casa.

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Opinions and Policy

The Rapidly Changing Health Care Environment

—Pat DeLeon

As we begin to focus upon our forthcoming annual APA convention, to be held in Hawaii, we should reflect upon the challenge issued by Practice Directorate Executive Director Katherine Nordal at this year's exciting State Leadership Conference (SLC) to get personally involved in our state association's legislative efforts. "The clock is ticking toward full implementation of the law [President Obama's landmark Patient Protection and Affordable Care Act (ACA)] and January 1, 2014 is coming quickly. But January 1st is really just a mile marker in this marathon we call health care reform. We're facing uncharted territory with health care reform, and there's no universal roadmap to guide us. The details of ACA implementation vary from state to state, and so do the key players.... I want to highlight an important new development within APA, the Center for Psychology and Health. The Center includes a new Office of Health Care Financing, which will address challenges such as ongoing implementation of new psychotherapy billing codes and seeking new CPT (Current Procedural Terminology) codes that will adequately capture the work of psychologists in integrated care settings. Dr. Randy Phelps is heading up this office.... Yes, the clock is ticking toward January 1, 2014. But remember, we're not running a sprint. Health care reform is a marathon – we're in it for the long haul. New models of care and changes in health care financing won't take shape overnight. We can't hope to finish the marathon called health care reform if we're not at the starting line. Fortunately, many psychology leaders have embraced our call to action." SLC and our annual conventions have always been the highlight of the psychology year for me – such collective energy, vision, and enthusiasm. Katherine has a wonderful gift of vividly capturing the most critical agendas: This year, "Our practitioners increasingly will need to promote the value and quality they can contribute to emerging models of care. No one else is fighting the battles for psychology... and don't expect them to." Last year, "If we're not at the table, it's because we're on the menu. And I quite frankly don't want to be on anybody's plate to be eaten."

Randy's Vision: "APA launched its new Center for Psychology and Health under the direction of CEO Norman Anderson in January. One component of that Center is a new Office of Health Care Financing (OHCF), which we are currently setting up and will be directed by me. First, some background. As Norman has indicated in a number of venues, the purpose of the new APA Center for Psychology and Health is to vigorously pursue Goal Two of APA's Strategic Plan: Expand psychology's role in advancing health. The Center pulls together top leadership, staff, and major initiatives across all of APA to focus the association's efforts on four inter-related challenges outlined by Norman towards achieving this goal. They are: 1) Workforce, education and training challenges; 2) Influencing how we are viewed by policy makers, the scientific community, other disciplines and the public; 3) Addressing how we view and define ourselves; and, 4) What Norman calls the 'getting included, getting

paid' challenge. There is, and has been, a tremendous amount of work by APA on each of these challenges, and we will keep the membership informed.

"Specifically regarding the 'getting included, getting paid' challenge, hopefully you're aware of the ongoing advocacy by the APA Practice Organization to legislatively define psychologists as 'physicians' in Medicare, gain inclusion of psychologists in every state's Medicaid system, and legally challenge inappropriate insurance practices and parity violations. The new OHCF was created to augment those efforts, and will work in close partnership with Katherine and APAPO, although it will be housed in APA's Executive Office. Getting included as providers in all primary care and integrated care settings, playing a key role in inter-professional treatment teams, participating in Accountable Care Organizations (ACOs), etc., are all necessary, but not sufficient, steps to insuring our future. For example, if you (or your institution) are not being reimbursed for your services in the existing fee-for-service (FFS) system or in the newer care delivery models, you are at risk of being replaced by those who are reimbursable, or by lower cost providers.

"The AMA Strategy: Our strategy is to directly target this issue in the most critical national venues where financing policies and mechanisms are translated into actual reimbursement realities. The American Medical Association (AMA) is one of those venues, so a primary activity of the new OHCF for the immediate future is to coordinate and expand APA's involvement with the AMA. Their processes play a very direct and powerful role in shaping this country's health care financing policies and provider reimbursement levels – in both the public sector and the private health care market. The Center for Medicare and Medicaid Services (CMS) uses the AMA's recommendations to set the fees paid in Medicare. And, these Medicare fees become the benchmark for reimbursements in other federal programs such as TriCare (DoD) and Medicaid and, very importantly, the commercial insurance market.

"So how does the AMA influence the public and private reimbursement system throughout the country? The AMA owns and runs the confidential and proprietary process through which all health care procedures in the U.S. are described and then assigned a billing code (which is then used for reimbursement in virtually all payment systems), known as the Current Procedural Terminology (CPT) system. APA is a player at the AMA CPT Committee, and was represented there by Tony Puente from 1994-2008. In 2009, Tony became the first psychologist elected as a voting member of its governing body, the AMA CPT Editorial Panel. Since then, Neil Pliskin has represented APA at CPT. The AMA also owns and controls the highly confidential process by which 'work values' are determined for all CPT codes; i.e., for all health care procedures from surgery to psychotherapy and beyond. That committee is known as the Resource-Based Relative Value Update Committee or 'RUC.' Jim Georgoulakis is the APA representative to the AMA RUC, and has held that seat for a decade and a half.

"So the AMA defines the procedure codes used by all health care providers, including psychologists, and also assigns a valuation ('RVU') to each procedure. CMS bases its fees on the RUV recommendations of the AMA, so this is where 'value' translates to reimbursement dollars. Commercial carriers and other federal programs then use the CMS fee schedule as a benchmark in setting their rates.

"APA's Game Plan: As I noted, APA has been a player for many years at the AMA CPT and RUC through our volunteer representatives. But with pressures to transform the health care system accelerated by President Obama's ACA, it is critical for APA to kick its CPT and RUC involvement up a notch to be at the table even more actively. And while these processes are central to maintaining the existing fee-for-service (FFS) system in health care, the move to newer financing models such as 'bundling' and 'global payments' will still rely on current fees as the building blocks to value the contribution of individual team members. So psychology cannot afford to neglect this arena for both the present and the future.

"To that end, we are working very intensively at the CPT and RUC with colleagues Tony, Jim, and Neil on issues that affect both 1) mental health services by psychologists and 2) the delivery of psychological services in physical health and integrated care settings. The immediate priorities of the OHCF in each of those two domains are: Mental Health Codes -- * Complete the AMA RUC survey process for the three remaining CPT codes in the new mental health CPT code set that went into effect January 1st for the entire public and private mental health system. CMS is using an interim fee schedule, and will not release its final fees for all mental health codes until that survey work is completed. * Work with the AMA and the other mental health societies to develop an 'extended service' psychotherapy code for trauma, PTSD, and other treatments that extend beyond 60 minute sessions, because there is no code available in the new mental health code set. Codes for Integrated Care -- * Lobby CMS for permission to re-survey (through the RUC system) the existing Health and Behavior CPT codes, used for psychological treatments associated with physical disorders. Those codes are currently valued at 30-40% below

the comparable mental health codes. * Participate in the AMA's ongoing development of reimbursement codes for care coordination, transitional care, team conferences, etc. Psychologists are currently not reimbursable for these activities, and are not yet at the AMA table where they are being developed."

Health Resources and Services Administration (HRSA): Having finally completed deliberations on its very contentious Fiscal Year 2013 budget, the Administration recently submitted its request for Fiscal Year 2014. Administrator Mary Wakefield, who has participated in Cynthia Belar's Education Directorate Advocacy Breakfast: "Thanks to ACA, HRSA has an even broader role. Combined with first of its kind initiatives like the National HIV/AIDS strategy, HRSA's mandate continues to grow. Working with our DHHS partners, HRSA is responsible for 50 individual provisions in the health care law. These generally fall into three major categories. * Expanding the primary care safety net for all Americans – especially those who are geographically isolated, economically disadvantaged or medically vulnerable – for example, through expansion of the Health Center program. * Training the next generation of primary care professionals, while improving the diversity of the workforce and re-orienting it toward interdisciplinary, patient-centered care. HRSA does this through targeted support to students and clinicians and grants to colleges, universities and other training institutions. * Working with its partner agencies, HRSA is expected to greatly expand prevention and public health efforts to catch patients' health issues early – before they require major intervention; to improve health outcomes and quality of life; and to help contain health care costs in the years ahead. Our FY 2014 budget request places a strong emphasis on investing in programs that improve access to health care in underserved areas and allows the Health Resources and Services Administration to take important steps towards implementing healthcare reform and improving healthcare access for underserved populations. We are determined to work with our DHHS and other healthcare partners to assure the health of the Nation."

As a result of the continuing diligent efforts by Cynthia Belar and Nina Levitt, the HRSA budget request includes $2,892,000 for the Graduate Psychology Education (GPE) program, which was the level provided in FY 2012 (with a slight increase in FY 2013). This APA sponsored program funds accredited health profession schools, universities, and other public or private nonprofit entities to plan, develop, operate, or maintain doctoral psychology schools and programs in mental and behavioral health practice to train psychologists to work with underserved populations. The program is designed to foster an integrated and interprofessional approach to addressing access to behavioral health care for vulnerable and underserved populations. Fifty-five percent of graduates were underrepresented minorities and/or from disadvantaged backgrounds and 29% report practicing in a medically underserved area. In support of the program, HRSA noted that mental disorders rank in the top five chronic illnesses in the U.S. and that the National Alliance on Mental Illness reported approximately 6%, or one in 17 Americans suffers from a serious mental illness. Serious mental illnesses cost society approximately $193.2 billion in lost earnings per year. Individuals suffering from a serious mental illness earned at least 40% less than people in good mental health, confirming that mental disorders contribute to significant losses of human productivity. Over the years, we have come to appreciate that the federal government is much more sympathetic to paying for clinical services rendered by practitioners when it has supported their training.

The Office for the Advancement of Telehealth (OAT) would receive $11.5 million, which was also its level in FY 2012. Funds would be provided for two grants under the Licensure Portability Grant Program, as well as associated technical assistance and evaluation activities. OAT anticipates that 204 communities will have access to adult mental health services and 239 communities will have access to pediatric and adolescent mental services by FY 2014. The OAT programs are viewed as an integral component of the overall DHHS Improve Rural Health Care Initiative to expand the use of telecommunications technologies that increase access to and improve the quality of health care provided to rural and underserved populations. Telehealth programs strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas.

Very Timely Steps -- Division 31: "APA Division 31 and Division 42 received a CODAPAR grant to create a specific digest of the laws of each State, and then create State specific electronic health record (EHR) templates. All APA member psychologists will have access to the laws and templates. It should assist in the implementation of the ACA provisions that will require EHR use among integrated healthcare professionals. Check the Division's website for the grant proposal and additional information. To gain access, go directly to: http://www.apadivisions.org/division-31/membership/health-record-templates.aspx. The State specific EHR templates comply with the laws of each jurisdiction. The States have had an opportunity to have their digests and the templates reviewed through the volunteer efforts of their member experts on the ethics/law. Each State's vetted materials are now posted at the Division 31 Community website so that all APA members will have access to these free resources [Andy Benjamin, Division 31 Past-President]."

Intriguing Incremental Steps: Those involved in shaping APA's Guidelines for the Practice of Tele-

psychology, which is a collaborative effort by APA governance entities, the Insurance Trust, and the Association of State and Provincial Psychology Boards (ASPPB), have taken notice of the parallel evolution of the notion of an "E. Passport" by ASPPB. This would address a number of issues surrounding interjurisdictional telepsychology practice and ASPPB is currently seeking public comment on their preliminary proposal. "The primary objective of every regulator within the field of occupational regulation should be public protection. Regulators typically achieve public protection by establishing licensing standards, engaging in complaint resolution, and by facilitating education. A central consideration in evaluating the effectiveness of any proposed Telepsychology standard, guideline, or regulatory language is its ability to ensure that the practice of psychology is done competently and at the minimum standard of acceptable and prevailing practice. In essence, by asking, 'Will this solution to Telepsychology protect the recipients of the psychological services?'" The ASPPB Telepsychology Task Force is considering the E. Passport proposal as such a mechanism to monitor and regulate interjurisdictional telepsychology practice. This goes directly to the underlying issue of licensure mobility which, with the advent of technology and integrated health systems, must be effectively addressed in a timely manner if psychology is to remain competitive within the global health care environment.

Clinical Pharmacy: "Reciprocity of pharmacy licensure is possible across all the states, Puerto Rico, and the District of Columbia and is facilitated by a national licensure transfer process and a national jurisprudence exam. There is no multi-state compact, however, as in nursing. The National Association of Boards of Pharmacy (NABP) provides these national mobility resources as a service to member state boards of pharmacy and to licensees. NABP also provides the Model Pharmacy Practice Act and updates it regularly. The Model Act addresses key issues, including the regulatory framework for collaborative drug therapy management agreements between pharmacists and physicians, nurse practitioners, and other prescribers, Collaborative drug therapy management facilitates pharmacists' patient management activities which include the initiation, modification, and cessation of medication (June, 2011)." Pharmacy's visionary approach proactively addresses the complex issues surrounding providing telehealth services by their profession. Aloha,

Pat DeLeon, former APA President – Division 42

The Concept of Vicarious Liability

— David Shapiro

Psychologists may be liable for negligently selecting or hiring assistants and other employees. If a psychologist carelessly selects an incompetent assistant who, in some way, injures a client, the psychologist's negligence in hiring can result in liability. However, there does not even have to be negligent hiring for vicarious liability to apply. The law imposes vicarious liability on employers (sometimes called principals) for the actions of employees or agents. An agent is someone working on behalf of the employer. Due to the fact that psychologists often employ assistants, paraprofessionals, psychometrists, and other staff in professional practice, it is important to understand this type of liability.

A psychologist may be civilly liable for the negligence of an employee who is working within the scope of her or his employment. For instance, let us say that a psychologist hires a psychometrist to administer and score tests with the psychologist doing the final integration and report. If the psychometrist were to administer the test improperly, or score it improperly, and that faulty scoring leads to harm to the client of the psychologist, the psychologist may be liable for the harm. This vicarious liability arises even if the employing psychologist was very careful to avoid scoring errors.

Vicarious liability is not limited to employees. Partners are generally considered vicariously liable to clients and to other third parties for each others' negligence. Consider for a moment three psychologists in a partnership: each may be responsible for the professional negligence of the other two. For this reason, many psychologists are opting to establish practices that are not organized as partnerships, but rather as limited liability corporations (L.L.C.)

Vicarious liability does not apply to the work of independent contractors. The essential difference between an agent and an independent contractor is the right to control and direct activities.

Many similar concerns arise when we consider supervision, either of people in training, or those who are working in a practice in order to acquire enough hours to sit for a licensure examination. States vary tremen-

dously in terms of how sketchy or how detailed the licensing requirements are regarding supervision; some states provide only minimal guidance; others define what the duties of the supervisor are, the number of times they must meet, the nature of the documentation necessary, and the number of supervisees that a licensed psychologist may supervise. Some others require that the supervisor meet with each client in order to assess their treatment needs and assign that client only to a supervisee that the supervising psychologist has assessed as competent to provide that therapeutic service. Under any of these scenarios, the supervision creates the possibility of vicarious liability. The failure to exercise appropriate and careful oversight of someone under supervision is negligence and can give rise to liability. Enterprising psychologists have been known to set up a series of clinics across a state or geographical area, having little time to supervise all the staff in the different locations adequately. This is inviting a claim for negligence since it is virtually impossible to provide the level of intensive supervision adequately. In one recent case, a psychologist was the named supervisor of ten mental health clinics all across a particular state; one of his staff, an unlicensed professional, was seeing a parent and child for court ordered visitation. The child became very agitated and had to be hospitalized; the supervising psychologist knew nothing about the background of the case; there were no notes documenting any supervision, and the psychologist was held liable for damages.

If a psychologist responsible for supervision never reviews the supervisee's records, rarely consults with the supervisee, does not hold regular sessions to review the work, and is generally unaware of what the supervisee is doing, that individual is risking liability. Some courts have even held that a psychologist is negligent even if the supervisee never told the supervisor about some potentially unethical behavior, such as the supervisee having sexual relations with a client.

In short, psychologists need to be very careful and diligent when they undertake supervisory responsibilities. They should only supervise a limited number of individuals, carefully assess whether the supervisee can handle a particular case, and document all supervisory sessions.

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Focus on Clinical Practice

An Introduction to Psychotherapy Integration

— George Stricker

Psychotherapy integration is defined as an approach to psychotherapy that includes a variety of attempts to look beyond the confines of single-school approaches in order to see what can be learned from other perspectives. It is characterized by an openness to various ways of integrating diverse theories and techniques. Psychotherapy integration can be differentiated from an eclectic approach in that an eclectic approach is one in which a therapist chooses interventions because they appear to work, without looking for a theoretical basis for using the technique, and relies solely on supposed efficacy. The rationale of efficacy is reasonable, but too often it is based on imprecise memories of past experience without any reference to theory or research data. In contrast, psychotherapy integration differs from eclecticism in that it attends to the relationship between theory and technique.

The term psychotherapy integration has been used in several different ways (Stricker, 2010). The term has been applied to a Common Factors approach to understanding psychotherapy, to Technical Integration, to Theoretical Integration, and to Assimilative Integration.

Common Factors

Common Factors refers to aspects of psychotherapy that are present in most, if not all, approaches to therapy. These techniques cut across all theoretical lines and are present in all psychotherapeutic activities (Grencavage & Norcross, 1990). Because the techniques are common to all approaches to psychotherapy, the name Common Factors has been given to this variety of psychotherapy integration. There is no standard list of common factors, but if a list were to be constructed, it surely would include: a therapeutic alliance established between the patient and the therapist; exposure of the patient to prior difficulties, either in imagination or in reality; a new corrective emotional experience that allows the patient to experience past problems in new and more benign ways; expectations by both the therapist and the patient that positive change will result from the treatment; therapist qualities, such as attention, empathy,

and positive regard, that are facilitative of change in treatment; and the provision by the therapist to the patient of a reason for the problems that are being experienced.

No matter what kind of therapy is practiced, each of these common factors is present. It is difficult to imagine a treatment that does not begin with the establishment of a constructive and positive therapeutic alliance. This relationship has been found to be integral to any change that occurs in treatment (Norcross, 2002). The therapist and the patient agree to work together and they both feel committed to a process of change occurring in the patient. Within every approach to treatment, the second of the common factors, the exposure of the patient to prior difficulties, is present. In some instances the exposure is in vivo, and the patient will be asked directly to confront the source of the difficulties. In many cases, the exposure is verbal and in imagination. However, in every case, the patient must express those difficulties in some manner and, by doing so, re-experiences those difficulties through this exposure. In successful treatment, the exposure usually is followed by a new corrective emotional experience (Alexander & French, 1946). The corrective emotional experience refers to a situation in which an old difficulty is re-experienced in a new and more positive way. As the patient re-experiences the problem in a new way, that problem can be mastered and the patient can move on to a more successful adjustment.

Having established a therapeutic alliance, and being exposed to the problem in a new and more positive context, both the therapist and the patient always expect positive change to occur. This faith and hope is a common factor that is an integral part of successful therapy. Without this hope and expectation of change, it is unlikely that the therapist can do anything that will be useful, and if the patient does not expect to change, it is unlikely that he or she will experience any positive benefit from the treatment. The therapist must possess some essential qualities, such as paying attention to the patient, being empathic with the patient, and making his or her positive regard for the patient clear in the relationship. Finally, the patient must be provided with a credible reason for the problems that he or she is undergoing. This reason is based in the therapist's theory of personality and change. The same patient going to different therapists may be given different reasons for the same problem. It is interesting to speculate as to whether the reason must be an accurate one or whether it is sufficient that it be credible to the patient and not remarkably at variance with reality. As long as the reason is credible and the patient has a way of understanding what previously had been incomprehensible, that may be sufficient for change to occur

Historically, the first clear expression of Common Factors was that of Rosenzweig (1936). He coined the term Dodo bird effect to refer to the similar results of different approaches to psychotherapy (a finding that underlies the presence of common factors). For Rosenzweig, the common factors were the therapist's personality and ability to inspire hope; interpretations, which provide alternative and more plausible way of understanding problems, whether or not they are true; and the synergistic effects of one change on others.

The single most important presentation of the Common Factors approach was that of Frank (1961). Frank tried to identify commonalities across a wide variety of change processes, including such seemingly diverse efforts as psychotherapy, brainwashing, religious conversion, and placebo effects. These common factors initially included expectancy for change, arousal of hope, emotional arousal, encouragement of change outside the change process itself, encouragement of self-understanding through interpretations, and a corrective emotional experience. Later modifications focused on dealing with demoralization through restoring morale and increasing self-esteem (J. D. Frank & Frank, 1993). The approach to doing this included an emotionally charged healing relationship; a healing setting; a myth based on a rational and credible conceptual scheme to explain symptoms; and a healing ritual.

Technical Eclecticism

Technical eclecticism is most common among those practitioners who refer to themselves as eclectic. In Technical Eclecticism, there is no unifying theoretical understanding that underlies the approach. Rather, the therapist relies on previous experience and on knowledge of the theoretical and research literature to choose interventions that are appropriate for the patient.

There are some excellent examples of technical eclecticism, although these are so well worked out and systematic that they may belong in another category (Beutler, Consoli, & Lane, 2005; Lazarus, 2005). For Lazarus, who made the first presentation of Technical Eclecticism, there is a core adherence to social learning theory, girded by a systematic rubric (BASIC-ID) for understanding the breadth of the patient's difficulty. The letters in the acronym BASIC-ID refer to concerns in the areas of Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal functioning, and Drugs/Biology. For Beutler, whose system is referred to as Prescriptive Psychotherapy, the unifying principle is treatment matching, which is based on well-developed research findings.

Theoretical Integration

The third approach to psychotherapy integration is called Theoretical Integration. This is the most difficult level at which to achieve integration because it requires integrating theoretical concepts from differ-

ent approaches, and these approaches may differ in their fundamental philosophy about human behavior. Theoretical Integration tries to bring together various theoretical approaches and then to develop what in physics is referred to as a "Grand Unified Theory." Neither psychotherapists nor physicists have been successful to date in producing a Grand Unified Theory. It is difficult for me to imagine a theory that really can combine an approach that has one philosophical understanding with a different approach that has a different philosophical understanding (Messer & Winokur, 1980). For example, a psychodynamic approach believes that an early difficulty leads to a pattern of behavior that is repetitive, destructive, and nearly impossible to resolve. In contrast, cognitive-behavior therapy (CBT) sees problems as much more amenable to change. This difference may represent a basic incompatibility between the two theories. Therefore, theoretical integration would be faced with the task of integrating a theory about the stability of behavior with a theory about the ready changeability of behavior, and unless this obstacle can be overcome, Theoretical Integration will not be achieved.

Nonetheless, there have been many attempts to develop such high level integrative approaches, and some of these are imaginative and highly influential. The first, and perhaps still the most important of these (Wachtel, 1977), combined psychodynamic and behavioral approaches. Interestingly, although CBT now is regarded as a unique approach to psychotherapy rather than as an integrative effort, it represents a theoretically integrative attempt to add the concepts of cognitive science to the well-developed area of behavior therapy.

Even if the grand vision of a unified theory is not fully accomplished, much of value can be done when the most valuable aspects of different theoretical efforts can be joined in a synergistic way.

Assimilative Integration

The fourth, and most recent, major approach to psychotherapy integration is Assimilative Integration (Messer, 1992). Assimilative Integration is an approach in which the therapist has a commitment to one theoretical approach but also is willing to use techniques from other therapeutic approaches.

As an example, a therapist may try to understand patients in terms of psychodynamic theory, because he or she finds this most helpful in understanding what is going on in the course of the treatment. However, the therapist may also recognize that there are techniques that are not suggested by psychodynamic theory that work very well, and these may then be used in the treatment plan. The psychodynamic therapist can occasionally use cognitive-behavioral techniques such as homework, and may occasionally use humanistic approaches, such as a two-chair technique, but always retains a consistent psychodynamic understanding. For an example of assimilative integration, see Stricker (2006), and for a full presentation, see Gold and Stricker (2001). The treatment can take place in a way that is beneficial to the patient and is not bound by the restrictions of the therapist's favorite way of intervening. The patient may not be aware that integration is taking place, for he or she feels that a consistent approach is being maintained. Most patients are not familiar with theory, don't realize that different techniques are generated by different theoretical understandings, and only are concerned with whether or not the treatment is helpful. Inherent in any attempt to achieve assimilative integration is the challenge of accommodation, an understanding of how the home theory must be altered in order to embrace the value of the technique that was not suggested by that approach.

The obvious similarity between Assimilative Integration and Technical Eclecticism is that both rely on a wide variety of therapeutic techniques, focusing on the welfare of the patient rather than on allegiance to any particular school of psychotherapy. The major difference between the two is that Assimilative Integration is bound by a unifying theoretical understanding whereas Technical Eclecticism is free of theory and relies on the experience of the therapist to determine the appropriate interventions. The similarity between Assimilative Integration and Theoretical Integration is that Assimilative Integration begins with a single theory and brings together techniques from different approaches, whereas Theoretical Integration tries to bring together those theoretical approaches themselves. In each of these three approaches, the effect of the Common Factors is present, and perhaps paramount.

Inherent in psychotherapy integration is the conviction that there is no one approach to therapy that is suitable for every patient. Both in single-school approaches and in psychotherapy integration, the treatment must be suitable for the individual patient. In making the treatment suitable for the individual patient, the therapist must understand the patient, and that establishes a place for theory. Assimilative Integration is particularly useful in that theory helps in the understanding of the needs of the patient, but then several different technique can be assimilated within that theoretical framework. The treatment plan then must undergo continuous revision as the understanding of the patient gets fuller and deeper over the course of the treatment.

In any case, the general point in two of these approaches, Assimilative Integration, and Theoretical Integration, is that there is a clear value to the role of theory in psychotherapy integration, whether the theory deals with the way integration works (Theoretical Integration) or the framework that governs the choice of interventions (Assimilative Integration).

Common Factors and Technical Eclecticism are not as concerned with theory, but view the benefit of the patient to be of more significance than adherence to any single theory.

Psychotherapy Integration has developed to the point that it now is represented in most major textbooks of psychotherapy (e.g., Stricker & Gold, 2011). It also has developed an identity through an influential organization. The Society for the Exploration of Psychotherapy Integration (SEPI) was established in 1983 and has grown into an international organization that hosts an annual conference and publishes a quarterly journal, the Journal of Psychotherapy Integration. For readers who wish to learn more about psychotherapy integration, SEPI maintains a website (http://www.sepiweb.org/) that contains several articles, information about the next conference, an application for membership, and other materials of interest.

Footnote

This column presents an introduction to psychotherapy integration, and draws heavily on material I prepared previously for inclusion in the newsletter for Division 29, and on my recent book (Stricker, 2010).

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A Deeper Look at Utilizing Mindfulness Techniques in Your Private Practice Setting

— Stephanie T. Mihalas and Ryan G. Witherspoon

In January of 2013, one of us (STM) attended a workshop entitled, "Mindfulness Based Childbirthing and Parenting (MBCP)," supported by the University of California San Diego and founded by Nancy Bardacke, CNM. The workshop included six rigorous days of mindfulness training and practice, based upon the principles of Buddhist mindfulness meditation and Mindfulness Based Stress Reduction (MBSR), developed at University of Massachusetts Medical Center in 1979 by John Kabat-Zinn PhD and Saki Santorelli, EdD. The retreat tested boundaries related to one's sense of self, role as psychologist, and deeper issues related to the development of the soul. Throughout the six-day journey, the workshop was an exploration of the role mindfulness might play as a self-care tool by psychologists, how mindfulness might be integrated as a tool in the clinical realm, and, if not used properly, how mindfulness might be detrimental to patients. This paper explores the personal and professional connection to the concept of mindfulness, the use of mindfulness by children, and mindful parenting.

Mindfulness Meditation – General Background

Mindfulness is described by Kabat-Zinn (2005) as "the awareness that arises from paying attention, on purpose, in the present moment, and non-judgmentally" (p.108). For much of the day, the mind is snarled and entangled with superfluous information or is rehearsing and rehashing information that leads to anxious and depressive patterns. Mindfulness moves the practitioner away from the "muddiness" of the past and future through intentional acts of self-regulation and focus. Internal and external experiences are reviewed with curiosity, acceptance, and openness. Mindfulness is the repeated action of coping or dealing with prolonged, possibly negative stimuli; whereas, relaxation training serves to provide symptom relief rather than bringing more awareness to an issue (Edenfield & Saeed, 2012). Mindfulness practices can be achieved through focused attention to the breath, a movement, or an action (such as exploration of a meal, also known as mindful eating). For a detailed review of techniques and applications, please see Germer, Siegel and Fulton's comprehensive introduction for clinicians (2005; in press).

The research on mindfulness meditation suggests that it can benefit a variety of populations including those suffering from chronic medical conditions (Bohlmeijer, Prenger, Tall, & Cuijpers, 2010), children (Schoeberlein & Koffler, 2005), pregnant mothers (Vieten & Astin, 2008), and patients diagnosed with depression and anxiety (Hofmann, Sawyer, Witt, & Oh, 2010). The research is mixed regarding the exact mechanisms of change behind mindfulness due to methodological limitations (Edenfield & Saeed, 2012). However, some studies point to neurophysiological changes suggesting that mindfulness exerts powerful changes in the brain. A recent article by Chiesa and Serretti (2010) using neuroimaging and electroencephalography (EEG) suggests that meditators improve self-regulation and sleep vis-à-vis activation of theta and alpha waves in the pre-frontal cortex (PFC) and anterior cingulate cortex (ACC). The beneficial outcomes described above may be explained by the eight fundamental attitudes cultivated during mindfulness practice as cited in Bardacke (2012):

1. Beginner's mind: Approach each moment as though it is new, unique, and may never happen again. Beginner's mind allows one to be open to what is in the moment rather than carrying rigid expectations. This framework cultivates new-found joy in old experiences and competes with internalized mental models of old unconscious patterns. Practitioners who may have experienced trauma learn to discern old fears or previous patterns of threatening experiences or triggers from situations in the current reality. What may seem frightening at first, may now be seen more keenly as safe and harmless.
2. Non-judging: Allows separation of thoughts and behaviors from the essence of the true self. This is very liberating for many people who feel shame, guilt, and despair and connect their emotional well-being to their sense of self-worth. Non-judgment allows space between the thoughts that take place during the silence of one's practice and what may happen at a later time. This is very much similar to the psychological term of "decentering" whereby one can recognize thoughts like passing clouds but not attach to them.

3 and 4. Patience and Non-Striving: Understanding and accepting that life unravels and unfolds at a certain pace and no matter how hard or soft one tries to push, a specific timetable is at play. During a mindfulness practice, one learns to be patient with his or herself in the moment even when feelings may be difficult or painful.

5. Trust as Self-Reliance: This tenet is about building intuition in one's body and mind. To listen to

the sensations in the body or to an inner voice, allowing both to guide the self to make a decision. Self-efficacy and agency are built in this space.

6. Acknowledgement Moving Towards Acceptance: Acknowledgement of a situation as it is, even if it is neither perfect nor meets expectations. Oftentimes people embark on uphill battles to change others, or to alter unpalatable situations. However by being fully aware and accepting of a situation or person, this conflict can be avoided. Rather, the person is able to "go with the flow," feeling empowered in a situation instead of reactive.
7. Letting Be: In mindfulness, one may turn towards the difficult emotion to understand it rather than away, or overly-attaching to the problem. The concept of "letting be" is like taking a surf board and riding the wave no matter how good or bad the experience may be.
8. Kindness: Being considerate and patient with oneself when exploring difficult situations or when demands become overwhelming. During the practice of mindfulness meditation, being kind instead of punitive can create a beautiful way to spend time with oneself, ceasing for a period the tape recorder of negative self-statements that play periodically throughout the day.

The basic tenets of mindfulness can be reflected upon, remembered and applied during formal and informal practice. The tenets are what make mindfulness meditation different from relaxation, or transcendental meditation, or other spiritual and religious practices. Without coming back to the core essence of mindfulness, one may just be engaging in "exercises" rather than acts that cultivate the mind and soul.

Practicing Mindfulness as a Clinician

In order to teach mindfulness, practitioners must be proficient in mindfulness themselves and must have undergone appropriate training (Barnett & Shale, 2012; Kostanski & Hassed, 2008). We believe the ebb and flow of emotions, thoughts, and even bodily sensations can only be understood with one's own consistent practice. Patients often ask questions regarding the "how's," "what's" and "why's" of meditation and it is extremely important to be able to have "walked the walk" so that a trusting relationship can be built between therapist and client. More importantly, personal experiences with mindfulness instills trust in the process and motivation to continue forward. A few applications below might serve as an introduction for the development of one's own personal or professional mindfulness and self-care practices.

The research on self-care and mindfulness has primarily been conducted with masters-level clinicians. Unfortunately, there is a paucity of literature related to (a) professional development and the use of mindfulness, (b) the relationship between self-care and mindfulness, and (c) self-efficacy and outcomes with patients related to mindfulness in the in the doctoral level psychological community.

Mindfulness may enhance foundational skills for competence as a therapist, including increased attentional capacity (e.g., selective, dividing, sustained and attention switching) and tolerance of affect which is important for empathic capacity. Greason and Cashwell (2009) found that among counseling students (masters and doctoral level) mindfulness predicted attention, interpersonal reactivity, and self-efficacy. Another study found that between five and eleven brief periods of mindfulness, plus 15 minutes of post-meditation processing, impacted a number of therapist characteristics important for the therapeutic alliance in counselor education students (Buser, Buser, Peterson, & Seraydarian, 2012). There were no major differences between extended and control conditions, which may indicate that a brief introduction to meditation practice may be adequate to develop better abilities and further enhance outcomes with patients.

The research clearly supports the link between mindfulness and clinical outcomes for patients. As such, how can psychologists carve out time in their day to engage in meditative practices? Many clinicians argue that time is a major barrier to practice, as workdays are filled with back-to-back patients, crises, and paperwork. Nonetheless, becoming mindful between sessions or during a lunch break may serve as a source of rejuvenation to become ready for the next session or day ahead. Mindfulness allows for a separation from vicarious trauma, burnout, and compassion fatigue (Christopher & Maris, 2010). Below is a list of exercises psychologists may engage in for a brief period of time to become grounded, centered, and gain a sense of well-being.

Exercise 1 (Air on Skin). For approximately one to two minutes, pay attention to the interplay between the air and the hair on your skin. Questions to consider: Do you feel the hair moving back and forth on your arms? Does your skin feel cold or hot? When you pay attention to your body acutely, does it give you any cues regarding how you are feeling? The point of the exercise is to experience rather than judge the moment. This is an easy way to "get back in your body" after a difficult session with a patient.

Exercise 2 (Mindful Filing). Consider the way you do charting, note taking, or billing. Are you rushing around the office attempting to multi-task or do you focus singularly on the task at hand? After seeing a patient, you may move to a mindful space by starting to "note." This term refers to allowing the inner voice to attend to one's movements or behaviors. For example, "I am pulling the file from the file cabinet. I am opening the file. I am placing my note in the progress notes section of the file." By "noting," the mind is intensely

focused on the task, the peripheral issues are at bay, and an act of mindfulness is accomplished while simultaneously taking care of patient business. This may help the psychologist to feel less overwhelmed with all the tasks that need to be accomplished during the day. Mindful filing may also decrease errors in billing and charting.

Exercise 3 (Mindful Breathing). Mindful breathing focuses on the breath as the most important sensation in the body – follow the breath at the nostrils, the belly, or the chest, making a choice to focus on the inhalations or exhalations. Notice with a focus on the breath what sensations change in each moment. Thoughts need not be forced out or judged; merely acknowledged. Mindful breathing may serve as a place of solitude or potentially a place of angst for some people, as the level of stillness can be anxiety-provoking. Therefore, ideally, it is recommended to begin one's practice of mindful breathing before or after work to allow time to explore what arises during the practice. Ten minutes of seated breathing meditation is a good starting point with a goal of 30 minutes—allowing the body and mind to adapt to the practice. Once one is comfortable with mindful breathing and finds it more soothing than provocative, it can be used as a source of solace to practitioners, even in a three to five minute block of time between patients.

Youth and Mindfulness

A frequently cited phrase, "beginner's mind" represents the concept of an infant or young child touching, tasting, smelling, or learning about something for the first time. Just imagine a young child who is surprised by a new sound or a new taste and the pleasures and woes registering on the child's face depending upon the sensation. Approaching situations with a "beginner's mind" allows for preconceived notions to be placed aside, for disappointment from unmet expectations to be circumvented, and for the joy of new (and old) experiences to be experienced. Teaching mindfulness to children has the potential to enhance memory, promote self-management, increase feelings of self-control, and finally sets the foundation for children to cope with challenging situations.

Modifications of teaching mindfulness to children are minimal but should be considered. First, children require concrete and clear examples of techniques and sometimes require modeling of the technique as well. Within this framework, a rationale is also helpful for teenagers and can increase motivation (Thompson & Gauntlett-Gilbert, 2008). Metaphors have been shown to be helpful in concretizing some of the more abstract concepts, such as bringing the focus of attention to the breath when it wanders. For example, Kornfield (2003) developed a "puppy" metaphor to explain how the mind becomes distracted and needs to be "trained." The metaphor's pretense is that as puppies learn to sit and follow commands, they often straw away; yet it would be unfair to punish the puppy because it is merely learning. The proper way to handle the puppy would be to bring it back to its original position and provide the command to "sit" again. While this may happen repeatedly, anger and judgment are not needed.

Second, providing a range of mindful strategies and techniques is helpful, so children and teens will not become bored in their daily practice. Examples include paying attention to different genres of music, doing mindful practices in places like the park or a museum, or using mindfulness for everyday activities like homework or one's morning routine. Practical applications are critical to the promotion and maintenance of continued practice.

Third, children should start with short time frames of one to three minutes for seated meditations, in order to set them up for success. Finally, it is recommended that parents also engage in mindfulness as a way to understand the mindfulness process more fully, reinforce and model behavior, and be more present in the everyday functioning of their children (Lee-Corbin & Evans, 1996; Barankin, & Khanlou, 2007).

The following are three mindful exercises appropriate for children and adolescents:

Exercise 1. Following the advice of Hooker and Fodor (2008), who recommend starting with a mindfulness practice that does not focus on self as a way to ease into the process, mindful drawing requires the participant to draw an object of his/her liking. Notably, the ability to draw is not the focus of the activity. Instead the practice is about paying attention to the colors, lines, and general qualities of the picture. After some time has passed (10-15 minutes), the youth should draw the object again and compare the drawings and see what details are different. Reflection should be focused on what it is like to spend time paying attention and noticing things that one would typically not notice. Time processing can link this to awareness with friends, parents, school work and, most importantly, making a distinction between "automatic pilot" and "being in your body."

Exercise 2. Awareness of Environment is the concept of having youth pay attention to how they interact with their environment; for some youth, they may realize they do not pay attention to the dance between their own thoughts and bodies and people and objects around them. Symbolism recommended by Hooker and Fodor (2008) to help aide this process include having youth pretend they are holding a camera lens and taking pictures and then describing what is seen in their imagined photographs. Similarly, children can be encouraged to take on the role of newspaper reporters and journal about nuanced experiences day to day outside of therapy. What is often found by this practice is teens become aware

of many novel things in their environment: pictures hanging on walls in the auditorium, anxiety provoking feelings when they walk by a certain teacher, scripts they play when interacting with family members.

Exercise 3. Mindful texting is the art of stopping automatic responses and impulses and instead encourages the teen to be more "in charge" of whether a text back will be a "response" or a "reaction." Teens are asked to look at urges, impulses, and feelings that arise through the texting process. For example, does a certain person elicit an angry response; or does the teen feel an incessant urge to respond immediately to certain friends but not others. Teens are asked to "check in" when they text and notice how it can become an automated or compulsive process for them, and how this may be related to other things in their lives. The processing behind mindful texting (the thoughtful action of noticing thoughts, feelings, sensations, and behaviors that arise as a result of stimuli - in this case a text) is a critical component to help teens make sustained cognitive or behavioral change.

Parenting in a Mindful Way

Everyday Blessings (Kabat-Zinn & Kabat-Zinn, 1997) explores the beauties and challenges of parenting. The book coins the term "mindful parenting" which essentially challenges parents to focus on what is important in the day to day functioning of childrearing rather than becoming jumbled in trite issues such as messy rooms or less than timely homework completion. Mindful parenting encourages parents to recognize their own limitations, frustrations, and to become aware of the "interdependent" nature of the child-parent relationship. When parents are able to see the bi-directional impact of the relationship and how behaviors ebb and flow as part of a systemic process, parents are able to be attuned to take responsibility for their impact on their children rather than displacing blame onto them. This dynamic is hopefully viewed as a long-term engagement rather than an incident about which to become enraged. Duncan, Coatsworth, and Greenberg (2009) suggest that through mindful parenting, coercive and punitive cycles of parent-child interactions may be minimized and more satisfying and deeply attached relationships will prevail. Duncan et al. (2009) developed a model that dominates the mindful parenting literature and includes five tenets to guide the development of mindful parenting: (a) listening with full attention; (b) nonjudgmental acceptance of self and child; (c) emotional awareness of self and child; (d) self-regulation in the parenting relationship; and (e) compassion for self and child.

Listening with full attention is based on the concept that by paying attention closely to children, parents inherently communicate that their children are important and deserve being heard. So often, children complain that their parents are on their cell phones or computers and "never listen." When this lack of full attention is enacted, children's sense of safety and security may be threatened, as their primary attachment figure does not present as an all-encompassing "protector" for them (Fonagy & Target, 1997). Likewise, by paying full attention, parents can become more apt at monitoring not only their children's verbal behavior but their actions and patterns as they enter the teenage years. Teenagers have been found to share and disclose more about their lives when parents have reared them in a mindful way (Smetana, Metzger, Gettman, & Campione-Barr, 2006).

Nonjudgmental self-awareness encourages parents to first become aware of their own internal working models of what a child "should be" like. Reflection is then encouraged on the types of deep-seeded beliefs and parental expectations that are conveyed to the child. Finally, the third component of nonjudgmental self-awareness is the acceptance that parenting is a challenging task. Within that challenge, parents are asked to begin to accept the trials and tribulations of parenting without resignation; it is a longstanding acceptance of their children, meeting them "where they are" during the developmental process, while communicating clear boundaries and expectations. Emotional awareness of self and child helps to deter automatic cognitive processes that contribute to negative patterns of parenting. If a parent is able to remain mindful of what is transpiring within themselves and their child, they can make more attuned responses rather than reacting from an automatic orientation.

Hand-in-hand with being attuned to one's child is the regulation of one's own responses and reactions. Modeling a consistent response style is one way that parents may engage in affect regulation. When a parent remains calm, intense reactions or emotions are not transmitted to the child. Instead, a child learns how to handle stressful situations through self-regulation and a safe base for exploration is afforded because a child knows what types of responses to expect from a parent. The final tenet of mindful parenting is compassion towards self and child. By being compassionate towards a child, a parent may be able to respond more empathically. Likewise, parents who are less critical of their own parenting have been found to interact better with their children with healthier and more positive developmental outcomes (Coleman & Karraker, 2003).

The exercises to increase mindfulness for parents are similar to any adult mindful practice including body scan, mindful movement, and gathas (i.e., short poems or phrases to inspire mindfulness and joy) (see Chapter 7 for a list and explanation of common practices, Bardacke, 2012). However, we recommend that parents continue to reflect on their own mindfulness practice and their relationship with their children through the following self-analysis:

- Am I living in the present moment or am I always rushing from one extracurricular activity to the next? Am I able to enjoy each moment with my children or does the lack of time during the day cause undue stress on the family?
- Why am I reacting with such vigor to my child? What about this situation is cultivating such an intense response? Is this past or present reality?
- What are my expectations for parenting? How did my parents react to me and give me space to grow and master my environment? How does this impact my child(ren)?
- How do I encourage my child(ren) to be brave and assertive? To cultivate a strong ego? What may I do to further propel their sense of self forward?

Mindful parenting is not only engaging in certain practices, or analyzing interactional patterns, but also a way of being. There is a quality of keen awareness of the cycles of emotional regulation and dysregulation of family functioning. Mindful parents are like long bamboo sticks amidst a windy storm: strong, sturdy, and flexible. Mindful parents weather the storm and have adaptable children to show for it.

Conclusion

At the end of the day, mindfulness is about awakening to the beauty of living each day to the fullest extent. Mindfulness opens up a person's psyche to a deeper level of understanding of the ebbs and flows of the spirit and the natural environment that surrounds the human condition. Both psychologists and their patients should continually assess whether they are ready and capable to engage in mindfulness practices; acknowledging how the practice is either an aide or hindrance in the developmental process.

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Therapy Groups that Work: A Scientist-Practitioner Approach to Social Skills Training for Children

— Erika C. Rich, Angel Roubin, and Xochitl C. Leevers

Social skills are vital for academic success, effective interpersonal communication, and the establishment of positive peer relations for children of all ages (see Asher & Parker, 1989, for a review). There is an abundance of research linking low peer acceptance with difficulties ranging from aggression, mental illness, failure to complete school, and criminal activity (e.g., Kupersmidt, Coie, & Dodge, 1990; Parker & Asher, 1987; Parker, Rubin, Price, & DeRosier, 1995). Largely based on the predictive nature of poor peer relationships, social skills training for children has emerged as a primary treatment approach and, as such, an impressive literature base now exists supporting its efficacy (see McFadyen-Ketchum & Dodge, 1998; Nangle, Erdley, Carpenter, & Newman, 2002, for reviews). For example, research has pinpointed that only one reciprocal friendship is enough to protect a child from loneliness and depression (e.g., Nangle, Erdley, Newman, Mason, & Carpenter, 2003). This particular finding inspired the development of the COMPASS (Curriculum on the Management and Promotion of Appropriate Social Skills) and LTC (Learning to Cope…Cooperate…Care) playgroups at Rich & Associates in Los Angeles, California—in the hopes of finding that one true friend for every child.

Inception of Social Skills Training in Private Practice

COMPASS is the flagship program at Rich & Associates and serves children ages 3-6. COMPASS was developed (Carpenter, 2002) initially for a younger age group due to the relative paucity of social skill interventions available for preschoolers (Bierman & Montminy, 1993; Nangle et al., 2002; Price & Ladd, 1986) and the fact that early intervention has been found to result in greater and more stable changes in social behavior (Schneider & Byrne, 1987). Certain problematic behaviors, such as aggression, become fixed and stabilized as early as eight years of age (Tremblay, Masse, Pagani, & Vitaro, 1996), and peer reputational bias becomes increasingly more difficult to overcome as children age (Asher & Coie, 1990; Rich, 2010). The LTC playgroup emerged as an outgrowth of the COMPASS program for first through third graders also in need of social skills training.

Clinical Fit of the Groups

COMPASS and LTC were designed to meet the unique needs of high-functioning, sometimes gifted, children. Reviews of the social skills literature have revealed that social skills programs aimed at a special education population are much less effective than those for higher functioning children (Gresham et al., 2001a). While heterogeneity of group members' diagnoses/presenting problems creates a balanced group dynamic, past research finds that groups composed of homogenously high-functioning children results in higher treatment gains (DeRosier, Swick, Davis, McMillen, & Matthews, 2011). Approximately one-third to one-half of the children in the Rich & Associates groups do not meet criteria for a formal diagnosis other than perhaps an adjustment disorder, and the remaining children tend to have diagnoses of anxiety disorders, autism spectrum disorders, or attention-deficit/hyperactivity disorder (ADHD). In an initial intake appointment, a play session is conducted to evaluate play skills, conversation abilities, and the amount of insight a child has into his or her social difficulties. All of these indicators aid in group placement. Every 12 weeks, progress on goals is assessed through informal evaluation during group sessions and parent feedback and goals are revised as necessary.

Playgroup Session

Each playgroup session begins with structured free play. Designed to be similar to indoor recess times at school, the children are not required to play with a specific person or toy. In order to encourage interactive play with peers, there is a limited choice of toys (rotating from session to session) available. A games table with age-appropriate games and two to three pretend play stations are made available (e.g., blocks, Legos, grocery store, Magnetix, farm with animals, etc.). Children share materials by necessity and are prompted to enter and exit play appropriately. Conflict resolution is facilitated by therapists as needed.

In COMPASS, a typical skill-building exercise (10-15 minutes total) would be a puppet show where the children see two puppets having a difficulty—such as one puppet not listening to the other puppet's ideas during play. The children are asked questions about what the puppets are doing, how they resolve their conflict, and whether this ever happens to them. Clients are then encouraged to practice the skill reviewed in the puppet show (e.g., sharing, playing by the rules, listening to friend's ideas) during a paired play segment that is supervised by a parent, much like a play date. Therapists circulate and provide feedback to parents on how to coach their child in play.

In LTC, the last half of each session is devoted to a particular skill-building activity that typically requires group cooperation. For example, in the "Paper Tower" activity, the group is divided into two teams and given a stack of scrap paper with the instructions: "As a team, you must build one tower out of this pile of paper. Teams with more than one tower will be disqualified. The team with the highest tower will win." The children then begin the task of listening to each other's ideas, communicating their ideas, trying to see another's perspective, and negotiating a solution. This is challenging for the children and requires therapist facilitation. The competitive aspect of the game mimics real life and often brings out frustration in the children, which is dealt with in the moment. During the debriefing, therapists and clients discuss what was hard about this task, what ended up making their team successful, and how this can help clients in other kinds of tasks/situations.

How Our Groups Are Unique

The effectiveness of social skills training ranges from being weak to highly effective (e.g., Gresham, Sugai, & Horner, 2001b). The goal in creating the groups at Rich & Associates was to incorporate only those components with demonstrated effectiveness. The use of empirically supported techniques such as coaching, contingency management, and a parent component is what makes our social skills groups unique.

A Coaching Intervention

Both COMPASS and LTC utilize the basic framework of a coaching intervention: direct instruction (rationale for the skill; how and when to use it), modeling, rehearsal, and specific feedback to teach the desired, often novel, social skills (see Bierman, 2004; Elliott & Gresham, 1993, for a review). In the COMPASS program, the direct instruction and modeling are facilitated by the use of puppets (Mize & Ladd, 1990), whereas direct instruction with in vivo role-plays are used in LTC. Research shows that this direct teaching component, in addition to coaching during play activities, greatly improves children's initiations, responses to peers, and overall interaction skills (Kroeger, Schultz, & Newsom, 2007).

Due to the more advanced cognitive abilities of the older groups, the LTC curriculum includes more sophisticated, cognitively-based, problem-solving strategies. Examples of these social problem-solving methods are generating multiple alternative solutions, thinking about the consequences of actions, and pairing solutions and consequences (e.g., Spivack & Shure, 1974). Research shows that positive effects from programs utilizing a social problem-solving approach are maintained up to one year post-treatment (Dereli, 2009).

Contingency Management Procedures

Integral to both COMPASS and LTC, contingency management procedures have one of the largest effect sizes in all of children's mental health (Forness, Kavale, Blum, & Lloyd, 1997) and are considered effective components of a social skills program, regardless of individual treatment goals (Maag, 2006). We therefore use contingent attention, praise, direct feedback, prompting, and redirection to reinforce individualized target behaviors (Bierman, 2004; Elliott & Gresham, 1993). In the LTC playgroup, a token economy is also utilized. Each child earns stars towards a group goal number of stars needed for a reward or privilege. Stars are given for a wide variety of friendly and compliant behaviors, with special attention paid to the target behaviors for each individual child. Our ability to target individual treatment goals within the group format is critical for its effectiveness (Gresham et al., 2001a; Maag, 2006; Matson, Matson, & Rivet, 2007; White, Keonig, & Scahill, 2007).

Parent Component

Parents are in the room, observing and at times facilitating, the social skills group during each session. In addition, three concurrent parent and child sessions occur within each of the 12-session cycles of the COMPASS and LTC playgroups. During these parent sessions, parents learn various techniques for facilitating their children's friendships, such as how to manage child behavior on play dates, network with other parents, organize their child for play, encourage emotional regulation, and coach their child to join in with others. This parent component is likely critical to the effectiveness of COMPASS and LTC, as past studies have found that the inclusion of parents in a child-focused social skills intervention increases effectiveness (e.g., DeRosier et al., 2011; Webster-Stratton & Hammond, 1997). Frankel and colleagues (2010a) also found that parent training on how to host playdates both increased the number of playdates and resulted in improved child responses to play requests from classmates (Frankel, Gorospe, Chang, & Sugar, 2010a). Importantly, the ability of COMPASS and LTC playgroups to penetrate the natural environment through the parent component is a hallmark of an effective program (Gresham et al., 2001a; Maag, 2006; Matson et al., 2007; White et al., 2007).

COMPASS Outcome Data

In a small pre/post sample of 23 high-functioning children (40% with a primary diagnosis of Autism Spectrum Disorder, 36% ADHD) completing one 12-session cycle of the COMPASS program (attrition rate was 0%), the pre/post changes were both clinically and statistically significant on all measures (Nangle, Carpenter,

Table 1. Evidence-Based Components of COMPASS and LTC Social Skills Groups

Clients	Content	Techniques
Heterogeneous	Parent Component: to promote generalization	Coaching: direct instruction, modeling, rehearsal, and feedback
High Functioning	Skill-Building Exercises: emphasis on individualized target behaviors	Contingency Management: contingent attention, praise, direct feedback, prompting, redirection

Shepherd, & Fales, 2008). Participants were recruited through their participation in the COMPASS group. The data were collected following UCLA Institutional Review Board approval and informed consent was given to all participants. On the Social Skills Rating Scale (SSRS; Gresham & Elliott, 1990), Parent Form, statistically significant improvements were found on the two subscales: Social Skills and Problem Behaviors. On the COMPASS Skills Questionnaire (created to specifically assess gains on the skills directly taught in COMPASS), statistically significant gains were also made. Less conflict was found on play dates according to the Quality of Play Questionnaire (Frankel & Mintz, 2011). All measures were parent report and represented changes that parents believed to be present in a variety of settings (e.g., school, home, play dates). These measures are routinely administered to group participants. These gains were clinically significant in addition to being statistically significant. For example, on the Social Skills subscale of the SSRS, scores moved from the below average to the average range of functioning. Importantly, scores on the Quality of Play Questionnaire dramatically improved, with all children having socially appropriate playdates at post-treatment. It is important to note that because there was not a control group, we cannot completely rule out other explanations for these improvements, such as spontaneous remission.

Importantly, parents reported high levels of satisfaction with the treatment Parents answered each question of the satisfaction questionnaire on a Likert scale of 1 (not at all satisfied) to 5 (very satisfied). On perceived improvement, parents reported an average of 4.15 (N = 21; range = 3.16 to 5.00), whereas general satisfaction was an average of 4.52 (N = 21; range = 3.67 to 5.00). These scores indicate that the improvements likely generalized to the home setting and that parents will be motivated to continue utilizing the learned techniques.

Maintaining the Integrity of the Scientist-Practitioner Model

This article demonstrates an attempt to provide evidence-based services to children and their families within a private practice setting and evaluate outcomes. Although it is often not feasible to launch randomized, controlled clinical trials within a private practice setting, it is certainly reasonable to apply the findings of these research projects in thoughtful and competent ways to the everyday practice of clinical psychology. For example, private practitioners can develop interventions by culling a variety of empirically supported techniques that pertain to a particular clinical question or client presentation. The COMPASS outcome data presented here illustrates that programs designed through thoughtful combination of evidence-based techniques can result in clinically and statistically significant improvements for clients.

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From Research to Practice

— Kimberly Pillon, Jenelle Johnson and Andrea Kozak Miller

Text Based Crisis Line

Clinicians work with youth who suffer from depression including those who have thought about and/or attempted suicide. Suicide was the third leading cause of death among 15-24 year olds and accounts for almost 5,000 deaths a year according to the Center for Disease Control and Prevention. Hotlines have been found to significantly reduce a caller's feelings of hopelessness and the likelihood of attempting suicide, however studies have shown young adults rarely use them. In the last decade texting has become the largest form of communication for 12-17 year olds. In an effort to reach youth seeking help, EMS, Crisis Call Center, the University of Nevada, and the Nevada Office of Suicide Prevention developed the nation's first call center that accepts text messages called The Text Today program. This article conveys the findings from the pilot of the service and includes tables of the results of the pilot of the program. The results of the program show that a text based crisis line increased the amount of youth seeking help and over 300 youth were accessing the system for help and support. More than half of the texts during the pilot of this program were repeat texters. Clinicians and call centers who work with youth might be interested in looking at how the program was set up and more details about the results of the pilot.

Evans, W. P., Davidson, L., & Sicafuse, L. (2013). Someone to listen: Increasing youth help-seeking behavior through a text based crisis line for youth. *Journal of Community Psychology, 41,* 471-487. Reprint request to William Evans at: wevans@unr.edu

Treatment of Social Anxiety Disorder Using Online Virtual Environments in Second Life

Clinicians have been effectively treating patients with social anxiety disorder (SAD) through evidence-based therapy. However, Yuen et al. (2013) point out that over 80% of people with social anxiety disorder do not receive any type of treatment (p. 51). Reasons for people not receiving treatment may include cost, time, transportation, or the fear of social interactions. Due to the ease of availability of the Internet and media websites, clinicians can now treat this population by using Second Life. Second Life is an online virtual environment that therapists and clients can potentially utilize to meet remotely for therapy sessions. The virtual environment, including the presence of avatars and virtual locations, provides a highly flexible array of visual stimuli for potential in-session exposure exercises (Yuen et al., 2013, p. 52). Clinicians can use Cognitive Behavioral Therapy (CBT) along with the virtual worlds in Second Life when treating patients with SAD. Second Life offers a wide variety of different virtual worlds to choose from. Users create an avatar and may go into different virtual worlds such as bar settings or conference rooms to complete their sessions. Patients actively involve themselves in activities and interact with other avatars while going through their treatment with their clinician. Researchers Yuen et al. (2013) conducted a study on feasibility, acceptability, and initial efficacy of CBT for SAD using Second Life to treat adults with generalized SAD (p. 52). Findings show that Second Life was effective in reducing social anxiety symptoms, along with reducing avoidance and disability, it improved depression, and more importantly, findings show that Second Life increased quality of life. Clinicians may be interested in a full reprint of this article to learn more about Second Life, how to utilize Second Life during therapy, and what the sessions consisted of to make virtual environments so successful in treating SAD.

Yuen, E. K., Herbert, J. D., Forman, E. M., Goetter, E. M., Comer, R., & Bradley, J. C. (2013). Treatment of social anxiety disorder using online virtual environments in Second Life. *Behavior Therapy, 44,* 51-61. Reprint requests to James D. Herbert at: James.herbert@drexel.edu

Playing with Horses

Clinicians work with youth who struggle with self-esteem, self-efficacy, and who are disengaged at school and in their communities. The article by Maujean et al. (2103) presents a practical study for youths who are not responding to the traditional treatments for low self-esteem, self-efficacy, or disengagement. The use of animal-assisted therapy has grown in recent years and horses have been known to offer additional and unique therapeutic qualities. Equine-facilitated psychotherapy (EFP) uses horses as co-therapists to teach emotional growth and learning. The task of caring for a horse involves trust, respect, and responsibility and requires the clients to use nonverbal communication, assertiveness, and teamwork. The researchers conducted a

study with 16 adolescents who had not responded to traditional forms of treatment. The results showed strong evidence that the behaviors and skills learned in the EFP program had transferred to the client's everyday life and exhibited a positive effect in their attitudes towards life. This study demonstrated that EFP therapy is an alternative treatment to increase the development of life skills and improve the levels of confidence and engagement in youths at risk for mental illness and disengagement. Clinicians might be interested in the description of the length of time for treatment, a specific case example, and the types of discussions held at the end of each week.

Maujean, A., Kendall, E., Roquet, L., Harp, T., & Pringle, G. (2013). Connecting for health: Playing with horses as a therapeutic tool. *Journal of Community Psychology, 41*, 515-522. Reprint requests to Annick Maujean at: a.maujean@griffith.edu.au.

A Clinical Trial of In-Home CBT for Depressed Mothers in Home Visitation

Awareness has been brought to the attention of mental health providers about in-home visitation programs following the birth of a child. Many mothers go undiagnosed with depression and postpartum depression. There have been certain programs introduced that utilize in home programs, but they have been unsuccessful as many of the in-home visitors were not recognizing symptoms of depression or did not have the credentials to treat depression. Referrals were given out to the mothers to seek mental health care in their community, but many did not utilize the help. Programs like In-Home Cognitive Behavioral Therapy have been introduced to help these mothers with depression. Clinicians and or mental health providers provide treatment to mothers in the home that focuses on the needs of the new mother. They may detect and treat depression and offer child health and development assistance. Ammerman et al. (2013) explains that mothers served by home visitation are typically socially isolated, impoverished, and underemployed. As a result, home visitation programs spend considerable time working directly with mothers to address such issues as stress and coping, health, social functioning, and educational advancement (p. 2). In recognizing and strengthening the needs of the mother, she will be a better provider to her children. Researchers Ammerman et al. (2013) conducted a study focusing on the treatment of depression through In-HomeCognitive Behavioral Therapy (IH-CBT) and found that IH-CBT and concurrent home visiting had substantial improvements relative to home visiting alone in diagnosed Major Depressive Disorder, self-reported depressive symptoms, clinician ratings of depressive symptoms, and overall functioning (p. 10). In addition, mothers felt that they were more confident as parents and felt closer to their child. Clinicians may be interested in obtaining a copy of the full reprint of the article to gain a better understanding on the importance of In-Home visits. In addition, clinicians may be interested in the instruments that were used in this study along with more in-depth results of the study.

Ammerman, R. T., Putnam, F. W., Altaye, M., Stevens, J., Teeters, A. R., & Van Ginkel, J. B. (2013). A clinical trial of in-home CBT for depressed mothers in home visitation. *Journal of Behavior Therapy.* Advance online publication. doi:10.1016/j.beth.2013.01.002

Reprint requests to Robert. T. Ammerman at: robert.ammerman@cchmc.org

Cocaine Abstinence and Contingency Management with Older and Younger Individuals

Clinicians work with older clients who are seeking drug abuse treatment. The number of older substance abusers has risen rapidly as well as the number of older adults seeking treatment substitution therapy. Older clients may have distinctive characteristics and treatment needs compared to their younger equivalents. In addition to demographic differences, older substance abusers generally have prominent and severe health-related issues that can worsen with drug use and create harsher consequences than the younger abusers. The Center for Substance Abuse Treatment recommends that treatment is age specific and addresses psychological, social, and health concerns of older abusers. Contingency Management is based on basic behavioral principles that detect abstinence and uses tangible reinforcers for abstinence. This study was done with 193 participants, some receiving contingency management plus standard care and some receiving only standard care. This study found that clients 40 years and older had a greater response and longer duration time in contingency management than those who were their younger counterparts. Interestingly, there was not a difference in severity of medical conditions between the older and younger groups. Clinicians might be interested in the multivariate breakdown of variables included in the article.

Weiss, L., & Petry, N. M. (2013). Older methadone patients achieve greater durations of cocaine abstinence with contingency management than younger patients. *The American Journal of Addiction, 22*, 119-126. Reprint requests to Nancy M. Petry at: npetry@uchc.edu

Couple Communication among Problem Drinking Males and Their Spouses: A Randomized Controlled Trial

Clinicians often times see clients with alcohol related issues. Alcohol can influence couple communication problems such as criticism, defensiveness, and negative communication. Behavioral Couple Therapy (BCT) focuses on behavioral exchange therapy, communication skills training, and problem-solving training. Research demonstrated that BCT is a good treatment in reducing negative statements in male problem drinkers and their spouses. BCT has shown positive results in enhancing marriages by increasing positive communication skills. Researchers Walitzer et al. (2013) recently conducted a study that evaluated the effects of alcohol-focused spouse involvement and BCT on couple communication in the context of group drinking reduction treatment for male problem drinkers (p. 2). When the spouse is involved, the spouse learns more effective skills and lessons the negative communication while the male spouse is receiving alcohol treatment which may lead to a reduction in drinking. Walitzer et al. (2013) provide results that couples with alcohol focused treatment plus BCT have decreased negative statements and increased problem-solving statements to a greater extent than did couples with alcohol focused treatment without BCT (p. 20). The relationship is enhanced with better communication and a reduction in alcohol consumption. In addition, an increase in problem solving skills was shown in the couples who received BCT. Clinicians might be interested in a full reprint of this article to obtain the practitioner points that cover treatment focus. Focus areas include how they may involve the spouse, how they can encourage spouses from counterproductive behavior and become more supportive, how actively involving the spouse could be a cause of the male partner's drinking reduction, and to show spouses how to decrease negative statements and improve in positive communication.

Walitzer, K., Dermen, K., Shyhalla, K., & Kubiak, A. (2013). Couple communication among problem drinking males and their spouses: A randomized controlled trial. *Journal of Family Therapy.* Advance online publication. doi: 10.1111/j.1467-6427.2013.00615.x Reprint requests to Kimberly Walitzer at: walitzer@ria.buffalo.edu

Focus on Diversity

African Americans and psychotherapy: Addressing disparities through cultural competency

— Erlanger Turner

Many African Americans are reluctant to seek therapy. Research has identified numerous reasons why this population is less likely to use psychotherapy. For example, studies have reported that African Americans are less likely to seek services due to financial reasons (Diala et al., 2002), attitudes and stigma (Turner, 2012), or religion (Mishra et al., 2009). As a profession, the American Psychological Association (APA) has strived to meet the needs of diverse individuals by establishing standards that require psychologist to be culturally responsive as part of the ethics code. These standards are particularly important given that 71% of licensed psychologist self-identify their race/ethnicity as Caucasian/White a (APA Center for Workforce Studies, 2011).

What is cultural competency?

Cultural competency has been defined several ways. According to Sue (2006), cultural competency is comprised of three central concepts: (1) cultural awareness and beliefs – which refers to a providers' sensitivity to his or her personal values and biases; and how these may influence psychological practice, (2) cultural knowledge– which is described as having knowledge of the clients culture, worldview, and expectations, and (3) cultural skills – which refers to a providers' ability to intervene in a manner that is culturally sensitive and relevant. Given the high unmet need by African Americans, the field of psychological practice must make continued strides to meet the mental health needs of these individuals.

Helpful steps for improving cultural competency in treatment:

1. Psychologists must become aware of their own values, beliefs, and stereotypes. Additionally, they should be aware of how clients may react to their

own personal characteristics (e.g., gender, age, ethnicity, etc). With regards to working with African American clients, it is important for practitioners to recognize the impact of their race and education on the perceptions of their African American clients. At the same time, it is important to not let your own stereotypical views of African Americans influence your attitude towards your client.

2. Psychologists need to understand their clients' background and characteristics such as family structure, social class, and culture. It is important to not assume that all African Americans have encountered the same experiences. There is great diversity and heterogeneity within ethnic minority groups. It is paramount that clinicians explore individual experiences of family interactions, traditions, and social injustices.
3. Consider providing a pre-therapy intervention. During your initial session with African American clients, it may be helpful to discuss the following:

- What is psychotherapy?
- How can psychotherapy help?
- Describe what will be required during the course of treatment.

4. African Americans may avoid psychotherapy because they see little value in the service. It may be important to establish credibility early in the process. This does not involve pointing out the number of degrees you have on your wall. For many clients from ethnic minority groups, credibility involves showing them that you can help improve their problem. By helping clients decrease their symptoms and/or provide them with a sense of understanding of their situation, you can establish yourself as a credible practitioner. This can improve the therapeutic alliance and prevent premature termination.
5. When working with clients from dissimilar cultural backgrounds, be attentive to your discomfort and resistance. It is not uncommon for psychologists to have difficulties dealing with their own feelings of discomfort or uncertainty when working with culturally diverse clients. African American clients may challenge your recommendations directly or indirectly, may have inconsistent session attendance, or may have religious beliefs that may make the treatment process difficult. It is importance to recognize these frustrations and learn how to use these moments to better understand yourself in an effort to help your client.

[a]Approximately 30,000 respondents did not report race/ethnicity

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Further readings:

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Focus on Ethics

The Ethical Practice of Psychology in Small Unified Communities

— Katherine L. Zane and Jeffrey E. Barnett

Recently, Firestone and Barnett (2012) provided readers of the *Independent Practitioner* with information about ethical practice in the rural setting. A number of important issues relevant to clinical practice in this work setting were discussed, including informed consent, clinical competence, confidentiality, boundaries and multiple relationships, and fees and financial arrangements, with an emphasis on positively and proactively addressing these issues in order to manage these aspects of practice in the most effective manner possible. In addition to rural communities, independent practitioners may work in a range of other special work settings, raising some similar issues that must be thoughtfully addressed to be able to fulfill our ethical obligations to our clients.

Special Work Settings

Traditionally, the representation of a small-community psychologist has been limited to rural settings. However, there are a number of other settings that one should consider when acknowledging ethical issues and practice in small communities (Schank, Helbok, Haldeman, & Gallardo, 2010). Special work settings are small communities that are comprised of a unified form of diversity. There are numerous small communities in which one can live and practice. Examples include lesbian, gay, bisexual, transgender (LGBT) communities, communities of color and cultural-ethnic or religious affiliated settings, and not relevant to this article's focus, small college communities and the military.

Special work settings include all communities of which a practitioner is a member and in which the practitioner lives and works. They may be small, isolated, and/or insular communities. While they each bring with them their own unique characteristics, they have a number of features, and thus, challenges, in common. Examples of special work settings for independent practitioners include:

- The LGBT psychologist who is politically and socially active in the local LGBT community, who lives in this community, whose clinical practice is in this community, and whose practice specializes in psychotherapy with LGBT clients.
- The bilingual Latino/a psychologist who lives and raises her or his family in a small Latino community, who participates in social, civic, and religious activities in the community, whose practice is located in this community, and who serves the members of this community in her or his practice.
- The Orthodox Jewish (or Catholic, Muslim, Protestant, etc.) psychologist who lives in the local Orthodox Jewish community, raising her or his family in this community, worshiping there, participating in social and civic activities there, and whose practice that specializes in child psychology is located in that community and whose clients come from that community.

Similar to the rural setting, members of these special work settings face a number of unavoidable challenges that must be addressed in order to practice ethically and competently. One might consider the option of locating one's practice outside of the community where she or he lives and serving a different population in one's practice. However, but similar to what happens in the rural setting, residents of these insular, isolated, and/or small communities will frequently feel most comfortable receiving psychological services from a professional they know from the community, someone they know to be a respected member of the community, someone they have interacted with previously, someone likely to share similar values, and someone who will understand their lifestyle and world view (Schank & Skovholt, 2006).

While of course the lives of individuals within each of these communities may be quite diverse, overall, residents of each of these special work settings may share much in common with other community members. These similarities and shared experiences help the independent practitioner to understand the lives, challenges, and needs of local residents as well as to have credibility with them. There often exists a strong feeling of knowing that the independent practitioner will understand the client, key issues and challenges in her or his life, and will 'get them.'

Despite the range of special work settings that may exist and the range of individual differences among members of these communities, psychologists in each of these settings must navigate ethical dilemmas and challenges including, but not limited to, boundary issues and multiple relationships, confidentiality and its limits, and clinical competence issues. While there are

clearly a number of benefits to being a member of one's community and living and practicing within it, these commonly occurring challenges must effectively be addressed and managed in order to best serve the clinical needs of one's community.

Initial Decisions and Steps

In these special work settings, practitioners will have to make the initial decision of whether it is in both the client's and the practitioner's best interest to initiate a therapeutic relationship. The psychologist will need to assess the possible conflicts or consequences, as well as the psychologist's own motives prior to beginning the relationship (Schank & Skovholt, 2006). In a situation where one does not feel it appropriate to take on the client, whether it is an issue of competence or boundaries, referring the community member to another professional would be most appropriate. Yet, a referral is not always a viable option when there is the consideration of geographic proximity or isolation, as well as the community member's partiality to seek professional assistance from someone who shares similar values, speaks the same language, and so on. Additionally, because isolation, stress, and burnout are often associated with the challenges of living and working in these settings, psychologists may reduce these professional pitfalls through collaboration and seeking consultation with colleagues, both locally as well as in other similar special work settings across the country.

Boundaries and Multiple Relationships

Similar to the rural setting, the existence of multiple relationships is unavoidable for the independent practitioner who lives and works in one of these close-knit communities. The Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code; APA, 2010) makes it clear in Standard 3.05, Multiple Relationships, that not all multiple relationships are considered unethical, and therefore to be avoided. This standard highlights that only those relationships that might reasonably be expected to impair the objectivity or judgment of the psychologist or that bring with them a significant risk of exploitation of or harm to the client should be avoided.

How these decisions are made in special work setting communities by independent practitioner psychologists may at times be quite challenging. There will often be situations where multiple relationship situations are unavoidable, but may not be inconsistent with the professional relationship. In fact, the participation in multiple relationships may at times be relevant to why the community member seeks out the practitioner for treatment. Further, it also may be a positive factor that adds to the psychologist's understanding of the client and that increases the client's feeling of being understood. At times, in these communities the question is not "should I work with this client?" but rather, "how best can I work with this client?" The reason for this is that referral options may be limited and even when they are available, community members may not be open to them.

The cautious practice of making a referral whenever any sort of multiple relationship is present (something possible in many urban and suburban settings) is not a viable option in these work settings. Most frequently, because of limited referral options, the situation will be that the client receives treatment from the practitioner or not receive the needed treatment. Some flexibility is therefore important and a rigid approach to boundaries and multiple relationships will likely prove to be inimical to clinical practice in these settings (Barnett, Lazarus, Vasquez, Morehead-Slaughter, & Johnson, 2007; Lazarus & Zur, 2002).

Many psychologists have acknowledged feeling ill-prepared for incidental contacts with clients in their local community (Sharkin & Birky, 1992) with most reporting "little or no training experience dealing with incidental encounters with clients" (p. 328). As this is typically an everyday occurrence in small communities, being prepared for these interactions in the community is of great importance for the practitioner and client alike. Acknowledging the reality of living and working in these communities is an issue that should be openly discussed from the outset of the professional relationship and handled in a manner comfortable for and respectful to the client.

Additionally, professional boundaries are a key issue for practice within many ethnic communities. In contrast to individualistic thought, collectivist cultures value overlapping relationships. As cited in Schank and Skovholt (2006), multiple relationships are commonly considered "desirable" or even "essential" when practicing appropriate psychotherapy (Pederson, 1977, p. 243). Furthermore, issues of boundaries are common within ethnic communities. For example, many Asian communities view gift giving as a sign of expressing gratitude or respect (Sue, Bingham, Porché-Burke, & Vasquez, 1999). Refusing the gift in an effort to cautiously respect boundaries may actually be found by clients to be disrespectful and even offensive. Thus, it is vital that "we expand our 'small' community mentality, particularly when working with ethnocultural communities, to reflect the larger ecological systems in which those we intend to serve reside" (Schank, Helbok, Haldeman, & Gallardo, 2010, p. 510).

Similarly, religiously affiliated psychologists also may regularly encounter issues related to professional boundaries. In this setting, it is quite common for psychologists to find themselves active on the same church, synagogue, or mosque committee as their client. It is also common for psychologists to see different members of a family as clients, or to provide treatment to people who share friendships with each

other (Schank & Skovholt, 2006). It is the conviction in a common faith that draws the community together, and community members may perhaps hold distrust for an unknown psychotherapist outside of the community. Thus, as in other special work settings, harm may occur when not defining clear boundary and multiple relationship expectations at the outset of the therapeutic relationship (Hill & Mamalakis, 2001). Within this particular setting, role confusion is common for psychologists and their clients.

Therefore, psychologists must openly discuss and reach agreements with clients on how the relationships will be compartmentalized and managed (Barnett & Yutrenzka, 1994). It is recommended that special work setting psychologists engage in ongoing discussions with clients that begin within the informed consent process at the beginning of the professional relationship. In particular, issues and concerns should be addressed including the likelihood of a multiple relationship occurring, the client's expectations within this occurrence, and how commonly occurring challenges with be handled. Because these situations may be challenging it is recommended that practitioners use an ethical decision making process, consult with colleagues, and consider the relevant principles and standards of the APA Ethics Code.

Limits to Confidentiality

Similar to the rural setting, where the community is interconnected, these other special work settings are typically insular with secrets within these communities often difficult to keep. Thus, confidentiality is one of the most challenging issues within these communities. Community expectations may include the open sharing of information among community members, to include psychologists who are members of the community. Independent practitioner psychologists will need to educate community members on how psychologists address and manage issues of confidentiality and their importance in the psychotherapy relationship. Assisting community members to understand these issues should go a long way toward ensuring that community members are not alienated from the psychologist. Similarly, these prevailing community expectations and a lack of understanding of how psychologists manage confidential treatment information may result in some community members not seeking out needed services. So, again, educating community members about the ethics of psychologists in this regard may be important.

The likelihood of hearing information about clients through other community members puts the psychologist in a difficult position of knowing information without the client's own disclosure. It is recommended that this issue be addressed in advance as part of the informed consent process, but at times even this will not be sufficient. If one client discloses in treatment something about another member of the community it may prove quite vexing to know what to do with this information. Should it be disclosed to the other client? If so, will doing so give away the identity of the source of the information and thus violate that client's confidentiality? These can be challenging situations for practitioners in these communities. Consultation with colleagues is recommended and as has been mentioned, the use of open discussion of confidentiality expectations as part of the informed consent process as a preventative strategy is essential.

Clinical Competence

Similar to the rural setting, other special work settings often place heightened demands on the community psychologist. Whether due to limited resources such as lack of viable alternative options, or the psychologist's own limits of clinical competence, it is a significant challenge when dealing with a wide range of community members. Although the APA Ethics Code (APA, 2010) requires psychologists to acquire necessary competence when dealing with diverse populations, it is impossible to foresee and be prepared for every possible clinical need a client may present with (Knapp & VandeCreek, 2012). Despite the commonalities of values, beliefs, or community standards within these communities, practitioners must be prepared for the possibility of having to handle a wide range of presenting problems.

Standard 2.01, Boundaries of Competence (APA, 2010), requires that psychologists develop and maintain competence to deliver appropriate services. Yet, no psychologist can possess the competence to meet every client's treatment needs. Thoughtful decision-making and consultation with colleagues are needed when faced with situations where client treatment needs fall outside the practitioner's boundaries of competence. Yet, community expectations and limited referral options will at times place the practitioner in the situation where the options are treatment by the psychologist or the client going without needed treatment. Standard 2.01, Boundaries of Competence (APA, 2010) addresses these situations stating that "psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study" (p. 5). For those practitioners with limited access to expert colleagues and training opportunities in their local area, the use of various technologies such as the Internet may prove valuable in this regard.

Conclusions and Recommendations

Practitioners living and working in small, isolated, and/or insular communities face a number of challenges. Yet, when dealt with thoughtfully and proactively, they may be addressed in such a way as to strike a balance

between community expectations and clinical needs on the one hand and the practitioner's ethical obligations and personal realities on the other. For each of the ethical dilemmas and challenges addressed, practitioners must address the primary question of "does the potential benefit of (this action or decision) outweigh the potential for harm?" (Schank & Skovholt, 2006, p. 175). Practitioners in these settings have multiple obligations and responsibilities, which at times may seem inconsistent. It is always important to consider reasonably available options and alternatives when making these decisions as well as to honestly reflect on our ability to ethically and effectively provide needed services. When such questions exist, it is recommended that the Ethics Code, relevant practice guidelines (e.g., the APA Multicultural Guidelines; APA, 2003), and consultation with expert colleagues be a part of a deliberative decision-making process.

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APA
Division 42 Program Summary

121st ANNUAL CONVENTION

Honolulu, July 31 - Aug. 4, 2013

Hawai'i Convention Center

Hilton Hawaiian Village Beach Resort

Sheraton Waikiki Hotel

Wednesday - July 31

Symposium: Regaining and Maintaining Disciplinary Control of Psychological Services

8:00 AM 9:50 AM — Convention Center — Room 313B

Chair

Robert H. Woody, PhD, JD

Participant/1stAuthor

Robert H. Woody, PhD, JD
Jeffrey N. Younggren, PhD
Jeffrey Zimmerman, PhD

Invited Address (S): [Graham]

10:00 AM 10:50 AM — Convention Center — Room 323B

Chair

Steven Walfish, PhD

Participant/1stAuthor

Stanley R. Graham, PhD

Symposium: Savvy Survival Tips for Testifying in Court

11:00 AM 11:50 AM — Convention Center — Room 321B

Cochair

Kristina L. Roberts, PhD
June Ching, PhD

Thursday - August 1

Skill Building Session: Trauma in the Treatment Room What the Independent Practitioner Needs to Know

8:00 AM 9:50 AM — Convention Center — Room 317B

Chair

Lisa M. Rocchio, PhD

Skill Building Session: Who's Afraid of the Big, Bad Barrister?

10:00 AM 10:50 AM — Convention Center — Room 327

Chair

Robert S. Meyers, PsyD, JD

Skill Building Session: Mindfulness and Acceptance Based Behavioral Therapy for Anxiety and Comorbid Disorders

10:00 AM 11:50 AM — Convention Center — Room 304B

Chair

Lizabeth Roemer, PhD

Participant/1stAuthor

Lizabeth Roemer, PhD
Sarah Hayes Skelton, PhD

Friday - August 2

Symposium: High Conflict Coparent Counseling and Parent Coordination More Tools for the Practitioner's Toolbox

8:00 AM 9:50 AM — Convention Center — Room 302A

Chair
Jeffrey Zimmerman, PhD

Participant/1stAuthor
Jeffrey Zimmerman, PhD
Lauren J. Behrman, PhD

Skill Building Session (S): Tailoring Psychotherapy to Latina/o Communities

12:00 PM 1:50 PM — Convention Center —Room 304A

Chair
Miguel E. Gallardo, PsyD

Participant/1stAuthor
Miguel E. Gallardo, PsyD
Nahal C. Kaivan, MA
Raquel Tovar Goodwin, MA
Laura Zamora, BA

Symposium (S): Colleagues Thinking Together APA and ASPPB Explore Where Ethics and Licensure Converge

8:00 AM 9:50 AM — Convention Center — Room 306A

Chair
Alex M. Siegel, PhD, JD

Participant/1stAuthor
Stephen T. DeMers, EdD
Lisa R. Grossman, PhD, JD
Brian Stagner, PhD
Linda F. Campbell, PhD
Jacqueline Horn, PhD
Fred Millan, PhD

Discussant
Stephen H. Behnke, JD, PhD
Janet T. Thomas, PsyD

Saturday - August 3

Business Meeting: Board

8:00 AM 12:50 PM — Hilton Hawaiian Village Beach Resort
Hibiscus Suites I and II

Poster Session:

10:00 AM 10:50 AM — Convention Center — Kamehameha Exhibit Hall

Participant/1stAuthor
Amanda M. Kruszewski, MA
Jennifer Imig Huffman, PhD
Randolph B. Pipes, PhD

Symposium (S): Health Care and Payment Reform Laws and Psychologist Practice Success Strategies

10:00 AM 11:50 AM — Convention Center — Room 305B

Cochair
Elena J. Eisman, EdD
Barry S. Anton, PhD

Participant/1stAuthor
Elena J. Eisman, EdD
Nancy Lane, PhD
Benjamin F. Miller, PsyD
Barry S. Anton, PhD

Discussant
Helen L. Coons, PhD

Skill Building Session (S): Effective and Ethical Strategies for Collaborating With Media

10:00 AM 11:50 AM — Convention Center — Room 316B

Chair

Nancy A. McGarrah, PhD

Participant/1stAuthor

Angel Brownawell, BS
Allison B. Hill, JD, PhD

Social Hour and Awards Presentation

5:00 PM 6:50 PM — Hilton Hawaiian Village Beach Resort — Nautilus Suites I and II

Symposium: Empirical Validation for Smartphone and Mobile Device Apps

8:00 AM 9:50 AM — Convention Center —Room 305B

Chair

Marlene M. Maheu, PhD

Participant/1stAuthor

Marlene M. Maheu, PhD
Arlene B. Strugar, PsyD
Allison Hermann, PhD

Symposium: Working With Women of Color Challenges, Intersections, and Opportunities

10:00 AM 11:50 AM — Convention Center — Room 317B

Chair

Lillian Comas Diaz, PhD

Participant/1stAuthor

Sumru Erkut, PhD
Frances Trotman, PhD
Lula A. Beatty, PhD
Beverly Greene, PhD
Frederick M. Jacobsen, MD, MPH
Lillian Comas Diaz, PhD

Discussant

Melba J.T. Vasquez, PhD

Symposium (S): Nuts and Bolts of Successful Practice Early Career Options

12:00 PM 1:50 PM — Convention Center— Room 306B

Chair

Michael E. Schwartz, PsyD

Participant/1stAuthor

Kristina L. Roberts, PhD
Kelly Ray, PhD, MP

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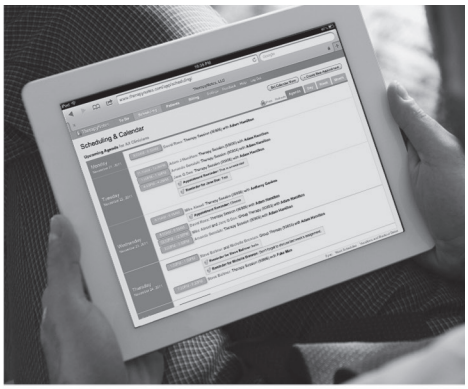

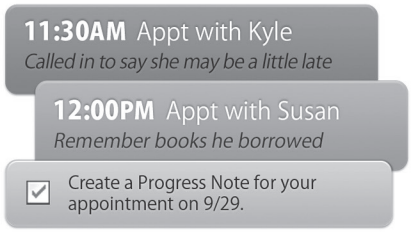

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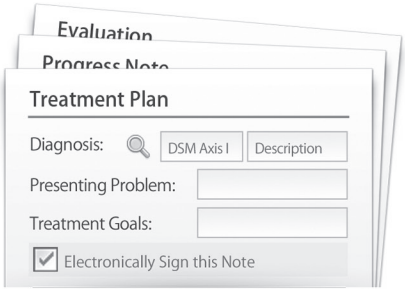

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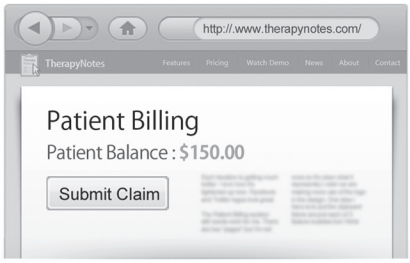

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Your full name: _____ Email address:_____

1. The corrective emotional experience refers to a situation in which an old difficulty is re-experienced in a new and more positive way.

(a)True, (b) False

2. According to Shapiro, when a psychologist chooses to undertake supervisory responsibilities they should do all of the following except:

(a) carefully access whether the supervisee can handle a particular case
(b) supervise a large number of individuals so he/she has extra help
(c) document all supervisory sessions
(d) supervise only a limited number of individuals

3. According to Zane and Barnett, the _____ makes the initial decision of whether it is in both the client's and practitioner's best interest to initiate a therapeutic relationship.

(a) the client
(b) the client's parent
(c) the practitioner
(d) the practitioner's referral

4. The research of mindfulness meditation suggests that a variety of populations may benefit from mindfulness including:

(a) persons suffering from chronic medical conditions
(b) children
(c) pregnant mothers
(d) patients working through depression and anxiety
(e) all of the above

5. According to the article "From Research to Practice", Second Life treats patients with:

(a) Dissociative identity disorder
(b) OCD
(c) Autism
(d) Social Anxiety Disorder

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