Your Summer 2015 IP

President’s Column

Pat DeLeon

Further Limits on Confidentiality

Treating Adult Survivors of Child Sexual Abuse

Addressing Sexual Health with Child and Adolescent Populations

Selective Mutism – More Than Just Shy

From Research to Practice

Linguistic Diversity: Strengthening your Connection with Non-Native English Speakers
Independent Practitioner

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Each year, the president of Division 42 has the privilege of concentrating on important and timely projects during their tenure in office. I have had the honor of focusing on fascinating and rewarding Publications & Communications (P & C) initiatives, in collaboration with Terrence Koller, Ph.D., P & C chair, and the talented heads of 42’s P & C committees. This labor of love has involved publisher and editor searches, expansion of operations to bring cutting edge innovative visions to action, policy and procedure modifications, along with enhancement of the infrastructure to ensure that the vital P & C components are well maintained and functioning at optimal levels in the changing practice environment.

P & C’s programs are multi-faceted and expansive. The domain covers all print publications of the Division and additional media and electronic formats sponsored by and identified with the Division. Not only does P & C communicate and connect with our 42 community, but provides vehicles for interfacing with other divisions, APA constituents and governance groups. Clearly, when all of the P & C programs are fully charged, we can facilitate the best connections with the 3,200 plus members of our special Division. Much like conducting a symphony orchestra concert, when all the components perform in synchrony, the resulting rendition is truly amazing.

42 has an astounding array of communication platforms that are constantly being updated, improved, and developed to actively engage its members and provide 24/7 resources for professional practitioners. I would like to highlight the enhanced workings of these incredible 42 programs which include the highly valued Independent Practitioner, the widely utilized 42 Listserv, the resource filled Division Website, Marketing & Public Education, Social Media, and the greatly anticipated Division Journal Practice Innovations being launched in 2016.

New Division 42 Journal – Practice Innovations

The breaking news is that our Division has prevailed in a major way. 42’s new Journal — Practice Innovations, is scheduled to begin publication in 2016. This quarterly circulated peer reviewed Journal will generate manuscripts of interest to psychological and mental health specialists, with direct relevance to practitioners and practice settings. The intention of the new Journal is to feature timely and important scholarly papers for practitioners to share findings, discoveries and theories on the most innovative practices in the field, facilitate discussion on topics of applied scientific knowledge and technology in the evolving healthcare environment, and to promote dissemination of information between professionals in the community.

I am thrilled to announce the Board of Director’s appointment of Steve Walfish, PhD as the inaugural Editor in Chief of Practice Innovations. The search committee unanimously recommended Dr. Walfish based on his exceptional qualifications in multiple realms: expertise in psychological practice, services, and settings; intricate familiarity with the needs of Division 42 members in professional practice; wide connection with prominent psychologists in the field; previous experience as past editor of the Independent Practitioner; well respected managerial and leadership skills; and specialized acumen in the business of practice.

We are grateful for the stewardship of Dr. Gerry Koocher who chaired both the RFT and editor search work groups and to the committee members (Drs. Lisa Grossman, Jeff Zimmerman, Linda Campbell and June Ching, ex-officio) for the time and effort that they devoted to the process. It is especially noteworthy that the journal was the dream of Lisa Grossman during her presidency and was brought to fruition through the stalwart and persistent efforts of Linda Campbell and Gerry Koocher. Without this vision and these efforts, the actualization of our own division journal would never have become a reality. We owe these visionary leaders a big Mahalo (thank you).
Independent Practitioner Bulletin (IP)

When members are asked what they consider to be a primary benefit of belonging to our Division, they will inevitably mention receiving issues of the Independent Practitioner bulletin (IP). Thanks to the excellent work of Editor Lawrence “Larry” Riso, PhD and Associate Editors Lori Thomas, JD, PhD and Stephanie Mihalas, PhD, the IP continues to be a prized asset for our 42 professional practitioners due to the quality dissemination of information on important areas of practice. Larry considers the IP to be one of the few publications that can have a profoundly direct and immediate impact on clinical practice, “it is where the rubber meets the road.” These descriptions reflect why the IP continues to be greatly prized by our members:

• Provides up-to-date articles on opportunities to enhance and expand clinical practice, including emerging niches
• Delivers skill building resources, tools and techniques to assist practitioners with developing the business of practice
• Informs practitioners on the latest therapeutic interventions
• Presents regular articles on the application of research into practice
• Disperses information on ethics, liability, malpractice and risk management
• Provides information on legal, legislative, and regulatory advocacy concerns that affect practice
• Focuses on diversity and multi-cultural applications in practice
• Disseminates news and announcements relevant to the Division such as 42 conferences, awards and events
• Generates editorial views, opinions and policies
• Offers testimonials from authors on survival skills in independent practice

The IP is primed for the future when Stephanie Mihalas takes over reigns as the IP Editor starting with the winter 2016 issue. Being the high performing and forward thinker that she is, Stephanie has already been executing her vision of expanding the editorial staff by recruiting for contributing editors in specific sections such as students/ECPs; business of practice; research and clinical practice; diversity; opinions and policy; and ethics, liability and risk management. With the expansion of the IP’s editorial staff, we anticipate an even higher quality IP on the horizon.

Listserv

I seriously doubt that any other Division has a listserv as well utilized and lively as that of Division 42. With 1,419 subscribers, our 42 listserv is hopping with electronic transmissions for our community of independent practitioners 24/7. Due to the nature of independent practice, professionals can be at risk of being isolated. Whereas, the Division 42 email list provides an immediate opportunity for members to reach out to other colleagues and ask questions when they may not have an office mate or nearby colleague to confer with. Looking at recent trends, these are hot topics that our listserv subscribers are communicating about:

• Referrals to trusted colleagues in all geographical locations
• Sharing resources on books, videos and treatment programs, apps
• Discussion of varied perspectives on clinical or ethical dilemmas
• Mini consultations on assessment, diagnosis and treatment
• Featured listserv discussions on:
  • Health and behavior CPT therapy codes
  • Evidence based practice resources
  • Outcome measures and treatment validity
  • Insurance billing for psychotherapy codes
  • Apps for health care and psychotherapy
  • Learning to maneuver health care systems, insurance panels including reimbursement systems and the business of practice
  • Sharing information of the development of niche practices
  • Division announcements

As our premiere listserv chair, Dr. Keely Kolmes has been rebuilding a supportive team of volunteers to assist with inquiries, resources, management and maintaining a culture of collegiality. On the mod squad are: Aimee Yermish, PsyD, Luis Morales Knight, PhD, Kimberly Smith, PsyD, Shannon Nicoloff, LP, RPT, Terry Koller, PhD, June Ching, PhD and Blaine Lesnik, PsyD (Advisor/Historian). Many thanks to Keely and her team for their diligence in developing and implementing improvements for the already remarkable listserv and taking it to an even advanced level of functioning. As I am writing, they have been hard at work on examining the language of our current listserv rules to ensure that they provide the most value to the members of Division 42 and are consistent with the APA rules for listserv usage; developing a policy and process to keep the listserv a respectful and collegial community; and creating guidelines to help members avoid client confidentiality violation when they seek consultations on the publicly archived listserv.
Social Media

Being the digital immigrant that I am, I sought out two savvy digital natives to assist in expanding our Division’s social media platforms. Derek Phillips, our Student Representative and Lindsey Buckman, PsyD, co-chairs of social media, have been simply amazing with this initiative, driving our Division’s social media presence to another realm. Taking a look at these stats, terrific things are happening with 42’s digital adaptations.

- Twitter = 3,407 followers (which is more followers than APAPO’s Twitter account)
- Facebook = 2,232 “Likes” (which is more “likes” than APAPO’s Facebook account)
- LinkedIn = 1,730 members

Derek and Lindsey also offered a well-received Twitter tutorial at the State Leadership Conference in Washington, DC in March with plans for future tutorials. Be sure to sign up for their next social media tutorial! We want to teach practitioners how to utilize social media to promote psychology and their practices.

Website: www.division42.org

Erlanger Turner, Ph.D. (Chair), and committee members (Serena Wadhwa, PsyD, Cristalle Sese, PsyD, and Luis Morales Knight, PhD), have been focusing on keeping our Website pages updated, while re-organizing content for appeal and usability. Through 42’s Division Website, members have electronic availability to numerous resources such as the IP; diversity resource guide, archives to ETIPS, practice forms, and access to state specific electronic health record (EHR) templates. They can also retrieve information from our member directory, find information on Mentorshoppe, and news on upcoming Division events and programs. How well utilized is our Website? Our popular Website averages over 2,000 page views per month, with about 36% as return visitors.

Another of my new initiative was the creation of a Division 42 Blog Corner on our Website, produced by Dr. Elaine “Laney” Ducharme. These monthly blog entries provide social media opportunities for informational sharing to improve professional practice outreach. Laney has generated postings on “Getting Kids to Go to Bed and Stay There,” “Finances and Your Relationship,” and also started a blog discussion on bipolar disorder. This blog project is yet another communication interactive vehicle for members. Come blog with us and be sure to let Earl know of ways we can continue improving our on-line Website for 42’s practice community.

Marketing & Public Education

Under the inventive directorship of Dr. Pauline Wallin, chair of Marketing & Public Education (MPEC), two newly formulated projects have been launched this year, as further demonstration of our commitment to provide innovative P & C offerings to our members. In the past, Pauline coordinated Virtual Learning Hours with nationally prominent experts sharing their expertise with members. Expanding on this VLH concept, this April, Pauline hosted the Division’s first webinar learning hour, with Brad Klontz, PsyD, CFP. His well-received topic was “The Psychology of Personal Finance: What Research Tells Us about the Financial Health of Psychologists and Their Clients – and Why it Matters.” Contact Pauline if you would like to volunteer your expertise in helping us build a webinar library from additional foremost experts in the field.

The MPEC Committee (Drs. Pauline Wallin, Julie Binde- man, Theo Tsaousides, Amy Vigliotti and Lean Wingear) has recently set up virtual mastermind groups for Division 42 members who want to share ideas and support one another in marketing their practices. Each group will consist of 4 – 6 psychologists who meet on a regular basis via conference call or videochat, according the preference of the group. Mastermind groups are a form of peer coaching, with group members invested in accomplishing their own personal and professional goals and in supporting the other members in accomplishing theirs. If you are interested, sign up and log in to the website: http://division42.org/content/mastermind-groups

As you can see there are amazing things happening in the land of P & C. 20 years ago, most of us probably didn’t have an e-mail address and now we can’t imagine operating without it. This is the fastest changing communications and technology period we’ve been in. Couple this with the altering landscape of health care and it is clear why it is essential that 42’s P & C is fully charged to assist our community of independent practitioners stay connected. Now that’s value added!

Warm Aloha,

June W. J. Ching, PhD, ABPP
President, Division 42
Opinions and Policy

The Inevitable Winds of Change
— Pat DeLeon

From a public policy/political perspective, one can sense that the U.S. Congress is steadily returning to the days of bipartisanship, collaboration, and focusing upon meaningful accomplishments. Recently, a number of congressional committees have recommended bipartisan bills; the most directly relevant to psychology is the Medicare “Doc Fix” legislation which has been a high priority for APA over the past several years, notwithstanding that it will add $141 billion to the projected federal deficit over the next decade. The potentially highly emotionally charged “No Child Left Behind” reauthorization was unanimously endorsed by the Senate HELP Committee, while efforts to reform civil-asset forfeiture laws have gained strong bipartisan support within the Senate Judiciary Committee. Although initially tied to the Attorney General’s confirmation deliberations, the far reaching Sex-Trafficking legislation was ultimately sent to the President after a 99-0 Senate vote. Similarly, this spring the Senate Commerce Committee has been exploring telehealth issues, again on a bipartisan basis. These efforts would simply not happen without the strong encouragement of the leadership of both political parties.

The APA State Leadership Conference (SLC)

The theme for this year’s exciting APA State Leadership Conference (SLC) was Practice Innovation and it was the 10th anniversary of David Ballard’s visionary Psychologically Healthy Workplace and Organizational Excellence awards presentations. Katherine Nordal stressed that: “Innovation involves new ideas and processes, change, upheaval and transformation. To be innovators we need to shake off some old ways of thinking about traditional practice models. We also need to shake off the negative attitudes some of our colleagues have about what’s happening in health care. This world is changing. Everyone in this room knows it. And health care is moving ahead – with or without psychology. Whether we move forward will be up to us! We need to think differently about our professional roles and the way we provide services. Too many psychologists are stuck in the traditional 50-minute therapy box. And that box is way too confining. We need to think creatively about where psychology can best influence our evolving health care system… how we practice… where we practice… and what we practice.”

Katherine recently addressed our interdisciplinary health policy class at USUHS and, as she did at SLC, urged our next generation to see and understand the bigger picture – the health care environment in which psychology (and nursing) lives. “We’ve developed a new registry to help fix the problem of low success rates with claims-based reporting, and to protect psychologists’ Medicare payments. Our Practice Organization was the first and only mental health organization to develop a registry. Unlike other registries, our APAPO RQRSPRO focuses on mental and behavioral health measures. We rolled out the registry in December and already have almost 1,200 registrants. We have long-term aspirations. We’re laying the groundwork for a qualified clinical data registry. Such a registry would give psychologists more choices of quality measures that better reflect the work that we do. Psychology should be the discipline that defines and expands the mental health quality measures available for Medicare and other public and private payers as these measures become more widely required.”

I was particularly pleased to see her continuing emphasis upon engaging psychology with Medicaid, which is one of the foundations of President Obama’s Patient Protection and Affordable Care Act (ACA). The Congressional Budget Office (CBO) estimates that the ACA will reduce the number of uninsured Americans by 32 million. Medicaid, which is a state administered program, is the largest single payer for mental health services in the nation, and as Katherine pointed out with Arkansas’s recent success, has the potential for reimbursing the services of psychology’s interns. Getting psychologists to seek recognition under Medicaid has been a struggle given its traditional lower reimbursement rates; however, those with vision could appreciate its long term significance even prior to the enactment of the ACA.

Most fittingly, Katherine also expressed all of psychology’s appreciation for the successful efforts of the Illinois Psychological Association and Beth Rom-Rymer in particular. “I want to share an example of a state that did a great job with collaborating and building partnerships. That state is Illinois, gaining prescriptive authority for qualified psychol-
Integrating Behavioral Health Into Primary Care

The California Technology Assessment Forum (CTAF) recently addressed the comparative clinical effectiveness and value of integrated behavioral health care. “Despite a long history of treating physical health conditions separately from behavioral health, the two are inextricably linked. Up to 70% of physician visits are for issues with a behavioral health component. A similar proportion of adults with behavioral health conditions have one or more physical health issues…. Depression and anxiety in particular are common in primary care settings but are often inadequately identified and treated, leading to a worsening of behavioral conditions and/or increased difficulty managing physical health conditions.”

As Katherine consistently emphasizes, CTAF also noted that no single approach to integration will work for all communities; rather, integration should be designed for a particular set of local or statewide circumstances. “In sum, there is a very large body of literature on the integration of mental health into primary care. Studies of different models of integration across wildly varying delivery systems demonstrate with great consistency that integrated care improves depression and anxiety outcomes, although the absolute benefits are only small to modest. Furthermore, integrated care improves patient quality of life and satisfaction with care.”

A Personal Reflection

A number of years ago, former APA President Stan Graham shared his thoughts about the prospect of having to decide what to do with all of the awards and plaques he had received over the decades. Perhaps send some of them to David Baker at the University of Akron’s Psychology Achieves for posterity? When they visit, our two grandchildren love to play in our closed-off roof dormer room. The competition for that limited space is exactly what Stan described. What to do with the Honorary Degree that former APA President Ron Levant bestowed upon me at Nova Southeastern University, or the impressive APA plaques and those from the State Associations which I visited during the past four decades? How about the autographed photographs with our psychology colleagues who have been elected to the U.S. House of Representatives or the meeting we arranged with then First Lady Hillary Clinton to provide APA with the opportunity to talk about her National Health Insurance proposal? Fond memories. However…. The Inevitable Winds Of Change. Aloha.

Pat DeLeon, former APA President

Forensic Consultation Service

Division 42 will be offering a Forensic Consultation Service. Different people with Forensic expertise will be available by email and/or phone for consultation about such issues as expert testimony, confidentiality of records, discovery requirements, and forensic assessment. The consultation service will begin in June and Dr. David Shapiro psyfor@aol.com will be available for consultation in June and Dr. Bruce Frumkin bfrumkin@aol.com will be available in July. The consultants for each subsequent month will appear on the listserv. The following list includes all current consultants and their month of availability:

1. June: David Shapiro psyfor@aol.com 954 632 2416
2. July: Bruce Frumkin bfrumkin@aol.com 305 666 0068
3. August: Cheryl Karp clk@CLKARP.com 520 323 3156
4. September: Steve Bloomfield sbloom271@aol.com 904 448 1519
5. October: Dawn Hughes hughes@drdawnhughes.com 212 481 7044
6. November: Steve Nelson snelson1550@gmail.com 307 690 9560
Further Limits on Confidentiality

— David Shapiro

I have discussed in a previous column the well-known limit of confidentiality having to do with mandatory child abuse reporting. In this paper, I will discuss some of the less known exceptions to confidentiality which occur in clinical practice.

Consider the following situation: Doctor T is treating a young woman, who came to him complaining that she has been experiencing disturbing symptoms suggestive of Posttraumatic Stress Disorder following what she describes as a sexual assault. The man who allegedly assaulted her has been charged with a criminal offense. His defense is that the sexual act was consensual, and did not involve force. The young woman enters psychotherapy and at some point the therapist receives a subpoena for her treatment records. He is somewhat startled by this, but, feeling that he must comply with a subpoena, he comes to Court the next day with his records in hand. He is then sworn in as an adverse or hostile witness and asked a number of questions concerning his treatment of the young woman. The defense attorney for the man charged with the assault has learned that the woman is in therapy and is attempting to diminish her credibility in the eyes of the jury by demonstrating that she is emotionally unsound. During a break, the defense attorney obtains a copy of the therapist's records and proceeds to cross-examine him in the following manner. The defense attorney asks him whether or not he has reached a diagnosis, and of course he replied that he has. The defense attorney then asks him what the diagnosis is and, considering the fact that this happened several years ago, he has diagnosed her on the multi-axial system of DSM-IV. His diagnosis on Axis I is Posttraumatic Stress Disorder and his diagnosis on Axis II is Borderline Personality Disorder. The defense attorney then questions him regarding what the definition of Borderline Personality Disorder is and eventually asks him whether or not the diagnostic manual speaks of the fact that borderline personalities are more prone to brief reactive psychoses than other kinds of mental disorders. The therapist answers in the affirmative. The defense attorney then probes further into the doctor's records and notices that in the history the woman has described the fact that in a previous relationship with a man, she filed a fraudulent charge of sexual assault against him when he sought to break off their relationship. Arguing this to the jury, the defense attorney obtained an acquittal for the defendant, since the jury could not be convinced beyond a reasonable doubt that a sexual assault had, indeed, occurred and that it may, in fact, be a product of the complainant's mental disorder and possible psychotic reaction.

What has just been described is called The Criminal Defense Exception to Privileged Communication. It does not exist in all states but is found in a substantial number of states. Therapists would be wise to check whether or not their state allows The Criminal Defense Exception to Privileged Communication.

The therapist in this case clearly reacted to his panic when he received a subpoena and never sought out any legal advice regarding how he could handle that subpoena. In fact, a subpoena does not have the power of a Court Order and a therapist can always file a Motion to Quash the subpoena or obtain what is called a Motion for a Protective Order. However, in order to do this, the therapist, either by himself/herself or through the services of an attorney, argues to the Court why the subpoena should not be honored. The therapist could then explain how much damage could be done to the patient and to the course of psychotherapy if those records were revealed in Court. The judge will conduct what is called an “in camera hearing” (that is, in chambers) and will determine whether what is called the probative value of having the records admitted outweighs the prejudicial value. Put in more simple terms, is the admission of the records more helpful for the determination of the case (probative) than harmful to the client and to the course of therapy (prejudicial)? Of course, if the therapist does not file such a Motion, indicating what the prejudicial value might be, the judge has only the arguments of defense counsel as to what the probative value would be and most likely would admit the records into evidence.

Therefore, the simple advice is that whenever a therapist receives a subpoena for material which they feel might be harmful to the patient or to the course of therapy, they should file a Motion to Quash or a Motion for Protective Order and be prepared to go to Court to defend the reasons why they cannot release the records. This would go a long way toward protecting the integrity of clinical records.

Correspondence regarding this article should be addressed to David Shapiro, Ph.D. at psyfor@aol.com
Focus on Clinical Practice
Treating Adult Survivors of Child Sexual Abuse: An Exploration of Definition and the Use of Client Identifiers in Therapy
— Rebecca Romo

The purpose of this article is to provide the treating therapist with considerations when working with adults who have been sexually abused as children. As the clinician in the consultation room with the adult survivor, the treating therapist is often the sole keeper of the individual’s most painful, private, and intimate experiences, and, as such, may carry the greatest potential to aid in the client’s healing. In this role, the treating therapist becomes a powerful presence for the client, a relationship that can define and shape how the client heals from states of harm. This article is presented to provide an opportunity for the treating clinician to develop greater understanding and nuance in their clinical work through an exploration of language. Specifically, the reader is presented with a focus on the working definition of sexual abuse as cited by the APA Board of Professional Affairs and some considerations regarding the implications of language, and, how the client self-identifies as significant variables, adding to the complexity of treating adult survivors.

Variations in the Definition of Child Sexual Abuse (CSA)

How one defines sexual abuse has been a matter of debate and disagreement throughout the years of research and clinical practice. Studies have looked at the variations in definition and have identified key challenges with the development of diagnostic tools and clinical interventions (Duffy, Keenan & Dillenburger, 2006). Peters, Wyatt, and Finkelhor (1986) categorized the broad array of definitions into two categories. There are relationship-specific definitions that base identification of childhood sexual abuse on how the client perceives their early experiences, such as “Were you ever the victim of sexual abuse or unwanted sexual contact as a child?” There are also activity-specific definitions that focus on whether the client experienced certain kinds of sexual activities, regardless of whether the client perceived those activities as abusive, such as “Were you exposed to oral or anal intercourse prior to age X?”

When different definitions for childhood sexual abuse are used in research, outcomes can vary. For example, one study looked at how childhood sexual abuse impacted sexual function and satisfaction in adult women (Rellini & Meston, 2007). The study compared participants with no sexual contact prior to age 16 to participants who had experiences with sexual abuse in childhood. The group of sexually abused participants was further split into two groups including those who self-identified as survivors (CSA) and those who did not identify as sexual abuse survivors (no sexual abuse identified; NSA). Results indicated the abused group scored higher on personal distress levels in comparison to the non-abused control group. However, the effect sizes were larger for the CSA group than for the NSA group. Furthermore, the CSA group endorsed more significantly negative impact on their current sexuality based on their childhood sexual abuse experiences than either the NSA or the control group and indicated higher levels of sexual distress.

As clinicians, it can be useful to understand how research outcomes can vary based on how the definition of childhood sexual abuse is operationalized. This may inform how treatment protocols are designed and/or what interventions may be considered relevant or irrelevant. However, it can also be useful for the clinician to be aware that the language the therapist uses within the consultation room may elicit different responses. As such, it is important for the treating professional to have an awareness of how such language is used and how different clients may relate to the various language presented. Likewise, it can be very useful for the treating clinician to become clear on the definition they hold as to what constitutes childhood sexual abuse.

APA Definition of Child Sexual Abuse

Child sexual abuse has been defined by the APA Board of Professional Affairs (1999) as “…contacts between a child and an adult or other person significantly older, or in a position of power or control over the child, where the child is being used for sexual stimulation of the adult or other person,” (p. 591). This activity-focused definition offers several insights into critical components of child sexual abuse including power hierarchy, directional use, and intent.

1. Power Hierarchy: The definition begins by identifying the “who” in the abuse dyad. The abuser is defined as an influential other - either one who is significantly older and/or one who has a position of power or control greater than the child’s. Childhood sexual abuse is not simply about physical contact - even sexual contact - between equals.
2. Directional Use: The definition clearly states that the child is being used - in other words, the child is being placed in service of another. Although it is not stated in this definition, the methods of placing a child in use may be subtle or overt including manipulation, force, coercion, or neglect if not accommodated.

Between the Lines: When reading the definition, it is also important to note that there is no mention of, or value placed on, the emotional, physical, or behavioral response of the child. The significance of the omission of these potential criteria cannot be understated, but the key point is that the child was used for something and was of diminished and unequal standing. This directional use criteria, when paired with the acknowledgment of a power hierarchy of some form, thus renders the child not as less culpable to what occurred - but entirely NOT culpable for the sexual abuse.

3. Intent: The definition highlights the key differentiation from other forms of child abuse in that the action of abuse was intended to provide sexual stimulation to the abuser. The definition does not specify or prioritize particular actions as meeting the standards for defining an act as sexual abuse. Instead, the point of view held within this definition is that any act whose intent is to stimulate a sexual response within the adult is not appropriate for adults/influential others to engage in with children. Again, while the definition does not elaborate on specific actions, one could surmise that this would include all acts that could stimulate sexual arousal including involving the use of children for child pornography, an audience to sexual acts, fondling, masturbating, sensual touching, anal or vaginal penetration, including intercourse.

Between the Lines: It may be read as equally important that the APA task force definition also did not include any discussion or component regarding the response of the child to the abusive act. While these acts certainly may have been innately horrifying or terrifying to the child, they may not have been consciously felt that way. Likewise, these actions may or may not have been stimulating in the child. It is not uncommon for children in sexual abuse cases to have split and/or conflicting experiences with the sexual abuse and the abuser, particularly if the abuser was someone close to the child. The child may have felt cared for or loved, and they may have also been given a type of special status with the abuser that may have felt good. Furthermore, the actions may have induced a pleasurable physical sensation in the child, or even a sexual stimulation in the child. This is of no matter in terms of the definition of child sexual abuse. At every point, the child’s specific response to the abuse does not do anything to change the classification as child sexual abuse. If the other was sexually stimulated or was seeking sexual stimulation, the act is then defined as child sexual abuse. Period.

The use of CSA Definition with Adult Survivors

Having clarity of these components can sometimes help the clinician to navigate the often murky waters of treating an adult survivor of childhood sexual abuse. Adult survivors may struggle with understanding what role they played in the sexual abuse of their childhood. They may take undue responsibility or believe they had control over the events. Or, they may feel just as out of control of their adult lives as they were in the abuse experiences as a child. Additionally, others around the adult or around the now-adult-as-a-child may have told them that they were, in fact, responsible for the sexual abuse. Or the abuser may have even insinuated that the child had some sort of “control” over them, “making” the abuser act that way. Even if there were no such responses, or if the responses were different than those listed here, the adult survivor has most often created some narrative or way of understanding what happened to them in childhood, and their way of understanding the past may enhance or impede their current functioning.

Having clarity that if sexual stimulation of the other was involved or intended always defines the action as child sexual abuse can sometimes free the therapist to draw necessary boundaries for the client that may never before have been drawn in terms of adult responsibility for actions. This clarity may not be beneficial to the client if the therapist uses it to force a therapist-preferred narrative or to insist that the client must then take on the label of victim, survivor, or otherwise. Rather, it can be helpful to reinforce the boundary that adults are responsible for taking good care of children and having the child’s best interests at heart and in mind - not the other way around. In fact, the therapist may even find it useful to highlight for the adult client how a child’s ego-centrism is developmentally necessary - possibly drawing on their own experiences of parenthood or their relationship with other children.

The therapist may find utility in demonstrating how, when a child is put in harms way by an adult, the child may even psychologically need to make sense of this as their fault. It might have served the child-self very well to have believed that “If only I hadn’t……” the abuse may not have happened. This keeps the need for the world to be safer than it is cognitively protected as a coping strategy so that the child will find ways to grow within it. However, this psychological service at the time of the abuse also leaves the child with a sense of responsibility and control far bigger than what they actually possessed.

As an adult, this narrative can sometimes be more health-
ily questioned as one has more perspective through contact with children or even through their own awareness of differences transitioning from child to adult. At times, the adult client may come to realize on their own that, no matter how they may have handled the sexual abuse experience, they never should have had to handle it. For others, the clinician may help the client in pointing this out. For some adult clients, it can be highly useful to present this definition in a direct and unwavering form. To leave it for the client to determine for themselves may result in a type of re-enactment of childhood where they are left to define right and wrong by themselves, unarmed by real guidance from a thoughtful and invested grown-up over what is theirs to control or not.

Of course, there is the other end of the continuum as well. For some clients, a forcing of this notion too early could rob them of some component of their self-dignity and worth that may be holding them together in some vital way - which could force them into seeing themselves as a victim that may not be useful at this stage of treatment, if ever. For some clients, these criteria may be best addressed later when other forms of coping have developed.

In either case, it is still useful for the therapist to maintain their own internal clarity about the definition of sexual abuse. The therapist must not become too complacent about, or even accepting of, the sexual abuse experience which could result in an unintended endorsement of the sexual abuse.

Additionally, adults often struggle acknowledging their vulnerability. That can turn the reality of childhood vulnerability into a sense of weakness, their flaw or mistake, because they did not prevent it or stop it - or, as mentioned above, they may even convince themselves that they were in control and that they made it happen because they wanted it. Even if the adult client is able to connect to the rights of their own children for children love, safety, and to know they are special, it is a very long journey to accept that they, as a child, fully deserved that too.

Some Considerations on the Use of Victim/Survivor Language

Client as Victim

For the victim of childhood sexual abuse, many of the challenges for healing from the abuse can come from language and how it was, and is, used to address their experience. I choose the word “victim” here carefully, although it is not one you will find me using very often, so that I may highlight a point I find useful for us as treating clinicians. While the more accepted term is “survivor” - it is a word highlighting the movement of time past the victimization experience or at least a hint at the possibility of working though trauma's impact. For some, the word survivor is too far of a leap away from the space where the client may actually be in the beginning, and one may benefit from being sensitive about using what may be felt to be overly-optimistic language.

The premature use of survivor language with one who has been victimized may, inadvertently, result in the client feeling alienated, that they are not doing this right, and the deficit lies in them.

The term victim, in its most basic form, means “one who is harmed by another”, and is derived from the Latin word victima which means “sacrificial animal.” This language is significant. As with the definition of child sexual abuse, there is a direction to the harm - it is not shared. One person gives and the other receives. One person possesses the capacity to exert influence over another - either through sheer size, might, age, manipulation, or power - and, in the case of childhood abuse - the client’s self needs and abilities are negated.

One way to think of this may be that the perpetrator of the abuse relegates the client’s self to non-existence, where it becomes, momentarily or habitually, “killed off” (or “sacrificed” in honor of the Latin origin) while the needs of this other dominant force prevails. The fact the client survived at all, to later be called “survivor,” in the consultation office as an adult, is a testament to human resiliency and to their skill and survivorship, for certain. But some arrive at our office door still unable to find or feel that state as a reality.

For the victim-identifying client, it is important that we, as the clinicians in the room, are able to honor and validate their experience. We must remain aware of this potential within our clients so that we do not engage in what others in their lives may have communicated to them - which is to assume that the abuse was in the past and is now done, and that they should no longer be impacted by it. By prematurely using the language of “survivor,” we may be placing an expectation on the client that they too should use this language - which then forces them to, in essence, pretend to be where we want them to be.

Client as Accomplice

Some adult sexual abuse survivors believe they were an accomplice to the sexual abuse. The sexual abuse definition may be most critical in helping those who are uncertain about their role or question if what they experienced was abuse at all - especially if it felt good at times, or if they continued to return, or even in some cases where they may have offered to participate. It can often take time for the adult client to recognize their own childhood needs and to see the powerful but often undetectable forces of influence upon the child. This is one time when the clinician must value the experiential struggle of their client and take care of their client with sensitivity and respect for their process,
while also remaining clear about this: No child, under any circumstance, should be used for sexual pleasure in another of greater power or influence.

**Client as Survivor**

Of course, the reverse may also be true in that the client may want and gain real value from the use of the language of survivorship. The use of survivor language by a client may reflect an authentic integration of their past experiences, with an honoring of the pain they went through, and a fuller view of the contexts surrounding their childhood experiences so that the sexual abuse experiences no longer define them. However, for some, the language is more of an “acting as if” step, hoping that, in using the survivor language, one may begin to feel like a survivor. There is also cultural/generational/societal influences to consider in the use of language. If you look at any self-help materials or listen to messages about child sexual abuse in the media, you will hear the preference for the language of survivorship. And given that we often learn to speak in the language of the culture which is often defined by those in power (Tolman, 1994), clients may have learned to use this language through environmental influence or simply as the only language made available to them.

To differentiate among these experiences, the clinician may draw upon not only the knowledge of what has happened or has been reported, but also the therapist’s “sense” of the client. If conflictual messages are present, nonjudgmental exploration can be useful in having the client better identify where they truly are, as opposed to where they might wish to be.

**Summary**

The language of definition and client-identification is a powerful, and yet often unaddressed, variable in the consultation room. With the examination of the APA Board of Professional Affair’s definition of child sexual abuse and the use of client identifiers to name the client’s experience, it is hoped that the clinician may find the language that best matches the client’s experience as opposed to matching the language of the clinician’s professional training and/or of the current cultural trend. For the individual adult survivor, the treating clinician may be the first person who can help them to truly develop their own authentic connection to, and narrative about, their own experience, free of the influence from the abuser, and in their own words.

**References**


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**The Birds and the Bees Revisited: Addressing Sexual Health with Child and Adolescent Populations**

— Maria Papachrysanthou Hanzlik

Discussing sexuality frequently is seen as a strictly adult topic. We protect children from “adult conversation” and “adult content” to maintain their innocence; however, sexuality is exhibited throughout the lifespan (Office of the Surgeon General, 2001). Children and adolescents, as well their parents, can exhibit a number of sexual concerns in clinical settings including curiosity about sexual anatomy, asking questions about the process of sex, emotional adjustment to maturing bodies, development of sexual identity, “sexting,” and pornography use, to name a few. Despite what the initial presenting problem may be, psychologists can expect sexuality-related concerns to arise in their child and adolescent clients. As a result, it is important for clinicians to be prepared to appropriately address sexual concerns as they arise clinically.

**Barriers to Addressing Sexual Topics with Youth**

If sexuality is a normative aspect of child and adolescent development, what keeps caregivers and clinicians from
addressing sexual topics with their younger patients? A number of obstacles interfere with appropriate communication with children around sex for parents and clinicians alike.

**Caregiver Issues**

One common issue that arises for parents when considering communication with their children about sex is misunderstanding what is considered “appropriate.” In reality, no age is too early to begin teaching children about sex. In fact, the Sexuality Information and Education Council of the United States, or SIECUS, created an early childhood sexual education task force which publishes guidelines for addressing sexuality issues in a developmentally appropriate manner from birth to five years of age (Right From the Start, 1998). Moreover, a partnership between Advocates for Youth, Answer, and SIECUS resulted in The Future of Sex Education (FoSE) Initiative, which published National Sexual Education Standards: comprehensive sex education guidelines and curriculum for children grades K through 12 (Future of Sex Education Initiative, 2012). Each developmental level contains eight standards: core concepts, analyzing influences, accessing information, interpersonal communication, decision-making, goal-setting, self-management, and advocacy. Additionally, for each developmental level, seven topics are potentially addressed as “essential content and skills” including anatomy and physiology, puberty and adolescent development, identity, pregnancy and reproduction, sexuality transmitted diseases and HIV, healthy relationships, and personal safety. These essential content and skills areas can vary widely across age groups. For example, the “identity” curriculum for children in grades kindergarten through second explores similarities and differences between how boys and girls are expected to act; whereas students in grades ninth through twelfth learn to differentiate between biological sex, sexual orientation, and gender identity expression.

Similarly, some adults may fear that discussion of sexual topics will lead to promiscuous, and increased frequency of, sexual behavior in teens. However, when examining the literature evaluating comprehensive sex education (CSE), data suggest teen involvement in programs that explore contraception as well as abstinence does not increase the onset of first intercourse, the frequency of sexual intercourse, or number of sexual partners (Kirby, 1997). In fact, according to Kirby (2001), CSE has been associated with a delay in first intercourse for teens. In addition, specific parent-adolescent discussions about condom use results in decreased risky sexual teen behavior when adolescents decide to have intercourse (Miller, Levin, Whitaker, & Xu, 1998; Hadley et al., 2009; Nappi et al., 2009).

Although recommending that parents have discussions with their children about sex is an appropriate first step, the data show that encouragement alone is insufficient to prompt parent-child sexual discussions to occur. In fact, results of a study conducted by Miller, Fasula, et al. (2009) indicate that, along with being encouraged, African-American mothers required knowledge, comfort, skills, and confidence to translate recommendations about discussing sex with their preteens into behavioral action.

Given that research suggests the importance of sexual communication between parents and children, psychologists can play a vital role in providing psychoeducation, encouragement, and modeling about how to talk to their children about sex. If children and adolescents are not obtaining accurate information from their parents in a way that is free of shame and embarrassment, then who or what will they turn to in order to get those needs met? Overall, psychologists possess the appropriate blend of knowledge, skills, and attitudes to facilitate meaningful parent-child conversations about sex. They are well-versed in child and adolescent development, family systems theory, and effective communication patterns, for instance; however, psychologists, too, often shy away from discussion around sexual issues.

**Psychologist Issues**

Parents are not the only adult figures who can experience discomfort addressing sexual topics with children and adolescents. Mental health professionals (Harris & Hays, 2008), including psychologists (Wiederman & Sansone, 1999; Hanzlik & Gaubatz, 2012), tend to shy away from addressing sexual issues with their patients. Despite the ubiquity of sexual concerns among individuals seeking mental health services (Wincze & Carey, 2001; Laumann, Paik, & Rosen, 1999), research indicates psychologists are not addressing sexual concerns with their patients. According to a 2012 study by Miller and Byers surveying 110 psychologists in the U.S. and Canada, approximately one third of participants indicated they did not ask any of their assessment/intake clients any questions related to sexuality. In addition, the data suggested participants asked only 22% of their therapy clients about sexual issues. The authors suggest psychologists tend to omit sexual discussion with clients from their clinical work based on low self-efficacy, or lack of confidence, about adequately addressing sexual issues. The literature suggests specific sexuality education and training, rather than general academic or clinical experience alone (Byers, 2011; Hanzlik & Gaubatz, 2010), is what increases comfort communicating and intervening with patients about sexual issues. Unfortunately, North American graduate-level psychology programs as a whole are not adequately preparing trainees to address sexual issues with their patients (Byers, 2011; Hanzlik & Gaubatz, 2010). To close the training gap, it is important that psychologists obtain additional, specific training in sexual topics in order to better meet the needs of their patients.
Practical applications: How to Address Sexual Issues with Children and Adolescents

Boundaries and good/touch bad touch are topics more commonly communicated to children from parents, teachers, medical professionals, and mental health clinicians; however, other aspects that promote sexual health are less clearly discussed. Although parents and professionals alike may understand the importance of discussing sexual topics with children, there may be a skills deficit in how to best approach and explain specific sexual topics. Despite the multitude of sexual topics that arise throughout each developmental level, psychologists can address sexual issues with children and adolescents in a number of ways. Below are general guidelines psychologists can use with caregivers to foster better communication with their children about sex.

- **Balance communicating facts about sexuality with cultural and personal values.** It is possible to discuss with children facts about anatomical terms for genitals, reproduction, relationships, purpose of intercourse, and privacy while also having parents convey how they think and feel about those issues. Separating facts from values provides children with the opportunity to understand their parents’ beliefs as well as provide room for developing their own values without omitting important information. Moreover, understanding the “why” behind parents’ beliefs may prompt a child to be more thoughtful about their own behaviors rather than attempt to rebel if a parent “lays down the law.”

- **Do not wait for children to bring up sexual topics.** Parents commonly address issues related to cultural traditions, spiritual beliefs, and etiquette long before a child asks about them. In turn, it can be important for caregivers to address sexual issues first to implicitly communicate they are good sources of information regarding sexual topics as well as to normalize these subjects.

- **Normalize discomfort.** In mainstream U.S. culture, open discussion of sexuality is not the norm. As a result, it is understandable that parents can possess a subjective sense of discomfort addressing sexuality with their children, particularly if sex was not openly discussed in their own families of origin. Informing caregivers that experiencing discomfort is understandable can help reduce pressure and subsequent avoidance of sexual issues.

- **Make room for parents to tell their own stories about how sexuality was addressed in their childhood.** Some caregivers have reservations about addressing sexual topics based on how these conversations were handled when they were children. Consider asking parents about their experience of learning about sex as children. Did they have negative associations or feel “dirty,” anxious, or embarrassed about their own sexual interests? How did their parents react to any sexual curiosity they may have had? What did they wish their parents would have said to them? Asking parents such questions can also facilitate formulation of their own values and solidify what they would like to convey to their children.

- **Sex education is a process, not just “the talk.”** Just as parents have ongoing conversations with their children about important family and cultural values, sexual topics are important to address throughout childhood and adolescence. As children grow, different developmental issues become salient. Moreover, knowing that discussing sexuality will not be reserved for a single, looming conversation can minimize undue pressure for parents to answer all questions at once.

Parents want their children to feel confident, develop a strong self-concept, and possess good decision-making skills. If we are ignoring and not addressing the sexual aspects of their self-hood, how will children and adolescents develop into cohesive adults with satisfying and fulfilling sexual relationships free of dysfunction? As Dr. Joycelyn Elders (2010), former U.S. surgeon general commented, “We cannot withhold information from children, adolescents, or adults, live in silence about this taboo subject and expect everything to turn out all right. We have tried ignorance and it does not work” (p. 249). Psychologists are well-suited to break through such silence to facilitate dialogues with youth and their families about sexual health, and by extension, work toward improving overall mental health.

**References**


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Jamie sits quietly on her own, while the other students laugh and talk around her. When Jamie is asked a question, peers say dismissively “she doesn’t talk.” The teacher, sensing her discomfort, skips her during circle time.

Ashley’s anxiety fills her with dread when she enters the music room. Unable to utter a sound, she withdraws and stares. Her teacher, convinced that Ashley is not trying, gives her a zero. She fails the course.

What is Selective Mutism?

Selective Mutism (SM) is an anxiety disorder characterized by a lack of verbal (and sometimes nonverbal) communication in specific settings. Although these children can often speak well in certain environments (e.g., at home with family or good friends), they are mute or extremely hesitant to communicate in other social settings (e.g., school, restaurants, stores). It is important to note that these children are able to use and understand speech, but demonstrate a persistent inability to communicate in specific settings, and this inability becomes a pattern of behavior. In order to diagnose SM, the mutism must be ongoing for at least one month; however, it is important to note that a lack of verbal communication in the first few months of the first year of school (whether that is preschool or Kindergarten) is considered within normal limits. To be diagnosed, the student must present impairment in daily functioning (typically at school or in public settings) for more than a month, and other explanations for the lack of verbal communication (such as a speech impairment, autism, and stuttering) must be ruled out. Children can have co-occurring diagnoses (such as Autism, speech impairments, etc.) but these other diagnoses cannot better explain the lack of speech in the school and/or public environments. Although each child is different, there are common traits of children with SM:

- difficulty responding and initiating verbally

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• difficulty communicating nonverbally
• generally average to above-average intelligence
• perceptive and sensitive
• freezing and/or awkward body movements when anxious, such as stiffness, tense shoulders, strained facial expressions, etc.
• poor eye contact
• slowness to respond (a long latency between the question and the child’s response)

Research suggests that SM impacts approximately 1 in every 100 children in elementary school (Bergman RL, 2002). Although 1% of the elementary school population may sound quite rare, it is similar to the current prevalence rates of Autism, a diagnosis that is widely known and recognized (Blumberg, 2013). Some researchers believe that prevalence rates may actually be higher – a lack of knowledge about the diagnosis or a lack of concern about the symptoms may be masking a much higher incidence. Since children with SM generally are not a behavioral problem (instead, they tend to be quite compliant, studious, and intelligent), the lack of verbal communication may not be enough for parents and school personnel to seek out treatment. SM has been found in numerous studies to be more common in females than males - girls are almost twice as likely to be diagnosed with the condition (Kumpulainen, 2002, Garcia, 2004).

Where Does SM Originate?

Originally, SM was thought to be caused by a traumatic incident in early childhood, such as neglect, abuse, or the observation of violence. The hypothesis followed that these children who experienced such trauma had chosen to become mute to keep a family secret or punish the offender. Treatment focused on uncovering the traumatic episode and addressing the underlying feelings or improving family relationships. However, no research has found a causal link between the development of SM and traumatic past experiences (Bergman RL, 2002).

As with most anxiety disorders, there appears to be a genetic component in the development of SM. The genetic predisposition for anxiety that runs in families can manifest differently for different family members, but the core genetic component appears to be the same. Thus, family members may have other types of anxiety (e.g., Social Phobia, Generalized Anxiety Disorder, and Obsessive Compulsive Disorder) but the genetic makeup of the child results in the anxiety manifesting as SM. It is not uncommon for children with SM to have parents with characteristics of SM or Social Phobia, and their siblings are more likely to exhibit symptoms of SM (particularly identical twins).

In addition to a genetic predisposition to anxiety, research demonstrates some abnormalities in brain reactivity in children with SM. Most research into the brain mechanisms of anxiety find that the amygdala plays a large role in modulating our reaction to and perception of anxiety (Davis, 1992). When our brain perceives a situation, person, or event to be dangerous, our amygdala reacts with the fight or flight response, sending out signals from our cortex to physically and mentally prepare our body. However, if the perceived situation is not truly dangerous, our cortex has a very difficult time turning off the signal from the amygdala. This is the way in which reactions to irrational or minor dangers develop into physiological anxiety responses. Likewise, research has shown over-reactivity in the amygdala of children with SM, meaning that they may perceive situations that have a verbal component as being extremely threatening. Furthermore, they have a much more difficult time returning to baseline functioning in comparison to non-anxious peers, and thus their brain functioning appears hyper-vigilant and over-reactive across time. This lack of habituation, or return to baseline, may be why these children’s fear is persistent and difficult to reduce.

As noted before, often parents of children with SM also have social anxieties, and this can affect the parent’s ability to cope with their own anxiety around their children. Thus, children may not only be genetically predisposed to anxiety, but may also be learning anxious behaviors via parental modeling. Parents may avoid social situations secondary to their own anxiety, reducing the child’s exposure to novel situations and people and limiting the number of opportunities the child has for practicing brave talking.” Additionally, parents may inadvertently portray the world as untrustworthy, thereby increasing the child’s anxiety.

For children with SM, the avoidance of speaking in select situations and environments acts as deliberate self-protection from the intense anxiety experienced by the child, not deliberate oppositionality (Bergman RL, 2002). Too commonly, adults in the lives of children with SM begin to believe that the child is just being “difficult” or “rude.” The natural reaction to this interpretation is increasing the communication expectations for the child and then punishing, shaming, or disciplining them for not speaking. Unfortunately, these consequences may both increase the anxiety around speaking and lead to lowered self-esteem and self-efficacy.

Conceptualizing Selective Mutism

SM is generally conceptualized as a fear-based pattern of avoidance. This avoidance cycle begins with a child who likely has a genetic loading for anxiety and perhaps with biological tendencies to become overly aroused and anxious in situations where communication is expected. The child is then exposed to expectations for communication (e.g., a question from a teacher). The child attempts to avoid the communication or interaction. When the child avoids the
interaction, it is socially uncomfortable for others to wait for a response and someone may jump in to “rescue” or speak for the child. This could be a teacher, parent, peer, or sibling. Thus, the expectation for communication is suddenly removed, and the child (and the others involved in the interaction) feels much better; anxiety and discomfort are removed. This reduction of anxiety accidentally reinforces the behavior, and the next time the child is in a similar situation, they are more likely to avoid verbal communication.

Assessing for Selective Mutism

It may appear that a diagnosis of SM is easy to make – if a child talks at home and does not talk at school or in public, they probably have SM. However, the process of substantiating a diagnosis, sifting through related issues, and determining the best course of action can be much more complex. Like any psychological diagnosis, consideration of SM involves researching the child and the family. However, unlike other diagnoses that may not take into consideration environmental factors, the diagnosis of SM necessitates a thorough investigation of the child’s school and public life. Assessing for SM (and ruling out other disorders) is a four-step process:

1. Diagnostic Interview with parents/teacher/caregivers
2. Questionnaires (SM Questionnaire, Bergman, 2008).
3. Structured observation or functional analysis
4. Rule out related or co-occurring disorders or weaknesses

Re-writing the Avoidance Script

Following the evaluation and diagnosis of SM, we begin the fun (but admittedly challenging) step – intervention. The main steps in intervention include:

1. Determining the treatment “team”
2. Building rapport between the child and interventionists
3. Educating the child about their anxiety
4. Developing the behavioral treatment plan, such as shaping or stimulus fading

A core treatment team (those responsible for carrying out the actual intervention) includes the parents, the keyworker within the school setting, and the mental health professional outside of the school setting. All members have different responsibilities:

A keyworker is the individual inside the school setting who is responsible for:

1. Managing and implementing the behavioral intervention inside the school setting
2. Generalizing speech to all school environments and with as many people as possible
3. Communicating with the teacher, parents, and treating psychologist

Most frequently, a keyworker is a person with either a mental health or speech/language background and training, such as a School Psychologist, Behavioral Analyst, Social Worker, Counselor, or Speech/Language Pathologist. However, determining a keyworker who can regularly meet with the child is difficult – professionals are overworked, caseloads are at capacity, and schools may have a limited number of special education personnel. Therefore, the functional or realistic criteria for a keyworker is someone who can consistently work with the child, is caring and interested in the intervention, is willing to be flexible and learn more about SM, and is a good personality match for the child.

Another important characteristic of a keyworker is availability for consistent intervention. Today’s schools encourage group pull-outs for special education services. This likely will not work for the child with SM – at least not at first. Although there are some notable exceptions (such as children who speak more easily when they are in the room with a friend or sibling), in order for most children to be successful, they need to first meet with the keyworker in a one-on-one interaction on a frequent basis. In order to make consistent and significant progress, meeting individually with the child for fifteen minutes three times per week is minimally necessary. There is a good reason for this – these children are practicing using avoidance strategies every single day, many times per day. In order to change their behavioral repertoire, we need to practice brave behaviors many times per day. The more frequent the practices, the better. If practices occur less than three times per week, it is very difficult to make progress. Meeting once per week or once every other week, as is the norm for most special education services in the school, is simply not frequent enough to encourage change.

The mental health professional outside of the school is responsible for:

1. Developing and maintaining the treatment plan through consultation with the school.
2. Training parents on strategies to increase communication with extended family/friends and in public settings.
3. Carrying out “brave practices” in the public setting, such as ordering at restaurants, calling people on the phone, asking where to find items in the store, and approaching peers on the playground.

Parental responsibilities include:

1. Advocating for the child in the school setting.
2. Maintaining documentation of everything (school meetings, recommendations by the psychologist, teacher notes, progress notes, etc.).
3. Communicating with the teacher, keyworker, and
1. Mother and child should have some time to “warm up” stimulus fading could include:
- the child has speech outside of the home setting.
- steps in and should be attempted as a first treatment technique if easier, more naturalistic, and more efficient than shaping.
- move to a new environment. Stimulus fading is generally of the school, and add in a new communication partner or exists, such as speaking to a parent in a closed-office setting.

Stimulus Fading allows us to take the speech that already exists, such as speaking to a parent in a closed-office setting of the school, and add in a new communication partner or move to a new environment. Stimulus fading is generally easier, more naturalistic, and more efficient than shaping, and should be attempted as a first treatment technique if the child has speech outside of the home setting. Steps in stimulus fading could include:

1. Mother and child should have some time to “warm up” in the room, playing and talking alone with the door closed or almost closed.
2. Novel person begins slowly entering into the room when the mother has obtained an appropriate volume of consistent speech from the child. The novel person should NOT respond in any way to what the child says or act as if they are attending to the child (no eye contact, no attention, no responses to the child’s activity or speech).

3. The novel person should very slowly enter the room, as far away from the child as possible, and busy themselves (i.e., type on the computer, pick up the room, or do paperwork). If the child begins to discontinue speaking or shows other general signs of anxiety, slow the entrance or stay in the same position for several minutes until the anxiety is reduced and speech resumes.

4. The novel person should slowly start making their way toward the child/mother by finding things to do in closer proximity to their interaction, but should continue to pay no attention to the child.

5. When the novel person is close to the interaction and the child has maintained speech, he/she can begin to silently attend to the interaction (just watching without commenting).

6. If the child tolerates attention to their speech, the novel person can begin to comment, reflect, or respond to what the child is saying.

7. When this seems comfortable and minimally anxiety-provoking, the novel person can begin asking occasional forced-choice questions (avoid open-ended or yes/no questions, which are less likely to elicit speech).

8. When the child is consistently responding to the novel person, the parent can begin fading out of the room.

**Stimulus Fading**

Stimulus fading allows us to take the speech that already exists, such as speaking to a parent in a closed-office setting of the school, and add in a new communication partner or move to a new environment. Stimulus fading is generally easier, more naturalistic, and more efficient than shaping, and should be attempted as a first treatment technique if the child has speech outside of the home setting. Steps in stimulus fading could include:

1. Mother and child should have some time to “warm up” in the room, playing and talking alone with the door closed or almost closed.
2. Novel person begins slowly entering into the room when the mother has obtained an appropriate volume of consistent speech from the child. The novel person should NOT respond in any way to what the child says or act as if they are attending to the child (no eye contact, no attention, no responses to the child’s activity or speech).

**Shaping**

For those children who are not yet speaking to anyone in any environment outside of the home, whose speech is very inconsistent or extremely quiet, or who have been involved in unsuccessful stimulus fading procedures, shaping speech is the best option. Shaping (otherwise known as the building of a communication ladder) involves breaking speech down into small, manageable steps, and reinforcing the slow, steady steps toward speech. A communication ladder (shaping procedure) can involve many small steps. Intervention should start where the child currently is functioning and progress up the ladder slowly but consistently. The communication ladder is based on three principals:

**Principal One:** Speaking in gradual steps helps the fear go away.

a. This is called exposure, but it’s really just structured practice. I can be though of like learning to ride a bike – at first, you start easy, with training wheels; then, parents hold on to the bike while you ride...
slowly with two wheels; eventually, you are riding alone slowly and then more quickly. At each step you gain confidence and that thing that was scary isn’t so scary anymore.

b. The first step is identifying what is feared (where it is scary to speak, who is it scary to speak to, etc.).

c. Then a ladder is created starting with least difficult scenarios (e.g., mimicking speech or nonverbal communication), going up eventually to really difficult scenarios (e.g., initiating speech with a stranger).

d. The ladder begins in the clinic or office, and when the child is successful, that step of the ladder is generalized to other environments (e.g., in public and at school).

e. At each step, the child gains confidence and a “scary” situation is faced, thereby making it not so difficult anymore!

Principal Two: Success is rewarded.

a. We all like rewards when we work hard, so communication ladders also have rewards!

b. When successful on the current step of the ladder, children are either immediately given a small reward (e.g., very small toy/candy) or are given a token (e.g., sticker, poker chip) that they can cash in later for a slightly bigger reward.

c. Furthermore, parents, keyworkers, and others in the child’s life give them verbal reinforcement for their “bravery.”

d. Finally, it is intrinsically rewarding to be successful, and this increases motivation to continue making progress on the communication ladder.

Principal Three: Keeping up the momentum is important!

a. We can keep up the momentum by communicating about what the child has been successful on, and what “step” of the ladder he/she is currently working on (that way, we don’t have stagnation in one environment – if the child is communicating with single words in the clinic, they should be working on that step in public and in school).

b. We can also keep up the momentum by being consistent and rewarding improvements in attempted speech.

The treatment of children with SM can be fun, rewarding, and effective! More information, including how to assess for SM, treatment plans, collaborating with schools, and special education planning can be found in a book by the current author (Kotrba, 2014).

References


Aimee Kotrba is a licensed clinical psychologist specializing in the expert assessment and treatment of Selective Mutism and Social Anxiety. Dr. Kotrba serves on the Selective Mutism Group (SMG) Board of Directors and as the psychological expert for a local Selective Mutism parent support group. She is an internationally recognized speaker and regularly offers local and national workshops on the identification and treatment of Selective Mutism for parents, professionals, and school personnel. Currently, Dr. Kotrba is the owner and director of Thriving Minds Behavioral Health, a clinic specializing in assessment, treatment, and consultation for children with Selective Mutism. Correspondence regarding this article should be addressed to Dr. Kotrba: akotrba@gmail.com
Attractiveness Discrimination in the Workplace

Practitioners of I/O Psychology are often charged with developing selection programs. Because hiring and retaining the right employees is fundamental to organizational success, discrimination and other forms of bias in the selection process can prove detrimental. Lee, Pitesa, Pillutla, and Thau (2015) conducted four studies to investigate how and why decision makers engage in attractiveness discrimination in selection decisions. Previous research has long suggested that attractive people universally experience more positive outcomes than their less attractive counterparts in a number of life domains, including the workplace. Using status generalization theory and interdependence theory as theoretical frameworks, Lee et al. (2015) proposed that different patterns of attractiveness discrimination exist based on gender and task-related interdependence. Four hypotheses were tested across four studies, using different samples, selection tasks, manipulations of applicant attractiveness, and manipulations of interdependence. The first two studies focused on same sex decision maker dyads. Studies 3 and 4 extended the original study designs by also including mixed-sex dyads. Hypothesis 1 predicted that decision makers would perceive attractive male, but not female applicants, as more competent. Hypothesis 2 predicted that when decision makers expect to have to cooperate with the applicant, an attractive applicant is preferred to an unattractive applicant when the applicant is male, but not female. Hypothesis 3 predicted that when decision makers expect to have to compete with the applicant, an unattractive applicant is preferred to an attractive applicant when the applicant is male, but not female. Hypothesis 4 predicted that higher perceived competence of attractive male candidates leads to higher relative perceived instrumentality of the attractive candidate to the decision maker when cooperation is expected, which in turn results in a higher selection preference for the attractive candidate. The reverse was hypothesized to be true when competition was expected. The data were analyzed using a combination of mixed effects ANOVA and OLS regression models. Results supported the four hypotheses across each study, challenging the idea that attractiveness is universally advantageous in the workplace. Depending on the specifics of the decision maker - candidate dyad, discrimination both in favor of and against attractive male candidates can be more likely. I/O practitioners, as well as other professionals involved in making selection decisions, might be interested in a full reprint of the article for a more detailed discussion of the studies and their associated practical implications.


Peer Victimization of Immigrant Youth

Because youth from immigrant families represent one of the fastest growing populations in the United States, supporting these children and adolescents as they navigate the acculturation process has become an increasingly popular challenge for practitioners who work in educational settings. Research suggests that the acculturation process is associated with a number of negative outcomes including discrimination, prejudice, racism, limited upward social mobility, language barriers, and school and community violence. Peer victimization, the most common form of school related violence, affects many children but when combined with the aforementioned risk factors, children from immigrant families may be disproportionately affected. Using social identity theory as a theoretical framework, Sulkowski, Bauman, Wright, Nixon, and Davis (2014) investigated differences in how youth were victimized, youth responses to victimization, and how peer bystanders responded to youth victimization. More specifically, they hypothesized that youth from immigrant families would be more likely to report being victimized because of their race, physical appearance, religion, and family income than non-immigrant youth. Due to a lack of prior research on youth responses to victimization, no hypotheses were formed a priori about bystanders responses to peer aggression. As part of the Youth Voice Project, data were collected from 2,929 youth who reported that they had been victimized two times per month. Of that sample, 280 reported being from families who had immigrated to the United States within the past two years. Due to non-normal dependent variable distributions, nonparametric tests were used to test between group differences. Results showed that youth from immigrant families were not only more likely to be physically hit, they were also more likely to report being victimized because of their race, religion, and family income. With regard to responses to victimization, youth from immigrant families were more likely to tell the aggressor how they felt, report the incident to a school official, make plans to retaliate, and
hit the aggressor than their non-immigrant counterparts. Non-immigrant youth were, conversely, more likely to pretend that they were not affected by the victimization. In terms of bystander responses to peer victimization, youth from immigrant families were more likely to report that bystander interventions were more likely to result in ‘making things worse’ for them. Collectively, these results suggest that for youth from immigrant families, an increased susceptibility to peer victimization makes and already challenging acculturation process that much more challenging. School psychologists and other practitioners who work with youth from immigrant families might be interested in a full reprint of the article for a more detailed discussion of the findings and their associated implications for intervention.


### Dialogical Space in Family Therapy

In working with families in therapy there is a striving for each member of the family to express their authentic selves. Erington explored the dialogical approach in family therapy with adolescents, the real and authentic experiences of the individuals in the therapy session, especially as it relates to a deeper understanding of the participants in the therapy session. The author stressed that it is the space in the therapy session, the weight and importance of not just what is said but how things are said, that is key in the dialogical approach. The back and forth between parties in the therapy session and understanding of both verbal and non-verbal communications lead to the understood meaning of the communications. Erington called attention to how the family members styles of interaction influence how an adolescent member communicates his/her story. The author discussed the role of therapy in helping an adolescent fully explain his/her story and not tailor it to be in line with the communication style of the family members. Authenticity of the story as well as of the therapist are described as important components in the session. Erington examined nonverbal cues in particular, both of the family members and of the therapist, and how they can influence the relationship, what is shared, and the session as a whole. Clinicians might be interested in the full reprint for the discussion of the therapist's use of self as well as the case example of an inner versus outer conversation during a therapy session.


### The Lived Experience of Parents of Children with Autism Spectrum Disorders

As clinicians, we often work with parents who have children diagnosed with autism spectrum disorder (ASD). Research suggests that, as compared to parents of typically developing children, parents who have children diagnosed with ASD have an increased proclivity for psychological disorders. In an effort to better understand the lived experience of these parents, Corcoran, Berry, and Hill (2015) conducted a meta-synthesis of the existing qualitative research on the lived experiences of parents of children with ASD. Inclusion criteria for the study included: (a) the use of qualitative methods; (b) participants had to be parents of child with ASD; (c) the study had to focus on the lived experience of parents; (d) the study had to be conducted in the United States. Using these criteria, a total of 14 studies published between 2001 and 2012, with a total 263 participants, were included. The data were analyzed using Noblit and Hare's methodological framework for meta-synthesis (as cited in Corcoran et al., 2015). Results revealed six major themes including: emotional stress and strain; adaptation; impact on the family; services; stigmatization; and appreciating the little things. Collectively, these results not only highlight the emotional strain associated with learning that one's child has an ASD, but also the daily stress involved in managing the care of children with ASD. From a practitioner's perspective, these findings have a number of implications including the normalization of parents' experiences, as well as advocacy for programs, services, and support. Clinical psychologists and other practitioners who work with families who have a child with ASD might be interested in a full reprint of the article for a more detailed discussion of the findings and their associated practical implications.


### Geriatric Depression, CBT, and Meaning Making

We work with older adults who are experiencing depression using evidence based practices such as Cognitive Behavioral Therapy (CBT). Holland et al. explored if CBT would not only help alleviate symptoms of depression in older adults but also help promote meaning making after stressful events have occurred. Meaning
The Effects of Postsecondary Education on Drunking

Binge drinking among college students is associated with a number of negative outcomes. Previous research suggests that alcohol use increases as adolescents transition into young adulthood, and then peaks around age 21. For young adults who attend postsecondary education (PSE) however, the increase in alcohol use occurs at a steeper incline. In an effort to extend the current body of research, Thompson, Stockwell, Leadbeater, and Homel (2014) conducted a study focusing on three key components. First, they distinguished between several types of PSE, including 2-year community college, 4-year university, and transfer programs. Second, they investigated how age of enrollment relates to patterns of alcohol use. Third, they used a Canadian sample, thereby extending the predominantly US based literature. Participants were recruited from the Victoria Healthy Youth Survey, a five wave multicohort study of young adults between the ages of 12 and 27, using random digit dialing of 9,500 private telephone listings. Of the original sample, the final analytic sample was restricted to 521 adolescents between the ages of 12 and 18. The data were analyzed using piecewise latent growth curve models. Results indicated that heavy drinking progressively increased after enrollment in PSE, regardless of the type of PSE. Younger students experienced steeper inclines in heavy drinking after enrollment in PSE than their older counterparts. Overall however, terminal high school graduates experienced the highest and most persistent increases in heavy drinking as compared to 2-year college students, 4-year college students, and transfer students. Collectively, these results suggest that heavy episodic drinking is not restricted to college students. Rather, it is a widespread problem, affecting adolescents and young adults alike, regardless of PSE. School psychologists and other clinicians who work with adolescents and young adults might be interested in a full reprint of the article for a more detailed explanation of the findings and their associated implications and conclusions.


**Bipolar Disorder and Anxiety**

When working with clients with multiple diagnoses one might review a large body of research to find evidence based techniques for the concurrent diagnoses. Hawke et al. examined individuals with comorbid bipolar disorder and anxiety disorder, focusing on the reciprocal relationship between the treatments for the two disorders. The researchers reviewed the high prevalence of comorbid diagnoses with bipolar disorder but also the lack of research which examined treatment specific to comorbid bipolar disorder and anxiety disorder. A past study by Parikh et al. examined cognitive-behavioral therapy (CBT) and psychoeducation for bipolar disorder. Hawke et al. completed a secondary analysis on this data, where participants with bipolar disorder had been randomly assigned to either a CBT treatment or psychoeducational treatment. The authors found that individuals with both a bipolar disorder and anxiety disorder had higher initial symptomatology but showed equivalent or better gains in both CBT and psychoeducational treatments to the other groups. Gains were seen in anxiety reduction as well as decrease in depressive symptomatology. Clinicians might be interested in the further discussion of types of treatments recommended for individuals with bipolar disorder and anxiety disorder.

Focus on Diversity
Linguistic Diversity: Strengthening your Connection with Non-Native English Speakers
— Doug Haldeman

Let me say from the outset: my stake in this issue is personal. Having grown up in a bilingual, multi-generational family (here I am, pictured with Mormor and Morfar – Swedish for grandma and grandpa – at age 5), I appreciate the struggles faced by people whose native language is not English. I greatly value the unique cultural points of view embedded in language, which is the means of transacting most of our work as psychologists. In my Swedish immigrant family, for example, I learned more than just a second language – I learned about the core values of Swedish culture and society; why we do not try to “stand out” socially; and why we believe in equal treatment, equal access to health care for all, and high taxes.

Different cultural groups vary in the degree to which they put faith in psychology. So, for those that need and seek assessment or treatment and do not speak English very well, finding an appropriate service setting can be challenging. The disparity between the number of psychologists who are prepared to offer services in languages other than English (estimated at 1-2% of us) versus the number of people whose English is limited (estimated at 20% of the US population) says a great deal about the ever-widening gulf between our own ranks and the multicultural society we seek to serve. This may be why over half of non-native English speakers do not return to therapy after the first session (Bahtia & Ritchie, 2012; Kim, 2011). Generational and acculturation differences among bilingual or non-English speakers may also have something to do with this finding.

There are said to be almost 7,000 different languages spoken in the world today, many of which are spoken here in the United States. Language, although historically understudied and given scant attention in the general area of diversity (Santiago & Altarriba, 2002), is of critical importance to the practitioner. It is the doorway to understanding culture and normative behavior. In every language, there are words and concepts that do not directly translate in to English. Having a grasp of at least normative cultural behavior, if not fluency in the language, is helpful in establishing connection with a non-English speaker.

What does it mean to be bilingual? Technically, it simply means the ability to use more than one language – but to what degree? On one end of the bilingualism spectrum are individuals who learned a second language in early life, and continue to use it on a daily basis as adults. On the other end are people who learned a second language later in life, and use it infrequently, but have some receptive and expressive competence. Most bilinguals fall somewhere in between (Mindt et. al., 2008). And although both the primary and secondary languages appear to be stored in the same neural pathways, bilinguals tend to be advantaged on tasks of cognitive control (owing to suppression of the second language) and disadvantaged on other tasks (owing to competition/interference; lesser fund of expressive vocabulary than monolinguals, but greater overall in both languages) (Mindt et. al., 2008).

Language also has interesting effects on memory and personality. Altarriba (2003) found that bilingual Latino/a clients expressed emotional material more vividly in Spanish. With regard to traumatic events, for example, Heredia & Brown (2004) in a study of bilingual trauma survivors, found that the language in which the trauma was experienced, and the language in which it is being recalled, has an effect on retrospective memory. Similarly, Javier et. al. (2003) suggest that the person’s native language reflects a more emotionally rich texture, but that traumatic events may be easier to recall in the second language owing to a detachment effect.

It has long been suggested that linguistic use among bi/multi-linguals reflects variations in personality. An early study of bilingual French/English speakers using the TAT reflected different elements of personality, emotion and
judgment depending upon which language the person was using (Ervin, 1964). These findings have been replicated numerous times since, suggesting that bilinguals express different aspects of personality depending upon which language they are speaking (Dewaele & Pavlenko, 2003).

As previously mentioned, there are few bilingual therapists in contrast with the bilingual mental health population. Short of learning a new language, we offer some suggestions for practitioners working with bilingual clients:

• Show humility; the inability on the part of the practitioner to speak the client’s native language is your “issue,” not the client’s;
• Face person directly, but do not insist on eye contact;
• Speak slowly, without slang, jargon, or syntactical complexity; ask questions in one sentence, several ways;
• Clarify your role, purpose and limitations;
• Be patient.

(Adapted from Fontes, 2008)

Additionally, Gomez (2007) suggests that a practitioner does not have “be Latino in order to be helpful.” Learning even a bit of another language can go a long way with many people in establishing a connection of trust. In addition, the use of interpreters needs to be carefully considered from the standpoint of informed consent, and choice of interpreter – there are few certified interpreters, and the practitioner must make sure that the interpreter is competent in the language, and not related in any way to the client.

Apart from that, we can strive to incorporate linguistic diversity in psychology training programs; recruit bi/multilingual students; and emphasize the importance of linguistic diversity in improving access to health care through public policy. What we say, and how we say it, is fundamental to psychological service. If we truly seek to serve a multicultural society, language is an aspect of diversity that must be considered.

References


Douglas C. Haldeman is Chair of the Doctoral Program in Clinical Psychology at John F. Kennedy University in Pleasant Hill, CA. Correspondence regarding this article should be addressed to: doug@text.com
Greetings for Division 42 Programming

— June W.J. Ching

Aloha Division 42 Colleagues. On behalf of the Division 42 Board of Directors and especially our 2015 Program Co-Chairs, Drs. Stephanie Mihalas and Luis Morales Knight, it is my great pleasure to share with you our Division 42 Programming for the 2015 APA Convention to be held August 6-9 in Toronto, Canada.

I am very proud of our extensive array of skill building programs and symposiums, all specifically designed to help practicing psychologists thrive in the changing landscape of healthcare. Please take a few minutes to check out all our impressive offerings. Even if you’ve never attended before, now is the perfect time to come to Convention. Invest in your practice; develop new cutting edge skills and network with your 42 friends and colleagues at our member social hour.

I am particularly excited about the breadth and outstanding quality of our Division 42 Programming. Over the four day span, we have 14 scheduled sessions, in which a total of 17 CEU’s are available for attendees. Our Division 42 program will feature offerings in emerging areas of practice, clinical treatment modalities, business of practice, inter-organizational collaborations for licensure mobility, ethic and legal issues, evidence-based technology applications, cultural considerations and human trafficking.

Whether you are a student, early or mid-career psychologist or a seasoned expert, I know that you will be stimulated, intrigued and inspired by attending our programs and connecting with your 42 Community. I very much look forward to seeing you in Toronto, Canada!

Warm Aloha,
June W. J. Ching, Ph.D., ABPP
President, Division 42

Thursday — August 6

Learning From Our Mistakes — Best Practices to Build, Grow, and Sustain Private Practice
8:00 AM - 9:50  Convention Centre/Room 201D North Building-Level 200
Beth Trammell, Robyn Kittrell, and Robin Lett
Session Type: Skill-Building Session

Collaborative Approaches — APA and ASPPB Working Together Where Ethics and Licensure Converge
10:00 AM - 11:50AM  Convention Centre/Room 203D North Building-Level 200
Alex M. Siegel, Linda Campbell, Steve DeMers, Lisa R. Grossman, Martha N. Storie, Brian H. Stagner, Fred Milln, Stephen H. Behnke

Trauma Treatment in Independent Practice Settings — Ethical and Relational Issues,
12:00 PM - 12:50  Convention Centre/Room 206A North Building-Level 200
Lisa M. Rocchio, Christine Courtois

Keys to Success in Starting and Building a Private Practice
1:00 PM - 2:50 PM  Convention Centre/Room 809 South Building-Level 800
Trina F. Young Greer and Steven A. Greer

Friday — August 7

Should Psychotherapists Disclose Their Own Psychological Problems?
8:00 AM - 8:50  Convention Centre/Room 201D North Building-Level 200
Andrew Pomerantz

Evidence-Based Apps and Text-Messaging — Legal and Ethical Strategies for Your Practice
9:00 AM - 9:50  Convention Centre/Room 201D North Building-Level 200
Marlene Maheu, David D. Luxton, Frederick Muench

Emerging Areas of Practice — Addressing Women’s Financial Concerns
10:00 AM - 11:50  Convention Centre/Room 103A North Building-Level 100
Jana Martin, Maggie Baker, Mary Gresham
The Evolution of Psychotherapy— Can Biofeedback Advance the Practice of Psychotherapy?
4:00 PM - 5:50  Convention Centre/Room 206D North Building-Level 200
Carol S. Austad, Cosima Hoetger, Paul Lehrer, Donald Moss, Lynda Thompson, Patrick Steffen

Saturday — August 8

Protecting Your Practice — Compliance Plans and Documentation of Clinical Notes
8:00 AM - 8:50  Convention Centre/Room 201D North Building-Level 200
Donna Rasin-Waters, James M. Geourgoulakis, Patrick H. DeLeon

Family Therapy Across Cultures — When the Outsider Is Invited In
9:00 AM - 10:50  Convention Centre/Room 203B North Building-Level 200
Stephanie T. Mihalas, Luis F. Morales Knight, Krista Kovatch, Jessica M. Martin Family

Division 42 Business Meeting
11:00 AM - 3:50  Fairmont Royal York Hotel/Territories Room Main Mezzanine

Adolescents’ Struggle With Parent’s Deployment and Reentry---Assimilative Family Therapy Model
11:00 AM - 11:50  Convention Centre/Room 202D North Building-Level 200
Patricia Pitta

Mindfulness, Theory, and Practice —Childhood Through the End-of-Life
12:00 PM - 1:50  Convention Centre/Room 717B South Building-Level 700
David M. Ziga, Luis F. Morales Knight, Stephanie T. Mihalas, Jonathan S. Kaplan

Division 42 Social Hour
Sat 8/8 6:00 PM - 7:50  Fairmont Royal York Hotel/Quebec Room Main Mezzanine

Sunday — August 9

Primer for Attaining Board Certification
8:00 AM - 8:50  Convention Centre/Room 713A South Building-Level 700
Vladimir Nacev

Sex Trafficking — A New Look at an Old Problem
9:00 AM - 10:50  Convention Centre/Room 203B North Building-Level 200
Lenore E. Walker, Giselle Gaviria, Chelsey Mahler, Melissa Jackson, Natalie Sarachaga-Barato

Congratulations to our colleagues who have received Division 42’s 2015 Awards! Our Award Recipients are:

For Distinguished Psychologist of the Year: Dr. Bruce Frumkin. Dr. Frumkin has made substantial and significant contributions to our division, to APA, to forensic psychology, and more broadly to psychology as a profession. Distinguished Division leadership includes creating and leading the organization of our annual forensic conferences. Dr. Frumkin’s leadership on APA’s Council of Representatives includes having had direct impact on APA’s policy position regarding the impact of interrogation practices on subjects of interrogation, a direct reflection of his expertise in suggestibility and coercion. Additionally, Dr. Frumkin made significant contributions through his scholarly writ-

For the Mentoring Award: Dr. Lisa Grossman. Many leaders among our own division, APA and our profession more broadly have had the benefit of Dr. Grossman’s mentorship. She has consistently nurtured the Division’s Mentorshoppe program to its current success and status as a highly valued member benefit. Dr. Grossman consistently serves as guide, role model, teacher and sponsor in the context of a unique and distinctive personal relationship that provides knowledge, advice, challenge, counsel and support in the — Continued on page 102
Welcome to Fast Forward! 2015
Building a Thriving Practice in Today’s Ever-Changing Marketplace

Independent practice is at a crossroads.

Threats include increasing competition from a growing number of less expensive mental health providers; insurance companies, who are closing panels to new providers and federal and state agencies, who are transitioning away from fee for service reimbursement. Failure to adapt to these challenges means you risk watching the practice you’ve created, or hope to create, vanish before your eyes.

Attend Fast Forward! 2015 and learn the key strategies for adapting to these threats while building thriving and sustainable practices.

One of the most powerful ways to keep your practice viable is to create a niche practice, a business strategy that brands you as an expert and differentiates you from all the other “providers.” Consumers prefer to see an “expert and will often pay out of pocket even if you aren’t in their insurance network.

EARN UP TO 20 HOURS OF CE CREDIT while you gain expertise in setting up your niche practice from such experts as Dr. David Carbonnel (Fears and Phobias: A Perfect Niche); Drs. Jason Ong and Jaime Cvengros (The Nighttime as Niche: The Practice of Sleep Psychology); Dr. Karen Donahey (Establishing a Niche Practice in Sex Therapy) and Dr. Elaine Ducharme (Knock Knock Who’s There? Assessment and Treatment of Complex Trauma and DID- a full day workshop) as well as a host of other practice niche experts.

You will also learn about “Establishing Niches Outside of Traditional Healthcare Settings” from experts Drs. Gerry Koocher, Jana Martin and Steve Walfish. Other presentations will feature psychologists who work in such areas as collaborative divorce and dentistry.

We will also feature Practice Development workshops designed for students and early career psychologists (Building a Successful Independent Practice in Psychology with Dr. Michael Schwartz) as well as for mid and later career psychologists (Growing and Sustaining a Private Practice with Dr. Steve Walfish.) In addition, you can discover innovative ways to brand yourself as an expert from marketing gurus Drs. Pauline Wallin, Linda Sapadin and Eileen Kennedy-Moore (Establishing Yourself as the Go-To Expert).

BACK AGAIN THIS YEAR- OUR VERY POPULAR TRUST WORKSHOP- this year’s topic “Adventures on the Electronic Frontier: Ethics and Risk Management in the Digital Era” features Dr. Eric Harris. Don’t miss this opportunity to get 6 credits in ethics and a 15% discount on your professional liability insurance (For Trust Insureds.)

Fast Forward’s unique format features our very successful Speed Mentoring Workshop and also builds in plenty of time for networking and relaxing with colleagues at our welcome reception and nightly dine around dinners. Our hotel, the historic and iconic Hard Rock Hotel is ideally located in the heart of downtown Chicago, within walking distance of beautiful Millennium Park, The Art Institute and Chicago’s famous Lakefront. Our incredible nightly conference rate of $194 (which includes free WiFi and discounted parking) means that even if you live nearby, you can take advantage of our special rate and enjoy a rockin weekend in downtown Chicago.

Join us at the 2015 Fast Forward! Conference October 2-4 at the Chicago Hard Rock Hotel. I look forward to seeing you in sweet home Chicago!

You may register by visiting the Division 42 website at www.division42.org
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<td>Building a Successful Independent Practice in Psychology: Where to begin and how to thrive&lt;br&gt;Michael E. Schwartz, Psy.D., Independent Practice&lt;br&gt;3 CE credits&lt;br&gt;Designed for Students and Early Career Professionals</td>
<td>Knock, Knock, Who's There? Assessment and Treatment of Complex Trauma and Dissociative Identity Disorder&lt;br&gt;Elaine Ducharme, Ph.D., ABPP, Independent Practice&lt;br&gt;6 CE credits</td>
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<td>Establishing a Niche Practice in Sex Therapy&lt;br&gt;Karen M. Donahey, Ph.D., Independent Practice&lt;br&gt;3 CE credits</td>
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<td>SATURDAY</td>
<td>Niche Practices in Women's Health: Strategies for Collaborative and Co-Located Care&lt;br&gt;Helen L. Coons, Ph.D, ABPP, Independent Practice&lt;br&gt;3 CE credits</td>
<td>Alternative Dispute Resolution Niche Practices&lt;br&gt;Jeff Zimmerman, Ph.D., ABPP, Independent Practice&lt;br&gt;Lauren Behrman, Ph.D, Independent Practice&lt;br&gt;3 CE credits</td>
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<td>The Nighttime as a Niche: The Practice of Sleep Psychology&lt;br&gt;Jason Ong, Ph.D., Rush University Medical Center&lt;br&gt;Jamie Cvengros, Ph.D., Rush University Medical Center&lt;br&gt;3 CE credits</td>
<td>Collaboration with a Smile: Psychologists Working with Dentists and Orthodontists&lt;br&gt;Jana N. Martin, Ph.D., CEO, The Trust&lt;br&gt;3 CE credits</td>
<td>Establishing Yourself as the Go-to-Expert&lt;br&gt;Linda Sapadin, Ph.D., Independent Practice&lt;br&gt;Pauline Wallin, Ph.D., Independent Practice&lt;br&gt;Eileen Kennedy-Moore, Ph.D., Independent Practice&lt;br&gt;3 CE credits</td>
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<td>Speed Mentoring with Lunch&lt;br&gt;Advanced Registration required - additional charge for lunch</td>
<td>A Model Evidence-Based Intervention Program for Gender-Based Trauma Survivors: Survivor Therapy Empowerment Program (STEP)&lt;br&gt;Lenore E. A. Walker, Ed.D., Nova Southeastern University&lt;br&gt;3 CE credits</td>
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<td>Expanding Niche Opportunities Outside of Healthcare Settings&lt;br&gt;Nancy Molitor, Ph.D. Independent Practice; Chair, Fast Forward&lt;br&gt;Jana Martin, Ph.D. CEO, The Trust&lt;br&gt;Gerry Koocher, Ph.D., ABPP Dean, DePaul University College of Science and Health&lt;br&gt;Steve Wolfish, Ph.D. Independent Practice, The Practice Institute&lt;br&gt;1 CE credit</td>
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<td>SUNDAY</td>
<td>Adventures on the Electronic Frontier: Ethics and Risk Management in the Digital Era&lt;br&gt;Eric A. Harris, Ed.D., J.D.&lt;br&gt;6 CE credits</td>
<td>Navigating Legal Dilemmas in Clinical Practice&lt;br&gt;June W. J. Ching, Ph.D., ABPP, Independent Practice&lt;br&gt;David L. Shapiro, Ph.D., Nova Southeastern University&lt;br&gt;3 CE credits</td>
<td>Assimilative Family Therapy: Helping Couples Break Intergenerational Patterns and Unconscious Messages&lt;br&gt;Patricia Pitta Ph.D., ABPP&lt;br&gt;3 CE credits</td>
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Search for Associate Editor of The Independent Practitioner

The Associate Editor (AE) assists the Editor in the development of quarterly issues of the Bulletin. This includes the solicitation of articles appropriate for the Bulletin, review of submissions to be considered for publication, and proofreading the galley proofs just prior to the publication of each issue. The AE may also write Editorials that will appear in the IP.

It is the charge of the Editor and AE to make the Independent Practitioner (IP) a publication of excellence that Division 42 members will want to read, find useful in their clinical and business aspects of their practice. While final responsibility of the content of the IP lies with the Editor it is expected that the Editor and AE will develop a collaborative and close working relationship to produce an outstanding resource for Division 42 members.

The AE will also participate in Division committee meetings. These may be directly related to the IP, as well as other publication and communication outlets of the Division. In addition, the AE will participate in Division Board meetings as a nonvoting member. If funds are available they may attend the Division Mid-Winter meeting.

This is a volunteer position and runs for a three year term. It is expected that the AE will become the next Editor of the IP at the conclusion of the three year term, though the responsibility for this decision lies with the Division 42 Publications and Communications Committee. The position of Editor does carry a small stipend.

The IP is also in search of Contributing Editors (CEs) for the following sections of the IP: Focus on Clinical Practice; Focus on Business of Practice; Focus on Diversity; and Focus on S/ECP issues. The role of the CEs will be to search for submissions within the practice domain, review the submissions, and coordinate submissions with the Editor and AE.

Those interested in applying should send a Statement of Interest and a copy of their CV to Jeannie Beeaff at Div42apa@cox.net

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