Independent Practitioner

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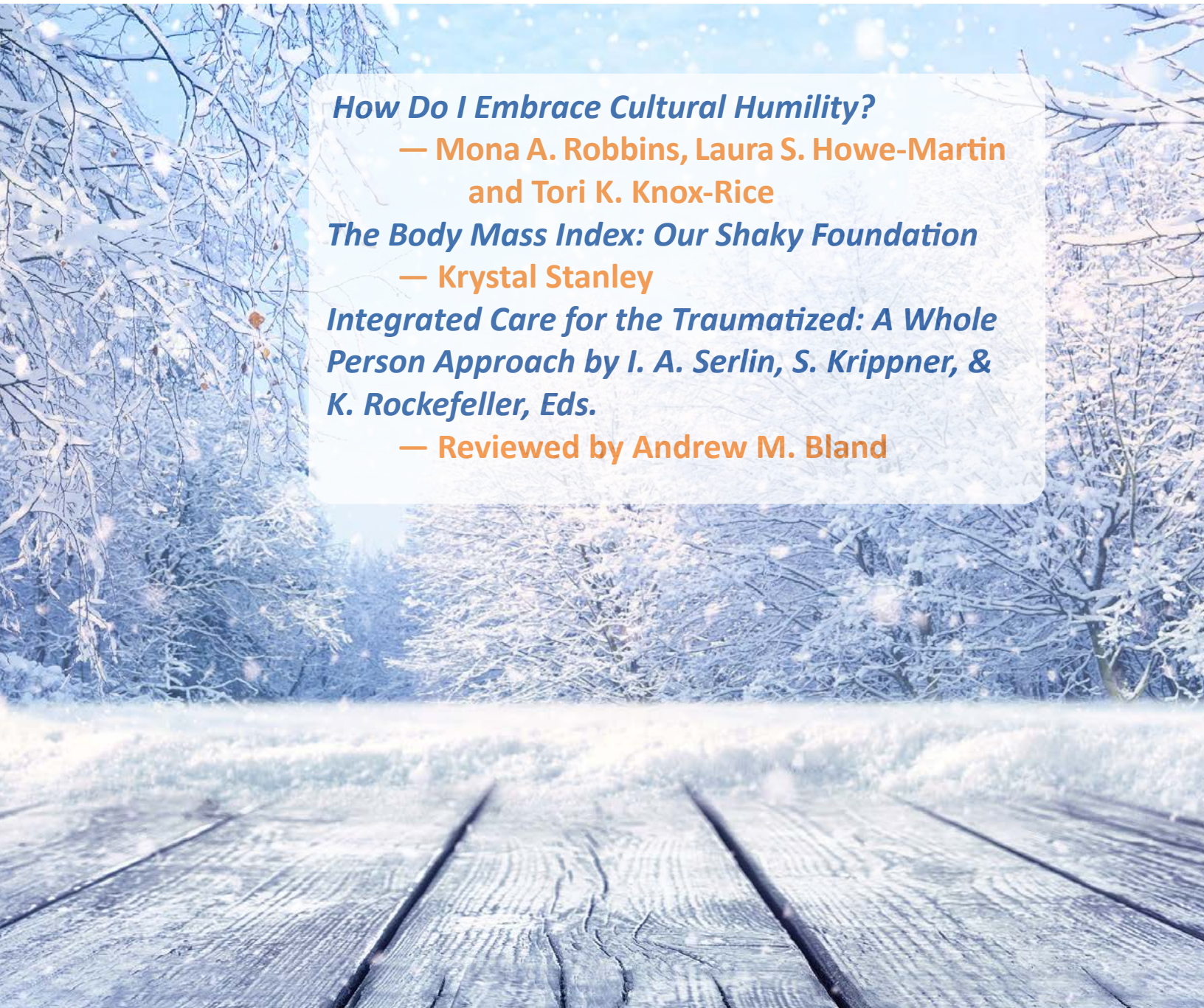

Independent Practitioner

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About the Independent Practitioner
Submission deadlines: February 10 for Spring issue
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Submissions:
All submissions (including references) must be formatted in APA style (with the exception that abstracts should be omitted) and emailed as an attached Word file to the Editor and Associate Editor. If you do not have attached file capabilities, mail the disc to the Editor. Hard copies are not needed. Please write two sentences about yourself for placement at the end of the article and provide contact information you would like published (e.g., address, phone, E-mail, web page). Photos are appreciated and should be sent directly to the Central Office. Most submissions should be limited to approximately 2,500 words (6 double-spaced pages), although longer submissions will be considered at the Editors' discretion.

All materials are subject to editing at the discretion of the Editors. Unless otherwise stated, the views expressed by authors are theirs and do not necessarily reflect official policy of Psychologists in Independent Practice, APA, or the Editors. Publication priority is given to articles that are original and have not been submitted for publication elsewhere.

Advertising:
Advertisements are accepted at the Editors' discretion and should not be construed as endorsements.

Table of Contents

President's Column

Presidential Initiatives for 2020

Judith Patterson

Dear Colleagues and Friends,

I am genuinely pleased to serve as President of 42 for 2020. The Division has been home to me for many years and I am proud to have served on Council, the Board, as fellows chair and as membership chair. Most of all, I am so excited to be working with the finest caring, dedicated and professional colleagues. Our division is fortunate indeed to have so many volunteers and an exceptional membership that is enthusiastically committed to patients, innovation around solid principles and meeting the needs of practitioners.

As a result of my work as Membership Chair and input the membership committee received from the Member Surveys we conducted, I have decided to focus my presidential year on the structure and functions of the division in an effort make us more resilient to changes in the profession and expectations of members. With that goal in mind, I am forming a Presidential Task Force to Re-envision 42.

The work of the task force is based on the following initial rationale:

1. Division 42 has been structured for a large membership. Recent years have seen membership decrease and members aging. Over 50% of the present membership are life-sustaining members who do not pay dues to the division.
2. Some members report that the division is becoming irrelevant for them and is not focused on what they need and expect.
3. Recent surveys of membership show six themes of interest for members: Technology Consultation, Business of Practice Consultation, Education and Training/CE, Collegial Support (Networking, Connections, Community), Self-care for Psychologist Practitioners and Advocacy for Practice.

4. The traditional committee structure, for the most-part, is not actively producing products/services to meet members expectations. Committees lose their purpose and enthusiasm and might be replaced by a more fluid structure such as time-limited task forces or interest groups.
5. The dissolution of the APAPO has left gaps in services, products and oversight for practice, leaving an opening for Division 42 to step into this void and creating new opportunities for our members.
6. The title "Independent Practice", now appears to limit the divisions scope and the division is seen as a home exclusively for private practitioners, yet practice areas are broadening, especially for ECPs and mid-career psychologists.

The membership of the Re-envisioning Task Force is important. I am very pleased to tell you that Dr. Nancy Molitor has agreed to act as chair of the task force, that Dr. Jana Martin has agreed to act as process consultant and that twelve other members have agreed to serve. Membership will include student, ECP, mid-career and seasoned 42 leaders.

The task Force has already begun its work. In August, at the APA Convention, the group met for a brainstorming session and addressed three questions: 1) If you were starting a new practice division, what would you want it to do for you? 2) What products and services would you hope it provides to you? and 3) If this practice division did not have committees, how would you structure it to do its work? You could feel the excitement in the room as members challenged their own preconceptions and fundamental assumptions and opened up to new and challenging creations.

During the Fall and Winter, the task force held small group calls that focused on specific subjects that fit into the overall plan. These calls lay the ground work for an in-person planning session in February prior to the Board meeting. This with culminate in the presentation to the Board of a solid draft document of proposals that address the following goals:

1. Identify who our target audience is
2. Identify what our target audience needs and wants
3. Brainstorm and create ways a division can best meet those needs and wants
4. A) Strategy/Function (e.g., mission statement, vision, goals, title/name)
5. B) Structure (e.g., committee/task force/other groups)
6. C) Resources (e.g., products and services)
7. Engage and enhance members' experience of being a part of the Division for sustained growth and retention
8. Raise the awareness of the profession to the resources available through Division 42

As a second initiative, Dr. Derek Phillips and Dr. Lindsey Buckman will co-chair a Leadership Development Initiative for 42. This will help identify and recruit members for leadership positions in the division and on committees and boards of the APA. It has the added goal of providing opportunities for members to gain the knowledge and skills that will assist them in being effective leaders in such a large and complicated organization.

Dr. Sam Marzouk represents us on an Inter-divisional Technology group headed by Dr. Jack Tsai from Division 18. This group is developing a webinar series on technology for practice and we are pleased to be part of this initiative. I want to thank Dr. Sara Smucker Barnwell for her initial work on this effort and to also thank Dr. Amy Van Arsdale for the work she is doing as 2020 Division Conference Chair in preparation for the August APA Convention.

As you can see, our focus for 2020 is to create ways to increase our relevancy and enhance our service to you. Although the Envisioning Task Force membership has been set and is already functioning, we anticipate that there will be ample opportunities for members to be involved in products and services resulting from the initial exploration and recommendations. Please follow our progress and consider giving your talents to the division.

My very best,

Judy

Judith Patterson, President

Cultural Diversity Training - Part 2
How Do I Embrace Cultural Humility?

Tori K. Knox-Rice, Laura S. Howe-Martin, and Mona A. Robbins

The present commentary is the second of a two-part series exploring cultural competence, humility, and awareness. The frist part can be read in the Fall 2019 issue of the *Independent Practitioner*. Part 2 in this series aims to have a greater focus on the practical use and implementation of humility-informed practice across both clinical and professional settings. We expand the conversation around cultural competence and provide useful strategies for independent practitioners working with multicultural populations.

Cultural competency has become a foundation in the training of both psychologists and medical providers. It has long been associated with a virtue of knowledge, and a model from which clinicians may seek to practice. However, just "learning" information about cultural groups, particularly as it relates to something as complex as culture, may not translate into effective or sensitive clinical practice. Evidence suggests that attempts to practice under the good intention of becoming entirely "culturally competent" may result in reinforcing stereotypes about cultural groups (Malat, 2013). Findings like this support our previous emphasis (Part 1 of this series) on cultural humility as a useful frame in practice for all groups.

Humility encompasses a dynamic and lifelong process focusing on self-reflection and personal critique that encourages one's awareness of how identities interact with those of the client and environment (Hook, Farrell, Davis, DeBlaere, Van Tongeren & Utsey, 2016; Tervalon & Murray-Garcia, 1998; Watkins, Hook, Owen, DeBlaere, Davis & Van Tongeren, 2019). In a way, cultural humility serves as a proxy for developing cultural knowledge and skills that enhance the services clinicians provide.

According to the recently updated APA's updated *Multicultural Guidelines,* psychologists "seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic" (American Psychological Association, 2017). These recommendations encourage clinicians to develop an understanding of their own cultural background and the ways their own cultural history influences their personal attitudes, values, and beliefs. By being introspective, we may begin to appreciate the intersectionality that exists between an individual's identity and the social problems they may experience. Further emphasis is on the importance of developing an understanding and knowledge of different worldviews that individuals from diverse backgrounds may hold. Together, these guidelines reinforce the complexity of multicultural practice and recognize how each individual's background is shaped by their own experiences.

The Dimensions of Humility

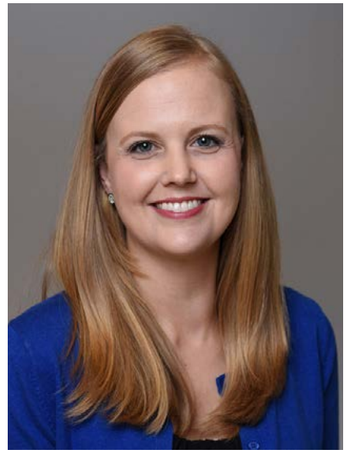
Integrating cultural humility into practice begs the question: how does one learn to be humble? Humility has been recognized as having three dimensions: self-awareness, openness, and transcendence (Morris, Brotheridge & Urbanski, 2005). *Self-awareness* and the ability to engage in critical self-reflection have been identified as the basis for recognizing one's own strengths and weaknesses (Hook et al., 2016; Tangney, 2000). When it comes to cultural humility, critical self-reflection begins with a close look into your own identity. As clinicians, we are encouraged to reflect on our own cultural identities and consider how it influences our worldview.

Taking an honest look at ourselves may be easier said than done, especially if we aren't used to deliberately examining parts of our identity. Start by asking yourself - what are the most salient features of your identity? How has your identity, or how you view yourself changed over the course of your life? These questions represent the foundation of self-reflection and mirror a process our patients may experience throughout treatment (Ortega & Faller, 2011).

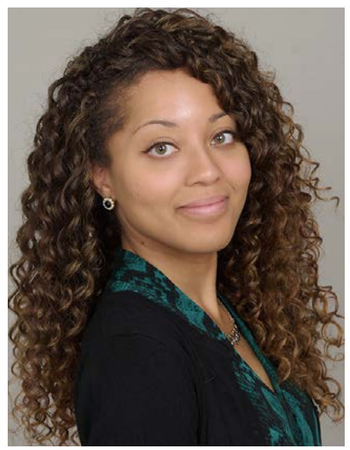
The second dimension of humility -*openness* - refers to an awareness of personal imperfections which involves knowing and accepting one's own shortcomings. When applying this to clinical practice, openness may refer to a clinician's awareness of internalized biases or negative beliefs about a particular culture/group of people. In clinical settings where unconditional positive regard is often valued, it may be tempting to push aside assumptions in an effort to reduce biases or ignore negativity. Clinicians should be encouraged to instead become aware of their biases and beliefs and actively work to recognize assumptions about identity. As highlighted in Part 1 of this series, Hays' ADDRESSING framework (Hays, 1996; 2016) is an excellent starting point for considering a wide variety of identities an individual may have. This mnemonic, although not comprehensive, refers to Age and generational influences, Developmental or acquired Disabilities, Religion and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National Origin, and Gender identity (Hays, 2016). To start the process of considering your own identity, explore what each aspect of your own culture means in a greater societal context as well as how it influences your daily life experience. Just like our clients, we each have family beliefs, historical values, instilled values, and prejudices. Try to consider what privileges or struggles your identity affords or limits in your interactions. In what ways do you experience power or privilege based on your identity? Reflect on your automatic assumptions about identity, such as pathologizing a client's passivity rather than acknowledging cultural difference in communication. As you bring any unexamined assumptions into awareness, you may begin to allow yourself to examine perceptions that could unknowingly sustain biases or prejudice.

The third dimension of humility -*transcendence* -may be viewed as the capacity for an individual to connect with a larger perspective. This is reflected in the concept of "knowing what we don't know", and the recognition that there are some aspects of culture to which we are oblivious. In such cases, it is important to examine our own internal process of understanding concepts that may have gone unexamined. Ask yourself: what are your gut reactions to people whose values don't overlap with your own? When values or beliefs that don't align with your own, what does it mean to

Mona A. Robbins



Laura S. Howe-Martin



Tori K. Knox-Rice

consider yours as the norm? When you take an authentic look at how you conceptualize your own values, you begin to become open to other points of view (Lu & Wan, 2018).

Initial Therapy Contact Opportunities

Clinicians practicing from a lens of cultural humility readily reassess how they practice and continuously re-examine the appropriateness of their approach for the clients they serve. This process may begin with the initial evaluation and intake procedures. For instance, open-ended questions on intake documents may help in conveying awareness that cultural identity is best when not reduced to a dichotomous checkbox. Such a practice also serves as a positive introduction to the therapeutic relationship, an important first step towards having clients share and define their personal identity. For example, you might alter intake forms to allow patients the option to fill in the blank with regard to racial or gender identity.

When listening to a client describe their reason for coming to therapy, be attentive to elements of identity that might affect the foundation of a positive therapeutic alliance. Don't shy away from the innate power difference present in the therapeutic relationship. Instead, consider how power and privilege can be acknowledged and explored. How might a client's social identity influence their beliefs about mental health? What cultural stigmas might present themselves during treatment, and have an impact on progress? Considering each of these questions sets the stage for recognizing what clients bring with them to therapy, and enable us to adjust accordingly.

Developing Humility in Clinical Practice

Embracing cultural humility does not mean learning a set of skills that can only be used in *certain* contexts or with *specific* clients. Instead, cultural humility represents a receptivity to learning, the ability to recognize and acknowledge ones' errors, and continued openness to absorb new perspectives, ideas, and concepts (Hook, Davis, Owen & DeBlaere, 2017; Tangney, 2000). When it comes to integrating cultural humility with our patients, the ability to recognize "cultural opportunities" can be beneficial. A *cultural opportunity* refers to a moment where there is a chance to address some part of a client's identity relevant to the content being discussed (e.g. historical trauma, the negative impact of discrimination, microaggressions). The recognition of these moments may have a meaningful impact on the therapeutic relationship by affirming clients' concerns and showing your desire to explore issues related to their identity and experiences. An added benefit to recognizing these in-session opportunities is the impact attuning to them can have on client outcomes. Clients report having better therapy outcomes when they perceived their clinician as being responsive to in-session opportunities to explore cultural factors pertaining to their experience (Owen and colleagues, 2016). In contrast, "missed" cultural opportunities, or neglecting to explore cultural factors, resulted in worse therapy outcomes.

One specific example of heightened awareness would be in your own examination of patient stressors in the workplace. If you believe a patient is experiencing interpersonal conflict solely due to their own choices, behaviors and/or cognitions, you may be missing out on the potential impact of institutional or societal factors that represent discriminatory barriers for the patient. The same could be said for identifying "poor self-advocacy" as the primary barrier to stable employment, rather than also considering the role of broader discriminatory practices. Both examples illustrate "missed" opportunities in exploring important aspects of a client's experience; cultural humility in this context requires an open mind and the recognition of numerous possibilities behind a reported stressor, beyond that of the individual.

Cultural Humility in Clinical Supervision

The movement toward incorporating cultural competency into practice has fostered the opportunity to develop strategies for continuous improvement in clinical practice *and* supervision. Humility itself is a foundational skill in supervisory roles that provide guidance to trainees (Paine, Sandage, Rupert, Devor, & Bronstein, 2015). In order to have a meaningful influence on developing practitioners, a supervisor might be more effective to assess their own cultural viewpoints and actively recognize their own personal biases. Openness, emulating an other-orientation, self-assessment, and recognizing one's own imperfections can serve as a supportive basis for clinical supervision (Watkins, Hook, Ramaeker, & Ramos, 2016; Hook, Watkins, Davis, Owen, Van Tongeren & Marciana, 2016).

It is important to consider the meaningful ways humility can be incorporated into the supervisory hour. One method is through a lens of *multicultural orientation*. Multicultural orientation (MCO) refers to an interpersonal stance of embracing an understanding of how culture informs clients' lives. MCO adapts the concept of cultural humility by focusing on a way of being with clients rather than relying on specific knowledge or skills (Davis et al, 2018). It is clear how MCO can be beneficial with clients, however, the concept can also be integrated into supervisory settings. An approach that includes responding to therapeutic cultural markers with supervisees may have long-term positive effects on the training experience. Burkard, et al (2006) found that attending to multicultural issues in supervision was associated with a stronger supervisory alliance. Integrating multicultural practice in supervision has also been associated with trainee's increase in personal awareness of culture (Watkins, Hook, Owen, DeBlaere, Davis & Van Tongeren, 2019). The added outcome is a stronger supervisory alliance, increase in the personal awareness of the supervisor, and the creation of a culturally sensitive work environment (Gatmon, et al 2001; Dickson, Jepsen & Barbee, 2008).

Although we may strive to address clinical issues related to diversity as they emerge, sometimes topics relevant to culture and identity do not organically present themselves. Fortunately, there are ways to integrate diversity into supervision as a routine part of clinical practice. Supervisors may adopt the responsibility of infusing multiculturalism into training via vignettes, case examples, or role-plays. If we are to consider a deeper level of humility in supervision, we must also include attending to supervisees' attitudes during discussions of clinical content.

However, we acknowledge that anxiety and personal discomfort are common reasons clinicians may doubt the need to infuse culture into supervision (Hook, Watkins, Davis, Owen, Van Tongeren & Marciana, 2016). Succumbing to this anxiety might result in avoidance of difficult topics and ultimately a lost opportunity to facilitate trainee development (Gay, 2018). Therefore, coping with resistance that can arise by openly normalizing the natural desire to avoid difficult emotions is important to help students move beyond fear and defensiveness. This form of cultural learning, the ability to recognize defensive feelings, develops over time, and clinical supervisory relationships are an excellent setting to enhance this development. Attending to "culture" during supervision may be direct, such as actively addressing specific cultural dynamics as they arise in therapy. This could be asking the supervisee to discuss their initial reactions to working with a client while encouraging awareness of how their own cultural identities affect case conceptualization, treatment planning, and the overall therapeutic relationship. By highlighting these areas supervisors are implicitly communicating that diversity is important and something worth considering

Putting It All Together

We are all dedicated lifelong learners. From our continuing education activities to self-studies, we seek to continuously expand our knowledge base. Despite this commitment to maximizing what we know, one cannot strive to know everything about all cultural identities. It is simply not feasible. However, as clinicians and supervisors, we can embrace a stance of humility by recognizing how much we do not know and doing something about it.

Embracing cultural humility is a journey that starts at the personal level. Cultural humility requires an open awareness and commitment to self-examination. Consider what this means for you. Recognize there are different ways of perceiving the world and push yourself to view from different lenses whenever possible.

It may be beneficial for independent practitioners to consider developing their own plan for continued exploration of what it means to embrace humility. Immersion has been found to maximize the effects of personal growth (Ishii, Gilbride & Stensrud, 2009). Consider developing your own immersion activity--for example, purposefully connect with another culture about which you know very little, through local (or even international) events and activities. Continue to engage in periodic self-reflection--notice discomfort when it appears and address via consultation any difficult emotions that arise from your clients.

Additional Resources

We hope this article has been a helpful aid in exploring how you might embrace cultural humility in your own clinical practice! If this has sparked additional interest in cultural humility, we recommend the following educational tools, books, and articles.

- *Developing Cultural Humility: Embracing Race, Privilege and Power 1st Edition*
- *The Four Skills of Cultural Diversity Competence (Methods/Practice with Diverse Populations) 4th Edition*
- Culturally Connected: www.culturallyconnected.ca

References

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. The American Psychologist, 58(5), 377.

American Psychological Association (2017). Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. Retrieved from: http://www.apa.org/about/policy/multicultural-guidelines.pdf

Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., ... & Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. Journal of Counseling Psychology, 53(3), 288.

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., ... & Placeres, V. (2018). The multicultural orientation framework: A narrative review. Psychotherapy, 55(1), 89.

Dickson, G. L., Jepsen, D. A., & Barbee, P. W. (2008). Exploring the relationships among multicultural training experiences and attitudes toward diversity among counseling students. Journal of Multicultural Counseling and Development, 36(2), 113-126.

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing*, *27*(3), 210-217.

Gay, G. (2018). Culturally responsive teaching: Theory, research, and practice. Teachers College Press

Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolfa, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter?. Journal of Multicultural Counseling and Development, 29(2), 102-113.

Hays, P. A. (1996), Addressing the complexities of culture and gender in counseling. *Journal of Counseling & Development. 74*: 332-338. doi:10.1002/j.1556-6676.1996.tb01876.x

Hays, P. A. (2016). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy (3rd edition).* Washington, D.C.: American Psychological Association.

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. Journal of Counseling Psychology, 60(3), 353.

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. Journal of Counseling Psychology, 63(3), 269.

Hook, J. N., Watkins Jr, C. E., Davis, D. E., Owen, J., Van Tongeren, D. R., & Marciana, J. R. (2016). Cultural humility in psychotherapy supervision. American Journal of Psychotherapy, 70(2), 149-166.

Ishii, H., Gilbride, D. D., & Stensrud, R. (2009). Students' internal reactions to a one-week cultural immersion trip: A qualitative analysis of student journals. Journal of Multicultural Counseling and Development, 37(1), 15-27.

Lu, C., & Wan, C. (2018). Cultural self-awareness as awareness of culture's influence on the self: Implications for cultural identification and well-being. Personality and Social Psychology Bulletin, 44(6), 823-837.

Malat, J. (2013). The appeal and problems of a cultural competence approach to reducing racial disparities. Journal of general internal medicine, 28(5), 605-607.

Morris, J. A., Brotheridge, C. M., & Urbanski, J. C. (2005). Bringing humility to leadership: Antecedents and consequences of leader humility. Human relations, 58(10), 1323-1350.

Ortega, R., & Coulborn Faller, K. (2011). Cultural humility for child welfare professionals: A paradigm shift. Child Welfare, 90(5), 27-49.

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. Professional Psychology: Research and Practice, 47(1), 30.

Paine, D. R., Sandage, S. J., Rupert, D., Devor, N. G., & Bronstein, M. (2015). Humility as a psychotherapeutic virtue: Spiritual, philosophical, and psychological foundations. Journal of Spirituality in Mental Health, 17(1), 3-25.

Roysircar, G. (2004). Cultural self-awareness assessment: Practice examples from psychology training. Professional Psychology: Research and Practice, 35(6), 658.

Tangney J.P. (2000). Humility: Theoretical perspectives, empirical findings and directions for future research. Journal of Social and Clinical Psychology, 19, 70-82.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of health care for the poor and underserved, 9(2), 117-125.

Warner, C. B. (2015). The role of clinical supervision in moving cultural awareness to cultural competence through case conceptualization. World, (1), 8.

Watkins Jr, C., Hook, J. N., Owen, J., DeBlaere, C., Davis, D. E., & Van Tongeren, D. R. (2019). Multicultural orientation in psychotherapy supervision: Cultural humility, cultural comfort, and cultural opportunities. American journal of psychotherapy, appi-psychotherapy.

Watkins Jr, C., Hook, J. N., Ramaeker, J., & Ramos, M. J. (2016). Repairing the ruptured supervisory alliance: Humility as a foundational virtue in clinical supervision. The Clinical Supervisor, 35(1), 22-41.

Wear, D. (2008). On outcomes and humility. Academic Medicine, 83(7), 625-626.

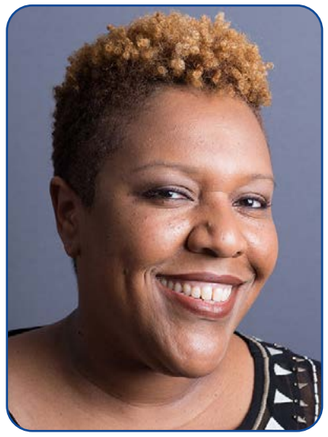
Villegas, A. M., & Lucas, T. (2002). Educating culturally responsive teachers: A coherent approach. Suny Press.x

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: essential foundation for clinical researchers. Applied nursing research: ANR, 26(4), 251–256. doi:10.1016/j.apnr.2013.06.008

The Body Mass Index: Our Shaky Foundation

Krystal Stanley

My original plan for this article was to write about the intersection of race and weight bias, but I learned new information about the origins of the Body Mass Index (BMI) that I thought would be beneficial to share. This August at APA I attended a seminar entitled, *Black Women with Eating Disorders- Eating Because We're Hungry or Because Something's Eating Us?,* and the first speaker, Dr. Carolyn Coker Ross, spoke about the variety of factors that influence the disordered eating behavior of Black women (e.g., historical and personal trauma, acculturative stress, and the historical denigration of Black women's bodies). After the seminar I asked Dr. Ross if she would be willing to talk to me and she agreed to do so, and we spoke for an hour by phone on October 10, 2019.



Carolyn Coker Ross, MD, MPH, is a physician who is currently based in San Diego, CA. Over her 30+ year career she has worked in the areas of preventative medicine, integrative medicine, addictions, and eating disorders. For the past 8 years Dr. Ross has been running The Anchor Program (https://www.anchorprogram.com/), a non-diet coaching program that she developed for women. The program consists of a 12-week process/psychoeducation group where members can discuss struggles with food and body image concerns, meetings with a dietician, and 6-months of follow-up once the 12-week intensive group has ended. I asked Dr. Ross how she helps members let go of the "thin ideal" and weight loss, and she said that one of the first things she shares with the group is that our cultural ideals about weight were developed by a group of insurance auditors who decided where to draw the line between weight and health. She said that she also spends quite

a bit of time providing psychoeducation on a variety of topics that may be impacting participants' behaviors (e.g., understanding how personal traumas may impact weight and exploration how each individual's personal beliefs about weight were formed) and debunking myths about weight (e.g., there is no "perfect" weight for every person, the number on the scale is not directly related to health risk, etc.). She stated, "The focus on weight is the problem, not the solution" (C. Ross, personal communication, October 10, 2019).

I was intrigued by Dr. Ross' statements about how the "ideal body" was determined so I set out to learn more about the development of the BMI. Adolphe Quetelet (1796 - 1874) was an artist and statistician who was one of the first people to apply statistics to "social physics" (e.g., the measurement of complex social phenomena). His main interest was to create a composite of "the average man" (*l'homme moyen*) which would be based on population averages of height and weight (Quetelet, 2019). He posited that human physical variance existed on a normal curve, but as he began collecting data, he struggled to fit the data into a normal curve. In response to this dilemma, he began collecting data on the development of newborns and children. He found that their increases in length/height was often associated with weight gain, but not in the proportions that he had hypothesized (e.g., that weight would be the square of the height), and he applied his findings to adults (Eknoyan, 2008).

In the United States during the early 20th century, insurance adjusters began to notice and document an increase in deaths among their heavier subscribers. Louis Dublin (1882 - 1969), a statistician and the Vice President of The Metropolitan Life Insurance Company, sought to develop height/weight tables, but he encountered similar issues as Quetelet. He found a wide range of weights for various heights for both sexes, and he assumed that this variation was due to body "shape" or "frame". To solve this problem, he divided his distribution into thirds and labeled them "small", "medium", and "large" frames, and within each category, he took the average of the weights and labeled them "ideal", and later, "desirable". For insurance purposes, undesired weight was 20-25% of the ideal weight and morbid obesity was 70 - 100% of the ideal weight. In 1972, Ancel Keys (1904 - 2004), also a statistician and dietary scientist, and his colleagues were the first to begin using Body Mass Index instead of Quetelet's Index to describe these weight tables (Eknoyan, 2008).

While Quetelet's interest in "the ideal man" was not explicitly about weight or obesity, the BMI has come to be the standard by which bodies are evaluated by the medical establishment, and as a result, our culture as a whole. Historically, "plumpness" was considered a sign of wealth and good health, or, at the very least, regular access to food. It is notable that both Quetelet and Dublin found wide variations in weight, but rather than accepting this as the norm, they instituted an "ideal" where none existed naturally. I'm reminded of a statement from my previous article about how weight has been medicalized and places body size on a continuum of "healthy vs. unhealthy" that focuses on deviations rather than variations, which often results in larger bodies being stigmatized. During our talk Dr. Ross stated: "No matter how hard people try, their weight does what it does naturally...not everyone will be thin." (C. Ross, personal communication, October 10, 2019). Scientists have found that there are genes that people carry that contribute to weight gain (Farooqi & O'Rahilly, 2006; Kolata, 2016), and aside from that, there are diseases that contribute to weight gain (e.g., hypothyroidism, depression, and Cushings disease), as well as medications and treatments for disease, such as psychiatric medications, diabetes treatment, and steroids (Kolata, 2016; www.nhs.com).

It is generally assumed that individuals who are obese by BMI standards are inherently unhealthly while those in the normal range are healthy and free from risk of disease, but research has shown that individuals who are considered obese can be fit and metabolically healthy (e.g., free from risk of disease) and those who are in the normal BMI range may actually be at risk for disease (Ortega et al., 2012). The reason is that there is a difference between subcutaneous fat which is visible to the eye as it exists just under the skin (e.g., what makes people fat) and visceral fat which exists around the abdominal organs. Researchers have found that visceral fat makes people susceptible to cancer, heart disease, and other high-risk diseases. Individuals who are in the normal BMI range but who have visceral fat are colloquially referred to as "skinny fat", and belly fat a sign that such a person may have visceral fat (Connor, 2014).

One of the main criticisms of the BMI is that it is not culturally sound, which is not surprising as the bulk of the participants in the original samples were of European descent. The consequence is that the BMI may overpredict risk for disease in some non-White populations while underpredicting risk disease in others. The reason for this is that BMI has been assumed to provide some data about the percentage of body fat that an individual may have. For instance, research has shown that the body composition of Black women is significantly different from that of their non-Black counterparts. The former have been found to have more bone and muscle mass, and less percentage of body fat per weight (Gasperino, 1996). In a study of 555 Black, White, and Hispanic women, the average weight of the Black women in the sample was 20 pounds more than that of the other women, yet their percentage of body fat was identical to that of the other women in the sample (Rahman & Berenson, 2010).

The information I have presented in this article shows that solely relying on body size or BMI does not provide an accurate picture of underlying disease risk or overall health, but, as I discussed in my previous article, weight bias continues to exist among medical professionals. In my conversation with Dr. Ross she said, "We [physicians] blame the patient for that [their weight], and there is no precedent in history of blaming someone for a problem that they come to us to fix." (October 10, 2019).

I will end this article with a few questions for us to ponder and a final quote from Dr. Ross.

- What if we accept that there are both fat and thin bodies, and we don't assign any meaning or value to either?
- Knowing what we know about the development of the BMI and its limitations, how can we continue to accept it as a valid measure of health?
- How can we as psychologists, for the benefit of our patients and ourselves, continue to challenge our assumptions about weight and health, and share what we know with our clients?

Dr. Ross said something that I thought would be beneficial for all of us as we are all victims of our negative cultural beliefs about fat:

"What is more important to you: to continue to suffer around your weight and be sidelined in your life so you are not doing the things you want to do, not enjoying the things you want to enjoy, or is it important to get back into your life and end the suffering, and see what your body does?" (October 10, 2019).

References

https://www.nhs.uk/live-well/healthy-weight/nine-medical-reasons-for-putting-on-weight/.

Adolphe Quetelet. (2019, November 11). Retrieved from https://en.wikipedia.org/wiki/Adolphe_Quetelet.

Ancel Keys. (2019, November 15). Retrieved from https://en.wikipedia.org/wiki/Ancel_Keys.

Connor, S. (2014, March 9). Scientists find the origin of 'bad' fat linked to heart disease and. Retrieved from https://www.independent.co.uk/life-style/health-and-families/health-news/scientists-find-the-origin-of-bad-fat-linked-to-heart-disease-and-cancer-9180037.html.

Eknoyan, G. (2007). Adolphe Quetelet (1796 1874) the average man and indices of obesity. *Nephrology Dialysis Transplantation*, *23*(1), 47–51.

Farooqi, I. S., & O'Rahilly, S. (2006). Genetics of Obesity in Humans. *Endocrine Reviews*, *27*(7), 710–718. doi: 10.1210/er.2006-0040

Gasperino, J. (1996). Ethnic differences in body composition and their relation to health and disease in women. *Ethnicity & Health*, *1*(4), 337–347.

Kolata, G. (2016, December 12). One Weight-Loss Approach Fits All? No, Not Even Close. Retrieved from https://www.nytimes.com/2016/12/12/health/weight-loss-obesity.html?auth=login-email&login=email.

Ortega, F. B., Lee, D.-C., Katzmarzyk, P. T., Ruiz, J. R., Sui, X., Church, T. S., & Blair, S. N. (2012). The intriguing metabolically healthy but obese phenotype: cardiovascular prognosis and role of fitness. *European Heart Journal*, *34*(5), 389–397. doi: 10.1093/eurheartj/ehs174

Rahman, M., & Berenson, A. B. (2010). Accuracy of Current Body Mass Index Obesity Classification for White, Black, and Hispanic Reproductive-Age Women. *Obstetrics & Gynecology*, *115*(5), 982–988. doi: 10.1097/aog.0b013e3181da9423

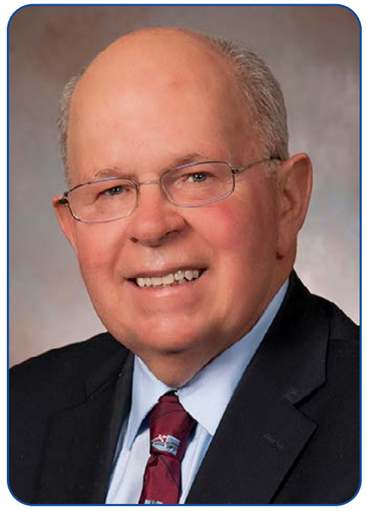
Opinions and Policy

"We Will Rock You"

Pat DeLeon

The First Annual APF Soiree: This October, along with a number of APA Past Presidents including Florence Denmark, I had the pleasure of attending the American Psychological Foundation (APF) Soiree, honoring three distinguished, highly engaged citizens. Terry Keane, APF President: "On Thursday evening October 24th, we hosted our first Fund Raising Soiree at the Winery District in Washington, DC. With 150 people in attendance, the Soiree was a huge success. Its goal was to raise funds for the APF Visionary Awards that support key projects for young psychologists, either graduate students or early career investigators. In a remarkably beautiful setting high above the Anacostia River, the event raised more than $160,000 for projects studying gun violence, violence against women, sexual assault, and sexual harassment. Planning for the event began last Spring and included both the staff of APF, the Board of Directors, and volunteers from across the country. The event was sponsored by The Trust (Jana Martin, CEO), EBSCO, Pearson, Patricia Stark, Bank of America/Merrill Lynch, Jenner & Block, PAR, and Rainier Behavioral Health. Rounding out the support were sponsorships from Palo Alto University, Ultimate Software, and WBW Consulting.

"California Representative Alan Lowenthal was on the guest list and made supporting remarks about the goals and objectives of the APF and added his own contribution to the mix of those providing generous philanthropy to support this important work. Also in attendance was APA's Arthur Evans who supported APF's mission of promoting psychological science in areas of great importance to the nation. He highlighted that the Soiree was an important strategic initiative in that it was focusing upon joint initiatives between Psychology and the corporate sector. APA's President-Elect Sandy Shullman – herself a past APF Board Member – suggested that the support of young psychologists who are entering the workforce is central to our mission of making the world a better place. The focus on gun violence and violence against women was important to Sandy as prevalence rates of these problems in America are reaching staggering proportions. She vowed her continuing support of APF's goals through her Presidency and for this we are all eminently grateful.



"The evening was hosted by Ann McDaniel, sister of APA Past-President Susan McDaniel. Ann is a renowned journalist and media business executive who spent many years at *Newsweek* and *The Washington Post*. She is currently a consultant to Graham Holding Companies. Ann introduced the three honorees of the evening. First, was Vanessa Tyson, who is an associate professor of politics at Scripps College in California. She has made a career of standing up for survivors of abuse and is a founder of the Boston Area Rape Crisis Center. She's also established a program for female juvenile offenders at the Massachusetts Department of Youth Services. Last year, she bravely spoke up about abuse at the hands of the standing Lt. Governor of Virginia knowing full well that this would make her a target of criticism. With a stunning display of poise and thoughtfulness, she accepted the APF's Visionary Award for her work on behalf of women who are survivors of interpersonal violence.

"Robert Schentrup was also honored for his work on behalf of his sister, Carmen Schentrup, who was killed in the massacre at the Marjorie Stoneman Douglas High School in Florida. He is a sophomore at the University of Florida and majoring in Psychology. He spoke eloquently about the scourge of gun violence in America and the need for remedial action. He founded ZeroUSA and is active in the March for Our Lives initiatives nationwide. Robert also received a Visionary Award for his courage and passionate approach to intervening at an individual and group level to influence public policy in the country. His words were inspiring to all of us in attendance.

"Finally, Christine Blasey Ford of Palo Alto University was recognized for her courage and willingness to 'Speak Truth to Power' in her testimony before the Senate Judiciary Committee in 2018 regarding Brent Kavanaugh's confirmation to the United States Supreme Court. She was introduced by Professor Heidi Li Feldman of Georgetown Law Center who established a Go Fund Me page to underwrite some of the costs sustained by our honoree taking the step to publicly challenge the nomination of Judge Kavanaugh. Residual funds were contributed to the Fund for Trauma Psychology in APF to establish a grant on Sexual Assault and Harassment named in honor of Dr. Ford. The first award will be given this year.

"To complete the evening, APA and APF Past President Dorothy Cantor led the internet-based auction that capped off the evening and raised approximately $50,000 more for the express purpose of supporting APF Visionary Grants. Given that APF is only able to support eight of some two hundred Visionary Grant submissions, the additional resources will raise our pay-line in the interest of bring Psychological Science to bear on critical societal problems. With great thanks to our APF staff, Board of Directors, Honorary Board Members, and our Soiree Committee, I'd like to extend my deepest appreciation to all for their participation. It was simply the best evening, in a stunning venue, with a great many friends of the APF. And, the Washington Nationals were coming home to DC, leading the World Series 2-0 and eventually wining the Series 4-3 over the talented Houston Astros. With the success of the APF Soiree and the Nationals' first pennant, Washington was in a celebratory mode that week."

APA President-Elect: "It is truly an honor to be elected by my peers to represent the American Psychological Association as President in 2021. I am deeply humbled by this trust and faith. The four pillars of my Presidential campaign were: Advocacy, Inclusion, Leadership, and Experience. As I move through the Presidential year, I will continue to infuse these, along with Collaboration, through my work as I believe they are necessary to continue strengthening our association and creating a positive impact within APA, the discipline, and the world. I will continue to embrace the goal of One APA as I believe that for psychology to have a significant impact and achieve the goals of our strategic plan, we must have a united organization. I look forward to collaborating with my colleagues over the next three years" (Jennifer Kelly).

Reflections from the Past: Division 42 member Carol Shaw Austad and I have many fond memories of one of our most visionary and, we expect as a direct result, highly provocative APA Presidents, Nicholas "Nick" Cummings. A World War II Veteran, Nick was the first Pres-

ident of the California School of Professional Psychology (CSPP); founded the National Academies of Practice; testified before the Senate Finance Committee on psychology's eventual inclusion in Medicare – resulting in the Colorado demonstration project; and established Biodyne for psychology during the height of the Managed Care era. "Since the APA no longer requires the inclusion of the history of psychology in its teaching programs, many important and even fascinating events have long been forgotten. Few, if any, remember the so-called proposed American Professional Psychology Association (APPA). As a 95-year-old past APA President (1979) I may well be the only one who vividly recalls a fascinating series of events. In the early and mid-1970s there was much discussion about the domination and distortion of clinical psychology by academic programs that were dominated by rat and pigeon running.

"Following the lead of Gordon Derner's truly professional program at Adelphi University, many clinical and counseling psychology programs created the American Professional Psychology Association and got it approved by the U.S. Department of Education in Washington, DC. Over 20 university programs joined and the APPA was about to become a reality when its elected President Gordon Derner asked for a one-year delay as it had been his ambition to be the first truly clinical APA President. He ran again and lost for the fifth time. I had been persuaded to run and that year was overwhelmingly elected. I then rightly devoted my loyalty and energy to the APA and the proposed APPA faded away" (Nick Cummings).

Carol: "Nick is a distinguished soul who has earned his title 'Psychology's Provocateur.' He has always been a disrupter and he is proud of it. I had the privilege of writing his biography. I felt fortunate to be able to call out his amazing accomplishments and share in so many memories that were communicated to me by Nick, his family, his professional friends and his professional foes, as well as historical archives. Nick's life is a personal odyssey that reflects the history of APA and today's psychotherapy for over 60 plus years. It takes a book to summarize his accomplishments. Nick has always possessed an uncanny ability to foresee the future and act on his predictions. From the beginning of his career, well over half a century, Nick got it right, grasped the big picture, and as his grandma told him 'do the right thing.'

"Of course, his actions inevitably upset the status quo, created an uproar among traditionalists. He stimulated controversy and critical thinking among his psychological colleagues on so many issues. Here's the skinny – Nick's most significant contribution to psychology has been the invention of an innovative therapy model. I know because I worked at an HMO like Nick's Kaiser in California. Nick predicted the future of psychotherapy and created Intermittent Psychotherapy Throughout the Life Cycle. It integrates mind and body, or psychology and medicine. Today's term is 'Integrated Care.' It is true translational work. Through the medical offset effect research, we can see the effects that the right kind of psychological intervention can interact with the physical body and bring about the mind-body treatment. His model weaves together psychotherapy theory, clinical practice, research, and practice setting. It fits the needs of modern psychotherapy. This model will survive and thrive *if* psychology passes it on to its students. The best is yet to come as more people discover Nick Cummings' work and apply it to their own therapy room" (Queen, 1977). Aloha,

Pat DeLeon, former APA President – Division 42 – November, 2019

Book Review

Integrated Care for the Traumatized: A Whole Person Approach

by I. A. Serlin, S. Krippner, & K. Rockefeller, Eds.
Rowman & Littlefield, 2019, 222 pp.

Review by Andrew M. Bland

"The deepest roots of trauma cannot be talked about or explained away; they must be discovered, felt, and lived through."
– Orah Krug (2019, p. 265)

Conceptualization and treatment of trauma have progressed rapidly during the last decade. The diagnostic criteria for Post-Traumatic Stress Disorder (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) have become regarded as too simplistic when applied to many clients, as complex trauma has become better understood and proposed as its own diagnostic category (Briere, 2019; Kinsler, 2018). In the meantime, whether PTSD should even be classified as a disorder also has been increasingly called into question, with PTSI ("Injury") having been proposed as a more fitting term that is less pathologizing and that accounts for an emotional wound that is amenable to healing attention and transformation (Joseph, 2019; Levine, 2010; Sword, 2019). Furthermore, as it has become better recognized that therapies which emphasize rapid recovery and/or reliving past traumas can be overwhelming for clients (Levine, 1997) and can bring about negative outcomes (Serlin et al., 2019a), there has been increasing pushback against therapies based principally on exposure and/or on the goal of clients establishing habituation (Briere, 2019).

Moreover, the American Psychological Association's (APA) recommendations for PTSD treatment, as articulated in its *Clinical Practice Guideline* (APA Guideline Development Panel, 2019), have been critiqued by Dauphin (2019) and by Norcross and Wampold (2019) on theoretical/philosophical, methodological, and empirical grounds. For example, these authors have argued that the *Guideline* is overly biased toward medicalized, manualized therapeutic modalities centered around standardization and symptom reduction. Further, the *Guideline* also has been critiqued for ignoring the roles of the therapy relationship, of the helper-as-person, and of the therapist's responsiveness and adaptiveness to individual clients—which decades of research suggest are the strongest determinants of sustainable psychotherapy outcome (Angus et al., 2015; Elkins, 2009, 2016; Rogers, 1961). Accordingly, as of this writing, over 57,300 clinicians, both in the United States and internationally, have petitioned against the *Guideline* (Alliance for the Inclusive Integration of Science and Practice in Psychology, n.d.).

Humanistic-Existential Approaches to Trauma Work

As an alternative to prescriptive, preordained

(Mølbak, 2012) trauma treatment models, approaches to trauma work that are grounded in and/or consistent with the humanistic-existential tradition in psychology have recently received renewed interest and support. These models emphasize the interdependence of: (a) the therapeutic relationship as the vehicle for sustainable change, (b) holistic and systemic conceptualization, (c) spirituality and mindfulness, and (d) personal growth and resilience.

First, regarding the value of the therapeutic relationship as the vehicle for sustainable change (Bland, 2013; Bland & DeRobertis, 2018, 2019; Cain et al., 2016; Elkins, 2009, 2016; Hoffman et al., 2015), humanistic-existential psychologists emphasize that therapeutic relationships provide corrective experiences (Bland, 2014; Castonguay & Hill, 2012) that catalyze second-order (transformative) change processes (Bland, 2013, 2019; Murray, 2002; Schneider & Krug, 2017) and that are conducive to the formulation of new narratives, new learning, and neural plasticity (Cozolino, 2010). Applied to trauma, relational damage is understood as the core of traumatic experience (Norcross & Wampold, 2019), and effective trauma work entails providing clients, on an individualized basis, with a relationship that "sends a message of how the current world is and can be safer" (Kinsler, 2018, p. 44) and that enables clients to engage deeply with questions of meaning in their suffering, rather than provide quick short-term solutions (Cameron, 2019; Merriman-Khanna, 2018). The therapeutic relationship requires ongoing cultivation and maintenance of therapeutic presence (Bland, 2013; Schneider & Krug, 2017) as an alternative to, as described by Cameron (2019), therapists' fearfully employing standardized procedures as a defense against the inherent ambiguity, contradictions, and paradoxes in trauma work. These principles have been applied specifically to trauma by way of attachment-based models and methods for adults (Courtois, 2014; Kinsler, 2018; Soloman & Siegel, 2003), for children (Hughes, 2018), and for people with addiction (Maté, 2010), with medical problems (Maté, 2003; Harris, 2018), and with legal issues (Polizzi & Braswell, 2009) that tend to be attributable, directly or indirectly, to trauma.

Second, humanistic-existential theorizing is grounded in holistic and systemic conceptualization (Bland & DeRobertis, 2019) as an alternative to, as described by Joseph (2019), the linear, allopathic, and hedonistic assumptions of medicalized trauma treatment models built around symptom reduction. For example, Schneider (2008) proposed that nearly all clients' presenting issues could be traced to some form of unresolved trauma—which includes not only acute or chronic trauma directly experienced by clients but also implicit (i.e., intergenerational, inherited) trauma that impedes optimal functioning via one's inevitable involvement in toxic and stifling family (see also Firestone et al., 2013) and/or cultural (see also Schneider, 2013) dynamics. Thus, a primary task of therapy in general—but especially that focused on trauma—is to help clients assume and develop the role of a transitional character who serves to break vicious cycles of implicit trauma (Wolynn, 2016).

Third, spirituality and mindfulness have been part of the humanistic-existential movement (and especially its offshoot, transpersonal psychology) almost from the beginning (Bland & DeRobertis, 2019). Today, their influence can be found in (a) emerging literature on spiritual integration in psychotherapy (Jones, 2019), especially as applied to trauma work (Walker et al., 2015); and in (b) mindfulness-based approaches intended to enhance traumatized clients' capacities for metacognition and emotional regulation (Briere, 2019) and for self-compassion (Neff, 2011). Spiritually-integrated therapy encourages clients to sit with discomfort and to develop a greater sense of connectivity with their suffering in order to transcend it.

Fourth, humanistic-existential psychologists regard traumatic experiences not as past events to be reckoned with and overcome, but rather as opportunities for personal growth and cultivation of awe as they are encountered fully in the present (Schneider, 2004). Joseph (2019) stressed that the phenomenon of post-traumatic growth, which recently has gained increasing attention in the trauma literature, offers an alternative focus for trauma treatment beyond the conventional assumptions of illness ideology (i.e., working toward absence of observable symptoms) and of the necessity of change being motivated externally. Rather, change is assumed to come from within, and the role of the therapist is to cultivate conditions that promote inner change and that stimulate developmental movement in clients. Consistent with classic humanistic-existential theorizing (e.g., of Rogers, Horney, Maslow, Goldstein, and Erikson), post-traumatic growth refers to "increasing congruence between the self-structure and trauma-related experience" that is conducive to increased self-determination (Joseph, 2019, p. 14). As such, post-traumatic promotes greater self-knowledge and appreciation, self-integration and coherence, and increased senses of empathy and resilience (Merriman-Khanna, 2018). In this sense, resilience is understood not as an effort to bounce back to a time of better functioning, but rather as the ability to "struggle well" (Walsh, 2016, p. 5) by positively adapting "*despite* adversity" (Hostinar & Davis, 2019, p. 643, emphasis added) and actively pursuing a process of meaning-making in the face thereof (Frankl, 1988; May, 1967).

Despite this progress in conceptualization and implementation of these four areas in trauma work, additional underexplored humanistic-existential domains remain to be incorporated into conventional mainstream trauma treatment—in part, because they are sometimes dismissed as pseudo-scientific on the grounds that they have not been adequately researched. To counter this seemingly knee-jerk dismissal, in the early years of the new millennium, humanistic-existential psychologists (Criswell, 2003; DeRobertis, 2016; Fischer, 2003; Wong, 2017) have called for additional supporting research (versus philosophical argument alone) to prevent humanistic-existential contributions from becoming atrophied in an evidence-based zeitgeist. In turn, recent research has lent credence to the therapeutic value of, for example, expressive therapies for traumatized children (Klorer, 2017) and collective forms of healing (Saul, 2014; Walsh, 2016). The latter employ group techniques to enhance both community functioning *and* individuals' lives by stressing the interdependence of relationships *among* groups of people, not just *between* individuals. These forms of psychosocial healing come in response to a critique that trauma work tends to be limited to individual therapy which is based on "highly specialized, standardized, and culturally limited approaches [and] an overly narrow focus on types of recovery needs" (Olweean, 2019, p. 163).

Serlin et al.'s (2019) *Integrated Care for the Traumatized*

In *Integrated Care for the Traumatized: A Whole-Person Approach*, editors Ilene Serlin, Stanley Krippner, and Kirwan Rockefeller have compiled 11 papers by master therapists who have incorporated these underexplored humanistic-existential domains with current research in their therapeutic work with traumatized people. The book is comprised of four sections: (a) theoretical and methodological foundations, (b) whole-person models as employed in a group therapy context, (c) community-focused healing models, and (d) emerging directions in trauma work.

Following the Foreword, in which Figley (2019) applauds the book's focus on a "kind of care [that] is extremely adaptable" to clients' unique needs, experiences, and preferences (p. viii), theoretical and methodological foundations are laid out in Part 1. In Chapter 1, the editors outline the book's theoretical and philosophical focus on a whole-person approach that represents a paradigm shift away from an illness orientation and toward a growth-oriented, genuinely bio-psycho-social-spiritual model that is built on the assumption that "struggle with adversity may lead to the discovery of strengths and enhancement of life's meaning" as well as renewal of purpose (Serlin et al., 2019a, p. 1). With its emphasis on encouraging recovery, prevention, resilience, self-care, and growth, this whole-person approach (a) "incorporates intention, awareness, and mindfulness as the mediating variables between cognition and behavior"; (b) "includes the areas of meaning, beliefs, and existential choice" that are conducive to renewed will to live and to the active development of new narratives; and (c) "honors the spiritual dimension of life" (p. 1).

In Chapter 2, Rotter and Wertz (2019) critique the limitations of randomized-control trial research on trauma and resilience. The authors argue that, although symptom checklists and diagnostic criteria offer uniformity, they also run the risk of misdiagnosis and of "disempowering those [that helping professionals] seek to support" when isolated symptoms are approached out of their lived context (p. 13). Rotter and Wertz contend that by (a) "focusing on the abstract relationship between predictors and outcomes without addressing the fundamental psychological questions of why these relationships exist," and (b) operationalizing and measuring resilience "by what it is not—the absence of clinical trauma symptomatology" (pp. 12-13), the assumptions of conventional empiricism fail to account for the contextual, cultural, and psychological significance trauma symptoms hold for individuals. As an alternative, the authors propose the phenomenological method—with its focus on describing and understanding the experience of trauma, rather than on diagnosing and intervening—and they provide examples from military trauma to illustrate their points.

Six whole-person models as employed in a group therapy context are presented in Part 2. For each model, the authors provide (a) narrative case vignettes that illustrate both their relevance and adaptation in various settings and cultural contexts (including numerous international examples); (b) discussion about practical strategies and considerations for implementing the models in practice, as well as training and credentialing requirements; and (c) a summary of supporting research for both its theoretical underpinnings and its practice effectiveness.

In Chapter 3, Kalayjian and Diakonova-Curtis (2019) present the first author's seven-step Integrative Healing Model and its practical application in *Meaningfulworld's* Humanitarian Outreach Programs, which provide a framework for assessing, exploring, releasing, and eventually reintegrating traumatic experiences via the cultivation of meaning-making and forgiveness. Next, Kuriansky (2019) demonstrates the value of employing art activities for the purposes of projective assessment and of play, projective expression, contact comfort, and offering transitional objects in the interest of promoting children's resilience, empowerment, and connection to others—especially for those from cultural backgrounds in which conventional therapy is considered taboo (Chapter 4). Then the effectiveness of dance movement therapy is covered in Chapter 5 (Güney & Lundmark, 2019). Specifically, dance is explored as a tool for psychosocial support for refugee populations who have experienced displacement and are seeking asylum and who exhibit decreased self-esteem, physical detachment and psychosomatic symptoms, as well as difficulty appropriately using language to express and manage their emotions.

Engelman (2019) focuses on animal-assisted interventions that utilize the transpersonal, psychophysiological, and post-traumatic growth dimensions of the human-animal bond to heal emotional and interpersonal withdrawal that results from trauma (Chapter 6). In Chapter 7, Israel (2019) describes Toscani and Hudgins' Therapeutic Spiral Model, a clinically-modified psychodramatic approach that promotes spontaneity and creativity, with the intent of expanding traumatized individuals' windows of tolerance, developing self-compassion and emotional regulation, and overcoming dysfunctional social roles that re-enact traumatic interpersonal dynamics and assuming more transformative ones. Zimbardo et al.'s (2012) Time Perspective Therapy is summarized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals' biases toward negative past experiences and fatalism with recollections of positive memories that occurred around the time of a traumatic event as well as working with them in the present, in the interests of creating a more affirming future and of spurring recognition of the choices they have in how they approach their experiences.

Three papers on community-focused healing both in and outside the U.S. comprise Part 3 (again, replete with case examples and discussions about practical applications and research considerations). The editors emphasize that their decision to include these papers is a deliberate response to a critique of American psychologists' excessive focus on individuals at the expense of the impact of trauma on communities (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Terror and War (NATAL) Professional Team (2019) reflect on the organization's efforts to serve as a multidisciplinary therapeutic home for trauma casualties related to the Israeli-Arab conflict. Then Eshowsky (2019) explores the wisdom of indigenous healing restorative circles as applied to addressing and transforming suppressed and/or unrecognized trauma-based emotions that underlie youth and gang violence (Chapter 10). Further, the core principles of the Catastrophic Trauma Recovery Model and the Social Health Care training and treatment program are delineated in Chapter 11. Olweean (2019) demonstrates how these models serve to break cycles of transgenerational trauma that fuel polarization, war, and violence both within and between communities.

Finally, emerging directions in trauma work are addressed in Part 4. Chapter 12 offers an alternative to the almost exclusive focus in the literature on the negative outcomes of caregiving and on helpers' own symptom relief and stress management (Serlin et al., 2019a; see also Kang & Yang, 2019; Merriman-Khanna, 2018). Pardess (2019) presents a strengths-based model that employs mindfulness training and creative modalities to not only prevent burnout and compassion fatigue, but also to promote caregiver satisfaction, regeneration, and renewed sense of purpose via vicarious post-traumatic growth. In the closing Chapter 13, Serlin et al. (2019b) emphasize that their volume is far from comprehensive, but rather provides a gateway to dialogue about "different aspects of a whole-person approach" that "make a unique contribution to the growing field of traumatology" (p. 203). After identifying and reflecting on the specific contributions of each chapter, they acknowledge that the magnitude of the whole-person approach can be daunting for some. On the other hand, the editors conclude that their intention was to spur awareness of "the complexity of trauma," to cut through simplistic solutions and complacency, to promote humility, and to stimulate networking in the interest of "sharing of compassion, empathy, and hope" as an antidote to a fractured world (p. 205).

Evaluation

By promoting humility in the face of the complexity of trauma, *Integrated Care for the Traumatized* appropriately challenges contemporary therapists to move outside of their comfort zones. The approaches outlined within this book can help therapists think about the possibility of evidence-based approaches that serve the greater goal of enhancing clients' optimal functioning as described by humanistic-existential psychologists (Bland & DeRobertis, 2019) more than merely reducing clients' symptoms. In addition, these approaches may stimulate therapists to consider extending their roles as healing presences into the community beyond the trappings of conventional office settings. In particular, the chapters on collective healing of trauma serve to disrupt fixed individualistic assumptions that characterize most therapy in the U.S. but that also can be perceived as threatening to people from/in a different cultural context (Robbins et al., 2019; Serlin et al., 2019a). Accordingly, this book has the potential to offer an indirect form of cross-cultural encounter (Adler, 1975; Montuori & Fahim, 2004) that promotes new learning conducive, in this case, to enhancing therapists' abilities to handle complexity and ambiguous circumstances (DeRobertis, 2017; O'Hara, 2018) that often characterize trauma work.

Moreover, this certainly is not the first time that arts- and narrative-centered approaches to trauma work have been introduced in the literature. Indeed, for several decades, volumes by Capacchione (1980) and McNiff (1991) have spelled out means of systematically employing expressive modalities to promote healing of trauma. However, arguably because of their incompatibility with experimental methods that support medicalized treatments focused principally on symptom reduction (Joseph, 2019), until recently these therapeutic approaches have enjoyed only fringe support from the mainstream psychotherapy community. Serlin et al.'s book thus arrives at a timely moment.

Concurrently during the last decade, qualitative inquiry and single-subject design—both of which reflect the idiographic focus advocated by founding humanistic psychologists (Bühler & Allen, 1972; Maslow, 1966)—have received increased legitimization and/or refinement in psychology, as evidenced by their inclusion for the first time in the recently-published 7th edition of the APA *Publication Manual* (American Psychological Association, 2020). By way of this methodological progress, Serlin et al.'s book also serves to legitimize and demonstrate the effectiveness of narrative, expressive, and collective approaches to healing trauma by supporting their theoretical underpinnings with findings from both narrative case study and single-subject quantitative research.

In addition to therapeutic and methodological contributions, *Integrated Care for the Traumatized* also provides support for the practical application of numerous long-standing theoretical contributions of humanistic-existential psychologists that tend to be overlooked—or worse, dismissed—due to their problematic conflation with the worst of the "counterculture" associated with the 1960s-70s (Bland & DeRobertis, 2017, 2018, 2019). To validate these principles, the authors of the chapters of this book have integrated research findings from contemporary neuroscience as well as parallel constructs found in emerging literature on resilience (Southwick & Charney, 2018; Walsh, 2016) and on protective factors that promote it. These include access to secure attachment relationships, to other relevant social networks, and to quality community resources, as well as capacities for emotional regulation, executive functioning, self-efficacy, and meaning-making and the social conditions that foster them (Masten, 2014; see also Bland & DeRobertis, 2017). Doing so serves to continue overturning humanistic-existential psychology's reputation as a historical relic by demonstrating its contemporary and measurable relevance (Bland & DeRobertis, 2018; DeRobertis, 2013, 2016).

The authors of the chapters in *Integrated Care for the Traumatized* also present a solid case that sustainable trauma work involves much more than conventional talk therapy. This is especially pertinent during an era in which, as Muller (2018) argued, orientation to process is increasingly endangered in a cultural climate characterized by misuse of short-term outcomes measurement. At the same time, the authors also make clear that expressive therapies involve much more than a kind of action therapy that, without adequate debriefing with and follow-up from an empathetically-attuned therapist, can serve to reinforce experiential avoidance (May, 1972).

As a book seemingly intended to provide introductory exposure to these therapeutic modalities, it lives out its aim admirably. Each chapter is appropriately concise and accessible in its presentation of both technique and empirical support. Although at times some of the summaries and descriptions could have offered even more detail to embellish the authors' points, each chapter also provides plenty of current references and other resources for follow-up exploration and evaluation. As such, the book serves well as a one-stop introduction to almost a dozen underacknowledged perspectives and under-researched methods for healing relational trauma and their practical applications in the current era and in variety of settings worldwide.

Conclusion

While perhaps not a stand-alone volume on trauma work, with its grounding in the humanistic-existential tradition, *Integrated Care for the Traumatized* fills, in Maslow's words, a "huge, big, gaping hole" in trauma psychology (Zweig & Bennis, 1968, 17:55). It serves as an excellent introductory resource for both students and seasoned professionals to supplement existing texts on relational, mindfulness-based, and mind-body healing of trauma at the individual level by surveying group approaches that involve narrative, expressive, and indigenous collective healing methods. As such, it fits neatly on a shelf alongside Kinsler's (2018) *Complex Psychological Trauma: The Centrality of Relationship* and Levine's (1997) *Waking the Tiger: Healing Trauma*. My hope is that, by virtue of their reach, these currently "alternative" modalities will eventually find their way further into the mainstream in the same way that attachment, resilience, qualitative inquiry, and single-subject design—all once radical ideas proposed by founding humanistic psychologists (Bland & DeRobertis, 2017, 2019; Bühler & Allen, 1972)—have been embraced and incorporated into traumatology in the last decade. Accordingly, volumes like *Integrated Care for the Traumatized* may contribute to the continuing maturation of trauma work in a more humanized direction, paving the way for organic healing methods that offer the possibility of sustainable change and growth at both the individual and collective levels.

References

Adler, P. (1975). The transitional experience: An alternative view of culture shock. *Journal of Humanistic Psychology, 15*(4), 13-23. https://doi.org/10.1177/002216787501500403

Alliance for the Inclusive Integration of Science and Practice in Psychology. (n.d.). *Protect PTSD treatments that work!* Retrieved November 30, 2019, from https://www.thepetitionsite.com/480/492/776/protect-ptsd-treatments-that-work/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

American Psychological Association. (2020). *Publication manual of the American Psychological Association* (7th ed.). https://doi.org/10.1037/0000165-000

American Psychological Association, Guideline Development Panel for the Treatment of PTSD in Adults. (2019). Summary of the clinical practice guideline for the treatment of Posttraumatic Stress Disorder (PTSD) in adults. *American Psychologist, 74*(5), 596-607. https://doi.org/10.1037/amp0000473

Angus, L., Watson, J. C., Elliott, R., Schneider, K., & Timulak, L. (2015). Humanistic psychotherapy research 1990–2015: From methodological innovation to evidence-supported treatment outcomes and beyond. *Psychotherapy Research, 25*(3), 330-347. https://doi.org/10.1080/10503307.2014.989290

Bland, A. M. (2013). A vision of holistic counseling: Applying humanistic-existential principles in the therapeutic relationship. *Journal of Holistic Psychology, 2*, 277-282.

Bland, A. M. (2014). Corrective experiences in corrections counseling. *Journal of Theoretical and Philosophical Criminology*, *6*(1), 46-74. https://www.jtpcrim.org/Jan-2014/Article-2-Andrew-Bland.pdf

Bland, A. M. (2019). The Personal Hero Technique: A therapeutic strategy that promotes self-transformation and interdependence. *Journal of Humanistic Psychology, 59*(4), 634-657. https://doi.org/10.1177/0022167818763207

Bland, A. M., & DeRobertis, E. M. (2017). Maslow's unacknowledged contributions to developmental psychology. *Journal of Humanistic Psychology*. Advance online publication. https://doi.org/10.1177/0022167817739732

Bland, A. M., & DeRobertis, E. M. (2018). Humanistic psychology. In D. S. Dunn (Ed.), *Oxford bibliographies in psychology*. Oxford University Press. https://doi.org/10.1093/obo/9780199828340-0225

Bland, A. M., & DeRobertis, E. M. (2019). The humanistic perspective. In V. Zeigler-Hill & T. K. Shackelford (Eds.), *Encyclopedia of personality and individual differences*. Springer. Advance online publication. https://doi.org/10.1007/978-3-319-28099-8_1484-2

Briere, J. (2019, September 28). *Reconsidering trauma: Treatment advances, relational issues, and mindfulness* [Keynote address]. East Meets West in Psychotherapy Conference, Philadelphia, PA, United States.

Bühler, C. M., & Allen, M. (1972). *Introduction to humanistic psychology*. Brooks/Cole.

Cain, D. J., Keenan, K., & Rubin, S. (Eds.). (2016). *Humanistic psychotherapies: Handbook of research and practice* (2nd ed.). American Psychological Association.

Cameron, A. (2019). Trauma-focused presence. *Journal of Humanistic Psychology*. Advance online publication. https://doi.org/10.1177/0022167819880653

Capacchione, L. (1980). *The creative journal: The art of finding yourself*. Swallow.

Castonguay, L. G., & Hill, C. E. (Eds.). (2012). *Transformation in psychotherapy: Corrective experiences across cognitive-behavioral, humanistic, and psychodynamic approaches*. American Psychological Association.

Courtois, C. A. (2014). *It's not you, it's what happened to you: Complex trauma and treatment*. Telemachus.

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). Norton.

Criswell, E. (2003). A challenge to humanistic psychology in the 21st century. *Journal of Humanistic Psychology, 43*(3), 42-52. http://doi.org/10.1177/0022167803043003004

Dauphin, V. B. (2019). A critique of the American Psychological Association Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. *Psychoanalytic Psychology*. Advance online publication. https://doi.org/10.1037/pap0000253

DeRobertis, E. M. (2013). Humanistic psychology: Alive in the 21st century? *Journal of Humanistic Psychology, 53*(4), 419-437. https://doi.org/10.1177/0022167812473369

DeRobertis, E. M. (2016). On framing the future of humanistic psychology. *The Humanistic Psychologist, 44*(1), 18-41. https://doi.org/10.1037/hum0000014

DeRobertis, E. M. (2017). *The phenomenology of learning and becoming: Enthusiasm, creativity, and self-development*. Palgrave Macmillan.

Elkins, D. N. (2009). *Humanistic psychology: A clinical manifesto*. University of the Rockies Press.

Elkins, D. N. (2016). *The human elements of psychotherapy: A nonmedical model of emotional healing*. American Psychological Association.

Engelman, S. R. (2019). Animal-assisted interventions with those who are traumatized. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 73-89). Rowman & Littlefield.

Eshowsky, M. (2019). Indigenous healing psychotherapy and healing circles. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 147-160). Rowman & Littlefield.

Figley, C. (2019). Foreword. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. vii-ix). Rowman & Littlefield.

Firestone, R. W., Firestone, L., & Catlett, J. (2013). *The self under siege: A therapeutic model for differentiation*. Routledge.

Fischer, C. T. (2003). Infusing humanistic perspectives into psychology. *Journal of Humanistic Psychology, 43*(3), 93-105. https://doi.org/10.1177/0022167803043003008

Frankl, V. E. (1988). *The will to meaning: Foundations and applications of logotherapy* (expanded ed.). Meridian.

Güney, S. S., & Lundmark, D. S. (2019). Dance movement therapy for social change. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 59-71). Rowman & Littlefield.

Harris, N. B. (2018). *The deepest well: Healing the long-term effects of childhood adversity*. Houghton Mifflin.

Hoffman, L., Vallejos, L., Cleare-Hoffman, H. P., & Rubin, S. (2015). Emotion, relationship, and meaning as core existential practice: Evidence-based foundations. *Journal of Contemporary Psychotherapy*, *45*(1), 11-20. https://doi.org/10.1007/s10879-014-9277-9

Hostinar, C. E., & Miller, G. E. (2019). Protective factors for youth confronting economic hardship: Current challenges and future avenues in resilience research. *American Psychologist, 74*(6), 641-652. https://doi.org/10.1037/amp0000520

Hughes, D. A. (2018). *Building the bonds of attachment: Awakening love in deeply traumatized children* (3rd ed.). Rowman & Littlefield.

Israel, S. (2019). The Therapeutic Spiral Model: A psychodramatic whole-person approach for working with trauma. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 91-107). Rowman & Littlefield.

Jones, R. S. (2019). *Spirit in session: Working with your client's spirituality (and your own) in psychotherapy*. Templeton.

Joseph, S. (2019). Posttraumatic growth as a process and an outcome: Vexing problems and paradoxes seen from the perspective of humanistic psychology. *The Humanistic Psychologist*. Advance online publication. https://doi.org/10.1037/hum0000156

Kalayjian, A., & Diakonova-Curtis, D. (2019). The seven-step Integrative Healing Model. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 29-37). Rowman & Littlefield.

Kang, J. H., & Yang, S. (2019). A therapist's vicarious posttraumatic growth and transformation of self. *Journal of Humanistic Psychology*. Advance online publication. https://doi.org/10.1177%2F0022167819889490

Kinsler, P. J. (2018). *Complex psychological trauma: The centrality of relationship*. Routledge.

Klorer, P. G. (2017). *Expressive therapy with traumatized children* (2nd ed.). Rowman & Littlefield.

Krug, O. T. (2019). Existential-humanistic and existential-integrative therapy: Method and practice. In E. van Duerzen, E. Craig, A. Längle, K. J. Schneider, D. Tantam, & S. du Plock (Eds.), *The Wiley world handbook of existential therapy* (pp. 257-266). Wiley.

Kuriansky, J. (2019). Expressing art for helping children heal in crisis and disaster. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 39-58). Rowman & Littlefield.

Levine, P. A. (1997). *Waking the tiger: Healing trauma*. North Atlantic.

Levine, P. A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. North Atlantic.

Maslow, A. H. (1966). *The psychology of science: A reconnaissance*. Gateway.

Masten, A. S. (2014). *Ordinary magic: Resilience in development*. Guilford.

Maté, G. (2003). *When the body says no: Exploring the stress-disease connection*. Wiley.

Maté, G. (2010). *In the realm of hungry ghosts: Close encounters with addiction*. North Atlantic.

May, R. (1967). *Psychology and the human dilemma*. Von Nostrand.

May, R. (1972). *Power and innocence: A search for the sources of violence*. Norton.

McNiff, S. (1992). *Art as medicine: Creating a therapy of the imagination*. Shambhala.

Merriman-Khanna, O. (2018). Humanistic psychology, trauma studies, and post-traumatic growth. In R. House, D. Kalisch, and J. Maidman (Eds.), *Humanistic psychology: Current trends and future prospects* (pp. 186-195). Routledge.

Montuori, A., & Fahim, U. (2004). Cross-cultural encounter as an opportunity for personal growth. *Journal of Humanistic Psychology, 44*(2), 243-265. https://doi.org/10.1177/0022167804263414

Mølbak, R. L. (2012). Cultivating the therapeutic moment: From planning to receptivity in therapeutic practice. *Journal of Humanistic Psychology, 53*(4), 461-488. http://dx.doi.org/10.1177/0022167812461305

Murray, R. (2002). The phenomenon of psychotherapeutic change: Second-order change in one's experience of self. *Journal of Contemporary Psychotherapy, 32*(2/3), 167-177.

Neff, K. (2011). *Self-compassion*. New York, NY: Morrow.

Norcross, J. C., & Wampold, B. E. (2019). Relationships and responsiveness in the psychological treatment of trauma: The tragedy of the APA clinical practice guideline. *Psychotherapy, 56*(3), 391-399. https://doi.org/10.1037/pst0000228

O'Hara, M. (2018). Humanistic cultural praxis for an emerging world. In R. House, D. Kalisch, & J. Maidman (Eds.), *Humanistic psychology: Current trends and future prospects*. Routledge.

Olweean, S. S. (2019). Whole-person approaches in individual and communal healing of trauma. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 161-185). Rowman & Littlefield.

Polizzi, D., & Braswell, M. (Eds.). (2009). *Transforming corrections: Humanistic approaches to corrections and offender treatment*. Carolina Academic Press.

Robbins, B. D., Kinderman, P., Karter, J. M., Jackson, T., & Farley, F. (2019, August 8-11). *Diagnosing diagnosis roundtable on the status and future of diagnostic reform* [Conference session]. American Psychological Association 2019 Convention, Chicago, IL, United States.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin.

Pardess, E. (2019). Promoting caregiver satisfaction and regeneration. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 189-202). Rowman & Littlefield.

Recanti, J. Y., & the NATAL Professional Team. (2019). Israel Trauma and Resiliency Center– NATAL: Twenty years of coping with invisible wounds. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 129-146). Rowman & Littlefield.

Rotter, B., & Wertz, F. J. (2019). Methodological diversity in the study of trauma treatments. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 11-25). Rowman & Littlefield.

Saul, J. (2014). *Collective trauma, collective healing: Promoting community resilience in the aftermath of disaster*. Routledge.

Schneider, K. J. (2004). *Rediscovery of awe: Splendor, mystery, and the fluid center of life*. Paragon House.

Schneider, K. J. (Ed.) (2008). *Existential-integrative psychotherapy: Guideposts to the core of practice*. Routledge.

Schneider, K. J. (2013). *The polarized mind: Why it's killing us and what we can do about it*. University Professors Press.

Schneider, K. J., & Krug, O. T. (2017). *Existential-humanistic therapy* (2nd ed.). American Psychological Association.

Serlin, I., Krippner, S., & Rockefeller, K. (2019a). The whole-person approach to integrated health care. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 1-10). Rowman & Littlefield.

Serlin, I., Krippner, S., & Rockefeller, K. (2019b). Integrative health care of the whole person: Conclusion and recommendations. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 203-205). Rowman & Littlefield.

Soloman, M. F., & Siegel, D. J. (Eds.). (2003). *Healing trauma: Attachment, mind, body, and brain*. Norton.

Southwick, S. M., & Charney, D. S. (2018). *Resilience: The science of mastering life's greatest challenges* (2nd ed.). Cambridge University Press.

Sword, R. (2019). Time-focused psychotherapy: Time perspective therapy. In I. A. Serlin, S. Krippner, & K. Rockefeller (Eds.), *Integrated care for the traumatized: A whole-person approach* (pp. 109-125). Rowman & Littlefield.

Walker, D. F., Courtois, C. A., & Aten, J. D. (Eds.). (2019). *Spiritually oriented psychotherapy for trauma*. American Psychological Association.

Walsh, F. (2016). *Strengthening family resilience* (3rd ed.). Guilford.

Wolynn, M. (2016). *It didn't start with you: How inherited family trauma shapes who we are and how to end the cycle*. Penguin.

Wong, P. T. P. (2017). Meaning-centered approach to research and therapy, second wave positive psychology, and the future of humanistic psychology. *The Humanistic Psychologist, 45*(3), 207-216. https://doi.org/10.1037/hum0000062

Zimbardo, P., Sword, R., & Sword, R. (2012). *The time cure: Overcoming PTSD with the new psychology of Time Perspective Therapy*. Jossey-Bass.

Zweig, L., & Bennis, W. (Producers). (1968). *Being Abraham Maslow* [film]. https://www.youtube.com/watch?v=s-fmo04EZP3o

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Concerns about the "Professional Relationship"

David Shapiro

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Central to all malpractice litigation is the concept of the professional relationship. If there is no professional relationship between the plaintiff and defendant, there cannot be any lawsuit. There are, of course, exceptions: if the plaintiff is a child or someone who is mentally disabled, the parents or guardian may have the authority to file the suit; if the patient has died, under many circumstances, the executor of the estate may sue. In cases involving harm to a third party, the victim or the victim's family can sue provided that they can demonstrate that the therapist could control the behavior of the patient. (While this sounds highly unusual, many courts have accepted this as a premise in duty to warn cases, though recently some courts have been questioning the assumption.) Despite these exceptions, it is often only the identified patient who can file suit.

What then determines who is a patient, and when does that relationship begin. As frequently as the concept of professional relationship is invoked, what actually is the definition [[definition of what??]] and when does it begin? This is not as simple as it sounds. When asked this question, some [[who? Psychologists? Lawyers?]]would say that it begin whenthere is a financial relationship. This, of course, does not cover situations in which pro bono services are rendered. Most people would not adhere to an idea that in pro bono counseling, there is no professional relationship. Some would argue that it is when a treatment plan is established. As often as this concept is utilized, it [[what is IT?]] in fact is not well defined.

Perhaps one of the earliest discussions came in the case of Oregon v. Miller (1984). This case is not binding in any other state, but it is instructive and may be reviewed for guidance. In Miller, the concept of professional relationship was conceptualized as a mutual agreement between patient and therapist that future professional contact would occur after the initial contact. What happened?

In the case of Ramona v. Isabella(1997), a young woman (not a child) was in treatment with a psychiatrist and gave her sodium amytal. She started to speak about sexual abuse by her father when she was much younger. The father was invited to a therapy session so his daughter could confront him. When the father was confronted, he denied the allegations and filed suit against the therapist for implanting "false memories." The intriguing legal issue in this case was whether the father had any legal standing to sue, since it was his daughter, not he, who had the professional relationship. Eventually, after several hearings, the court of appeals ruled that the father did, in fact, have a professional relationship and did have legal standing to sue[[based on what?]]. Still, it gives us pause when we consider the arguments that could be made pro and con in such a situation. [[For example, pro …. And con…..]] In fact, recognizing that this can be very complex, the [[need full citation here]]Ethical Principles of Psychologists and Code of Conduct (2003, 2010, 2016), Standard 10.02, we are urged to make very clear , when more than one party is involved, who is the identified patient or client, who is in another role (such as a collateral) and what issues regarding confidentiality and privilege are involved in the various relations.

More recently, an intriguing issue was litigated in the state of Indiana (2003). In Thayer v, Orrico, a woman who worked at a mental health facility and was in treatment with one staff member there, began an intimate relationship with another staff member who was not her therapist. During the course of their personal relationship, she shared with her paramour many details about her life, including the medications she was taking, and the fact that she had difficulty coping with her son who had an attention deficit disorder. Her paramour, being also a psychologist, suggested she try other herbal medicines rather than the ones she was taking, and also gave her advice about how to deal with her son. After a period of time, the romantic?relationship ended. Sshe then attempted to sue this man for malpractice. His defense was that she had no legal standing to do so because he did not have a professional relationship with her. The trial court granted his motion for a summary judgment [[explain summary judgment]](dismissing the case), but the woman appealed. The court of appeals responded in a very striking manner. It said that the issue of whether or not there was a professional relationship was a "matter of material fact" [[explain material fact] and that it had to be submitted to the jury for a determination of whether it was or was not professional. The court of appeals basically stated that one of the factors that needed to be considered was the plaintiff's subjective perception of whether or not there was a professional relationship. In other words, would it be "reasonable" under the law to conclude, based on the advice given, that there was a professional relationship, even though the psychologist never scheduled appointments with her, and never collected a fee?

We can see, therefore, that there are many complexities involved in defining a professional relationship. We need to take into account, through documentation in our records who is (are) the identified patient(s), what obligations go with each determination, and what the perception is of the individual of the nature of the relationship. . We also need to be very clear, when friends and family approach us for advice that we make it clear that we are not entering into a professional relationship with them.

References

Ethical Principles of Psychologists and Code of Conduct(2016) Washington,D.C.: APA

Oregon v. Miller 709 P.2d,225(1984)

Ramona v.Ramona Court of Appeals, Second District, Division 1, California No. B111565 (1997)

Thayer v. Orrico , 792 N.E. 2d. 919 (2003)

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