How Do I Embrace Cultural Humility?
— Mona A. Robbins, Laura S. Howe-Martin and Tori K. Knox-Rice

The Body Mass Index: Our Shaky Foundation
— Krystal Stanley

— Reviewed by Andrew M. Bland
Independent Practitioner

Editor: Eileen A. Kohutis, PhD (2019-2021)
2 W. Northfield Road
Suite 200
Livingston, NJ 07039
(973) 716-0174
e-mail: eileen@drkohutis.com

Associate Editor: Theresa M. Schultz, PhD (2019-2021)
630-323-3050 x42
email: doctmschultz@gmail.com

Bulletin Staff
Patrick DeLeon, PhD, JD, Opinions and Policy Contributing Editor
David Shapiro, PhD, Forensic Editor and Liability, Malpractice, and Risk Management Contributor
Rick Weiss, Layout Design Editor

Division 42 Central Office
Jeannie Beaff
919 W Marshall Ave.
Phoenix, AZ 85013
602-284-6219
Fax: 602-626-7914
Email: div42apa@cox.net

602-284-6219

630-323-3050 x42

About the Independent Practitioner
Submission deadlines: February 10 for Spring issue
May 10 for Summer issue
July 20 for Fall issue
November 15 for Winter issue

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.

Copyright:
Except for announcements and event schedules, material in the independent Practitioner is copyrighted and can only be reprinted with the permission of the Editor.

Table of Contents

From the President

President’s Column — Judith Patterson

Focus on Diversity


The Body Mass Index: Our Shaky Foundation — Krystal Stanley

Opinions and Policy

“We Will Rock You” — Pat DeLeon

Book Review

Integrated Care for the Traumatized: A Whole Person Approach by I. A. Serlin, S. Krippner, & K. Rockefeller, Eds. — Review by Andrew M. Bland

Liability, Malpractice, and Risk Management

Concerns about the “Professional Relationship” — David Shapiro

Advertising Rates

Back Cover (7.5” x 5”) $750.00
Inside Back Cover (7.5” x 10”) $750.00
Full Page (7.5” x 10”) $500.00
One Half Page (7.5” x 5”) $300.00
One Quarter Page (3.5” x 5”) $200.00

10% Frequency Discount
Classified Advertising $5 per line, $25.00 minimum
Subscription Rates for Non-members $42.00 annually
Subscription Rates for Students $10.00 annually
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 structure and functions of the division in an

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 Mollitor has agreed to act as chair of the task force, that Dr. Jana Martin has agreed to act as process consultant and that twelve of the task force, that Dr. Nancy Molitor has agreed to act as chair.

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.

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-di- visional 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 services 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
Focus on Diversity

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 first 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 understanding how each individual’s background is shaped by 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, Brokeridge & 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; Tangleyn, 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’ ADRESSING 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...
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 process or in instances, open-ended questions on intake documents may help in conveying awareness that cultural identity is best when not reduced to a dichotomous check-box. 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 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, 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 others’ viewpoints, 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 supervision 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 times 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 defensive. 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). It may be beneficial for independent practitioners to 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**


**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 preventive 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/psycho-education 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 exercise behavior) with individuals’ 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.”

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 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 moves where 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 (Faroqio & 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 unhealthy 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, researchers have found 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 55 Black, White, and Hispanic women, the average weight of 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 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/.
Opinions and Policy

“Will We 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 24, 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 supportive 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 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 Tezam Psychology in APA 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 profile in the interest of bringing 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 winning the Series 4-3 over the talented Houston Astros. With the success of the APF Soiree and the Nation’s 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...
I felt fortunate to be able to call out his amazing
earned his title ‘Psychology’s Provocateur.’ He
faded away” (Nick Cummings).

I then rightly devoted my loyalty
suaded to run and that year was overwhelm-
again and lost for the fifth time. I had been per
a one-year delay as it had been his ambition to
its elected President Gordon Derner asked for
the APPA was about to become a reality when
U.S. Department of Education in Washington,
chology Association and got it approved by the
many clinical and counseling psychology pro-
ly 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 pro-
gress created the American Professional Psy-
chology 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 per-
suaded to run and that year was overwhelm-
ingly 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 memo-
ries that were communicated to me by Nick, his family, his professional friends and his profes-
sional foes, as well as historical archives. Nick’s life is a personal odyssey that reflects the his-
tory 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 tradition-
alis. 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 Intermit-
tuent 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, clini-
cal practice, research, and practice setting. It fits the needs of modern psychotherapy. This model will survive and thrive if psychotherapy 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

Integrated Care for the Traumatized:
A Whole Person Approach

by I. A. Serlin, S. Krippner, & K. Rockefeller, Eds.

Review by Andrew M. Bland

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 PTSD (“Injury”) having been proposed as a more fitting term that is less pathol-
ogizing 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 Asso-
ciation’s (APA) recommendations for PTSD treatment, as articulated in its Clinical Prac-
tice Guideline (APA Guideline Development Panel, 2019), have been critiqued by Dauphin (2019) and by Norcross and Wampo-
id (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-per-
son, 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 peti-
tioned 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

Book Review

Integrated Care for the Traumatized:
A Whole Person Approach

by I. A. Serlin, S. Krippner, & K. Rockefeller, Eds.

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)
trauma treatment models, approaches to trauma work that are grounded in and/or consistent with the humanistic-existential tradition in psychology have recently received increased attention. 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 & DeRoberts, 2018, 2019; Cain et al., 2016; Elkins, 2009, 2016; Hoffman et al., 2013), 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 (Foyez, 2010). Applied to trauma, relational damage is understood as the core of traumatic experience (Norcross & Krug, 2017) and that are conducive to the development of new narratives, new learning, and neural plasticity (Foyez, 2010). The therapeutic relationship as the vehicle for sustainable change (Bland & DeRoberts, 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 transcendent 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 refers to “increased self-determination (Joseph, 2019, p. 14). As such, post-traumatic growth promotes self-knowledge and appreciation, self-integration and coherence, and increased senses of empathy and resilience (Merrimann-Khanna, 2018). In other words, “The task of therapy is understood as an effort to bounce back to a time of better functioning, rather than as the ability to ‘feel good again’” (Walsh, 2016, p. 5) by positively adapting “despite adversity” (Hostinar & Davis, 2019, p. 645, 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—indeed, 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; DeRoberts, 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 fearful 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 & Brasewell, 2009) that tend to be attributable, directly or indirectly, to trauma.
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 do exist, they also run the risk of misdiagnosis and of “disen- powering 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 relationships 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 alterna- tive, the authors propose the phenomenologi- cal 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) narra- tive case vignettes that illustrate both their rele- vance and adaptation in various settings and cultural contexts (including numerous interna- tional 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 In- tegrative Healing Model and its practical appli- cation in Meaningfulworld’s Humanitarian Out- reach Programs, which provide a framework for assessing, exploring, releasing, and eventually reintegrating traumatic experiences via the cultivation of meaning-making and forgive- ness. Next, Kuriansky (2019) demonstrates the value of employing art activities for the purposes of projective assessment and of play, projec- tive expression, contact comfort, and offering transitional objects in the interest of promoting children’s resilience, empowerment, and con- nection 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 (Günay & Lundmark, 2019). Specifically, dance is explored as a tool for psychosocial support for refugee popula- tions who have experienced atrocities and are seeking asylum and who exhibit decreased self-esteem, physical detachment and psycho- somatic symptoms, as well as difficulty appro- priately 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 withdraw- al that results from trauma (Chapter 6). In Chapter 7, O’Hara (2019b) presents a strengths-based model that employs mindfulness training and creative expression, contact comfort, and offering constructive, empathetic responses to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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 discus- sions about ethical applications and research considerations). The editors emphasize that their decision to include these papers is a delib- erate response to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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 discus- sions about ethical applications and research considerations). The editors emphasize that their decision to include these papers is a delib- erate response to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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 discus- sions about ethical applications and research considerations). The editors emphasize that their decision to include these papers is a delib- erate response to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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 discus- sions about ethical applications and research considerations). The editors emphasize that their decision to include these papers is a delib- erate response to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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 discus- sions about ethical applications and research considerations). The editors emphasize that their decision to include these papers is a delib- erate response to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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 discus- sions about ethical applications and research considerations). The editors emphasize that their decision to include these papers is a delib- erate response to a critique of American psy- chologists’ excessive focus on individuals at the expense of the impact of trauma on communi- ties (Serlin et al., 2019a). In Chapter 9, Recanati and the Israel Trauma Center for Victims of Ter- ror 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 approaches that are applied as described by Zimbardo et al.’s (2018) Time Perspective Therapy is summa- rized in Chapter 8 (Sword, 2019). This model emphasizes replacing traumatized individuals’ biases toward negative past experiences and fatalism with recollections of positive mem- ories that occurred around the time of a trau- matic 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.
Concurrently during the last decade, qualitative inquiry and single-subject design—both of which reflect the idiographic focus advocated by founding humanistic psychologists (Bùhler & DeRobertis, 1972)—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 critique, the 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 (Bùld & DeRobertis, 2017, 2019). To validate these principles, the authors of the chapters in 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 Bùld & DeRobertis, 2017). Doing so serves to continue overturning humanistic-existential psychology’s reputation as a historical relic by demon-strating its contemporary and measurable relevance (Bùld & 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 introduction 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 reading. As a whole, 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 psychotherapy research (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 body-mind 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 attachment that, by virtue of their reach, qualitative inquiry, and single-subject design—always radical ideas proposed by founding humanistic psychologists (Bùld & DeRobertis, 2017, 2019; Bùhlér & 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 number of directions, paving the way for organic healing methods that offer the possibility of sustainable change and growth at both the individual and collective levels.

References


Curtis, C. A. (2014). We don’t have what it’s happened to you: Complex trauma and treatment. Telemacus.


Concerns about the “Professional Relationship”

David Shapiro

Reprinted from the??? issue of the Independent Practitioner

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 when there 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 amyotal. 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. When 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. She 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

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

Good Books!

Read any good books, lately? Was it engaging? Or old wine in a new bottle? Was the book about a new technique? Ground-breaking? A big yawn? We, at the IP, would love to know what you thought about it. Why not write a book review?

For more information, contact Eileen A. Kohutis at eileen@drkohutis.com.
New Member Resource Area on Division website

Do you have a favorite Form, or practice Template that you would like to share with your colleagues. How about an online resource that you frequently utilize?

You are invited to contribute forms, templates and other documents to share with colleagues, and to download documents that others have contributed.

You are also invited to submit annotated links of books, movies, TV series and other media that you have found helpful in your work, or that you have enjoyed in your leisure time.

If you would like to share a resource or take advantage of what others have shared, log in to the Division website and go to the Member Resource page under the Resources tab.

Disclaimer: The resources and links below are provided by individual members of Division 42. They are not produced or endorsed by Division 42 or by APA. To ensure compliance with the laws and ethics in your jurisdiction, you are advised to consult with your own attorney and/or insurance risk manager prior to adopting them for your practice.