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Factors that can ***Affect the Effectiveness***

WHAT'S INSIDE

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contents

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PAGE 3

PAGE 6

PAGE 14

REGULAR FEATURES

FEATURES THIS ISSUE

ALSO INSIDE

PSYCHOLOGISTS RESPOND to Proposed CMS Rule That Would REDUCE MEDICARE RATES FOR PSYCHOLOGISTS BY ALMOST 11%: Change, if Adopted, Would Likely Ripple Throughout All Commercial Insurers

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*

The Centers for Medicare and Medicaid Services (CMS) has proposed sweeping regulation changes that would, among other things, decrease reimbursement rates for psychologists by almost 11%. Because most commercial insurers base their reimbursement on a percentage of Medicare rates, such a reduction, if adopted, would likely result in a similar drop by commercial insurers over the next year or two.

PPA, APA, and other state psychological associations launched a massive effort to generate letters to CMS objecting to the rate reduction. In addition, APA, working in conjunction with other mental health groups, has lobbied Medicare directly on this issue. The opportunity for responding to the APA/PPA alert to send letters to CMS ended on October 5, 2020 and it will be several months before CMS issues its final regulations.

California had the highest number of APA/psychologist responders to the alert at 918 and Pennsylvania was second with 768. Ohio was third with 573 and no other state came close. Pennsylvania and Minnesota were tied for the most respondents per capita. This was an outstanding accomplishment given that there were 50 states, the District of Columbia and Puerto Rico in the "competition." PPA's response rate was almost three times higher than the average response rate across the United States. Due to a peculiarity of APA's monitoring system it only identified APA members who responded to the alert, so the actual alert from PPA and other states far exceeded the number reported by APA.

This effort is occurring at a time when the mental health needs of the population are exploding while the resources available to address those needs are shrinking. Even commercial insurers are hard pressed financially as their expenses have risen sharply due to COVID-19, and their resources have decreased sharply as the increase in unemployment has forced many beneficiaries to lose coverage.

FACTORS RELATED TO FAILURES OR DETERIORATION in Psychotherapy

SAMUEL KNAPP, ED.D., ABPP[1]; *Director of Professional Affairs*

During my training as a psychologist in the 1970s I watched a series of films called *Three Approaches to Psychotherapy,* also known as the Gloria Films. Three leading psychotherapists of the time, Carl Rogers, Albert Ellis, and Fritz Perls interviewed Gloria on tape. Gloria was a real person; the tapes were not rehearsed, and each psychologist used the interview to illustrate their approaches to psychotherapy. Rogers deftly expressed empathy for Gloria, helped her open up about her life situation, and one could see the relationship building. Perls and Ellis were directive and blunt with her (perhaps insensitive or aggressive), which left Gloria dissatisfied with their interviews.[2] Perls and Ellis moved immediately into demonstrating their techniques without building a relationship. In some ways they showed what not to do in psychotherapy.[3]

As much as psychologists want to see their patients get better, some patients may get worse over the course of psychotherapy or, like Gloria felt with her interviews with Perls and Ellis, feel dissatisfied with their psychotherapy. Sometimes the presenting symptoms of patients get worse; sometimes patients develop new forms of distress. Other patients get worse in one domain of their life, but get better in other domains (Rozenthal et al., 2018). Castonguay et al. (2010) estimated that between 5 and 10% of outpatient clients get worse throughout the course of psychotherapy and Moos (2012) estimated that between 7 and 13% of patients in substance misuse treatment get worse throughout treatment. Rates of deterioration or negative experiences may be higher for crisis intervention (Coyle et al., 2018) or in-patient psychiatric services (e.g., Rehker et al., 2017).

The fact that a patient deteriorated does not necessarily mean that the psychotherapy caused it. For example, Cuijpers et al. (2018) found that patients in waiting list control groups had a deterioration rate of 10% which was higher than the 4% rate of deterioration for patients who received the treatment, suggesting that treatment reduced the risk of deterioration. Nonetheless, the trajectories of some mental disorders are so pernicious that we lack known treatments to prevent some patients from declining. Also, sometimes the process

1 The author thanks Dr. John Gavazzi for reviewing a previous version of this article.

2 The films are still available, and Gloria's daughter has written a book *Living with Gloria* about the impact the filming had on her and her mother. She reported that Gloria corresponded with Rogers up until her death in the late 1970s (Alves, 2014).

3 Later I undertook an intensive 5-day workshop at Ellis' Institute for Rational Living and found him to be far more sensitive and supportive in psychotherapy than what he displayed in that film and in other public demonstrations.

of psychotherapy necessarily involves discussing painful experiences or activities. Although such explorations may be inherently painful, skilled psychotherapists strive to minimize the discomfort involved. Hopefully, this discomfort will be transitory and will facilitate eventual symptom reductions. Nonetheless, some behaviors on the part of psychotherapists do increase the likelihood of treatment failure and deterioration. Special attention needs to be paid to potentially iatrogenic behaviors because the first step in doing good in psychotherapy is to avoid doing harm.

> ***"Practitioners will experience increased treatment success by regularly assessing and responsively attuning psychotherapy to clients' cultural identities."***

How Effective Are Psychologists in Recognizing Patient Deterioration?

Psychotherapists sometimes do not identify those patients who are deteriorating in psychotherapy. Walfish et al. (2012) found that psychotherapists estimated that 3.6% of their patients deteriorated during psychotherapy (about 1 in 25 patients). Since the actual rate of deterioration is around 8%, then about 2 in 25 patients get worse (Castonguay estimated between 5 and 10% of patients get worse). This suggests that most psychotherapists are good at predicting who is getting better or worse. Alternatively, it also suggests that the actual deterioration rate is about twice as high as psychotherapists had estimated.

When psychotherapists identified patients as deteriorating, they relied on client self-reports, their own observations, a worsening of the client's life by objective indicators such as job loss or relationship breaks, scores on standardized outcome measures, or indirect client behaviors, such as missed appointments or a lack of cooperation in treatment (Hatfield et al., 2009). This finding suggests the importance of monitoring client progress, including the option of using objective outcome or progress measures for all clients, even for those who report that they are doing well or who appear to be responding well to treatment.

What Aspects of Psychotherapy Could Be Harmful?

Many harmful behaviors are the inverse of the helpful evidence supported relationship building behaviors connected to good outcomes (see related article this issue). For example, the relationship factors related to good outcomes facilitate a close and trusting treatment relationship coming from psychotherapist empathy, positive regard, and genuineness. Conversely, the relationship factors related to a poor outcome include a blunt, sarcastic, or demeaning interpersonal style, or humor that appears to embarrass or belittle a patient. While few psychologists would ever deliberately try to denigrate a patient, one could understand how an effort to be clear could come across as being unnecessarily blunt, or where an attempt to help the patient gain perspective through the use of humor, could be construed as humor at the expense of the patient.

Microaggressions against racial or ethnic minorities are also associated with poorer patient outcomes. Patients reported fewer microaggressions from counselors who were striving for cultural humility (Hook et al., 2016). "Practitioners will experience increased treatment success by regularly assessing and responsively attuning psychotherapy to clients' cultural identities" (Norcross & Lambert, 2018, p. 309). Culture can be defined broadly to include gender stereotypes as well as racial, ethnic, or religious stereotypes. For example, unhelpful behaviors in working with boys and men include a "generalized negative set of anticipation or stereotypes about males" (Mahalik et al., 2012, p. 594). This finding may reflect a lack of self-awareness on the part of the psychologists concerning their own experiences with gender.

Other relationship factors related to positive outcomes include those that promote or respect autonomous patient decision making, such as developing a collaborative relationship with the patient, or developing consensually agreed upon treatment goals. Although one might wish to convey optimism to a patient by acting authoritatively and increasing the credibility of one's treatment approach, a *doctor-knows-best model* of decision-making has limitations, especially if it fails to accommodate client preferences or expectations for treatment (Park et al., 2016).

Finally, psychotherapy can fail or even harm patients if psychologists fail to adapt to the needs or preferences of their patients. The failure to adapt could involve the implementation of a treatment protocol with too much rigidity. Outcomes tend to be better if psychologists follow the spirit or gist of an evidence-informed treatment protocol. However, dangers can occur if psychologists are too faithful to the letter of the protocol and fail to modify it according to the patient characteristics or immediate needs. Examples of these variables include, but are not limited to, education level, SES status, coping style, degree of attachment, culture, religious beliefs, or other diagnostic or transdiagnostic factors. Similarly, dangers can also occur if the psychologist modifies the treatment so much that its effective elements are lost. The optimal interventions retain the essential elements of the treatment yet modify or adapt treatment to patient needs and concerns.

Conversely, the failure to adapt may reflect an unwillingness to respect reasonable preferences on the part of the patient. Patients may request, for example, a psychologist of a specific gender (or age). In one large college counseling center, many Muslim students preferred to see the Muslim psychotherapist on staff (and some Muslim patients specifically requested not to see her). Or, for example, some patients may prefer to meet once every two weeks as opposed to once a week. Weekly sessions tend to get better outcomes than less frequent sessions (Erickson et al., 2015). Psychologists can explain their research-based preference for weekly sessions to their patients. However, sometimes patients have

financial or schedule-related problems that make weekly sessions impractical. Therefore, psychologists need to balance the benefits of weekly meetings with the patient's preferences and financial limitations.

How Can Psychologists Minimize the Potentially Harmful Effects of Psychotherapy?

Psychologists can take several steps to minimize the risk of patient deterioration including, the early identification of patients who are not benefitting from treatment, ensuring that they use evidence-supported techniques to build and maintain relationships, incorporating patients preferences when appropriate, being sensitive to cultural differences, anticipating and preparing patients for rough spots in psychotherapy, and being aware of their own negative reactions to patients.

Psychologists are generally good at identifying patients who are benefiting from psychotherapy and those who are not. Nonetheless, psychotherapists tend to underestimate those who are deteriorating during psychotherapy. Routinely soliciting client feedback or using outcome measures can help identify client deterioration better and earlier.

Much of what we know about behaviors related to treatment failures are the inverse of what we know about behaviors related to treatment success. Behaviors of psychologists that respect patient autonomy and facilitate caring relationships tend to lead to treatment success. Behaviors of psychologists that undercut those principles tend to risk treatment failure. For example, Norcross and Lambert have identified agreement on goals and a strong therapeutic alliance as two of the factors known to improve patient outcomes; whereas the lack of bonding with a psychotherapist and lack of clear goals are associated with deterioration in patients (Moss, 2017).

Effective psychologists make a special effort to incorporate patient preferences into as much of psychotherapy as is clinically indicated. The failure to do so risks to patient dissatisfaction, lack of motivation, and treatment failure. Effective psychologists balance directiveness with sensitivity, are alert to cultural, gender, religious and other issues, and tailor treatments to the unique circumstances of their patients.

Effective psychologists attempt to anticipate and prepare patients for some unpleasantness in psychotherapy, such as the experience of emotional pain that comes from discussing distressing life experiences. A balance needs to be drawn, however. Psychologists who help patients anticipate negative feelings may help these patients normalize their reactions. On the other hand, psychologists who overemphasize potential negative experiences may reduce patients' expectations of benefit and interfere with the quality of treatment (Rozenthal et al., 2018).

Effective psychologists monitor their feelings toward their patients. They are aware that negative feelings towards some patients are inevitable and that these negative feelings may bleed into unproductive or harmful responses to patients. "Clients scrutinize our affective responses toward them as closely as we observe our clients" (Wolf, Goldfried, & Muran, 2017, p. 183). Effective psychotherapists can use peer consultation groups to help them monitor their feelings and learn ways to transform the negative reactions into a positive information loop and to transform their initial reactions into more productive ways of responding.

In addition, when the end of psychotherapy draws near, effective psychologists will anticipate that some patients may feel dependence on their psychotherapists and need help in transitioning to a life without psychotherapy (Holsting et al., 2017).

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USING PRINCIPLES OF CHANGE to Improve Treatment Success

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Psychotherapy outcome research is very difficult because many variables, including patient/client, psychotherapist, and contextual factors, intertwine in complex ways. Learning the latest in psychotherapy outcome research and applying it to one's practice is even more daunting. Efforts by psychologists to improve the quality of their work need to consider the complexity of the services being delivered and the limited discretionary time available to most psychologists for enhancing their practice patterns. The literature on *principles of change* offers accessible information on how psychologists can improve client outcomes.

The *principles of change* literature supplements, but does not replace, the *comparative effectiveness* literature and other ways to identify effective elements of change. For example, the American Psychological Association is developing *practice guidelines* to help psychologists focus on specific clinical conditions.[2] These are helpful resources, but incomplete because treatment techniques account for a small portion of the variance in outcome. Also, many psychologists are already familiar with the list of evidence-based treatments developed by Division 12 (Clinical) of the American Psychological Association (see https://www.div12.org/treatments/). The APA Presidential Task Force on Evidence-Based Practice defines it as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (2006, p.273). Similarly, according to Norcross and Wampold, the best outcomes occur when psychotherapists consider "the problem, the person, and the treatment" (2019, p. 391), not just the treatment technique alone, and Norcross and Lambert (2018) claim that "the therapist relationship accounts for as much, and probably more, of the variance as particular treatment methods" (p. 307)

The importance of the therapeutic relationship and clinical judgment are captured in the principles of change literature. This article reviews the principles of change literature (Castonguay, Constantino, & Beutler, 2019) and integrates it with conclusions about outcomes from different sources, such as evidence-based psychotherapy relationships (Norcross & Lambert, 2018) and studies on expert psychotherapists (Hill & Castonguay, 2018).

Principles of Change

The principles of change are brief statements on what research has revealed about what is effective in psychotherapy regardless of the theoretical orientation of the psychologist. Research teams developed these principles after reviewing hundreds of potentially relevant articles. McAleavey et al. (2019) updated a previous list of *principles of change* and listed potential principles that did not have enough information to justify their inclusion in the final list. Readers may benefit from reading Castonguay, Constantino and Beutler (2019) where they elucidated the concepts in more detail and practitioner psychologists described how they applied the principles in real life cases.

The principles are transtheoretical. In fact, Goldfried (2020) has noted that psychotherapists from widely different theoretical orientations (Prochaska and Norcross [2018] identified 15 leading systems although there are many more less influential ones) often used different words or different theoretical rationales to describe the same observed psychological phenomena related to treatment. Using this assumption, the principle of change literature therefore attempts to unify practitioners of different theoretical orientations.

The principles are designed to be user friendly and to apply to the day to day work of psychologists. One of the primary advocates of the principles of change research, Dr. Louis Castonguay has long advocated for research that is meaningful and helpful to practitioners. Some psychotherapy researchers become so involved in their own research questions

1 The authors thank Dr. John Gavazzi for his review of an earlier version of this article.
2 *Specialty guidelines* deal with conduct related to certain areas of practice (such as child custody evaluations), and *practice guidelines* deal with conditions that are the subject of treatment (such as post-traumatic stress disorder).

or details of methodology that their studies risk becoming irrelevant to the average, everyday practice of professional psychology. Castonguay and his colleagues represent a different perspective on research, which sees its value increased when practitioners inform the researchers of the issues facing them and participate as equals in the research. Dr. Castonguay is a past-chair and active participant in PPA's Practice Research Network Committee.

McAleavey et al. (2019) identified 38 principles of change supported by psychotherapy research. They classified the principles as client prognostic, treatment/provider moderating, client process, therapy relationship, or therapist intervention principles. These principles are paraphrased in Table One.

Table One: Summary of the Principles of Change

Client Prognostic Factors

Clients tended to benefit more from psychotherapy if they have (are)

- Higher baseline functioning
- Non comorbid personality disorder
- Secure attachment
- Higher initial expectations of benefit
- Intrinsically motivated for treatment
- In the advanced stage of readiness

Clients tended to benefit less from psychotherapy if they have

- Lower SES
- Experienced adverse childhood events
- More negative self-attributions

Therapist/Moderating Principles

Clients tended to benefit more from psychotherapy if they

- Receive interventions consistent with their level of problem assimilation[3]
- Have less resistance
- Have better interpersonal skills
- Are matched to their preferred therapy role, demographics, and treatment type
- Have their preference for religiously oriented treatment met

In addition, clients with

- Less motivation tended to benefit if psychotherapists are responsive and person-centered
- Higher baseline impairment benefited more from intense and longer treatment
- Externalizing behaviors improved more with treatment focused on behavior change and symptom reduction
- Internalization behaviors improved more with treatment focused on insight
- Severe impairments and few social supports benefited more if treatment addresses social or medical needs
- Substance abuse problems equally benefited from psychotherapists who have had or have never had substance use problems themselves

Client Process Variables

Clients tended to benefit more from psychotherapy if they

- More actively participate in the treatment process[4]
- Are less resistant to treatment

Therapist Relationship Principles

Clients tended to benefit more from psychotherapy if they experience (or have)

- A higher quality of therapeutic alliance
- More psychotherapist positive regard and affirmation, congruence, or empathy
- Psychotherapists who can effectively deal with alliance ruptures
- Psychotherapists who use supportive self-disclosure

Therapist Intervention Principles

Clients tended to benefit more from psychotherapy if their psychotherapists

- Use a higher proportion or higher quality of psychodynamic interpretations
- Receive feedback on a routinely delivered outcome measure
- Give them feedback on their performance in psychotherapy
- Are more flexible in their administration of a treatment intervention
- Selectively/responsively foster more adaptive interpersonal change or foster more client self-understanding and emotional experiencing
- Use non-directive interventions skillfully
- Selectively/responsively foster behavior change

3 Problem assimilation refers to the extent that clients recognize and understand their problems

4 Active participation in the treatment process refers to completion of homework and adherence to the treatment.

The principles of change do more than reflect common sense or common knowledge about psychotherapy. It is true that some of the principles reinforce what most competent psychotherapists already know about psychotherapy, such as the importance of a collaborative approach with clients, the value of psychotherapist affirmation, congruence, and empathy, and the benefit of selective supportive self-disclosures. However, other commonly held assumptions turned out to lack empirical support. For example, the idea that younger clients benefit from psychotherapy more than older clients does not hold up under empirical scrutiny. Also, psychotherapists who have had substance use problems do not get better outcomes than psychotherapists who have not had substance use problems when working with clients with substance use problems, and so on.[5]

The principles can give psychologists cause for productive reflection. For example, as it applies to complex or difficult clients, two of the principles of change are that "clients with low socio-economic status and employment problems may benefit less from psychotherapy than clients with higher socio-economic status and no employment problems," and "clients who have experienced adverse childhood events may benefit less from psychotherapy than clients who did not experience adverse childhood events" (McAleavey, 2019, p. 16). We do not read these principles as discouraging psychologists from working with complex clients, but as a caution that some clients may need extra resources, treatment modifications, or additional supports to do well in psychotherapy.

Several themes struck us as we studied this literature. One theme was the importance of collaborating closely with clients and respecting their decision-making capacities as much as is clinically possible. One of the principles, for example, was that "clients who more actively participate in the treatment process may benefit more from psychotherapy than clients who less actively participate" (p. 17). Other principles of change reflect the importance of client participation in decision-making. Clients benefit more if their preferences concerning psychotherapist demographics, treatment type, and religious/spiritual accommodation are met. Moreover, treatment works better when clients are intrinsically motivated or less resistant to treatment. If clients are resistant to treatment, they do better if psychotherapists are more non-directive than directive.

The value of respecting client autonomous decision-making is also one of the salient values identified in principle-based ethics. According to principle-based ethics, moral agents should generally follow these principles which, on their face, represent good ways to behave. Client autonomous decision-making needs to be respected unless it is contravened by a competing moral principle, such as nonmaleficence. According to Beauchamp and Childress (2019), one could justify respecting client decision-making on absolute terms: unless contravened by other principles, clients should make major decisions about their treatment. However, this review suggests that respecting client autonomy may also be justified, in part, on the grounds that it can improve client well-being and make treatment more successful. For example, Knapp (2020) noted that respect for client decision-making appeared to be a common feature of evidence-supported treatments for persons at risk to die from suicide.

A second theme that struck us was the value of feedback. One of the principles of change states that "Clients whose therapist receives feedback on a routinely measured outcome measure may benefit more from psychotherapy than clients whose therapist does not receive feedback" (p. 18). Another principle states that "Clients who receive feedback from their therapists on their performance in treatment benefit more from psychotherapy than clients who do not receive feedback" (McAleavey et al., 2019, p. 19). This last principle does not require psychologists to greatly modify their style of psychotherapy but adds a dimension that might not be previously sufficiently appreciated. Not only does it calibrate the psychologists' assessment of progress, it also communicates to clients that their feedback is important.

According to the better-than-average-effect (Dunning et al., 2004) people tend to overestimate themselves in a wide range of activities and health care professionals are not immune to that effect. For example, in a review of studies involving physicians, Davis et al. (2006) found that physicians' self-assessment of their competence usually found low or no correlation with external assessments and "a number of studies found that the worst accuracy in self-assessment was among physicians who were the least skills and those who were the most confident" (p. 1094). Findings on the overestimation of one's ability have occurred in studies of psychotherapists (Walfish et al., 2012).

Feedback is also implicit in some of the other principles. For example, "Clients whose therapist uses high quality psychodynamic interpretations may benefit more from psychotherapy than clients whose therapist use lower quality psychodynamic interpretations" (p. 18). The quality of psychodynamic interpretations refers to the accuracy of the interpretative feedback and its centrality to the interpersonal life of the client.

A final theme is that many of these principles make sense from the standpoint of *self-determination theory* (Ryan et al., 2011), which holds that people have improved well-being if they meet their motives for affiliation ("the need to feel connected with and significant to others, p. 230), autonomy ("self-endorsed or volitional actions," p. 230), and competence ("confidence in one's capacity to affect outcomes," p. 230). Many of the principles of change appear consistent with what one would expect from self-determination theory. The relationship-oriented principles

5 Here and in other places, it is important to read the principles carefully. The principles do not state that having a substance abuse problem (or other life experience) cannot help an individual psychotherapist become better when working with clients with substance use problems. No doubt some psychologists have developed insight, motivation, or perspective because of their unique life circumstances. What the principle says is that, on the average, having a psychotherapist with a history of substance use problems does not improve client outcomes over having a competent psychotherapist without a history of substance use problems.

deal with affiliation or the closeness to another person.

The alliance-related principles deal with autonomy or the ability to make one's own decisions. Autonomy supporting behaviors are those "that foster or encourage voice, initiative, and choice and that minimize the use of controls, contingencies, or authority as motivators" (p. 230). One can see how interventions that seek collaboration with clients and involve them in the treatment plan or alters therapy to fit their preferences would be considered autonomy supporting behaviors.

Finally, psychotherapy is often effective to the extent that it helps clients to gain the ability or competence to alter their emotions, thoughts, or external circumstances. The feedback that clients receive may give them information needed to affect the outcomes they desire.

Integrating Principles of Change with Evidence-Based Relationships

The apparent scientific support for these principles is strengthened when one views the high congruence between these identified principles and the conclusions reached by other sources of psychotherapy research, such the body of work dealing with evidence-based psychotherapy relationships. Psychotherapy researchers often distinguish between techniques and relationships. Techniques refers to the procedures used to effectuate change whereas relationships refer to "the feelings and attitudes that the therapist and client have toward each other, and the manner in which they are expressed" (Norcross & Lambert, 2018, p. 304).

The treatment relationship has a major impact on client outcomes, perhaps even more than treatment techniques, although we must be careful not to bifurcate these two aspects of psychotherapy too sharply. The summary of evidence-based relationships by Norcross and Lambert identified several aspects of the psychotherapeutic relationship that lead to good outcomes. Norcross and Lambert also noted that how psychologists implement or express these relationship factors may have to be adapted, according to the client's preferences for treatment, desire to incorporate religion or spirituality into treatment, and culture or ethnicity.

In developing their conclusions on evidence-based relationships, Norcross and Lambert appropriately identified the limitations of their research, including difficulty in slicing up the psychotherapeutic relationship into different facets. For example, alliance, collaboration, and goal consensus are "demonstrably effective" in creating client change even though the concepts overlap somewhat. For example, Tyron et al. (2018) defined collaboration to mean that "the patient and the clinician work together to achieve treatment goals" (p. 373), even though collaboration appears as an aspect of alliance building and goal consensus. Fortunately, research articles accompanying the review by Norcross and Lambert clarify and operationalize these concepts.

Norcross and Lambert identified several factors related to change that overlap with, are closely similar to, or are identical to those identified in the principles of change literature, including the importance of factors related to respecting client decision-making. They also concurred with McAleavey et al. on the importance of collecting and receiving client feedback. Finally, Norcross and Lambert identified the importance of factors related to forming an alliance, such as empathy, positive regard, congruence, and genuineness. They highlighted the importance of adjusting treatment to the client's coping style, attachment style, and resistance to treatment.[6]

Integrating Principles of Change and Psychotherapist Effectiveness Research

From 15% to 20% of psychotherapists consistently have better outcomes and 15% to 20% consistently get worse outcomes. Castonguay and Hill (2018) reviewed the research on why some psychotherapists tend to get better outcomes than others. Castonguay and Hill are appropriately modest about their conclusions, noting that most of the data has been gathered with clients in managed care settings or college students from university counseling centers that participate in outcome research. Some techniques are overrepresented in the outcome data, and so on. Nonetheless some general trends emerged that may have implications for all psychologists.

Four factors largely account for differences in psychotherapist outcomes: the ability to form an alliance, facilitative interpersonal skills, healthy self-questioning, and deliberate practice (Wampold et al., 2018). Of these four, the strongest evidence is on the ability to form an alliance. *Alliance formation* refers to the bond between the psychologist and client, agreement on goals, and agreement on the tasks of psychotherapy. Not surprisingly, the ability to agree on treatment goals was identified in both the principles of change literature and the evidence-based relationship literature. Furthermore, to the extent that the therapeutic alliance includes respecting client goals, one could link therapeutic alliance to respecting client decision-making. Psychotherapists who are skilled at building therapeutic relationships tend to have good relationships with all their clients. Consequently, one should consider alliance-building as a skill that can be improved through supervision, self-reflection, and practice; and not simply an idiosyncratic experience that occurs when two people just happen to like each other.

Facilitative interpersonal skills refer to emotional expression, hopefulness, empathy, warmth, and a problem focus. These skills were identified as factors in the principles of change and evidence-based relationships literature. Empathy refers to "understanding what another person is experiencing or trying to express" (Elliott et al., 2018, p. 399) and is considered by Norcross and Lambert to be "demonstrably effective" in improving client outcomes. Overall empathy accounts for more of the treatment outcome than do specific treatment methods. Perhaps empathy can

6 Norcross and Lambert evaluated the relationships factors as demonstrably effective, probably effective, or possibly effective. We did not distinguish between these varying levels of certainty in some portions of this review.

be effective because it serves as a model for teaching clients to show more compassion toward themselves (Warson et al., 2014).

The role of healthy self-doubt is perhaps best reflected by the title of an article by Norwegian researcher Helena Nissen-Lie, "love yourself as a person, doubt yourself as a therapist" (Nissen-Lie et al., 2015). This is productive self-doubt that is ever questioning one's abilities and striving to do better. One might consider this a growth-oriented mindset in which an effort is made for continual improvement. Practitioners may display healthy self-doubt in different ways but soliciting client feedback (one of the principles of change) may be an important reflection of healthy self-doubt.

The healthy self-doubt literature resonates with those of us who promote self-reflection among psychotherapists including the importance of getting early feedback in client progress in treatment or and on the quality of client relationships (Knapp & Gavazzi, 2011). Self-reflection is also important in adjusting the therapy process, if necessary. Some relationship problems may include cultural differences, misunderstandings, or miscommunications. Psychotherapists who are identified by their clients as being sensitive to cultural differences tend to get better outcomes, whereas psychotherapist self-rated cultural competence was unrelated to client outcome (Soto et al., 2018).

The principles of change related to the therapeutic alliance, facilitative skills, and feedback are listed in Table 2, along with corresponding support from the evidence-based relationships and comparative outcomes literature.

Table Two: Relationship Factors Related to Outcome Across the Principles of Change, Evidence-Based Relationships and Psychotherapy Effectiveness Literature

Quality of Feelings Generated –

From Evidence-Based Relationships: Empathy, Positive Regard, Congruence/Genuineness, and Managing Countertransference
From Comparative Outcome: Facilitative Relationships
Principles of Change: Clients benefit from supportive self-disclosures[7]

Feedback

From Evidence-Based Relationships: Collecting and Delivering Client Feedback
From Comparative Outcome: Healthy Self-Doubt[8]
Principles of Change: Clients who receive feedback from their psychotherapist perform better in psychotherapy, psychotherapists who receive feedback on client progress tend to perform better in psychotherapy

Respect Client Decision Making

From Evidence-Based Relationships: Collaboration, Goal Consensus, Alliance in Psychotherapy, Adapting psychotherapy to client preferences, reactance level, and stages of change
From Comparative Outcome: Ability to form an alliance including goal consensus and collaboration
Principles of Change: Clients who actively participate in treatment process benefit more, Clients who are resistant to psychotherapy benefit less

The final factor identified by Castonguay and Hill is deliberate practice, which refers to activities designed to improve one's skills that often involve repetition, rehearsal, and the incorporation of feedback. This does not refer to the routine performance of skills, but "must be focused on achieving specific targets just beyond a performer's current abilities, guided by the conscious monitoring of outcomes and carried out over a period of time" (Chow et al., 2015, p. 338). For example, one of the principles of change says that "clients whose therapist selectively/responsively uses nondirective interventions skillfully may benefit more from psychotherapy than clients whose therapist uses nondirective interventions unskillfully" (McAleavey, 2019, p. 19). Those

7 Norcross and Lambert opined that supportive self-disclosure was promising as an effective aspect of relationship but did not consider the evidence sufficiently strong to consider it probably effective.

8 Norcross and Lambert opined that healthy self-doubt had empirical support for it, "but not a sufficient number of empirical studies" (p. 304) to include it in their list of supported variables.

psychologists who learned how to use nondirective interventions skillfully likely did so through deliberate practice.

Equally instructive are the factors that are not associated with better outcomes which include the age or gender of the psychotherapist, self-reported interpersonal skills, or theoretical orientation. The lack of a finding for age, which may be a proxy for years of experience, is especially startling for those of us who have years or decades of experience as psychologists. When asked, many psychologists will report that they learned a great deal from their experiences and have gotten better over time, which the data does not appear to support.

It is possible to reconcile the apparent difference in what the research says (psychotherapist do not get better with age) and the self-report of psychologists (whom we highly respect as competent and self-reflective) who claim that they do get better with age. The studies on effectiveness of psychologists over time rely on group data. On average, the outcomes of older psychologists are no better than younger psychologists. But most likely, individuals within that older psychologists group vary, with some experienced psychologists getting better outcomes and other experienced psychologists getting poorer outcomes than the average of less experienced psychologists. Most likely many older psychologists did get better with experience, some stayed the same, and others got worse despite their experience.

Summary and Recommendations

Principles of change are user friendly statements that can help psychologists reflect upon the factors related to treatment success and adjust their treatment plans accordingly. Many of the findings are consistent with the conclusions reported in the literature on effective treatment relationships and effective psychotherapists. Some of the take-aways that struck us are that:

- Psychologists are likely to get better outcomes if they develop a collaborative relationship with clients and agree upon treatment goals.
- The core principles of client-centered psychotherapy (empathy, unconditioned positive regard, congruence) have withstood the test of time and continue to be important ingredients in ensuring good client outcomes. To those we could also add managing countertransference, repairing alliances, selective use of self-disclosures, and so on.
- Respecting client autonomy, one of the salient principles in principle-based ethics, appears to underlie several of the principles of change.
- Psychologists who have a growth-oriented mindset (healthy self-doubt) and are receptive to feedback tend to get better outcomes. This healthy self-doubt may be reinforced by regular feedback from clients to help inform treatment decisions.
- Adaptations to the client's culture, religious beliefs, and other client preferences can improve outcomes.
- Age or experience of the psychologist does not ensure improved outcomes, but it does allow for the possibility of improved outcomes if it involves self-reflection and deliberate practice.

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Virtual Fall CE Week
November 9 - 14, 2020

EVENT SCHEDULE

MONDAY, NOVEMBER 9

9:00 - 10:00 a.m.
Therapeutic Relationship in CBT (Live Only)
Presenter: Judith Beck, PhD
1 CE Credit

12:00 - 1:00 p.m.
ADHD in Life: A More Useful Model of ADHD: Part 1
Presenter: Ari Tuckman, PsyD
1 CE Credit

TUESDAY, NOVEMBER 10

12:00 - 1:00 p.m.
Overcoming Perfectionism: How to Stop Moving the Goalposts
Presenter: Matthew John Zakreski, PsyD
1 CE Credit

2:00 - 3:30 p.m.
Optimizing Delivery of Exposure Therapy for Pediatric Anxiety & OCD: Part 1
Presenter: Emily Becker Haimes, PhD
1.5 CE Credits

WEDNESDAY, NOVEMBER 11

9:00 - 11:00 a.m.
Pennsylvania Child Abuse Recognition and Reporting - Act 31
Presenter: Rachael Baturin, MPH, JD
2 CE Credits

12:00 - 1:30 p.m.
Self-Care Journey in the Age of COVID-19
Presenters: Jeffrey Sternlieb, PhD; Samuel Knapp, EdD, ABPP
1.5 CE Credits

2:00 - 3:30 p.m.
Optimizing Delivery Exposure Therapy for Pediatric Anxiety & OCD: Part 2
Presenter: Emily Becker-Haimes, PhD
1.5 CE Credits

THURSDAY, NOVEMBER 12

10:00 - 11:00 a.m.
Supporting International and Exchange Students During an Unprecedented Time: Prevention and Intervention Best Practices
Presenter: Yuhong He, PhD
1 CE Credit

12:00 - 1:30 p.m.
The Aging Therapist
Presenters: Rachel Ginzberg, PsyD; Ira Orchin, PhD; Samuel Knapp, EdD, ABPP
1.5 CE Credit

4:00 - 5:00 p.m.
The Impact of COVID-19 on Romantic Relationships: Supporting Ourselves and Our Clients Through Grand Systemic Change
Presenter: Meghan Prato, PsyD
1 CE Credit

FRIDAY, NOVEMBER 13

9:00 - 11:00 a.m.
Understanding and Effectively Treating Clients from Honor-Shame Cultural Backgrounds
Presenter: Carmen Ranalli Morrison, PhD
2 CE Credits

Keynote Speaker

12:00 - 1:30 p.m.
Personalizing Psychotherapy: Tailoring Treatment to the Entire Patient (Live Only)
Presenter: John Norcross, PhD
1.5 CE Credits

2:00 - 3:00 p.m.
Essential Competencies When Working with Suicidal Patients
Presenters: Samuel Knapp, EdD, ABPP; Brett Schur, PhD
1 CE Credit

SATURDAY, NOVEMBER 14

9:00 - 10:30 a.m.
You Don't Need to be a "Genius" to Understand Gifted Individuals: Part 1
Presenter: Matthew John Zakreski, PsyD
1.5 CE Credits

11:00 a.m. - 12:30 p.m.
Adolescents with Chronic Medical Illness: Role of the Mental Health Provider in Their Treatment
Presenter: Judith Bijoux-Leist, PsyD
1.5 CE Credits

1:00 - 2:30 p.m.
You Don't Need to be a "Genius" to Understand Gifted Individuals: Part 2
Presenter: Matthew John Zakreski, PsyD
1.5 CE Credits

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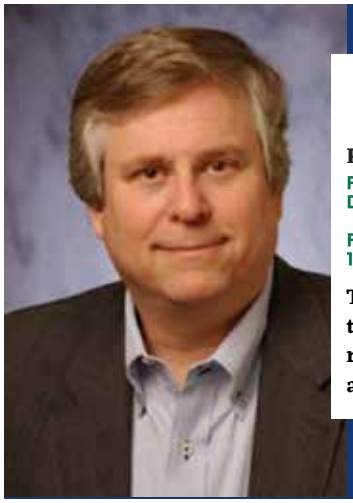
PPA's Act 31 program is approved by the Department of Human Services (formerly the Department of Public Welfare) and the Department of State to offer the 2 continuing education credits needed to fulfill the child abuse requirement. PA CE Provider Number: CACE000007

In Memoriam

Jerome H. Resnick, Ph.D. (March 13, 1936 – January 14, 2020)

Jerry Resnick devoted his career to the academic and clinical practice of psychology. He served as PPA President from 1973-1974. He passed away in Elkins Park, Pennsylvania on January 14, 2020. He is survived by his wife, Dr. Debra Resnick, who is also a psychologist and member of PPA, and his three sons Daniel, Justin and Jonathan, and five grandchildren.

(Click here to read more.)



PPA Fall CE Week Virtual Keynote Address
Register Now!

Personalizing Psychotherapy: Tailoring Treatment to the Entire Patient

PRESENTED BY
DR. JOHN NORCROSS

FRIDAY, NOVEMBER 13
12:00 - 1:30 PM

This keynote will provide integrative, evidence-based methods for adapting psychological treatments to individual clients and their singular contexts. We shall review the meta-analytic results of an interdivisional APA task force on transdiagnostic matching and then consider assessing and accommodating patient preferences, when clinically and ethically feasible.

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Join the Colleague Assistance Committee Today!

For all members of our society and especially for health care workers such as psychologists, this is a particularly challenging and stressful time. Our well-being is a major factor in the work that we do whether we are functioning as care-givers, teachers, researchers, or as a combination of these roles. It impacts the quality of care we provide and the help we deliver. Others are more likely to benefit from our effors as we stay healthy and focused.

WHO ARE WE?

The Colleague Assistance Committee is made up of PPA members who have expressed interest in helping others to have satisfying and rewarding careers and to avoid the damage that can sometimes occur from the inherent stress in the kinds of work we do. The committee is designed to look at self-care and what promotes our best work.

WHAT DO WE DO?

The committee emphasizes self-care in order to help professionals provide ethical, high quality care. We promote measures to maximize positive professional functioning and career satisfaction and to minimize the negative impacts of the demands and stresses of our work.

If you care about how we fare in doing our work and would like to help us learn more about the promotion of our professional and personal effectiveness through self-care and spreading greater awareness of what impedes versus promotes our wellness, contact us about joining the Colleague Assistance Committee.

If you are interested in joining the Colleague Assistance Committee, please reach out to Dr. Meghan Prato (meghan.prato@me.com) for more information. Help promote wellness through better self-care!

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

CLINICAL PSYCHOPHARMACOLOGY:
Our New Specialization

ANTHONY RAGUSEA, PSYD, MSCP, ABPP

You may have already heard the news—at this year's APA conference a vote cemented clinical psychopharmacology's place as the newest specialty field for professional psychologists. It joins the pantheon of specialties like clinical psychology, school psychology, forensic psychology, and neuropsychology that define areas of psychological practice requiring advanced knowledge, skills, and training. Why does this matter?

Many psychologists today can still remember when the idea of psychologists prescribing psychotropic medication mentioned at a conference could bring about both cheers and boos. It was a controversial and polarizing subject that could bring otherwise reasonable psychologists nearly to blows, not unlike other controversial ideas, like the creation of the PsyD degree. And like other steps along the evolutionary path of psychology, as time went on the controversy died down and prescription privileges became viewed by most as not just an acceptable goal but a necessary one. The first psychologists began prescribing medications in the early 1990's as part of a Department of Defense demonstration project. Today, five states and hundreds of specially trained psychologists have shown over nearly 25 years that psychologists can prescribe safely and responsibly. Throughout that time, APA has taken gradual steps toward legitimizing the practice of pharmacotherapy, such as in 1996 when APA formally endorsed a model prescriptive authority bill and training curriculum, and in 2000 when the APA Insurance Trust announced it would cover prescribing psychologists, and in 2011 when APA adopted practice guidelines for psychologists involved in pharmacological issues, and again in 2019 when APA updated its training model for prescribing psychologists.[1] Now, in 2020, another step has been taken to recognize the important, growing, and legitimate role prescribing psychologists have in our profession.

Specialization is important for many reasons. Specialization helps to assuage fears expressed by some that *all* psychologists will eventually become prescribers. A specialization, by definition, is an activity that most psychologists will not engage in because they do not have the requisite skills. The process of obtaining specialization status within APA is long and arduous, and approval is a verification of the extensive foundation of knowledge, training, and qualifications needed to become a clinical psychopharmacologist. Specialization is also another mechanism to ensure high quality treatment, by setting standards and opening the door to an eventual board certification process. Specialization is also symbolic, it implies that the practice of pharmacotherapy is not something we "tolerate" psychologists doing, but something psychologists can *aspire* to.

There may always be psychologists who think about psychologists prescribing with suspicion. But the healthcare environment is changing, the profession of psychology must evolve, and prescribing psychologists show us that psychologists can both swim in water and walk on land with equal facility!

1 For more on the early history of RxP, the reader is referred to Sammons, M., Levant, R., and Ullman, R. (2003) *Prescriptive Authority for Psychologists: A History and Guide. Washington, DC: American Psychological Association.*

The PPA Ethics Committee, in conjunction with the Early Career Psychologist Committee, has developed a series of practice tips for early career psychologists, although they may be helpful for psychologists at any state in their career. More tips will appear in the January issue of *The Pennsylvania Psychologist*.

Practice Tip **ONE:**
INVEST IN YOUR INFORMED CONSENT PROCESS.

"Was the patient informed of this ahead of time?" Many times, conflicts occur because the patients did not understand the parameters of psychotherapy, how it was going to be conducted, or the expectations of them before psychotherapy began. When conducting family therapy, for example, were all family members informed about how information was going to be shared (or kept private) before psychotherapy began? When conducting assessments, was the client aware of their right (or lack of right) to the assessment report?

The Trust (formerly the APA Insurance Trust) contains an informed consent agreement that can be downloaded and modified as psychologists wish. It covers the common questions that may arise during psychotherapy. Although the APA Ethics Code does not require psychologists to have a written informed consent agreement that patients sign, it is usually good to use such a signed written document with a copy given to the patient and a copy kept in the patient file. The informed consent form should be tailored to the service being provided. Informed consent forms for child psychotherapy or forensic work, for example, would differ from informed consent forms for adult psychotherapy. The informed consent forms for children should include information on the age on which children can consent to treatment and control the release of their treatment records.

It is good to review the informed consent agreement with patients in addition to giving them a written document. Two psychologists I know have short videos on their website for prospective patients that describe what psychotherapy involves and that supplements, but does not replace, the face to face conversation about informed consent. In addition, psychologists should revisit issues of informed consent throughout treatment as needed. Informed consent is seldom a one-time event.

One reason that informed consent is so important is that is shows respect for the patient and concern that they understand the rules governing therapy and that it is evidence of an effort to be fair. Often misunderstandings occur and these are not always the result of malice or carelessness. Patients can be very distraught when they first enter psychotherapy and may fail to attend carefully to all the information given to them. For example, many psychologists will charge patients a fee for cancellations without a 24-hour notice and may include this in their informed consent agreement. Patients are more likely to view the fee as fair if it was explained to them ahead of time and was included in a written document that the patient signed.

Practice Tip **TWO:**
STRIVE TO UPGRADE THE QUALITY OF YOUR SERVICES

Caught in the day-to-day demands of work and family life, it is easy for psychologists to let their professional development slide. Most of us have had the experience of rushing home from a stressful day at work to pick up the kids and trying to be pleasant and appropriately parental toward them. It is not easy. With all these pressures there is a temptation to do the minimum continuing education and let professional development slide.

But it is a bad decision to devalue continuing professional development. We psychologists do not magically get better over time and through experience. On the contrary, some of us may get worse over time and eventually could become embedded in less-than-optimal practice patterns. Experience is most useful if it is accompanied by feedback, reflection, consultation, or continuing education. We get better as psychotherapists through the same mechanisms that helped us get proficient in psychotherapy in the first place which is to invest time in improving our skills through study, reflection, feedback, and effort.

Continuing professional development can take many forms in addition to participating in formal continuing education programs. It could also include activities designed to improve one's cultural Ideally throughout your career span you will not only maintain your competence but expand upon it over time. Remember that by focusing on your professional development, you will be

- Acting in accordance with your values of promoting public health,
- Making your work more rewarding as your skill set improves, and
- Making a good business decision to deliver a high-quality product.

Practice Tip **Three:**
SET LIMITS AND KEEP THEM

Set limits. It is important for psychologists to understand their areas of proficiency and stick to their areas of competence. Knowing what one cannot do well is just as important as knowing what one can do well. Although the Ethics Code permits psychologists to extend themselves outside of their scope of proficiency in an emergency or when working with underserved populations, psychologists should not extend themselves without thinking through the issues carefully.

One senior psychologist said, "Resist pressures/temptations to go beyond your limits." It is true that the APA Ethics Code allows psychologists to go outside their areas of competence if they are in an underserved areas and services are not available. But psychologists should decide to go outside of their lane of competence only after careful deliberation.

Practicing within limits means not only selecting patients more carefully, but also setting time limits. No psychologist can be available to all potential patients and may have to decline some referrals because of time restrictions. It is true that we must sometimes extend ourselves in terms of availability during patient emergencies, but these should be relatively rare exceptions.

No one can be competent with every patient in every session. Competence is fluid depending on the totality of the psychologists' workload and personal stressors. The best psychologists are sensitive to the drains caused by their emotional labor and adjust their workload accordingly.

Sometimes psychologists exceed their limits because of a misguided understanding of altruism. I value altruism very highly. But altruism should not be confused with runaway compassion or unethical altruism which are actions that on the surface appear altruistic, but when considered in more detail can be harmful or destructive.

For example, we have known of conscientious psychologists who became involved in forensic cases even when they lacked adequate skills to do the job adequately. One psychologist spent hours writing a beautifully written and detailed and comprehensive psychological evaluation for an attorney. The problem, however, was that the report did not address the forensic issues before the court. The report wasted precious resources on generating information that was irrelevant or at best tangential to the case.

Practice Tip **Four:**
DEVELOP GOOD PRACTICE HABITS

One well regarded authority on health care referred to competence as being both "habitual and judicious," meaning that it involves good habits as well as good decisions. One might also refer to the good habits part of competence as professional hygiene. One might be able to get away with not brushing their teeth for a while, but it leads to more problems in the long run. Prudent psychologists make these suggestions part of their day-to-day lives.

When asked what practice habits they thought were important, a group of experienced psychologists offered these suggestions:

- Have a standardized assessment protocol for your patients that includes the content of the structured interview, assessments (if any), and your informed consent agreement.
- Make continuing professional development a routine part of your professional life.
- Take breaks during the day. Allow yourself a time cushion during the day. In the worst scenario you can use the time for unexpected clinical demands that may arise.
- Routinely assess the extent to which your patients are progressing. Use standardized instruments if it can help you monitor their progress carefully.
- Stay on top of the office finances. If you are having a problem with the finances, then ask for help.
- Be sure to eat well, get enough sleep, exercise, and laugh.
- Finally, the one piece of advice that was mentioned most frequently was that it is very important to keep good clinical notes.

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CE QUESTIONS FOR THIS ISSUE

EARN 1 CE CREDIT FOR THIS ISSUE!

The articles selected for 1 CE credit in this issue of the Pennsylvania Psychologist are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. **During this renewal period only, the limit on the number of home study and distance learning continuing education hours has been lifted. For this renewal period, psychologists can receive all of the continuing education through home studies or distant learning programs. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits of continuing education into the next renewal period.**

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($40 for nonmembers) and mail to:

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Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before November 30, 2022.

Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Factors Related to Treatment Effectiveness

1. According to the American Psychological Association, specialty guidelines deal with

a. Conduct related to certain areas of practice
b. Conditions that are the subject of treatment
c. Ethical principles that must be followed by all psychologists
d. All the above

2. Principles of change are brief statements of what research has revealed to be effective

a. Regardless of the theoretical orientation of the psychotherapist
b. Depending on the theoretical orientation of the psychotherapist
c. Depending on the age or education level of the psychotherapist
d. In the area of relationship building alone

3. According to the authors, common themes in the principle of change literature include

a. The importance of collaboration with patients
b. The importance of giving and receiving patient feedback
c. Similarities with what would protect from self-determination theory
d. All the above

4. According to Norcross and Lambert, techniques refer to

a. The procedures used to effectuate change
b. The feelings and attitudes that the psychotherapists and patients have toward each other
c. Brief statements of what is effective in psychotherapy regardless of the theoretical orientation of the patient
d. All the above

5. According to Wampold et al. (2018), the psychotherapist factors related to outcome include

a. The ability to form an alliance
b. Facilitative interpersonal skills
c. Healthy self-doubt
d. Deliberative practice
e. All the above

6. The authors believe that

a. All psychotherapists get better with age and experience
b. The age and experience levels of the psychotherapist never have an impact on patient outcomes
c. Most likely, some psychotherapists get better with age and experience; some get worse; and some stay the same

Factors Related to Treatment Failures

7. According to the review by Castonguay et al. (2010), about _____ percent of patients deteriorate during psychotherapy

a. 1% to 3%
b. 5% to 10%
c. 7% to 13%
d. 9% to 18%

8. The conclusion that Cuijpers et al. (2018) reached was that patients in the waiting list control group deteriorated _____ than patients in the treatment group.

a. Less often
b. More often
c. At the same rate

9. Walfish et al. (2012) found that psychotherapists predicted their patients deteriorated at a rate that was _____ of actual deterioration rates.

a. Almost completely identical
b. About half
c. About two times higher
d. About three times higher

10. According to the author, psychologists using treatment protocols should

a. Never deviate from the treatment protocol
b. Freely deviate from the treatment protocol
c. Adapt the treatment protocol to patient needs, while retaining the elements essential to receive good results

11. Psychologists can minimize harm to their patients by

a. Routinely soliciting client feedback by using outcome measures
b. Adapting treatments to the patient's culture if clinically indicated to do so
c. Ensuring that they focus on building and maintaining a good relationship with their patients
d. All the above

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, November 2020

Please circle the letter corresponding to the correct answer for each question.

1. a b c d	4. a b c d	7. a b c d	10. a b c
2. a b c d	5. a b c d e	8. a b c	11. a b c d
3. a b c d	6. a b c	9. a b c d	

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist:*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

_____

Please print clearly.

Name _____

Address _____

City _____ State_____ Zip _____ Phone ( ) _____

I verify that I personally completed the above CE test.

Signature _____ Date _____

A check or money order for $20 for PPA members ($40 for nonmembers) must accompany this form. Mail to: Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

Now available online, too! Purchase the quiz by visiting our online store at papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

2020 PPA CONTINUING EDUCATION

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2020, we are expanding the options. We hope you'll join us for one or more of these programs!

Calendar

NOVEMBER 9 - 14, 2020
Virtual Fall CE Week

FRIDAY, NOVEMBER 13, 2020
Virtual Fall CE Week Keynote Address
Personalizing Psychotherapy: Tailoring Treatment to the Entire Patient
Presented by: John Norcross, PhD
12:00 – 1:30 pm
Virtual Webinar

MONDAY, NOVEMBER 16, 2020
ADHD in Mind: Neurology Drives Psychology (in Both Romantic Partners)
12:00 – 1:00 pm
Virtual Webinar

MONDAY, NOVEMBER 23, 2020
ADHD in Love: An Individual Condition that Drive Relationship Dynamics
12:00 – 1:00 pm
Virtual Webinar

Home Study CE Courses

Act 74 CE Programs
The Essentials of Screening and Assessing for Suicide Among Older Adults – 1 CE

Talking About Suicide: The Patient's Experience and the Therapist's Experience (Webinar) – 1 CE

The Assessment, Management, and Treatment of Suicidal Patients: 2020 – 3 CE

Act 31 CE Programs
Pennsylvania Child Abuse Recognition and Reporting: 2020 – 2 CE

Pennsylvania Child Abuse Recognition and Reporting: Extended Version 2020 – 3 CE

General CE Programs
Ending the "Silent Shortage" through RxP (Webinar) – 1 CE

*Ethics and Self-Reflection** – 3 CE

*Ethics and Professional Growth: 2019** – 3 CE

Overcoming the Challenges of Counseling Children and Teens Online (Webinar) – 1 CE

This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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Registration materials and further conference information are available at papsy.org.