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Clinical Social Work Association

The National Voice of Clinical Social Work

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summer 2014

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IN THIS ISSUE ...

It is with great optimism and passion that I begin the Presidencey of the CSWA

Susanna Ward, LCSW, PhD, Acting President CSWA

As clinical social workers, we know that life can send us surprises. We help our patients with the anxiety and confusion that surprises can bring. One way to describe what LCSWs do is help others figure out how to accept the unexpected.

I mention this because I find myself in a VERY unexpected position, that of Acting President of CSWA! Though I have been serving as the Board's Vice President/State Liaison, I did not plan to take on the challenge and opportunity of the Presidency until July, 2015. However, due to recent circumstances, that timeline has been moved up to July, 2014. Nonetheless, I hope to be able to give our wonderful Board and thriving professional organization the leadership that both deserve. I appreciate all your support as the Board transitions and CSWA continues to grow.

A word about our past-President Stephanie Hadley: Stephanie stepped in at a time when CSWA was not nearly as strong as it is today. Under her gentle guidance, we have seen the growth of our membership, growth in affiliated state societies; the development of our outstanding position paper on Online MSW Education; increased political advocacy with members of Congress; and excellent additions to the CSWA Board. Though Stephanie had to step aside for personal reasons, please join me in thanking her for her outstanding service to CSWA over the past three years.

A word about my professional background: After serving in various clinical settings (including private practice) in both the Northwest and the Southeast for nearly 20 years, I became the first Executive Director of the Kentucky Society for Clinical Social Work about 5 years ago. In the 1980's, I received my MSSW from University of Tennessee and later obtained a second Master's Degree in Humanities (with an emphasis on Literature) from California State. In my quest to maintain my educational growth, I also acquired a PhD in psychology through coursework at both Seattle Pacific University and Westbrook University. I believe this has helped me to have an understanding of the similarities and differences of both of these mental health disciplines.

The CSWA Board and I are still developing goals as I transition into the CSWA Presidency. We hope to tell you more about them in the next Newsletter and through emails to membership. We have some very exciting opportunities for CSWA members that I hope to provide information on shortly. In the meantime, I hope you will all take advantage of our monthly Clinical Dialog with up to the minute articles of professional interest; CSWA HIPAA templates; information on Medicare, including specifics on PQRS; templates for opting out of Medicare; and a sample of the new CMS-1500 (02/12), all available on the CSWA website (www.clinicalsocialworkassociation.org) .

I look forward to getting to know you all, I welcome your suggestions, and I value your commitment to clinical social work!

Keep Your Membership Information Updated

Log on at:

www.clinicalsocialworkassociation.org

Step 1 – Simply click on the **EDIT** button at the top of the screen

Step 2 – Click on **MEMBER INFORMATION** and update your personal information. You can check the box that indicates that you want your information included in the Member Roster and then you will be able to select what specific information you would like to have listed.

Step 3 – Go to the bottom of the page and click on **SAVE**. Your information will automatically transfer to the Member Roster where it will be available for other members who may be looking for referrals out of their area.

The New Listserv

Laura Favin

I am very pleased to announce that the Clinical Social Work Association's new listserv is now online and the conversations are flowing. The CSWA Listserv is a membership benefit, designed to promote the exchange of resources; networking opportunities; legislative updates; practice and agency services; educational events; job opportunities; and clinical and practical information relevant to the clinical social work profession. CSWA encourages lively and supportive dialogue via our listserv, and welcomes participation from users at all levels of membership. I hope you will join us in this pertinent discussion regarding clinical social work. It promises to be a wonderful resource for our profession.

It all can be quite confusing to navigate Googlegroups, through which we have our listserv. In the process of establishing a flowing dialogue on the web, some clarification is necessary.

1. To post an email to the group send it to: clinicalsocialworkassociation@googlegroups.com
2. PLEASE NOTE: There is a distinction between, Google accounts, Google group accounts (which is what our listserv is through) and Gmail.
3. If you would like access the CSWA listserv online, to review past conversations or posts, or to switch the mode in which you receive the emails on your own, you must have an account with Google.
   - Sign up with Google for an account with the email address to which you wish to receive emails.
   - The Google account email address you use must be consistent with the email that is used for this Google Group (nothing to do with Gmail).
   - This can be updated to make it all consistent. But you must update your Google account on your end.
4. You can participate as a member of this group without any of the above accounts. You just can't access the online version without a Google account. If you just want to receive and send emails through the listserv, then you just make sure that Laura Favin, the listserv moderator has the email address to which you wish to receive emails.
5. You do have the option of receiving messages in a digest, once a day, format. You will receive your emails a day later than they are posted to the listserv but they will come in one email.
   - In order to do this you must have a google account with the email you are using to receive the CSWA listserv emails.
   - Then you can sign into your google groups account and change how you receive emails. Or, if you need assistance, you can always ask me to change it on the moderator's side. Please let me know if you need assistance with this.
6. Please let me know if you would prefer to be removed from this list or if you have any questions.

If you have any questions about which of your email addresses was used for this CSWA listserv google group you can email me, Laura Favin, the listserv moderator, at lafave1@gmail.com and we can research this together.

We all look forward to many important discussions and a tremendous exchange of information through the CSWA listserv.

Affiliate Socieities and CSWA: Mutual Growth and Commitment

Susanna Ward, LCSW, PhD, Acting President CSWA

The Clinical Social Work Association (CSWA) continues to grow in numbers and momentum. This is due in large part to the increased support of our affiliated state societies. As the National Voice of Clinical Social Work, our strength lies in the mutually beneficial relationships with CSWA state affiliates.

These relationships have changed from the way they existed when our national organization was the Clinical Social Work Federation. The attempt to have intertwined organizations with separate structures just did not work. The cost of bi-annual meetings, a "Board" of over 60 people, an Executive Director and Administrator trying to link national and state organizations while experiencing conflicting goals, proved to be unmanageable. Hence the "birth" of the Clinical Social Work Association where national goals are decided by a Board with members from throughout the nation and state goals are now driven by the individual states.

Affiliated state societies reach out to the Association when they require the support that a national organization best provides. Examples include:

- identifying national legislation that affects clinical social work practice, meeting with members of Congress, and numerous other offerings provided by our Government Relations Committee under the direction of our legislative guru, Laura Groshong.
- regular and ongoing consultation with NASW leadership.
- providing current articles on clinical practice through our Clinical Dialog led by the knowledgeable Gail Nagel.
- tracking the changes occurring as a result of the Affordable Care Act and providing presentations/webinars on the use of EHRs, PQRS, information on HIPPA, ACOs, health homes, Medicare, and changes to DSM and ICD codes.
- our superb Newsletter, ACCESS, run by sterling, yet humble, Editor Eric Huffman
- position papers about pertinent and current issues, such as online social work education, which help educate the public about clinical social workers as mental health providers.
- position papers other pertinent issues, such as insurance, the importance of privacy in our work, parity and more.
- the offering of ethical and legal assistance from our ethics expert, Ginny Luftman.

Our affiliated societies, in turn, educate their members as to the benefits of membership and the always present need for representation on both state and national levels. To our knowledge, the clinical social work voice in national policy and legislation is currently provided by CSWA only! Advocacy for clinical social work, specifically, is provided by CSWA and its State Affiliates.

An article from our newest state affiliate, the New York State Society for Clinical Social Work, will be coming out in the next issue of ACCESS. New York has already hosted a successful webinar on PQRS with CSWA's Laura Groshong. Other states are asking for similar webinars and in-person presentations from CSWA. Our calendar is quickly filling with requests from our state affiliated societies.

State affiliated societies currently include Alabama, Arizona, Greater Washington, Idaho, Kentucky, Minnesota, Missouri, North Carolina, South Carolina, New York, Pennsylvania, Texas, Virginia, and Washington State. Groups that may not have a society, but have an informal connection with CSWA include Delaware, Florida, Illinois, Michigan, Montana, and Oregon. CSWA is actively engaged in discussions with the California Society. Our annual Summit , held in Washington DC with representatives from most affiliated societies in attendance, was started two years ago by our Past President, Robin McKenna. The annual Summit is one reason for the growth and influence CSWA is experiencing today.

I hope this gives you all a sense of how the Association and affiliated state societies work together to support our profession and enhance the clinical services we provide to our patients. Let's continue to grow our clinical association, support one another, and strengthen our national voice!

Third-Party Coverage Improvement: Case Study in Washington State

Laura Groshong, LICSW, Director, Washington State

As we all know, LICSWs face problems with insurance reimbursement. I have received hundreds of emails from clinical social workers in private practice who have had problems getting treatment reimbursed as an in-network provider, an out-of-network provider, for the number of sessions weekly/monthly, for treatment needed beyond the length of treatment approved; lack of coverage by diagnosis, by treatment method, by CPT code, and more. The reimbursement rates are problematic with the exception of companies that reimburse for the CPT code 90837. While CSWA is not able to address all these problems directly at this time, we would like to provide an example of how individual societies may be able to advocate for changes with individual insurance companies in their state/jurisdiction, based on a successful result in Washington State.

One of the maddening things about dealing with all these issues is the fragmented insurance system in which we currently work and the ways that some LICSWs seem to have more cooperation getting reimbursement from insurers than others. There are differences in geographic location; some states are relatively happy with the reimbursement rates and coverage that they receive from major insurers, others are constantly frustrated. After 15 years of studying these issues, I have come to the conclusion that there is no one-size-fits-all answer to the third-party payment problems. Each region/state has its own challenges and requires its own strategies. This article offers a strategy that worked in Washington State to improve reimbursement for LICSWs with a major insurer. While this may not be the solution in every state there may also be some elements of this successful campaign that would work in your state or jurisdiction. Dealing with problems one at a time instead of globally may be more productive.

In January of 2014, LICSWs who were panelled with Regence BlueShield, who had been receiving payment for the CPT code 90837, stopped receiving payment for claims after three sessions. They were told that this was the policy of Regence BlueShield, one of the three major insurers in Washington State. It took awhile for the Washington State Society for Clinical Social Work to realize the scope of the problem but by March it was clear that a systematic change in the way LICSWs and other mental health clinicians were reimbursed had occurred. Some clinicians resubmitted claims under 90834. Some appealed their denied claims. Some patients appealed the denied claims. Some LICSWs were paid as usual for 90837. The situation was complicated by Regence decision to create two 'classes' of providers, with those who were 'scored' as 'outliers' because they had typically seen patients more than once a week and/or more than a year. The implementation of the Milliman Guidelines, an actuarially-based conceptualization of treatment that redefined all mental health conditions as 'episodic', i.e., all mental health treatment should be used for is to alleviate an episode of emotional distress, not resolve underlying emotional conflicts. These Guidelines deny that there are chronic mental health conditions, which may require years of treatment to help patients remain stable and improve.

Attachment disorders are particularly at risk in the Milliman standards in terms of coverage as the value of the treatment relationship as a curative factor is summarily denied. Trauma-related problems are more readily seen as needing ongoing treatment but still at levels that most LICSWs would see as restricted in ways that are harmful to the well-being of the patient. These underlying issues did not get resolved in the discussions that took place with Regence but will be the subject of future discussions. Keeping goals specific and accepting that not all problems can be solved at once is an important component to dealing with insurance companies.

A request for information about problems with Regence was sent out to all WSSCSW members to find out the extent of the problems with Regence and left open for only a week. Other mental health groups were invited to participate, notably the Washington State Coalition of Mental Health Professionals and Consumers, who participated with WSSCSW in the process. The 54 responses were collated into a list of the problems reported,

which was sent to Regence, and a conference call was set up with Regence behavioral health administrators. That one-hour call resulted in a resolution of the use of 90837 by LICSWs and other clinicians, and a description of internal problems that had led to the mistakes in coverage. Everyone who had appealed their denials was paid in full from the beginning of the year. Those who had 'down-graded' their CPT codes to receive payment will have their cases reviewed. Among other lessons learned here was the importance of fighting for the standard of mental health care that we believe is needed and appealing cases where that treatment is denied.

Another important reason for the success of this effort was the pulling together of many mental health organizations. While CSWA continues to work on improving the LICSW reimbursement rates at the national level, we also strive to work with other organizations when the opportunity arises. This model can be duplicated in other localities.

For members who would like to see a template of a survey that can be used to gather information from members, go to the CSWA website and look under the "Members Only" section under "Templates". Additionally, watch for a Position Paper on clinical social work practice that will be sent to all members of Congress and can be used to clarify the work that we do when that is called into question. It is up to us as individuals and organizations to advocate for fair reimbursement for our work and CSWA is here to help in that effort.

Raising fees during therapy?

Richard S. Leslie, JD, Attorney at Law

Under what circumstances is it appropriate to raise a patient's fee during the course of therapy? Does raising one's fee during the course of therapy raise the issue of exploitation? Is there a limit to the size of the increase? Is a twenty-five percent increase ethically permissible?

While there may be a law or regulation somewhere that addresses this issue, I am not aware of any that directly addresses the raising of a patient's fee during the course of therapy. In short, I would argue that raising one's fee during the course of therapy does raise the issue of exploitation. A therapist or counselor might seek to raise his or her fee for a variety of reasons. Some argue that raising the fee of an existing patient should be viewed as exploitation because the patient or client came in with an understanding of the fee, and then, just when the patient became reliant upon the practitioner, the practitioner raised the fee. Patients may justifiably feel exploited – especially if not informed of the possibility of raises, or the limitations (e.g., as to frequency or percentage) to raises, in the disclosures made to patients before the commencement of treatment.

Codes of ethics of professional associations may not address the issue directly, or at all, because of their sensitivities to antitrust concerns. Those that address the issue are likely to require disclosure to the patient concerning the possibility of future increases and/or prior reasonable notice of an increase. Generally, laws, regulations, or codes of ethics will require that the practitioner disclose, prior to the commencement of treatment, the fee to be charged for the services to be rendered or the basis upon which the fee will be computed or determined. If a practitioner wants to reserve the right to raise fees during the course of therapy, assuming there is no statutory or ethical prohibition against such action, that fact should be disclosed to the patient, in writing, prior to the commencement of treatment. Other information might also be considered for inclusion, such as the frequency or number of raises possible, the percentage of any possible increase, and the amount of prior notice to be given of a proposed increase.

Because of the potential for allegations of exploitation, and in order to avoid the drafting of a complex disclosure statement regarding this issue, it might be easiest and safest to raise fees for new patients and to continue to see existing patients at the fee that is established at the out of their treatment. Of course, the practitioner is free to implement policies around fees as he or she deems appropriate – provided that no law, regulation, or ethical code provision is violated. With respect to the twenty-five percent increase question, practitioners should carefully consider whether such an increase could be considered to constitute exploitation under the circumstances, or whether it would be considered as reasonable and fair by the patient, by an ethics committee, or by the state licensing board.

Reprinted with permission of CPH & Associates (Avoiding Liability Bulletin, May 2013 Volume 1). Richard S. Leslie is an attorney who has practiced at the intersection of law and psychotherapy for the past 25 years. Most recently, he was a consultant to the American Association for Marriage and Family Therapy (AAMFT), where he worked with their various state divisions to develop and implement their legislative agendas. He also provided telephone consultation services to AAMFT members regarding legal and ethical issues confronting practitioners of diverse licensure nationwide. Additionally, he wrote articles regarding legal and ethical issues for their Family Therapy Magazine and presented at workshops on a variety of legal issues.

Medical Masquerades: When "Psychological" Disorders Are Physical

Stacy Taylor, LCSW

Matt[1] was 15 years old when his parents went through a high-conflict divorce. Matt became more sullen, and his grades plummeted. His mom, an acquaintance of mine, did what many concerned parents would do: she brought him to a psychotherapist. The psychologist came up with a reasonable explanation: Matt was understandably depressed and angry about his parents' divorce; because he felt powerless, he was attempting to exert control through his acting-out behavior.

Therapy continued for several months, though Matt began manifesting a variety of other symptoms, including headaches. When his headache became severe, his mom took him to the Emergency Room, where a concerned physician ordered a brain scan. The diagnosis: a benign, but rapidly growing, brain tumor. Matt had surgery and made a slow, but steady, recovery.

Rachel, age 42, was a happily married woman, with a secure job and a lovely home, although she was plagued by unexplainable bouts of depression. When I saw her for therapy, she presented as animated, although prone to sudden mood shifts. Rachel also was coping with some medical problems, including chronic pain, obesity, and infertility.

During the year I saw Rachel, she was hospitalized five times for severe depression. Her condition became so life-threatening that I made a number of urgent calls to Rachel's psychiatrists, her internist, and hospital social workers to advocate for thorough medical evaluation, including a work-up by an endocrinologist. All of my attempts were dismissed.

Rachel ended up losing her job, marriage, and house. She had to move to another state to be cared for by relatives, and I lost touch with her. To my surprise, three years later, I received a message on my answering machine from Rachel who informed me that she was finally referred to an endocrinologist and was diagnosed with a thyroid condition that contributed to her severe depression, as well as her weight problems and infertility. She was on thyroid medication and doing significantly better.

Matt and Rachel are both dramatic examples of what has been dubbed, Medical Masquerades (MM)[2]. MMs are medical problems that are misdiagnosed by medical and mental health professionals as psychological. While Matt and Rachel's stories are striking, their experiences are not unique.

Some people suffer for years, and even decades, with puzzling symptoms that confound professionals and are resistant to medical and psychological treatment. Many cases are dramatic like Matt and Rachel's, with unnecessary psychiatric hospitalizations or delayed treatment for life-threatening illness. Other situations are much less perilous, though they diminish the quality of life for the person, and propel him or her into an endless and expensive quest for a cure.

According to the book, Mind or Body, by Dr. Robert Taylor (no relation to me), all mental health professionals will regularly see clients whose psychological suffering is due to a biological condition[3]. In a study cited in Mind or Body, l00 patients admitted to a psychiatric hospital were extensively evaluated for underlying organicity. Half of the patients had biological illnesses that were either causing or exacerbating psychiatric symptoms.

In another study of over 2,000 outpatients, l8% had organic diseases that were causing their psychiatric symptoms. According to Taylor, patients are mistakenly diagnosed for an average of four years, though often longer; some people are never properly diagnosed, or the true cause of their distress is only discovered upon autopsy.

Taylor advises professionals to ask ourselves, "What other than the obvious might be the cause of or a contributing factor to the presenting symptoms?"

Why are MMs Missed?

Part of the reason that MMs are so often overlooked is human nature; we tend to hold fast to our belief systems. If physicians treat a woman like Rachel, who is middle aged, overweight and having mood swings, they immediately think of depression.

What complicates matters is that often there is a life issue that convinces professionals that the symptoms are psychiatric. For Matt, it was his parents' divorce, and for Rachel it was infertility. But most people have some type of life stressor. Hence, Taylor counsels therapists not to immediately assume a symptom is psychological.

Taylor had a powerful impact on the mental health realm in the l980's, when he taught classes for psychologists on MMs, and published, Mind or Body. The State of California took note of the serious problem, and ordered its psychiatric clinics to run a full battery of medical tests on patients. Unfortunately, the project was never fully funded or implemented.

These days, there are unique reasons why many MMs are dismissed as psychological. These include the advent of managed care, the development of SSRIs, and reliance on medical tests even when clinical symptoms may point to an organicity.

For instance, prior to the development of certain tests and anti-depressants, if a woman presented to her physician as overweight, depressed, lethargic, and with low libido, many doctors would have prescribed thyroid medication. Given that the prior class of anti-depressants -- the tricyclics -- had significant side effects, doctors would have wanted to avoid prescribing them whenever possible. But once the TSH (Thyroid Stimulating Hormone) blood test was developed to evaluate thyroid conditions, it would be very unlikely for a doctor to prescribe thyroid medication unless the patient tested positive on the TSH test. The problem is that many thyroid experts, including a major specialist group, believe that the TSH range is inaccurate, and that half of all sufferers are not diagnosed[4]. Now women presenting with the above symptoms would likely be prescribed a safer anti-depressant, such as an SSRI, not thyroid medication.

Not only has medicine been heavily impacted by reliance on tests and medications, but managed care has created rigid standards physicians must follow. Doctors have less time to carefully evaluate their patients. With overworked physicians rushing to meet their patient quotas, while dealing with insurance issues, many medical problems can be overlooked.

Red Flags for MMs

If physicians so often miss MMs, how can LCSWs correctly diagnosis them? The answer is that we can't, and we reach beyond our scope of practice by trying to do so. However, as psychotherapists we can inform ourselves about the red flags for MMs, and use this information to educate our clients and to make appropriate referrals.

I have culled from several books[5]. some signs and symptoms to look for during sessions. While not all clients will, of course, present with an MM, the following may suggest one and may prompt a referral to a medical professional:

Client appearance: Pay close attention to how each client appears, including his/her gait, size, hair and complexion, and affect. Note anything unusual, including the following: dishevelment, gross errors in dress, excessive drowsiness, movement problems (tremors or rigidity), hair thinning or prematurely grey (could indicate low thyroid), or bulging eyes (which could point to Grave's Disease).

For instance, Gail presented as excessively sleepy during our sessions. A woman in her late 30's, she was also 75 pounds overweight. I urged Gail to have a thorough medical evaluation and to talk to her doctor about possible testing for thyroid problems and/or sleep apnea. She was eventually diagnosed with sleep apnea.

Cognitive impairment: A possible key to a MM could be any cognitive impairment, including memory problems, difficulty with speaking or writing, inattention, errors in judgment, or disorientation.

For example, Adam was a young man who missed our first appointment since he forgot. He did come to our second one, but he spoke concretely and missed subtle social cues. He also presented as easily distracted. I wondered whether Adam had a substance abuse problem, attention deficit disorder, or Asperger Syndrome.

I was startled to find out the real reason for Adam's symptoms: he had had a stroke due to a rare brain infection. In shaky handwriting, he revealed this on my intake form, where I ask about medical conditions and surgeries.

Psychiatric symptoms: Even if clients present with psychiatric symptoms, this doesn't mean that their condition is simply psychiatric. There are numerous medical diseases that mimic psychiatric ones, as well as comorbidity. As with Rachel, mood disorders can be caused or exacerbated by thyroid problems. People diagnosed with attention deficit disorder may have blood sugar fluctuations, for instance, hypoglycemia. Visual hallucinations often point to organicity. Many people with paranoia have an underlying biological problem.

In addition to the above, the following raise the possibility that a client's symptoms may be a Medical Masquerade:

- Sudden onset of symptoms, with no prior history of symptoms, particularly over age 35.
- Age 55 or older.
- No readily identifiable cause.
- Intractable symptoms that persist or get worse despite medical or psychological treatment.
- Coexistence of chronic illness.
- Females going through hormonal changes, such as puberty or peri-menopause (the years prior to a woman's menses stopping. When her period stops for one year, this is called menopause).
- Sexual functioning complaints: In one study of l00 men with impotence who underwent thorough medical evaluation, cited in Mind or Body, 70% were found to have a medical problem, for instance, diabetes. Low libido in women and men can often be linked to hormonal imbalances and thyroid problems.

Common MMs

While there are at least a hundred medical illnesses that can mimic a psychiatric condition, I've listed below some of the more common ones. For more information, please consult the books listed in the footnote section.

Endocrine disorders, such as hyperthyroidism or hypothyroidism (that is, high or low thyroid). Thyroid problems have become epidemic, possibly due to environmental contamination. Not only do thyroid problems have the potential to cause psychological symptoms, including depression, hypomania or mania, anxiety, panic attacks, even psychosis, but left untreated, they can lead to high blood pressure, elevated cholesterol, infertility, and osteoporosis.

Seizure disorders can cause cognitive and behavioral problems that may be misdiagnosed as simply psychiatric.

Organic brain disorders, such as temporal lobe epilepsy or Alzheimer's Disease, can cause personality changes, mood instability, impulse control problems, and anxiety.

Blood sugar disorders: Diabetes and hypoglycemia may cause irritability, anger problems, anxiety, and mood swings that may be misdiagnosed. Hypoglycemia is a common disorder that often evades professionals. It is rare for people to be medically evaluated for hypoglycemia, since testing is expensive and time consuming.

Lyme Disease: a tick-born illness that can remain latent in a person's system for months or even years after exposure.

Brain injuries: Any injury to the brain can cause damage, especially if the person has lost consciousness, even briefly. It can be helpful to ask whether the person has ever had a brain injury or concussion, for instance, through sports.

Brain tumors can cause a plethora of psychiatric symptoms, including mood swings, anxiety, or changes in personality.

While the following aren't diseases per se, they are important to note because they can lead to physical illness.

Foreign travel, particularly recent, can be linked to viruses, bacterial infections, or parasites, all of which may cause symptoms dismissed as psychological.

Specialized diets, such as vegetarian or vegan. Restricted diets can lead to vitamin deficiencies. Vegetarian and vegan diets are very high in carbohydrates that can cause erratic blood sugar throughout the day. Diets high in fish can be toxic for mercury that may produce cognitive and behavioral problems. Poor eating habits, such as skipping meals or eating too much sugar, can also cause psychiatric-like symptoms, including irritability and anger outbursts.

Vitamin deficiencies, particularly Vitamin D, Vitamin B-12, and Folic Acid. Low electrolytes, perhaps from too little or even too much water, can also cause psychiatric-type symptoms.

Chemical exposure: environmental contaminants, such as mold, lead, and various chemicals can cause symptoms.

Caffeine: In our fast-paced world, many people are drinking so many caffeinated drinks, that they can become anxious, hyperactive, and even manic.

Aspartame: a common sugar substitute in most diet drinks that has been linked to psychiatric and medical problems.

Medications, vitamins, and supplements, some of which can produce psychiatric-like symptoms, particularly in combination with each other or with illicit drugs or alcohol.

Peri-menopause: While symptoms of peri-menopause usually begin when a woman is in her 40's, they can start in her 30's or even, in some rare cases, her 20's. Symptoms can include anxiety, mood swings, and/or panic attacks. Infrequently, peri-menopause can cause major psychiatric symptoms, including mania. It is not uncommon for symptoms to be dismissed as merely psychological.

Conclusion

Dr. Robert Taylor estimates that about l0% of all clients in out-patient therapy have an MM that is causing or contributing to psychological symptoms. The numbers are even higher for inpatients as well as certain populations, for instance, the elderly. Taylor states, "Any human service professional actively engaged in seeing clients can expect to see a significant number of organic masquerades over the course of a clinical career."

As LCSWs, we are committed to help alleviate client suffering. One way to do this is to educate ourselves about medical illnesses that can mimic psychiatric ones. At the same time, we are not medical professionals; we need to be cognizant of the limits of our practice and encourage clients to inform themselves. Armed with information, clients may be able to advocate for themselves with the medical establishment and discover the true reason for their distress.

Footnotes

1 While all of the examples cited are true, identifying information has been changed for confidentiality purposes.

2 Along with the term, "Medical Masquerade," other phrases used to denote the same phenomenon include: "Clinical Masquerade," "Organic Masquerade," and "Psychological Masquerade."

3 Taylor, Robert, Mind or Body, 1982, NY: McGraw Hill. Updated version of the book was published in 2007 under the title: Psychological Masquerade.

4 The American Association of Clinical Endocrinologists issued a press release in January 2003 entitled, "Over 13 Million Americans with Thyroid Disease Remain Undiagnosed." The group stated, "The prevalence of undiagnosed thyroid disease in the United States is shockingly high," and they recommended a narrowing of the TSH range of normal from 0.5 to 5.0 to 0.3 to 3.04. Unfortunately, most doctors and laboratories have not followed these recommendations.

5 Along with Robert Taylor's work, please refer to the following books: Morrison, James, When Psychological Problems Mask Medical Disorders, 1997, NY: Guilford Press; Schildkrout, Barbara, Unmasking Psychological Symptoms, 2011, NJ: Wiley Press; and It's Not All In Your Head, Swedo, Susan and Leonard, Henrietta, 1996, NY: HarperCollins.

This article is reprinted from The Clinical Update, Volume XLV, Number 4, December 2013, the newsletter of the California Society for Clinical Social Work. Stacy Taylor, LCSW, is a psychotherapist in private practice in Berkeley. While she sees clients for most presenting problems, she specializes in anxiety disorders, as well as chronic pain and illness. She is the author of the book, Living Well with a Hidden Disability, published in 1999 by New Harbinger Publications. To contact Stacy, you can email her stacytaylortherapy@gmail.com. Her website is: http://www.stacytaylortherapy.com/

Integrative Clinical Practice and Personal Preference

F. Diane Barth, LCSW

When I was in graduate school, and again in psychoanalytic training, the message about integrating theories was very clear: it muddies the waters, complicates and often interferes with the work, and leaves both client and clinician feeling confused and dissatisfied. Yet even so, my training in both social work and psychoanalysis was, to my mind, made up of a mixture of theories, approaches and ideas. Today the perspective on integrative thinking is significantly different. Connors (2011) calls it a "climate change." Gitterman and Germain (2008) write that clinical work in today's complex world is enhanced by an integrated social work practice and Fawcett (1997) describes a very similar trend in the training of psychiatrists, with psychiatry residents receiving training in behavioral techniques and body-mind concepts as well as psychodynamic concepts and traditional psychopharmacology.

Integration is not isolated to the field of mental health. Ideas from a wide range of other fields such as biology, genetics, neuroscience, medicine, law, religion, philosophy and history are now integrated into clinical practice. Of course the reverse is true as well. Concepts from psychoanalysis and psychotherapy are woven into our culture so fully that ideas like "oedipal conflict" and "separation-individuation" and "secure attachment" are almost taken for granted, even integrated into popular television shows, magazine articles and novels. The idea that parents influence their children's psychological development, once an unrecognized aspect of psychological thinking, is now a cultural given. Yet with more than 400 different psychotherapies in practice today (Roth & Fonagy, 2005), any attempt to integrate can indeed become muddy and confusing if we are not careful. How can a clinician decide not only when, but how, where, what and why to integrate at any given time with any specific client?

This is not an easy question to answer. I have discussed many of the factors involved in my new book (Barth, 2014). Recognizing that making these decisions can be both complex and complicated, I would like to focus in this essay on one very specific aspect of any integrative process, that is, the issue of personal preference. There are many questions that arise as soon as we begin to address this question in the context of clinical material. For instance, whose personal preference are we considering: a clinician's? a client's? a supervisor or instructor's? a theoretician's or author's? Is there a place for personal preference in a psychotherapeutic interaction, or does the very concept imply unbounded countertransference enactments? And what about the question of evidence-based interventions? I would suggest that the issue of personal preference is one of the reasons integrative theory has traditionally had a bad name.

The goal of well-established, scientifically-proven theory is to avoid the possibility that a clinician will impose personal needs and neuroses on unsuspecting clients. Similarly, training and personal psychoanalysis are meant not only to help clinicians develop skills but also to expose and explore personal bias and expand understanding of human dynamics and needs beyond a clinician's personal experience. Yet even within this context, there must be room for what Mishna, Van Wert & Asakura (2013) call "clinical wisdom." As they put it, even evidence-based practices require a use of integration of "empirical evidence … where appropriate, while leaving plenty of room for the knowledge of both practitioners and clients to influence therapeutic interactions." (Mishna, Van Wert & Asakura, 2013 p. 293). It seems to me that it would be useful to openly acknowledge and integrate personal preference into the process of integrative theory. Eisold (2011) has addressed a similar question in relation to psychoanalytic training. He writes,

> …although most institutes have developed under the umbrellas of particular theoretical orientations, they have each also developed particular and distinctive skills and clinical orientations.They can be viewed as communities of practitioners that have trained themselves to notice and respond to particular constellations of clinical problems and issues in particular ways. Given our pluralistic and inclusive world, we all aspire to a range of sensitivities and repertoires of responsiveness, but in fact we have developed in special ways within our unique communities. We are good at some things, less good at others. (p.913)

Wallerstein (1995)suggests that there are two theories of psychoanalysis, which I believe applies to most clinical work, whether or not a clinician works psychodynamically. These are what he calls "theoretical explanatory systems created to give coherence and order and a sense of psychological understanding" and "clinical theory, encompassing the discernible clinical events of conflict, resistance, and transference—countertransference interplay palpable in our daily clinical encounters. (p.528). Like Wallerstein, I have found that clinicians often choose a particular theoretical approach on the basis of their own personalities and psychodynamics as well as those of clients. Schedler (2010) has similarly suggested that evidence-based work can be and often is subject to personal bias. This is not to suggest that we dispense with theory (see Mitchell,1994; and Schafer, 1993 for excellent discussions of the importance of training and personal preference). Like Eisold (2011), I believe that a firm theoretical base is necessary for good clinical work. Further, I would suggest that theory and evidence are both crucial to an integrative practice. I am simply suggesting that personal preference needs to be recognized as a factor even in the training process – for example, personal needs, values and beliefs all influence clinicans' choice of graduate school and postgraduate training, which then influence the theoretical approach taken by that clinician, which then influence how a clinician chooses to practice. Similarly, it is relatively well-known that one of the most significant influences on a clinician's work is her own therapist (see Wallerstein, 1995). Taking personal preference into account would therefore seem to be an important component of the self-reflection necessary to any integrative process. Here is a brief clinical illustration.

In my early days as a clinician, I worked with a number of clients diagnosed with "Borderline Personality Disorder." In those days, Kernberg (2000) was writing about psychodynamic treatment of borderlines, and my supervisor encouraged me to read as much as I could about their understanding of and work with these clients. She also encouraged me to set firm and consistent limits about such things as payments, session times and extratherapeutic contact. Since I was in several cases significantly younger than my clients, I found it difficult and sometimes embarrassing to try to do this. Fortunately for me, most of my clients paid regularly and respected the therapeutic time. Very few called outside of their therapy hours, but when they did they generally seemed to have legitimate reasons for doing so.

However, one older woman, who I will call Mary, was almost always late for her appointments and almost always began to talk about some very painful material near the end of the session. She would sob inconsolably and refuse to leave my office, making me late for my next appointment. She also regularly called me between sessions, often in a crisis, and she would fall apart when I tried to end the conversation. I could end up speaking to her several times a week, each time for at least forty-five minutes, for which I of course was not being paid. My efforts to set limits with her, like my efforts to engage her in an exploration of the behaviors, were met with indignation and criticism. She told me, "You are just an automaton. You just do what the books say to do. There's not an ounce of feeling in you."

Not surprisingly, I found Mary incredibly painful to work with, not just because she attacked me, but because I felt terrible about myself after each session (Davies, 2002, has a wonderful discussion of this aspect of a difficult clinical encounter. Unfortunately, at the time I had not read the article.) On the one hand, I concurred with her assessment of me. I had no sympathy for her. I just felt manipulated and angry. What, I wondered, was the matter with me? What kind of therapist could have no empahty for these terrible stories she told me? On the other hand, I felt incompetent and began to consider other possible occupations – preferably something in which I would have no human contact. When I spoke with my supervisor, she suggested that Mary was using splitting, projection and projective identification to get the bad parts of herself out and into me. As a result of these defenses, she could feel that she was good, but it meant that she saw me as all bad. Yet despite – or maybe because of – this splitting, Mary stayed in therapy with me, and I continued to be a therapist. I am not sure that I helped her very much, but the therapy was certainly intense and interesting – for her, I believe, as well as for me.

I began to read Kohut (1971) and discovered Adler (1985), a self psychologist who focused on some of the self-selfobject needs of clients with borderline personality disorder. I learned that Mary could not hold onto an image of me in the time between our sessions, and that without that connection, she could not soothe herself when she became sad or angry. Her splitting, Adler suggested, was the result of fragmenting, which was related to both poor object constancy and an inability to manage her affects. Following Adler's suggestions, I began to set up regular, time-limited and very structured phone contact with Mary between sessions. With the knowledge that she was going to speak to me on a daily basis, she was soon able to stick to the ten minute limit I set on our conversations. I also began to explain to her

that I was going to stop our session ten minutes ahead of time so that we could review and wrap up any difficult discussion. She pushed back, but this technique seemed to help, with the result that she began arriving on time and leaving almost on time.

Of course, much has been written about these disorders since that time. Linehan (1993) offes many useful techniques for handling the kinds of struggles that clients like Mary deal with on a daily basis. Today I integrate many of these ideas into my work with clients with Borderline Personality Disorder. I have learned over the years that not only does a client's needs and personality play an important role in my decisions about when to utilize different techniques, but I also have learned that my own needs at a given time will also be factors. When supervising other therapists, I encourage them to consider different approaches, to learn not only techniques but also theory and research behind the techniques. I then open up a question of what seems most manageable to them – based on their knowledge of a specific client and also of themselves. A very quiet, sensitive and soft-spoken therapist once told me that she thought a firm, possibly even aggressive approach would be most useful for a particular client. I asked if that was something she was comfortable doing. She smiled wryly and said, "No, I was just thinking that it would be a good way to get rid of her!"

Conclusion

To conclude, I would like to make two final points. First, we cannot do what we cannot do, no matter what theory we choose to follow. Training allows us an opportunity to expand our comfort zone, to try new approaches and consider new theory. It also allows for a period of confusion, which is a necessary, albeit often unpleasant component of learning. But it is also important to remember that, no matter how much skill and knowledge one has, no single clinician can work effectively with every client. As Eisold (2011) writes, "We are good at some things, less good at others." (p.913) When we recognize the role of personal preference in our integrative choices, we can also accept that there are some clients who need an approach that we cannot – or do not wish to – provide. This may be a discussion for another essay.

Thinking about and exploring different theories and approaches, and trying to find a way to use what might actually work for Mary made me aware of dynamics I did not understand and helped me work with her. Yet openly acknowledging and integrating personal preference allowed me to explore which techniques felt not only more helpful for Mary, but also more manageable for myself as a clinician. Learning about a wide range of approaches is both necessary and therapeutic in today's integrative climate. Recognizing the role of personal preference makes an integrative practice more manageable.

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The Strengths and Weaknesses of Interpersonal Skills

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We all want to become better clinicians, to become more effective at our profession.

To accomplish this, we buy the latest book, attend the latest workshop, practice mindfulness and engage in whatever we believe will facilitate our growth.

Most times, we try to learn new theories and paradigms for perceiving and influencing behavior, both the client's and our own.

Our labels and descriptions of others tend to statically objectify process. We then maintain an illusion of certainty about the other, and perhaps about ourselves as well.

The danger here is that the more we think we know, the less we really see as our vision is altered through the lens of our ideas.

These thoughts may merely reflect our humanity, after all we are only human. Yet, if we begin to believe or invest in these thoughts as the only reality we are being inauthentic and creating empathic failure.

The research on the common factors, as well as on feedback is pretty conclusive: empathy, genuineness, the provision of hope all correlate with competent performance.

(Duncan Miller and Hubble, 2004). When outcome and process measures are solicited from the client, this leads to improved therapeutic effectiveness. But as Scott Miller has stated, these factors and procedures also lead to a plateau where performance remains somewhat static for most of us.

Evidence of Other Competent Interpersonal Skills

Lambert, Anderson, Ogles, Patterson and Vermeersh's (2009) research study on therapeutic effectiveness followed this trend. The highest success rate from this study correlated to high performances in the Facilitative Interpersonal Skills Task. (FIT) This instrument measured therapist's skill sets in perceiving, understanding and communication as well as the capability to influence others to apply suggested solutions and change behaviors. The scales included verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance bond capacity and problem focus.

Along with this, Dr. Daniel Goleman, in his research on neurobiology and emotional-social-intelligence, breaks down empathy (and other interpersonal traits) into two categories: perceptual and relational. In the perceptual arena, there is "*primary empathy*" based on mirror neurons that we have in the amygdala. These neurons reflect and mimic another's emotional state on a subliminal level. Certain neurological injuries and illnesses (such as autism) may impact our ability to perceive others feelings. He also discusses attunement and pacing which can be best described as listening with full receptivity, giving undivided attention to the other. In this manner we are practicing acceptance and perhaps "unconditional positive regard." Next he describes "*empathic accuracy*." Here we are connecting the neo-cortex with our inner experience and perception. In this manner we are developing conscious awareness of what the other is experiencing. And of course our accuracy will increase when we solicit feedback from the other. Finally, he discusses "*social cognition*." This is knowledge about how the world works, an understanding of outspoken social norms and ability to decode social signals in groups and knowing how one's behavior may impact others.

The relational side of empathy is more proactive in our exchanges. First comes "*synchronicity*," the ability to unconsciously adapt to the social cues we perceive. It is an intrinsic flexibility to be in harmony and sync with the other's emotional state. Next, "*self-presentation*" is the ability to present one's self in ways that make a desired impression. It's the ability to assume a posture without posturing. In a sense, it's the ability to be authentic and genuine. "*Influence*" involves the constructive shaping of an outcome of an interaction using tact and self-control. Goleman suggests that this involves the modulation of our impulses for dominance with both empathy and social cognition.

It is a kind of confidence that we bring to the table. Finally, "*concern*" is our impulse to take empathic action for others. It is authentic compassion.

Strengths as Weaknesses

So, we have a variety of respected researchers telling us what behaviors correlate with successful therapeutic outcomes. So why can't we just start a whole new process for training and educating our mental health professionals?

Well, aside from the politics and conflicts between schools of thought and academic institutions highly invested in their own paradigms… we have another problem.

I would contend that we have been missing something important in our analysis.

I would think that all of these behaviors and traits would be considered strengths for any clinician, and for most all people and professions.

The problem is, every strength is also a weakness. And frequently, most of us can't really tell which is which. What I mean by this is simply that an objective observer may not be able to differentiate the "genuine" positive behavior from it's negative "counterfeit." This may be due to a variety of factors, including the abstract levels of meaning for the labels we have as well as the fact that strength and weakness are best defined and seen in specific contexts.

Receptive Non-Directive Behaviors

For example, let's take a look at some of what I would like to think are some of the more positive *RECEPTIVE/NON-DIRECTIVE* behaviors linked to competent clinical interactions. I believe that these actions are more passive and reactive to another's verbal and nonverbal communications. A few of these may be acceptance, *compassion, trust, openness, patience and flexibility*. If the old adage is indeed true then these behavioral qualities may have a "*shadow*" side where they become weaknesses:

Receptive Strengths	Receptive Weaknesses
Acceptance	Complacency
Compassion	Pity and Sympathy
Trust	Gullibility
Openness	Exposed, Defenseless
Patience	Procrastination
Flexibility	Placation

Receptive Directive Behaviors

Likewise, we also have more proactive RELATIONAL-DIRECTIVE behaviors that are also highly effective at helping people to change. These are the means we may use to influence another's actions and process. Here are a few and their likely shadow counterparts, where they become weaknesses as well:

Receptive Strengths	Receptive Weaknesses
Assertiveness	Aggressiveness,
Directness,	Controlling
Genuineness	Denigrating,
Ordered/	Belittling
Structured	Obsessive
Spontaneous	Compulsive
Humorous	Impulsive
Verbal Fluency/	Sarcastic, Mocking
Facileness	Manipulative
Confidence	Righteousness,
Pride	Rigidity
	Arrogance

Now you may contend that these are qualitatively very different behaviors over all.

I would agree with you. Yet, can you really tell them apart from mere observation?

I don't know if there can be any objective certainty any one of these behaviors from its' "shadow" form, except for at least one of the participants in the interaction. In this sense, the determination is purely subjective. The difference between making love and rape is consent. If we have no awareness as an outside observer to that consent, it would be difficult to tell the difference.

Determining the Difference

Here's where the clinician needs to make valuation of their own process, the client's process and the outcome for the client. The positive receptive aspects all have one feature in common. They are used to empower BOTH the other and the self, much like Martin Bubers I-Thou relationship. I believe that all receptive strengths turn into weaknesses when the clinician (or any person) compromises their own health, welfare, esteem and integrity for the "other," and/or simply to maintain a relationship with the other.

(Let's differentiate "clinician" from "parents of infants and children" here, despite our tendencies for counter-transference.)

The "heroic" therapist often sees the client as a "victim" and can diminish their strengths, resilience and abilities. I would contend that they are survivors of that abuse, not mere victims. Yes, we need to be empathic and ally with any client who is in pain or fear and be able to emotionally partner with them, even in validating how they have been misunderstood and injured. Yet we also need to be cautious. Would-be heroes also tend to create a "villain" in the process and of course vilify others in the client's life not deserving of such a label. This is not to say that our client's are never used and exploited by others, or suffer from abuse and neglect. We have both a moral and legal obligation to protect children, the elderly and those who would be harmed by our client's actions (including suicidal actions against themselves). However, it is not up to us to save anyone, perhaps except ourselves. Our clients will save themselves as well...Yet perhaps there is something deeper here…

There are those folks out there that believe that they have the right to use and exploit others, sometimes for a good cause. Our relational strengths become weaknesses when we compromise another's health, welfare, integrity or esteem to benefit or aggrandize ourselves. When we are invested in proving how good we are or in demonstrating our knowledge, authority, power and control for our ego's sake –then we are all in danger.

Consequently, I would suggest that we have three ways to differentiate receptive and relational strengths and weaknesses in any clinical interaction:

1. Initiating informed consent about the scope of our capabilities and limitations as a clinician.
2. Obtaining feedback from the client on our receptive and relational behaviors for process effectiveness.
3. Obtaining corroboration about the client's behavior through feedback and significant others for outcome effectiveness.
4. Continual self-analysis and self-awareness of the client's impact on our affect, imagery and ideation.
5. Getting consultation when we are unsure and stuck.

Defining Health, Welfare and Esteem/Integrity

We all have various codes of conduct we're required to follow in order to maintain our licenses, accreditations or standings in some professional organization. These are both laws and ethical standards that we all attempt to follow. To break these rules may jeopardize both our ability to practice and subsequently the welfare of our clients.

I'm not really talking about these as much as I am as getting clinicians to define these very subjective abstractions for themselves, as well as to obtain them from their clients. Our mandate is simple, taking care of ourselves and while providing effective care for our clients based on the collaborative goals set in therapy. With all labels we can maintain an illusion of certainty about the other and perhaps about ourselves as well. The danger here is that the more we think we know, the less we really see as our vision is distorted through the lens of our ideas. We need to embrace our confusion, to be open to the possibility of change. Yet we still need to embrace our certainty to maintain the boundaries of our security.

Obviously we need to learn how to do both. Here's another way to see it:

POSSIBLE TRAITS OF A TRULY EMPATHIC-EFFECTIVE CLINICIAN

- Compassion without pity.
- Pride without arrogance.
- Humility for it's own sake.
- Adaptation without placation.
- Honesty without righteousness.
- Humor without depreciation.
- Knowledge without idealization of said knowledge.
- The ability to follow, lead and to wait.
- A healthy disrespect for unnecessary pain, martyrdom and tyranny.
- A healthy respect for the intent behind behavior.
- A genuine liking of human beings.
- A genuine liking of one's self.
- The ability to hold a position that maintains integrity.
- The choice to be effective as opposed to merely being right.
- A capability to accept and admit to confusion and limitations.
- An equal capability to embrace certainty and strength.
- Openness, receptivity, and natural warmth.
- The ability to hold the client accountable for their choices and behavior.
- The ability to readily admit to one's mistakes, errors and to actively repair the alliance.

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Can Therapists Depend on Evidence-based Treatments to Create Positive Outcomes in Psychotherapy?

George Rosenfeld

Contemporary psychotherapy, especially in the public sector, is evolving into the treatment of problems by evidence-based techniques. Supported by face validity and increasingly required for reimbursement, this treatment model is gaining acceptance as the standard of care. However, there are concerns with this latest direction that economic and political forces are driving psychotherapy. Although treatments supported by research should be relied on, the concern is that the rush to apply evidence-based treatments may be premature, inadequately supported by research, and often unsuccessful.

The clinical research suggests two challenges to relying on evidence-based treatments:

First, the research literature indicates that all active therapies seem equally effective, and therefore, no particular theoretical approach is dramatically superior to another, so there are no treatments of choice. *The Consumer Reports* survey ("Mental Health," November, 1995), the National Institute of Mental Health (NIMH) Treatment for Depression Collaborative Research Program (Elkin, et al., 1989), and meta-analyses of comparisons of active treatments (Luborsky, et al., 2002)[1] , and "Study after study, meta-analysis after meta-analysis, and Luborsky, et al.'s meta-meta-analysis have produced the same small or non-extent difference among therapies... the evidence points to all active therapies being equally beneficial (Messer & Wampold, 2002, p. 19)." This finding that most forms of psychotherapy do about equally well is known as the **Dodo bird verdict** based on the Dodo bird's quote in *Alice in Wonderland* that "everybody has won so all shall have prizes."

If treatments are equally effective and their unique therapeutic qualities do not foster more change than other active treatments, then we are led to conclude that factors that active therapies have in common account for client change. This is not a new discovery. Building on the pioneering work of Rosenzweig (1936), Jerome Frank (1971, p. 350) identified factors common to all psychotherapies that contribute to their success. His research indicated that: "Common to all psychotherapies are an emotionally charged, confiding relationship; a therapeutic rationale accepted by patient and therapist; provision of new information by precept, example and self-discovery; strengthening of the patient's expectation of help; providing him with success experiences; and facilitation of emotional arousal." Recent formulations of the Common Factors sub-divide them into Treatment Techniques, the Therapeutic Relationship, Client Characteristics, Extra-therapeutic forces, and Placebo effects. Research has shown that each of these common factors is highly related to outcome and each can be sufficient to create change or derail progress. Treatment techniques appear to account for 5-15 % of the variance of outcome, while the other forces of change account for the other 85%; therefore forces other than treatment techniques should be the central focus of our efforts to improve treatment effectiveness.

The second challenge to depending on evidence-based treatments is that the research literature is incomplete and difficult to apply to clinical work. The vast majority of treatment approaches have not been subjected to sound outcome research. Only a few treatments have been studied empirically. For instance, in a review of outcome studies on youth in the last forty years, 71% involved learning-based (cognitive-behavioral and behavioral) interventions (Weisz, Doss & Hawley, 2005). However, "Family therapy, and parent work in parallel with individual treatment for the child, have rarely been evaluated, despite the fact that these are probably the most frequent psychosocial approaches in routine clinical work (Roth & Fonagy, 2006, p. 423)." These researchers concluded that "in many respects the field is at too early a stage to make many evidence-based recommendations about which treatments

[1] Based on comparisons of active psychotherapies for adults, these researchers meta-analyzed 17 meta-analyses and found a "low and non-significant" difference between treatments (Cohen's d=.20) which was further reduced after correcting for the researcher's alliance (d=.12). Miller, Wampold & Varhely (2008) replicated these findings in outcome studies on youth.

show the most benefit for which disorders" (p. 424).

Other types of selection biases make it difficult to generalize research findings to clinical populations. Clients are a different species than research subjects who are often selected for their potential to benefit from the intervention. For example, comorbidity runs rampant in clinical practice while researchers seek subjects who have only one diagnosis. Probably 50% of patients can be expected to have at least one comorbid diagnosis (Wittchen, et al., 1998). Twenty-one percent of people with one DSM-IV diagnosis might meet the criteria for 3 or more disorders (Andrews, et al., 2002). Therefore, research subjects who typically have one diagnosis can be expected to be healthier than therapy clients. So it is no surprise that "The more patients excluded in a given study, the higher the percent of patients that showed improvement." (Westen & Morrison, 2001).

A major concern with therapy built on treatment techniques is that it marginalizes the contribution of the common factors instead of building upon them to improve outcome. The following are some of the sources of change that could be a focus of treatment but risk being disregarded when therapy is viewed as the providing of treatment techniques.

Client characteristics: What the client brings to the session is often minimized in treatments where change is attributed to what the therapist does. Some clients are resistant; while some get better despite the therapist, as they take from therapy what they need. The clients' motivation, theory of change, capacity to use a relationship to foster healing, ability to cope with stress, expectation of success and failure, their developmental level when problems began, and other factors can dramatically influence outcome. Not dealing with these characteristics can undermine treatment. In treating youth not only their characteristics need to be considered, but the caregiver's views need to be dealt with for therapy to be successful. "Parents' beliefs about the cause of their children's problems, perceptions about their ability to handle such problems, and expectations about the ability of therapy to help them… influence three aspects of treatment: help seeking, engagement and retention, and outcome (Morrissey-Kane & Prinz, 1999, p. 183)."

The therapeutic alliance cannot be relegated to the sidelines. The degree of agreement between client and therapist on goals (Tyron & Winograd, 2002; Creed & Kendall, 2005) and methods to accomplish them, and the affective bond between therapist and client, all of which compose the therapeutic alliance, correlate similarly with outcome (r=.22) in adults (Martin, Graske & Davis, 2000) and in youth (Shirk & Karver, 2003). The therapeutic relationship can be therapeutic in itself or it can facilitate the effectiveness of therapist interventions. The strength of the alliance can enable clients to stay in therapy when an intervention does not initially work and the alliance can allow clients to work through ruptures in the therapeutic relationship when the therapist upsets the client by not conforming to the client's transference expectations. It is often the capacity of the alliance to rebound from this type of damage that is associated with client improvement (Stiles, et al., 2004). In treating youth the therapeutic alliance with their caregiver(s) is moderately related to the youth's outcome (Karver, Handelsman, Fields & Bickman, 2006).

Therapist characteristics of friendliness (Samstag, Batchelder, Muran, Safran & Winston, 1998), warmth and genuineness (Truax, Altmarm, Wright & Mitchell, 1973), positive regard, empathy (Rogers, 1957; Miller & Baca, 1983) and support vs. confrontation (Keijsers, Schaap & Hoogduin, 2000), as well as the therapist's faith in the client and the treatment plan have been shown to predict outcome (Luborsky, McLellan, Diguer, Woody & Seligman, 1997). Also, the timing of interventions is often crucial. A common error is to introduce an intervention before the client is ready. Surprisingly, the therapist's gender, type of academic degree, years of training (Berman & Norton, 1985) and theoretical orientation do not appear related to outcome.

Common processes embedded in most interventions contribute to outcome. They might include: providing hope, desensitization, operant conditioning, modeling, the disconfirmation of irrational and pathological beliefs (Weiss, 1993), being listened to by a caring person, shifting the client's focus of attention (for example, from affect to cognitions, from self to others, from present to past, and visa versa), focusing the client's attention on an acknowledged problem or a problem that the client has been told that he or she has, and activating client self-observation (Beitman & Soth, 2006; Korotitsch & Nelson-Gray, 1999). In most treatments the client receives encouragement and support to change and the client's attention is focused on therapeutic activities between sessions while their problems are explained in a way that (1) replaces the pessimistic way the client has constructed his or her condition and (2) encourages the client to pursue more healthy responses. Typically problems are reframed and externalized.

Also, irrespective of the type of therapy one of the most powerful things a therapist can do to improve outcome is to solicit feedback from the client about the session, the course of treatment and the state of the therapeutic relationship. Clients may be better judges of their progress than therapists, since clients' ratings of the strength of the alliance correlate higher with outcome than therapist's ratings (Horvath & Symonds, 1991; Bachelor & Horvath, 1999). Treatment outcome has been shown to improve when clients give therapists early feedback about their sense of progress in therapy and their disappointments with the therapeutic alliance (Duncan, Miller & Sparks, 2004; Miller, Duncan & Hubble, 2004). Just giving therapists feedback that clients are not progressing can improve client attendance and outcome (Whipple, et al., 2003). It's scary but productive to ask the client for feedback.

Extra-therapeutic forces can affect treatment efficacy. After Jay Haley helped propel family therapy to be the orientation of choice for many therapists, he then wrote a possibly satirical paper extolling the benefits of individual therapy for children (Montalvo & Haley, 1973) in which he identified many powerful aspects of individual therapy. Surprisingly none of these powerful contributors to change were a part of the actual treatment. They were all extra-therapeutic processes. For example, he noted the benefits of the child having individual time with the parent while they traveled to and from treatment, the pressure on family members to change their behavior to look good to the professional to whom the youth was reporting about their behavior, the competition parents might feel if they worried that the child was becoming too fond of the therapist-outsider, the need to organize the family to keep regular appointments, the parents' need to set more limits on their child who might have been given subtle permission to act-out by being treated by a therapist who was permissive in the service of encouraging the child to express him or herself, the elevation of play as a means of relating to the child, and the parents tendency to rely on the therapist thus altering patterns with other family members. Outcome can be dramatically influenced by such forces as relatives' support or sabotage, access to community resources, finances, scheduling difficulties, family pathology, and new found love or religion.

Placebo effects are robust and contribute to client improvement. The research indicates that when compared to placebo treatments that are provided by equally trained therapists, who provide a similar number of sessions of similar length, treatments do not have significantly different outcomes from placebo treatments (Wampold, Minami, Tierney, Baskin & Bhati, 2005). The therapist's and client's belief in the therapy, rather than the therapy itself can determine the course of treatment. Probably "50 percent of clients respond well to placebo drugs or therapies (Seligman, 2002, p. 6)."

To recap: Therapists should not view themselves as primarily providing evidence-based techniques to produce change. Change in psychotherapy is influenced by treatment techniques; but outcome is more strongly affected by interrelated common factors, particularly client characteristics, the therapeutic relationship, therapist characteristics, common processes in treatment techniques, extra-therapeutic forces, and placebo effects. Enriching these factors can be more productive than obsessing about treatment techniques.

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What I Had Before I Had You

Gail Nagel LISW-CP, DPNAP

Sarah Cornwell takes us to the Jersey Shore, Snooki's home base. You can smell the hot dogs rotating on the open-air grill from the greasy spoon, the day old popcorn and the spilled sodas on the sun heated boardwalk. The noise of the game rooms and carnival rides overrides the sound of the ocean. The setting is as gritty as this story of three generations in a family struggling with mental illness.

Unlike Jeannette Walls' *The Glass Castle*, this is not a memoir. However Sarah Cornwell is as familiar with her characters as if they grew up together. The poignant manner in which she sculpts Myla, Olivia and Daniel reveals her affection for these people. She extends beyond the consequences of untreated mental illness, to the deeper issues in all families about acceptance and forgiveness.

This is her first novel, following her success with short story and in screenwriting. In her bio you discover she is the daughter of a therapist and counts as friends many who work within the field. Her writing is intensely visual and in the essence of short story, almost poetic in its language. It's believable, not like some of the overly dramatic scenes we see in cinema or television. It moves beyond the stereotypic to develop the individuals in ways that allow the reader to identify.

Those of you familiar with magical realism, such as the work of Gabriel Garcia Marquez in *One Hundred Years of Solitude*, will appreciate the author's use of that binary aspect to depict situations between Myla and her daughter Olivia. As you read, you wonder if a state of mania embodies that same duality of what is real and what is fantasy. Your clarity regarding the seduction of the illness is enhanced by Olivia stating her understanding regarding her mother, "What if all the transcendent moments of your life, the sound-track moments, the radiant detail, the gleaming thing at the center of life that loves you, that loves beauty – God or whatever you call it- what if all this were part of your illness? Would you seek treatment?"

Now, you might ask, as clinical social workers, this is 'busman's holiday', so why would we want to read it? In a roundabout way, this is a resource. I was having a conversation with a client who asked if I had read Alexander McCall Smith's *No.1 Ladies Detective Agency*. In fact, I had. She went on to say, "With my family history how would I know what a good relationship was? But reading this book and seeing how the two main characters related, I know I want that."

Isn't this the stuff of narrative therapy? We all have life events that we strive to give meaning, our stories and the reworking of them through time, give us perspective on just what happened, why and what do we do with it now. Michael Hoyt, author of *Some Stories Are Better Than Others*, states, he is "more and more interested in what is sometimes called narrative constructivism, how people put their story together. Rather than having the idea that we discover our reality, or that it's an objective thing that we find, we are oftentimes creating it. How we look at things affects what we'll see; and what we see affects what we'll do."

Sarah Cornwell's book is illustrative of family struggles, disappointments and has a generosity of spirit as exemplified by Olivia who forgives her mother for her choices stating she was "a burning star, a tigress, a prophet". To quote Garcia Marquez, "What matters in life is not what happens to you but what you remember and how you remember it." Perhaps something we could all embrace.

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