Part 5: Boundaries, Ethics and Professional Development

David S. Prescott, LCSW, LICSW
2023
Welcome!

Safer Society FOUNDATION

1

Welcome!

2

Flow

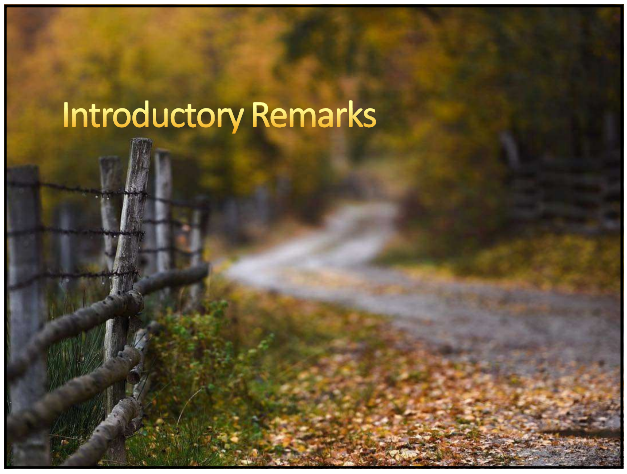
- Introductory remarks
- What are ethics?
- What are the most common issues?
- Case examples from the field
- Boundaries
- Professional development: Where do we go from here?

3

Please note

- I'm including lots of extra slides!
- These are for your enjoyment and thought.
- They are a bonus and not the result of poor time management.
- If we can cover them, we will. ☺

4



5

Warning!

- This will be provocative
- We should come down on only one side:
  - Thoughtful, ethical practice

6

Safety

- Keep it simple!
- Our work is hard enough
- Be careful out there!
  - (With apologies to Hill Street Blues…)

7

Trivia Questions

- What is the number one crime committed by treatment providers?

If you thought that was easy…

- What is the second most common crime committed by therapists?

8

Consider…

- *Unless we are truly supporting autonomy in our attempts to help people, we may not be helping them.*
- "Am I supporting autonomy and if so, how?" can be an excellent first step in resolving issues.

9

Major considerations in trauma

1. Distinguishing facts from appearances
2. Objective reality/findings and client experience
3. Questions about our role and who the client is:
   - Autonomy support versus righting wrongs/fixing things
   - Seeking disclosures of trauma based on therapist beliefs

10

Ethics or Boundaries?

- The case of the trauma therapist who…
- bought emotional support equipment…
- to bring his dog onto airplanes

- How does integrity factor into our work?
- How might our our integrity blunders become retraumatizing?

11

Major Problem

- Ethical and boundary problems happen to people who think they're at no risk.
- Being a little anxious about boundaries and ethics can be a good thing.
  - Good people can do bad things
- For managers, our ethics should include providing an excellent workplace as well as outstanding treatment

12

13

Ethics

- Codes vary according to profession, although the central tenets can be very similar.
- Be sure to be familiar with the ethics codes of your profession and professional organizations.
- Be aware that laws also vary by state, province, and other jurisdictions.

14

15

What are ethics?

- Principles for behavior.
- The moral correctness of conduct
- Ethical codes protect the client and guide the professional

16

Ethical Practice

- We have a duty to ourselves, our clients, and our fellow citizens to maintain ethical practice at all times.
- Breaches of professional ethics always lead to harm.

17

The Big Three

- Beneficence
  - Kindness, wellbeing, mercy, etc.
- Autonomy
  - Client right to self-determination
- Nonmaleficence
  - Avoiding harm or unacceptable risk of harm

18

Why should we care about this?

- Threat to safety of clients, staff, and public
- Known high-risk context for escape
- Venue for contraband and drug traffic
- Contaminates the treatment environment
- Illegal, unethical, and policy violation
- Disaster for employee, family, and facility or organization

19

Relationships & Boundaries

- Do you look forward to seeing a particular client when you come to work?
- Have you done anything with a client you would not want your supervisor or your family to know about?
- Would you be reluctant to have a coworker observe your behavior for a whole day?
- Do you talk about personal matters with clients?
- Do you believe you can ask a client to do personal favors for you?
- Have you ever received personal advice from a client?

20

Relationships & Boundaries

- Have you said anything that you wouldn't want recorded?
- Do you have thoughts or fantasies of touching a particular client?
- Do you have the right to touch a client wherever and whenever you want?
- Do you have a feeling of not being able to wait to share good/bad news with a client?
- Do you think clients are not allowed to say no to you, no matter what you ask?
- Have you ever allowed clients to talk about past sexual experiences or sexual fantasies, or tell sexual jokes in your presence outside of treatment?

21

Robin's Rule

When you're getting ready in the morning, check yourself out in the mirror.

If you say to yourself…

"Hey, you look pretty good."

…Check yourself out again.

22

Responsibility

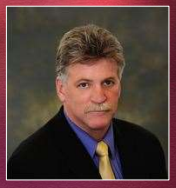
Generally speaking

- Our client is:
  - The clients themselves
  - Their families
  - The programs
  - The community

23

Sawyer & Prescott, 2011

- *The therapist has an ethical responsibility to the client, a legal responsibility to the court, and a moral/ethical responsibility to the community*



24

25

Vulnerabilities

- It is easy to minimize vulnerability when:
  - Clients are ambivalent about treatment
  - Their crimes are severe
  - They have exploited the vulnerabilities of others

26

Smith & Fitzpatrick, 1995

- Three principles underlying therapist-client relationships:
  - Abstention: refraining from self-seeking and personal gratification
  - Neutrality: Focusing on the client's therapeutic agenda
  - Therapists strive for client independence and autonomy

27

28

Trivia Question

- What are the two most common ethical complaints in our field?
- Coercive treatment
- Misuse of assessments

29

Novotny, 2020

- Common ethical mis-steps and how to avoid them:

1. Working outside your scope of practice
2. Not documenting suicidality or violence
3. Failing to protect patient privacy

30

Pope & Vetter (1992) ethical quandaries

Category	n	%
Confidentiality	128	18
Blurred, dual, or conflictual relationships	116	17
Payment sources, plans, settings, and methods	97	14
Academic settings, teaching dilemmas, and concerns about training	57	8
Forensic psychology	35	5
Research	29	4
Conduct of colleagues	29	4
Sexual issues	28	4
Assessment	25	4
Questionable or harmful interventions	20	3

31

Pope & Vetter (1992) ethical quandaries

Competence	20	3
Ethics (and related) codes and committees	17	2
School psychology	15	2
Publishing	14	2
Helping the financially stricken	13	2
Supervision	13	2
Advertising and (mis)representation	13	2
Industrial-organizational psychology	9	1
Medical issues	5	1
Termination	5	1

32

Pope et al. (2021)

1. State the dilemma, question, or concern as clearly as possible
2. Anticipate who will be affected by the decision
3. Figure out who, if anyone, is the client
4. Assess whether our areas of competence – and missing knowledge, skills, experience, or expertise – are a good fit for this situation

33

Pope et al. (2021)

5. Review relevant formal ethical standards
6. Review relevant legal standards
7. Review relevant research and theory
8. Consider whether personal feelings, biases, or self-interest might affect our ethical judgment.
9. Consider whether social, cultural, religious, or similar factors affect the situation and the search for the best response.

34

Pope et al. (2021)

10. Consider consultation
11. Develop alternative courses of action
12. Think through the alternative courses of action
13. Try to adopt the perspective of each person who will be affected.
14. Decide what to do, review or reconsider it, and take action.
15. Document the process and assess the results.

35

36

37

To disclose or not to disclose?

- Client doesn't know if she should confront the male family member who abused her.
- Resolving ambivalence versus providing advice.

38

39

To disclose or not to disclose?

- Youth in treatment discloses molesting his mother while she sleeps.
- What are the limits of confidentiality?
- What are obligations to disclose?

40

41

Confidentiality

- 12-year-old: What we talk about is confidential, right?
- Clinician: Yes, and…
- 12-year-old: Good, 'coz my dad's been taking pictures of me with no clothes on, only necklaces. What should I do?
- What's the ethical dilemma?

42

Key aspects of informed consent

43

Informed Consent – Civil Commitment

- 1) A client signs consent to treatment but he spells his name backwards
- 2) The same client then signs his name upside down
- 3) A client signs informed consent and adds "Signed under duress and threat of returning to prison"

44

Child Sexual Abuse Imagery

- A client in treatment discloses having viewed child sexual abuse imagery. He is not subject to court orders or supervision conditions.

45

46

Threat

- 14-year-old
- Privacy is everything
- Conversations with guardian happen only in his presence
- Threatens to kill his 3-year-old sister

- What's the ethical dilemma

47

Disclosure

48

Excited Utterance

- Doc, there's something I gotta tell you…
- I killed a guy in a barfight…

49

50

Those pesky disclosures

- I was 13
- At a party
- I saw an 18 year old shoot dope
- He died
- They took him out to the woods and buried him
- What's the ethical dilemma? How to resolve?

51

52

Ethnicity

- Civil commitment
- Allegations of institutional racism
- Led to the unfortunate nickname…
- *Prescott Hair Initiative*

- What's the dilemma? How to resolve?

53

Polygraph failure

- Polygraph w/o parental consent
- Moving forward
- Moving back
- What do we need to know?

- The case of the angry man whose results led to questions of murder.

54

55

Records

- Juvenile justice agency
- Records are confidential
- Outpatient providers can't access inpatient records
- What's the dilemma? How to resolve?

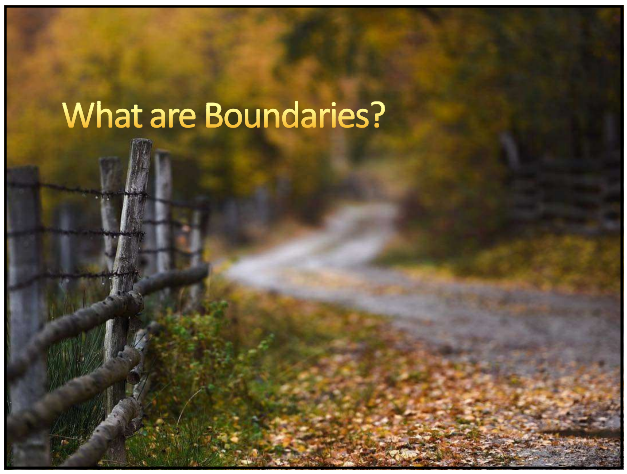
56

Additional Considerations

(Thanks to Pope & Vasquez)

- Being ethical is an ongoing process
- Being ethical is a verb, not a state or trait
- Formal codes don't take the place of thoughtful approaches
- Legal standards should not be confused with ethical responsibilities
- The overwhelming majority of professionals are conscientious and caring
- Many of us are better at spotting ethical issues in others than in ourselves

57



58

What are Boundaries?

- Protected and connected
  - Both are required for the safety of all

59

Protected and Connected

60

61

Ask

- How does this action benefit the client?

62

Be very, very clear about your intentions

63

EMAIL is DISCOVERABLE

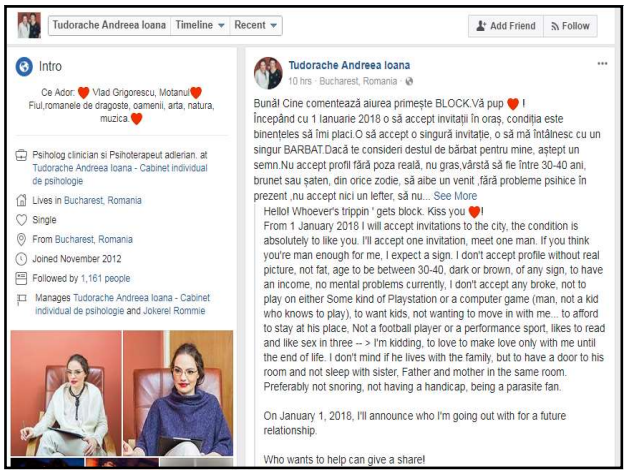
- You only think they need probable cause…
- DOC investigation turns up ties to others employed elsewhere
- Administrator affair with supervisee
- Leaked emails regarding Harvard cheating
- "confidential" incident report leaked to home addresses
- ATSA listserv restrictions
- Spilled cup of coffee

64

Social Media

- Public versus private settings
- Visibility to clients and their families
- Visibility to colleagues and co-workers
  - Gun auction example
  - "I call them MAPs" discussion

65



66

Two kinds of boundaries…

Structural:

- Clarity and consistency of
  - Time
  - Place
  - Fees
  - The service itself

67

Two kinds of boundaries…

- Interpersonal:
  - Physical contact
  - Gifts
  - Self-disclosure
  - etc.

68

Consider…

- Attempting to "save" clients
- Expectations of trust
- Physical touch
- Personal space and related boundaries
- Role of client feedback

69

What's what?

- Boundary crossings: non-pejorative. Departures from commonly accepted practice. May or may not benefit the client.
- Boundary violation: Departure from accepted practice that places the client or therapeutic process at risk.

70

Before we talk about anything else

- How to manage ethical and boundary violations:
  - Culture: No secrets (repeat X3)
  - All staff make clear to others there are no secrets anywhere (repeat X3)
  - This is for the safety of clients and the program alike
  - Make every attempt to involve the other person

71

72

Examples

- I'm not sure this is such a good idea. Let's both go talk to the director.
- We both know that this can't stay secret. Would you like to speak with the director before I do, or should we both go together?
- We can't be in this situation alone. It would be bad for the kids, the program, and us. We need to talk to the director

73

What happens in programs that have few or no complaints?

74

Encouragement

75

Our work environments

- Expect hard work and professional development (deliberate practice)
  - ("when do I start?")
- Everyone is responsible for their own morale
  - Step up to the plate
- Part of drawing a paycheck is showing up to work…
  - Ready, willing able
  - Rested

76

77

Think prevention

78

An ounce of prevention

- Documentation
  - Why document?
    - Contractual obligations
    - If we were all hit by a bus…
    - Protection of all parties
  - If it's not on paper it doesn't exist

79

What makes the professional?

- Dress Code
- Showing up – timeliness
- Follow-through
- Open Mind
- Presentation of self – manners, etc.
- Life-long commitment – who you have been to this young person and their family can never change.

80

#1: Team Spirit

- Everyone is depending on you
- Be on time, do what you say you'll do
- Be helpful
- Give more than you get

81

Do no harm

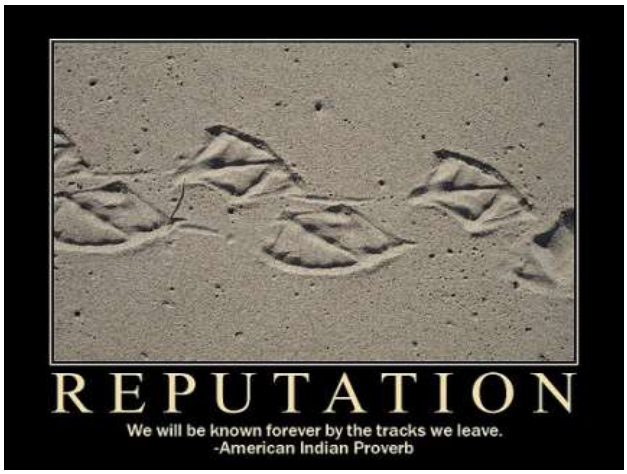
- No sex
- NEVER say bad things about clients or their families
- No scared straight
- Be strength-driven, not symptom-driven

82

83

Dual Relationships

84



85

Dual Relationships

- Probation officer as co-facilitator
  - Observes group
  - Equal responsibility for treatment?
  - Represents court
  - Carries out orders of the court
  - Therapist can then be seen as agent of the court
  - Affects therapeutic alliance (?)
  - Increased client vulnerability due to wanting to look good?

86

Dual Relationships

- With kids
- With families
- Self-Disclosure
- Whose needs are we meeting?

87

Dual Relationships

- With each other
  - Privacy
  - Outside relationships
  - Harassment

88

Non-compete

- Stealing cases
- Privacy beyond confidentiality
- No hiring away

89

Disclosure to Administration

- Medical conditions
- Psychiatric conditions
  - For protection of self as well as clients

90

Summarizing key points

- Offer choices, explore choices, clarify choices within all contexts
- Be the person who offers choices when all other choices have been taken away.
  - Multiple choice where possible
  - Not "do it or go to prison"
- Be very clear about assessment limitations

91

Program Culture

Getting there is harder than we think

92

Relationships

- Alliances and cliques can destroy good programs, but…
- The appearance of alliances and cliques can be even more harmful
- *A lot of bad things happen when people just don't pick up the phone. Just pick up the phone!*

93

Basics

- People form theories about themselves and others based on very little information
- These are called schemas
- The less information you have, the more likely you are to draw conclusions on schemas
- Example: *Mr. X is a supervisor. Supervisors don't understand people at the front lines. Mr. X is therefore not trustworthy.*

94

Basics

- Confirmation bias happens we have beliefs. It is easy to disregard evidence that our beliefs are wrong.
- *Supervisors X and Y are friendly. We are not as friendly with each other. Therefore, when they agree on something, it's because those two are friends and I'm stuck with their decision.*

95

The Antidote

- Programs should expect all staff to put the clients and the program ahead of momentary personal consideration. Obviously, one's long-term self-care is also important.
- Your client is the clients, their families, and the program itself.

96

Collaboration

- Treatment driven by the client's needs
- Staff trained in therapeutic engagement
  - e.g., welcoming, inviting
- focusing the client on us so he's not focused on others… engagement is vital.
- Supervisor is apparent
  - Chain of command, not cult of personality
- Doing no harm is an explicit value

97

Collaboration *(cont'd.)*

- Rejection of micro-aggression is an explicit value in all domains
- The ongoing 2nd chance (students re-engaged rather than punished)
- Rejection of lectures (talking to a client when they're not ready to listen)
- Teaching accountability rather than "holding them accountable"

98

Collaboration *(cont'd.)*

- Jargon discouraged
- Clients participate in risk management strategies
  - Joint commitment to success
- Consider "emotional bank accounts": all responses consider long-term needs
- Overnight staff in residential programs can be given special training in engagement

99

Regarding Consequences

- Punishment in disguise?
- Getting to what's real:
  - Does "acting out" get to consequences?
  - Or does it invite adults to understand?

100

Regarding Response

- Guided by values, not the moment
- Considers long-term development
- Involves teaching

101

What it takes

- Courage
- Willingness to give up lip service to non-coercive treatment
- Willingness to engage with all elements of a person's life

102

Basic Assumptions

- Everyone does better when they are listened to
  - Listening can prevent bad behavior
- Everyone needs to tell their story
- Everyone needs to experience competence
- The more we talk about ourselves, the less our work is about *them*.

103

Excellent Staff

- Dwain
  - *"Just keep singing Sesame Street"*
  - *"Just remember: These guys have nothing"*
- Shawn
  - *"Just keep to the routines"*
- Ray
  - *"Just keep talking to them"*
  - *"Just remember where they're from"*
- Kurt
  - *"Just keeping listening"*

104

Excellent Staff

- Keep routines going
- Know their clients
- Can spot trouble before it happens
- Set limits early
  - *"We're all going to set limits sooner or later, so we might as well do it now"*

105

What it means

- Annoying behavior means: *"I'm getting upset and need help"*
- Disruptive behavior means: *"Listen to me"*
- Dangerous behavior means: *"I'm losing control"*
- Possibly lethal behavior means: *"Stop me"*

106

Building Patience

- Try to imagine a 15 minute video of the worst 15 minutes of their life
  - Do you think you *can* imagine it?
  - Do you want to watch it?
  - If you did, what would you learn?
  - If you did, how might it change your view of them?

107

So who are we?

- We're not the judge or jury
- We're not the Warden
- We're not the ones who are going to change these kids...
- We're the ones setting up the environment where these guys can change

108

Manners

- 4 basic skills:
  - Please
  - Thank you
  - Excuse me
  - I'm sorry
- Addressing people respectfully:
  - "*David*" or "*Mr. Prescott,*" but never "*Prescott*"

109

Words to give up…

- Why
- It sounds like…
- How does that make you feel…
- You people…

110

Staying on track

- Please…
- whoa…
- please…
- you have a choice…
- As soon as you ___, we can ___

111

Teamwork

- Supporting patients starts with supporting each other
  - If you don't think you can talk about it somewhere, that's a real problem!

112

When you come to work…

- Prepare
  - Use drive time; set things up the night before
- Bring your manners with you: It's Showtime!
- Expect resistance ("bring me the puck")
- Roll with resistance

113

When you come to work…

- Be ready to listen
- "Be the change you want to see"
- Approach, Smile, Greet
  - (not "stalk, attack, kill)
- Tell the truth

114

When you get caught up…

- If it feels wrong, it probably is wrong
- If you have any doubts, then there's no doubt
- Team approach!
  - Bring in a supervisor, another staff, etc.

115

Good Attitudes

- I am not the same as my work
- I'm not alone in this
- My attitude will dictate a lot of what happens at work
- Everyone's sexuality is different
- No one has all the answers, but I have places to go to get them

116

Good Attitudes

- The work day is only one small piece of the real work we do.
  - It's about contributing to reducing the harm of sexual abuse
  - In the end, whether a patient gave us a hard time today is much less of a concern

117

Self-Care & Burnout

118

Why do we keep doing this work?

- There is no denying that working with persons with sexual behavior problems is challenging.
- Some of our clients will be really good at "pushing our buttons".
- How do we offset our natural tendencies to be empathic and helpful with our natural tendencies to be angry and upset at what our clients have done?

119

Why do we keep doing this work?

- Reduce the number of potential victims.
- On average, a poorly managed client will create many more victims that a well managed client
- Clients have the right to receive appropriate treatment and care
- For clients to have a quality of life as close as possible to that of others without disabilities
  - Lifestyle balance
  - Self-determinism (to the extent safely possible)

120

Vicarious Trauma

- Vicarious trauma
- Compassion fatigue
- Co-victimization
- Secondary survivor
- Emotional contagion
- Cost of caring

121

Vicarious Trauma

- High Risk Professionals:
- Interview and counsel trauma victims
- Working with families and victims
- Working with person who have abused
  - counselors, health/hospital staff, emergency workers, child protection, corrections, law enforcement, volunteers

122

Vicarious Trauma

- A human phenomenon:
- …if a person holds the capacity for empathy, he or she will experience distress when hearing about dreadful things that have happened to others.

123

Vicarious Trauma

- Vicarious trauma challenges core beliefs individuals hold about self relationships, the nature of the world they live in, and their overall system of meanings and values.
- VT is a normal human consequence of exposure to traumatic material second-hand.

124

Predictors & Mediators of Secondary Traumatic Stress Effects

- Individual Factors
- Situational & Environmental Factors

125

Individual Factors

- Personal History
  - Personal experiences of trauma, loss, victimization
- Personality & Defensive Style
- Coping Style
  - Coping mechanisms
- Current Life Context
  - private life situation
- Training & Professional History
- Personal Therapy

126

Situational Factors

- Workload
- Nature of the work
- Nature of the clientele
- Cumulative exposure to trauma material
- Relationship with co-workers
- Social and cultural context
- Supervision

127

Mitigation Factors

- How good are you taking care of yourself?
  - Self-care in the workplace
  - Self-care in your personal life
- Holistic approach
  - Maintaining a balanced lifestyle is central to effective self-care

128

Mitigation Factors

- The more balanced we are across this full range of personal care, the more we are able to cope with the stresses and demands that we will face.
- Create opportunity for renewal, simple pleasures, and enjoyment.

129

Kindergarten

- Most of what I really need to know about how to live, and what to do, and how to be, I learned in Kindergarten. Wisdom was not at the top of the graduate school mountain, but there in the sandbox at nursery school. These are the things I learned:

130

Kindergarten

- Share everything.
- Play fair.
- Don't hit people.
- Put things back where you found them.
- Clean up your own mess.
- Don't take things that aren't yours.
- Say sorry when you hurt somebody.

131

Kindergarten

- Wash your hands before you eat.
- Flush.
- Warm cookies and cold milk are good for you.
- Live a balanced life.
- Take a nap every afternoon.
- When you go out into the world, watch for traffic, hold hands, and stick together.

132

What do we really know about professional development?

How can we get better at our work?

133

Why me?

- 38 years in practice in all facets of this work
- Have seen many people fail as well as succeed
- Have studied how people learn (and don't learn) in my own trainings and those of others

134

Central Point

"Love yourself as a person and doubt yourself as a therapist."

— Helene Nissen-Lie

135

Background Information

136

Ego is the enemy!

- When you see someone with a big ego, it can mean:
  - They've stopped growing professionally
  - They may keep getting better in some areas but are closed off to others.
  - They are less wiling to learn from feedback or other experiences
  - They may be putting more socio-affective resources into maintaining their status than into staying effective
  - "Building self up by putting others down"
  - Self-assessment bias (will explore this later)

137

Take-Home Skill #1

- Professional development comes in many forms, so:
- Express kindness and gratitude to your colleagues
  - Mind your manners
  - Use greetings in emails
  - Emojis in low doses

Remember that they are suffering as much or more than you.

138

Take-Home Skill #2…

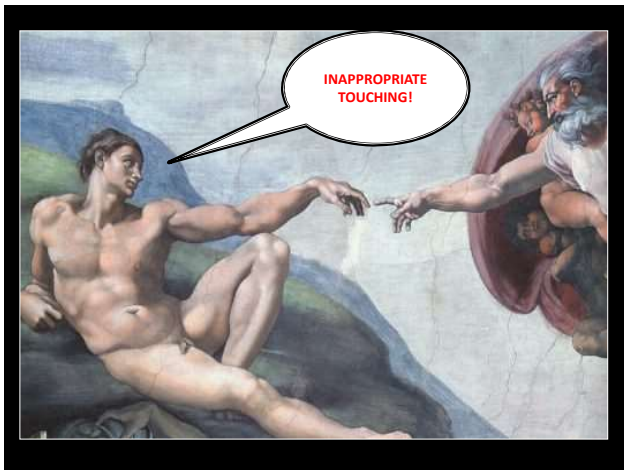
Take care of yourself!

139

We suffer from illusions

140

141



142

And what we see...

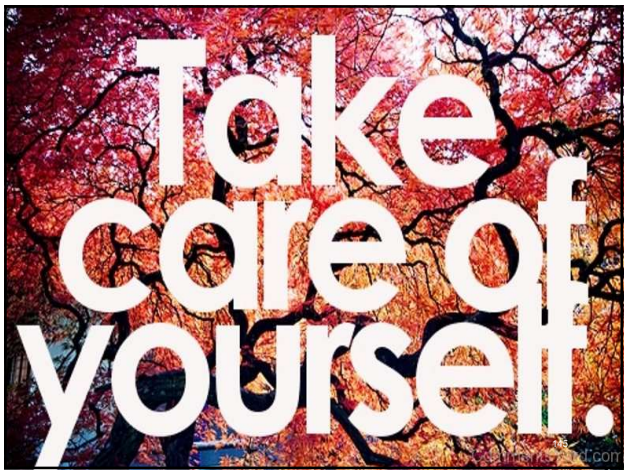
143

Still, there is a question...

Do we choose this work?

Does this work choose us?

144


Take care of yourself.

145

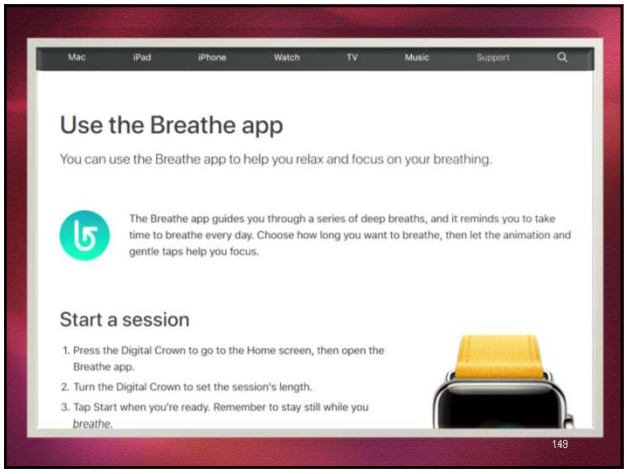

On the Evolution of Inpatient Treatment

146


And if you've ever worked with kids...
We're going to sit here until all of you settle down. And I don't care HOW long it takes!

147

148

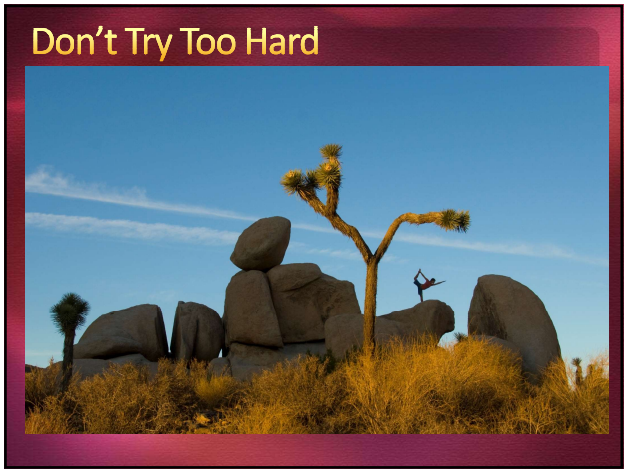

Mac
iPad
iPhone
Watch
TV
Music
Support
Use the Breathe app
You can use the Breathe app to help you relax and focus on your breathing.
The Breathe app guides you through a series of deep breaths, and it reminds you to take time to breathe every day. Choose how long you want to breathe, then let the animation and gentle taps help you focus.
Start a session
1. Press the Digital Crown to go to the Home screen, then open the Breathe app.
2. Turn the Digital Crown to set the session's length.
3. Tap Start when you're ready. Remember to stay still while you breathe.
149

149


HeartMath emWave2, Charcoal Gray HeartMath
151 customer reviews | 58 answered questions
2+
emWave2
About the product
Use emWave2 on the go as a portable training device and store your sessions for later review
Run a session while at your computer and watch your coherence through real-time charts , Ear sensor and two-way, finger-operated control button.
Store all session information on your computer for future comparison and review
Four challenge levels including a challenging advanced user mode.This type of measurement is known as heart rate variability analysis or HRV.

150

151



152

153

What's Up With Treatment?

154

Treatment context: What works?


Clinical Psychology Review 73 (2019) 101752

Contents lists available at ScienceDirect

Clinical Psychology Review

journal homepage: www.elsevier.com/locate/clinpsychrev

Review

Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness

Theresa A. Gannon[a,*], Mark E. Olver[b], Jaimee S. Mallion[a], Mark James[a]

[a] Centre of Research and Education in Forensic Psychology, School of Psychology, University of Kent, UK
[b] Department of Psychology, University of Saskatchewan, Canada

155

Gannon et al. (2019) Key Findings

- Treatment associated with 32.6% reduction in sexual reoffending (9.5% treated, 14.1% untreated)
- Sexual offence specific treatment programmes best when
  - Consistent input from registered psychologists (vs. inconsistently present, not present or unknown)
  - Supervision provided (vs. absent or unknown); better effects when provided by psychologists (vs. combination of psychologists and nonpsychologists)
  - Incorporation of some form of arousal reconditioning (vs. none or unknown)

156

What *else* works to prevent reoffending?

- Common factors of effective psychotherapy (e.g., Marshall, 2005; Marshall et al., 2002)
- Comprehensive re-entry planning (e.g., Willis & Grace, 2008, 2009)
- Cognitive transformation (e.g., Maruna, 2001)
- Achieving informal social control (e.g., Sampson & Laub, 1993)

157

What works?

Who works?

158

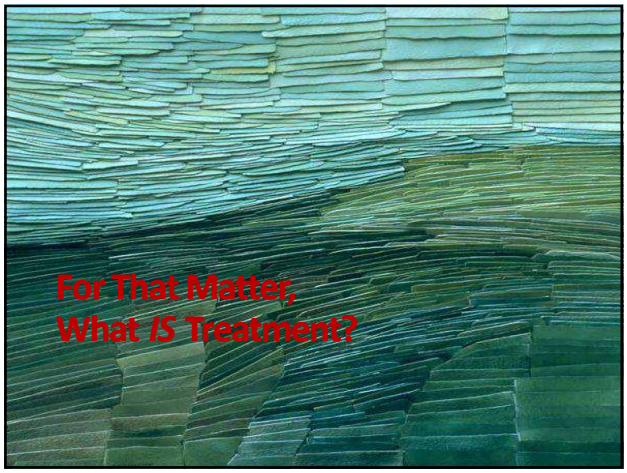
Review: What's the end game?

- Completing treatment?
- Sustaining lasting and meaningful change?

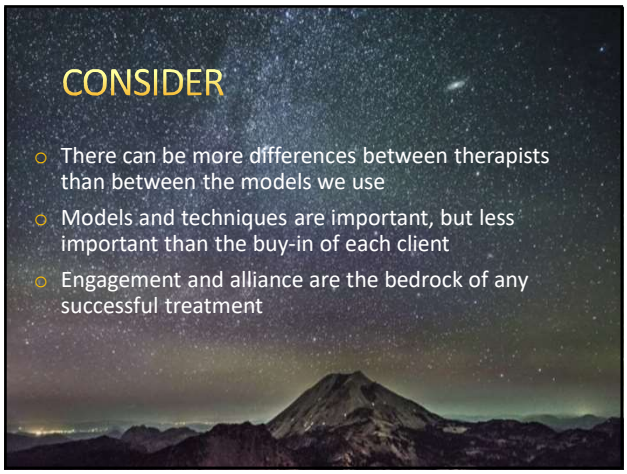
159


Wait…
What *IS* Change?

160

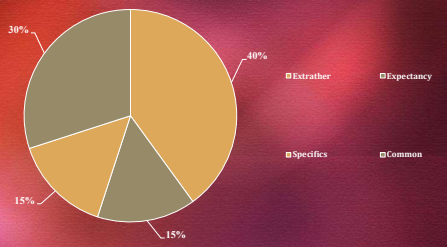

For That Matter,
What *IS* Treatment?

161


CONSIDER
There can be more differences between therapists than between the models we use
Models and techniques are important, but less important than the buy-in of each client
Engagement and alliance are the bedrock of any successful treatment

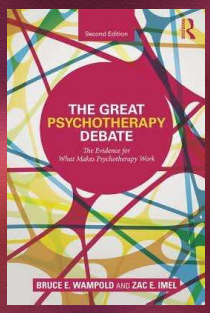
162

Factors Influencing Outcomes



163

Recommended Source



164

Implications For Professional Development

- Study your population deeply
- Study each client deeply
- Expertise at engaging with clients involves moving from the micro to the macro as well as vice versa
- Use models and techniques in the service of developing yourself professionally

165

What are some of the barriers to professional development?

166

Self-Assessment Bias

167

Walfish et al., 2012

- No differences in how clinicians rated their overall skill level and effectiveness levels between disciplines.
- On average, clinicians rated themselves at the 80th percentile
- Less than 4% considered themselves average
- No one rated themselves below average
- Only 8% rated themselves lower than the 75th percentile
- 25% rated their performance at the 90th% or higher compared to their peers

168

Dirty Little Secrets

- … from outcome studies
  - More difference between the best and the worst therapists **within** any treatment method, than there is **between** treatment methods
  - Some therapists are better than others
  - Hiatt & Hargrave (1995) asked therapists to estimate their effectiveness in a treatment study
    - The LEAST effective therapists rated themselves as being among the most helpful

169

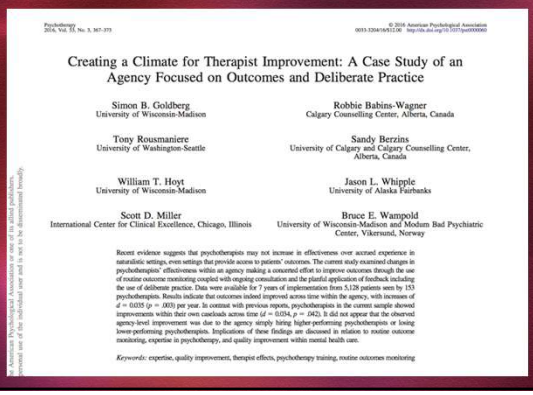
Are you Effective?

Wampold & Brown (2005)

- 581 therapists
- 6,146 real world clients
- Average sessions = 10
- 46% depression, 30% adjustment disorder, 11% anxiety, plus other diagnoses
- Who got the best outcomes?
  - Training makes no difference
  - Profession makes no difference
  - EXPERIENCE makes no difference
  - Diagnosis makes no difference

170

Are you Experienced?



Psychotherapy
2016, Vol. 53, No. 3, 367–375

© 2016 American Psychological Association
0033-3204/16/$12.00 http://dx.doi.org/10.1037/pst0000060

Creating a Climate for Therapist Improvement: A Case Study of an Agency Focused on Outcomes and Deliberate Practice

Simon B. Goldberg
University of Wisconsin-Madison

Robbie Babins-Wagner
Calgary Counselling Center, Alberta, Canada

Tony Rousmaniere
University of Washington-Seattle

Sandy Berzins
University of Calgary and Calgary Counselling Center, Alberta, Canada

William T. Hoyt
University of Wisconsin-Madison

Jason L. Whipple
University of Alaska Fairbanks

Scott D. Miller
International Center for Clinical Excellence, Chicago, Illinois

Bruce E. Wampold
University of Wisconsin-Madison and Modum Bad Psychiatric Center, Vikersund, Norway

Recent evidence suggests that psychotherapists may not increase in effectiveness over accrued experience in naturalistic settings, even settings that provide access to patients' outcomes. The current study examined changes in psychotherapists' effectiveness within an agency making a concerted effort to improve outcomes through the use of routine outcome monitoring coupled with ongoing consultation and the planful application of feedback including the use of deliberate practice. Data were available for 7 years of implementation from 5,128 patients seen by 153 psychotherapists. Results indicate that outcomes indeed improved across time within the agency, with increases of $d = 0.035$ ($p = .003$) per year. In contrast with previous reports, psychotherapists in the current sample showed improvements within their own caseloads across time ($d = 0.034$, $p = .042$). It did not appear that the observed agency-level improvement was due to the agency simply hiring higher-performing psychotherapists or losing lower-performing psychotherapists. Implications of these findings are discussed in relation to routine outcome monitoring, expertise in psychotherapy, and quality improvement within mental health care.

Keywords: expertise, quality improvement, therapist effects, psychotherapy training, routine outcomes monitoring

171

2022 Replication

- Does practice really make perfect? A longitudinal analysis of the relationship between therapist experience and therapy outcome: A replication of Goldberg, Rousmaniere, et al. (2016)
- Sylvan Germer, Vanessa Weyrich, Anne-Kathrin Bräscher, Kaline Mütze, Michael Witthöft
- *Across all operationalizations of experience (time since first patient and number of cases treated) and therapy outcome (change in psychopathology, response, remission, and early termination), results largely suggest no association between therapists' experience and therapy outcome. Preliminary evidence suggests that therapists need fewer sessions to achieve the same outcomes when they gain more experience. Therapeutic experience seems to be unrelated to patients' change in psychopathology.*

172

Good News:

- The average client in therapy winds up better off generally than 80% of those who don't enter.
- Mandated clients generally respond as well as voluntary clients.

Bad News:

- Dropout rates range between 40-50%.
- 10% of clients get worse, and clinicians are rarely able to identify them. (Juvenile rates are higher.)

173

Proficiency vs. Excellence

- Proficiency in most fields can be achieved within 6 months
- The same goes for therapy
  - Most people are at their most effective 1 year after licensing/registration
  - Confidence improves throughout career
  - Competence does not

174

What Can We Do?

Some methods

175

Culture of Feedback

- Superior therapists elicit more negative feedback
- Atmosphere in which clients are free to rate their experiences
  - Without retribution
  - With a hope of having an impact
- Beyond displaying openness, this involves introducing available outcome measures thoughtfully and thoroughly
- Not just more forms to fill out!

176

Openness and Surprise

177

Example

- Anker, Duncan, & Sparks (2009) in JCCP
- Couples therapy (n = 410)
- Feedback condition
  - nearly 4 times the rate of clinically significant change
  - maintained a significant advantage at 6-month follow-up while attaining a significantly lower rate of separation or divorce.

178

Miller, Duncan, et al. 2006

- 75 therapists and 6,424 clients over two years
- Formal, ongoing feedback about the alliance and progress in treatment resulted in significant improvements
  - client retention and outcome
- Clients of therapists who did not seek feedback regarding the alliance were three times less likely to return for a second session and had significantly poorer outcomes

179

Routine Outcome Monitoring

- Tracking global outcomes
- Tracking the working alliance
- Session-by-session feedback
- Examples include Youth Outcome Questionnaire, Outcome Rating Scale, Session Rating Scale, etc.

180

Outcome Rating Scale

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing*

Individually
(Personal well-being)
|----------|

Interpersonally
(Family, close relationships)
|----------|

Socially
(Work, school, friendships)
|----------|

Overall
(General sense of well-being)
|----------|

181

Session Rating Scale

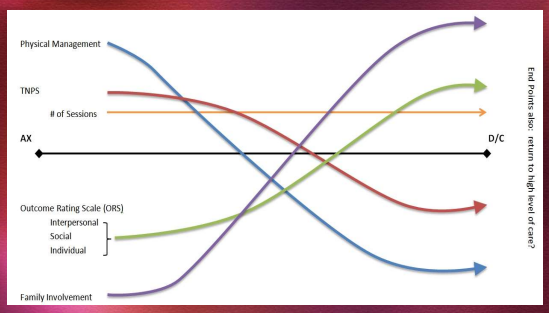
Please rate today's session by placing a mark on the line nearest to the description that best fits your experience:

I did not feel heard, understood, and respected	Relationship	I felt heard, understood, and respected
We did not work on or talk about what I wanted to work on or talk about	Goals and Topics	We worked on and talked about what I wanted to work on and talk about
The therapist's approach is not a good fit for me	Approach or Method	The therapist's approach is a good fit for me
There was something missing in the session today	Overall	Overall, today's session was right for me

(Miller, Duncan, & Johnson, 2002)

182

Welcome to My World



183

More Take-Home Skills

- Establish a culture of feedback
- Get actionable feedback:
  - Clients
  - Colleagues

184

If it works, do more of what is working!

185

If it does not work, do something different!

186

Let's make a plan for becoming a better therapist

Courtesy of Daryl Chow and Scott Miller
(for demonstration purposes)

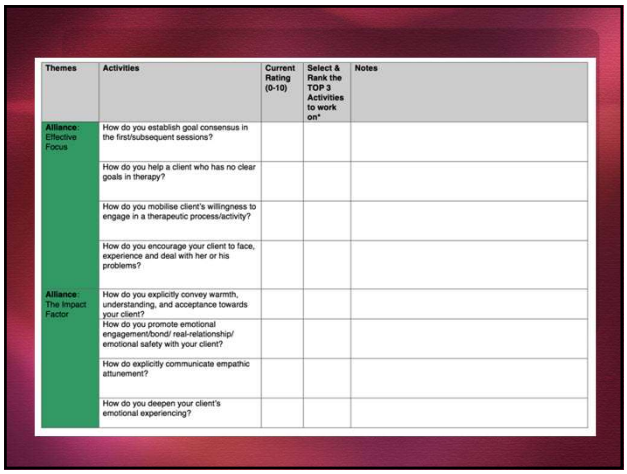
187

Themes	Activities	Current Rating (0-10)	Select & Rank the TOP 3 Activities to work on*	Notes
Model/ Technique/ Structure: "The Sandwich"	How do you start a first session?			
	How do you start a subsequent session?			
	How do you conduct an induction into therapy? (Optimising Expectations of Therapy) - what to expect - role of therapist, role of client - provide an acceptable and adaptive explanation for the client's distress? - provide a treatment plan rationale that is consistent with the explanation of client's distress?			
	How do you close a session?			
	How do you elicit detailed and nuanced feedback?			
	How do you integrate the use of feedback measures into therapy?			
	How do you prepare for a planned closure of therapy?			
	Others (pls describe)			

188

Themes	Activities	Current Rating (0-10)	Select & Rank the TOP 3 Activities to work on*	Notes
Hope & Expectancy	How do you communicate a hopeful and optimistic stance towards your client? (generate possibilities)			
	How do you convey a sense of confidence and belief in your treatment approach?			
	Others (pls describe)			

189

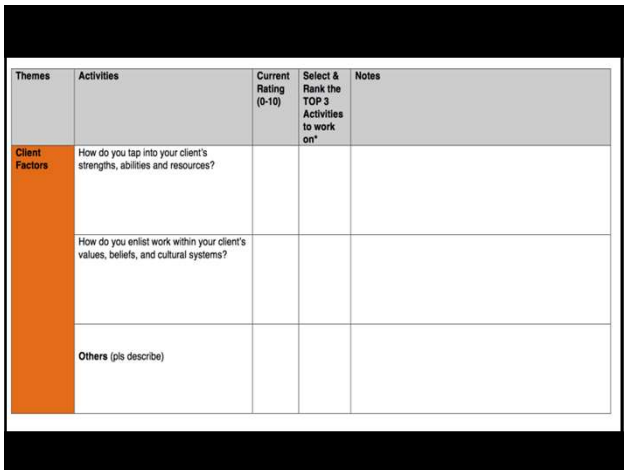


Themes	Activities	Current Rating (0-10)	Select & Rank the TOP 3 Activities to work on*	Notes
Alliance: Effective Focus	How do you establish goal consensus in the first/subsequent sessions?			
	How do you help a client who has no clear goals in therapy?			
	How do you mobilise client's willingness to engage in a therapeutic process/activity?			
	How do you encourage your client to face, experience and deal with her or his problems?			
Alliance: The Impact Factor	How do you explicitly convey warmth, understanding, and acceptance towards your client?			
	How do you promote emotional engagement/bond/ real-relationship/ emotional safety with your client?			
	How do explicitly communicate empathic attunement?			
	How do you deepen your client's emotional experiencing?			

190

	How do you provide a corrective emotional experiencing with your client			
Alliance: Motivation	How do you assess and work with a client's readiness for change?			
	How do you increase homework compliance?			
Alliance: Difficulties	How do you deal with alliance rupture?			
	How do you deal with an angry client?			
	How do you deal with a client who is feeling hopeless?			
	How do you deal with strong and difficult emotions arising in the session?			
	How do you manage a client who is high risk of suicide?			
	How do you manage a client is mandated for treatment?			
	Others (pls describe)			

191



Themes	Activities	Current Rating (0-10)	Select & Rank the TOP 3 Activities to work on*	Notes
Client Factors	How do you tap into your client's strengths, abilities and resources?			
	How do you enlist work within your client's values, beliefs, and cultural systems?			
	Others (pls describe)			

192

Themes	Activities	Current Rating (0-10)	Select & Rank the TOP 3 Activities to work on*	Notes
Therapist: The Use of the Self	How do you regulate *your* anxiety in a difficult interaction with your clients?			
	How do you manage your counter-transference towards your client?			
	How do you activate reflective functioning in-session with your clients (vs. being reactive and rational)?			
	How do you utilize self-disclosure?			
Therapist: Outside of Sessions	How do you engage in solitary deliberate practice *outside* of sessions in your typical work-week?			
Others (pls describe)				

193

When Supervising

- Begin with a case and consider:
- What are this clients goals?
- Who are you in this client's life, from his/her perspective?
  - (clarifying relationship)
- What things do and don't work for him/her in treatment
  - (clarifying tasks and approach of therapist)
- What cultural considerations exist?
  - Is the therapist taking these into account in constructing services?

194

Example

- The seemingly impossible case: Unmotivated, uninterested, has had enough of therapists
- Explore client goals
  - His desire for freedom and living in the community indicates a strong priority on personal choice and independence.
  - Set therapist goal of exploring other goals with interest and no agenda as part of a regular conversation; not overtly clinical
- Explore client relationship
  - Who is this therapist in the client's life? Just an innately annoying person? Define what the therapist can and can't do

195

Example

- Therapist approach
  - Open discussions about what is working for the client, what kind of approaches may be necessary, and why.
  - It may be as simple as "what's in it for you".
- Cultural considerations
  - What strongly held values assist or impede this case?
  - Client comes from a family in which receiving assistance of any kind is considered a sign of weakness.

196

Implementation: Lessons Learned

197

Implementing New Methods

(Fixsen et al., 2005; Prescott et al., 2022)

- Level 1 training
- Level 2 training
- Coaching and consultation
- Establish benchmarks of progress: What's the endgame?
- Use/develop a fidelity monitoring tool
  - Note: Since the pandemic, online training means some spacing between sessions is possible in order to prevent information overload

198

Where to start?

- Get your leadership on board first
- Ensure a culture that supports some trial and error
  - Beware of workspaces that only allow you ever to do what you are already good at
    - "You're like a tool that they take out of the drawer only when they need you."
- Implementation/Getting better takes at least two years of work to be visible at the client level.

199

Challenges to Implementation

- "We tried the GLM, but we thought it was confusing. So we went back to what we were already doing."
  - Successful implementation of any approach takes two years or more (Fixsen et al., 2005)
  - Treatment effects can take well over two years to begin to improve (Brattland et al., 2018)
- "We got ourselves trained in the GLM and now we're doing it."
  - Consultation and continuous efforts at improvement matter.

200

Challenges to Implementation

- Cultural considerations
  - Surprisingly, most has been along individualistic/collectivistic cultural lines
  - The role of relationships and friendships
  - The role of independence
  - Ultimately, the answer is in how clients weight the importance of these PHGs
  - Cultural differences between client and their community

201

Challenges to Implementation

- The belief that "we already do this."
  - Is the practitioner using the actual PHGs as they are defined?
  - Is the practitioner using the PHGs as they are defined?
  - Can the practitioner identify the PHGs that are important to this client?
  - Can the practitioner describe how the PHGs were implicated (or not implicated) in the client's problematic behaviors?
  - Does the practitioner have a solid understanding of how PHGs interact with causal processes implicated in the client's offending?

202

Challenges to Implementation

- The belief that "we already do this."
  - Has the practitioner conducted a solid assessment of the client's strengths (as they related to prosocial acquisition of PHGs) and accounted for how the client can apply them to treatment and to his or her life beyond treatment more effectively?
  - Can the practitioner identify the obstacles in the client's good life plan?
  - Can the practitioner identify how the client has sought to implement a good life plan in the past? In the present, and how they plan to implement in the future?
  - Have the practitioner and client arrived at the answers to questions such as how the client and others around them will know that they are attaining a good effectively or ineffectively?

203

Challenges to Implementation

- "This is easy"
  - Therapist qualities (WERD; Marshall, 2005)
  - Underlying "Spirit" of delivery (PACE; Miller & Rollnick, 2013)
  - Prioritizing skills that promote change
  - Actively and explicitly seeking client feedback (Prescott, Maeschalck, & Miller, 2017)
  - Focus on PHGs, conceptualization of risk factors, and how each is implicated in offending, as above
  - Understanding obstacles to achieving a good life
    - (See Prescott & Willis, 2021)

204

Challenges to Implementation

- "We've made a simplified GLM"
  - Combining PHGs can lead to one or more going unaddressed (e.g., spirituality)
  - Decisions about combining PHGs or abandoning them typically made by administrators without client feedback.
  - Clinical convenience can mean ignoring significant portions of clients' lives.
  - When you've implemented the GLM, simplification becomes very simple indeed.

205

Ultimately

- Effectively using methods and models involves effective therapeutic practice
- The therapist who delivers it is the most important variable
  - It's not just "what works," it's "who works"
- Instead of "nothing works" we can ask, "Has nothing been implemented?"

(hat tip to Faye Taxman)

206

To Recap

- Cognitive barriers:
- "I'm already really good" (self-assessment bias)
- "This is easy"
- "I already know how to do this"
- "I can make this even simpler"

207

Improving Implementation

GLM Fidelity Monitoring

Prescott, Willis, (2021); Prescott, Willis&Ward, (2022)

208

GLM Fidelity Monitoring Tool

Table 1

GLM Fidelity Monitoring Tool Overview

GLM Fidelity Monitoring Tool Section	Fidelity Indicator
1. Fundamental Considerations and Processes • Qualities of the therapist, as perceived by the client and others • Underlying "spirit" of treatment delivery • Prioritizing clinical skills that promote change • Actively and explicitly seeking client feedback	0 – 2 rating[a]
2. GLM-Specific Considerations and Processes • Focus on Good Life goals • Conceptualization of risk factors • Good Life goals implicated in offending • Obstacles to achieving one's Good Life plan	0 – 2 rating[a]
3. Client-Focused GLM Considerations • Ten questions exploring therapist's progress developing a GLM grounded case conceptualisation and therapy plan for individual clients	Extent to which each question can be answered

[a]0 = poor (or absent) fidelity, 1 = partial fidelity, 2 = fidelity

209

Questions?

Comments?

Thank you!

210