Psychodynamic Psychotherapies: Included in this category are Freudian psychoanalysis and Jung's analytical psychology.

1. **Freudian Psychoanalysis:** Freudian psychoanalysis reflects a deterministic and pessimistic view of human nature that views current psychological problems as being due to unconscious unresolved conflicts that arose during childhood. It also assumes that these conflicts cause anxiety and are the result of the divergent demands of the three aspects of personality – the id, ego, and superego: (a) The *id* is present at birth, and its life (sexual) and death (aggression) instincts are the primary source of psychic energy. It operates according to the pleasure principle and seeks immediate gratification of its instinctual needs using unconscious irrational means. (b) The *ego* develops at about six months of age and operates according to the reality principle. Although it also seeks to at least partially gratify the id's instincts, it attempts to do so in realistic rational ways. (c) The *superego* is the last aspect of personality to develop. It represents the internalization of society's values and standards and acts as the conscience. It attempts to permanently block (rather than gratify) the id's instincts.

Freud's theory also proposes that, when the ego is unable to resolve a conflict between the id and superego using rational means, it resorts to one of its *defense mechanisms*. The defense mechanisms deny or distort reality and operate on an unconscious level, and they include repression, denial, reaction formation, projection, and sublimation: Repression is the basis of all other defense mechanisms, is involuntary, and involves keeping undesirable thoughts and urges out of conscious awareness. Denial is an immature defense mechanism that involves refusing to acknowledge distressing aspects of reality. Methods of denial include ignoring, distorting, and rejecting reality. Reaction formation involves defending against an unacceptable impulse by expressing its opposite, projection involves attributing an unacceptable impulse to another person, and sublimation involves channeling an unacceptable impulse into a socially desirable (and often admirable) endeavor. The occasional use of defense mechanisms is adaptive, but repeated reliance on them keeps a person from resolving the conflicts that are causing anxiety.

The main goals of Freudian psychoanalysis are "to make the unconscious conscious and to strengthen the ego so that behavior is based more on reality and less on instinctual cravings and irrational guilt" (Corey, 2016, p. 26). The primary technique of psychoanalysis is analysis of the client's free associations, dreams, resistance, and transference, and the process of analysis consists of four steps (Greenson, 2016): (1) *Confrontatio*n involves helping clients recognize behaviors they've been unaware of and their possible cause. (2) *Clarification* brings the cause of behaviors into sharper focus by separating important details from extraneous material. (3) *Interpretation* involves explicitly linking conscious behaviors to unconscious processes. (4) Repeated interpretation leads to catharsis (the experience of repressed emotions) and insight into the connection between unconscious material and current behavior and then to *working*

through, which is a gradual process during which the client accepts and integrates new insights into his/her life.

2. **Jung's Analytical Psychology:** Jung accepted some aspects of Freudian theory but rejected others. For example, Jung believed that behavior is driven by both positive and negative forces, that personality continues to develop throughout the lifespan, and that behavior is affected by the past and the future. Jung also divided the unconscious aspect of the psyche into the personal and collective unconscious: The *personal unconscious* consists of a person's own forgotten or repressed memories, while the *collective unconscious* consists of memories that are shared by all people and are passed down from one generation to the next. The collective unconscious contains archetypes, which are universal thoughts and images that predispose people to act in similar ways in certain circumstances. They're expressed in myths, symbols, and dreams and include the persona, shadow, hero, and anima and animus.

The primary goal of analytical psychotherapy is to bring unconscious material into consciousness to facilitate the process of *individuation*, which occurs primarily during the second half of life and is "the process by which a person becomes a psychological 'in-dividual,' that is, a separate, indivisible unity or whole" (Jung, 1968, p. 275). Techniques used to achieve this goal include dream interpretation and the analysis of transference, which Jung viewed as being due to the projection of elements of the personal and collective unconscious.

Humanistic, Existential, and Other Psychotherapies: This category includes humanistic therapies (person-centered and Gestalt therapies), existential therapies, reality therapy, positive psychology, and personal construct therapy.

The humanistic and existential therapies are sometimes categorized jointly as humanistic-existential therapies. However, while the two approaches share a number of similarities, they also differ in important ways (Jones-Smith, 2019; Winston, 2015): In terms of similarities, humanistic and existential therapies both focus on the here-and-now and adopt a phenomenological orientation, which means they prioritize a client's subjective experience over objective reality. They also reject the medical model and use of clinical labels and, consequently, concentrate on a client's internal qualities and perspective rather than the client's symptoms. In terms of differences, humanistic therapies emphasize acceptance and growth and help clients become more fully-functioning and self-actualizing. In contrast, existential therapies emphasize freedom and responsibility and "help clients confront the anxieties that arise from the awareness of one's existential condition … [and cultivate] authentic engagement with one's world" (Winston, 2019, p. 45).

1. Person-Centered Therapy: Rogers's person-centered therapy is also known as client-centered therapy and is based on the assumption that all people have an innate drive toward *self-*

actualization, which motivates them to achieve their full potential. According to Rogers, the drive toward self-actualization can be thwarted when a person experiences incongruence between his/her self-concept and experience. Conditions of worth are one source of incongruence and occur, for example, when parents provide a child with love and acceptance only when the child behaves in certain ways. According to Rogers, people often react to incongruence defensively by distorting or denying their experiences which, in turn, leads to psychological maladjustment.

The primary goal of person-centered therapy is to help the client become a "fully functioning person" who is not defensive, is open to new experiences, and is engaged in the process of self-actualization. To achieve this goal, person-centered therapists provide clients with three *facilitative (core) conditions*: empathy, unconditional positive regard, and congruence. Empathy involves understanding the client's perspective and communicating that understanding to the client, unconditional positive regard involves valuing and accepting the client as a person, and congruence involves being genuine, authentic, and honest.

2. **Gestalt Therapy:** Gestalt therapy is based on the assumptions that (a) people are motivated to maintain a state of homeostasis, which is repeatedly disrupted by unfulfilled physical and psychological needs, and (b) people seek to obtain something from the environment to satisfy their unfulfilled needs in order to restore homeostasis. Neurosis (maladjustment) occurs when there's a persistent disturbance in the boundary between the person and the environment that interferes with the person's ability to fulfill needs. *Boundary disturbances* include the following: Introjection occurs when people adopt the beliefs, standards, and values of others without evaluation or awareness, while projection occurs when people attribute undesirable aspects of themselves to other people. Retroflection occurs when people do to themselves what they'd like to do to others; deflection occurs when people avoid contact with the environment; and confluence occurs when people blur the distinction between themselves and others.

Gestalt therapists consider gaining *awareness* of one's current thoughts, feelings, and actions to be the curative factor in therapy. Strategies used to increase awareness include dream work and the empty chair technique. Dream work involves having the client role-play parts of his/her dream that represent disowned parts of the client's personality. The empty-chair technique requires the client to interact with opposing aspects of his/her personality (e.g., top dog and underdog) or to resolve "unfinished business" with a significant person in the client's past or present. In contrast to psychodynamic therapists, Gestalt therapists do not foster or interpret a client's transference but, instead, help the client distinguish between his/her "transference fantasy" and reality.

3. **Existential Therapies:** Existential therapies were derived from existential philosophy and were developed by several psychiatrists and psychologists including Irvin Yalom, Rollo May, and Viktor

Frankl. These therapies emphasize personal responsibility and choice and are based on the assumption that "each person must ultimately define his/her personal existence" (Nigesh & Saranya, 2017, p. 112). Existential therapists view psychological disturbances as the result of an inability to resolve conflicts that arise when facing four *ultimate concerns of existence*: death, freedom, isolation, and meaningless (Yalom, 1980). They also distinguish between two types of anxiety (May, 1950): *Normal (existential) anxiety* is in proportion to an objective threat, does not involve repression, and can be used constructively to identify and confront the conditions that elicited it and motivate positive change. In contrast, *neurotic anxiety* is disproportionate to an objective threat, involves repression, and keeps people from reaching their full potential. The primary goal of therapy is "to help clients lead more authentic lives … by assisting them in taking charge of their life, helping them choose for themselves the values and purposes that will define and guide their existence, and supporting them in actions that express these values and purposes" (Corey, 2004, p. 84). Existential therapists consider an authentic therapist-client relationship to be the most important therapeutic tool but may use other techniques such as questioning, interpretation, and reframing.

4. **Reality Therapy:** Glasser's (1965) reality therapy is based on choice theory, which proposes that people have five basic innate needs (love and belonging, power, fun, freedom, and survival) and that the ways a person chooses to fulfill his or her needs determine whether he/she has a success or failure identity: When a person chooses to fulfill his/her needs responsibly (in positive, constructive ways that don't infringe on the rights of others), the person has adopted a *success identity*. In contrast, when a person chooses to fulfill his/her needs irresponsibly (in negative, destructive ways that infringe on the rights of others and do not always help the person get what he/she wants), the person has adopted a *failure identity*.

The primary goal of reality therapy is to replace the client's failure identity with a success identity by helping the client assume responsibility for his or her actions and adopt more appropriate ways to fulfill his or her needs. Strategies used by reality therapists are summarized by Wubbolding's (1998) WDEP system: Therapists ask clients about their wants and needs, determine what the client is currently doing to foster awareness of his/her behaviors, encourage the client evaluate his/her own behaviors, and help the client create a plan of action.

5. **Positive Psychology:** As described by Seligman and Csikszentmihalyi (2000), positive psychology "is about valued subjective experiences: well-being, contentment, and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present)" (p. 5). Flow is an important concept in positive psychology and refers to "a state in which people are so involved in an activity that nothing else seems to matter; the experience is so enjoyable that people will continue to do it even at great cost, for the sheer sake of doing it" (Csikszentmihalyi, 1990, p.4). People are most likely to experience flow when there is a

challenge-skill balance, which occurs when people believe that they have the skills needed to meet an activity's challenge and the challenge and skill level are both relatively high. A distinctive characteristic of positive psychology is its emphasis on using the scientific method to evaluate its theories, concepts, and interventions. For example, empirical research has linked positive emotions and optimism to increased longevity and positive psychology interventions to improved physical health (Park et al., 2016).

6. **Personal Construct Therapy:** Kelly's (1963) personal construct therapy focuses on how people construe (perceive, interpret, and anticipate) events. It proposes that there are alternative ways of doing so and that people can change the way they construe events to alleviate undesirable behaviors and outcomes. According to Kelly, construing involves the use of *personal constructs*, which are bipolar dimensions of meaning (e.g., fair/unfair, friend/enemy, relevant/irrelevant) that arise from a person's experiences and may operate on an unconscious or conscious level.

Practitioners of personal construct therapy consider the therapist and client to be partners who work together to help the client identify and replace maladaptive personal constructs. For example, Kelly developed fixed-role therapy to help clients try out alternative personal constructs. It involves having the client role-play a fictional character that is described by the therapist and construes events in alternative ways.

Interpersonal psychotherapy, solution-focused therapy, therapy based on the transtheoretical model, and motivational interviewing are brief therapies that are often asked about on the EPPP.

1. **Interpersonal Psychotherapy:** Interpersonal psychotherapy (IPT) focuses on the interpersonal factors that contribute to a client's current symptoms. It's based on the medical model and views depression and other mental disorders as treatable medical illnesses, and its primary goals are symptom relief and improved interpersonal functioning. Although IPT was originally developed by Klerman and Weissman (Klerman, Weissman, Rounsaville, & Chevron, 1984) as a treatment for acute depression, it has been modified to treat bipolar disorder, eating disorders, and several other disorders. Therapy involves three stages: (a) During the *initial stage*, the therapist determines the client's diagnosis and the interpersonal context of the client's symptoms. This information is then used to identify the primary problem area that will be the focus of treatment. For depression, the problem areas are interpersonal role disputes, interpersonal role transitions, interpersonal deficits, and grief. During this stage, clients are assigned the "sick role" in order to allow them to be ill without blaming themselves for their symptoms and to view their illnesses as temporary and treatable. (b) During the *middle phase*, the therapist uses a variety of strategies to address the problem area identified in the initial stage. Commonly used strategies include encouragement of affect, role-playing, communication analysis, and decision analysis. (c) During the *final stage*, the therapist addresses issues related to termination and relapse prevention.

2. **Solution-Focused Therapy:** Solution focused therapy (de Shazer, 1991) focuses on solutions to problems instead of the etiology and nature of problems. Solution-focused therapists adopt a goal-directed collaborative approach and use several types of questions to help clients identify treatment goals and personal strengths and resources that will help them achieve those goals: (a) The *miracle question* is used to help establish the focus of treatment as the future (rather than the past or present) and identify treatment goals. Example: If a miracle happened during the night and your problem was solved, how would you know that a miracle occurred? (b) *Exception questions* are used to help clients identify times when their problems did not exist or were less intense. Example: Can you think of a time in the past two weeks when you and your partner did not argue? (c) *Scaling questions* help clients evaluate their current status or their progress toward achieving their goals. Example: On a scale from 1 to 10, with 1 being totally relaxed and 10 being the most stressed you've ever been, how stressed are you now?

Each therapy session is structured and involves asking questions, providing feedback, and assigning a task to complete before the next session. For example, the formula first session task is assigned at the end of the first session and requires clients to identify something in their lives that they want to continue.

3. **Transtheoretical Model:** The transtheoretical model (Prochaska & DiClemente, 1983) integrates concepts and strategies from multiple therapeutic approaches and is based on the assumption that strategies are most effective when they match the person's stage of change. It distinguishes between six stages of change, and the primary goal of the first five stages is to help the client advance to the next stage:

(a) *Precontemplation:* Clients in the precontemplation stage have no intention of taking action to change their behaviors in the next six months. They may be in denial about their problems or may have made multiple unsuccessful attempts to change and believe that change is impossible. These individuals are likely to resist advice or change interventions but may benefit from consciousness raising, dramatic relief (experiencing and expressing emotions), and environmental reevaluation (examining how the environment affects their behavior).

(b) *Contemplation:* Clients in this stage plan to change in the next six months but they're ambivalent about changing, which may make it difficult for them to transition to the next stage. These individuals benefit from self-reevaluation (evaluating how they feel about the situation) in addition to the strategies that are useful for individuals in the precontemplation stage.

(c) *Preparation:* Clients in the preparation stage plan to take action within the next month. Useful strategies for these individuals support their decision to change and include self-reevaluation and self-liberation (believing that change is possible and making a commitment to change).

(d) *Action:* Clients in the action stage are taking action to change their behaviors. Effective strategies for these individuals include contingency management, stimulus control, and counterconditioning.

(e) *Maintenance*: Clients transition to the maintenance stage when they have maintained the desired behavior change for six months. The primary focus of treatment for individuals in this stage is relapse prevention which involves the same strategies useful for individuals in the action stage.

(f) *Termination:* Clients in this stage are confident that their risk for relapse is low.

According to this model, motivation to change is affected by three factors – decisional balance, self-efficacy, and temptation. Decisional balance is the strength of the person's beliefs about the pros and cons of changing and is most important as a determinant of motivation during the contemplation stage. Self-efficacy refers to the confidence the person has about his/her ability to change and avoid relapse. It's an important determinant of whether a person transitions from the contemplation to the preparation stage and then from the preparation to the action stage. Temptation is the intensity of the urge to engage in the undesirable behavior and is usually strongest during the first few stages of change.

Finally, note that the order of the stages is fairly easy to memorize because the name of each stage describes the stage and its order in the sequence (e.g., the precontemplation stage occurs before the contemplation stage which occurs before the preparation stage). Alternatively, the acronym PC-PAM-T may help you remember the names and order of the stages.

4. **Motivational Interviewing:** Motivational interviewing (MI) is a "method for enhancing intrinsic motivation by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). It was originally developed as an intervention for substance use disorders but has since been applied to a number of other mental and physical health problems. MI incorporates elements of Rogers's person-centered therapy and Prochaska and DiClemente's transtheoretical model as well as Bandura's concept of self-efficacy and Festinger's notion of cognitive dissonance. Like the transtheoretical model, it assumes that interventions are most effective when they match the client's stage of change. MI can be tailored for clients in any of the transtheoretical model's stages of change, but it is considered to be particularly useful for reducing the resistance and ambivalence of clients who are in the precontemplation or contemplation stage (Miller & Rollnick, 2002).

Strategies used to enhance a client's motivation include evoking hope and confidence by, for example, (a) developing discrepancy by helping clients see the difference between their current behaviors and their values and goals and (b) eliciting and strengthening change talk, reducing sustain talk, and resolving discord. *Change talk* consists of statements that favor change – e.g., I'd probably feel a lot better if I stopped smoking. *Sustain talk* consists of statements that favor maintaining the status quo – e.g., I'm just not ready to stop smoking. *Discord* consists of statements that signal dissonance in the therapist-client relationship – e.g., You just don't understand what I'm going through. Another strategy is decisional balance (DB) which involves having the client identify the pros and cons of change. It was originally described by Miller and Rollnick as a useful technique for resolving a client's ambivalence, but they subsequently concluded that it is appropriate only in certain situations. According to Miller & Rollnick (2009, 2013), DB is useful when a clinician's goal is to maintain a neutral position about the direction of change while assessing a client's readiness for change. However, it is contraindicated when the goal is to resolve the client's ambivalence in order to promote change because, by identifying the negative consequences of changing, the client may actually become less willing to take steps to do so.

Research has shown that MI is effective when used as a stand-alone treatment and can improve the benefits of other treatments when it is combined with them. For instance, Marker and Norton's (2018) meta-analysis of the research found that patients with anxiety disorders who received MI prior to cognitive behavior therapy (CBT) exhibited greater symptom reduction than did patients who received CBT only. In addition, Randall and McNeil's (2017) review of the

research found that the combination of MI and CBT was more beneficial than CBT alone for several disorders, including general anxiety disorder (GAD) and obsessive-compulsive disorder (OCD). Finally, there is evidence that, for some disorders and populations, MI has similar beneficial effects whether it is delivered in-person or via telehealth. As an example, King et al. (2020) compared the effectiveness of in-person therapy and videoconferencing for providing Brief Alcohol Screening and Intervention for College Students (BASICS), which is a brief intervention for high-risk drinking that combines MI with personalized feedback, harm reduction, and relapse prevention. The results of their study confirmed that both methods of delivering BASICS significantly reduced alcohol use and related problems.

5. **Brief Psychodynamic Psychotherapy:** Brief psychodynamic psychotherapy encompasses several time-limited alternatives to longer-term psychodynamic psychotherapies. The different versions vary in terms of their explanations for the development of psychological problems, the issues they focus on in therapy, and the specific techniques they use. For example, some versions focus on unconscious conflicts, while others focus on dysfunctional interactional patterns. Despite their differences, the brief psychodynamic psychotherapies share several characteristics (Demos & Prout, 1993; Dewan, Weerasekera, & Stormon, 2009; Messer, 2001): First, they assume that change can occur during a brief therapeutic process or that therapy can begin a change process that will continue after therapy ends. Second, they agree that therapy should have limited goals that are identified and agreed upon by the client and therapist during the initial sessions of therapy. Third, practitioners of these therapies believe they are appropriate for only certain types of clients (e.g., clients who can benefit from insight-oriented therapy and are able to form a therapeutic alliance). Fourth, practitioners adopt an active role from the beginning of therapy to quickly establish a therapeutic alliance with clients and then to ensure that therapy stays focused on major issues so goals can be accomplished within the time limits of therapy. Fifth, practitioners emphasize the development of positive (versus negative) transference and may rely more on exploration or education than on interpretation. Sixth, due to the brevity of therapy, practitioners address loss, separation, and other concerns related to termination of therapy early in treatment.

Foundations of Family Therapy: Most approaches to family therapy have their roots in general systems theory and cybernetic theory. General systems theory was originally used by biologists to describe the functioning of living and non-living systems. It predicts that all systems consist of interacting components, are governed by the same general rules, and have *homeostatic mechanisms* that help them maintain a state of stability and equilibrium. Cybernetic theory is concerned with the mechanisms that regulate a system's functioning and distinguishes between negative and positive feedback loops: *Negative feedback loops* resist change and help a system maintain the status quo, while *positive feedback loops* amplify change and disrupt the status quo.

Communication theory was another important contributor to family therapy. Bateson and his colleagues at the Mental Research Institute were not only among the first to recognize the usefulness of general systems theory and cybernetics for understanding family functioning but also proposed that certain types of repetitive patterns of communication and interaction produce problematic behavior. For example, Bateson (1972) linked the development of schizophrenia to *double-bind communication*, which occurs when a person receives two contradictory messages from a family member and is not allowed to comment on the contradiction. Bateson also distinguished between symmetrical and complementary interactions: *Symmetrical interactions* reflect equality and occur when the behavior of one person elicits a similar type of behavior from the other person. Symmetrical interactions can escalate in intensity and become a "one-upmanship game." In contrast, *complementary interactions* reflect inequality and occur when the behavior of one person complements the behavior of the other person. A common complementary pattern is for one person to assume a dominant role, while the other assumes a subordinate role. Problems occur in families when interactions between family members are exclusively symmetrical or complementary.

Several recent approaches to family therapy are influenced by postmodernism which challenges the basic premises of general systems theory, including the premise that there are universal laws that govern systems and can be discovered by scientific research. These approaches adopt a constructivist or social constructionist perspective and assume that there are multiple viewpoints and realities. They view family therapy as a shared process in which the therapist forms a collaborative relationship with the family and helps family members identify alternative ways of interpreting and resolving problems.

Specific Family Therapies: For the exam, you want to be familiar with the following family therapies:

1. **Extended Family Systems Therapy:** Bowen's extended family systems therapy is also known as intergenerational and transgenerational family therapy. Bowen derived his approach from work with children with schizophrenia and their families, which led to his conclusion that the

transmission of certain emotional processes from one generation to the next is responsible for the development of schizophrenia in a family member. Terms used by Bowen to describe family functioning include the following:

(a) *Differentiation:* Differentiation is both intra- and interpersonal. The intrapersonal aspect is a person's ability to distinguish between his or her own feelings and thoughts. This ability makes it possible for the person to separate his or her own emotional and intellectual functioning from the functioning of others, which is the interpersonal aspect of differentiation. A person with a low level of differentiation becomes "emotionally fused" with other family members.

(b) *Emotional Triangles:* According to Bowen, when a family dyad experiences tension, it may recruit a third family member to form an emotional triangle which helps alleviate tension and increase stability. For example, a husband and wife may reduce the conflict between them by becoming overinvolved with one of their children. The likelihood that an emotional triangle will develop increases as the levels of differentiation of family members decrease.

(c) *Family Projection Process:* The family projection process refers to the parents' projection of their emotional immaturity onto their children, which causes the children to have lower levels of differentiation.

(d) *Multigenerational Transmission Process:* The multigenerational transmission process is an extension of the family projection process and refers to the transmission of emotional immaturity from one generation to the next. It occurs when the child most involved in the family's emotional system becomes the least differentiated family member and, as an adult, chooses a spouse or partner who has a similar level of differentiation. This couple then transmits an even lower level of differentiation to one of its children. This process continues in subsequent generations and eventually results in the development of severe symptoms in a child.

Bowen believed that increasing differentiation in one family member facilitates greater differentiation in other family members. Consequently, Bowenian therapists often see only two family members in therapy – usually the parents – or the individual family member who is most capable of increasing his or her level of differentiation. The primary goal of therapy is to increase each family member's differentiation, and several strategies are used to achieve this goal: Therapy begins with an assessment that includes constructing a *genogram* that depicts family relationships and important life events for at least three generations and is used to help family members understand intergenerational patterns of functioning. During therapy, Bowenian therapists ask questions that are designed to defuse emotions and help family members identify how they contribute to family problems. They also teach family members how to interact with their families-of-origin in ways that alter triangulated relationships. Bowenian

therapists assume the role of coach and stay connected with family members but remain neutral and avoid becoming involved in the family's emotional processes. To reduce emotional reactivity, they have family members talk directly to them rather than to each other.

2. **Structural Family Therapy:** Minuchin's structural family therapy is based on the assumption that a family member's symptoms are related to problems in the family's structure, and identifies subsystems and boundaries as important aspects of a family's structure: *Subsystems* are smaller units of the entire family system that are responsible for carrying out specific tasks. For instance, the parental subsystem consists of family members who are responsible for caring for the children. *Boundaries* are implicit and explicit rules that determine the amount of contact that family members have with each other. Boundaries differ in terms of degree of permeability and exist on a continuum: At one end of the continuum are boundaries that are overly diffuse and lead to enmeshed relationships; at the other end are boundaries that are overly rigid and lead to disengaged relationships. Midway between the two are clear boundaries that let family members have close relationships while allowing each member to maintain a sense of personal identity.

Minuchin identified four rigid family triads, which are boundary problems that help parents obscure or deny their conflicts: (a) A *stable coalition* occurs when one parent and a child form an inflexible alliance against the other parent. (b) An *unstable coalition* is also known as triangulation and occurs when each parent demands that the child side with him or her. (c) A *detouring-attack coalition* occurs when parents avoid the conflict between them by blaming the child for their problems. (d) A *detouring-support coalition* occurs when parents avoid their own conflict by overprotecting the child.

For practitioners of structural family therapy, maladaptive behaviors are due to a dysfunctional family structure that causes the family to repeatedly respond inappropriately to developmental and situational stress. The primary goals of therapy are to alleviate current symptoms and change the family structure by altering coalitions and creating clear boundaries. Therapy focuses on promoting behavior change rather than insight and consists of three overlapping phases – joining, evaluating, and intervening: (a) *Joining* is used by a therapist to establish a therapeutic alliance with the family and relies on three techniques: Mimesis involves adopting the family's affective, behavioral, and communication style; tracking involves adopting the content of the family's communications; and maintenance entails providing family members with support. (b) A therapist's next task is to evaluate the family's structure to make a structural diagnosis and identify appropriate interventions. Evaluation includes constructing a *family map* that depicts the family's subsystems, boundaries, and other aspects of the family's structure. (c) The therapist then uses reframing, unbalancing, boundary making, enactment, and other interventions to achieve therapy goals: *Reframing* involves relabeling a problematic

behavior so it can be viewed in a more constructive way. *Unbalancing* is used to alter hierarchical relationships and occurs when the therapist aligns with a family member whose level of power needs to be increased. *Boundary making* is used to alter the degree of proximity between family members. And *enactment* involves asking family members to role-play a problematic interaction so the therapist can obtain information about the interaction and then encourage family members to interact in an alternative way.

3. **Strategic Family Therapy:** Haley's strategic family therapy is based on the assumptions that struggles for power and control in relationships are core features of family functioning and that "a symptom is a strategy that is adaptive to a current social situation for controlling a relationship when all other strategies have failed (Goldenberg & Goldenberg, 2013, p. 317). It also assumes that power and control are determined primarily by hierarchies within a family and that maladaptive family functioning is often related to unclear or inappropriate hierarchies.

The primary goal of therapy is to alter family interactions that are maintaining its symptoms. To achieve this goal, strategic family therapists assume an active role and use a variety of strategies that are aimed at changing behavior rather than instilling insight. The initial session is highly structured and consists of four stages: During a brief *social stage*, the therapist welcomes the family and observes the family's interactions. Next is the *problem stage*, in which the therapist elicits each family member's view of the family problem and its causes. In the *interactional stage*, family members discuss their different views of the family's problem, and the therapist observes how family members interact when addressing the problem. In the final *goal-setting stage,* the therapist helps family members agree on a definition of the family's problem and concrete therapy goals that target the problem.

During subsequent sessions, the therapist uses a combination of straightforward and paradoxical directives. Straightforward directives are instructions to engage in specific behaviors that will change how family members interact. Paradoxical directives help family members realize that they have control over problematic behavior or use the resistance of family members to help them change in the desired way. They include prescribing the symptom, restraining, and ordeals: *Prescribing the symptom* involves instructing family members to engage in the problematic behavior, often in an exaggerated way. *Restraining* involves encouraging family members not to change or warning them not to change too quickly. And an *ordeal* is an unpleasant task that a family member is asked to perform whenever he or she engages in the undesirable behavior.

4. **Milan Systemic Family Therapy:** Milan systemic family therapy is based on the assumption that "the family as a whole protects itself from change through homeostatic rules and patterns of communication" (Browning & Green, 2003, p. 69). Patterns of communication are referred to

as family games, and family games associated with problematic behaviors are rigid, involve power struggles between family members, and are known as “dirty games.” Leading contributors to systemic family therapy include Salvini-Palazzoli, Boscolo, Ceechin, and Prata.

The primary goal of therapy is to alter the family rules and communication patterns that are maintaining problematic behavior. This involves providing the family with information that challenges family games and helps family members develop communication patterns that increase the family’s ability to adapt to change. Milan systemic family therapy is distinguished from other family therapies by its use of a therapeutic team and five-part therapy sessions (pre-session, session, intersession, intervention, and post-session) and gaps between therapy sessions of four to six weeks. Strategies include hypothesizing, neutrality, circular questioning, positive connotation, and family rituals: *Hypothesizing* is “a continual interactive process of speculating and making assumptions about the family situation” (Adams, 2003, p. 125). The first hypotheses are based on information obtained in the initial telephone interview, and hypotheses are modified during therapy as new information about the family’s functioning is acquired. *Neutrality* refers to the therapist’s interest in the family’s situation and acceptance of each family member’s perception of the problem. *Circular questioning* involves asking each family member the same question to identify differences in perceptions about events and relationships and uncover family communication patterns. For example, a therapist might ask each member, “When mom is depressed, what does Dad do?” *Positive connotation* is a type of reframing that helps family members view a symptom as beneficial because it maintains the family’s cohesion and well-being. Its purpose is to change the family’s perception of a symptom from an individual family member’s illness to, instead, a behavior that’s voluntarily controlled and well-intentioned and involves the entire family system. *Family rituals* are activities that are carried out by family members between sessions and are designed to alter problematic family games. For example, when parents are competitive in their control of children’s behaviors or family events, the therapist might instruct the mother to make all family decisions on odd-numbered days and the father to make all family decisions on even-numbered days.

5. **Conjoint Family Therapy**: Satir’s (1983, 1988) conjoint family therapy is also known as the human validation process model and was influenced by humanistic psychology and communication and experiential approaches to family therapy. According to Satir, family systems seek a state of balance, with family problems arising when balance is maintained by unrealistic expectations, inappropriate rules and roles, and dysfunctional communication. With regard to the latter, Satir distinguished between four dysfunctional communication styles: *Placating* involves agreeing with or capitulating to others due to fear, dependency, and a desire to be loved and accepted. *Blaming* involves accusing, judging, and bullying others to avoid taking responsibility and to hide feelings of vulnerability and worthlessness. *Computing* involves taking an overly intellectual and rational (super-reasonable)

approach to avoid becoming emotionally engaged with others. *Distracting* involves changing the subject and making inappropriate jokes to distract attention and avoid conflict. Satir also identified a *congruent (or leveling) style*, which is a functional style that's characterized by congruence between verbal and nonverbal messages, directness and authenticity, and emotional engagement with others.

The primary goal of conjoint family therapy is to enhance the growth potential of family members by increasing their self-esteem, strengthening their problem-solving skills, and helping them communicate congruently. Satir viewed the therapist's "use of the self" as the most important therapeutic tool and proposed that therapists have multiple roles when working with clients, including facilitator, mediator, advocate, educator, and role model. She also used several techniques to achieve therapy goals, including family sculpting (which involves having each family member take a turn positioning other family members in ways that depict his/her view of family relationships) and family reconstruction (which is a type of psychodrama that involves role-playing three generations of the family to explore unresolved family issues and events).

6. **Narrative Family Therapy:** Practitioners of narrative family therapy consider a person's problems "as arising from, and being maintained by, oppressive stories which dominate the person's life" (Carr, 2012, p. 141), and they view these stories as being socially constructed. They also assume that the problem – not the person – is the problem. In other words, the problem is not internal to the person but is something that exists outside the person. For example, instead of saying that a family member is depressed, a narrative family therapist would say that depression sometimes causes problems for the person. The leading contributors to narrative family therapy include White and Epston.

The primary goal of narrative family therapy is to replace problem-saturated stories with alternative stories that support more satisfying and preferred outcomes. The process of therapy varies somewhat among practitioners but generally involves the following stages (Gehart, 2014): (a) Meeting family members involves getting to know them separate from their problems by asking them about their interests and everyday activities. (b) Listening involves paying attention to what family members say to identify dominant discourses and unique outcomes, which are also known as "sparkling moments" and are experiences that are not consistent with problem-saturated stories. (c) Separating family members from their problems involves externalizing the problems. (d) Enacting preferred narratives involves identifying alternative stories that lead to more satisfying realities and identities. (e) Solidifying involves strengthening alternative stories by, for example, writing letters of support to family members and expanding the family's network of social relationships to include individuals who will support its new stories.

A narrative family therapist assumes the role of collaborator and uses questions and other techniques to help family members identify current stories and construct alternative, healthier ones: For instance, *externalizing questions* are used to help clients view their problems as being outside themselves, while *opening space questions* help family members identify unique outcomes. Asking a family member what his anger tells him to do is an example of an externalizing question, and asking family members if there have ever been times when conflicts didn't control their lives is an example of an opening space question. Other interventions include therapeutic letters, therapeutic certificates, and definitional ceremonies: The therapist writes therapeutic letters to family members to reinforce their emerging alternative stories. Therapeutic certificates are given to family members toward the end of therapy to acknowledge their accomplishments. And definitional ceremonies provide family members with opportunities to tell others how they overcame their problems and celebrate the changes they've made in their lives.

7. **Emotionally Focused Therapy:** Emotionally focused therapy (EFT; Johnson & Greenberg, 1987) is a brief evidence-based treatment that integrates principles of attachment theory, humanistic-experiential approaches, and systems theory. It was originally developed as a treatment for couples but has also been applied to families and individuals. As a couple's intervention, EFT was designed to help emotionally distressed partners who want to strengthen their relationship and stay together. EFT for couples is contraindicated when the partners have different agendas for their relationship or therapy, when the therapist believes that emotional vulnerability is not safe or advisable (e.g., when there is ongoing physical abuse in the relationship), or when a partner has an untreated substance use disorder. (Note that the terms "emotionally focused therapy" and "emotion-focused therapy" are sometimes used interchangeably but that the two differ, with the latter referring to various therapies that emphasize emotion as the target of change.)

EFT is based on the assumptions that (a) emotions are essential to the organization of attachment behaviors and influence how people experience themselves and their partners in intimate relationships, (b) the attachment needs of partners are essentially healthy and adaptive but problems arise when needs are enacted in the context of attachment-related insecurities, and (c) relationship distress is maintained by the ways in which interactions between partners are organized and by the dominant emotional experiences of each partner (Johnson & Denton, 2002). Practitioners of EFT assume that helping partners express and deal with their emotions is the fastest and most effective way to solve problems, and the primary goal of therapy is to expand and restructure the emotional experiences partners have with each other so they can develop new interactional patterns and experience attachment security within their current relationship. Therapy involves three stages: assessment and cycle de-escalation,

changing interactional positions and creating new bonding events, and consolidation and integration.

The potential usefulness of eye movement desensitization and reprocessing (EMDR) in couples therapy was first addressed by Shapiro (2001), and it has subsequently been integrated into several approaches to couple therapy including EFT. For example, Eberro and Sommers-Flanagan (2007) have described how EMDR and EFT can be combined as a treatment for couples who were affected by war trauma, and Knox (2015) conducted a study to investigate the effectiveness of the combined treatment for members of this population. His study involved comparing outcomes for couples who received EFT only, EMDR only, combined EFT and EMDR, or no treatment. Knox found that couples in the combined EFT and EMDR group experienced the greatest improvement in marital satisfaction and attachment security, while those in the EMDR only group had the greatest reduction in posttraumatic symptoms.

8. **Functional Family Therapy:** Functional family therapy (FFT) is an evidence-based treatment for at-risk adolescents (e.g., those who have conduct disorder and/or a substance use disorder) and their families. It incorporates elements of structural, strategic, and behavioral family therapy, and it is based on the assumption that problematic behaviors within a family serve important relationship functions – i.e., they regulate interpersonal connections and relational hierarchies. Consequently, the primary goal of FFT is to replace problematic behaviors with nonproblematic behaviors that fulfill the same relationship functions. Therapy ordinarily involves 8 to 30 sessions over a 3- to 6-month period, and it consists of three stages (Sexton & Alexander, 2005) : During the *engagement and motivation stage*, emphasis is on forming a therapeutic alliance with family members and helping family members reduce feelings of hopelessness and negativity, increase positive expectations for change, and develop a family-focused understanding of its presenting problems. Techniques used during this stage include joining and reframing. Once family members are engaged and motivated, the *behavior change stage* begins. During this stage, immediate and long-term behavioral goals are identified and an individualized treatment plan for the family is implemented. Techniques used during this stage include training in parenting, communication, problem-solving, and coping skills. During the final *generalization stage*, the focus is on linking family members to community resources and helping them generalize their acquired skills to new problems and situations and identify ways to avoid relapse.

9. **Multisystemic Therapy:** Multisystemic therapy (MST) is an evidence-based treatment that was originally developed for adolescent offenders at risk for out-of-home placement and their families, but it has subsequently been adapted for adolescents with other serious clinical problems including psychiatric disturbances, substance abuse, and childhood maltreatment. MST is based on Bronfenbrenner's (2004) ecological model which views individuals as being

embedded in and influenced directly and indirectly by multiple systems. Consequently, it focuses "on the specific individual, family, peer, school, and social network variables that contribute to a youth's presenting problems, and on interactions between these factors linked with the presenting problems" (Schoenwald & Henggeler, 2005, p. 107). The MST model includes nine treatment principles that are applied using an analytic process (the "MST Do-Loop") that structures the development, implementation, and evaluation of the treatment plan. The core principles are finding the fit between identified problems and their broader systemic context; focusing on positives and strengths; increasing responsibility; being present-focused, action-oriented, and well-defined; targeting behavior sequences; using developmentally appropriate interventions; encouraging continuous effort; stressing evaluation and accountability; and promoting generalization.

MST is provided in the family's home and community settings where problems occur, and it incorporates interventions derived from strategic and structural family therapy, behavior therapy, and cognitive-behavior therapy. It targets factors that are driving problem behaviors. For example, when an assessment indicates that the drivers of an adolescent's daily marijuana use are low parental monitoring of the adolescent's behavior and ineffective discipline, the adolescent's poor social skills and friendships with peers who use drugs, and the availability of drugs in the adolescent's neighborhood, these factors will be addressed in therapy. MST is delivered by a multidisciplinary team that is tailored to the adolescent's and family's target behaviors. For an adolescent with academic and conduct problems, frequent use of marijuana and cocaine, and a recent arrest for cocaine possession, the team will likely include a caseworker, family therapist, substance abuse counselor, and other individuals who will work with the adolescent in the adolescent's school and neighborhood (Greene & Heilbrun, 2011). Research has confirmed that the effectiveness of MST is reduced when treatment fidelity is low (i.e., when MST is not implemented as intended). Consequently, a quality assurance system is used to promote treatment fidelity. System components include initial and booster training of therapists; ongoing supervision and consultation; measures that evaluate the adherence of the therapist, supervisor, and consultant to the MST model; and a program implementation review that is completed every 6 months by the supervisor and expert consultant (Henggeler, 2011).

Group Therapy: For the exam, you want to be familiar with the formative stages of group therapy and the therapeutic factors provided by group therapy.

1. Formative Phases of Group Therapy: According to Yalom and Leszcz (2005), therapy groups usually experience three overlapping formative stages: During the *initial orientation, hesitant participation, search for meaning, and dependency stage*, group members are concerned with clarifying the nature and purpose of the group and depend on the leader for structure, acceptance, and answers to their questions. Interactions between members often focus on

describing symptoms and previous treatments and involve giving and seeking advice. Next is the *conflict, dominance, and rebellion stage.* In this stage, members compete for power and control and attempt to establish a pecking order. Members tend to be critical of each other, and some may become hostile and resentful toward the therapist as they become aware that they're not going to become the therapist's "favorite child." The final formative stage is the *development of cohesiveness stage.* In this stage, conflict between group members decreases, and cohesiveness increases as members begin to trust each other and the therapist. Members may reveal the real reason why they have come to therapy and show concern when a member is absent or drops out of therapy. The development of cohesiveness marks the beginning of a mature group that can deal effectively with the concerns and problems of group members.

2. Therapeutic Factors: Yalom and Leszcz (2005) describe 11 therapeutic factors that are responsible for the effects of group therapy: group cohesiveness, instillation of hope, universality, altruism, imparting information, development of socializing techniques, corrective recapitulation of the primary family group, interpersonal learning, imitative behavior, catharsis, and existential factors. Of these factors, group cohesiveness is considered to be the analogue of the therapeutic alliance in individual therapy, is viewed as a precondition for the other therapeutic factors, and has been most consistently found to be a strong predictor of positive group therapy outcomes.

Beck's Cognitive-Behavior Therapy: Beck's cognitive behavior therapy (CBT) was originally developed as an intervention for depression and is now considered to be an evidence-based treatment not only for depression but also for bipolar disorder, generalized anxiety disorder, anorexia nervosa, bulimia nervosa, schizophrenia, obsessive-compulsive disorder, PTSD, and a number of other psychiatric disorders. It has also been found useful as an adjunct treatment for chronic pain. For example, there is evidence that, for patients with rheumatoid arthritis, CBT is useful not only for reducing comorbid depression and anxiety but also for improving coping skills and self-efficacy and reducing pain intensity and fatigue, especially when CBT is provided early in the course of the disease (e.g., Dixon et al., 2007; Sharp, 2016; Shen et al., 2020).

CBT is based on the assumption that psychological disturbance is due largely to maladaptive cognitive schemas, automatic thoughts, and cognitive distortions:

(a) *Cognitive schemas* are core beliefs that develop during childhood as the result of experience and certain biological factors such as biological reactivity to stress. Schemas are enduring, can be maladaptive or adaptive, and are revealed in automatic thoughts. Beck proposed that different disorders are associated with different maladaptive schemas, which are also known as cognitive profiles. According to Beck, the cognitive profile for depression consists of negative beliefs about oneself, the world, and the future.

(b) *Automatic thoughts* are verbal self-statements or mental images that "come to mind spontaneously when triggered by circumstances … [and] intercede between an event or stimulus and the individual's emotional and behavioral reactions" (Beck & Weishaar, 2014, p. 245). Automatic thoughts can be positive or negative. Negative automatic thoughts are characterized by a distortion of reality, emotional distress, and/or interference with the pursuit of life goals and can contribute to psychological distress (Beck, 1995). Practitioners of CBT often have clients record negative automatic thoughts outside therapy in a Dysfunctional Thought Record (DTR) whenever they feel their mood is worsening. When using a DTR, the client records the event or situation that led to an unpleasant emotion, the automatic thoughts that preceded the emotion, the type of emotion and its intensity on a scale from 0 to 100, an alternative rational response to the automatic thought, and the outcome (the emotion and any change in behavior elicited by the rational response).

(c) *Cognitive distortions* are systematic errors in reasoning that often affect thinking when a stressful situation triggers a dysfunctional schema that, in turn, affects the content of automatic thoughts. Common distortions include arbitrary inference, selective abstraction, dichotomous thinking, personalization, and emotional reasoning: *Arbitrary inference* involves drawing negative conclusions without any supporting evidence. *Selective abstraction* involves paying attention to and exaggerating a minor negative detail of a situation while ignoring other aspects of the situation. *Dichotomous thinking* is the tendency to classify events as representing one of

two extremes – for example, as a success or a failure. *Personalization* involves concluding that one's actions caused an external event without evidence for that conclusion. And *emotional reasoning* is reliance on one's emotional state to draw conclusions about oneself, others, and situations.

The primary goals of CBT are "to correct faulty information processing and to help patients modify assumptions that maintain maladaptive behaviors and emotions" (Beck & Weishaar, 2014, p. 244). Practitioners of CBT adopt an active, structured approach and use a variety of cognitive and behavioral techniques to achieve these goals. Cognitive techniques include redefining the problem, reattribution, and decatastrophizing; behavioral techniques include activity scheduling, behavioral rehearsal, exposure therapy, and guided imagery (which is used to facilitate relaxation and decrease anxiety and pain). An essential feature of CBT is its reliance on *collaborative empiricism*, which is "a collaborative therapeutic alliance between the therapist and client in which they become coinvestigators as they examine the evidence to accept, support, reevaluate, or reject the client's thoughts, assumptions, intentions, and beliefs" (Shiraev, 2017, p. 252). Another feature is the use of *Socratic dialogue*, which involves asking the client questions that are designed to clarify and define the client's problems, identify the thoughts and assumptions that underlie those problems, and evaluate the consequences of maintaining maladaptive thoughts and assumptions.

Other Cognitive-Behavioral Interventions: For the exam, you also want to be familiar with the following cognitive-behavioral interventions.

1. **Rational Emotive Behavior Therapy:** Ellis's rational emotive behavior therapy (REBT) attributes psychological disturbances to irrational beliefs, which tend to be "absolute (or dogmatic) and are expressed in the form of 'must's,' 'should's,' 'ought's,' 'have to's,' etc. … and lead to negative emotions that largely interfere with goal pursuit and attainment" (Ellis & Dryden, 1997, p. 5). "I must do well on all of the important projects I take on; if not, I'm an inadequate person" and "You must take care of me when I need you to do so; if not, you're not a good person" are examples of irrational beliefs.

Ellis uses an *A-B-C-D-E model* to explain psychological disturbance and the process of change in therapy: A is an activating event, B is the client's irrational belief about that event, C is the emotional or behavioral consequence of that belief, D is the therapist's use of techniques that dispute the client's irrational belief, and E is the effect of these techniques, which is the replacement of the irrational belief with a more rational one. Practitioners of REBT use a variety of cognitive, behavioral, and emotive techniques, including active disputation of irrational beliefs, rational-emotive imagery, systematic desensitization, and skills training. Research has found that REBT is an effective treatment for depression, anxiety, conduct problems, anger, and several other disorders and conditions (e.g., DiGiuseppe, 2010).

2. **Self-Instructional Training:** Self-instructional training (Meichenbaum, 1977) was initially developed to teach problem-solving skills to children with high levels of impulsivity but has since been applied to other populations and problems. It consists of five stages: During the initial *cognitive modeling stage*, children observe a model perform a task while the model verbalizes instructions aloud. In the second *overt external guidance stage*, children perform the same task while the model verbalizes the instructions. Next is the *overt self-guidance stage* in which children perform the task while verbalizing the instructions aloud themselves. This is followed by the *faded overt guidance stage* in which children perform the task while whispering the instructions. And finally, during the *covert self-instruction stage*, children perform the task while repeating the instructions subvocally. The instructions used by the model and children while performing the task address four skills: identifying the nature of the task, focusing attention on the task and the behaviors needed to complete it, providing self-reinforcement that sustains appropriate behavior, and evaluating performance and correcting errors.

3. **Stress Inoculation Training:** Stress inoculation training (Meichenbaum, 1996) focuses on improving the ability of clients to deal better with ongoing and future stressful situations by teaching them effective coping skills. It consists of three phases. During the initial *conceptualization/education phase*, clients are provided with information about stress and its effects and are encouraged to view stressful situations as "problems-to-be-solved" (p. 4). In the *skills acquisition and consolidation phase*, clients learn a variety of cognitive and behavioral coping skills which may include relaxation, self-instruction, and problem-solving. Finally, during the *application and follow-through phase*, clients use newly acquired coping skills, first in imagined and role-playing situations and then in real life situations.

4. **Acceptance and Commitment Therapy:** Acceptance and commitment therapy (ACT) is based on the assumptions that "psychological pain is both universal and normal and is part of what makes us human" (Boorman, Morris, & Oliver, 2017, p. 218) and that psychological inflexibility causes psychological problems and is characterized by a "rigid dominance of psychological reactions over chosen values and contingencies in guiding action" (Bond et al., 2011, p. 678). With regard to pain, ACT distinguishes between clean and dirty pain: *Clean pain* is also known as clean discomfort and refers to natural levels of physical and psychological discomfort that are inevitable and cannot be controlled. *Dirty pain* is also known as dirty discomfort and refers to the emotional suffering that's caused by attempts to control or resist clean pain.

The main goal of ACT is to increase psychological flexibility, which involves addressing six core processes that foster acceptance, mindfulness, commitment, and behavior change and counter the processes that contribute to psychological inflexibility: *Experiential acceptance* counters experiential avoidance and is "the active and aware embrace of private experiences without unnecessary attempts to change their frequency or form" (Hayes, Pistorello, & Levin, 2012, p.

982). *Cognitive defusion* counters cognitive fusion and is the ability to distance oneself from one's thoughts and feelings and view them as experiences rather than reality. *Being present* counters attentional rigidity to the past and future and involves being in contact with whatever is happening in the present moment. *Awareness of self-as-context* counters attachment to the conceptualized self. It's the ability to view oneself as the context in which one's thoughts and feelings occur rather than as the thoughts and feelings themselves. *Values-based actions* counter unclear, compliant, or avoidant motives and depend on the ability to use one's freely chosen values to guide one's behaviors. And *committed action* counters inaction, impulsivity, and avoidant persistence and refers to a commitment to continue to act in ways consistent with one's values in the future, even when faced with obstacles. Interventions target these six processes and include metaphors, mindfulness strategies, and experiential exercises. ACT is considered to be an evidence-based treatment for a number of conditions including chronic pain, psychosis, depression, anxiety disorders, and obsessive-compulsive disorder.

5. **Mindfulness-Based Interventions:** Mindfulness refers to "moment-to-moment awareness of one's experience without judgment" (Davis & Hayes, 2011, p. 198). It has been incorporated into several therapeutic approaches including acceptance and commitment therapy and dialectical behavior therapy and is the core strategy of mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT). *MBSR* was originally developed "to make mindfulness meditation available and accessible in a Western medical setting while remaining true to the essence of Buddhist teachings" (Sauer & Baer, 2010, p. 4). It's used to help people cope with stress, pain, and illness and consists of an eight-session group program that focuses on teaching participants several mindfulness meditation practices including awareness of breathing, yoga, and sitting and walking meditation.

MBCT combines elements of MBSR and CBT. It was originally developed as a method for treating recurrent depression (Segal, Williams, & Teasdale, 2001), and research has confirmed that it's an effective treatment not only for depression but also for a number of other conditions including anxiety, chronic pain, and insomnia. The primary goal of MBCT is to "enable clients to become self-aware, so they can learn to de-centre from distressing thoughts, feelings, bodily sensations and behaviours" (Scott & Adam, 2017, p. 246). It incorporates psychoeducation, mindfulness meditation practices, and cognitive-behavioral techniques and, like MBSR, usually consists of an eight-session group program.

Based on their meta-analysis of research on the effectiveness of mindfulness-based interventions, Khoury and his colleagues (2013) concluded that they are effective for treating both psychological disorders and physical/medical conditions but are more effective for psychological disorders, especially depression, anxiety, and stress. Research has also been conducted to identify the change mechanisms that account for the beneficial effects of these

interventions. A frequently cited systematic review and meta-analysis of this research conducted by Gu et al. (2015) found that there is consistent and strong research support for decreased emotional and cognitive reactivity as the change mechanism, moderate support for increased mindfulness and decreased rumination and worry, and insufficient support for increased self-compassion and psychological flexibility.

6. **Cognitive-Behavioral Therapy for Suicide Prevention:** There are several versions of cognitive-behavioral therapy for suicide prevention: Wenzel, Brown, and Beck's (2009) *cognitive therapy for suicide prevention* (CT-SP) is a brief intervention that was designed to prevent repeat suicide attempts by adults who recently attempted suicide. It consists of three phases: conceptualization of the suicidal mode and developing a safety plan; acquisition of cognitive, behavioral, and affective coping skills; and consolidation of coping skills and relapse prevention. Bryan's (2019) *cognitive-behavioral therapy for suicide prevention* (CBT-SP) is a brief treatment for suicidal patients, while Bryan and Rudd's (2018) *brief cognitive-behavioral therapy for suicide prevention* (BCBT) is a version of CBT-SP for active-duty members of the military. CBT-SP and BCBT both focus on emotion regulation, cognitive flexibility, and relapse prevention. Finally, Stanley et al.'s (2009) *cognitive-behavioral therapy for suicide prevention* (also known as CBT-SP) was developed for adolescents who recently attempted suicide and combines elements of cognitive-behavioral therapy and dialectical behavior therapy. It consists of acute and continuation phases that include individual and family sessions: The acute phase consists of chain analysis (identification of events that led to the suicide attempt), safety planning, psychoeducation, addressing reasons for living, and case conceptualization. The continuation phase focuses on generalizing and consolidating behavioral and cognitive skills and relapse prevention.

Safety planning is an essential component of cognitive-behavioral therapy for suicide prevention. For example, Stanley and Brown (2012) developed a safety planning intervention (SPI) that can be used as a component of cognitive-behavioral therapy or as a stand-alone intervention in emergency departments or other emergency situations or any other time when longer-term care is not feasible or available. The SPI consists of six steps that start with the use of internal strategies and switch to external strategies when internal strategies do not work: (1) recognizing the warning signs of an imminent suicidal crisis, (2) using internal coping strategies (e.g., going for a walk, reading a book), (3) utilizing social contacts as a means of distraction or support, (4) contacting family or friends who may help resolve the crisis, (5) contacting mental health professionals or agencies, and (6) reducing access to lethal means. [Note that a safety plan is not the same as a no-suicide contract, which is a verbal or written agreement that requires clients to promise they will abstain from attempting suicide. While research has found the SPI and other safety plans to be useful for reducing suicidality, there is no empirical

evidence supporting the use of no-suicide contracts (e.g., Ferguson et al., 2022; Rudd et al., 2006).]

Finally, with regard to effectiveness, there is evidence that cognitive-behavioral therapies for suicide prevention reduce suicidal ideation and suicide attempts, feelings of hopelessness, and depression. The research has also found that these benefits occur regardless of a person's gender, severity of suicidal ideation, and number of suicide attempts (Bryan et al., 2018; Bryan & Rudd, 2018).

Prevention: The most frequently cited models of prevention were developed by Gerald Caplan and Robert Gordon.

1. Caplan's Model: Caplan (1964) distinguished between three types of prevention: primary, secondary, and tertiary.

(a) The goal of *primary prevention* is to reduce the occurrence of new cases of a mental or physical disorder. Primary preventions are aimed at an entire population or group of individuals rather than specific individuals, and the population or group may or may not be restricted to people who are known to be at elevated risk for the disorder. Examples are a public education program about depression and suicide, a school-based program for fifth graders to prepare them for the transition to middle school, and prenatal care for low-income mothers.

(b) The goal of *secondary prevention* is to reduce the prevalence of a mental or physical disorder in the population through early detection and intervention. Secondary preventions are aimed at specific individuals who have been identified as being at elevated risk for the disorder. Providing tutoring to elementary school students who are beginning to have academic difficulties and using a screening test to identify individuals at risk for depression and then providing identified individuals with counseling are secondary preventions.

(c) The goal of *tertiary prevention* is to reduce the severity and duration of a mental or physical disorder. Tertiary preventions target people who have already received a diagnosis of a mental or physical disorder and include relapse prevention and rehabilitation programs. Social skills training for patients with schizophrenia, halfway houses, and Alcoholics Anonymous are tertiary preventions.

2. **Gordon's Model:** Gordon's (1983) model distinguishes between universal, selective, and indicated prevention: *Universal preventions* are aimed at entire populations or groups that are not restricted to individuals who are at risk for a disorder. A drug abuse prevention program for all high school students in a school district is a universal prevention. *Selective preventions* are aimed at individuals who have been identified as being at increased risk for a disorder due to their biological, psychological, or social characteristics. A drug abuse prevention program for adolescents whose parents have a substance use disorder is a selective prevention. *Indicated preventions* are for individuals who are known to be at high-risk because they have early or minimal signs of a disorder. A drug abuse prevention program for adolescents who have experimented with drugs is an indicated prevention.

The Institute of Medicine (Mrazek & Haggerty, 1996) expanded Gordon's model to create a continuum of care model that includes prevention, treatment, and maintenance. In this model, universal, selective, and indicated preventions are restricted to people who have not received a diagnosis of a mental or physical disorder. Treatment strategies are aimed at people who have

received a diagnosis, and maintenance strategies are for people who have received treatment for a disorder and focus on preventing chronicity or relapse and/or providing rehabilitation.

Mental Health Consultation: Caplan (1970) distinguished between four types of mental health consultation. Each type consists of a triad that includes a consultant, a consultee (therapist or program administrator), and a client or program.

1. **Client-Centered Case Consultation:** This type of consultation focuses on a particular client of the consultee who is having difficulty providing the client with effective services (e.g., is having trouble identifying an appropriate treatment). The consultant's goal is to provide the consultee with a plan that will benefit the client.

2. **Consultee-Centered Case Consultation:** Consultee-centered case consultation focuses on the consultee with the goal of improving his/her ability to work effectively with current and future clients who are similar in some way – e.g., clients with traumatic brain injury, clients from a specific racial/ethnic minority group. The goal of this type of consultation is to improve the consultee's knowledge, skills, confidence, and/or objectivity. Caplan identified several factors that contribute to a consultee's lack of objectivity. One of these is *theme interference*, which occurs when a consultee's biases and unfounded beliefs interfere with his/her ability to be objective when working with certain types of clients.

3. **Program-Centered Administrative Consultation:** This type of consultation involves working with program administrators to help them clarify and resolve problems they're having with an existing mental health program. The consultant's goal is to provide administrators with recommendations for dealing with the problems they've encountered in developing, administering, and/or evaluating the program.

4. **Consultee-Centered Administrative Consultation:** Consultee-centered administrative consultation focuses on improving the professional functioning of program administrators so they're better able to develop, administer, and evaluate mental health programs in the future.

Mental health consultation differs from *collaboration* in several ways. For example, a consultant has little or no direct contact with a consultee's client and is not responsible for the client's outcomes. In contrast, a collaborator usually has direct contact with the client and shares responsibility for the client's outcomes.

Interprofessional collaboration: Interprofessional collaboration (IPC) is a "partnership between a team of health providers and a client in a participatory collaborative and coordinated approach to shared decision making around health and social issues" (Canadian Interprofessional Health Collective, 2010, p. 11). Dragan and Marino (2018) note that IPC most often occurs in primary care settings where it serves three primary functions: improvement of patient care, improvement of health outcomes for patients, and decreased healthcare costs.

However, reviews of the research suggest that the effects of IPC in primary care settings are inconsistent. For example, in their overview of previous systematic reviews of IPC in primary care, Carron et al. (2021) report that, while most studies confirm that IPC has positive effects on clinical outcomes, the process of care, and patient satisfaction, the research has provided mixed results with regard to its effects on quality of life; physical, emotional, and social functioning; and health behaviors and practices.

IPC is considered to be particularly useful for addressing the multiple and complex healthcare needs of older patients, and it is often referred to as integrated care in research involving members of this population. Results of this research provide some evidence that integrated care for older patients is associated with improved access to care; increased patient satisfaction with services provided; and fewer emergency department visits, hospitalizations, and long-term care placements (e.g., Baxter et al., 2018; Hebert et al., 2010).

Efficacy and Effectiveness Research: Much of the empirical research evaluating psychotherapy outcomes can be categorized as efficacy research or effectiveness research. *Efficacy research studies* are also known as clinical trials and maximize internal validity (the ability to draw conclusions about the cause-effect relationship between therapy and outcomes) by maximizing experimental control. For example, participants are randomly assigned to groups in these studies and therapists use treatment manuals to ensure that treatment is provided in the same way to all participants. In contrast, *effectiveness research studies* maximize external validity (the ability to generalize the conclusions drawn from the study to other people and conditions) by providing therapy in naturalistic clinical settings. Both approaches have strengths and weaknesses, and a useful strategy for evaluating treatment outcomes is to first conduct an efficacy study to determine a treatment's effectiveness in well-controlled conditions, and then conduct an effectiveness study in "real world" settings to determine its generalizability, feasibility, and cost-effectiveness (Jacobson & Christensen, 1996).

Psychotherapy Outcome Research: Frequently cited research on psychotherapy outcomes include studies conducted by Eysenck; Smith, Glass, and Miller; and Howard and his colleagues.

1. **Eysenck:** Hans Eysenck is probably best known for his conclusions about intelligence and personality: He proposed that intelligence is due primarily to heredity, with about 80% of variability in IQ scores being due to genetic factors. His personality theory also stresses the role of heredity and distinguishes between three major personality traits: extroversion, neuroticism, and psychoticism. Eysenck (1952) is also known for his controversial conclusions about the effectiveness of psychotherapy (1952), which were based on his review of 24 empirical studies that reported treatment outcomes for "neurotic" patients who participated in psychoanalytic or eclectic psychotherapy. Because the studies did not include no-treatment control groups, Eysenck used other studies to estimate the spontaneous remission rates of neurotic patients

who received custodial care in an inpatient facility or medical care from a physician. Based on this data, Eysenck concluded that 44% of patients who participated in psychoanalytic psychotherapy, 64% of patients who participated in eclectic psychotherapy, and 72% of patients who did not participate in psychotherapy experienced an improvement in symptoms. He proposed that these results not only showed that psychotherapy is ineffective but that it may actually have detrimental effects since the average recovery rates for psychotherapy patients were lower than the average spontaneous remission rate for patients who did not receive psychotherapy.

Eysenck's conclusions were challenged by advocates of psychotherapy who pointed out that his study had several methodological flaws. For example, Luborsky (1954) noted that the comparisons Eysenck made were questionable because patients were not randomly assigned to groups and, consequently, initial differences in patient characteristics could account for at least some of the differences in recovery rates. In addition, Bergin (1971) noted that the criteria Eysenck used to determine recovery were questionable and found that use of different criteria produced a recovery rate of 83% for patients who participated in psychoanalytic psychotherapy and 30% for patients who did not receive psychotherapy.

2. **Smith, Glass, and Miller:** Eysenck's article generated a great deal of research on psychotherapy outcomes, and Smith, Glass, and Miller (1980) were the first to use *meta-analysis* to combine the results of studies that compared the outcomes of patients who received psychotherapy to the outcomes of patients in either a no-treatment control group or an alternative (non-therapy) treatment group. Their analysis included 475 studies and produced a mean effect size of .85, which means that the average patient who received psychotherapy was "better off" than 80% of patients who did not receive psychotherapy. [An effect size indicates the mean difference between groups in terms of a standard deviation, and an effect size of .85 indicates that the mean outcome score for patients who participated in psychotherapy was .85 standard deviation above the mean outcome score for patients who did not receive psychotherapy. In a normal distribution, 84% of scores are below a standard deviation of 1.0, and 80% (slightly less than 84%) are below a standard deviation of .85. Note that, for the exam, you just need to remember that an effect size of .85 means that the average patient who received psychotherapy was better off than 80% of patients who didn't receive therapy. You do not need to understand why this is so, but we've included the explanation for those of you who are curious about the interpretation of an effect size of .85.]

3. **Howard and Colleagues:** Howard and his colleagues (1986, 1996) investigated the relationship between the duration of psychotherapy and its outcomes. Based on the results of their research, they developed two models to describe this relationship:

(a) The *dosage model* is also known as the dose-effect model and states that there's a predictable relationship between number of therapy sessions and the probability of measurable improvement in symptoms. Specifically, it predicts that 50% of therapy clients can be expected to exhibit a clinically significant improvement in symptoms by six to eight sessions, 75% by 26 sessions, and 85% by 52 sessions.

(b) The *phase model* proposes that psychotherapy outcomes can be described in terms of three phases: The initial *remoralization* phase occurs during the first few sessions and is characterized by an increase in hopefulness. This is followed by the *remediation phase*, which occurs during the next 16 sessions and involves a reduction in symptoms. The final *rehabilitation phase* involves "unlearning troublesome, maladaptive, habitual behaviors and establishing new ways of dealing with various aspects of life (e.g., problematic relationship patterns, faulty work habits, and trouble-causing personal attitudes)" (1996, p. 1061). An implication of this model is that different outcome measures should be used during different phases of therapy – i.e., measures of subjective well-being during the remoralization phase, the severity and frequency of symptoms during the remediation phase, and life functioning during the rehabilitation phase.

Other Psychotherapy Research: The following are other important issues related to psychotherapy research and outcomes.

1. **Common Factors in Psychotherapy:** Because the research has found that different psychotherapy approaches have similar beneficial effects (APA, 2012), a number of researchers have attempted to identify elements common to the various approaches that contribute to psychotherapy outcomes. For example, based on their review of the research, Norcross and Lambert (2011) attribute 30% of variability in psychotherapy outcomes to patient contributions, 12% to the therapeutic relationship, 8% to the treatment method, 7% to therapist characteristics, 3% to other factors, and 40% to unexplained variance.

2. **The Working Alliance:** The psychanalyst, Ralph Greenson (1967), was the first to describe the therapeutic relationship as consisting of three components: working alliance, real relationship, and transference-countertransference. Of these, the working alliance (which is also referred to as the therapeutic alliance) has been studied most extensively. As defined by Greenson, the working alliance is "the relatively non-neurotic, rational relationship between patient and analyst which makes it possible for the patient to work purposely in the analytic situation" (p. 46). Studies have identified the working alliance as a core common factor across all types of psychotherapy and have found a strong working alliance to be a significant predictor of successful psychotherapy outcomes. For example, a recent meta-analysis of the research by Fluckiger, Del Re, Wampold, and Horvath (2018) confirmed that, for adult therapy clients, "the positive relation of the alliance and outcome remains across assessor perspectives, alliance and

outcome measures, treatment approaches, patient (intake-) characteristics, face-to-face and Internet-mediated therapies, and countries" (p. 316).

3. **Client-Therapist Matching:** The results of research investigating the effects of client-therapist matching in terms of race and ethnicity vary, depending on the outcome measure and clients' race or ethnicity. For example, Cabral and Smith's (2011) meta-analysis of the research produced an effect size of .32 for the impact of matching on clients' perceptions of their therapists but an effect size of only .09 on measures of therapy outcome. In addition, Sue et al. (1991) found that the effects of matching on treatment outcomes varied, depending on client race/ethnicity: Their study indicated that racial/ethnic matching reduced premature termination rates for Asian, Hispanic, and European American clients but not for African American clients and that matching was associated with improved treatment outcomes only for Hispanic American clients. There's also evidence that matching in terms of factors other than race and ethnicity are more important for therapy outcomes: Comas-Diaz (2012) report that their review of the research indicated that "clinicians' cultural competence, compassion, and … worldview were more important than ethnic matching between client and clinician" (2012, p. 173).

Researchers have also investigated the effects of a client-therapist match in terms of personality on the process and outcomes of therapy. For example, Taber et al. (2011) examined the impact of client-therapist personality similarity as measured by Holland's Self-Directed Search on the therapeutic alliance and therapy outcomes. The results of their study indicated that client-therapist personality congruence had a positive impact on the clients' perceptions of the client-therapist alliance but did not have a direct effect on therapy outcomes. More recently, Perez-Rojas et al. (2021) looked at the effects of clients' perceptions regarding similarity to their therapists in terms of the Big Five personality traits. They found that clients who perceived their therapists as being similar to them in terms of conscientiousness and openness to experience reported stronger relationships with their therapists and better progress in therapy.

4. **Utilization of Mental Health Care Services:** Research has found that utilization rates of mental health care services vary, depending on client gender, age, sexual orientation, and race/ethnicity. With regard to gender, the 2020 National Health Interview Survey (NHIS; Terlizzi & Norris, 2021) found that, for all adult respondents, women were more likely than men to have taken medication for mental health conditions and to have received counseling or therapy from a mental health professional in the previous 12 months. In terms of age, the 2021 NHIS (Terlizzi & Schiller, 2022) found that the percentage of adults who received any mental health treatment (therapy or medication) in the past 12 months was greatest for respondents ages 18 to 44 followed by, in order, those 45 to 64 years of age and those 65 years of age and older.

The studies have also found that rates of mental health problems among college students and their utilization of mental health services have both increased in recent years. However, despite

increased utilization rates, the majority of college students with mental health problems still do not seek services even when they are available (Bruffaerts et al., 2019). Most studies on treatment barriers have found that attitudinal barriers are more often cited by college students than are structural barriers (e.g., Ebert et al., 2019): Preferring to handle the problem alone, preferring to talk to friends and family members about the problem, and being embarrassed are examples of attitudinal barriers; the cost of treatment and problems with time or scheduling are examples of structural barriers. Research results vary with regard to the effects of stigma (an attitudinal barrier): Studies have confirmed that higher levels of stigma are associated with lower willingness to seek mental health treatment and dropping out of treatment prematurely (e.g., Fullmer, et al., 2021). However, some research suggests that personal (self) stigma has declined in recent years while perceived (public) stigma has not changed (Lipson et al., 2019). Finally, there is evidence that education- and contact-based anti-stigma interventions have a positive impact on attitudes toward mental health treatment and willingness to seek treatment (Kosyluk et al, 2016): Education-based interventions challenge and replace stereotypes and myths about mental illness and its treatment with accurate information. Contact-based interventions provide face-to-face or internet-mediated contact with a person who has successfully managed a mental disorder.

In terms of sexual orientation, the studies have generally found that sexual minority (gay/lesbian and bisexual) men and women utilize mental health care services at higher rates than sexual majority (heterosexual) men and women do. For example, data from the 2013 to 2015 National Health Interview Surveys (Platt, Wolf, & Scheitle, 2018) revealed that sexual minority men and women were two to four times more likely than heterosexual men and women to have talked with a mental health professional in the past year.

Finally, for members of different racial/ethnic minority groups, data from the 2021 National Survey of Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2022) indicated that, among adults ages 18 and older, the use of outpatient mental health services in the past year was highest for respondents who identified themselves as belonging to two or more racial groups followed by those who identified themselves as White and lowest for respondents who identified themselves as Asian. For inpatient mental health services, use was highest for respondents who identified themselves as belonging to two or more racial groups followed by those who identified themselves as American Indian or Alaska Native and lowest for respondents who identified themselves as Asian.

5. **Psychological Interventions and Medical Costs:** The American Psychological Association has concluded that research on psychotherapy outcomes has “demonstrated that courses of psychotherapy reduce overall medical utilization and expense” (2012, p. 2). For example, with regard to expense, Chiles, Lambert, and Hatch’s (1999) meta-analysis of research conducted

between 1967 and 1997 indicated that participation in psychological interventions by patients undergoing surgery, patients with a history of medical overutilization, and patients receiving treatment for substance misuse or other psychological disorder usually resulted in a *medical cost offset*. They found that 90% of the studies included in their analysis reported evidence of a medical cost offset and that the average cost savings attributable to a psychological intervention was 20%.

6. **Economic Evaluation:** The economic evaluation of healthcare programs involves using information about program costs and benefits to inform decision-making. Cost-benefit analysis, cost-effectiveness analysis, and cost-utility analysis are three methods of economic evaluation. *Cost-benefit analysis* (CBA) can be used to compare the costs and benefits of one or multiple interventions. When using CBA, costs and benefits are both expressed in monetary terms. As an example, Knapp et al. (2013) compared individual placement and support (IPS) and standard vocational rehabilitation for helping people with severe mental disorders obtain employment. When the costs of implementing the two interventions and their benefits (as measured by expected earnings) were compared, IPS produced a greater net benefit. *Cost-effectiveness analysis* (CEA) is used to compare the costs and benefits of two or more interventions when benefits cannot be expressed as monetary values. The Knapp et al. study used cost-effectiveness analysis to compare the costs and benefits of IPS and standard vocational rehabilitation, with benefits being measured as percent of participants who worked for at least one day during the follow-up period, percent of participants who dropped out of the program they were assigned to, and percent of participants who had to be readmitted to the hospital. IPS was found to be more effective than vocational rehabilitation for all three benefits. Finally, *cost-utility analysis* (CUA) is used to compare the costs of two or more interventions on quality-adjusted life-years (QALYs), which combines measures of gain in the health-related quality and the quantity (duration) of life. For instance, Sava, Yates, Lupu, Szentagotai, and David (2009) used CUA to compare the costs and benefits in terms of QALYs of three treatments for depression: cognitive therapy (CT), rational-emotive behavior therapy (REBT), and fluoxetine (Prozac). Results indicated that CT and REBT both had greater cost-utility than fluoxetine but did not differ significantly from each other.

7. **Effects of Age, Gender, and Socioeconomic Status on Psychotherapy Outcomes:** Research investigating the effects of age, gender, and socioeconomic status on psychotherapy outcomes has not produced entirely consistent results, but the best overall conclusions are that they have little or no impact on outcomes and that apparent differences are due to other factors (Boswell, Constantino, & Anderson, 2016). For example, Nordberg and colleagues (2014) found that, when initial severity of symptoms was controlled, client age explained essentially none of the variance in psychotherapy outcomes. Also, while some studies have linked low socioeconomic

status to premature termination, there's evidence that this relationship is due to transportation difficulties and other factors.

8. **Biases in Psychological Research and Theory:** Psychological research and theory can be affected by a number of biases, including gender biases and the WEIRD sampling bias. Gender biases can cause research results and conclusions drawn from those results to be nonrepresentative of the actual experiences and behaviors of men and/or women: *Alpha bias* is the tendency to exaggerate differences between men and women and can reinforce gender stereotypes and justify discriminatory practices. In contrast, *beta bias* is the tendency to ignore or minimize differences between men and women. It can lead to the erroneous conclusion that the results of research that included only male participants also apply to females, and vice versa. Alpha and beta biases have been linked to *androcentrism*, which means "male-centered" and occurs when male behaviors and traits are considered to be the norm while female behaviors and traits are viewed as deviations from the norm and often as abnormal or inferior.

As described by Henrich, Heine, and Norenzayan (2010), WEIRD is an acronym for western, educated, industrialized, rich, and democratic cultures. According to these investigators, studies published in the world's top journals have over-relied on samples drawn from WEIRD cultures and, consequently, their results may have limited generalizability. As an example, Henrich et al. note that the Big Five personality traits have been derived primarily from research that included WEIRD samples and argue that, as a result, conclusions about the universality of the Big Five drawn from this research may not be valid. Some evidence for this claim is provided by Gurven et al. (2013), who found that the Big Five personality traits do not accurately describe the personalities of a largely illiterate indigenous population of forager-farmers in the Bolivian Amazon. (Note, however, that the universality of the Big Five continues to be debated, with studies like Gurven et al.'s being criticized on methodological grounds.)

9. **Routine Outcome Monitoring:** Routine outcome monitoring (ROM) is also known as feedback-informed treatment and measurement-based care and is considered to be a transtheoretical and transdiagnostic evidence-based practice (Scott & Lewis, 2015). As described by Lewis et al. (2019), it consists of four components: "(1) a routinely administered symptom, outcome, or process measure …, ideally before each clinical encounter; (2) practitioner review of data; (3) patient review of data; and (4) collaborative reevaluation of the treatment plan informed by the data" (p. 326). ROM may involve the use of clinician rating scales but most often uses standardized patient self-report measures such as the Partners for Change Outcome Management System (PCOMS), which is used to assess a client's progress and the quality of the therapeutic relationship (Lambert & Harmon, 2018). Studies have confirmed that ROM is more effective than less frequent feedback and is associated with several benefits including increased rates of clinically significant improvement and significant reductions in client

deterioration during therapy and premature termination (e.g., Carlier & van Eeden, 2017; Fortney et al., 2017; Lambert, 2010; Lewis et al., 2019). In addition, a number of studies have found that ROM is most effective for clients who are at risk for treatment failure.

Despite evidence of its benefits, ROM is underutilized by clinicians due to client and clinician barriers (e.g., Boswell, Kraus, Miller, & Lambert, 2015; Lewis et al., 2019): Client barriers include concerns about confidentiality and the time needed to complete the measures. Clinician barriers include the belief that information provided by ROM is not more accurate than clinical judgment; a lack of training in the use of ROM; unease about the potential effects of ROM on the therapeutic relationship; concerns about the time it takes to administer, score, and interpret measures, create a report, and provide feedback to clients; and concerns about how results of ROM will be used by employers and insurance companies.

10. **Transdiagnostic Treatments:** Transdiagnostic treatments are designed to address a range of diagnoses that not only share symptoms but also biological, psychological, and environmental mechanisms that increase the risk for and maintain those symptoms. “The premise underlying transdiagnostic treatments is that the commonalities across disorders outweigh the differences and that targeting the … [commonalities] may have a number of important benefits compared to diagnosis-specific approaches” (McEvoy, Nathan, & Norton, 2009, p. 21). For example, transdiagnostic treatments can reduce the cost and amount of time associated with training psychologists to deliver numerous diagnosis-specific interventions and they’re better suited than single-diagnosis treatments for addressing comorbidities. Systematic reviews and meta-analyses of the research have generally confirmed that, in terms of effectiveness, transdiagnostic psychological treatments are equivalent or superior to comparison treatments (Dalgleish, Black, Johnston, & Bevan, 2020). For example, based on the results of their meta-analysis, Newby and colleagues (2015) concluded that transdiagnostic treatments are as effective as diagnosis-specific treatments for anxiety and may be more effective for depression.

Some transdiagnostic treatments consist of evidence-based strategies that are applicable to disorders within a single diagnostic category, while others consist of strategies that are applicable to disorders from different categories. Cognitive Behavioral Therapy-Enhanced (CBT-E) is an example of the former and was designed as an intervention for anorexia nervosa, bulimia nervosa, and other eating disorders (Fairburn, Cooper, & Shafran, 2003). It is based on the assumption that these disorders share the same core psychopathology of overvaluation of body shape and weight (Fairburn et al., 2003). Examples of the latter include the following: (a) The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2011) is an emotion-focused, cognitive-behavioral intervention for anxiety, depression, and related disorders. It views neuroticism as the core characteristic shared by these disorders and focuses on mechanisms associated with neuroticism, including deficits in emotion regulation

and avoidance of intense emotional experiences. (b) Emotion-Focused Therapy-Transdiagnostic (EFT-T; Timulak & Keogh, 2020) was developed as a treatment for depression, anxiety, and related disorders and targets the chronic painful emotions of loneliness/sadness, shame, and fear/terror that underlie these disorders. (c) Acceptance and Commitment Therapy (ACT) is a cognitive-behavioral intervention for a wide range of mental health and medical conditions. It is based on the assumption that "pain, grief, disappointment, illness, and anxiety are inevitable features of human life… [and its primary goal is] helping individuals adapt to these types of challenges by developing greater psychological flexibility" (Dindo, Van Liew, & Arch, 2017, p. 546). (d) Parent-Child Interaction Therapy (PCIT) was originally developed as a treatment for disruptive behavior disorders but has since been found to be an effective intervention for anxiety, mood, and trauma-related disorders and child maltreatment. It is based on the premise that emotion dysregulation is "a core process in the etiology of myriad early-onset psychopathology symptoms" (Rothenberg, Weinstein, Dandes, & Jent, 2018, p. 720), and a primary goal of therapy is improving a child's emotion regulation.

11. **Telepsychology and Evidence-Based Psychotherapy:** Telepsychology is also referred to as telehealth and telemental health and is "the provision of psychological services using telecommunication technologies ... [that] include but are not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, and Internet (e.g., self-help websites, blogs, and social media)" (APA, 2013, p. 792). Interest in telepsychology has increased in recent years, especially with regard to the delivery of evidence-based psychotherapy (EBP). As noted by Wangelin, Szafranski, and Gros (2016), EBP delivered via telepsychology is associated with several benefits over EBP delivered in-person: It decreases patients' and providers' costs (e.g., costs related to travel and transportation); increases access to psychotherapy for individuals who have no or limited access (e.g., for members of rural and underserved populations); and reduces the stigma and embarrassment that some individuals experience when receiving psychotherapy at treatment facilities.

The research has also found that, despite the benefits of telepsychology, psychologists often express concerns about its use. For example, the American Psychological Association (2020) surveyed U.S. psychologists who were providing telehealth (mostly via videoconferencing) to some or all of their patients, and the majority stated that providing therapy via telehealth was more challenging than providing in-person therapy. When asked about the challenges their telehealth patients experienced, the most frequently cited challenge was internet access or connectivity followed by, in order, general technical difficulties and finding a private place to connect from. In addition, Watson et al. (2023) asked a sample of U. S. psychologists to select the barriers that impeded their own use of telehealth from a list of 19 barriers. The most frequently selected barriers were, in order, inadequate access to technology, diminished

therapeutic alliance, technological issues, diminished quality of delivered care or effectiveness, and privacy concerns.

A number of studies have been conducted to evaluate the effectiveness of interventions delivered via telehealth for a variety of psychiatric disorders including the following:

a. Anxiety Disorders: There's evidence that psychotherapy delivered via telepsychology is effective not only for treating individual anxiety disorders but also for treating comorbid anxiety and mood disorders. For example, Berryhill and colleagues (2019b) conducted a systematic review of studies evaluating the effectiveness of videoconference-delivered psychotherapy – most often cognitive-behavioral therapy (CBT) – for treating panic disorder with agoraphobia, generalized anxiety disorder, and social anxiety disorder. Their analysis indicated that the majority of studies found significant improvement in anxiety symptoms following participation in videoconferencing psychotherapy, with controlled studies finding no significant differences between videoconferencing and in-person therapy. In addition, Stubbings, Rees, Roberts, and Kane (2013) compared videoconferencing-delivered CBT to in-person CBT and found them to be similarly effective for reducing comorbid anxiety and depression and improving quality of life.

b. Posttraumatic Stress Disorder (PTSD): Most studies evaluating the use of telepsychology for treating PTSD have found it to be comparable to face-to-face interventions in terms of effectiveness. For example, in their systematic review of studies evaluating telepsychology for veterans with PTSD, Turgoose, Ashwick, and Murphy (2018) found that trauma-focused therapies (e.g., exposure therapy, behavioral activation) delivered via telepsychology or in-person were similar in terms of the reduction of PTSD symptoms, attendance and dropout rates, client satisfaction, and therapist fidelity to treatment protocols. However, the studies included in their review did not provide entirely consistent results with regard to the therapeutic alliance: While therapists providing telepsychology said they didn't have trouble developing rapport with clients, some reported barriers to developing a therapeutic alliance, such as the inability to detect nonverbal communications.

c. Major Depressive Disorder: The research has demonstrated the effectiveness of telepsychology for treating major depressive disorder. In their systematic review of studies comparing videoconferencing and in-person psychotherapy, Berryhill and colleagues (2019a) found that most studies reported statistically significant decreases in depressive symptoms following videoconferencing psychotherapy, with no statistical differences between videoconferencing and in-person groups receiving the same intervention. There's also evidence that telepsychology is useful for alleviating the insomnia and chronic pain that often accompany depression (Wangelin, Szafranski, & Gros, 2016). Finally, while a study evaluating the effectiveness of telephone-administered CBT found it to have a lower attrition rate than in-person CBT had, other studies have found that attrition rates for other modes of telepsychology

vary, depending on the population and type of intervention (Bee et al., 2008; Mohr et al., 2012).

d. Bulimia Nervosa: Research evaluating telepsychology-delivered treatments for bulimia nervosa (BN) has found that it has beneficial effects but is not necessarily as effective as in-person treatments. For example, Mitchell et al. (2008) compared videoconference-delivered and in-person delivered versions of manual-based CBT for BN. Overall, the results indicated that the two versions had similar attrition rates and that both produced beneficial effects on outcome measures following treatment. However, there were some differences: Patients receiving in-person CBT had non-significantly higher rates of abstinence from binge eating and purging and significantly greater reductions in eating disordered cognitions and depression. In a more recent study, Zerwas and colleagues (2017) compared a manualized version of CBT group therapy for BN delivered via an Internet chat group and the same treatment delivered via traditional face-to-face group therapy. They found that patients in both groups experienced a decrease in binge eating and purging and comorbid symptoms of depression and anxiety but that the pace of recovery was slower for patients who received therapy via the Internet. Several investigators have identified reasons why CBT for bulimia and other eating disorders might be more effective when it is delivered in-person. For example, Gros et al. (2013) note that regular in-session weight measurement is an important component of CBT for eating disorders but may be omitted when it is delivered via video telehealth because of difficulties in moving the camera to record the client's weight and other logistical problems.

12. **Stepped Care:** "Stepped care is a model of healthcare delivery with two fundamental features. First, the recommended treatment within a stepped care model should be the least restrictive of those currently available, but still likely to provide significant health gain. Second, the stepped care model is self-correcting … [which means] that the results of treatments and decisions about treatment provision are monitored systematically, and changes are made ('stepping up') if current treatments are not achieving significant health gain" (Bower & Gilbody, 2005, p. 11). The primary goals of stepped care are to increase the efficiency of health care services and the accessibility of effective treatments through better allocation of scarce mental health resources.

There are several models of stepped care: Some apply to specific disorders, while others are non-specific and can be applied to various disorders and conditions. With regard to the former, commonly cited models for depression usually include four steps that are similar to those described by Broten, Naugle, Kalata, and Gaynor (2011):

Step 1 - Assessment and Monitoring: This step includes evaluating the patient's symptoms and "watchful waiting" which is appropriate for patients with minor depressive symptoms and involves monitoring their symptoms.

Step 2 – Interventions Requiring Minimal Practitioner Involvement: Step 2 interventions include psychoeducation about the symptoms and course of depression, treatment options, and signs of relapse; bibliotherapy as a preventive technique for patients who are at high risk for depression or are experiencing an increase in symptoms and as an adjunct to other treatments; and computer-based interventions that track patients' symptoms and use multimedia with interactive components designed to help patients cope with depression and anxiety.

Step 3 – Interventions Requiring More Intensive Care and Specialized Training: This step may include group therapy, individual psychotherapy, and/or medication. (Note that some models identify group psychotherapy and brief individual psychotherapy as initial choices for this step followed by longer-term psychotherapy with or without antidepressant medication for patients who do not respond adequately to group or brief individual therapy.)

Step 4 – Most Restrictive and Intensive Forms of Care: This step is for patients with severe depressive symptoms and consists of voluntary or mandated inpatient care.

13. **Treatment Fidelity:** Treatment fidelity is also known as intervention fidelity, program fidelity, and implementation fidelity. It refers to the degree to which a treatment is delivered as intended and is affected by the therapist's adherence to the treatment protocol and competence in delivering the treatment. Research has confirmed that treatment fidelity is important for both research and clinical practice: In research, a treatment's effectiveness cannot be adequately evaluated without high fidelity. In clinical practice, when fidelity is low, it is not possible to determine if poor or unexpected treatment outcomes are due to how the treatment was implemented or to other factors. As noted by Breitenstein et al. (2010), "diminished fidelity may be why interventions that work well in highly controlled trials may fail to yield the same outcomes when applied in real life contexts" (p. 164). Breitenstein et al. state that measures of fidelity for community-based interventions are usually tailored to the particular intervention but often take the form of self-reports by the practitioner and intervention participant and/or observations of in vivo or recorded intervention sessions by a trained observer who rates the practitioner's adherence and competence.

Digital Mental Health Interventions (DMHI): DMHIs "use online and/or mobile formats to deliver psychological strategies and interventions … [and] range from self-guided tools to facilitate a skill or behavioral strategy (e.g., track activity or mood, self-monitor eating behaviors, increase relaxation/practice meditation), to more complex and comprehensive interventions [e.g., cognitive-behavioral therapy (CBT) for depression]" (Graham et al., 2020, p. 1081). The results of studies on DMHIs suggest there is a research-to-practice gap (Carlbring et al., 2018; Mohr et al., 2017): Randomized controlled trials (efficacy studies) confirm they can have outcomes similar to those of face-to-face psychotherapy. However, implementation (effectiveness) research in health care settings has produced less supportive results and

suggests that this is due to several factors, including inconsistent use by patients, the uncertainty of providers about how to engage patients, and lack of clarity about how providers should integrate digital interventions into the overall care of patients. DMHIs sometimes include support by a professional or paraprofessional, and research investigating the impact of human support has most often confirmed that it has beneficial effects. For example, Werntz et al. (2023) conducted a systematic meta-review of 31 meta-analyses of studies comparing human support versus no support for a variety of mental health conditions and for type of support. They found that, of the 45 effect sizes reported in the meta-analyses, 22 indicated that support was significantly better than no support in terms of outcomes and 13 indicated that support was slightly (non-significantly) better than no support. Of the remaining effect sizes, 4 indicated no significant difference between support and no support, and 6 indicated that non-support was significantly or non-significantly better than support. They also found no consistent differences in outcomes when support was provided by a therapist or other professional or by a peer, staff member, or other nonprofessional.

Models of Disability: As described in the Americans with Disabilities Act (ADA), a person with a disability has a physical or mental impairment that substantially limits a major life activity, has a record of such impairment, or is regarded as having such an impairment because of an actual or perceived physical or mental impairment. Experts distinguish between a variety of disability models, but most categorizations include the medical and social models. For example, the American Psychological Association's (2012) *Guidelines for the Assessment of and Intervention with Persons with Disabilities* distinguishes between four scientific models of disability: biomedical, social, functional, and forensic. The *biomedical model* is also known as the medical model and views disabilities as medical conditions that deviate from the norm and disrupt a person's physical and/or cognitive functioning. From this perspective, a disability is intrinsic to the individual and the focus of intervention is on identifying and providing treatments that will manage, alter, or cure the medical condition causing the disability. The *social model* views a disability as a difference rather than an abnormality or deficiency and as due primarily to aspects of society that create barriers for people with disabilities (e.g., negative attitudes, discrimination, exclusion, architectural barriers). Interventions based on this model focus on making societal and environmental changes. The *functional model* views a disability as the cause of a person's inability to perform his or her function or role at work or elsewhere. It recognizes a person's medical condition but focuses on identifying what accommodations, modifications, or assistive technology devices are needed to improve the person's functioning (Chronister & Fitzgerald, 2018). Finally, the *forensic model* focuses on legal concepts and "requires objective proof of impairment and disability and determination of the honesty and motivation of individuals seeking recognition, benefits, or compensation for disability" (APA, 2012, p. 45). In other words, the primary focus of this model is on distinguishing between

honest and dishonest people (e.g., malingerers) in order to identify the appropriate interventions or consequences.

Terms and Concepts: The following are terms and concepts related to cross-cultural psychology that you want to be familiar with for the EPPP:

1. **Worldview:** As described by Sue, worldview "affects how we perceive and evaluate situations and how we derive appropriate actions based on our appraisal" (2006, p. 64). He proposes that worldview is affected by culture and can be described in terms of two dimensions: locus of control and locus of responsibility: (a) People with an *internal locus of control and internal locus of responsibility* (IC-IR) believe they are in control of their own outcomes and are responsible for their own successes and failures. (b) People with an *internal locus of control and external locus of responsibility* (IC-ER) believe they could determine their own outcomes if given the chance but that others are responsible for keeping them from doing so. (c) People with an *external locus of control and external locus of responsibility* (EC-ER) believe they have little or no control over their outcomes and are not responsible for them. (d) People with an *external locus of control and internal locus of responsibility* (EC-IR) believe they have little control over their outcomes but tend to take responsibility for their own failures.

According to Sue and his colleagues, the IC-IR worldview is characteristic of mainstream American culture, while the other three are characteristic of some minority cultures. They also propose that a difference in a therapist's and client's worldviews can affect the therapeutic relationship. For example, clients who have an IC-ER worldview are likely to be the most challenging for a White therapist who has an IC-IR worldview because these clients are likely to view the therapist and therapy as sources of oppression and to be reluctant to self-disclose, to want take an active role in therapy, and "to seek action and accountability from a more privileged therapist" (2019, p. 115).

2. **Acculturation:** According to Berry (1990), when members of a minority group are in contact with a majority group, they can adopt one of four acculturation strategies that represent different combinations of retention/rejection of their own minority culture and the majority culture: (a) People who adopt an *integration strategy* retain their own minority culture and adopt the majority culture. (b) People who adopt an *assimilation strategy* reject their own minority culture and adopt the majority culture. (c) People who adopt a *separation strategy* retain their own minority culture and reject the majority culture. (d) People who adopt a *marginalization strategy* reject their own minority culture and the majority culture. Berry has related the acculturation strategies to *acculturative stress*, which he defines as "a stress reaction in response to life events that are rooted in the experience of acculturation" (2005, p. 708). Acculturative stress occurs when individuals are facing significant problems related to acculturation that cannot be easily or quickly resolved. According to Berry, people who adopt an integration strategy experience the least acculturative stress, while those who adopt a marginalization strategy experience the most acculturative stress.

Cultural distance and cultural fit are two factors that affect the acculturation process. Both terms have been applied primarily to immigrants, with immigrants being the minority and the host society being the majority (e.g., Ward et al., 2001). *Cultural distance* refers to differences in the culture of an immigrant's home country and the culture of the host country in terms of language, core values and beliefs, government, legal system, and other basic cultural characteristics. A large cultural distance is associated with an increased likelihood that immigrants will experience acculturative stress and difficulty adapting to the host country. *Cultural fit* refers to the degree to which an immigrant's personality and other personal attributes are similar to the cultural values and norms of the host country. A good cultural fit makes it easier for an immigrant to adapt to the host country.

3. **Healthy Cultural Paranoia:** Ridley (2005) proposed that an ethnic minority client's unwillingness to disclose personal information to a White therapist may be due to one of two types of paranoia: *Functional paranoia* is an unhealthy psychological condition that involves pervasive suspicion and distrust. An ethnic minority client with functional paranoia is unwilling to disclose personal information to an ethnic minority or White therapist. In contrast, *healthy cultural paranoia* also involves suspicion and distrust, but it's a normal reaction to prejudice and discrimination. An ethnic minority client with healthy cultural paranoia is willing to self-disclose to an ethnic minority therapist but unwilling to self-disclose to a White therapist unless certain conditions are met – i.e., the therapist discusses the meaning of the cultural paranoia with the client and encourages the client to distinguish between when it is and is not safe to self-disclose.

4. **Racial Microaggressions:** Sue et al. (2007) define racial microaggressions as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (p. 271). They also distinguish between three types of microaggression: (a) *Microassaults* are explicit racial derogations that are usually intentional and meant to hurt the intended victim. They include name-calling and explicit discriminatory acts and are most similar to what is referred to as "old-fashioned" racism. (b) *Microinsults* are verbal and nonverbal messages that are insensitive to or demean the person's racial or ethnic background or identity. They include pathologizing the culture and communication styles of people of color, assigning a level of intelligence to a person of color on the basis of the person's race ("ascription of intelligence"), and assuming that a person of color is dangerous or deviant in some way based on the person's race. Implying that an African American employee was hired only because of affirmative action is a microinsult. (c) Microinvalidations are "communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (p. 274). They include assuming that members of racial/ethnic minority groups are foreigners, unwillingness to acknowledge race (color blindness), and asserting that race has

no effect on a person's success or other life outcomes (myth of meritocracy). Assuming that an Asian American student was not born in the United States and complimenting him on his "good English" is a microinvalidation.

5. **Internalized Racism and Colorism:** *Internalized racism* is also known as internalized racial oppression and occurs when a person accepts society's negative beliefs and stereotypes related to his or her own racial group. *Colorism* is a form of internalized racism and is also known as color consciousness. It refers to "discrimination within a racial group based primarily on skin hue or color and may also include other physical characteristics such as hair texture and eye color .... [In the United States and some other countries, this involves] preferences for lighter skin over darker skin within a community of color" (Lomotey, 2010, p. 529). The use of skin-lightening products by people of color is a manifestation of colorism.

6. **White Privilege:** As described by Peggy McIntosh (1998), white privilege consists of unearned benefits that are conferred upon White individuals based solely on their skin color and are inaccessible to racial/ethnic minorities. McIntosh proposes that most White people are unaware of their race-related privileges because they are maintained by denial, and she provides several examples of privileges that Whites tend to take for granted: For example, they can usually go shopping without being followed or harassed by store clerks or security staff, can turn on the television and see people of their race widely represented, can arrange to protect their children most of the time from people who might not like them, and are never called upon to speak for members of their racial group. Neville, Worthington, and Spanierman (2001) point out that White privilege occurs at both macro and micro levels: At the macro level, White privilege is systemic and consists of the benefits, rights, and immunities that Whites have within institutions – for example, more favorable educational opportunities and housing conditions, better health care, and higher salaries. At the micro level, White privilege is primarily intrapsychic and interpersonal and includes a sense of entitlement and social validation of Whiteness.

Several authors have proposed that White privilege not only has substantial negative economic, political, and social costs for racial/ethnic minorities but also some negative consequences for Whites. Spanierman et al. (2006), for instance, state that these consequences include distorted beliefs about race and racism, limited exposure to people of different races and ethnicity, and irrational fear of people of different races and ethnicity. It has also been pointed out that unacknowledged White privilege can interfere with a White therapist's ability to develop multicultural counseling competencies (e.g., Neville, Worthington, & Spanierman, 2001).

7. **Etic vs. Emic Perspective:** Psychologists can adopt an emic or etic perspective when working with clients from different cultural backgrounds. A psychologist who has an *emic perspecti*ve believes that behavior is affected by culture and, as a result, psychological theories and

interventions that apply to members of one culture may not apply to members of other cultures. In contrast, a psychologist who has an *etic perspective* believes that behavior is similar across cultures and that the same psychological theories and interventions are appropriate for everyone, regardless of their cultural background.

8. **Autoplastic vs. Alloplastic Interventions:** *Autoplastic interventions* focus on making changes in the client so that he or she can successfully adapt to the environment. Strategies aimed at helping a client gain insight into his or her problems or change his or her behavior are autoplastic interventions. *Alloplastic interventions* focus on altering the environment or situation to fit the client's needs, desires, or other attributes. Removing oneself from a stressful situation – for example, by changing jobs – is an alloplastic intervention.

9. **Cultural Encapsulation:** Wrenn (1962) coined the term "cultural encapsulation" to explain the inability of some mental health professionals to work effectively with members of different cultural backgrounds. As described by Wrenn, culturally encapsulated mental health professionals are insensitive to cultural differences and believe that their own cultural assumptions about what constitutes mental health or normality applies to people from all cultural backgrounds.

10. **Tight vs. Loose Cultures:** Cultural tightness-looseness refers to the strength of a culture's social norms and tolerance for deviant behaviors: Tight cultures have strong social norms and low tolerance for deviant behaviors; loose cultures have weak social norms and high tolerance for deviant behaviors. According to Gelfand and her colleagues (Gelfand, 2012; Harrington & Gelfand, 2014), tightness-looseness is related to the ecological and human-made challenges that nations and states have historically encountered. For example, nations and states with a history of high population density, greater vulnerability to natural disasters and disease, and scarcity of resources are likely to become tight because they need strong norms and punishments for deviant behaviors to ensure their survival, while nations and states without these challenges survive with weaker norms and acceptance of deviant behaviors.

Gelfand and her colleagues have categorized nations and states in the United States in terms of their degree of tightness and looseness based on data collected in 33 nations and 50 states. For example, with regard to nations, these investigators classified Pakistan, Malaysia, and India as the three "tightest" countries and Estonia, Hungary, and Israel as the three "loosest" countries. With regard to states, Mississippi, Alabama, and Arkansas were classified as the three "tightest" states, while California, Oregon, and Washington were classified as the three "loosest" states.

Gelfand, Nishii, and Raver (2006) have identified several ways that individuals in tight and loose cultures differ. For example, in tight cultures, there is greater conformity to social norms, a tendency to engage in risk avoidance behaviors, and a preference for stability. In loose cultures,

there is greater willingness to act in ways that deviate from social norms and engage in risk-taking and innovative behaviors and a greater openness to change. In addition, Harrington and Gelfand (2014) found that individuals living in tight states have higher levels of conscientiousness and lower levels of openness to experience than do individuals living in loose states, while the opposite is true for individuals living in loose states.

11. **Integration Paradox:** There is evidence that, contrary to what might be expected, higher-status immigrants (i.e., those who are highly educated and economically successful) are more likely than lower-status immigrants to report experiencing discrimination and disrespect and, as a result, are less likely to identify with and have positive attitudes toward mainstream society (Verkuyten, 2016). There are several explanations for this *integration paradox* (e.g., Schaeffer & Kas, 2023): One explanation is that, because higher-status immigrants have greater access to mainstream society at school, at work, and in their communities, they are more likely to encounter discrimination. Another explanation is that, because of their higher levels of education, higher-status immigrants have more sophisticated cognitive abilities and, consequently, are more aware of discrimination and more likely to interpret their experiences in terms of discrimination. [Note that the integration paradox is sometimes confused with the unrelated *immigrant paradox*, which refers to the observation that, for some immigrant groups, recent immigrants tend to have better physical health, mental health, and educational outcomes compared to more established immigrants and nonimmigrants (e.g., Gandhi et al., 2022).]

12. **High- vs. Low-Context Communication:** Hall (1976) distinguished between two communication styles: *High-context communication* relies heavily on group understanding, nonverbal messages, and the context in which the communication occurs and is characteristic of several cultural minority groups. In contrast, *low-context communication* relies on the verbal message, is independent of the context, and is characteristic of the White (mainstream) culture. As noted by Sue (2006), problems can arise in therapy when the therapist and client have different communication styles. For example, “the fact that African Americans may communicate more by HC [high context] cues has led many to characterize them as nonverbal, inarticulate, [and] unintelligent” (p. 164).

13. **Diagnostic Overshadowing:** The term “diagnostic overshadowing” was initially used to describe the tendency of mental health professionals to attribute all of the problems of people who have received a diagnosis of intellectual disability to that diagnosis and overlook other problems (Reiss, Levitan, & Szyszko, 1982). Since then, the term has been applied to other client characteristics. For instance, Sue and Sue (2012) note that therapists are exhibiting diagnostic overshadowing when they assume that the presenting problems of gay clients are due to the clients’ sexual orientation without considering other explanations.

14. **Own-Race Bias:** The own-race bias (ORB) is also known as the other-race effect and cross-race effect and refers to the tendency of people to more accurately perceive and identify the faces of individuals of their own race than the faces of individuals of other races. The research has found that ORB is prevalent among all racial groups, although there is some evidence that, in America, it is somewhat more prevalent among White than Black individuals (e.g., Anthony et al., 1992). A commonly cited explanation for ORB is that people are better able to recognize differences among individuals of their own race because they have had the most exposure to those individuals. ORB has some important implications. For example, with regard to eyewitness testimony, the studies have found that cross-race identifications produce more misidentifications ("false alarms") than own-race identifications do (e.g., Meissner et al., 2005). Note that researchers have identified similar own-age and own-gender biases (e.g., Wright & Stroud, 2002; Wright & Sladden, 2003).

15. **Minority Stress Theory:** Minority stress theory was developed by Meyer (2003) to explain the increased risk for mental health problems among sexual-minority individuals. It proposes that sexual-minority individuals experience chronic stressors related to their stigmatization that increase their vulnerability to mental health problems. The theory also distinguishes between proximal and distal minority stress processes: Proximal processes occur within the person and include concealment, fear of rejection, and internalized heterosexism; distal processes are external to the person and include verbal and physical harassment, prejudice, and discrimination. The theory has also been applied to other stigmatized minority groups and to physical health and other outcomes.

16. **Credibility and Gift Giving:** Sue and Zane (2009) propose that credibility and gift giving are important when working with Asian American and other non-Western clients. *Credibility* refers to the client's perception of the therapist as trustworthy and is determined by the therapist's ascribed and achieved status: Ascribed status is the position or role assigned to the therapist by the client's culture. For example, age and gender are characteristics that contribute to a therapist's credibility in some cultures. Achieved status is the therapist's expertise – e.g., the therapist's experience working with members of the client's culture. *Gift giving* refers to the direct benefits that a client perceives he/she receives from therapy. These include providing the client with reassurance and a sense of hope, normalizing the client's feelings, and using interventions that reduce the client's depression or anxiety. Sue and Zane note that direct benefits must be given as soon as possible in therapy to help establish achieved credibility and reduce premature termination from therapy by demonstrating the relationship between therapy and the alleviation of the client's problems.

17. **Evidence-Based Practice and Culturally Adapted Interventions:** As defined by the American Psychological Association, *evidence-based practice in psychology* (EBPP) "is the integration of

the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (2006, p. 273). The term "evidence-based practice" is often used interchangeably with the terms "evidence-based interventions" and "evidence-based treatments." However, some experts use evidence-based practice as a more general term and evidence-based interventions and treatments to refer to "interventions for which there is consistent scientific evidence showing that they improve client outcomes" (Drake et al., 2001, p. 180). Also, the terms "evidence-based treatments" and "evidence-based interventions" are sometimes used interchangeably with the term "empirically supported treatments," but the latter term is often used to refer only to treatments that have been found to be effective by scientific research that meets certain criteria – for example, multiple group studies that found the treatment to be superior to no-treatment or to be equivalent or superior to an established treatment.

Culturally adapted interventions involve "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meaning, and values" (Bernal, Jimenez-Chafey, & Rodriguez, 2009, p. 362). Adaptations may include incorporating content that's culturally appropriate and relevant (e.g., issues related acculturation, racism, and religion and spirituality) and/or altering the format and delivery of treatment so that it's culturally compatible (e.g., delivering treatment in the client's native language, adopting a culturally compatible interpersonal style, and including indigenous healers in the delivery of treatment).

Note that the adaptation of EBTs has created a "fidelity-adaptation dilemma" that requires psychotherapists to determine to what degree they will adopt "the standardized nomothetic scientific top-down approach that demands fidelity in its implementation and the idiographic casewise bottom-up approach that demands sensitivity and responsiveness to each person's unique needs" (Castro, Barrera, & Steiker, 2010, p. 214). Based on their review of the research, Sue, Zane, Nagayama Hall, and Berger conclude that "the preponderance of evidence shows that culturally adapted interventions provide benefit to intervention outcomes … [but] this added value is more apparent in the research on adults than on children and youths" (2009, p. 541). In addition, the studies have found (a) that adaptations are more effective when they involve adding features to an intervention than when they involve replacing a component of an intervention (Blakely et al., 1987), and (b) that culturally adapted interventions are most beneficial for clients who have the greatest need for them – for example, clients who are not fluent in English and clients with low levels of acculturation (Griner & Smith, 2006).

Culturally Competent Psychotherapy: A culturally competent psychotherapist has the cultural awareness, knowledge, and skills necessary to provide effective professional services to members of diverse populations (Sue & Torino, 2005). Guidelines for working with members of

several culturally diverse groups are provided below (Paniagua, 2014; Sue & Sue, 2015). Keep in mind that an essential contributor to cultural competence is being aware of relevant guidelines while being careful not to overgeneralize them.

1. **African Americans:** When working with African American clients, therapists should (a) consider the client's cultural identity, level of acculturation, and worldview; (b) keep in mind that racism and other environmental factors may be contributors to the client's presenting problems; (c) be aware that the client's extended kinship network is likely to include nuclear and extended family members, friends, and members of his/her church and community; (d) know that roles within African American families are often flexible and that male-female relationships tend to be egalitarian; and (e) empower the client by, for example, helping the client acquire the problem-solving and decision-making skills he/she needs to control of his/her own life. With regard to interventions, African American clients usually prefer an egalitarian therapist-client relationship and a time-limited, problem-solving approach. Boyd-Franklin (2003) recommends using a multisystems approach, which involves intervening in numerous systems and at multiple levels that include the individual, his/her immediate and extended family, nonblood relatives and friends, church and community services, and social service agencies.

2. **American Indians:** When working with American Indian clients, therapists should (a) consider the client's cultural identity, level of acculturation, and worldview; (b) identify possible environmental contributors (e.g., discrimination, poverty, acculturation conflicts) to the client's presenting problems; (c) be aware that American Indians often adhere to a collateral social system that incorporates the family, community, and tribe; (d) recognize that cooperation, sharing, and generosity are important cultural values and that the interests of the family and tribe take priority over the interests of the individual; (e) be aware that American Indians are likely to regard wellness as depending on the harmony of mind, body, and spirit and illness as the result of disharmony; (f) keep in mind that American Indians tend to place more emphasis on nonverbal than verbal communication, consider listening to be more important than talking, and view direct eye contact as a sign of disrespect and a firm handshake as a sign of aggression; and (g) foster a collaborative therapeutic relationship and build trust by demonstrating familiarity with and respect for the client's culture and admitting any lack of knowledge. A collaborative, problem-solving, client-centered approach that avoids highly directive techniques and incorporates American Indian values and traditional healers is usually preferred. LaFromboise, Trimble, and Mohatt (1990) recommend using network therapy, which helps empower clients to cope with life stresses by mobilizing relatives, friends, and tribal members to provide support and encouragement.

3. **Hispanic/Latino Americans:** When working with Hispanic/Latino American clients, therapists should (a) consider the client's cultural identity, level of acculturation, and worldview; (b)

identify possible environmental contributors (e.g., discrimination, poverty, acculturation conflicts) to the client's presenting problems; (c) determine the client's beliefs about the nature of his/her presenting problems and be aware that Hispanic Americans often express psychological symptoms as somatic complaints; (d) consider how a client's religious and spiritual beliefs might inform assessment, diagnosis, and treatment decisions; (e) keep in mind that Hispanic/Latino Americans tend to emphasize family welfare over individual welfare; (f) be aware that Hispanic/Latino American families may be patriarchal and stress *machismo* (male dominance) and *marianismo* (female submissiveness); and (g) adopt a formal style (*formalismo*) in the initial therapy session but a more personal style (*personalismo*) in subsequent sessions. With regard to interventions, Hispanic/Latino American clients are likely to prefer cognitive-behavior therapy, solution-focused therapy, family therapy, and group therapy. Therapy may be most effective when it incorporates culturally congruent techniques such as cuento therapy (the use of folktales to present models of adaptive behavior) and dichos (the use of proverbs and idiomatic expressions to help clients express their feelings).

4. **Asian Americans:** When working with Asian American clients, therapists should (a) consider the client's cultural identity, level of acculturation, and worldview; (b) identify environmental factors that may be contributors to the client's presenting problems; (c) be aware that differences in acculturation within families may be a source of conflict; (d) determine the client's beliefs about the contributors to his or her presenting problems and be aware that Asian Americans often have a holistic view of mind and body and express psychological problems as somatic symptoms; (e) be aware that Asian American families tend to be hierarchical and patriarchal, adhere to traditional gender roles, and emphasize family needs over individual needs; (f) keep in mind that a fear of losing face and shame are powerful motivators for Asian Americans and may affect their willingness to discuss personal problems and express emotions; (g) maintain a formal style during the course of therapy; and (h) be aware that, for Asian American clients, periods of silence and avoidance of eye contact are expressions of respect and politeness. With regard to treatment, Asian Americans are likely to prefer cognitive-behavior therapy and other brief structured goal-oriented, problem-focused approaches that focus more on the family than the individual. They are also likely to expect the therapist to be a knowledgeable expert who gives advice and suggests specific courses of action while also encouraging their participation in identifying goals and solutions to their problems.

5. **Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) Clients:** LGBTQ men and women are more than twice as likely as heterosexual men and women to have mental disorders during their lives, especially anxiety, depression, and substance misuse, and there is evidence that bisexual individuals have more mental health problems than do gay men and lesbian women (e.g., Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2016). With regard to utilization rates, the research has found that sexual minority individuals utilize mental health

services at higher rates than do heterosexual individuals and that gender differences vary: Heterosexual women have higher utilization rates than heterosexual men do, but gay men have higher rates than lesbian women do and bisexual men and women have similar rates (Platt, Wolf, & Scheitle, 2018). There is also evidence that identifying as a sexual minority is associated with an increased risk for premature termination from therapy (Anderson, Bautista, & Hope, 2019).

With regard to the optimal type of psychotherapy, experts stress the importance of combining evidence-based practices with culturally competent services. For LGBTQ clients, this means providing affirmative therapy, which is characterized by "the integration of knowledge and awareness by the therapist of the unique development and cultural aspects of LGBT[Q] individuals, the therapist's own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process" (Perez, 2007, p. 408). For example, when using cognitive-behavior therapy with LGBTQ clients who have received a diagnosis of major depressive disorder, it is important to distinguish maladaptive thoughts from thoughts that reflect a normal response to the stigmatization clients have experienced because of their sexual or gender orientations.

Sexual identity milestones are an important consideration when working with LGBTQ clients. Research has confirmed that milestones usually emerge in the same order but that the ages at which they occur are affected by age cohort, with younger cohorts experiencing milestones at earlier ages. For example, Bishop and colleagues (2020) reported the results of the Generations Study, which examined the health and well-being of LGB individuals representing three age cohorts: 18 to 26, 32 to 43, and 50 to 60. Included in this study were questions about participants' ages at which they first experienced five sexual identity milestones: In order of their occurrence, these milestones are awareness of same-sex attraction; self-identification as lesbian, gay, or bisexual; same-sex sexual behavior; disclosure as a sexual minority to a straight friend; and disclosure as a sexual minority to a family member. Consistent with previous research, Bishop et al. found that members of the younger cohort experienced all milestones at the earliest ages followed by, in order, members of the middle cohort and members of the older cohort. Finally, several researchers have studied the effects of sexual identity milestones on the mental health of LGB individuals. For example, with regard to disclosure of sexual identity to others ("coming out"), Jordan and Deluty's (1998) survey of lesbian women found that, the greater the extent of disclosure to others, the greater the women's self-esteem and positive affectivity and the lower their anxiety. More recently, Pachankis, Cochran, and Mays (2015) found gender differences in the effects of disclosure for respondents to the California Quality of Life survey: Compared to lesbian women who reported they had not disclosed their sexual orientation to another person, those who said they had recently disclosed were significantly less likely to report having major depressive disorder. In contrast, compared to gay

men who reported they had not disclosed, those who said they had recently disclosed were significantly more likely to report having major depressive disorder and generalized anxiety disorder.

6. **Older Adult Clients:** With the exception of neurocognitive disorder, the rates of mental disorders are lower among older adults than their younger and middle-aged counterparts (Kessler et al., 2005). However, many older adults experience mental health problems (with anxiety and depression being most common), and their symptoms may differ from those of younger adults. For example, with regard to depression, older adults are more likely to complain about physical and cognitive symptoms than emotional distress (e.g., to complain of frequent headaches, increased pain, changes in appetite, tiredness, low energy, and impaired memory and concentration rather than sadness) and to report irritability, insomnia, weight loss, and other symptoms associated with anxiety (Guccione, Wong, & Avers, 2012). With regard to treatment, the research has generally found that the effects of psychotherapy are comparable for older and younger adults but that older adults may respond more slowly to therapy and benefit most when treatment is tailored to their cognitive, sensory, and physical needs.

General guidelines for working with older adults are provided in APA's (2014) *Guidelines for Psychological Practice with Older Adults*. They include the following: (a) Consider how your own attitudes and beliefs about aging might impact your assessment and treatment of older adults. For example, be aware that many stereotypes of older adults are inaccurate and can affect clinical decisions. (b) Be aware that "the heterogeneity among older adults surpasses that seen in other age groups" (p. 40), and recognize how gender, age, race/ethnicity, sexual orientation, and other factors may affect the experience and expression of psychological problems of older adults. (c) Be familiar with normal biological changes associated with increasing age (e.g., changes in sensory acuity and cognitive functioning) and be able to distinguish between normative changes and changes due to physical illness or medications. (d) Be aware that older adults respond favorably to a variety of types of psychotherapy but that some interventions have been found to be particularly effective for older adults with certain disorders (e.g., cognitive-behavior therapy and reminiscence therapy for depression). (e) Acquire the knowledge and skills needed to make culturally sensitive adaptations to interventions that increase their effectiveness for older adults. This may include modifying an intervention's process and/or content – for example, slowing the pace of therapy by shortening the length of sessions, increasing the number of sessions, and/or decreasing the frequency of sessions; accommodating hearing loss by reducing ambient noise; and addressing physical illness, grief, cognitive decline, and other problems that are experienced more often by older than younger adults.

For the EPPP, you want to be familiar with the names and characteristics of the stages of the following identity development models. Note that the first stage of each of the racial/cultural identity models is characterized by the person's lack of acceptance and/or awareness of his/her culture as an element of his/her identity, while the last stage is characterized by the person's acceptance and appreciation of his/her culture (Lee, 1999).

Atkinson, Morten, and Sue's Racial/Cultural Identity Development (R/CID) Model:

The R/CID Model (Atkinson, Morten, & Sue, 1998) distinguishes between five stages of identity development that differ in terms of how members of racial and cultural minority groups view members of their own minority group, other minority groups, and the majority group.

1. **Conformity:** People in the conformity stage have either neutral or negative attitudes toward members of their own minority group and other minority groups and positive attitudes toward members of the majority group. They accept negative stereotypes of their own group and consider the values and standards of the majority group to be superior. These individuals prefer a therapist from the majority group and view a therapist's attempts to help them explore their cultural identity as threatening.

2. **Dissonance:** As the result of exposure to information or events that contradict their worldview, people in this stage question their attitudes toward members of their own minority group, other minority groups, and the majority group. They're aware of the effects of racism and are interested in learning about their own culture. They may prefer a therapist from the majority group but want the therapist to be familiar with their culture, and they're interested in exploring their cultural identity.

3. **Resistance and Immersion:** People in this stage have positive attitudes toward members of their own minority group, conflicting attitudes toward members of other minority groups, and negative attitudes toward members of the majority group. These individuals are unlikely to seek therapy because of their suspiciousness of mental health services. When they do seek therapy, they're likely to attribute their psychological problems to racism and prefer a therapist from their own minority group.

4. **Introspection:** During this stage, people question their unequivocal allegiance to their own group and are concerned about the biases that affect their judgments of members of other groups. They've become comfortable with their cultural identity but are also concerned about their autonomy and individuality. These individuals may prefer a therapist from their own minority group but are willing to consider a therapist from another group who understands their worldview, and they're interested in exploring their new sense of identity.

5. **Integrative Awareness:** People in the integrative awareness stage are aware of the positive and negative aspects of all cultural groups. They're secure in their cultural identity and are

committed to eliminating all forms of oppression and becoming more multicultural. Their preference for a therapist is based on similarity of worldview, and they're most interested in strategies aimed at community and societal change.

Cross's Black Racial Identity Development Model: Cross's Black Racial Identity Development Model has been revised several times. The original model was known as the Nigrescence Model (Cross, 1971) and distinguished between five stages:

1. **Pre-Encounter:** People in the pre-encounter stage idealize and prefer White culture. They have negative attitudes toward their own Black culture and may view it as an obstacle and source of stigma.

2. **Encounter:** People in this stage question their views of White and Black cultures as the result of exposure to events that cause them to become aware of the impact of racism on their lives. These individuals are interested in learning about and becoming connected to their own culture.

3. **Immersion-Emersion:** People in this stage reject White culture and idealize and become immersed in their own culture.

4. **Internalization:** During this stage, defensiveness and emotional intensity related to race decrease. People in this stage have a positive Black identity and tolerate or respect racial and cultural differences.

5. **Internalization-Commitment:** People in this stage have internalized a Black identity and are committed to social activism to reduce all forms of oppression.

Cross (1991) subsequently reduced the number of stages to four by combining the internalization and internalization-commitment stages. Cross and Vandiver (2001) then changed its name to the Black Racial Identity Development Model and reduced it to three stages, with each stage including multiple identity subtypes. The first stage is the *pre-encounter stage*, which includes assimilation, miseducation, and self-hatred subtypes. The second stage is the *immersion-emersion stage*. It consists of intense Black involvement and anti-White subtypes. And the third stage is the *internalization stage*, which consists of Black nationalist, biculturalist, and multiculturalist subtypes.

Sellers, Smith, Shelton, Rowley, and Chavous's Multidimensional Model of Racial Identity: The multidimensional model of racial identity (MMRI) developed by Sellers and his colleagues (1998) does not describe sequential stages of identity development but, instead, proposes that a person's racial identity may vary across time and situations. It was developed for African American individuals and defines African American racial identity "as the significance and qualitative meaning that individuals attribute to their membership within the Black racial group

within their self-concepts" (p. 23). It also distinguishes between four dimensions of racial identity: *Racial salience* is the extent to which a person's race is a relevant part of his/her self-concept at a particular point in time and in a particular situation. For instance, race may become more salient for a person when he/she witnesses or experiences discriminatory behavior or is the only African American in a restaurant, classroom, or other social setting. *Racial centrality* is the extent to which a person normatively defines him/herself in terms of race and is affected by the importance of race to the person relative to other identities such as gender and religion. As an example, for some African American women, gender may be more important than race for their identities while, for others, the opposite may be true. In contrast to salience, centrality is relatively stable across situations. *Racial regard* includes private and public regard. Private regard refers to the extent to which a person feels positively or negatively toward African Americans and how positively or negatively he/she feels about being an African American. Public regard refers to the extent to which a person feels that others view African Americans positively or negatively. Private and public regard are not necessarily related and a person can have, for example, negative private and public regard or positive private regard and negative public regard. Finally, *racial ideology* refers to a person's beliefs and opinions about the ways African Americans should live and interact with society. Sellers and his colleagues distinguish between four racial ideologies:

(a) Individuals with a nationalist ideology view the African American experience as being unique and believe African Americans should control their own destinies with minimal input from other groups.

(b) Individuals with an oppressed minority ideology emphasize the similarity of the oppression experienced by African Americans and members of other minority groups, and they're interested in forming coalitions with other groups.

(c) Individuals with an assimilationist ideology emphasize similarities between African Americans and the rest of American society and believe that African Americans should work within the system to change it.

(d) Individuals with a humanist ideology emphasize the similarities of all humans, give race low centrality, and are more concerned with issues facing the human race such as peace, poverty, and climate change.

According to Sellers and his colleagues, a person's ideology may depend on the context. For instance, a person might believe that African Americans should patronize African American-owned businesses as often as possible (nationalist ideology) but also think that African Americans should have more social contact with White individuals (assimilationist ideology). Sellers et al. also propose that the four dimensions of racial identity can help clarify why

individuals respond to similar situations differently. As an example, two African American adults with similar regard and ideology may act differently in the same situation because race has high salience for one person in that situation but low salience for the other person.

Helms's White Racial Identity Development (WRID) Model: Helms's (1984, 1995) WRID Model consists of two phases – abandonment of racism and defining a nonracist White identity. Each phase includes three statuses, and each status is characterized by a different information processing strategy (IPS) that people use to think about race-related issues.

1. **Contact:** This status is characterized by a lack of awareness of racism and satisfaction with the racial status quo. People in this status usually have had limited contact with people from racial minority groups and may describe themselves as being colorblind. IPS: obliviousness.

2. **Disintegration:** People transition to this status when they become aware of contradictions that create race-related moral dilemmas – for example, a conflict between the belief that all people are created equal and their unwillingness to live in an integrated neighborhood. These dilemmas cause confusion and anxiety. IPS: suppression and ambivalence.

3. **Reintegration:** People in this status have attempted to resolve the dilemmas of the previous status by believing that Whites are superior to minority group members and blaming minority group members for their own problems. IPS: selective perception and negative out-group distortion.

4. **Pseudo-Independence:** People transition to this status when faced with an event that makes them question their beliefs about Whites and members of minority groups. It's characterized by a superficial tolerance of minority group members that may be accompanied by paternalistic attitudes and behaviors that perpetuate racism. IPS: reshaping reality and selective perception.

5. **Immersion-Emersion:** People in this status search for a personal meaning of racism and an understanding of what it means to be White and to benefit from White privilege. IPS: hypervigilance and reshaping.

6. **Autonomy:** People attain a state of autonomy when they develop a nonracist White identity, value diversity, and can explore issues related to race and racism without defensiveness. IPS: flexibility and complexity.

According to Helms, a White therapist's identity status impacts his or her effectiveness when working with clients from minority groups. She proposes that a progressive therapist-client relationship is optimal for the development of a positive therapeutic alliance and occurs when the therapist has a more integrated and flexible racial identity than the client has. Evidence for the impact of White identity status has been provided by several studies, including research

showing that White therapists with higher racial identity statuses also have higher levels of multicultural counseling competence (e.g., Vinson & Neimeyer, 2003).

Troiden's Model of Homosexual Identity Development: According to Troiden's model of gay and lesbian identity development, "homosexual identities are most fully realized … when self-identity, perceived identity, and presented identity coincide; that is, where an accord exists among who people think they are, who they claim they are, and how others view them" (1988, p. 31). It distinguishes between four stages:

1. **Sensitization:** This stage occurs during childhood and is characterized by feeling different from same-sex peers. Young girls may feel that they're not feminine or pretty and are more independent and aggressive than other girls are; young boys may say they're less interested in sports and less aggressive than other boys and are more interested in art, reading, and other solitary activities.

2. **Identity Confusion:** This stage begins in middle or late adolescence when individuals start to feel sexually attracted to individuals of the same sex and suspect that they're gay or lesbian. This suspicion leads to uncertainty and anxiety which they attempt to alleviate with denial, avoidance, repair (attempting to change), redefinition (viewing homosexual feelings as a phase), or acceptance.

3. **Identity Assumption:** The transition to identity assumption occurs when the person begins to accept a gay or lesbian identity, which is usually between 19 and 21 years of age for males and between 21 and 23 years of age for females. Individuals in this stage seek out social and sexual relationships with gays or lesbians and disclose their sexual orientation to gay and lesbian peers and adults and to some heterosexual family members and friends.

4. **Identity Commitment:** People in this stage have internalized a gay or lesbian identity, accepted homosexuality as a way of life, and are comfortable disclosing their sexual orientation to heterosexual individuals including family members, friends, and coworkers.

Worthington, Savoy, Dillon, and Vernaglia's Multidimensional Model of Heterosexual Identity Development: Worthington et al.'s (2002) model defines heterosexual identity development "as the individual and social processes by which heterosexually identified persons acknowledge and define their sexual needs, values, sexual orientation and preferences for sexual activities, modes of sexual expression, and characteristics of sexual partners" (p. 510). It is based on the assumption that sexual identity development involves two interacting processes – an individual sexual identity process and a social sexual identity process – which occur during five sexual identity statuses: *Unexplored commitment* is characterized by a sexual identity that reflects "microsocial (e.g., familial) and macrosocial (e.g., societal) mandates for acceptable gender roles and sexual behavior and/or avoidance of sexual self-exploration" (p. 515). *Active*

exploration involves “purposeful exploration, evaluation, or experimentation of one’s sexual needs, values, orientation and/or preferences for activities, partner characteristics, or modes of sexual expression” (p. 516). *Diffusion* is characterized by an absence of active exploration and commitment. People experiencing diffusion may be confused about many aspects of identity, not just sexual identity. *Deepening and commitment* entails moving toward “greater commitment to one’s identified sexual needs, values, sexual orientation and/or preferences for activities, partner characteristics, and modes of sexual expression” (p. 519). *Synthesis* is marked by integration of one’s sexual identity with other identities (e.g., gender, race/ethnicity).

In one of the few studies comparing heterosexual-identified and sexual-minority-identified individuals, Konik and Stewart (2004) found that the sexual-minority-identified participants in their study often described their sexual identities as more salient and sexual identity development as a more effortful process than did heterosexual-identified participants. They also found that the two groups differed in terms of their scores on a measure of global identity development: Heterosexual-identified participants obtained higher scores on the less advanced stages of global identity development – i.e., identity foreclosure, moratorium, and diffusion. In contrast, sexual-minority-identified participants obtained higher scores on global identity achievement. Konik and Stewart suggest that the greater effort of sexual-minority-identified individuals in developing a sexual identity may facilitate achievement of other aspects of their identity.