INTRODUCING
PSYCHODYNAMIC CONSULTATIONS
TO THE PUBLIC SECTOR

an initiative proposed by
The Section for Applied Clinical Psychoanalysis
Section V of the Society for Psychoanalysis
and Psychoanalytic Psychology
INTRODUCING
PSYCHODYNAMIC CONSULTATIONS
TO THE PUBLIC SECTOR

CONTENTS

Introduction .................................................................................................................................................. 1

1. Rationale: Why Are We Doing This? ................................................................................................. 1
2. The Intervention: What Are We Doing? ............................................................................................... 2

Setting Up an Intervention ...................................................................................................................... 4

1. Identify Suitable Agencies .................................................................................................................. 4
2. Finding Consultants ............................................................................................................................... 6
3. Consulting Agreements ......................................................................................................................... 9
4. Selecting Staff Therapists ................................................................................................................... 10
5. Introductory Workshop ......................................................................................................................... 13
6. Consolidating the Year’s Learning ........................................................................................................ 16

Research Measures and Data Collection .................................................................................................. 17

7. Closed Ended Measures .................................................................................................................... 17
8. Qualitative Measures ........................................................................................................................... 18

Timeline .................................................................................................................................................... 19

Protecting Identities and Personal Information ....................................................................................... 21

Costs .......................................................................................................................................................... 22

Where Do We Go From Here? Next Steps .............................................................................................. 23

---

1 We are grateful for a grant from the FAR Fund that covered the costs of the pilot study and the design of this manual.
Appendices ........................................................................................................................................ 23
  i. Example of Business Agreement Between Section V and Agency ........................................ 24
  ii. Example of Consulting Agreement Between Agency and Consultants ............................... 28
  iii. Workshop Template .............................................................................................................. 31
  iv. PowerPoint Presentation ........................................................................................................ 33
  v. Letter of Consent to Be Signed by Therapists Before Participating in Study ...................... 34
  vi. Quantitative Measures and Instructions .............................................................................. 43
      • Therapists Professional Development Scales ................................................................. 43
      • Work and Wellbeing Survey ......................................................................................... 45
  vii. Qualitative Measures and Instructions to Interviewers ..................................................... 46
      • Guide for Interviewing Therapists ................................................................................. 46
      • Guide for Interviewing Consultants ............................................................................. 48

Acknowledgments ...................................................................................................................... 50

If you would prefer to read this manual online go to:
http://psychodynamiccommunityconsultations.com

This initiative has been designed and is being administered by the Section for Applied Clinical Psychoanalysis. This manual is, of course, part of that venture. We shall update it regularly as we add new sites and as we learn more about taking psychodynamic consultations into the public sector. Please get in touch with Ghislaine Boulanger (ghislaine242@gmail.com) if you can think of changes and additions that should be made to the manual. This is a living document!

If you are not already a member of the Section, please consider joining us. Go to the Join tab on our website: https://section5div39.wildapricot.org/

December 2018
INTRODUCTION:

“I look forward to my weekly time with my consultant...

I think we are all fortunate to have this opportunity to consult with highly respected people across the U.S. who are donating their time to us. ...This feels like a win-win for clients, families, therapists, and administration...I have spoken to colleagues at other agencies who wish they had the same opportunity.”

1. Rationale: Why Are We Doing This?

As the pressure to meet state regulations mounts in the public sector, and insurance companies curtail the number of sessions they cover in a year, the emphasis on evidence based treatments, most often in the guise of some form of Cognitive Behavioral Therapy, continues unabated. Meanwhile, knowledge about and the ability to practice psychodynamically have all but vanished from most community mental health settings. In keeping with the name and mission of our Section, The Section for Applied Clinical Psychoanalysis (Section V of the Society for Psychoanalysis and Psychoanalytic Psychology) has designed and evaluated an intervention to demonstrate to staff therapists in these settings that psychodynamic work, no matter what form it takes, is relevant to the populations they serve. Simultaneously, it is our goal to prove to clinic administrators that exposure to psychodynamic thinking and clinical interactions will increase their staff’s professional satisfaction, thereby reducing burnout.

Members of a committee specially appointed by the Section V Board designed this intervention. Several of them spent large portions of their careers practicing, supervising in and/or directing mental health agencies in the not-for-profit sector. They understand only too well the challenges faced by clinicians in these settings; they know that the demand for services exceeds resources; they have experienced firsthand the burden of meeting excessive regulatory requirements, and the responsibility of providing needed services to a patient population that covers the breadth of the diagnostic spectrum.

---

2 Most of the quotations in red italics were volunteered by the therapists at the Family Service League and Charity Child Guidance mental health clinics who have taken part in this project. Some of the comments come from consultants; those are identified as such.

3 Committee members are listed on page 44.
Supervisory support is essential to help clinicians in these settings meet the daily challenges of their work: developing clinical skills, maintaining job satisfaction, and minimizing burn-out. Yet, as funding sources have shrunk and the cost of care has increased, therapists and their supervisors in community mental health are under ever increasing pressure to meet productivity and paperwork requirements imposed by clinic, state, and federal regulations. These demands leave little time for therapists to discuss actual cases with their supervisors, to reflect on their experiences with patients, and to wonder about the patient’s experience with them. These skills are the building blocks of a psychodynamic clinical training.

We had two reasons to propose this intervention. One is to address staff burnout by increasing the therapists’ work satisfaction and improving their sense of professional development.

Our second goal in proposing this intervention is to ensure that the benefits of working psychodynamically, even in the limited circumstances that the delivery of mental health services in the public sector affords, become evident to the staff therapists.

Only too aware of the level of demoralization their staffs were expressing, the Clinical Director at the Family Service League in Huntington, N.Y. and the Director of Psychological Services at Clarity Child Guidance Center in San Antonio, Tx, invited us to test our proposed intervention with their staff. The Family Service League intervention ended in January 2018, the Clarity Child Guidance Center began their intervention in May 2018.

2. The Intervention: What Are We Doing?

In the proposed intervention, psychoanalysts and experienced psychodynamic clinicians are paired with staff therapists for weekly individual consultation sessions. The goal is to meet (in person, by phone, or by any HIPAA compliant videoconferencing app) for a minimum of 40 sessions or over the course of a twelve month period. The consultants are drawn from the larger psychoanalytic community. They are experienced clinicians who share our concern about the lack of interest in psychodynamic work in the public sector and share our hope that this program, and others like it, will start to reverse this trend. They generously volunteer their time.
Simultaneously, we are collecting and analyzing data to measure the outcome of these interventions. Quantitative measures gauging professional satisfaction and professional development are administered to each therapist at the beginning of the project, mid-way through, and at the conclusion of the twelve-month period. Qualitative data is collected from both therapists and consultants in the month after the consultations end. So far we can report that although the number of subjects limits generalizability, preliminary findings from an analysis of the Family Service League quantitative data revealed significant improvements in work satisfaction and self-perceptions of development as a therapist at the conclusion of the intervention.

This manual is intended to take you step by step through the intervention. We list best practices, although we are aware that it is not always possible to follow these to the letter. We follow a timeline and include copies of agreements with agencies and consultants, and a template for a daylong introductory workshop. As we stated above, research is an essential component of this intervention. Our research methods and the instruments selected are described in this manual. The Appendix includes copies of the closed ended instruments being used, and qualitative questions to ask of both therapists and consultants. We look forward to including statistical findings from each of the agencies that adopt this intervention. In this way, by aggregating data from several sites, our conclusions will be more robust and generalizable.

“If just one person got one thing out of the consulting, it would be great. But every week I hang up the telephone and say, ‘Wow.’”

**Invitation:**

We invite any agency interested in replicating this intervention or an individual psychologist interested in taking the intervention to a particular clinic with which he or she is familiar, to get in touch with us. Meanwhile this manual describes our experience in the first two agencies. We have taken pains to describe what we believe at this point to be the best practices in carrying out this intervention, but we know that individual sites will want to modify some of these steps. They are guidelines, we are interested in learning the ways that you have found to implement the project. We invite you to join us.

Ghislaine Boulanger: Ghislaine242@gmail.com
Larry Rosenberg: lmrphd@gmail.com
SETTING UP AN INTERVENTION

Step 1: Identify Suitable Agencies

It has been our experience that having personal contacts in the agencies that adopt our intervention is important. Whether these are professional colleagues we have known for years, supervisors in a given agency, colleagues who attend presentations we give, recommendations from the consultants who have volunteered their time, or word of mouth from one clinic director or administrator to another, we have found that administrative staff, and sometimes staff supervisors, in community mental health settings are willing to meet with us to describe the situation in their particular agency and to explore the possibility of implementing an intervention like the one we propose.

Before any intervention can take place, establishing a working alliance with senior managers at these agencies is of critical importance. It is essential to set up meetings to review the process in detail before an agency formally agrees to adopt the intervention.

Any agency that adopts this intervention must designate an administrator who will be the liaison with Section V and take responsibility for initiating and following the process each step of the way, from the planning phase through the active phase, and beyond (see Keeping in Touch, Step 6). The administrator’s duties include:

- Ensuring that an agreement between the agency and Section V has been signed. See Appendix i.

- Selecting and individually briefing staff therapists prepared to take part in the program.

- Assigning a number to each therapist so that his or her participation is anonymous.

- Creating a record that includes therapist #, name, type of degree, year of degree, #years practicing, whether a staff therapist or fee for service, preferred mode of treatment, previous exposure to psychodynamic theory and practice.

- Ensuring that all therapist participants sign consent forms before beginning the consultations. See Appendix ii.
• Locating and working with psychodynamic psychologists and psychoanalysts, whether they are local or participating long distance, to undertake the consultations. Section V always stands ready to help with this process.

• Ensuring agreements between the consultants and the agency are in place.

• Organizing the workshop and applying for continuing education credits.

• Pairing consultants with staff therapists.

• Staying in regular touch with consultants and trouble-shooting issues that arise during the consultations.

• Setting a date for concluding consultations and communicating that date clearly to both consultants and therapists at least eight weeks before termination.

• Coordinating quantitative data collection with Section V.

• Managing the collection of qualitative data and coordinating analysis with Section V.
Step 2: Finding Consultants

“Every time I put myself in a public sector context, I am moved. I feel part of the world. I’m transformed just because of that.” —Comment from a consultant

Many psychoanalytic colleagues generously agreed, indeed they were eager to play a part in this project. Although the therapist participants and the consultants often told us that they wished they could have met with their consultants in person, by and large it was not possible to find enough suitably trained consultants whose offices were within commuting distance of a given clinic. Nonetheless, the consultations yielded many very rich and fruitful consulting relationships whether by phone, FaceTime or Zoom; it should be noted that Skype is not HIPAA compliant.

“I would emphasize how much I enjoyed talking to my consultant. When I first started, I was nervous, I didn’t know what types of questions I would be asked. You get into a routine or in a rut and then this person from this institute comes. I would say after very conversation with her I did feel lighter in ways.”

We emphasize the importance of selecting consultants who are trained psychoanalysts or who practice as psychodynamic clinicians. In both cases, consultants should have at least six years’ experience supervising psychodynamic trainees in graduate schools, internships, and/or institute settings.

Finding enough consultants can be a time consuming project. A two-step process seems to be most effective. As soon as an agency has been identified and has agreed in principle to adopt the intervention, a preliminary email is sent to the listserves of local and national psychoanalytic associations, societies and training institutes describing the project and the scope of work for the consultants and asking for volunteers. Then, when a starting date for the intervention has been set -- and this may be three or four months later -- check back individually with each of the colleagues who expressed interest in the project to see if they are still prepared to volunteer in the program.

In Section 4 we describe in more detail the ways in which a relationship with a consultant differs from supervision. The agreement the consultant is asked to sign with the agency clearly stipulates the extent of the consultant’s responsibility:

“Consultation is not considered clinical supervision. The Agency maintains full responsibility for quality of care and the Consultant is not responsible...
for active treatment or for The Agency’s policies, procedures or practices. The Consultee is responsible for reconciling any discrepancy between consultative discussions and Agency policy with his/her Agency supervisor.”

Feedback from consultants has described the ways in which the consultation relationship developed over time, and how or whether the consultants perceived changes in the way their consultees worked.

“We met on FaceTime. She was sitting on her couch with a blanket in sweats. As we worked together, the blanket disappeared. She used her hands more to show me with movement.” —Comment from a consultant

Several consultants were disturbed by the “unreasonable demands” placed on the therapists with whom they had been consulting. They were struck by the number of patients the therapist was required to see in a day and the never-ending paperwork that had to be completed; during their feedback sessions, they wondered how this intervention can possibly have an impact under such conditions. It is our impression that the therapists experience their consultants’ distress (which always appears to have been expressed professionally and empathically, if at all, ) as necessary validation; as they see it, a distinguished colleague is witnessing their difficult work conditions and is nonetheless committed to helping them think about how to work productively under these circumstances.

“I find myself lately feeling isolated and at times just feeling alone in this even though you do talk to co-workers. When I speak with my consultant, it makes me feel less alone, more understood with the stress that is related to this job and my cases, and it does have me start to view cases in a different way.” —Comment from a therapist.

We had hoped to avoid this “culture” shock that some of the consultants experienced when they learned about the realities of working in a community mental health center. In preliminary emails, we tried to prepare consultants who are not familiar with the current conditions that prevail in most agencies to understand the workload and bottom line emphasis in these settings. We offered teleconferences for consultants either before beginning the intervention or at regular intervals during the year. In the course of the year, the project administrators also fielded individual telephone calls and had email exchanges with consultants who voiced their frustration about the conditions under
which their consultees were expected to work. In one or two cases, consultants sought confirmation about the difficulties the therapists were facing.

Some consultants acknowledged during the feedback that they felt helpless in regards to the system; although several of them recognized that the agency simply represents the unfortunate reality of practicing in a community mental health clinic that accepts government funding. And yet, with very few exceptions, the therapists they worked with felt supported and understood by their consultants. Several therapists asked how I (GB) had known to match them with their particular consultant. Since, with one exception, the pairs were matched randomly, we heard this question as a reflection of the consultants’ skill at adapting to these very different working conditions and considerably lower levels of experience than they normally encounter as supervisors.
Step 3: Consulting Agreements

Before officially beginning this intervention, several Consulting Agreements with the agency must be in place. These agreements outline the scope of work, agree to data sharing, and give Section V the right to publish the findings. An agreement between the agency and Section V also ensures that HIPAA procedures are observed. Some agencies may wish to enter into separate agreements with each individual consultant, distinguishing clinical consultations from supervision and again ensuring HIPAA compliance. In either case, it is important to ensure that the agency assumes responsibility for quality of care and neither Section V nor the consultant is held responsible for active treatment, or for the agency’s policies, procedures, and/or practices.

In the Appendices i and ii we offer examples of these agreements. In all likelihood, individual agencies will want to produce their own agreements, or alter these templates. Agencies replicating this study are advised to seek legal counsel from an expert in professional practice before signing the agreement.
Step 4: Selecting Staff Therapists

“You can fall in love with supervision.”

“Sometimes it was a good challenge to know I had to present my work.”

We recommend that the person who is administering this project speak individually to each therapist who is being offered an opportunity to take part in the program a month or six weeks before the intervention is scheduled to begin. In that conversation, it is important to stress that participation is voluntary and that the therapists, while each is crucial to the overall plan, will remain anonymous, identified only by number except, of course, to their consultant.

In our current placements, therapists who have agreed to participate in this project represent a wide range of clinical training and experience: they have degrees in social work, Masters degrees in mental health, degrees in psychology at both the masters and doctoral levels, and certificates in marriage and family counseling; they have been working between 6 months and 25 years; some, but very few of them, have been exposed to psychodynamic thinking. Some of them are fee for service; others are members of the clinical staff.

We strongly suggest that meetings between consultants and therapists do not take place during the hours that the therapist is working, but this is hard to enforce. When consultations take place at work, emergencies can disrupt the continuity of the consultations. Nonetheless, it is important to leave the arrangements about how and when to meet up to each therapist consultant/therapist dyad.

The Consultation Agreement (see Appendix ii) formally describes the educational nature of the relationship between therapist and Consultant, making clear that clinical responsibility rests with the Agency and the therapist’s supervisor.

“Clinical Consultation involves the discussion of cases between professionals for the purpose of receiving continuing education from The Consultant in the form of instruction and feedback. It is the Consultee’s responsibility to determine the degree to which he/she should incorporate the instruction and feedback into treatment within the context of The Agency’s policies and practices and as part of their normal supervision process.”
The relationship between the staff therapists and consultants that we encourage is unusual; unlike most supervision it is entirely voluntary, and there is no oversight from either the agency or from the program administrators. Unlike supervision in most agencies, consultations are not designed to help the therapist meet agency requirements; rather the focus is on the therapist’s treatment relationships. Psychodynamic consultation is non-judgmental, supportive, and educational for the therapist, its aim is inquisitive rather than directive. It is a reflective process; the therapist is encouraged to examine his or her own thoughts and feelings as she interacts with the client, while simultaneously considering the client’s experience of events that occur outside of the office, as well as the client’s experience of the therapeutic relationship. The consultation is focused not just on the therapist’s experience with the client but also, when the opportunity presents itself, with the consultant. The consultant encourages the examination of conscious experience, but also attends to unconscious processes that may be influencing the client’s and therapist’s thinking, behaviors, and emotional state, or may be interfering with the therapeutic process. The consultants naturally model this reflective process during the consultation itself. In sum, it is our goal to help therapists in the public sector find ways of better engaging, understanding, and empathizing with their clients, expanding their clinical repertoire, enhancing the quality of the therapeutic relationship, and improving treatment outcomes.  

Nine of the 12 Family Service League therapists described positive to very positive reactions to the regular consultations.

“Sometimes I don’t know how I would do this if I didn’t speak to my consultant every week.”

Several experienced having to call their consultants regularly as a burden, but one of these concluded

“Whenever I get off the phone with her a majority of times I feel better about myself, and the work that I do with clients.”

---

The fact that the relationship with the consultant was independent of the clinic struck several as a relief

“I did like having someone that wasn’t in the clinic to bounce ideas off. The supervision we’re getting in the clinic is more administrative. It doesn’t leave us time to talk about cases.”

“I could see there were different ways to approach things. It helped me be more flexible. I could think differently about problems clients bring instead of thinking the way I normally do, I could contemplate different things.”
Step 5: Introductory Workshop

Once a start date for the intervention has been selected, an introductory workshop should be scheduled to take place shortly before the therapists and consultants are introduced to one another (by email). The purpose of this workshop is to remind the therapists that their participation is voluntary, and, of course, thank them for being a part of this intervention. Without being specific about the research question, the necessity of participating in the data collection is emphasized.

The workshop should be mandatory for all the therapists participating in the intervention. Offering CE credits for the workshop is an added incentive.

We designed a 6 hour workshop to familiarize staff therapists with the principles of psychodynamic thinking and practice, and to introduce the concept of consultations and how they differ from supervision. During the live consultations, two of the staff therapists who take part in the intervention agreed to an in vivo consultation with a consultant conducted in front of the group. In Appendix iii you will find a template for the workshop and criteria established for 5 CE credits awarded upon completion.

Following a PowerPoint discussion about the guiding principles of psychodynamic consultations and each of the live consultations, the audience is encouraged to ask questions, not just of the presenters, but also to engage one another in thinking through the dynamics of the cases that were presented.

Observing live consultations is crucial to helping therapists understand how the principles of psychodynamic treatment can be integrated into their ongoing work and to understand the consultation process. The live consultations implicitly demonstrate the difference between a consultation and the more directive supervision that the therapist is used to in the clinic. However, the chain of command is clearly stated, the clinic supervisor has ultimate responsibility for the treatment; the consultant serves as a sounding board for the therapist, raising different kinds of questions about the dynamics of the case and the therapist’s experience in engaging with this particular patient.

In Appendix iv we include the PowerPoint presentation used at the two sites where we have instituted this initiative so far. In each case, Larry Rosenberg and Steven Spitz gave the presentation. With sufficient advance warning, Drs. Rosenberg and Spitz would be available to make these presentations, though the PowerPoint slides may be used by someone else. Alternative presentations could be given, but we emphasize that a discussion on the principles of psychodynamic treatment combined with live consultations is intrinsic to the workshop and a necessary prelude to the consultations.
We note that offering selected readings before and during the workshop did not elicit much interest from the therapists. Clearly they are already inundated with paper work and required reading only adds to their burden. It has proved far more effective when individual consultants responded to expressed interest from the therapists during the course of their work together. On the other hand, each of the participants from the workshops given at the Family Service League on Long Island and at the Clarity Child Guidance Center in Texas “agreed” or “strongly agreed that learning about the guiding principles of psychodynamic therapy and having an opportunity to observe live consultations were valuable learning experiences.

“Seeing the real life experiences of the consultants and the presenters was very helpful.”

Several participants added spontaneously that having the opportunity to exchange ideas with colleagues after watching the live consultations added significantly to their learning experience during the workshop.
Step 6: Consolidating the Year’s Learning

At the conclusion of the consultations at the Family Service League in Huntington, several of the participants, both consultants and therapists, expressed reluctance to end the consultation process, some therapists even made plans to continue consultations on an as needed basis.

It was clear to us that although the termination had been discussed during the consultations and was known a year in advance, several of the therapists experienced it as an unwelcome end to what had become a very rewarding experience. This ending amounted to a loss of support for their clinical work and for themselves as professionals. Of course, this goes against the spirit of our intervention which is intended in part to improve therapist wellbeing, nor did it give therapist participants an opportunity to consolidate what they had learned during the year of consultations. We felt it important to find a way continue our engagement with this community. Therefore, at the invitation of the Clinic Director at the Family Service League, it was decided that every other month, members of the Section V board or the CMHC Steering Committee would take turns leading a live consultation and discussion during one of the clinic’s regularly scheduled staff meetings. At the Family Service League, in addition to the therapists who participated in the initiative during the preceding year, several additional staff therapists have asked to be included in these meetings.

We anticipate that other sites will find different ways to continue the therapists’ engagement with psychodynamic ideas and practice. Group supervision conducted by a psychoanalyst or experienced psychodynamic therapist from the local community would be one option. Whether that supervision takes place during work hours or not would be at the discretion of the clinic project administrator.
RESEARCH MEASURES AND DATA COLLECTION

1. Closed Ended Measures

Before taking part in this project, each participating therapist must sign a consent form provided by Barry Dauphin dauphivb@udmercy.edu at the University of Detroit Mercy. (There is an example of the consent form in Appendix v) The research for this project is overseen by Dr. Dauphin who has obtained Institutional Review Board approval for the intervention and the instruments selected for use. He and his students will take responsibility for adding each new site to the IRB.

To keep the burden on therapist participants to a minimum, two closed ended instruments that together take less than 20 minutes to complete have been selected:

The first is The Therapists’ Professional Development Scales, developed by the Society for Psychotherapy Research: Collaborative Research Network. This scale measures the therapists’ sense of mastery and progress in their professional development. The TPDS is comprised of 22, 6-point Likert items anchored by “not at all” and “very greatly”. The items fall under 3 headings, Since Your Work Began, Overall, At the Present Time, and In Your Recent Therapeutic Work, How Much.... For example; “Since your work began, how much have you succeeded in overcoming your past limitations as a therapist?”, or “Overall, at the present time, how well are you able to detect and deal with your patients’ emotional reactions to you?”, or “In your recent therapeutic work, how much do you feel you are changing as a therapist?”

The second instrument, The Work and Well-Being Survey (UWES), measures the nature of affect and investment associated with work and the workplace. This instrument developed by Schaufeli & Bakker (2003), is comprised of 17, 7-point Likert scale items anchored by Never and Always. For example: “I find the work that I do full of meaning and purpose”. Or, “I am enthusiastic about my job.”

The scales can be found in Appendix vi. The therapists participating in this study are expected to complete demographic information and both scales online at three points during the intervention: shortly before the consultations begin, six months later and as soon as possible after the consultations have ended.
2. Qualitative Measures

Exit interviews were scheduled as soon as the consultations had ended and no more than a month afterwards. Each therapist and consultant was contacted by an assigned interviewer, either by telephone or email, in order to schedule an interview. This sometimes takes persistence on the part of the interviewer!

In order to avoid bias, the interviewers had played no role in the intervention itself; pains were taken to avoid having the same interviewer interview consultants and therapists who had worked together. The qualitative questions in the appendix below were used as a guide. The interviewers had the option to pursue further lines of inquiry that seemed germane. These interviews were not recorded, but interviewers were encouraged to take extensive notes and to transcribe them.

On the transcripts therapists were identified by their project number that corresponded to the number used in their online responses to the closed ended measures. Naturally, interviewers knew the name of the therapists. Consultants were identified by their own names.

The interview guides for therapists and consultants along with instructions to the interviewers are in Appendix vii.
TIMELINE/CHECKLIST

As will be clear from reading this manual, once an agency has been selected, many steps must be followed before consultations can begin. Several of these tasks occur concurrently, but participating agencies should allow at least four months to complete the initial tasks. During the consultations, quantitative data must be collected, and a termination date set. After termination, the final round of quantitative is collected, and both consultants and therapists debriefed about their experience. This checklist provides a timeline for these tasks.

- Begin search for consultants
- Draw up agreements with the agency
- NB It is not advisable to proceed with the next steps until these agreements have been signed.
- Select a workshop date to precede consultations by a week or two
- Select a start date for the intervention
- Identify therapists who will take part
- Confirm with consultants who have shown interest
- Ask each consultant to sign agreement with the agency
- Ensure first set of quantitative measures has been completed online a week before the workshop takes place
- Match consultants with therapists
- Workshop takes place
- Consultations begin

- Midway through the year’s consultations, ensure that the second set of quantitative measures has been completed online
☐ Check with consultants who have not been in touch

☐ After 9 months, email both consultants and therapists setting a termination date. Remind them that there will be a chance for individual feedback once the intervention is complete.

☐ After 11 months check with consultants that individual termination dates have been set. Ask each consultant to estimate how many consultation sessions they have held in all. Remind them that there will be an opportunity for debriefing when the consultations have terminated.

☐ For consultants who work near the agency, check whether they would be interested in conducting one or several of the live consultations to be offered at the agency in the coming year.

☐ Once consultations have ended, therapists complete third set of online quantitative measures.

☐ Over the next month qualitative data/feedback is individually collected from both consultants and therapists.
As we stated above, the relationship between the consultant and the therapist is a private one. Of course, the consultant knows the therapist’s name as does the Project Administrator. But once the Project Administrator has assigned a project i.d. number to the therapist, all communications with the therapist appear under that number. The quantitative and qualitative feedback is collected under that number. Again, the psychologist who interviews the therapist to obtain their qualitative feedback also knows the therapist’s name, but the Project Administrator is responsible for removing any identifying data from the feedback and assigning the correct project i.d. number before the qualitative data is entered into the record.
COSTS

The costs of this intervention are minimal. Section V Board members, and the members of the CMHC donate their time administering the project. The Project Administrator is usually a paid staff member at the site where the intervention takes place. Most significant, the consultants also volunteer their time.

The research is overseen by Professor Barry Dauphin in the clinical program at the University of Detroit Mercy. Working with both qualitative and quantitative data affords his students an opportunity to become familiar with this unusual and growing data set.

When the program was being developed, two research assistants were paid out of a $4,000.00 startup grant from the FAR Fund. The RAs researched suitable instruments, helped in the development of qualitative instruments, and helped in coding both quantitative and qualitative data. Now that the closed ended instruments have been selected and are coded online at the University of Detroit Mercy, those costs are no longer necessary.

The FAR Fund grant was also used to provide breakfast, lunch, and snacks during the daylong workshop at the Family Service League, and to reimburse travel costs and the cost of registering for a conference where two members of the Family Service League presented along with the two of the principal investigators.
WHERE DO WE GO FROM HERE?  
NEXT STEPS

We are actively seeking additional community mental health centers to join this project. Please get in touch with either Ghislaine Boulanger ghislaine242@gmail.com, or Larry Rosenberg: lmrphd@gmail.com if you would like to discuss possibilities.
APPENDICES

i. Example of Business Agreement Between Agency and Section V

ii. Example of Consulting Agreement Between Agency and consultants

iii. Workshop Template

iv. PowerPoint presentation: Some guiding principles of psychodynamic consultations

v. Letter of consent to be signed by therapists before participating in study

vi. Quantitative Measures and Instructions

   • Therapists Professional Development Scales

   • Work and Wellbeing Survey

vii. Qualitative measures and instructions to interviewers

   • Guide for interviewing therapists

   • Guide for interviewing consultants
Appendix i

Example of Business Agreement
Between Section V and Agency

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT (the “Agreement”) is entered into on the 
_______ day of_____________________, 20________, by and between:

____________________________(hereinafter referred to as “Covered Entity”)

and ______________________(hereinafter referred to as “Business Associate”).

WHEREAS, Covered Entity has engaged Business Associate to perform certain services 
or provide certain goods, or both;

WHEREAS, Covered Entity possesses or will possess individually identifiable health 
information, which information is subject to the Health Insurance Portability and 
Accountability Act of 1996 (“HIPAA”), the regulations promulgated by the U.S. 
Department of Health and Human Services (“HHS”) thereunder and the Health 
Information Technology for Economic and Clinical Health Act, Title XIII of the 
American Recovery and Reinvestment Act of 2009 (“HITECH”);

WHEREAS, in the course of performing services or providing goods to Covered Entity, 
Business Associate may receive such protected health information from Covered Entity 
or otherwise obtain access to such information; and

WHEREAS, Covered Entity seeks to ensure that Business Associate appropriately 
safeguards all such protected health information.

NOW, THEREFORE, the parties hereby agree as follows:
1. DEFINITIONS

a. “Breach” shall have the same meaning as the term breach in HITECH Section 13400(i).

b. “HIPAA Regulations” means regulations promulgated under HIPAA by HHS, including, but not limited to, 45 C.F.R. Parts 160 and 164.

c. “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 C.F.R. §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

d. “Unsecured PHI” shall have the same meaning as the term unsecured protected health information in HITECH Section 13402(h)(i).

e. Any terms used, but not otherwise defined, in this Agreement shall have the same meaning those terms have under HIPAA, HITECH, and the HIPAA Regulations.

2. PERMITTED USES AND DISCLOSURES

Business Associate may use and/or disclose PHI received from, or created or received on behalf of, Covered Entity to perform functions, activities or services for or on behalf of Covered Entity as set forth in a service agreement between Business Associate and Covered Entity, provided that such use or disclosure would not violate HIPAA, HITECH or the HIPAA Regulations if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

a. **Use or Disclosure.** Business Associate shall not use or disclose PHI other than as permitted or required by this Agreement or as required by law. Business Associate shall comply with all provisions of HIPAA, HITECH, and the HIPAA Regulations that relate to the privacy and security of PHI and that are applicable to Covered Entity and Business Associate.

b. **Safeguards.** Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as specifically provided for by this Agreement, including, without limitation, (i) implementing administrative, physical and technical safeguards to reasonably protect the privacy and security of PHI; and (ii) ensuring that any subcontractor or agent that receives PHI from Business
Associate agrees to implement reasonable and appropriate safeguards to protect the privacy and security of PHI.

c. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Breach of Unsecured PHI or any use or disclosure of PHI by Business Associate that violates the requirements of this Agreement. Business Associate shall cooperate with and assist Covered Entity in any investigation and/or cure of a Breach of Unsecured PHI or other violation of this Agreement.

d. **Reporting.** Business Associate shall report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware, as soon as reasonably practicable.

e. **Subcontractors and Agents.** Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate as a result of this Agreement.

f. **Access.** At the request of Covered Entity, Business Associate shall provide to Covered Entity (or to an individual) access to PHI contained in a designated record set in order to comply with the access provisions contained in 45 C.F.R. §164.524 and/or the policies of Covered Entity. Such access shall be provided by Business Associate in the time and manner designated by Covered Entity, including, where applicable, access by electronic means pursuant to HITECH Section 13405(e).

g. **Amendment.** At the request of Covered Entity or an individual, Business Associate shall make any amendment(s) to PHI in a designated record set that the Covered Entity directs or agrees to pursuant to the amendment of records provisions in 45 C.F.R. §164.526 and/or the policies of Covered Entity. Such amendments shall be made by Business Associate in the time and manner designated by Covered Entity.

h. **Audit and Inspection.** Business Associate shall make internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available to the
Covered Entity or to the Secretary of HHS, or his or her designee, for the purposes of the Secretary determining Covered Entity’s compliance with HIPAA. Such information shall be made available in a time and manner designated by Covered Entity or the Secretary of HHS.

i. **Documentation of Disclosures.** Business Associate shall document such disclosures of PHI, and such information related to such disclosures in order to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528, the policies of Covered Entity and HITECH Section 13405(c).

j. **Accounting.** Business Associate shall provide to Covered Entity or to an individual information collected in accordance with Section 3(i) of this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528 and HITECH Section 13405(c).

k. **Breach Notification.** In the event of a Breach of Unsecured PHI maintained by Business Associate, Business Associate shall notify Covered Entity of such Breach, without unreasonable delay and no later than 60 days from the date of discovery of the Breach. Said notice shall be written in plain language and shall include (i) the identification of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate, to have been accessed, acquired or disclosed; (ii) a brief description of what happened, the date of the Breach, if known, and the date of discovery; (iii) the type of personal health information involved in the Breach; (iv) any precautionary steps to be taken; (v) a description of what Business Associate is doing to investigate and mitigate the Breach and prevent future breaches; and (vi) how affected individuals may contact Business Associate to ask questions or learn additional information.

4. **OBLIGATIONS OF COVERED ENTITY**

   a. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA, HITECH, or the HIPAA Regulations if done by Covered Entity.

   b. Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such
limitation may affect Business Associate’s use or disclosure of PHI.

c. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Business Associate’s use or disclosure of PHI.

d. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.

5. TERM AND TERMINATION

a. Term. The term of this Agreement shall begin on the date first written above and shall continue until the Agreement is terminated in accordance with the provisions of Section 5(b) or 5(c) hereof, or when the underlying service agreement between the parties terminates.

b. Termination by Covered Entity for Cause. Upon Covered Entity’s knowledge of a material breach of the terms of this Agreement by Business Associate, Covered Entity may, in its sole discretion, either (i) provide Business Associate with notice of and an opportunity to cure such breach and then terminate this Agreement if Business Associate does not cure breach or end the violation within time period specified by Covered Entity, or (ii) terminate this Agreement immediately. If neither cure of the breach nor termination of the Agreement is feasible, Covered Entity shall notify I-IHS of the uncured breach.

c. Termination by Business Associate for Cause. Upon Business Associate’s knowledge of a material breach of the terms of this Agreement by Covered Entity, Business Associate shall provide Covered Entity with notice of and an opportunity to cure such breach and then terminate this Agreement if Covered Entity does not cure breach or end the violation within a time period specified by Covered Entity. If neither cure of the breach nor termination of the Agreement is feasible, Business Associate shall notify HFIS of the uncured breach.

d. Effect of Termination.

i. Upon termination of this Agreement, for any reason, Business Associate shall
return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

ii. Notwithstanding the foregoing, in the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make the return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of the PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

6. MISCELLANEOUS

a. Regulatory References. A reference in this Agreement to a section of HIPAA, HITECH, or the HIPAA Regulations means the section in effect or as amended.

b. Amendment. The parties agree to take such action necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of any applicable statute, rule or regulation.

c. Survival. The respective rights and obligations of the parties hereto under Section 5(d)(1) and 5(d)(2) of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with any applicable statute, rule or regulation.

e. State Law. Nothing in this Agreement shall be construed to require Business Associate to use or disclose PHI without written authorization from the individual who is the subject of the PHI, or written authorization from any other person, where state law requires authorization for such use or disclosure.

f. Injunctions. Covered Entity and Business Associate agree that any violation by Business Associate of any of the provisions of this Agreement may cause irreparable harm to Covered Entity. Accordingly, in addition to any other
remedies available to Covered Entity at law, in equity or under this Agreement, Covered Entity shall be entitled to an injunction or other decree of specific performance with respect to any violation by Business Associate of any of the provisions of this Agreement, or any explicit threat thereof, without any bond or other security being required and without the necessity of demonstrating actual damages.

g. **Indemnification.** Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from or relating to the acts or omissions of Business Associate in connection with the representations, duties and obligations of Business Associate under this Agreement.

h. **No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended or shall be deemed to confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, obligations, remedies or liabilities.

i. To the extent that any provisions of this Agreement conflict with the provisions of any other agreement or understanding between the parties, this Agreement shall control.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the date first written above.

_________________________________________  ______________________________________
Name of Covered Entity     Name of Business Associate

BY: ___________________________  ___________________________
Signature of Authorized Representative  Signature of Authorized Representative

_________________________________________  ______________________________________
Name and Title     Name and Title
BUSINESS ASSOCIATE AGREEMENT – ADDENDUM

The following is an addendum to the Business Associate Agreement (BAA) between ______________________________________ (hereinafter referred to as The Agency) and ___________________________________ (hereinafter referred to as Section V of the Society for Psychoanalysis and Psychoanalytic Psychology) (hereinafter referred to as the Consultation Coordinators).

The Agency will grant permission to the Consultation Coordinators to retain control of any materials, guides, handbooks, seminars, surveys, articles, and/or other information created, produced, or collected by the Consultants during the course of this consulting agreement or any materials or information created or compiled by the Consultation Coordinators after the consulting agreement expires. Such materials will not include any identifying information concerning The Agency, or its staff or patients. The agency agrees that all materials and/or information created, produced, or collected by the Consultation Coordinators during the course of this consulting agreement shall be the property of the Consultation Coordinators. The Agency agrees that the consultants will have sole discretion as to how this material and/or information is used, published, limited, or otherwise controlled. The Consultation Coordinators agree to inform the Agency of their intentions to use this material and to share any written material with them. The Agency agrees that the Consultation Coordinators shall maintain their ownership and control over all materials and/or information created, produced, or collected by the Consultants even after the consulting agreement expires.

The Agency’s Representative: ______________________________________

Name/Title: ______________________________________ Date: ______________________

The Business Associate: ______________________________________

Name/Title: ______________________________________ Date: ______________________
CONSULTING AGREEMENT

This agreement is made this ________________ day of ________________, between
_________________________________________ hereinafter The Agency,
and _____________________________________, hereinafter The Consultant,
whose mailing address is ____________________________________________

The Consultant is participating in this agreement under the auspices of Division 39,
Section V: Applied Clinical Psychoanalysis of the American Psychological Association,
hereinafter referred to as the Consultation Coordinators.

The Consultant and The Agency agree as follows:

1. TERM
   This agreement shall commence and terminate The agreement may be renewed at
   the option of The Agency, up until the day that the original agreement herein expires.
   This agreement may be terminated by either party without the consent of the other
   party, but only upon thirty (30) days notice. Such notice must be made in writing and
   sent first class mail to the following:

   The Consultant: ________________________________________________

   The Agency: ___________________________________________________

2. PAYMENT
   The Consultant will provide the services to be defined in this agreement free of
   charge to The Agency.
3. DUTIES OF THE CONSULTANT AND AGENCY

Clinical Consultation: The Consultant shall provide clinical consultation to identified therapists (hereinafter Consultees) working at The Agency’s clinic. Approximately forty consultations will take place in the course of twelve months via telephone or secure webcam connection.

i. Clinical Consultation involves the discussion of cases between professionals for the purpose of receiving continuing education from The Consultant in the form of instruction and feedback. It is the Consultee’s responsibility to determine the degree to which he/she should incorporate the instruction and feedback into treatment within the context of The Agency’s policies and practices and as part of their normal supervision process.

ii. Consultation is not considered clinical supervision. The Agency maintains full responsibility for quality of care and the Consultant is not responsible for active treatment or for The Agency’s policies, procedures or practices. The Consultee is responsible for reconciling any discrepancy between consultative discussions and Agency policy with his/her Agency supervisor.

j. The Consultant shall abide by all federal rules (e.g. Health Insurance Portability and Accountability Act) regarding the management of protective health information.

k. A business associate agreement (BAA) shall be maintained by the Consultation Coordinators and Consultants and The Agency. Both the Consultation Coordinators and the Agency shall designate a compliance officer to monitor such contract.

l. The Agency will provide appropriate space (primarily to be located at the Huntington Clinic at 55 Horizon Drive, Huntington, NY 11743) to conduct any scheduled training sessions by the Consultation Coordinators.

4. NON-DISCLOSURE

The Consultation Coordinators and the Consultants agree that they will not at any time during or after the term of this agreement reveal, divulge, or make known to any person, corporation or entity of any kind the contents of any method or manner in which The Agency conducts its business, without the express permission of The
Agency. All information garnered during the duration of this agreement is considered privileged and proprietary and may not be revealed by the Consultants without the express permission of The Agency.

As part of the BAA, The Agency will grant permission to the Consultation Coordinators to retain control of any materials, guides, handbooks, seminars, surveys, articles, and/or other information created, produced, or collected by the Consultants during the course of this consulting agreement or any materials or information created or compiled by the Consultation Coordinators after the consulting agreement expires. Such materials will not include any identifying information concerning The Agency, or its staff or patients. The agency agrees that all materials and/or information created, produced, or collected by the Consultation Coordinators during the course of this consulting agreement shall be the property of the Consultation Coordinators. The Agency agrees that the consultants will have sole discretion as to how this material and/or information is used, published, limited, or otherwise controlled. The Consultation Coordinators agree to inform the Agency of their intentions to use this material and to share any written material with them. The Agency agrees that the Consultation Coordinators shall maintain their ownership and control over all materials and/or information created, produced, or collected by the Consultants even after the consulting agreement expires.

5. NON-ASSIGNABILITY
Neither party shall have the right to assign or transfer this Agreement or any of the rights or obligations hereunder, nor subcontract any portion of the work, without the prior written consent of the other party.

The Agency’s Representative ________________________________________________________________

Name/Title: ______________________________________________________________________________Date:________________________

The Consultant’s Representative ________________________________________________________________

Name/Title: ______________________________________________________________________________Date:________________________
Appendix iii

Workshop Template

**Psychodynamic Principles, Psychodynamic Consultation, and Community Mental Health**

**9.30am-4.15pm**

9:30 am  Coffee and registration

10:00-10:20 am  Introduction:

10:20-11:20 am  PowerPoint presentation: Some guiding principles of psychodynamic consultations: See Appendix IV

11:20-11:35 am  Break

11:35-12:20 pm  Live consultation

12:20-1:00 pm  Debriefing with audience

1:00-1:45 pm  Lunch break

1:45-2:15 pm  Introduction to the research

2:15-3:00 pm  Live consultation:

3:00-3:30 pm  Debriefing with audience:

3:30-3:45 pm  Break

3:45 pm  Summary, final questions, further readings, what next?

4:00 pm  Participants to fill in evaluations

---

6 This sample workshop is provided as a guide only. Participating agencies will want to customize the program to meet their own needs.
For the 5 CE credits offered for attending this workshop, the following educational goals were listed:

At the conclusion of this workshop participants will be able to:

1. Explain four guiding principles of psychodynamically oriented clinical consultation.
2. Discuss the direct application of these principles as they have observed them during two live clinical consultations.
3. Assess the advantage of adding psychodynamic consultations to their regular clinic-based supervision.
4. Describe how to make use of their own thoughts and feelings as they arise in the course of their work with clients.
Appendix iv

PowerPoint Presentation: Some Guiding Principles of Psychodynamic Consultations

THE PRINCIPLES OF PSYCHODYNAMIC PSYCHOTHERAPY

Section V of Division 39
The Section of Applied Clinical Psychoanalysis
January, 2017

Download for your own use this PowerPoint presentation of thirteen slides that appear on the next six pages at: http://psychodynamiccommunityconsultations.com
*The Unconscious*

- The vast majority of what goes on in our minds occurs outside of consciousness
  - This is an empirically determined fact
- Thoughts, feelings and motivations influence our behavior in ways that are outside of our conscious awareness
- This is part of what the therapist and the patient are to discover together

*Making Meaning out of Behavior*

- All behavior has meaning
  - It is our job to join the client in figuring out what their behavior means
  - That meaning will, initially, not likely be conscious to the client (e.g. A patient comes late for appointment)
**Psychic Causality**

- *Stuff* (behaviors, events) happens for reasons
  - They are not always as accidental or random as they seem
- Things are over-determined
  - They have multiple causes
- Symptoms/behaviors are also not randomly determined
  - They happen for reasons outside of our awareness
  - They are adaptations, compromises with ourselves

**Internal Conflict**

- It is not uncommon for people to have mixed and opposing feelings that exist within themselves and may be of an unconscious nature (e.g., I want to be promoted but keep sabotaging myself because I am unconsciously scared that I can't do the job; or, a student reports that he forgot to bring a book he had to read, and then realizes that it had caused him to have a nightmare
  - This is distinct from conflict between people
- Internal conflict is the source of many unwanted behaviors
**Defense**

- Defenses help to manage our unwanted thoughts, feelings, and behaviors.
- Defensive processes, in the psychoanalytic sense, are unconscious in nature.
- Defenses always compromise reality to one degree or another.
- They can be more subtle or primitive in nature.
- The more primitive the defense, the greater the distortion of reality (e.g., sublimation vs. denial).
- Defenses also serve an adaptive function so there is a reluctance to give them up.

**Symptoms**

- Just as with medical findings, a symptom is a reflection of an underlying problem (e.g., a cough or a headache could be caused by a number of underlying problems).
- These symptoms are compromises struck by the patient with themselves as a way of managing undesired feelings and thoughts.
- The less tolerable side of these conflicts is kept from consciousness by way of defense mechanisms.
**Past Informs Present**

- Past experiences shape us
  - How we think about ourselves
  - How we think about others
  - Our beliefs about ourselves and the world around us
- The past has an ongoing influence
  - It lives in the present
- We are not trying to discover the past, but the ways in which it evidences itself in present symptoms and relationships
- It lives within the therapeutic relationship

---

**Transference and Countertransference**

- **Transference:**
  - We don’t experience any new relationship in an entirely new manner
  - Our approach, wishes, and expectations are shaped by prior relationships
  - Transference refers to the influence of these past relationships on the patients experience of the therapist and the therapeutic relationship
- There is empirical evidence to support the idea that those therapies that include work with transference phenomenon have better outcomes than those that do not
Transference and Countertransference

- **Countertransference:**
  - Refers to the influence of the therapist’s past on his/her reaction to the patient
  - The term countertransference has had multiple meanings over time
  - We all have emotional reactions to our patients
  - These reactions can inform us about ourselves but also provide important information about what may be occurring for our patients
  - The exploration of both transference and countertransference are useful to the therapeutic process

How the Psychodynamic Process is Viewed

- Non-Directive
- Psychoanalytic therapy is **not** something **done to** or practiced on another person. It is something **done with** another person.
- It is based on mutual respect and trust and assumes that this takes time to fully develop
- The therapist is trying to understand something and assist with something that cannot be attained without partnership with the patient
- There is a humility about this
- Requires tolerance of ambiguity and deprivation on the part of both
How the Psychodynamic Supervision Process is Viewed

- A collaboration between supervisor and supervisee
- A reflective process
- A process that is not directive
- One that is based on mutual respect and trust

Listening

- At several levels
  - Manifest Content
  - Latent Content
  - Sequence
  - Affect
  - Self
Appendix v

Letter of Consent to Be Signed by Therapists Before Participating in the Study.

Please check final wording of this consent form with Dr. Dauphin: 
dauphivb@udmercy.edu

Research Project Description

The Effect of Psychodynamic Case Consultation on Therapists' Work Experience

TO _________________________________________________________
[Full Name of Volunteer]

Our names are Barry Dauphin, Ph.D., ABPP, Larry Rosenberg, Ph.D., Ghislaine Boulanger, Ph.D. Dr. Dauphin is a faculty member in the Department of Psychology at the University of Detroit Mercy. Dr. Rosenberg is a psychologist in private practice. Dr. Boulanger is on the faculty of the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis.

We have asked you to agree to be a volunteer in some research we plan to conduct. Before we can accept your consent, we want to make known to you the following information pertaining to the project.

1. **Explanation of the Purpose.** The purpose of the study is to understand the role psychodynamic clinical consultation can play on therapists’ perceptions of their clinical work experience.

2. **Explanation of the Procedures.** Staff providing clinical services at a Long Island Community Mental Health Center will participate in a day long workshop discussing the principles of psychodynamic psychotherapy and observing live psychotherapy consultations. They will be asked to complete some self-report questionnaires about their professional development, work involvement and well-being. They will also
be asked to respond to some open-ended questions about their work. Following the workshop staff will begin having individual weekly consultations with licensed clinicians practiced in psychodynamic psychotherapy. 6 months and again 12 months after the consultations begin, staff will be asked to repeat the questionnaires originally administered.

3. **Expected Risks.** There are no likely risks to the participants given that all of the questionnaires will be de-identified to ensure confidentiality. Furthermore, the clinicians are aware of the purpose and nature of the study and signed informed consent at the time the study was initiated.

4. **Expected Benefits.** This study has the potential of improving clinician’s experience of their work as well as their ability to view their patients from an alternative perspective. Consultations are designed to assist clinicians in making use of their experience of their patients and provide an opportunity for enhanced professional development. Completion of the forms may help participant therapists clarify the nature of their experiences as they partake in weekly consultations.

5. **Confidentiality.** Confidentiality will be maintained by having the participants assigned research identifiers so that no personal information is attached to their responses. Research protocols will be kept in a locked file drawer in the office of Barry Dauphin, PhD, ABPP.

The confidentiality of the records will be maintained unless the law requires disclosure.

Confidentiality of records will be maintained by Barry Dauphin, PhD, ABPP.

6. **Offer To Answer Questions.** We hereby offer to answer any questions you might wish to ask concerning the procedures used in this research at this time. Furthermore, we may be reached during the hours of 9 AM until 5 PM at 313-993-1650 or by e-mail @ dauphivb@udmercy.edu or lmrphd@gmail.com or ssoldz@bgsp.edu. If you have questions concerning your rights as a volunteer, you may contact Dr. Elizabeth M. Hill, Chair, UDM Institutional Review Board, 313-578.0405 or hillelm@udmercy.edu.
7. **Freedom To Withdraw Consent.** If you consent to be a volunteer in this research project, you are nonetheless free to withdraw your consent and discontinue participation at any time without prejudice to you. You should also understand that the investigator has the right to withdraw you from the research project at any time. A volunteer’s participation may be concluded for failure to follow instructions given to them by the investigator.

8. **Compensation.** There is compensation for participation.

9. **Significant New Findings.** Any significant new findings that are developed during the course of this research which may relate to the volunteer's willingness to continue participation, such new findings will be provided to the volunteer.

10. **Future Data Use.** Occasionally, the same or another researcher will request the permission to review or use previously gathered data from a completed research project for a different project. If confidentiality of the data is protected and if the UDM Institutional Review Board has approved the study, would you be willing to give your permission to the release of your data collected from your participation in the current study without prior notification?

    ______ Yes, I give my permission for the future use of data obtained in this study initials, (contingent on the preceding conditions.)

    ______ No, I do not give my permission for the future use of data from this study. initials
Appendix vi

Quantitative Measures

Society for Psychotherapy Research: Collaborative Research Network

THERAPISTS' PROFESSIONAL DEVELOPMENT SCALES

Therapist Identification Code: ______________________________ Date _____________________

1. Overall, how long is it since you first began to practice psychotherapy? _____ Years _____ Months
   [Count practice during and after training but exclude periods when you did not practice.]

   Since you began working as a therapist...
   0=Not at all  1=Little  2=Some  3=Moderately  4=Greatly  5=Very greatly

2. How much have you changed overall as a therapist?  
   0  1  2  3  4  5

3. How much do you regard this overall charge as progress or improvement?  
   0  1  2  3  4  5

4. How much have you succeeded in overcoming past limitations as a therapist?  
   0  1  2  3  4  5

5. How much have you realized your full potential as a therapist?  
   0  1  2  3  4  5

Overall, at the present time...
   0=Not at all  1=Little  2=Some  3=Moderately  4= Much  5=Very Much

6. How much mastery do you have of the techniques and strategies involved in practicing therapy?  
   0  1  2  3  4  5

7. How well do you understand what happens moment-by-moment during therapy sessions?  
   0  1  2  3  4  5

8. How well are you able to detect and deal with your patients' emotional reactions to you?  
   0  1  2  3  4  5
9. How good are you at making constructive use of your personal reactions to patients?  
0 1 2 3 4 5

10. How much precision, subtlety and finesse have you attained in your therapeutic work?  
0 1 2 3 4 5

11. How capable do you feel to guide the development of other therapists?  
0 1 2 3 4 5

In your recent therapeutic work, how much...

0=Not at all 1=Slightly 2=Some 3=Moderately 4=Greatly 5=Very much

12. Do you feel you are changing as a therapist?  
0 1 2 3 4 5

13. Does this change feel like progress or improvement?  
0 1 2 3 4 5

14. Does this change feel like decline or impairment?  
0 1 2 3 4 5

15. Do you feel you are overcoming past limitations as a therapist?  
0 1 2 3 4 5

16. Do you feel you are becoming more skillful in practicing therapy?  
0 1 2 3 4 5

17. Do you feel you are deepening your understanding of therapy?  
0 1 2 3 4 5

18. Do you feel a growing sense of enthusiasm about doing therapy?  
0 1 2 3 4 5

19. Do you feel you are becoming disillusioned about therapy?  
0 1 2 3 4 5

20. Do you feel you are losing your capacity to respond empathically?  
0 1 2 3 4 5

21. Do you feel your performance is becoming mainly routine?  
0 1 2 3 4 5

22. How important to you is your further development as a therapist?  
0 1 2 3 4 5

This work is licensed under the Creative Commons Attribution-Non-Commercial-NoDerivs 3.0 Unported License. This license is held by the Society for Psychotherapy Research Collaborative Research Network: (SPR/CRN), c/o d-orlinsky@uchicago.edu or hronnestad@psykologiuio.no. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-nd/3.0/ or send a letter to Creative Commons, 444 Castro St., Suite 900, Mountain View, CA, 94041, USA.
Work & Well-being Survey (UWES)®

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, place a 0 before the statement. If you have had this feeling, indicate how often by indicating in the space before the statement the number—from 1 to 6—that best describes how frequently you feel that way.

0 = Never
1 = Almost never (a few times)
2 = Rarely (once a month or less)
3 = Sometimes (A few times a month)
4 = Often (Once a week)
5 = Very often (A few times a week)
6 = Always (Every day)

1. ___ At my work, I feel bursting with energy
2. ___ I find the work that I do full of meaning and purpose
3. ___ Time flies when I’m working
4. ___ At my job, I feel strong and vigorous
5. ___ I am enthusiastic about my job
6. ___ When I am working, I forget everything else around me
7. ___ My job inspires me
8. ___ When I get up in the morning, I feel like going to work
9. ___ I feel happy when I am working intensely
10. ___ I am proud of the work that I do
11. ___ I am immersed in my work
12. ___ I can continue working for very long periods at a time
13. ___ To me, my job is challenging
14. ___ I get carried away when I’m working
15. ___ At my job, I am very resilient, mentally
16. ___ It is difficult to detach myself from my job
17. ___ At my work I always persevere, even when things do not go well

© Schaufeli & Bakker (2003). The Utrecht Work Engagement Scale is free for use for non-commercial scientific research. Commercial and/or non-scientific use is prohibited, unless previous written permission is granted by the authors.
Appendix vii

Qualitative Measures

1. Instructions to interviewers for therapist feedback

Although we have collected closed ended data from the therapists, the information you are gathering here will be crucial in helping us understand their experience in more detail. We are not asking you to tape these interviews, but please take careful notes. The interview guide has a place for yes/no answers. You can fill these in on the guide and return them. Then we shall need a written summary of each interview, with the name of the person you interviewed clearly marked. (In the case of the consultees/therapists, we shall remove the names and replace them with identifying numbers since we are promising them anonymity.) The interview guide follows:

Guide for Interviewing Therapists

Now that your weekly consultations have ended, we would like to ask you to tell us something about what the experience was like. Your answers will be anonymous. We shall use them to help us improve programs like this in the future, so it’s important to hear both your positive and negative thoughts and feelings. We need to know what you think we should change and what should remain the same, and, of course, whether we should offer programs like these in other clinics in the future.

Before we begin, can you tell me when you talked to your consultant? Was it during working hours? At your scheduled break? When you were at home?

I’m going to ask questions to guide your answers but feel free to add other thoughts.

1. Can you tell me what the experience was like overall?
   • Is there anything in particular that comes to mind about the experience?

Now I’d like to get more specific about changes you may have noticed:

2. Do you think the consultations may have changed how you think about the problems your clients have?
   • If yes, how has your thinking changed?
3. Do you think the consultations have changed **how you listen** to your clients?
   
   • *If yes,* in what way has your listening changed?

4. Do you think the consultations have changed **your relationships with your clients**?
   
   • *If yes,* can you say in what way those relationships have changed?

5. What about **your feelings** about your clients, have they changed in any way?
   
   • *If yes,* how have they changed?

6. What about **your thoughts** about your clients, have those changed in any way?
   
   • *If yes,* can you say more?

7. Are there any other ways that the consultation affected how you think and feel about **your job**?

8. If you were to have another opportunity to get psychodynamic consultations,
   
   • Would you accept the opportunity?

   • What would you like to be different?
2. Instructions for interviewing consultants:

When you are interviewing a consultant, remember that this is just about the only chance that the consultants have to give us detailed feedback about their consulting experience over this last year. Many of them have expressed interest in having an opportunity to discuss the experience. We are not asking you to tape these interviews, but please take careful notes. The interview guide has a place for yes/no answers. You can fill these in on the guide and return them. Then we shall need a written summary of each interview, with the name of the person you interviewed clearly marked. The interview guide follows:

**Guide for Interviewing Consultants**

Now that you have completed the consultations with the therapist from the Family Service League, we would like to get some feedback from you about the experience. Your answers will not be identified, but we shall use them in our evaluation of this year’s pilot project, and as a way to improve the program when it is introduced in other sites. You know already that we hope to publish our findings once all the data has been analyzed.

1. First some practical questions.

   - Were your sessions by phone, FaceTime, Zoom or some other means?
   - How were cancellations handled?
     - None at all
     - How frequent were these cancellations?
     - Did you reschedule?
     - How willing was the therapist to re-schedule?

2. Did your relationship with your consultee evolve over the course of the consultation?

   - *If yes*, how did it evolve? *If no*, any thoughts about why?
3. Were there changes in the manner in which your consultee practiced during the course of your consultation?
   - *If yes*, what changes did you observe in: (use list below as a prompt)
     - Attitude toward clients
     - Ways of thinking about clients’ symptoms
     - Use of transference?
     - Ability to make use of themselves in understanding clients
     - Nature of their interventions
     - Attention to process?
     - Attention to latent as well as manifest content?
     - Sense of confidence about their work?
   - *If no*, do you think there is something that could be done to help implement change for the next future project?

4. As you know, we started this initiative because the overwhelming demands that State regulations place on clinics in the public sector make it difficult for administrators and supervisors to focus on the actual treatments the clinicians are providing. Were these administrative challenges raised by your consultee? How did he or she raise them and how did you handle the issue during your sessions?

5. What was the experience like for you as a consultant?

6. Can you suggest any ways in which we might change this program in the future?
ACKNOWLEDGMENTS

The Section for Applied Clinical Psychoanalysis
CMHC Initiative Team

Kori Bennett
Ghislaine Boulanger
Barry Dauphin
Bruce Grellong
Larry Rosenberg
Steven Spitz

Research Associates:
Debra Japko, Ph.D    Nawal Muradwij, M.A.

We are grateful to the following colleagues who volunteered their time as consultants during the last two years:

The following colleagues interviewed consultants and therapists during the qualitative data collection. Thanks so much to each of you:
Kori Bennett, Brian Brown, Ruth Fallenbaum, David Mark, Steven Spitz.

Finally, our thanks go to Christian Racine, Ph.D. and Joanna Hulsey L.C.S.W. from the Family Service League in Huntington, LI. Without your enthusiastic and steady support and the participation of the therapists and supervisors at the FSL this project would not exist.
This initiative has been designed and is being administered by the Section for Applied Clinical Psychoanalysis. This manual is, of course, part of that venture. We shall update it regularly as we add new sites and as we learn more about taking psychodynamic consultations into the public sector. Please get in touch with Ghislaine Boulanger (ghislaine242@gmail.com) if you can think of changes and additions that should be made. This is a living document!

If you are not already a member of the Section, please consider joining us. Go to the Join tab on our website: https://section5div39.wildapricot.org/

To download a pdf of this manual go to: http://psychodynamiccommunityconsultations.com

December 2018