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PRESIDENT'S COLUMN

New Years Resolutions for the Society of Clinical Psychology

Annette La Greca, Ph.D.

Greetings

I am truly honored to serve as the President of the *Society of Clinical Psychology* (*SCP*). For those of you who do not yet know me, I am a Fellow of SCP and a Distinguished Professor of Psychology and Pediatrics at the University of Miami, where I also serve as the Director of Clinical Training. Broadly speaking, my career has focused on risk and resilience factors that contribute to youths' and families' reactions to stressors and on the development of evidence-based interventions to prevent or reduce mental health problems.

Welcome to the New Year!

As I write this column, we've recently closed the door on 2020 (what a year!) and look forward to a better and brighter 2021. For many of us, the past year has been one of the most stressful and challenging years ever. Among other things, a worldwide pandemic, extreme political divides, and a reckoning with systemic racism and inequity had a tremendous impact on our daily functioning as clinicians, scientists, educators—and people. We are still in the process of addressing key issues that came to the forefront last year, and these issues will continue to shape our lives and work well into 2021 and beyond.

As we enter 2021, the *Society of Clinical Psychology* (*SCP*) remains committed to working to improve the field of clinical psychology. We have a long year ahead of us, with many tasks to accomplish and new challenges to greet us. So, as I begin my presidential year, let me offer several themes and goals for 2021—new year's resolutions, if you will.

One goal for *SCP* is to foster **greater coordination and collaboration** within the society and among the multiple Sections of *SCP*. The structure of *SCP*, with eight diverse Sections (e.g., assessment, women, and so on), enables psychologists with shared interests to work together on mutual goals in a focused manner, but it can also create silos that could limit the productivity and visibility of clinical psychology.

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As an example, *SCP* has a Diversity Committee and also a Section on the Clinical Psychology of Ethnic Minorities (*SCP*, Section 6). It becomes challenging to keep track of each group's activities, and important efforts to promote greater diversity, equity, and inclusion could be splintered and duplicated, rather than coordinated and strong. We are examining ways to address diversity and equity issues in a more coordinated manner. The *SCP* Diversity Committee, together with the Section on the *Clinical Psychology of Ethnic Minorities*, is working to create a coordinating hub of diversity-related activities, with involvement and representation from each of the *SCP* Sections. Greater coordination and co-sponsoring of diversity-related activities within *SCP* and the Sections would be an important goal. If you are interested in working on diversity, equity, and inclusion issues within SCP , please let me know as we are in the process of recruiting *SCP* members to participate in this overall effort.

Another goal for SCP is to increase the voice and involvement of diverse and early career members. SCP is a large division of APA, with about 3,000 members, many with established careers. Yet we are greatly underrepresented among early career psychologists (ECPs) and student members, many of whom also come from diverse backgrounds. ECPs and students are the future of clinical psychology! So, I'm asking the *SCP* Section on *Students and Early Career Psychologists* (Section 10) to help identify students and ECPs to actively serve on *SCP* committees and to encourage ECPs to become members of *SCP* as well (via financial incentives, such as free or reduced dues). SCP can also work with the Section on *Students and Early Career Psychologists* to promote mentorship and other relevant activities more directly. If you are a student or early career psychologist reading this column and want to become more involved in SCP please let me know!

A third goal is to **increase the visibility of** SCP **and its Sections – and what they have to offer -- among the psychology community** (and beyond). I have been a member of *SCP* for my entire career, yet I only recently became aware of the extensive program of continuing education activities that SCP hosts (with free CEs to members!). The *Society for the Science of Clinical Psychology* (Section 3) also hosts an impressive Virtual Clinical Lunch series, with a concerted effort to put forth more diversity-related content from BIPOC scholars. Now that we are more comfortable with the transition to virtual learning platforms (a bright spot of the pandemic) these webinar resources should be of great value to clinical psychologists, as they are accessible, evidence-based, high quality, and timely. Also stay tuned for the *SCP* programming at the upcoming APA convention in August. It will be offered virtually, and with a very modest registration fee. And there's more… Are you aware of all the awards (student, early career, and senior career awards) that SCP sponsors? Take a few minutes to check our website (see: https://div12.org). Thus, we need to get the word out about the valuable activities that SCP and its Sections provide – and partner with our Sections to extend our reach.

In addition to the above goals, I would like to see several themes promoted within the society's work. First and foremost, *SCP* will continue the excellent work on **diversity and equity issues** that were the focus our Past-President, Dr. Elizabeth Yeater. Elizabeth conducted a climate survey for *SCP* members and non-members to examine how we are doing across multiple domains within the *SCP*, with a particular emphasis on how effectively we are addressing issues of diversity, broadly defined. In addition, Elizabeth worked to compile a list of extensive resources on enhancing diversity-related training in graduate programs. Those materials will soon be disseminated on *SCP*'s website.

It will also be useful for *SCP* to b**uild on and expand the technology and telehealth movement in the science and practice of clinical psychology** that was spurred by the COVID pandemic. Telehealth is one of the silver linings of the pandemic, as it has greatly expanded the reach of mental health services. We've come a long way in a short time, but there is still much to learn and develop – for example, how best to conduct assessments remotely. Expect to see some programming for the *SCP* portion of the 2021 APA convention related to technology in clinical practice – both from *SCP* and its Sections.

Finally, in looking to the future (and on a personal note), I would like to see *SCP* play a greater role in **understanding the impact of disasters on the mental health** and well-being of children, youth, and adults, and in **efforts to prevent or ameliorate chronic distress** that develops in a significant minority of those exposed to such events. As a clinical psychologist and prevention scientist who works in this area, I am struck by the relative lack of attention given to this important area of mental health need and services. Yet, 2020 was a banner year for destructive weather-related disasters, with 20 billion-

dollar-plus disasters in the U.S. alone. In addition, 2020 witnessed a record-breaking hurricane season, with 30 named storms (6 of them major hurricanes). In particular, residents of Louisiana and parts of the US Gulf Coast endured 6 storms this year – in addition to all else that was going on. These events are occurring more often due to climate change, and this is an important area for clinical psychology to make its mark. Stay tuned for more on this topic in another column later this year.

In Closing…..

As we begin the new year, I would like to give a big "shout out" to Dr. Jon Comer, who just completed his year as Past President, for all his hard work on behalf of *SCP*. I'd also like to thank Dr. Elizabeth Yeater who – as our fearless *SCP* President – led us through the "Pandemic Year" admirably!

So, as 2021 unfolds, we have many tasks to accomplish and new challenges to greet us. But we also have hope. I see a light at the end of the tunnel – and I choose to see that light as sunlight.

Annette M. La Greca, PhD, ABPP
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Section 10 (Graduate Students and Early Career Psychologists) has developed a Clinical Psychology Mentorship Program. This program assists doctoral student members by pairing them with full members of the Society.

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For more information about the mentorship program, please visit

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The Hierarchical Taxonomy of Psychopathology (HiTOP): A Brief Introduction and Resource Guide for Clinical Psychologists

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The categorical approach to diagnosing mental health problems, embodied in the DSM, is almost ubiquitous in clinical psychology training, research, and practice. Over the past decade, though, the field has seen a surge of interest in new approaches to diagnosis. There is a growing sense that categorical diagnoses may have outlived their utility, especially for mental health research. But as easy as it is to criticize the DSM's many flaws (e.g., excessive comorbidity, within-diagnosis heterogeneity), there has been no obvious alternative.

The Hierarchical Taxonomy of Psychopathology (HiTOP) has emerged over the past several years as a legitimate challenger to the DSM (Kotov et al., 2017). It portrays mental disorders as a set of psychopathology dimensions, as opposed to categories, that vary in terms of breadth. Empirical research so far suggests that the HiTOP system has several advantages (outlined below), relative to categorical nosologies (Krueger et al., 2018).

We write this introduction to give an accessible overview of HiTOP's origins, current status, and future prospects. We gear our presentation to psychologists who are used to working with categorical diagnoses, and we aim to minimize jargon and technical detail. Our goal is for readers to know why and how they might apply HiTOP in their own work. Far from a thorough review, we touch briefly on several major themes and point out where readers can look for more specialized information.

Christopher C. Conway

What is HiTOP?

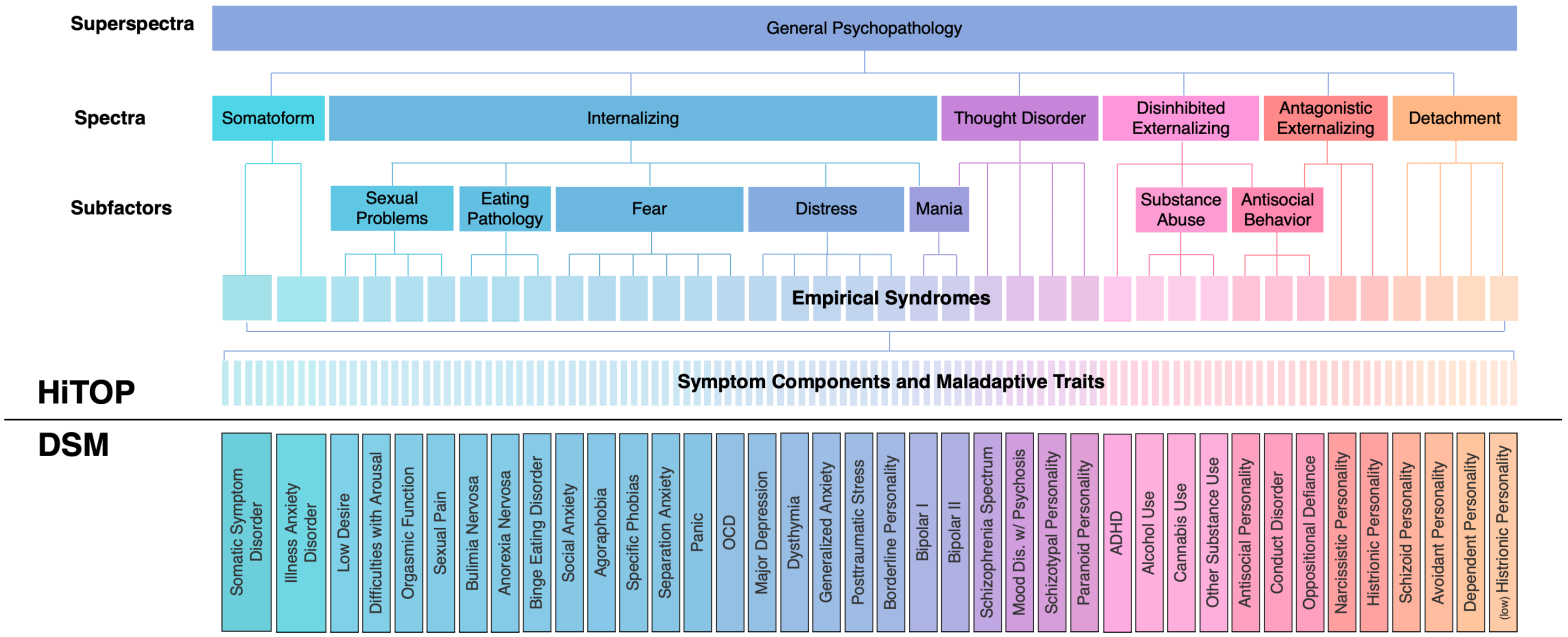
HiTOP is a model of the major components of psychopathology. These components are drawn from empirical data—sometimes decades of data—on how mental health problems (i.e., symptoms, diagnoses) cluster together. In 2015, a team of experts assembled to integrate all this evidence into a coherent system designed to evolve as new data come in. Figure 1 summarizes the current version of the HiTOP model.

There are three key aspects of the HiTOP model. First, it consists of psychopathology *dimensions*. We have known for some time that virtually all mental health problems are not natural categories that are either present or absent (see Haslam et al.'s [2020] meta-analysis). Rather, they exist on a continuum, and everyone in the population expresses them to *some degree*.

Second, paralleling the structure of other broad individual difference domains (e.g., personality, cognitive ability), there are *hierarchical relationships* among mental health phenotypes. At the bottom of Figure 1, the *symptom components* and maladaptive personality traits reflect tight-knit bundles of signs and symptoms, such as anhedonia, relational aggression, and hallucinations. Farther up are broader dimensions, such as *syndromes*[1] (e.g., social anxiety, depression), *subfactors* (e.g., distress, fear), and *spectra* (e.g., internalizing, disinhibited externalizing). These are increasingly more inclusive, heterogeneous constructs that represent the common themes among symptom clusters. At the apex of the hierarchy, the general factor of psychopathology—also called the "p-factor"—reflects the fact that nearly all mental health problems tend to go together (sometimes referred to as a "positive manifold").

Third, this model includes *the same content as the DSM*. The basic units are exactly the same, they are just sorted differently. This means that all of the clinical problems you are used to studying, assessing, and treating are represented in the HiTOP model, but they are sorted (and sometimes named) differently. HiTOP's

1 HiTOP syndromes are not replicas of DSM diagnoses. This is what the horizontal line in Figure 1 is intended to indicate. Instead, HiTOP's empirical syndromes are dimensional tendencies to experience a set of related signs and symptoms. See Conway et al. (2021) for discussion.



Grace N. Anderson

calling card is grouping symptoms into higher-order units based on observed/empirical patterns of symptom and diagnostic co-occurrence, synthesized across as many projects and populations as possible.

Why use HiTOP?

HiTOP's most basic contribution is to provide a data-based rubric for mental health problems. This is what HiTOP "is," but it is able to "do" other things to improve research and clinical activities. Here we note a few aspects of HiTOP's utility.

Breaking psychopathology down into tiers of dimensions enables investigators to pinpoint the exact level(s) of the hierarchy that contribute meaningfully to clinical outcomes. A classic problem with using DSM diagnoses is that diagnostic comorbidity and heterogeneity make it virtually impossible to decide what part of patients' symptomatology is "driving" an observed effect. HiTOP makes this problem much more tractable by explicitly differentiating spectra, syndromes, symptom components, and so on, that could be behind an association, such as the effect of social phobia on peer relationships. Now it is possible to empirically test, rather than assume, whether peer relationship dysfunction is attributable to individual differences on (1) a broad internalizing spectrum; (2) fear and/or distress subfactors; (3) syndromes such as social anxiety, depression, generalized anxiety; (4) symptom components such as social avoidance, anhedonia, irritability; or (5) some combination thereof. This nuance has the potential to significantly advance clinical theory and research design.

In the clinic, HiTOP can provide a much more detailed description of a patient's symptom presentation. The HiTOP system makes it possible to assess a full range of symptom components and maladaptive traits that are relevant to the patient's presenting complaint, rather than being restricted by one diagnosis (or a handful of related problems, such as substance use disorders) (Ruggero et al., 2019). Also, dimensions carry more information than binaries, meaning clinicians have a stronger sense of where a patient falls relative to clinical and community norms than when they make a binary diagnostic assessment (Markon et al., 2011).

Dimensions have other advantages, including more accurate progress monitoring. Compared to deciding whether a patient does versus does not have a condition, monitoring dimensional scores is a much more reliable and sensitive way to track progress through treatment (Rodriguez-Seijas et al., 2015). Studies show that dimensional thinking also improves prognostic decisions and judgments regarding patients' risk for psychosocial dysfunction and suicidality (e.g., Eaton et al., 2013).

Beyond these "tangible" benefits, possibly the biggest upside of transitioning to HiTOP is that it puts clinical psychology on stronger scientific footing. HiTOP is an attempt to frame the constructs we use in research and clinical work around the best available evidence, which has not always been possible in the DSM development process (cf. Kendler & Solomon, 2016). This guiding

María A. Larrazabal

principle should boost the field's credibility and the validity of nosology, etiological research, and intervention programs going forward.

How much should I invest?

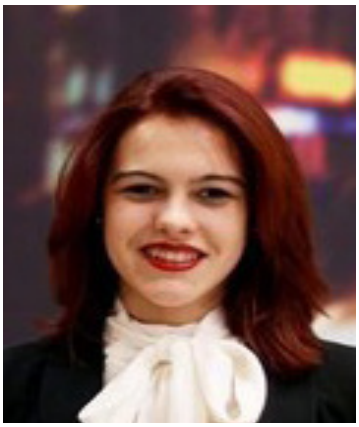
Over the history of clinical psychology, there have been regular attempts to think outside the DSM, but none have become widely adopted. The NIMH's Research Domain Criteria (RDoC) initiative is a possible exception (Insel et al., 2010), although the jury is still out on how much of an impact RDoC will make for most clinical psychologists, and former NIMH director Thomas Insel is on record saying that RDoC-oriented research failed to move the needle field-wide during his tenure (Rogers, 2017). So it is natural to wonder about HiTOP's significance and durability.

At the same time, there are reasons for optimism. Right now there seems to be a surge of interest in transdiagnostic approaches to psychopathology. The original research article presenting the HiTOP model has been cited over 1,000 times, according to Google Scholar, in about three years (Kotov et al., 2017). Enthusiasm seems to transcend the research-clinical divide, as well. Treatments that cut across DSM diagnostic categories are building momentum (Dalgleish et al., 2020). The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders is leading the way with compelling efficacy data (Barlow et al., 2017).

Some key organizational bodies are backing this trend. The NIMH swore off DSM categories in their RDoC-based strategic plan, which concentrates instead on continuously distributed biological mechanisms that relate to mental health (https://www.nimh.nih.gov/about/strategic-planning-reports/2020_nimh_strategic_plan_508_160162.pdf). The American Psychiatric Association has incorporated new dimensional elements into DSM-5 (e.g., ordinal ratings of substance use disorder severity), albeit to a smaller extent than was forecasted (Kupfer et al., 2002). The World Health Organization overhauled the personality disorder diagnosis in ICD-11 to align with a dimensional, hierarchical view of this domain, similar to the Alternative Model of Personality Disorder housed in DSM-5 Section III (Tyrer et al., 2019).

We view HiTOP as a good investment. It has decades of data behind it, and it aligns with a growing field-wide movement away from DSM categories toward more evidence-based options. Psychologists can test it out for themselves to see how it improves theory, research, and practice in their local context. We turn to suggestions for practical implementation in the next section.

We close this section with a metaphor that might help to understand the pros and cons of pursuing HiTOP. We think the decision between DSM and HiTOP is akin to the tension many psychologists feel when deciding whether to continue using SPSS (or similar programs with point-and-click interfaces) or make the switch to R (or another open-source, code-based software). SPSS's point-and-click menu is familiar but it arguably limits the control the analyst has over the project. In the same way, most of us are trained to understand psychopathology through DSM's lens, but this perspective may not be the most valid representation of mental health problems.



Maria Martin Lopez

How do I "do" HiTOP?

HiTOP dimensions can take the place of DSM categories in most research and clinical scenarios. The simplest way to incorporate these into your work is to measure them directly using HiTOP-consistent measurement instruments (Stanton, McDonnell, Hayden, & Watson, 2020). Kotov et al.'s (2017) Table 1 presents a thorough list of such assessment tools, which were generally developed via factor analysis of symptoms in a particular domain (e.g., psychosis, personality disorder). Most of the ones Kotov et al. recommend reflect the hierarchical nature of these domains, such that there are separate scales that tap into broad versus specific features. These measures generally also have published norms so assessors can characterize a particular patient or sample relative to relevant populations.

The Achenbach System of Empirically Based Assessment (ASEBA) measures for youth will be a familiar example for most tCP readers (Achenbach & Rescorla, 2001). This tool gathers information on internalizing and externalizing dimensions, as well as more fine-grain aspects of each of these domains. For instance, internalizing scores can be broken down into narrower components: anxiety, depression, social withdrawal, and somatic complaints without apparent medical cause.

Alexander L. Williams

Another measure we use often in our own work is the Inventory of Depression and Anxiety Symptoms (IDAS-II; Watson et al., 2012). Whereas the Beck Depression Inventory (BDI), Physician Health Questionnaire (PHQ-9), and other widely used scales lump different aspects of depression and anxiety into a single sum score, the IDAS-II separates the broad and specific components of emotional disorders so that they can be evaluated separately (Watson et al., 2007). For those interested in the cross-cutting features of anxiety and depression, the Dysphoria and General Depression scales capture the nonspecific aspects of this domain. If more precision is required, one can administer all (or a subset of) 17 lower-order scales (e.g., Panic, Social Anxiety, Traumatic Intrusions, and Insomnia) to describe symptom components and maladaptive traits in HiTOP's internalizing spectrum.

Kotov et al.'s (2017) list of HiTOP-conformant measures—which can also be found at https://hitop.unt.edu/clinical-tools/hitop-friendly-measures—are ready to use now, but they each cover just a fraction of the universe of mental health problems. A more comprehensive assessment form for the HiTOP model is now under development. A forthcoming special issue of the journal Assessment will detail the progress HiTOP's Measures Development Workgroup has made in generating and testing items that tap into the various components of the HiTOP structure. Until this measure is fully developed, assessments that aim to cover a lot of terrain must be done piecemeal.

The higher-order (i.e., broader) components of mental disorder can also "get into your dataset" via factor analysis, a statistical technique that is designed to detect the common thread(s) running through a set of observed variables (e.g., questionnaire responses, interviewer ratings) (see Conway, 2020, for a very brief introduction that invokes some HiTOP themes). This has been a mainstay of the HiTOP literature so far. Using narrower psychopathology variables as input, factor analysis can delineate the broader dimensions that account for patterns of covariance (e.g., factor analyses of ASEBA data established that the internalizing dimension provides a good explanation for the overlap among anxiety, depression, social withdrawal, and somatic complaints). The broad and specific components of some domain, parsed by factor analysis, can then be related to risk factors and clinical outcomes of interest. Over the past five to ten years, this has become a common practice in etiological research and is just beginning to be applied in clinical settings (see Conway, Snorrason et al., 2021, for an example).

How do I learn more?

This article is intended as a quick summary. For readers who want to know more, we suggest some ways to get started in this section. We also describe the structure of the HiTOP Consortium and opportunities to get involved.

There are a number of general introductions to the HiTOP system, including the Consortium's original publication in *Journal of Abnormal Psychology* (Kotov et al., 2017). Recent Consortium-led reviews in *World Psychiatry* (Krueger et al., 2018) and the *Annual Review of Clinical Psychology* (Kotov et al., 2021) also outline the model's development, scope, and promise. For people who are just getting to know HiTOP, we recommend an in-press article in *Current Directions in Psychological Science* (Conway, Krueger, & the HiTOP Consortium Executive Board, 2021), which spells out the philosophy and application of the HiTOP model for a general audience.

The HiTOP Consortium contains several workgroups (WGs) that concentrate on developing specific aspects of the model. Most of the WGs have published reviews of the evidence in their particular areas. The Utility WG described how to use the model to improve theory and inferences in psychological research (Conway et al., 2019). It also is working on a tutorial paper that walks readers through several examples, using publicly available data and code, of typical applications of the HiTOP model in clinical psychological research (Conway, Forbes et al., 2020). This paper is not yet published, but the Open Science Framework link in our reference section will take you to the preprint, data, and code.

The Genetics (Waszczuk et al. 2020) and Neurobiological Foundations (Latzman, DeYoung, & HiTOP Neurobiological Foundations WG, 2019) WGs described how the HiTOP model advances biological research, an area that for years has been chafing against the constraints of DSM diagnosis. The Personality WG outlined how personality—which is itself hierarchically oriented—interfaces with a hierarchical model of psychopathology (Widiger et al., 2019). Finally, particularly relevant to clinical psychologists, the Clinical Translation WG explained how the HiTOP model could transform clinical assessment and psychotherapy development, and how the HiTOP model can be put into practice now (including a case example) (Ruggero et al., 2019).

People who would like to get involved with the Consortium are invited to visit its website, where

there is a page with instructions on how to get in touch (https://renaissance.stonybrookmedicine.edu/HITOP/GetInvolved). Right now, there are two entry requirements: (1) a doctoral degree; and (2) a record of publishing "HiTOP-conformant research," which basically means any work connected to the dimensional and/or hierarchical structure of psychopathology. We note that these eligibility criteria may change in the near future. The first author (CCC), who is part of HiTOP's Executive Board, is happy to respond to emails about membership questions (or other aspects of the Consortium and its activity).

Caveats

Despite the weight of evidence behind it, HiTOP remains a work in progress, and not everyone agrees that it is ready for prime time. Recent issues of the journal *World Psychiatry* (October 2018 and February 2021) are good places to find critical appraisals of HiTOP's potential. We touch on some of the most important points here.

HiTOP does not yet cover some aspects of mental disorders that should be part of a comprehensive nosology. Several neurodevelopmental and neurocognitive conditions, for example, are not yet incorporated into the model (Kotov et al., 2021). Also, much of the Consortium's work thus far has been on symptom covariation on a between-person level; there has been very little work into symptom structure and dynamics within people, which arguably is a more important level of analysis from a clinical perspective (e.g., Wright & Woods, 2020). Some argue that factor analysis—with its assumption that latent dimensions are the common cause of observed symptoms/diagnoses—is not the ideal way to understand the structure of psychopathology (Borsboom, 2017), although others contend that latent dimensions can be useful ways to summarize symptom information regardless of their causal status (see Jonas & Markon, 2016). One could also argue that HiTOP does not convey information about biological bases of mental illness, which will continue to be a major focus of psychiatry and certain sectors of clinical psychology (Lahey et al., 2021). Recent efforts have been made, however, to describe the interface between HiTOP and RDoC, and how these two systems meaningfully complement one another (Michelini et al., 2020; see also Table 1 in Conway, Forbes et al., 2019).

Much of the criticism for HiTOP thus far has revolved around clinical implementation. Some observers believe that unfamiliarity of the model and incompatibility with current billing and insurance systems could be insurmountable practical problems (Tyrer, 2018; Zimmerman, 2021). It will unavoidably be difficult to break into the clinical landscape and mental health training programs (ranging from undergraduate courses to clinical internships), which are so thoroughly dominated by DSM, but there are some encouraging signs in recent research: practitioners tend to find dimensional rubrics like HiTOP to be clinically useful and, in many ways, prefer it to DSM's categorical model (Hopwood et al., 2020; Widiger & Mullins-Sweatt, 2010). The fact remains, though, that compelling evidence of clinical utility (e.g., ease of use, improved patient outcomes) will be needed to sway the clinical and training communities.

Conclusion

HiTOP is a more valid, scientifically tenable classification system than DSM. But the jury is still out regarding whether it will win over the professional community. We hope this article prompts clinical psychologists to consider how HiTOP can make valuable additions in their own research and clinical contexts.

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Ethical Considerations for Psychologists Looking to Offer Coaching Services

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COVID-19 has affected mental health practitioners and their practices in unanticipated ways. Many psychologists have adopted telehealth services and may be considering leveraging this new method of working with clients to add services to their existing practices to make themselves more marketable, accessible and – frankly – to pay the bills. One such service many psychologists may be considering is coaching.

At first glance, there appear to be several similarities between coaching and therapy. In many ways coaching and consulting have been long-standing components of psychology (Gebhardt, 2016). Life coaching is an ever-expanding area which originates from the desire to effect change in one's life. In order for us to delve into this conversation, first establishing some differences between coaching and psychotherapy may be helpful. One focus of coaching, according to the TRUST Risk Management Sample Coaching Document (https://parmastaging.trustinsurance.com/Portals/0/adam/Content/TQU3Dgx97k-xSlVJoOfE-A/File/Sample%20Coaching%20Contract.doc), is on the "development and implementation of strategies to reach client-identified goals of enhanced performance and personal satisfaction." Coaching may address issues like life balance or job performance. Psychotherapy, on the other hand, is focused on the identification, diagnosis, and treatment of mental and nervous symptoms and disorders. Our goal in therapy is often to alleviate or resolve symptoms and understand their origins.

Coaching is often seen as an unregulated practice (except in a few states; Aboujaoude, 2020; Anderson et al., 2012; Harris, 2019). Concerns amongst psychologists and some state psychology boards have been noted about the overlap between coaching and therapy services and the extent to which some may use the term "coaching" in an effort to avoid being subject to state board rules and regulations. Below we highlight some important ethical and practical considerations for psychologists who offer or who are considering offering coaching services.

Coaching vs. Therapy: Clarifying Roles and Expectations

As Aboujaoude (2020) points out, the line where coaching ends and where therapy begins is increasingly blurry. Both have a goal of helping and improving one's functioning but at point are coaching strategies also psychotherapy techniques? Clients might also be confused about the differences between a coaching and psychotherapy experience so providing explicit information at the outset is necessary to avoid confusion. A coaching contract (although analogous to informed consent, it may be helpful to further separate coaching and therapy services by calling only your psychotherapy consent "informed consent" and your coaching consent a "contract") should attempt to clarify to clients information about the goals of the service, expected risks and benefits, practice policies, fees and financial arrangements, confidentiality, and an explanation of what coaching is and how it differs from psychotherapy. -See TrustPARMA for a sample coaching contract (https://parma.trustinsurance.com/Resources/Articles/sample-coaching-contract).

While clinical psychologists have training in assessing and treating mental disorders, it may also be helpful for clinicians to delineate between areas of focus appropriate for psychotherapy and those appropriate for coaching. For example, clients responding to a psychologist advertisement for executive coaching for generalized anxiety may be confused in terms of the nature and focus of services (Aboujaoude, 2020).

Competence

Psychologists who are considering offering coaching services should also ensure that they have appropriate training. Specifically, 2.01 (a) Boundaries of Competence states, "Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2017). Several authors (e.g., Aboujaoude, 2020; Gebhardt, 2016) have noted that this may not be as clear cut in terms of coaching. While there are some training programs for coaches, it is not clear if there are standards for training that are accepted across all coaching professionals. In addition to core coaching tenets and strategies, psychologists should also determine their competencies to coach in specific areas (Harris, 2019). For example, a psychologist who would like to offer career coaching services should be able to demonstrate the requisite training, education and/or supervised experience in terms of career fit and development.

Multiple Relationships and Jurisdiction

Many believe it is unethical to serve as coach and psychologist either at the same time or in different periods of time (see APA Ethics Code (2017) Standard 3.05 Multiple Relationships). Anderson, Williams,

and Kramer (2012) noted, "As psychologists work to understand what services clients need, they need to stay true to the original role established when they initially contracted with the clients or completed the informed consent process" (p. 175).

As noted above, it can sometimes be difficult to determine where therapy ends and coaching begins in certain cases (Aboujaoude, 2020). For psychologists offering coaching services, this distinction can have important implications for practice in terms of the psychologist's role, especially when coaching clients reside in other states. There have been cases where psychologists have changed their role from "therapist" to "coach" with clients who moved to different states in order to circumvent state licensing rules. While some therapists may offer a rationale that this change maintains a continuity care and is in the patients' best interests, state licensing boards may not be sympathetic.

Fees and Financial Arrangements

Coaching services can be lucrative for psychologists and there are several different fee models that are used (Gebhardt, 2016). Psychologists who offer coaching services, however, should be aware of possible ethical conflicts in terms of fees and financial arrangements. Coaching is separate from psychotherapy and should not be billed as such. These are important rules to let clients know up front; there have been cases where clients who no longer can pay out-of-pocket for services have asked sympathetic therapists to bill their or a family member's insurance or provide a superbill for them to be reimbursed using service and diagnostic codes specific to mental health services. These types of deceptive activities can lead to serious consequences for the psychologist, no matter how well-meaning the therapist (see APA Ethics Code 2017, Standards 6.04 Fees and Financial Arrangements and 6.06 Accuracy in Reports to Payors and Funding Sources).

Confidentiality

Psychologists who are planning to offer coaching services should also consider confidentiality procedures, their reporting requirements (which are often state-specific) and how they will communicate these policies with clients (Gebhardt, 2016). In many states, mandatory reporting laws are attached to the professional rather than the specific activity; therefore, psychologists engaging in coaching activities may still be considered mandatory reporters, even though they are not in a psychotherapy or psychological assessment role.

Some coaching relationships may be paid by employers or organizations. In these situations, it should be made clear who has access to coaching session files (including notes) and under which circumstances (if any) a third party may access the records. For example, an organization paying for coaching services for employees may demand that a psychologist turn over records or have monthly meetings to discuss employee progress. Psychologists should determine before-hand what the policies will be and ensure that clients/patients consent to such disclosures.

Practical Considerations

Harris (2019) offers an excellent detailed discussion of some practical issues to consider for psychologists who are interested in offering coaching services. Some of these include:

Where to Practice: Office-based psychotherapy is generally limited to the state of licensure (multi-state licensure aside). However, what about telehealth and the ability to practice (virtually) anywhere? Most psychologists understand that they cannot just set up a professional psychology practice in any state of their choosing but the boundaries for coaching are somewhat unclear. Psychologists should check with state boards and possibly their malpractice carrier to determine whether they may be able to offer coaching services in other states. On a related note, psychologists should confirm whether their professional malpractice policy provides coverage for coaching services (Harris, 2019).

Documentation and Record-keeping: What types of records should you keep for coaching? Documentation for coaching will likely be different from psychotherapy paperwork but should include sufficient information to be able to understand what was happening during coaching sessions, demonstrate competence, and document risk and risk-minimizing procedures. Others have recommended that psychologists look at their documentation and determine whether the types of records kept are so close to psychotherapy records (e.g., treatment plan, diagnosis) that it could be inferred that you are practicing psychotherapy. For example, if notes and paperwork are kept on the same Electronic Health Record (EHR) system as psychotherapy notes, is there a chance that the relationship and activity could be seen as psychotherapy instead of coaching?

Screening and Accepting Clients: How will you determine whether a prospective client is appropriate for coaching? How do you determine whether underlying mental health issues may impact a coaching relationship or whether these may be primary problems for a client? A client with significant mental health problems who is not receiving related treatment may not be an ideal coaching client, as coaching meetings may quickly turn into therapy sessions. One ethical consideration is how similar is the complaint/ issue the client is presenting for coaching to the subject matter that would typically be addressed through psychotherapy? Psychologists may consider limiting coaching to specific focus areas that do not overlap with mental health treatment, such

as career enhancement. It may also be helpful to assess the power differential in the relationship; Harris (2019) points out that the closer to psychotherapy the relationship is, the higher the power differential. Finally, how are you identifying your high-risk clients? The higher risk coaching client may be more likely to have problems similar to those seen in psychotherapy.

Planning and Consultation: It may be helpful to develop a plan in the event a coaching client needs psychotherapy services at some point either in addition to or instead of coaching services or when problems may arise in the coaching-client relationship. In general, consultation with colleagues may be very helpful to address possible ethical and/or risk situations; psychologists offering coaching services should consider developing a network of professionals who are familiar with coaching and related issues.

Conclusion

Careful consideration of the similarities and differences between coaching and psychotherapy practices is an important component of ethical planning and risk management. Offering coaching services to augment a therapy practice may be appealing for several reasons. Caution, however, is warranted when the psychologist who uses the term "coaching" in order to extend psychotherapy relationships outside of the bounds of regulation or licensure. It is clear that jurisdictional boards and professional associations will need to weigh in on with practice suggestions and guidelines as there is potential for complaint from "clients" (be they coaching or therapy).

Because the lines between therapy and coaching are not always clear, psychologists who are considering offering coaching services need to be careful that their services are not simply psychotherapy under a different title. In the end, we recognize Harris (2019) for his excellent contributions in this area and second his "duck" analogy. The substance of your practices and policies may hold more weight to a licensing board than whether the professional labels it "coaching" or something else; as Harris states, "…if it waddles, quacks, and swims like a duck, it will be treated like a duck, even if you are calling it an elephant" (Harris, 2019, p. 6). Our hope is that this article provides psychologists with an overview of some of the tricky ethical issues that may arise in offering coaching services and will inform decisions to protect themselves and the welfare of those with whom they work.

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CE News: Society of Clinical Psychology Teams with the National Institutes of Health Science of Behavior Change Program

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On behalf of the Society for Clinical Psychology CE Committee, I am very pleased to announce that our Division has established a new liaison with the National Institutes of Health (NIH) Science of Behavior Change (SOBC) program. The NIH SOBC program is devoted to improving understanding of human behavior change across a broad range of health-related behaviors. The core mission of SOBC is to bring basic, clinical, and translational scientists across disciplines together to identify the underlying neural, cognitive, affective, interpersonal, and environmental mechanisms that bring about behavior change. The NIH SOBC has proposed a rigorous experimental medicine approach to serve as the framework for identifying the mechanisms that drive behavior change and for communicating scientific advances across disciplines.

What is our new SCP association with the NIH SOBC? We are joining with the SOBC to aid their goal of communicating scientific advances as well as the frame of inquiry that is represented by the experimental medicine approach. Through our CE program we are targeting this communication to psychologists in general and to our SCP members in particular. Specifically, we have become the CE provider for the NIH SOBC grand round and speaker series. In addition to state-of-the-art information on research and clinical advances, one task for the SOBC is to change how we think about clinical science, and the core importance of understanding the mechanisms behind treatments – addressing the question of why treatments lead to beneficial effects. Indeed, the SOBC Resource and Coordinating Center offers resources to facilitate the investigation of treatment mechanisms and the development of new mechanisms through a process of: (1) identifying hypothesized mechanisms of behavior change, (2) developing reliable measures of those mechanisms, (3) conducting experiments to influence those mechanisms, and/or (4) testing whether influencing a hypothesized mechanism indeed yields behavior change. All clinical scientists interested in viewing, downloading, or contributing measures for use in behavioral science, or related fields, should visit the SOBC Repository (https://measures.scienceofbehaviorchange.org/). Also, as is often apparent in NIH grant applications, use of an experimental medicine approach is encouraged or required across a wide range of NIH Institutes for clinical research (see https://commonfund.nih.gov/behaviorchange/related).

In sum, we welcome this tighter relationship between NIH SOBC and the SCP and we look forward to including their excellent programming in our CE offerings. The first of these CE presentations came on-line for us on January 6, 2021, with a very timely webinar on the "Roles for Behavioral Science in COVID-19 Vaccination Efforts." As a reminder, all SCP members now access to our CE program for free. Please make use of this excellent benefit of being an SCP member! ■

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SCP Member Spotlight on Thomas G. Plante, Ph.D., ABPP

Please provide an overview of your work

Although much of my early career was focused on clinical health psychology (e.g., eating disorders, anxiety disorders, and the psychological and health benefits of aerobic exercise), in more recent decades my work has shifted to the clinical integration of psychology and religion/spirituality. I do psychological evaluations and treatment for Catholic, Episcopal, and Orthodox clerics and clerical applicants, serve on a variety of local and national committees for child protection in the Catholic Church, and am perhaps most known for my clinical, research, and consultative work with clerical sex offenders and their victims, as well as screening applicants for seminary and religious life. Additionally, I teach and write a great deal on professional and personal ethics.

I am primarily a college professor teaching undergraduates at Santa Clara University, but also teach in psychiatry at Stanford University and maintain a small private practice in Menlo Park, California.

Where did you complete your training?

I graduated with an undergraduate psychology degree from Brown University and earned my PhD in clinical psychology from the University of Kansas. I did my clinical internship and postdoctoral fellowship at Yale University.

What is your current position/occupation?

I am the Augustin Cardinal Bea, S.J. University Professor, professor of psychology, and by courtesy, religious studies, at Santa Clara University and direct the Applied Spirituality Institute there. I am also a scholar in residence at the Markkula Center for Applied Ethics at Santa Clara and chair the university's IRB committee. Additionally, I am an adjunct clinical professor in psychiatry and behavioral sciences at Stanford University School of Medicine where I teach ethics and professional issues for child clinical psychology interns. I am also the editor-in-chief of the APA journal, Spirituality in Clinical Practice.

Can you describe the ways that your career has taken shape over time? How did you get to where you are today?

No matter how thoughtful, careful, and planful you might be, life so often takes you in unexpected directions. Since I am from Rhode Island, I assumed that I would settle in Rhode Island and work in behavioral medicine somehow affiliated with my alma mater, Brown University. I ended up teaching at Santa Clara and Stanford Universities and having a small private practice in northern California where my wife, Lori, is from. Lori and I were fellow clinical psychology graduate students at Kansas and I ultimately followed her back to California after training. Once in California, I worked full time in psychiatry at Stanford, but being a psychologist in a psychiatry department at Stanford had many career advancement limitations. That led me to move to the Children's Health Council where I was chief psychologist and director of mental health services. A friend of mine who is a Jesuit priest and clinical psychologist on faculty at Santa Clara at the time encouraged me to apply for a tenure-track faculty position there. I did and it has been one of the very best professional decisions of my career as I have been happily there for 27 years and love teaching undergraduates in an engaging and friendly Jesuit university.

Thomas Plante, Ph.D., ABPP

How long have you been a member of SCP? Please indicate any past or present roles in SCP (e.g., leadership, committees, task forces, etc.)?

I have been a member of SCP since about 1990. I have not had a leadership position recently but would be happy to get more involved!

Please describe any roles you have with APA or other national, state, or local organizations.

I am on APA's Council of Representatives (Representing Division 36, i.e., the religion and spirituality division) and the Council's Leadership Team. I have also been the Council's "civility ambassador" and chaired APA's civility working group to help psychologists effectively engage with one another as a profession.

I have also been vice chair of the national review board for the US Conference of Catholic Bishops working on policies and procedures for child protection in the Church. I am on similar regional and local committees on child protection for the Jesuits and for the Diocese of San Jose.