Chapter 6

COMPETENCE, HUMILITY, AND THE HUMAN THERAPIST

When patients seek our services, they hope we know how to help them. Ethical practice hinges on competence, including our ability to use our skills effectively to help our clients heal and cope with the challenges they face. Society gives us the power and privileges to help our clients, while holding us accountable for competence through the courts and licensing boards.

Cynthia Belar (2009) discusses our ethical responsibility to train competent psychologists and to maintain our own competence as our "social contract." She emphasizes that a central question for our training programs

> is whether we are producing what we say we are producing—a psychologist competent for entry to practice. This question comes from prospective students, prospective employers, and the public. Indeed our social contract with the public as an independent profession requires that we self-regulate in these matters (p. S63).

The importance of that social contract was emphasized by The European Association of Clinical Psychology and Psychological Treatment (EACLIPT) Task Force on *Competences of Clinical Psychologists* (2019): "Politicians, societies, stakeholders, health care systems, patients, their relatives, their employers, and the general population need to know what they can expect from clinical psychologists" (p. 1).

Some patients may expect magic. For them, competence means that we can guarantee results, act flawlessly, and meet all needs. While this superhero, shero, or theyro role can be tempting, and some of us find it difficult to turn down potential worshippers, it is not realistic. We don't have a magic wand that can disappear our clients' distress, pain, and difficulties. Unfortunately some therapists indulge their ego and take up residence in this delusional state.

This chapter is a reminder that as therapists, we are all human and imperfect. We all have weaknesses, blind spots, and biases, as well as strengths, abilities, and insights. Hence, it is important for us to keep a healthy dose of humility.

Failures of competence often spring from our human vulnerabilities. We face temptations, pressures, distractions, demands, and countless other forces. These forces can weaken our ability to know the limits of our competence and can sometimes block our ability to act effectively altogether. Consider, for example, the ways in which we have been socialized to respond to members of various groups. Unless challenged, this socialization affects our attitudes, beliefs, biases, and prejudices which may impact our competence to provide therapy or counseling to members of diverse groups. In addition, each of us has our own personal history, individual experiences, and an array of group-based reactions which can also impact our competence. See if the following self-assessment turns up any challenges to competence for you.

Imagine you are in your office and a new patient walks in. Set aside for the moment whether you have training to work with a member of the group. Focus only on whether the patient's membership in a specific group evokes any reactions in you that might weaken your competence to welcome, become interested in, listen openly to, empathize with, and create a positive working relationship with them. Also, consider how you may respond if you are a member of a social group that has a history of being harmed by the new client's social group (Chapters 7 and 23 provide more discussion). The array of patients you meet may include:

- A rich, young White man dressed in designer clothing and speaking in a condescending tone of voice.
- An extremely aggressive malpractice attorney who rarely loses a case, specializes in suing clinicians, and wins large judgments.
- A heavily tattooed teenager gang member with an accent, dressed in baggy pants that fall underneath his buttocks.
- A Black woman who is richer, more professionally successful, and personally happier that you ever hoped you could be and whose minor problem, which brought her to seek therapy, is one you've had for a long time and have been unable to overcome no matter what you tried.
- A member of US Immigration and Customs Enforcement (ICE) who comes dressed in uniform.
- A leader of the anti-choice movement who is deeply religious.

- A man who owns a string of "massage" parlors, which are occasionally raided by the police, resulting in the arrest of the young women who work there (but not their customers).
- A very successful political operative who opposes your most cherished values in the areas of social justice, human rights, and human well-being.
- Someone who uses racial slurs in therapy and sees that as freedom of speech and authenticity of self-expression.
- A gay-rights activist.
- A migrant worker who speaks English with an accent that is difficult for you to understand.
- A famous movie star.
- A man who has not bathed in a while because he lost his job and his water was cut off for nonpayment. He has an extremely strong body odor.
- A man under court order to seek therapy because he beats his wife.
- An animal-rights activist who breaks into research labs to free the animals.
- A physician whose specialty is performing abortions.
- A gun rights activist who carries a gun where open-carry laws allow but who also has a permit to carry a concealed weapon—He's coming to you because others keep telling him he has an anger problem and poor impulse control.
- A therapist who specializes in conversion or reparative therapy.
- An orthodox Jew.
- A wealthy White woman who has had several plastic surgery procedures on her face who wants you to change all of your other appointments to accommodate her busy schedule.
- A Catholic priest.
- A devout Muslim woman who wears a full burka.
- A medical researcher whose experiments on dogs involve inducing disabling pathologies, painful surgeries, and death within a matter of months.
- Someone who believes in the intellectual, cultural, and moral superiority of their race.
- A Black academician who is seeking mental health services to address the racism he experiences at work.
- A gender expansive Filipino who uses they pronouns.

How did you do? Turn up any potential challenges to competence? Achieving awareness of these challenges puts us in a better position to handle them carefully, knowledgeably, and ethically, and to approach each situation with humility.

Our own values and experiences as members of different groups contribute to our biases, blind spots, and other limitations. Our ethical awareness depends on us becoming aware of these limitations. Despite our best efforts to spot

problem areas, some of these challenges may stay hidden from our awareness for quite a while yet manifenst themselves in our moment to moment interactions with our patients, supervisees, mentees, and colleagues. We may pride ourselves on our lack of biases toward certain groups and yet our behaviors may seem somehow "off." Others may view what we say or do in regard to members of that group as avoidant, passive-aggressive, subtly hostile (words and behaviors sometimes termed "microaggressions"), or more openly biased—all of which may escape our attention. In addition, we may be well aware of the biases and prejudices that we have toward particular groups, but we may excuse them or view them as valid.

One tipoff that we may need to examine our competence to work with a particular group is if we talk about members of that group differently when they are present than when they are not within earshot. This difference in behavior, depending on whether members of a group are present, can be much more subtle than simply telling certain jokes, imitating accents, making generalizations about the group, and the like.

The theme of blind spots and biases affecting our competence on the individual level runs throughout this book and is a focus of Chapters 7 and 23—but a parallel theme is the way they affect the competence of organizations. For example, think of the different clinics, hospitals, and other agencies you've been to. Imagine the array of patients listed above each entering that agency, walking to the reception desk, and asking about getting help there. To what extent do you think each person would actually *feel* welcomed and get the help they need?

The opening chapters of this book rejected views of ethics as rigid rule following and presented an approach in which professional codes, administrative directives, legislative requirements, and other givens mark the start of a process of creative questioning and critical thinking. We search for the most ethical and positive way to respond to each unique patient with unique needs and resources in a unique context.

We carry on this creative questioning and critical thinking with a sense of humility as fallible human beings, vulnerable to fatigue, discouragement, frustration, anger, fear, and feeling overwhelmed. Our work depends on not just intellectual competence (knowing about and knowing how) but also what might be called *emotional competence for therapy* (Pope & Brown, 1996).

COMPETENCE AS AN ETHICAL AND LEGAL RESPONSIBILITY

Competence is hard to define. Licensing boards and civil courts sometimes specify defining criteria for areas of practice. More often, they require only that in whatever area of therapy and counseling the clinician is practicing,

they should possess demonstrable competence. Demonstrable competence requires clinicians to produce evidence of their abilities. Usually this evidence comes from formal education, professional training, and supervised experience, followed by continuing education.

A competence requirement often appears in ethical, legal, and professional standards. Here are some examples:

- Section 1396, of California Title 16 states: "A psychologist shall not function outside his or her particular field or fields of competence as established by his or her education, training and experience."
- Ethical Standard 2.01a of the APA's "Ethical Principles of Psychologists and Code of Conduct" (2017a) 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."
- The Canadian Code of Ethics for Psychologists (CPA, 2017a) states that "psychologists recognize the need for competence and self-knowledge. They consider incompetent action to be unethical in itself, as it is unlikely to be of benefit and likely to be harmful. They engage only in those activities in which they have competence or for which they are receiving supervision, and they perform their activities as competently as possible" (p. 18).
- The American Counseling Association (2014) ACA Code of Ethics states: "Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (p. 8). It also states that "multicultural counseling competency is required across all counseling specialties" and that "counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population" (p. 8).
- APA's (2017a) *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* states: "It is important to note that, for the purposes of the *Multicultural Guidelines*, cultural competence does not refer to a process that ends simply because the psychologist is deemed competent. Rather, cultural competence incorporates the role of cultural humility whereby cultural competence is considered a lifelong process of reflection and commitment" (Hook & Watkins, 2015; Waters & Asbill, 2013). This current iteration of the *Multicultural Guidelines* also recognizes the contributions of other culturally competent models of practice such as the American Counseling Association's (ACA) *Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession* (Ratts et al., 2016); the American Psychiatric

Association's *Cultural Formulation Interview* (American Psychiatric Association, 2013), and the *Standards and Indicators for Cultural Competence in Social Work Practice* (National Association of Social Workers, 2015, pp. 8–9).

The ethical requirement of competence recognizes that the therapist's power and influence (see Chapter 5) should not be handled in a careless, ignorant, and thoughtless manner. The complex, hard-to-define nature of therapy tends to cloud why this requirement makes sense. It becomes clearer by analogy to other fields. A physician who is an internist or general practitioner may do excellent work, but would any of us want that physician to perform coronary surgery or neurosurgery on us if they did not have adequate education, training, and supervised experience in these forms of surgery? A skilled professor of linguistics may have a solid grasp of a variety of Indo-European languages and dialects but be completely unable to translate a Swahili text.

COMPETENCE AND CONFLICT

Pulled by patients holding exaggerated beliefs about our abilities and pushed by our own impulse to step in and help, our humility may fail us and we may resist admitting to ourselves and the client that we lack competence for a particular situation. We may need new clients to pay the bills and fear shutting off a valued referral source. Managed care may require us to take the patient. Nevertheless, extensive education, training, and supervised experience in working with adults does not qualify us to work with children; solid competence in providing individual therapy does not qualify us to lead a therapy group; and expertise in working with people who are profoundly depressed does not qualify us to work with people who have developmental disabilities.

At times, complex situations require great care to determine how to respond to a client's needs while staying within our areas of competence. For example, a counselor may begin working with a client on issues related to depression, an area in which the counselor has had considerable education, training, and supervised experience. Much later the therapeutic journey leads into a problem area—bulimia—for which the counselor has little or no competence.

Alternatively, a client starts meeting with a counselor to deal with problems concentrating at work. Soon, the client says they suffer from agoraphobia. Can the counselor ethically assume that the course on anxieties and phobias that they took 10 years ago in graduate school makes them competent? The counselor must decide whether they have the time, energy, and interest in gaining competence through continuing education, study, or consultation to provide up-to-date treatment for agoraphobia or whether they need to refer the client or find some other way for the client to get competent help for agoraphobia.

Clinicians who work in isolated or small and rural communities often face this dilemma. They take workshops, consult long distance with experts, and come up with creative strategies to make sure that their clients receive competent care. Despite the clear ethical and legal mandates to practice only with competence, some of us suffer lapses. A national survey of psychologists, for example, found that almost one-fourth of the respondents indicated that they had practiced outside their area of competence either rarely or occasionally (Pope et al., 1987).

INTELLECTUAL COMPETENCE: KNOWING ABOUT AND KNOWING HOW

Intellectual competence involves one's fund of knowledge or "knowing about." In our graduate training, internships, supervised experience, continuing education, and other contexts, we learn about the research, theories, interventions, and other topics that we need to do our work. We learn to question the information and assess its validity and relevance for different situations and populations. We learn to create and test hypotheses about assessment and interventions. We find ways to keep up with the latest therapy research.

Part of intellectual competence is learning which clinical approaches, strategies, or techniques show evidence or promise of effectiveness and for whom do such techiques work. If clinical methods are to avoid charlatanism, hucksterism, and well-meaning ineffectiveness, they must work (at least some of the time). The practitioner's supposed competence means little if their methods lack competence. In his provocative article *The Scientific Basis of Psychotherapeutic Practice: A Question of Values and Ethics*, Jerry Singer (1980) emphasized the ethical responsibilities of clinicians keeping up with the emerging research basis of the methods they use.

Intellectual competence also means learning what approaches have been shown to be invalid or perhaps even harmful. George Stricker (1992) wrote:

> Although it may not be unethical to practice in the absence of knowledge, it is unethical to practice in the face of knowledge. We all must labor with the absence of affirmative data, but there is no excuse for ignoring contradictory data (p. 544).

Intellectual competence is not frozen in time. David Barlow showed how quickly well-designed research can change our views of which interventions are effective, worthless, or even detrimental. "Stunning developments in health care have occurred during the last several years. Widely accepted health-care strategies have been brought into question by research evidence as not only lacking benefit but also, perhaps, as inducing harm" (Barlow, 2004, p. 869; see also Sue, 2015).

Intellectual competence also means admitting what we do not know. We may know about depression in adults but not depression in kids. We may be familiar with the culture of one Asian population but not others. We may understand the degree to which the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) can assess malingering among criminal defendants but not whether it can identify leadership strengths among job candidates in the tech industry.

Intellectual competence also involves knowing how to do certain clinical tasks. We gain this kind of competence, the development of skills, through carefully supervised experience. We can't learn how to do therapy just by reading a book or sitting in a classroom; therapy is a set of skills that is learned through practice. The APA Ethics Code Standard 2.01c (APA, 2017a) encourages properly trained psychologists planning to provide services new to them to achieve competence in those new services through relevant education, training, supervised experience, consultation, or study. Both the APA Ethics Code (Standard 2.03) and the CPA's Ethics Code (Standards IV.3 and IV.4) recognize that knowledge becomes obsolete and that psychologists don't stop developing and maintaining competence when they become licensed.

EMOTIONAL COMPETENCE FOR THERAPY: KNOWING YOURSELF

Emotional competence for therapy, as described by Pope and Brown (1996), reflects our awareness and respect for ourselves as unique, fallible human beings. It includes self-knowledge, self-acceptance, and self-monitoring. We must know our own emotional strengths and weaknesses, our needs and resources, our abilities and our limits for doing clinical work.

Therapy can stir strong emotions in both therapist and client. Some clinical work places great emotional demands on us. For example, working with people who survive torture can evoke intense reactions that can lead to secondary trauma, despair, helplessness, and burnout (Allden & Nancy Murakami, 2015; Comas-Diaz & Padilla, 1990; Long, 2020; Pope, 2012; Pope & Garcia-Peltoniemi, 1991). To the degree that we are unprepared for the emotional stressors and strains of therapy, our attempts to help may be futile and perhaps even harmful.

Table 6.1 presents research findings about intense emotions experienced in therapy. The numbers indicate the percentage of therapists in each study who reported at least one instance of each behavior. Readers who have had experience as therapists or patients may wish to compare their own experience to these findings.

Therapists, of course, bring something to the work they do. Each of us has a unique personal history. Table 6.2 presents national survey results showing therapists' self-reports of their experiences of various kinds of abuse during childhood, adolescence, and adulthood (Pope & Feldman-Summers, 1992). These results suggest that almost one-third of male therapists and over

Table 6.1. Percentages of Intense Emotions and Other Reactions in Therapy

Behaviors	Study 1[a]	Study 2[b]	Study 3[c]
Crying in the presence of a client	56.5		
Telling a client that you are angry at them	89.7		77.9
Raising your voice at a client because you are angry at them			57.2
Having fantasies that reflect your anger at a client			63.4
Feeling hatred toward a client			31.2
Telling your clients of your disappointment in them	51.9		
Feeling afraid that a client may commit suicide			97.2
Feeling afraid that a client may need clinical resources that are unavailable			86.0
Feeling afraid because a client's condition gets suddenly or seriously worse			90.9
Feeling afraid that your colleagues may be critical of your work with a client			88.1
Feeling afraid that a client may file a formal complaint against you			66.0
Using self-disclosure as a technique	93.3		
Lying on top of or underneath a client			0.4
Cradling or otherwise holding a client in your lap			8.8
Telling a sexual fantasy to a client			6.0
Engaging in sexual fantasy about a client	71.8	28.0*	
Feeling sexually attracted to a client	89.5	87.0	87.3
A client tells you that they are sexually attracted to you			73.3
Feeling sexually aroused while in the presence of a client			57.9
A client seems to become sexually aroused in your presence			48.4
A client seems to have an orgasm in your presence			3.2

[a]A national survey of 1,000 psychologists with a 46% return rate.
[b]A national survey of 585 Division 42 (Psychologists in Independent Practice) members.
[c]A national survey of 600 psychologists with a 48% return rate.

*This question asked about fantasizing about sex with a client while engaging in sex with somebody else.

Source: Study 1 from "Ethics of practice: The beliefs and behaviors of psychologists as therapists," by K.S. Pope, B.G. Tabachnick, and P. Keith-Spiegel, 1987, *American Psychologists, 42*, pp. 993–1006. Study 2 from "Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system," by K.S. Pope, P. Keith-Spiegel, and B.G. Tabachnick, 1986, *American Psychologist, 41*(2), pp. 147–158. Study 3 adapted from "Therapists' anger, hate, fear, and sexual feelings: National survey of therapists' responses, client characteristics, critical events, formal complaints, and training," by K.S. Pope and G.B. Tabachnick, 1993, *Professional Psychology: Research and Practice, 24*, pp. 142–152. Copyright 1986, 1987, 1993 by the American Psychological Association.

Table 6.2. Percentages of Male and Female Therapists Reporting Having Been Abused.

Type of Abuse	Men	Women
Abuse during childhood or adolescence		
Sexual abuse by relative	5.84	21.05
Sexual abuse by teacher	0.73	1.96
Sexual abuse by physician	0.0	1.96
Sexual abuse by therapist	0.0	0.0
Sexual abuse by nonrelative (other than those previously listed)	9.49	16.34
Nonsexual physical abuse	13.14	9.15
At least one of the above	26.28	39.22
Abuse during adulthood		
Sexual harassment	1.46	37.91
Attempted rape	0.73	13.07
Acquaintance rape	0.0	6.54
Stranger rape	0.73	1.31
Nonsexual physical abuse by a spouse or partner	6.57	12.42
Nonsexual physical abuse by an acquaintance	0.0	2.61
Nonsexual physical abuse by a stranger	4.38	7.19
Sexual involvement with a therapist	2.19	4.58
Sexual involvement with a physician	0.0	1.96
At least one of the above	13.87	56.86
Abuse during childhood, adolescence, or adulthood	32.85	69.93

Source: From "National survey of psychologists' sexual and physical abuse history and their evaluation of training and competence in these areas." By K.S. Pope and S. Feldman-Summers, 1992, *Professional Psychology: Research and Practice, 23*, pp. 353–361. Copyright 1992 by the American Psychological Association. Adapted with permission.

two-thirds of female therapists have experienced at least one of these forms of abuse over their lifetimes.

While these experiences may—or may not—affect emotional competence for any of us as individuals, it is important not to assume a one-size-fits-all theory about how forms of abuse (or any other experience) may affect an individual therapist. No research supports the notion that all those who have

a history of abuse are more competent or less competent as therapists, or that those who have no history of abuse are more or less competent as therapists. Each instance must be evaluated on an individual basis, with the full range of available information and without stereotypes. What is key is for us to be aware of how such events affect us and what role, if any, they play in our emotional competence and our ability to respond effectively to clients.

Our work requires continuous awareness to prevent compromised performance, especially when we go through hard or challenging personal times. Chapter 17 discusses common consequences when a therapist or counselor is distressed, drained, or demoralized. These common consequences include disrespecting clients, disrespecting work, making more mistakes, lacking energy, using work to block out unhappiness, pain, and discontent, and losing interest.

Emotional competence includes the process of constantly questioning ourselves. Consider the following: Do the demands of the work we do as therapists, or other factors, suggest that the we need therapy in order to maintain or restore emotional competence? For many of us, creating self-care strategies that fit us as unique individuals and that sustain, replenish, and give meaning are an essential part of our work to maintain competence (see Chapter 17), particularly to maintain "emotional competence for therapy" (Pope & Brown, 1996, Pope, Sonne et al., 2006).

The psychology profession emphasizes the ethical aspects of self-care. General Principle A, Beneficence and Nonmaleficence, and Standard 2.06 of the APA Ethics Code (APA, 2017a) encourage psychologists to be aware of the possible effects of their own physical and mental health on their ability to help those with whom they work. The new proposed General Principle of Beneficence and Nonmaleficence also encourages psychologists to safeguard, protect, and contribute to the well-being, welfare, and rights of Persons and Peoples. Psychologists are also encouraged to maximize benefit and avoid or minimize harm in ways that respect the dignity of Persons and Peoples (APA Ethics Code Task Force, 2020, July 31).

The Canadian Code of Ethics for Psychologists, Standard II.11 (CPA, 2017a), states that psychologists "seek appropriate help and/or discontinue scientific or professional activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others." Standard II.12 states that psychologists "engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others."

The National Association of Social Workers (2017) and the American Counseling Association (2014) are among the other major mental health professions whose ethics codes highlight the role of self-care in supporting competence and preventing impairment.

Table 6.3 presents the results of a national study of therapists as therapy patients (Pope & Tabachnick, 1994). Eighty-four percent of the therapists in

Table 6.3. Therapists' Experiences as Therapy Patients

Item	Never	Once	Rarely	Sometimes	Often
In your own personal therapy, how often (if at all) did your therapist (N = 400)					
Cradle or hold you in a nonsexual way	73.2	2.7	8.0	8.8	6.0
Touch you in a sexual way	93.7	2.5	1.8	0.3	1.0
Talk about sexual issues in a way that you believe to be inappropriate	91.2	2.7	3.2	0.5	1.3
Seem to be sexually attracted to you	84.5	6.2	3.5	3.0	1.5
Disclose that they were sexually attracted to you	92.2	3.7	1.0	1.3	0.8
Seem to be sexually aroused in your presence	91.2	3.7	2.2	0.8	1.3
Express anger at you	60.7	14.3	16.8	5.7	1.8
Express disappointment in you	67.0	11.3	14.8	4.7	1.3
Give you encouragement and support	2.5	0.8	6.2	21.8	67.5
Tell you the they cared about you	33.7	6.7	19.5	21.8	16.3
Make what you consider to be a clinical or therapeutic error	19.8	18.0	36.2	19.0	5.5
Pressure you to talk about something you didn't want to talk about	57.5	7.5	21.3	8.8	4.0
Use humor in an appropriate way	76.7	8.8	10.0	2.2	1.5
Use humor in an inappropriate way	5.2	2.5	12.5	35.0	43.5
Act in a rude or insensitive manner toward you	68.7	13.0	12.0	4.0	1.5
Violate your rights to confidentiality	89.7	4.5	2.7	1.3	1.8
Violate your rights to informed consent	93.2	3.2	1.3	0.3	0.3
Use hospitalization as part of your treatment	96.2	1.8	0.5	0.5	1.0
In your own personal therapy, how often (if at all) did you (N = 400)					
Feel sexually attracted to your therapist	63.0	8.0	14.0	7.5	6.5
Tell your therapist that you were sexually attracted to them	81.5	6.2	5.5	3.0	2.7
Have sexual fantasies about your therapist	65.5	8.0	12.8	7.0	5.2
Feel angry at your therapist	13.3	9.5	32.7	28.5	15.0
Feel that your therapist did not care about you	49.5	13.0	19.0	12.3	5.5
Feel suicidal	70.0	8.5	9.5	8.3	3.0
Make a suicide attempt	95.5	2.5	1.0	0.0	0.0
Feel what you would characterize as clinical depression	38.5	15.8	16.0	16.5	12.5

(continued)

Table 6.3. *(continued)*

Note: Rarely = two to four times; sometimes = five to ten times; often = over ten times.

Source: From "Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs" by K.S. Pope and B.G. Tabachnik, 1994, *Professional Psychology: Research and Practice, 25*, pp. 247–258. Copyright 1994 by the American Psychological Association. Reprinted with permission.

this study reported that they had been in personal therapy. Only two respondents indicated that the therapy was not helpful, but 22% reported that their own therapy included what they believed to be harmful aspects (regardless of whether it also included positive aspects).

This research suggests that most therapists experience, at least once, deep distress. For example, 61% reported experiencing clinical depression, 29% reported suicidal feelings, and 3.5% reported attempting suicide. About 4% reported having been hospitalized. Readers may wish to consider their own experiences in the light of these findings.

Emotional competence in therapy is no less important than intellectual competence, and it is for that reason that we have included, beginning with Chapter 15, clinical scenarios at the end of each chapter. These scenarios describe hypothetical situations that this book's readers might encounter. Each is followed by a handful of questions designed to provide practice in the processes of the critical thinking explored in detail in Chapters 10–14. The first question in each sequence is a variant of "What do you feel?" Emotional competence leaves little room for denying, discounting, or distorting how we respond emotionally to the challenges of clinical work.

To the extent that these scenarios and questions form the basis of class or group discussion in graduate school courses, internships, in-service training, continuing education workshops, or other group settings, their value may be in direct proportion to the class's or group's ability to establish as safe an

environment as possible in which participants are free to disclose respons
that may be politically incorrect or "psychologically incorrect" (Pope, Sonn
et al., 2006) or otherwise at odds with group norms or with what some migh
consider the "right" response. Only if participants are able to speak honestly
with each other about responses that they might be reluctant to speak aloud in
other settings and to discuss these responses with mutual respect, will the task
of confronting these questions likely prove helpful in developing emotional
competence (Pope, Sonne et al., 2006).

Learning to discuss these sensitive topics and our personal responses to them
with others can help to strengthen our emotional competence and develop
resources for maintaining competence throughout our careers (see Pope,
Sonne et al., 2006, for a more thorough discussion of understanding taboos that
hurt therapists and clients). Our colleagues also constitute an invaluable source
of help to avoid or correct mistakes, identify stress or personal dilemmas that
threaten to overwhelm us, and provide fresh ideas, new perspectives, and sec-
ond and third opinions. A national survey of psychologists, in fact, found that
therapists rated informal networks of colleagues as the most effective resource
for prompting effective, appropriate, and ethical practice (Pope et al., 1987).
Informal networks were seen as more valuable in promoting ethical practice
than laws, ethics committees, research, continuing education programs, or
formal ethical principles. Our colleagues can help sustain us, replenish us,
enrich our lives, and play an important role in our self-care (Chapter 17).