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“When You Wish Upon a Star”

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As a third-year graduate student, I recall being asked to engage in a classroom debate on the question of whether good psychotherapists were “born versus made”. We were allowed a few weeks to prepare arguments before our teams faced off to debate the issue, with notecards of points and citations at the ready. As a young psychotherapy researcher and practitioner, as well as a double ruby debater, this class assignment was personal on many levels. Oddly, I do not recall which side of the argument I was assigned. I do, however, remember which side won: born. Based on the citations available 20ish years ago, it was hard to argue against innate expertise. Unfortunately, I continue to hear those same tired citations and persisting belief that training and education in psychotherapy is, essentially, irrelevant to the development of psychotherapy expertise.

I will pick one notable example that was likely on the required reading list for many: Strupp and Hadley (1979). Often referred to as Vanderbilt I, the primary finding of the study was that psychotherapists evidenced variable trajectories of effectiveness and that some therapists were better than others. The study was published in a psychiatry journal at a time when a new class of anti-depressant medications was entering the market on a large scale. Because of this, a message that dismissed psychotherapy effectiveness and disparaged psychotherapy training found ears at the ready. Design flaws were overlooked, the finding of variable trajectories was ignored, and the study was errantly cited and repeatedly mischaracterized. Strupp clearly appreciated the adverse impact of how the study and findings were portrayed. After nearly 20 years of citations involving mischaracterization, he attempted to clarify some of the most salient issues (Strupp, 1998). Yet, the earlier article continues to be misunderstood and speciously cited into the present. Worse, it is cited by psychotherapists. If we don’t value what we do, who will?

As conventional wisdom increasingly endorsed the idea that training and education were irrelevant, those psychotherapists who excelled in working with clients may have become even more vulnerable to the fundamental attribution error than is typical. I witnessed that phenomenon just a couple of years ago at a major psychotherapy conference when I attended a panel session featuring “master” (clearly inappropriately and anachronistically named) psychotherapists discussing their work and expertise with one another. During the question/answer period, I asked the panel to reflect back on their graduate training years and identify the single most important thing they learned during their training. Every single respondent on the panel stood firmly on the belief that they had learned nothing at all of significance during their graduate training and education. While they did not go quite so far as to suggest they were “born” with innate expertise, they very definitely perceived themselves to be entirely self-made experts.

I have re-visited that panel discussion in my head many times over the last cou-
ple of years. I wish I had not sat down quite so quickly. I wish I had probed the conditions that facilitated the development of expertise in these psychotherapists. I strongly suspect I would have learned that, albeit innately talented, supervisory relationships were key to their early developmental gains in specific expertise as psychotherapists. How many of us can look back and identify a formative supervisory relationship that left an imprint on us as psychotherapists?

There are many good quotes disputing the concept of being self-made, but my favorite is this one (variably attributed): “There is no such things as a ‘self-made’ man. We are made up of thousands of others. Everyone who has ever done a kind deed for us, or spoken one word of encouragement to us, has entered into the make-up of our character and of our thoughts, as well as our success.”

I am not dismissing innate talent but placing it in a larger context that expands credit and acknowledges the role of others. It is true that talented aspiring psychotherapists are already making small incremental gains in salient professional competencies, some via life experiences and others via instruction, even before the begin their formal training and education in psychotherapy (for a review that supports this conclusion, see Hatcher & Lassiter, 2007). Those preparatory experiences likely reflect the kind words or deeds, described by Adams, as well as the insights and resiliency tied to negative life events.

Importantly, there is a marked period of exponential professional growth in professional competencies during the professional training years, (see Price et al., 2017; Callahan, 2019, for empirical evidence of that effect). Not only does supervision and mentorship inherently underlie the entire zone of proximal development (Vygotsky, 1930-1934, 1978) for psychotherapy expertise, supervision transcends our professional training structures and is utilized worldwide in the development of psychotherapists. Further underscoring the importance of those years, when close supervision is discontinued, development of psychotherapy expertise typically stagnates (for a comprehensive review that reaches that conclusion, see Tracey et al., 2014). Taken together, it appears that close supervision and mentorship is critical to calibrating the expertise any given psychotherapist will carry forward into their career.

The relationships we nurture with one another, as psychotherapists, facilitate our expertise by providing conditions for safe exploration, identification of growth edges, and constructive feedback. Let’s be generous with credit for the sources of influence past and present and endeavor to meaningfully share our multigenerational expertise with one another into the future. Our Society can offset risk of professional isolation by providing a salve of meaningful connections that brings psychotherapists at every career stage together.

Author’s Note:
Have thoughts on this vision or anything else pertaining to the Society? Feel free to email me at Jennifer.Callahan@unt.edu and keep the dialogue going.

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Greetings Division 29 and SAP Membership! Happy 2020! Along with the start of the new year has come a shift in the team that will lead the charge in the production of the *Psychotherapy Bulletin*. Thank you to Lynett and Cara for their outstanding service to the Division in their editorial capacities, to Tracey for her continued organizational prowess, and to Kourtney who will serve as the Internet Editor. We (Joanna, Editor; Stephanie, Associate Editor; and Salwa and Kate, Editorial Assistants) are very excited to be part of a such a dynamic publication that is consumed by practitioners and scholars alike. The field of psychotherapy is ever evolving and we hope to present cutting edge pieces that move the discourse forward and engage our readership. It is through your ongoing support and contributions that this will be possible and we hope your voice will be represented in our 2020 editions!

In this first edition of the year, we have many wonderful articles for you to view, a column from our new President, Jennifer Callahan, and statements from the candidates being considered for leadership positions within the Division. Further, we want to formally introduce the special focus for the year, “The Person of the Psychotherapist: What We Bring to the Room.” Our editorial team is comprised largely of psychotherapy process and outcome researchers and it is our intent to increase discussion of the ways our personal, professional, and cultural identities influence our participation in this work. We welcome submissions that fit with this theme and also those that extend beyond it and represent your experiences and curiosities (applied or research focused).

Thank you to all who make the *Psychotherapy Bulletin* a success (readers, contributors, Division members, and more!). For submission guidelines or to write for the *Bulletin*, please visit our website ([http://societyforpsychotherapy.org/bulletin-about/](http://societyforpsychotherapy.org/bulletin-about/)). We do wish to highlight that we are changing our timeline for 2020 submissions starting with the next issue. The updated deadlines will be April 15th, July 15th, and October 15th. Please reach out with questions to joanna.drinane@utah.edu and we look ahead to a great year of collaboration!

Thank you,

*Joanna, Stephanie, Salwa, and Kate*
Ample research suggests that therapists differ in their level of effectiveness (Blow et al., 2007; Wampold, 2001). Even more striking is that therapist effects appear to be larger than treatment effects (e.g., Lindgren et al., 2010). These findings suggest that “who” the therapist is may be more important than the type of treatment used. Moreover, therapist training, experience, and theoretical orientation do not appear to explain the majority of therapist effects (e.g., Okishi et al., 2003; Stirman & Crits-Cristoph, 2011). Thus, it has been hypothesized that therapists’ personal characteristics impact treatment (e.g., Black et al., 2005; Heinonen et al., 2012).

Hypotheses regarding which therapist characteristics are important have centered around constructs such as: intelligence (e.g., Shedler, 2006), empathic ability (e.g., Hill et al., 2008), and interpersonal and attachment styles (e.g., Marmarosh et al., 2013). Unfortunately, the empirical literature has largely ignored some of these factors and produced inconclusive or limited results for others. For example, GRE scores and GPA are often thought to be markers of intelligence and work ethic. However, there has been limited research on how these scores relate to therapeutic abilities and the work that has been done does not suggest a positive association (Smaby et al., 2005; Hill et al., 2008). Given that GPA and GRE scores are the two most heavily weighted “objective” variables in the graduate admissions process (Norcross, 1997), the need for further research is clear.

A therapist’s empathic ability is also theorized to be important (e.g., Rogers, 1957) and research suggests that a significant portion of outcome variance is related to therapists’ level of empathic responding in session (e.g., Elliot et al., 2011). However, research on the amount that pre-screening measures of empathy can predict later therapeutic effectiveness is mixed (e.g., Hill et al., 2008; Moyers & Miller, 2013). Given the strong relationship of empathy to outcome, further investigation of empathy as an innate therapist characteristic is needed.

A therapist’s interpersonal and attachment style are also thought to be important. These constructs have been found to relate to the alliance (Diener & Monroe, 2011; Hilsenroth et al., 2012), the effectiveness of individual sessions (Mohr et al., 2005) as well as to problems in therapy (Black et al., 2005). However, the majority of these studies examine therapists’ interpersonal and attachment styles and therapeutic process/outcome concurrently. Thus, future work is needed to determine whether interpersonal and attachment styles measured prior to a therapist’s training can predict later therapeutic abilities.

In sum, while there is considerable evidence that therapist characteristics impact the process and outcome of
therapy, more work is needed. Developing a greater understanding of which therapist factors are most important and the degree to which these factors are innate versus developed through training will have important implications for graduate school admissions criteria. To add to this knowledge base, we examined whether a multi-method evaluation of trainees at the beginning of graduate school could predict which trainees would demonstrate the greatest therapeutic skill during their first clinical encounters. Given that the therapeutic alliance is one of the most reliable predictors of psychotherapy outcome (e.g., Horvath et al., 2011), we used client rated alliance as the first measure of therapeutic ability.

**Method**

*Participants*

Presently, data have been collected from 5 cohorts of clinical graduate trainees (N=44) attending a southeastern university. The participant group is currently 75% female with a mean age of 24 years (SD = 5.24). The racial composition of the sample is 68% European American, 16% African American, 9% Hispanic, 2% Asian American, and 5% other. In addition, participants’ academic records indicated a mean undergraduate GPA of 3.56 (SD = .28), quantitative GRE score of 147.73 (SD = 5.44) and verbal GRE score of 152.05 (SD = 4.82).

Volunteer undergraduate students from the same university served as therapy patients. These students were enrolled in a class focused on personal growth and they received course credit for participating in the sessions and writing a reflection essay. None of these undergraduates knew the researchers in this project, and their professor was not provided any information about the therapy sessions except that the students participated. The patient group (N = 44) is 75% female, 46% European American, 36% African American, 9% Asian American, 5% Hispanic, and 4% other. The mean age of the group is 20 years (SD = 2.13).

**Procedures**

*Multi-Method Assessment*

At the beginning of their graduate training (2nd day of class of the 1st semester), all clinical graduate students completed a multi-method personality assessment as part of their course work. A research assistant unaffiliated with the program administered, de-identified, and scored the assessments. All student responses are confidential and are not shared with anyone in the program.

*Therapy Sessions*

In their second semester, all clinical students took an introductory therapy course with curriculum based on Hill’s three-stage model as presented in *Helping Skills:Facilitating Exploration, Insight, and Action* (2009). As part of this course, each trainee was assigned an undergraduate student volunteer with whom they had four non-manualized therapy sessions. The first session was a 1.5-hour intake and the remaining three sessions were 45 minutes. Patients were told that they could use the sessions to work on whatever felt most important to them. However, they were instructed not to share concerns related to suicidal or homicidal ideation or child or elder abuse. Common presenting problems included relational difficulties, anxiety associated with school, and concerns regarding choosing a career path.

All sessions were videotaped. Trainees received supervision from the course instructor who is a licensed clinical psychologist. Following sessions one, two, and four, trainees received 1.5 hours of

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group supervision (2-3 trainees per group). In addition, students received 1.5 hours of individual supervision following session 3. Supervision focused heavily on the review of video-recorded case material with emphasis on case conceptualization and clinical interventions. For all students, this was their first training case.

**Measures**

Evaluation of therapist characteristics: During the initial assessment, trainees complete a number of self-report questionnaires. These include: The Experiences in Close Relationships-Revised (ECR-R; Fraley et al., 2000) to assess anxious and avoidant attachment styles, The Inventory of Interpersonal Problems-Short Circumplex (IIP-SC; Soldz et al., 1995), and The Perspective Taking Scale of the Interpersonal Reactivity Index (IRI; Davis, 1980, 1983). In addition, seven Thematic Apperception Test (TAT; Murray, 1943) cards are administered and scored by two expert raters using the Social Cognition and Object Relations Scale Global Rating Method (SCORS-G; Stein & Slavin-Mulford, 2018; Westen, 1995). GRE and undergraduate GPA were also obtained from participants’ applications.

Evaluation of alliance: The Working Alliance Inventory Client Form (Horvath & Greenberg, 1989) was rated by the clients following the 3rd session.

**Results and Discussion**

Multiple regression was used to explore whether we could predict client rated alliance (WAI-C total score) based on clinical trainees’ scores from the initial assessment. The independent variables included: Verbal and Quantitative GRE scores, undergraduate GPA, IIP-SC total score, IRI Perspective Taking score, SCORS-G total score, and ECR-R Avoidant and Anxious Attachment Scores.

The overall regression model significantly and robustly predicted ($p < .05, R = .58$) client rated alliance. In line with a recent meta-analysis suggesting that therapist interpersonal functioning is the therapist factor most strongly linked to treatment outcome (Lingiardi et al., 2017), we found that trainees’ self-reported interpersonal problems ($p = .05, \beta = -.42, sr^2 = .08$) and attachment related avoidance ($p = .05, \beta = .34, sr^2 = .08$) both made unique contributions to our model with moderate effects. Although none of the other variables made a unique contribution, it is important to note that undergraduate GPA was uncorrelated ($r = .03$), and quantitative ($p < .05, r = -.38$) and verbal ($p < .05, r = -.35$) GRE scores significantly and negatively correlated with client ratings of alliance. Given that GRE and GPA are used to screen most clinical and counselling applicants (e.g., Sampson & Boyer, 2001), these findings are particularly noteworthy. They are also in line with the limited previous work in this area. Specifically, they mirror Smaby and colleagues’ (2005) findings that verbal GRE scores negatively related to the Skilled Counseling Scale and Hill and colleagues’ (2008) finding that once outliers were accounted for, GPA was unable to predict therapeutic effectiveness.

**Conclusions and Future Directions**

Our findings raise concerns about common clinical and counselling program admissions processes which focus more heavily on grades and test scores than on relational qualities (Anderson et al., 2015). Our results suggest that assessing applicants’ interpersonal functioning is likely to be important in selecting effective therapists. Unfortunately, there is a lack of research regarding the validity of the admissions process in evaluating these characteristics (e.g., Kuncel et al., 2014). Specifically, while letters of recommendation and personal statements...
are almost ubiquitously used for this purpose in the initial review of applicants, they have been largely unstudied in terms of whether they can predict therapeutic ability (GlenMaye & Oakes, 2002). Thus, future research needs to examine the admissions process to clinically oriented programs and work to find valid methods for assessing candidates interpersonal functioning.

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Want to share your exciting news with your fellow members? Four times throughout the year, the enewsletter is dispersed to members of Division 29 in order to share accomplishments and announcements with fellow professionals. This is a great chance to not only to share your own news, but learn of other opportunities that arise. Email Kourtney Schroeder, the associate website editor, (interneteditor@societyforpsychotherapy.org) to share news and announcements about book releases, published articles, grants received, theses and dissertation defenses, etc.

We’d love to hear from you!
The Complex Nature of Therapeutic Empathy

Therapeutic empathy has long been identified as a particularly robust predictor of outcome (e.g., Elliot et al., 2018; Lafferty et al., 1989; Luborsky et al., 1988), yet its complexity has made it difficult to operationalize. Historically, some theorists have emphasized the sensory-emotional components (Kohut, 1959; Titchener, 1915), while others have emphasized the cognitive-rational components (Rogers, 1959). In a paradigm shift, however, contemporary theories have pointed to the empathic process (e.g., Rogers, 1975). The most emergent theories, among these, have emphasized the therapist’s capacity to dialectically shift between states of emotional resonance and co-regulation (Holmes & Slade, 2018). Psychotherapy research has yet to validate what appears to be a therapeutic “empathic dialectic,” though social neuroscience research has acknowledged the complexity of empathy, pointing to neurobiological events undergirding its component parts (e.g., Dana, 2018; Decety & Lamm, 2009). The purpose of this paper is to review definitions of therapeutic empathy, emphasizing those that have been supported by contemporary theory and research.

The History of Therapeutic Empathy

Empathy as an affective state. The concept of empathy originated with the German word einfühlung, defined as the projection of oneself into the objects of one’s perception, which gives way to a certain form of aesthetic appreciation (Lipps, 1905, as cited in Wispé, 1987). Lipps (1905) used einfühlung to describe how one comes to know another person, highlighting the role of motor mimicry, and the body’s resultant afferent feedback (as cited in Wispé, 1987). Borrowing and translating this term, Titchener (1915) coined the term empathy, as “the natural tendency to feel ourselves into what we perceive or imagine… [empathic ideas] are the converse of perceptions; their core is imaginal, and their context is made up of sensations” (p. 198). The stance of these earliest theorists, who emphasized the role of affective resonance in empathy, was partially commensurate with two psychotherapy theorists who rose to prominence thereafter: Heinz Kohut and Carl Rogers.

Therapeutic empathy as a developmental capacity. Kohut (1959) posited that empathy is a mode of psychoanalytic observation that involves “vicarious introspection,” or imagining what it would be like to be the patient as the patient reflects on their experience. Kohut

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also claimed that empathy is “as basic an endowment as... vision, hearing, touch, taste, and smell” (1977, p. 144), and this view of empathy was criticized for capturing only a “primitive form of empathic understanding” (Feshbach, 1987, p. 275). Kohut (2010) rebutted this and other criticisms, elucidating what he felt he had already made clear in his seminal paper from 1959: that the type of empathy therapists are capable of experiencing is contingent on their developmental level. Kohut did not go into much greater detail to describe empathy from the therapist’s perspective, since he ultimately remained tethered to a one-person model of psychotherapy, emphasizing the therapist’s role in uncovering the patient’s unconscious thoughts (Greenberg & Mitchell, 1983).

Therapeutic empathy as a multidimensional state or process. As opposed to Kohut, Rogers did not have the same allegiance to classical psychoanalysis and was able to break free from the one-person theory of psychology that confined Kohut. Rogers (1959) thus highlighted the therapists’ subjectivity in therapeutic empathy, emphasizing how important it is that therapists acknowledge the emotional separation between themselves and their patients, in order to avoid over-identifying with them. Later, Rogers (1975) contended that therapeutic empathy is best described as a multidimensional process, which means “being sensitive, moment by moment, to the changing felt meanings which flow in this other person... and sensing meanings of which he or she is scarcely aware (p. 142).” At the time, this perspective was radical because it initiated a focus away from the one-person model of psychotherapy and toward a two-person approach, where the therapist was considered another subject in the relationship with the client-subject (Aron, 1992; Benjamin, 1992).

Contemporary relational theorists have embraced this intersubjective viewpoint, which has enabled them to address the unconscious field between the therapist and the patient, or what Ehrenberg (1992) has called “the intimate edge.” From this perspective, Buechler (2008) has described the empathic process, suggesting that the therapist first “feel into” or affectively resonate with the patient’s experience, and then “feel out of” that experience, becoming aware of the patient’s emotions as distinct from their own. Like Ehrenberg (1992), Buechler (2008) described the tenuous boundary that can exist between self and other, and emphasized the importance of therapists’ self-regulation (i.e., self-reflection and interpersonal boundaries), which allows them to “emerge with unusual readiness to hear... the [patient’s] material” (p. 45).

Theories of Psychotherapy Process
Theories focused on the working alliance, define this as “agreements on the therapeutic goals; consensus on the tasks that make up therapy; and the bond between the patient and therapist” (Horvath et al., 2011, p. 10). This emphasizes a therapists’ capacity to respond flexibly to the needs of each patient, and in doing so, they highlight aspects of therapists’ self-regulation.

For example, Greenberg (2015) recommends that therapists’ use empathy to follow their patients’ emotional experience to build the alliance in the early phases of treatment, and that therapists use their emotional awareness (an aspect of self-regulation) to challenge patients’ emotional schemas in the later phases. Yet, as illustrated by Buechler (2008) and other theories, it seems therapeutic empathy involves both following and challenging patients.

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Throughout the psychotherapy process, and particularly when the therapist challenges the patient, ruptures—defined as “negative shifts in the quality of the therapeutic alliance or ongoing problems in establishing one” (Safran, 1993, p. 34)—are thought to be inevitable. To effectively (i.e., sensitively) address ruptures, Safran and Muran (2000) suggest that therapists consider themselves participant-observers, shifting their attention to the moment-to-moment intersubjective negotiations between themselves and their patients. By using “mindfulness-in-action” to explore these relational enactments, therapists can then, in turn, repair ruptures in the alliance.

Attachment theorists, Holmes and Slade (2018), embrace a similar view of the psychotherapy process. They emphasize therapists’ mentalization or capacity to understand and perhaps, put words to the states underlying the interpersonal experiences of themselves and their patients. Similar to mindfulness-in-action, mentalization serves to coregulate the patients’ arousal. These theories of the psychotherapy process point to an empathic dialectic: therapists’ capacity to shift from emotional resonance to co-regulation, depends on their own self-regulatory skills (i.e., mindfulness-in-action and mentalization), and works to co-create new relational possibilities with (and for) their patients.

**Empirical validation for the empathic dialectic**

Empirical research has validated aspects of the empathic dialectic in several studies, which have used different measures of empathy. The Interpersonal Reactivity Index (i.e., IRI; Davis, 1983a) is a self-report measure which includes affective and cognitive dimensions. The affective dimensions include empathic concern, or the tendency to experience other-oriented feelings of warmth and compas-
responding. Essentially, in this scale, cognitive empathy acts as a gatekeeper to the accurate measurement of affective empathy (p. 6).

It follows that the cognitive components of empathy (perspective-taking) coexist with the emotional components (personal distress empathy). Therefore, a therapist who is likely to engage in perspective-taking, is also likely to resonate with their patients’ internal states (i.e., to experience personal distress empathy).

Social neuroscience research supports the idea that empathy is a multidimensional process and that a certain degree of affective resonance (or personal distress empathy) is likely to be triggered alongside other forms of empathy. Administering functional magnetic resonance imaging (fMRI), behavioral, and self-report measures of empathy to non-therapists, Decety and Lamm (2009) found that several discrete neural networks are involved in empathizing with another’s pain. Some are linked to automatic self-oriented processes marked by emotional contagion (e.g., personal distress empathy) and others are linked to deliberate other-oriented processes marked by perspective-taking (e.g., empathic concern).

Commensurate with contemporary psychotherapy theories (Buechler, 2008; Holmes & Slade, 2018; Safran & Muran, 2000), Decety and Lamm (2009) similarly contend that emotion regulation is indispensable, because it tones down self-oriented states like emotional contagion (i.e., personal distress empathy) so that other-oriented states of empathy and compassion (i.e., empathic concern) may emerge. In turn, this facilitates co-regulation as the same neurobiological systems that control self-regulation are also responsible for sending out “cues of safety” (e.g., a genuine smile, or compassionate response) (Dana, 2018). Through co-regulation, the brains join as a single healing system (Hasson et al., 2012).

Conclusions, implications, and recommendations
Historically, psychotherapy theorists have emphasized the sensory-emotional (Kohut, 1959) or cognitive-rational components of empathy (Rogers, 1959), while theorists now define therapeutic empathy as a process (e.g., Buechler, 2008; Holmes & Slade, 2018). Drawing on contemporary theories and research, the current paper suggested the phrase “empathic dialectic” to refer to therapists’ ability to shift from states of emotional resonance and co-regulation, in order to effectively co-create corrective emotional experiences with (and for) their patients.

Consistent with American Psychological Association’s aim to develop “clinical competencies” for the accreditation of clinical psychology doctoral programs (Fouad et al., 2009), we recommend the empathic dialectic be added to the larger literature on clinical competencies. As this paper demonstrated, therapists’ can enhance their capacity to effectively navigate the empathic dialectic by developing more efficient self-regulation. Therefore, we advocate for therapists’ participation in relational supervision (Sarnat, 2012) and personal therapy (Orlinsky et al., 2005), which tend to enhance self-regulatory skills.

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Please note: Both authors identify as non-disabled, and share this information based on experiences, training, and passions about culturally responsive care with the disability population.

Introduction
When we, as a profession, consider ways to advance psychotherapy, we must begin by striving for nothing less than fair, accessible, and clinically competent services for all populations—especially those who have historically been underserved and underrepresented. One such population that is frequently overlooked and underappreciated on a global realm are persons with disabilities (PWD), who form the largest minority in the country (United States Department of Labor, 2017). In the United States alone, the Centers for Disease Control and Prevention (2019) reported that there are more than 61 million adults with a registered disability. The authors defined the term “disability” as a physical and or mental limitation that impacts one or more major life activities. This statistic equates to one in four U.S. adults, or 26% of our nation’s adult population (CDC, 2019).

The American Psychological Association’s Guidelines for Assessment of and Intervention With Persons With Disabilities (2012) described the lack of training psychologists receive as it pertains to disability. This is concerning in and of itself given the considerable amount of individuals living with disabilities. Limited training available in serving clients with disabilities further hinders the profession’s ability to advance. For our profession and psychotherapy as a whole to progress and provide the culturally responsive services to which our clients are entitled, the profession and clinicians must engage in a conversation about disability education, concerns, rights, and areas of advocacy.

Societal Messages
From a young age, children with disabilities hear they are different in various settings (i.e., school, doctors, society). Many professionals continue to operate from the medical model, which emphasizes “fixing” what is considered broken. This can imply that if something cannot be fixed, the person is “broken.” These environmental messages experienced by children with disabilities establish their worldview of themselves and others (Chapel, 2005). Environmental messages do not seize in childhood; they continue throughout the lifespan.
into adulthood with more complexities as the PWD experiences the world around them.

PWD deal with challenges and issues within their families, environment, and society. Depending on the family’s understanding of disability and the various identities held, those negative messages can be perpetuated and further oppress the PWD’s abilities and strengths. Families often have a negative understanding of disability based on the information they receive from professionals, which can also be influenced by cultural beliefs. Depending on the limitations of the PWD, families may assume the individual to be incapable. Due to these experiences, an understanding of how to work with clients with disabilities and the systems they navigate is vital to addressing concerns while providing culturally responsive care (Tapia-Fuselier & Ray, 2019). Providing sensitive care begins with understanding the barriers faced by PWD.

**Environmental Barriers**
The CDC (2019) describes different types of environmental barriers that exist, thus placing greater hardships on PWDs. These include:

- Attitudinal barriers (such as the use of stereotypes, stigma, discrimination)
- Communication barriers (such as means of communication that are inaccessible to PWD)
- Physical barriers (such as those that hinder mobility)
- Policy barriers (lack of familiarity or not adhering to enacted laws and regulations)
- Programmatic barriers (such as difficulties with the provision of healthcare services and programming)
- Social barriers (such as unequal employment rates and a lessened likelihood of graduating high school)
- Transportation barriers (often due to inaccessibility; CDC, 2019).

Wright (1983) provided that the gravity of one’s limitations can be amplified or reduced based on environmental conditions and that we cannot accurately consider concerns pertaining to coping and adjusting to one’s disability without first acknowledging the specific problem(s) within a social and physical environment. While clinicians without disabilities will not be able to truly understand the magnitude of barriers and their effects on persons with a disability, we must empathize and stay with clients in the process of maneuvering through various systems and encourage change on a communal level (Marini et al., 2018).

**Psychosocial Attitudes**
While perceptions and beliefs about disabilities vary depending on one’s location and country of origin, there are a plethora of reasons as to why disability-based stigma continues to exist across the globe. Values, beliefs, family members, places of worship, education systems, and the media can influence attitudes (Joe & Miller, 1987). In addition, outside factors such as perceptions of physical attractiveness, competencies and abilities, and communication skills can influence us (Gresham, 1982; Longo & Ashmore, 1995; Yuker, 1988).

We may perceive an increase in comfort to those who are most similar to us based on age, ethnicity, educational attainment, and socioeconomic status (Gosse & Sheppard, 1979; McGuire, 1969; Rabkin, 1972; Sue & Sue, 1999). Such factors, along with previously held beliefs, can influence one’s perception and attitudes toward other individuals—especially those with disabilities.

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Rohwerder (2018) found that disability stigma can often be attributed to misunderstandings and lack of familiarity with causes and types of disabilities, misperceptions about the abilities of persons with disabilities (e.g., not being able to contribute financially or engage in intimacy), and both proposed and enacted policies that do not support persons with disabilities. For example, historically, of the disability categories, persons with physical disabilities have been found to be least stigmatized, followed by individuals with cognitive disabilities, individuals with intellectual disabilities, and individuals with mental illnesses (Antonak, 1980; Charlton, 1998; Tringo, 1970). While invisible disabilities are becoming more accepted by society through mental health advocacy efforts, they continue to remain highly stigmatized due to misperceptions about invisible disabilities and what they entail. Many of the negative attitudes toward disability can ultimately be attributed to lack of contact and positive exposure to persons with disabilities, as well as a lack of knowledge base and education about disabilities.

While Olkin (1999) explained that a first impression, appearance, and the severity of one’s disability could, in fact, influence attitudes, initial negative attitudes lessen upon familiarity with the individual and an understanding that disability is but one trait. Increasing contact, familiarity, and accurate learning opportunities about disabilities (that are not based on media portrayals) can, and have, been shown to result in more positive attitudes toward PWDs and disabilities as a whole.

**Internalized Biases**

Before exploring the ways to improve serving PWD in psychotherapy, we must address internalized biases about PWD. Take a moment to consider the meaning placed on the word “disability.” Often, people create an image in their mind of what they see when they read the term “disability.” The image that appears may be representative of what society depicts as someone with a disability or based on personal experience. Examining the thoughts and feelings that we associate with the image are important to further work through biases about PWD.

Individuals without disabilities tend to concentrate on what they perceive to be adverse aspects of having a disability (Smart, 2009). If not checked, can influence clinicians’ work with clients and their families (Hartley, 2012). Therefore, therapists must strive to increase knowledge and competencies when working with the disability community.

Exploring self as the therapist is essential to address necessary conversations with clients with disabilities regarding their disability and intersecting identities. If internalized biases are not explored or addressed, clients with disabilities may encounter difficult experiences with a therapist, which could further oppress their disability identity. By working through misconceptions of PWD, therapists have more internal resources to inquire and manage aspects of the client’s life that may be difficult or uncomfortable to discuss (i.e., sex, relationships, barriers, life plan, etc.). Applying the information presented will lead to more thoughtful and responsive care for PWD.

**Recommendations**

- The use of expressive arts provides an opportunity to bridge PWD’s experience with a disability.
- Participate in psychology-focused and interdisciplinary-based training focused on serving clients with disabilities.

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• Update the intake paperwork process to be more accessible (i.e., online platform, large print, simple language, etc.).
• Ensure there is access to the clinic entrance, waiting room, and therapy room (signs, movable furniture, adjustable lighting) for mobility aids.
• Provide referrals and resources for auxiliary services to reduce healthcare barriers.
• Have access to interpreters (in-person or video relay), translation services for linguistically diverse and Deaf/deaf or hard of hearing clients.
• Consider cultural perspectives from family/partner(s) toward PWD disability.
• Apply an intersectionality framework when working with this population as all aspects of identity, including disability status, need to be considered.
• Identify ways to engage in advocacy (through legislative votes, conversations about accessibility, etc.).
• Utilize the APA’s Guidelines For Assessment of and Intervention With Persons With Disabilities and ARCA Disability-Related Counseling Competencies to ensure culturally responsive care.

Conclusion
Marini and Stebnicki (2018) described the extensive literature regarding the impact perceived adverse conditions can have on an individual, which is why clinicians must be willing to address social justice concerns hindering client development and growth within various realms of their lives. It is not enough for therapists to help clients adjust to living in a non-disabled world, as our work will then be left “unfinished or incomplete” (Marini & Stebnicki, 2018). As our profession continues to serve marginalized and underserved populations, such as persons with disabilities, increased education, training, and advocacy must remain at the forefront of our work.

References

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The field of psychology has traditionally focused on promoting the well-being of individuals, couples, families, and even groups, but has focused less on promoting the well-being and healing of communities as a whole. There is much that psychology can offer to promote connection and health within communities under stress. Specifically, psychology can offer insights into how collective action and activism can support community healing and well-being when impacted by hate incidents that have targeted various marginalized identities. Collective action involves people working together to achieve a common objective typically focused on challenging inequity, exclusion, and/or injustice rooted in the oppression of others (Millward et al., 2019). Activists are individuals who work toward this social change (Millward et al., 2019). Research on collective action in psychology has focused mostly on attributes of activists, predictors of activism, and how to motivate people to engage in collective action to create social change (Curtin & McGarty, 2016; Louis, 2009). However, there is very little existing research that focuses on activism as an act of healing.

In this article, a collaboration between the Womxn’s March Denver and the Graduate School of Professional Psychology at the University of Denver aimed at providing healing workshops to generally support the well-being of the community and specifically that of those engaged in community action, will be described. Summary and reflections on the community healing workshops will be discussed as an illustration of how psychology can help support those engaged in collective action.

Those involved in collective action, whether it is at the individual or organizational level, are at risk of burnout that can impact the sustainability of social movements and social change (Goriski, 2015). The awareness of large and overwhelming social problems can feel unsurmountable. Activists may experience pressure to act to the point where they struggle with saying no before reaching their limit (Maslach & Gomes, 2006). Those involved in collective action may feel shame in admitting that the work takes an emotional toll, thereby further isolating themselves instead of reaching...
out for support and tending to their personal well-being (Maslach & Gomes, 2006; Plyler, 2006; Rodgers, 2010.)

To sustain oneself in collective action, a constellation of skills such as self-reflection, cultivating mindfulness, and connecting with others are particularly important (Hick & Furlotte, 2009; Griffin & Steen, 2011). Many practices which activists may find to be supportive are similar to those suggested in psychotherapy, including mindfulness, slowing down and seeing the big picture, reaching out to friends and loved ones, and other forms of managing stress (Goriski, 2015). Connecting more compassionately to oneself and with others may be particularly important (Goriski, 2015).

While potentially stressful and overwhelming, engaging in collective action also has the potential to promote personal development and well-being (Montague & Eiroa-Orosa, 2018). Montague and Eiroa-Orosa (2018) identify various positive aspects involved in collective action. For example, collective action can support the development of self-awareness, identification, and expression of values specific to human rights and social justice. Further, a sense of self-efficacy can develop, which is often linked to positive well-being. Through collective action, resilience and activism skills are modeled by others, strengthening the individuals as well as the larger group of activists. Lastly, a strong sense of relatedness, a major predictor of psychological well-being, can result from a shared sense of purpose (Montague & Eiroa-Orosa, 2018).

**Collective Trauma in the United States**

The cumulative incidents of hate and violence referenced above, in combination with unknown and innumerable others, reflect collective trauma and stress in the United States (Pinderhughes et al., 2015). Collective trauma is defined as an aggregate of trauma experienced by community members or an event that impacts a few people but has structural and socially damaging consequences (Veerman & Ganzvoort, 2001). Collective trauma has also been described as a shared feeling of being subjected to horrendous events that leave negative marks on group consciousness (Gorman-Smith & Tolan, 1998).

The impact of collective trauma can be felt by individuals, groups, and even entire generations. The American Psychological Association’s 12th Annual Stress in America Survey found that Generation Z was overwhelmed by fears including mass shootings, the current state of the country and the future of the environment, with reports that the prior generation of “millennials” have the highest level of stress compared to other generations (APA, 2018). Within a social cultural context, collective trauma manifests itself by creating damaged and fragmented social relationships, dislocating social norms, and promoting unhealthy coping behaviors in the community such as violence and hate. Overall, a decreased sense of political and social efficacy can be a consequence (Pinderhughes et al., 2015). Incidents of hate media, which are modeled by people in power, have a pervasive impact on our community. This contributes to a collective fear of one’s safety and well-being as well as that of others. Despite the existence of trauma at the community level and the impact on the social cultural environment, there fails to be a coherent framework for healing at a community level, with much of the focus on addressing trauma at the individual level (Pinderhughes et al., 2015).

**Collective Action: Womxn’s March Denver**

The Womxn’s March Denver is an organization that represents collective action. Their mission is stated as “...a

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collective of womxn* committed to amplifying marginalized voices in the movement to end sexism, oppression, and injustice.” Through community engagement, protest, education, and leadership, they leverage their platform to ignite action (Womxns March Denver, 2018). They work to listen to those who have been silent, unite under the banner of oppression, and work to act with intention (Womxns March Denver, 2018). They are not affiliated with the national movement but work to mobilize those in the Denver Metro Area (Womxn’s March Denver, 2018).

On January 21, 2017, the date of President Donald Trump’s inauguration, the Womxn’s March Denver was originated. Of course, the Womxn’s March was not exclusive to Denver. In fact, in the first year, there were 680 Womxn’s Marches throughout the United States and 137 additional Marches throughout the world. Millions of womxn marched through the streets of cities across the world to protest a person in such a high position of power who overtly and actively expresses hate and intolerance.

The overwhelming response of womxn across the world may be a response to fear among many in larger society, particularly those who are marginalized and underrepresented, of leadership misusing power and dividing the community around gender, race, socioeconomic, among other potential divisions. In the United States, the political climate of the last three years has resulted in a country even more divided, shattered, and fearful as incidences of hate and violence have become more overt and commonplace. Further, incidences of sexual assault and related violence towards womxn have received increasing media coverage due to the “Me Too” movement as well as high profile allegations towards those in power such as Larry Nassar, Brett Kavanaugh, and Harvey Weinstein.

As stated in a Denver Post Article about the Womxn’s March (Gupta & O’Grady, 2020):

These last three years have deepened the rift in the moral fabric of our country. Instead of “making America great,” we have leaders who have opened the door for intolerance and would rather divide than unite us. Rather than appreciating and learning from each other, we distrust and belittle those who don’t look, pray, or love like we do. In this quest for “great,” we have lost sight of what it means to be good.

In this version of America, womxn are losing access to their reproductive freedoms. Immigrants hear shouts to “go back to where they came from.” Schools practice drills for active shooter scenarios leaving children petrified while other children are dying in cages at our borders. Swastikas are painted on buildings and headstones; bricks are thrown through the windows of houses of worship. People are targeted by violence for whom they love. Communities are torn and broken and our world is literally on fire.

We are expected to trust those in power, yet the most powerful people do not exercise trustworthy behavior. Instead, they attack the identities of others for their own self-interest. They abuse their power and then hide behind their lies. Where is the America that our parents and elders immigrated to in search of a better life? Does that better life really exist?

Collective Action & Healing: Community workshops

In response to the adversity, stress, and collective trauma, The Womxn’s March

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Denver, in collaboration with The Trauma & Disaster Recovery Clinic (TDRC), and the Caring for You and Baby Clinic (CUB) at the Graduate School of Professional Psychology, developed a community engagement initiative aimed at ameliorating the negative impacts of the social cultural environment and fostering support and healing for those participating in community action. The TDRC and CUB clinics are training clinics for graduate students in psychology that focus on providing accessible psychological services to the community and particularly those impacted by trauma, broadly defined and including childhood emotional, physical, and/or sexual abuse, natural disasters, political conflict, domestic violence and/or sexual assault, and the mental health needs of pregnant and postpartum families with infants and young children. The clinical staff of both clinics bring years of experience working with traumatized and marginalized populations, as well as a depth of understanding of the wealth of strengths, resources, knowledge, and resilience these same populations embody.

A series of community healing workshops facilitated a discussion of incidents that have divided local, national, and global communities. In the workshops, community leaders, activists, and allies explored the impact if these incidents on their personal and professional lives from the perspectives of their various intersecting identities. Participants were invited to share stories of adversity and healing as well as to mourn the multiple losses associated with collective trauma, with some of those losses tangible and some intangible such as the loss of feelings of safety and alterations to their worldview. Participants were then invited to discuss ways in which they nurture and sustain themselves generally and specifically in the work of collective activism by sharing wisdom from experience and providing resources and strategies to one another.

**Reflections and Insights Related to Community Healing Workshops**

The community healing workshops specifically addressed the socio-cultural-environmental aspects of collective trauma including rebuilding social relations, revitalizing damaged or broken social networks, and strengthening/elevating community connections. The workshops explored changing the narrative about community and the people within as well as organizing and promoting regular community engagement. These methods of promoting community relationships are suggested as a possible means to addressing the broken social and cultural environment that can result from collective trauma (Pinderhughes et al., 2015). The workshops integrated psychological concepts related to giving voice to experience, bearing witness, creating stronger relational bonds, and developing strategies to sustain oneself amidst challenges that speak to self-care and mitigating vicarious trauma. Below is a summary of themes that emerged based on the reflections and self-reports of the participants and facilitators.

Shared emotional experience. Participants expressed experiencing a shared emotional experience, wherein they reflected on ways that they were impacted by the social and cultural incidences of hate and violence locally, nationally, and globally in their personal and professional lives. Stories of being invalidated, silenced, and minimized were shared. Stories indicative of feeling fear within their own community were explored. In concert with these stories were emotional themes of anger along with hopelessness, burnout, exhaustion, and lack

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of motivation. The desire to fight injustice conflicted with feelings of wanting to give up. The themes paralleled trauma reactions in the desire to fight injustice, the desire to flee because of lack of hope, and the feeling of being frozen in a state of fear and disbelief around the pervasive and overt nature of incidences of hate and violence.

Developing connections. Participants bore witness to the experience of others. Although some reflected shared experience, there was an acknowledgement that differences exist related to various intersecting identities. A shared experience of distress and suffering was acknowledged as it related to various hardships in the community. Some described the shared experience of suffering related to the experiences of oppression; having been silenced and invalidated by others. Bearing witness to this in a brave space was reported to promote connection and understanding. Participants reflected on how witnessing and hearing the stories of others within this shared space promoted empathy and compassion. Participants expressed that this brought forth a strong sense of connection and common purpose that they experienced as energizing. In speaking about how to support one another, the need to come together for something (i.e., not against something or someone) was acknowledged. The need to uplift one another was named and emphasized, contributing to a shared sense of togetherness. Shifting from an “us vs. them” mentality to uplifting one another through recognition of the need for insight, healing, and action during the workshops was a powerful indication of community healing.

Sustaining ourselves in challenging times. As a way to support one another, participants were invited to discuss ways to sustain themselves during these challenging times. Suggestions for self-care were shared that allowed for new insights and also affirmed what people were already doing. For example, participants spoke of the need to find a community of like-minded people and reaching out to for help when needed. Participants spoke about a need to say “no” and setting boundaries related to work, despite the guilt that exists related to the belief of needing to be selfless to fight injustice. Participants discussed ways they take care of their bodies that included eating healthy and regular physical activity. Discussions about the need to focus attention on positive emotions, acknowledging accomplishments, and uplift one another and working collaboratively was emphasized. At the end of the workshop, participants expressed their hopes and wishes on a ribbon and reported motivations to continue to gain insight, heal, and take action, along with supporting their own well-being and the well-being of their community.

Summary
Psychology has much to offer to collective action and activism. More specifically, pervasive incidences of hate and injustice ripple through the community and can lead to collective trauma where individuals and communities fear for their safety, experience distress, are overwhelmed, and become isolated. This lack of community connection can negatively contribute to each individual’s overall well-being as well as the health of the community as a whole. Psychology offers opportunities for connection through sharing experiences, bearing witness, and the expression of emotion. In doing so, can support the well-being of communities. This article described in detail the collaborative efforts of a community activism group and a department of psychology as an example of the beneficial impact of collaboration across these endeavors. Further research on collective continued on page 28
action and healing as a way to mitigate or intervene with collective trauma would greatly benefit the discussion surrounding how psychology can not only support the well-being of individuals but also of communities.

References
According to the United States Census Bureau, 60.4% of the United States population consists of White persons not of Hispanic or Latino ethnicities, and 41.8% of the population consists of racial/ethnic groups identified as Black or African American, American Indian and Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, Hispanic or Latino, or those identified as being two or more races. From 2013 to 2017, 21.3% of the population, identifying as five years and older, reported speaking a language other than English in the home (United States Census Bureau, 2019), indicating there is a large amount of diversity and multiculturalism in the United States.

There is an overrepresentation of People of Color in the United States criminal justice system. Given their work within these systems, forensic psychologists must maintain cultural competence when interacting and serving diverse populations, including non-English-speaking individuals. In both forensic assessment and treatment, the use of interpreters is growing. However, training on the ethical use of interpreters is limited. The present article will highlight important ethical, clinical, and legal considerations when working with interpreters in forensic contexts.

Ethical and Clinical Considerations

Principle E of the Ethical Principles of Psychologists and Code of Conduct (Code of Ethics), as well as Guideline 2.08 of the Specialty Guidelines for Forensic Psychology, outline the ethical responsibility of psychologists to respect the cultural, individual, and role differences of all persons, including those of racial/ethnic and linguistic diversity (American Psychological Association [APA], 2017; APA, 2013, respectively). Further, the APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations recommends clients should receive services in the language requested or be referred to a provider who can provide services in the requested language (APA, 1993). Given the limited availability of providers, it may not be feasible to locate a provider with those qualifications. In such cases, the clinician should acquire a translator with the appropriate cultural background and who does not hold a dual role with the client (APA, 1993). In doing so, providers must be aware of areas of ethical vulnerability within both the assessment and treatment process when using interpreters.

Confidentiality

Standard 4.01 (Maintaining Confidentiality) and 4.02 (Discussing the Limits...
of Confidentiality) in the APA Code of Ethics requires psychologists to maintain the privacy of confidential information through reasonable action as well as review with the client the limits to which information can be kept confidential (APA, 2017). Although the evaluator or clinician is bound to psychology’s ethical guidelines, interpreters may not be and cannot be assumed to operate under the same bounds of confidentiality. Additionally, Maddux (2010) mentions the possibility of a dual relationship that may be present between a client and interpreter. Non-English-speaking individuals may have small communities in which there is increased contact between people of the same cultural group, which increases the probability of the client and interpreter having previous contact or relationship with one another. This contact could create a dual relationship that the evaluator may need to consider.

Interpreting Assessment Results
Standard 9.06 (Interpreting Assessment Results) of the APA Code of Ethics and Guideline 10.03 (Appreciation of Individual Differences) of the forensic specialty guidelines note that psychologists should consider the characteristics of a person when interpreting their assessment results. Idiographic characteristics, such as linguistic and cultural differences, could influence judgments and reduce interpretive accuracy (APA, 2017). With the involvement of an interpreter during an assessment, not only is the assessor interpreting the client’s responses, but they simultaneously have to interpret the responses through a language filter that contains individual differences from the interpreter. It is important to note that with an interpreter in the room, the dyadic relationship becomes triadic. Each factor that can be at play between the interpreter and the non-English speaking client can also be assumed possible between the interpreter and treatment provider. This is only exacerbated with multiple interpreters assigned to a client. Each different interpreter carries their personal combination of individual differences that, if not carried through the entirety of treatment with the same client, can affect the reliability and validity of treatment and evaluation.

The use of interpreters can also influence the reliability and validity of a forensic assessment. First, when considering the reliability of the assessment, both intrinsic and extrinsic factors require attention. For instance, intrinsically, gender across cultures carries different reactions. The amount of engagement, response, disclosure, and the overall presentation can be differentially affected whether the client or interpreter identifies as male, female, or does not identify with the binary definition of gender (Maddux, 2010). A female client may be less willing to share personal information with a male evaluator through the translation of a female interpreter. Similarly, social class may also function as a possible hindrance to assessment reliability. Client-interpreter rapport by individuals of the same culture is more sensitive to the differences in class than individuals of different cultures (Maddux, 2010).

Extrinsically, the lack of vocabulary available for direct translation and the type of translation utilized can lower the level of reliability of outcome interpretation. Often, especially with justice-involved topics, there are no words that directly translate some terms. For example, “An interpreter’s anxiety in forensic evaluation involving sexual matter may result in them explicitly changing a psychologist’s questions involving sexual details or relying more heavily on non-

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verbal signals of affirmation to avoid awkwardness” (Maddux, 2010, p. 57). Whether the interpretation is consecutive versus simultaneous, direct versus indirect, or presented in lay terms versus professional terms, all forms of interpretation provide unique nuances to the quality of the assessment results. Maddux (2010) explains that a level of trust mediated by the working alliance between the interpreter and the assessor must be present, or else the assessor may be at risk of losing control of the session. The speed of the session is determined by the use of consecutive or simultaneous interpretation, while direct or indirect translation determines the amount of side conversation.

The validity of assessment and treatment can be affected by the non-English speaker attempting to bypass the interpreter, dialect differences, or the ability of the interpreter. There may be instances when the client offers English responses to the assessor despite the availability of an interpreter (Maddux, 2010). In the case that the client communicates the correct English word, the validity of the assessment is saved. However, if the client offers the wrong English word for what the client meant to communicate, the evaluator may mistake the client’s lack of language competence as an incorrect response, invalidating any interpretation thereafter. Differences in dialect between the client and the interpreter may also be present, known or unbeknownst to the assessor (Maddux, 2010). As a result, there may be a decrease in the accuracy or specificity of interpretation that may hinder a client’s results. The interpreter’s capability for translation must also be considered (Maddux, 2010). The fluency level, certification, and cognitive abilities, such as working memory and executive functioning, are all properties of an interpreter’s ability to effectively translate an assessment from one language to another. Any single factor or a combination of these factors play a significant role in the confidence that an assessment can accurately interpreted by the evaluator.

**Legal Considerations**

In 1975, a California law was passed requiring the use of the English language in its courtrooms, but it lacked a mandate for providing interpreters to non-English speaking clients. The rationale provided for this law was the financial and time-sensitive burden on the court to locate, assign, and proceed with the trial. The state also argued that the law provided an incentive for non-English speaking participants of the court to learn English. However, the nature of this law fosters bias and discrimination against non-English speakers (Chang & Araujo, 1975). Chang and Araujo (1975) made two main arguments to advocate for a mandate to providing interpreters in the courtroom.

**Equal Protection**

Under the United States Constitution, individuals have the right to equal protection of the laws against racial discrimination (U.S. Const. amend. XIV). Chang & Araujo (1975) make a compelling argument that denying the assistance of an interpreter to a non-English speaker serves as grounds for illegal discrimination based on the postulation that language is tied closely to an individual’s race or national origin. Therefore, it can be argued that the court is discriminating against a person’s national origin. With this in mind, should a defendant be convicted without having been appointed an interpreter, it could imply that the individual’s incarceration was due to not knowing the English language to the extent that they could participate in their proceeding (Chang & Araujo, 1975).

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Due Process

Due process under the 14th Amendment upholds an individual’s right to fair treatment under the legal system (U.S. Const. amend. XIV). A fair trial guarantees the right to a speedy trial, confrontation with the witnesses against him, and effective counsel (U.S. Const. amend. VI). An interpreter may have to consider alternative ways of communicating with a defendant or take frequent recesses to ensure there are no misunderstandings (Chang & Araujo, 1975). Using an interpreter would inevitably consume amounts of time and prolong the trial process, inhibiting the ability to provide a proceeding within an acceptable amount of time. Moreover, without the ability to understand witnesses, defendants are denied the right to confront witnesses brought against them. As a result, the defendant would not maintain the ability to refute arguments made against them. Lastly, a language barrier between a defendant and their attorney would inhibit effective communication to engage the defendant in the trial process (Chang & Araujo, 1975). The combined inability to confer with an attorney and confront the witnesses prevents the defendant from participating and aiding in their defense. These limitations are similar to defendants found incompetent to stand trial on the basis of mental illness (Change & Araujo, 1975).

The Court Interpreters Act (1978)

Three years after Chang and Araujo wrote their 1975 article, President Carter enacted the Court Interpreters Act of 1978, which gave individuals the right to an interpreter if language serves as a barrier to their communication or comprehension of their proceedings (Court Interpreters Act of 1978). However, ten years later, an amendment to the original Act was made that left the responsibility of providing an interpreter to the courts (Court Interpreter Amendments Act of 1988). The courts would be required to request an interpreter on behalf of the non-English speaker instead of an interpreter automatically being appointed to them. Interpreters are not always appointed if “the speaker’s limited English ability is sufficient for conducting their case” (Maddux, 2010, p. 56). As a result, there are still limitations to the rights of those whose native language is not English and the services provided to them.

Recommendations for Professionals

The literature provides multiple recommendations on this topic. First, assessing language fluency would aid in the interpretation of assessment results for those whose first language is not English (Barber-Rioja & Rosenfeld, 2018). The assessor or clinician should be wary of miscommunication by the client attempting to bypass the interpreter. Second, to increase the reliability and validity of interpretations of assessment results, the assessor needs to record the behavioral observations of both the client and the interpreter. Assessors inconsistently report information regarding the interpreter, and interpretation services are not often documented in assessment reports (Maddux, 2010).

In response to minimizing factors that hinder reliability and validity, evaluators and clinicians are encouraged to:

- Adjust their language to avoid lengthy or complicated translation;
- Strive to seek interpreters from the same country as the client;
- Assess the client’s comfort level towards the interpreter;
- Discuss topics with the interpreter that will likely be included in the session before starting the session;
- Select neutral, well-trained interpreters;
- Discuss with the interpreter the need for direct interpretation;

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• Seek interpreters who can interpret in the same dialect as the client; and
• Use a single, consistent interpreter for all sessions with the same client (Barber-Rioja & Rosenfeld, 2018; Weiss & Rosenfeld, 2010).

Conclusion
With the high prevalence of diverse populations within the criminal justice system, it is increasingly important to practice ethical cultural competence when serving non-English speaking clients. Forensic psychologists are bound under the Code of Ethics, as well as the Specialty Guidelines for Forensic Psychology, to do no harm, exercise justice, and respect the rights and dignity of individuals who differ in individual characteristics, and consider these factors in the interpretation of assessment results. All the while, clinicians may need to advocate for legal ethics in the form of a client’s legal rights as minoritized groups in an unfamiliar environment, such as involvement in restoration for competency to proceed.

Author’s Note: As a reminder, please send your psychotherapy research-, practice-, and training-related Ethics questions to Apryl.Alexander@du.edu. Please note that questions may be selected by Dr. Alexander for inclusion in Psychotherapy Bulletin or on the SAP website/social media platforms at her discretion, and not all questions may be answered. In addition, the information provided to Dr. Alexander and SAP in this context is for the purpose of furthering public knowledge and discourse around ethical issues and will not be kept confidential.

References


U.S. Const. amend. VI.

U.S. Const. amend. XIV.

To swipe or not to swipe? Contemplating Mental Health Professionals’ Use of Online Dating Services

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As of May 2018, approximately 50 million Americans are using online and mobile app dating services (hereafter referred to as “online dating”; Seetharaman & Wells, 2018). With one out of five relationships now starting online (Cacioppo et al., 2013; Hamilton, 2016), mental health professionals and graduate students are likely using these services. Indeed, a recent study of mental health professionals’ usage of online dating services found 69.6% of graduate students and 65.4% of professionals surveyed reported using these services, most (64.9%) while working as a therapist (O’Neil et al., 2018). One of the benefits of online dating is the increased accessibility in meeting potential partners (Finkel et al., 2012; Valkenburg & Peter, 2007). Online dating may be especially helpful for people with marginalized identities who may have a harder time finding a partner than more privileged groups (Rosenfeld & Thomas, 2012; Valkenburg & Peter, 2007). For graduate students and professionals who moved to a new area and have a limited amount of free time, online dating can be a helpful way to meet potential partners (Donn & Sherman, 2002). There are many benefits to utilizing these services but there is potential risk and impact if a client finds their therapist’s online dating profile.

Despite the growing attention paid to ethical issues associated with psychologists’ use of social networking sites (DiLillo & Gale, 2011; Lannin & Scott, 2014; Lehavot et al., 2010; Taylor et al., 2010; Tunick et al., 2011; Zur, 2008), very little has been written about the use of online dating services’ potential ethical implications for mental health professionals. This lack of attention in the literature may result in training programs providing little to no coverage of the ethics of online and mobile app dating for mental health professionals.

What Does Online Dating Have To Do With Ethics?
The American Psychological Association’s Ethics Code (2002) clearly states that the code “applies only to psychologists’ activities that are part of their scientific, educational, or professional roles” (p. 2). Some behaviors, however, are both personal and professional (Pipes, Holstein, & Aguirre, 2005). Although dating is an inherently personal and private activity, there are ways in which dating activities can also be public. For example, if a client sees their therapist kissing someone at a bar, this activity has the potential to affect the client. In public settings, clinicians can see who is around them before they act. However, information online can be viewed, often anonymously, by many people. Anonymous viewing is particularly true for online dating, bringing up unique ethical concerns related to unintentional self-disclosure of the therapist, unintentional self-disclosure of the client, and concerns regarding the field’s continued on page 35
image if therapists and clients encounter one another’s profiles online.

**Unintentional Therapist Disclosure**

Clinicians have varying stances on the appropriateness of self-disclosure in therapy but how the client could be affected is a critical piece to evaluate when debating whether to disclose. The literature on the ethics of therapist self-disclosure highlights concerns that learning more about the therapist could potentially produce a dual relationship (Danzer, 2019; Taylor et al., 2010), cross professional boundaries (Audet, 2011; Danzer, 2019), alter the therapeutic relationship (Kolmes, 2013; Taylor et al., 2010), influence what clients disclose, affect the perception of the therapist as competent or credible (Audet, 2011), and/or increase issues related to transference (Taylor et al., 2010). Although the APA Code of Ethics does not have a standard forbidding therapist self-disclosure, it does have standards pertaining to avoiding harm and multiple relationships. Concerns about therapist self-disclosure and how this affects therapy uniquely affect clinicians who use online dating services. Most social networking sites, like Facebook and LinkedIn, enable individuals to stay in contact with people they already know but the purpose of joining an online dating site is to meet new people. To attract other people’s attention, online daters post personal information and photos for strangers to see while utilizing fewer privacy settings than typically used with social networking sites (O’Neil et al., 2018). Included in the pool of strangers viewing these profiles could be the clinician’s former, current, and potential clients. Due to the nature of how online dating works, therapists may unintentionally disclose information about themselves, which could affect the therapeutic relationship. Disclosures regarding a therapist’s sexual circumstances “are generally not considered suitable” (Smith & Fitzpatrick, 1995, p. 503) and yet these forms of disclosure are more likely to be encountered by a client who finds their therapist’s online dating profile (Kolmes, 2013). Knowing details about a therapist’s sex and relationship preferences could negatively impact the therapeutic relationship, damage a relationship built on trust, and compromise the effectiveness of therapy (Tunick et al., 2011).

**Unintentional Client Disclosure**

When an encounter happens in person, both parties are typically aware of what happened and can bring it up in therapy. Finding information online, however, can often be done anonymously. Seeing a client’s personal ad on a dating site discloses information about the client they may not want their therapist to know. This behavior violates Principle E, as it is not respectful of the client’s right to privacy (American Psychological Association, 2002; Kolmes & Taube, 2014). Gaining new information in this manner could also affect the therapist’s objectivity and perception of their client. If a couple is seeing a therapist for marital problems and the therapist discovers one of the partners has an online dating profile, how does the therapist handle this knowledge? Trying to address this with clients could damage the relationship and trust both parties have established with the therapist.

**Protecting the Profession’s Image**

The APA Ethics Code was created, in part, to protect the profession’s image (Pipes et al., 2005). Previously, a federal judge “was admonished for posting sexually explicit material on a private web site” because his behavior could “reasonably be seen as having resulted in embarrassment to the institution;” thus creating a precedent for concerns about an individual’s online be-

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behavior in their respective fields (Kaslow et al., 2011, p. 106). Learning more about a therapist’s personal life from a dating profile (some of which explicitly assess user’s interest in “hookups,” “discreet encounters,” etc.) has the potential to affect people’s perception of psychology and willingness to seek counseling services. For example, people who see that one psychologist enjoys sadomasochism and have misconceptions or biases about BDSM may start worrying that psychologists derive pleasure from other people’s pain and be reluctant to seek services to share their pain.

Recommendations
Currently, APA does not have any explicit ethical guidelines to help therapists consider the use of online dating services despite how many professionals are already using them. Some guidance seems desired. However, as 75.4% of a sample of 246 mental health professionals and psychology graduate students said APA should “definitely” or “probably” create ethical standards regarding the use of online dating services (O’Neil et al., 2018). Additionally, 69.5% of participants reported discussing the ethics of using social networking sites in graduate school or as part of a continuing education class. Still, only 15% of the same sample reported discussing the ethics of online dating services (O’Neil et al., 2018). To address this gap in the field and encourage supervisors and educators to discuss the ethics of online dating with their trainees, two sets of recommendations were developed: a set of variables to consider when contemplating whether to use online dating services and a set of recommendations for individuals who have decided to proceed with using these services.

What to Consider When Deciding Whether to Use Online Dating
The following variables could affect the likelihood of encountering a former, current, or potential client through an internet-based dating service.

• **Geographic location**: Do you live in a city or a rural area? Are you planning to use a dating service that uses geographic location to match people and, if so, is the geographic range set to a distance that includes where your clients live?

• **Job responsibilities**: Are you currently providing therapy services? If not, when did you stop? Do you plan to practice therapy again? Do you teach students or conduct research with participants who may encounter your dating profile?

• **Clinical population**: Do you work with an inpatient population who cannot access the internet for the duration of time you will be using dating services? Or young children who do not use dating services yet (but their parents might)?

• **Presenting concerns**: Do you work with clients who struggle with attachment and boundaries? Do your clients ask a lot of personal questions? Do you work with clients presenting with relationship concerns? What assumptions will your clients make about you and your competency in working with them if they encountered your online dating profile?

• **Theoretical orientation**: How does your theoretical orientation view self-disclosure?

• **Preference for a partner**: Are you searching for a partner with similar characteristics (e.g., age, sexual orientation) to your clients? Are you searching for a partner with a specific interest, physical trait (e.g., must be a particular ethnicity or height), characteristic (e.g., intelli-

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gent), or sexual preference (e.g., must be open to BDSM)? How would clients react, and what would they infer from learning their therapist’s preferences in a partner?

**Recommendations for Using Online Dating Services**

Clinicians using online dating services are encouraged to be mindful of the effect of unintentional self-disclosures could have on their clients. The following suggestions may help practitioners minimize their unintentional self-disclosures and consider how to address disclosures that do occur:

- **Use a social media policy with clients** (Kolmes, 2010). Kolmes’s (2010) social media policy is available online for therapists to adapt for their practices. They recommend including a statement that the therapist is on social media, and clients who find anything about the therapist online are welcome to bring it up in therapy (Kolmes, 2013).

- **Periodically search yourself to see what comes up** (Taylor et al., 2010; Lannin & Scott, 2014). Some clients look up their therapist online (Kolmes & Taube, 2011; Lehavot et al., 2010; Zur, 2008). Practitioners who are aware of their online presence can edit and restrict some of the content clients could find.

- **Be cognizant of the reputation associated with different dating services.** Some dating services may be more stigmatized than others. For example, SugarDaddy.com may elicit a stronger reaction from clients than using a service like eHarmony (O’Neil, 2019).

- **Use sites that enable you to see who has viewed your page/profile.** Therapists who know if a client has viewed their page can bring up what happened in therapy. Alternatively, some services (like Bumble) enable users to choose who they match with before the other party can see their content and indicate they are interested. This practice may enable users to avoid matching with former and current clients.

- **Utilize privacy settings and review them regularly** (Lannin & Scott, 2014; Lehavot et al., 2010). Some services pull information automatically from social media accounts, while others give users more autonomy in choosing what to include in a dating profile.

- **Avoid using a professional photo in your dating profile** (Kolmes, 2013). If using an online dating site that includes pictures, avoid using photos that are also on a professional website. Clients can take a professional photo of their therapist and conduct a Google image search with it that would result in the client finding any other sites containing the same photo (Kolmes, 2013).

- **Engage in thoughtful self-disclosure.** Practitioners should be mindful of what information and pictures they include on their dating profile and how it could affect a client or the therapeutic relationship if seen by a client. Seeing sexy or more revealing photos, for example, could impact the relationship more than seeing a face shot (Kolmes, 2013). Consider only posting content that you would feel comfortable with a client knowing.

- **Change or modify your name, occupation, and educational background** (Kolmes & Taube, 2014; Lannin & Scott, 2014; Leahovt et al., 2010). This adjustment would make it harder for clients to find their thera-

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pist’s profile. Kolmes (2013) suggested psychologists who decide to list their profession in their profile may want to include a statement below it; encouraging clients who find the profile to discuss anything they see on it with the therapist.

- **Utilize disclosed deception.** Instead of listing personal information, consider saying something like, “I would be happy to tell you more about my education and profession when we meet, but I have altered it here for professional reasons.”

- **Have a colleague review your profile for potential concerns** (Kolmes, 2013; Kolmes & Taube, 2014). A colleague may provide some insight into how a client could interpret the contents.

- **Do not accept matches with clients** (Kolmes, 2010; Taylor et al., 2010). O’Neil et al. (2018) found 2.4% of mental professionals using online dating services said they matched with a client. To reduce the possibility of multiple roles and blurred boundaries, psychologists should not accept clients as matches or affiliate their online dating profile with a client. If this was unavoidable due to the dating service used, use clinical judgment in processing what happened with the client.

- **If you are aware a client viewed your profile, discuss this with them** (Taylor et al., 2010). The majority of clients (72%) who found information on their therapist online did not discuss what they saw with their therapist (Kolmes & Taube, 2011).

- **Refrain from searching for clients to avoid unintentional client disclosure.** Kolmes and Taube (2014) found 2% of psychologists with online dating profiles deliberately searched for a client on an online dating site. The literature on searching for information on clients in non-emergency situations raises concerns about practitioners’ motives in searching for information, how new information affects client trust and therapist objectivity, and the ethics associated with discovering a client is engaging in harmful behavior (Kolmes & Taube, 2014; Lehavot et al., 2010; Tucknick et al., 2011). If a counselor happens to find information online about a client accidentally, they should talk to the client about it.

**Conclusion**
The APA Ethics Code does not explicitly address the behavior of its members with regards to their conduct online, but some of the content typically included in online dating profiles has the potential to negatively impact the therapeutic relationship and the field as a whole. Unintentional therapist and client disclosures risk jeopardizing the relationship and trust that psychologists strive to establish with their clients. Additionally, if a therapist and client’s online dating profiles were linked or “matched” in some way, the additional information about the client could risk the therapist’s objectivity, increase the likelihood of a dual relationship, and possibly result in the client believing in the possibility of a romantic relationship with a therapist. Training programs and supervisors are encouraged to talk to trainees about the possible professional implications of partaking in online dating. In this article, I attempted to provide some recommendations for using online dating services but certainly not all of the recommendations proposed will work for everyone. The purpose of the list of recommendations is not to tell practitioners what to do but to encourage mental health professionals to reflect on how using dating services has the potential to impact clients and to make decisions with these considerations in mind.

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Clinical situations involving high-risk factors (e.g., suicidality) can be stressful and demanding for therapists (Cramer et al., 2013; The Suicide and Self-Destructive Behaviors Study Group, 2018). Challenging client behaviors, including those related to high risk, have also been linked to burnout (Berger, 2011; Ross et al., 1989; Rupert & Morgan, 2005). Arguably, these factors can impact therapists’ competence (Simionato & Simpson, 2017).

Developmentally, early career psychologists have a higher risk of burnout than late-career psychologists (Craig & Sprang, 2010; Semionato & Simpson, 2017). Early career psychologists (ECPs) are transitioning from a student role to a professional role and face unique career adjustments and demands. Some of these demands include “starting a practice or career and starting a family” (Barnett, 2015), obtaining licensure, educational debt, and developing a professional identity (Green & Hawley, 2009). Newly licensed ECPs can also face the unique challenges of dealing with risk-related issues on their own for the first time (e.g., no direct supervisor guiding them) and stressors related to being the sole decision-maker (including changes related to liability). At the same time, many ECPs might be starting their licensed practice without the formal training needed for competency in the assessment and management of high risk-related issues. Furthermore, according to Groth & Boccio (2018), “practitioners’ formal graduate training in suicide risk assessment and management has been shown to be limited and, in many cases, inadequate” (p. 1241).

When ECPs start a new phase in their career or take on a new role in their existing position, this can create a stressful and demanding process of learning new procedures, navigating added responsibilities, and feeling emotionally and physically stressed. In addition, many ECPs might be new supervisors, and therefore have to manage not only their clinical caseloads but those from their supervisees.

All of these changes can be wonderful, growth-provoking, and engaging experiences. However, these experiences can also make ECPs feel vulnerable, especially when clinical situations require competence. Therefore, how can ECPs maintain their best selves in clinical situations involving risk? How do they connect with their secure base from which they can be curious, present, and helpful to clients?

Here are seven aspects to consider that might help us be our “best selves” when dealing with high-risk clinical situations.

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Self-care
• Engage in self-care on an ongoing basis (Cramer et al., 2013). Self-care starts with maintaining “a general good baseline,” which includes adequate amounts of sleep and food intake (Barnett, 2015). Self-care strategies and activities will vary based on what works for each individual and might include exercising, meditation, seeking support from others, spending time outdoors, etc. Find what works for you.
• Engage in self-care after dealing with a situation involving high risk to help restore you to your baseline. Examples of activities could include socializing, resting, completing a relaxation exercise, watching a video, using cognitive and behavioral coping strategies (Sim et al., 2016). Use anything that helps your body and mind reset.

Knowledge
• Learn specific content regarding risk-related issues, such as management of non-suicidal self-injury, suicidality, safety planning, homicidal risk, and substance use, among others. Knowledge regarding specific questions for assessment, including risk and protective factors, is central for clinical work. Additionally, knowing about general theories (such as the Interpersonal Theory of Suicide) might provide a framework to understand the client’s experience. Opportunities to gain such knowledge might include professional development activities (e.g., taking CE credits and/or attending conferences such as the ones from the American Association of Suicidology), consultation with others in your workplace or community, and reading books and academic papers on the subjects.
• Know the laws, protocols, and procedures regarding the management of high-risk situations. These can differ based on location and work environment. So, it is important to learn about protocols related to the specific place of work and the larger community (e.g., your state).
• Document your work (Cramer et al., 2013).

Consultation
• Engage in consultation regarding the case. This consultation can take the form of consulting with a colleague, discussing the case in a treatment team and/or crisis team, etc. All these activities have the value of bringing new information and/or perspectives to help us navigate challenging cases. Plan ahead regarding whom you could consult if needed (Cramer et al., 2013). Peer support can be highly valuable when navigating challenging clinical situations.

Teamwork
• Determine if there is a network of people with whom you can coordinate care or can alert if concerns arise. This network might include a psychiatrist working with the student, parents, friends, or significant others.
• If such a network is not in place, try to create one if possible. This might entail getting authorizations for release of information to parents and contacting them (unless the client is at imminent risk of hurting themselves or others, consent becomes unnecessary), connecting the client with a psychiatrist, and etc. Receiving assistance in a case involving high risk is not only good practice but might also help share the weight in cases that are too de-
emanding to carry on one’s own (Cramer et al., 2013).

Awareness of own reactions
- Be mindful of the different thoughts and emotional reactions that you have before, during, and after a particular high-risk case; noticing how they might be affecting you and your work (Cramer et al., 2013; Joiner, 2005; Sim et al., 2016).
- Be aware of and work on your countertransference. There are many definitions of countertransference, though I’m considering it as the “…therapist’s internal or external reactions that are shaped by the therapist’s past or present emotional conflicts or vulnerabilities,” Gelso & Hayes, 2007, p.25). If you have experiences that might get in the way of your current work, it is central to understand and address them to be able to bring your best self forward.
- Engage in ongoing self-reflection regarding risk-related situations. Consider your comfort when dealing with chronic and/or acute suicidality and/or homicidal thoughts, along with other risk factors. This knowledge could help you determine the type of work that might better suit you (where you can be your best self when dealing with risk). For example, this can be a factor in helping you choose between counseling centers—where staff members do not provide after-hours on-call services, where staff members provide such service, or a solo private practice versus a group practice where you might potentially have more support.

Setting boundaries
- Be mindful of and engage in setting boundaries (Sim et al., 2016). For instance, when working with a high-risk client, plan ahead of time and communicate when it is appropriate to contact you directly versus going to the emergency room. Boundaries can also be determined based on your own needs. For example, taking a pause when needed.

Compassion
- High-risk situations can be distressing and having a compassionate attitude toward ourselves and toward those whom we work with can be highly beneficial. This compassion does not mean that as psychologists, we sanction every behavior. A compassionate attitude can be a way to remind ourselves that those who are in front of us are suffering, are here for a reason, and we are doing our best to help them in this process. This attitude can be especially challenging when dealing with clinical situations such as meeting with someone with homicidal ideation and high levels of anger. However, tapping into compassion might help lighten our emotional load, open the space for curiosity, and help us focus on what the client (and any others involved in the case) directly needs at this moment.

The different topics previously addressed are by no means an exhaustive list of aspects to address when working with challenging cases involving risk. Nonetheless, these suggestions can provide a roadmap of areas that early career psychologists might consider when working with such cases. These suggestions may also serve as guidelines that can bring out our best selves into the therapy room. Future research might illuminate specific recommendations for ECPs when dealing with risk in clinical settings, and how these guidelines might continued on page 44
be similar and/or different to what is needed when dealing with risk during other periods in a psychologist’s career.

References


Just as psychotherapy is a fundamentally humanistic enterprise (Wampold, 2007), human interaction and social relationships are fundamental to learning the craft of psychotherapy research. Learning through guided apprenticeship (i.e., mentorship) is common whether one is training to become a physician, a plumber, a scientist, or simply learning to talk (Collins, 2006). The apprenticeship model has deep roots in the history of psychotherapy as well—the famous mentorship between Sigmund Freud and Carl Jung is one of countless examples (Humbert, 1988). At its best, mentorship is enjoyable, gratifying, and inspiring for both mentor and mentee (perhaps 1907 to 1911 for Freud and Jung). At its worst, mentorship can be frustrating, time-consuming, inefficient, and induce feelings of discouragement and resentment for both the mentor and mentee (perhaps 1912 onward for Freud and Jung).

As a second-year assistant professor, I find myself in the liminal space between mentee and mentor. Both roles have become salient parts of my professional identity. I am grateful for my experiences as a mentee. These relationships have been and continue to be deeply supportive and instructive. I am only beginning to develop my skills in mentorship, but my current mentees and early missteps have jumpstarted my learning process (with gratitude for their patience as I am learning). I offer here some reflections empirically supported by only the evidence of my own experience—primarily as mentee and more recently as mentor. As these are all my opinions, I have opted to not tire the reader by continuing to restate this fact throughout.

1. Find a Shared Purpose
As Hurston (1996) points out, research requires a purpose. Of course, every scientific study should have a purpose that is clearly articulated (and if not, an attentive reviewer is likely to highlight this important limitation). However, the shared purpose that forms the basis of a successful mentorship relationship is likely broader than that captured by a single study. Ideally, the purpose bringing one to a particular research area should be something both mentor and mentee care about sincerely. While re-
search being simply “me-search” is its own liability and can become a source of bias that inhibits the research process, there is no substitute for actually caring about the topic you study. A high degree of overlap in interests can go a long way in a mentorship relationship.

Mentees-to-be can benefit from asking themselves, “What aspect of psychotherapy truly interests me?” Is it the role of emotional expression, multicultural competence, the influence of client and therapist attachment, or the application of a specific cognitive behavioral technique to a specific disorder? Prospective mentees can greatly benefit from even a few hours spent reading abstracts of psychotherapy research journals, simply paying attention to which studies naturally grab their interest. I also encourage students seeking mentors to read their prospective mentors’ papers, asking themselves, “Would I have actually wanted to do the work to conduct this study? Would I have wanted to write this paper?”

At the end of the day, psychotherapy research is often dry and tedious. It commonly involves long hours of data analysis (not to mention study design, data collection, and learning data analytic methods), feeble attempts at making sense of confusing patterns of findings, and eventually, if we are lucky, opportunities to haggle (it can feel endlessly) with reviewers. It helps immensely to care about the topic over which you are laboring, and sharing that sincere interest with another makes the experience all that more enjoyable.

2. Get Your Hands Dirty

Students of psychotherapy research can (and should) take various methods classes. But, most of us need firsthand experience to really consolidate our learning. Collaborating on a specific project can be a great way to initiate and develop a mentorship relationship. Mentors can consider whether they have an available data set with which a mentee might be able to work. Or perhaps a portion of an upcoming paper that a mentee could draft? Ideally this takes place relatively early in graduate school (e.g., within the first year). In the best-case scenario, these early collaborations allow the mentee and mentor to start developing a symbiotic mentorship relationship, one in which both parties are able to benefit and neither party is being taken advantage of. In addition, early collaborations can help a mentee develop crucial skills necessary for pursuing their own independent work and building other collaborative relationships. These initial experiences can promote a sense of self-efficacy along with an accurate view of the joys and sorrows of the research process.

Early collaborations can be delicate and require patience and commitment from both parties. It can be particularly helpful to have clear expectations regarding the anticipated process and outcome of a particular project. Further, having both mentor and mentee follow through on their stated commitments is essential for building a foundation for collaboration.

3. Find Tasks Within the Mentee’s Zone of Proximal Development

I strongly encourage mentees to get their hands dirty with data analysis or manuscript preparation early in graduate training. The important caveat is that for these experiences to fulfil their educational potential and support a budding mentorship relationship, they must occur within the mentee’s zone of proximal development (and, ideally, the mentor’s area of expertise and interest). This, of course, takes a fair bit of finesse and honest self- and other-assessment.

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4. Do Not Look Down on Volunteer Opportunities

This is a primarily mentee focused suggestion, but one I have found so thoroughly useful that I could not leave it out. I have had numerous experiences in which I was allowed to do something I was largely unqualified to do (e.g., analyze data for the first clinical trial in which I participated) simply because I was not being paid. Of course, the capacity to work for free is a luxury and indicative of my own privilege and institutional financial support during graduate training. Clearly, graduate students and other trainees should be paid a living wage and compensated for their work. Yet if one is able, collaborating on a volunteer basis can be indispensable for developing psychotherapy research skills and building mentorship relationships. These low-investment interactions can offer both the prospective mentor and the mentee-to-be an opportunity to “test drive” a potential mentorship relationship and gauge the degree of synergy.

There are two important caveats here. First, even though financial resources are not being exchanged, it is crucial that both the mentor and mentee are clear about their commitment (e.g., the specific tasks they are planning to complete, the mentorship they are planning to provide) and follow through. Second, it can be tempting to take on volunteer opportunities that may be a bit outside of your actual area of interest. This can be worthwhile (e.g., to learn a particular method or work with a particular mentor), but should be done sparingly. Volunteering may be especially worthwhile if it allows you engagement with a research area you sincerely care about.

5. Open the Lines of Communication

Even with the best of intentions, varying degrees of conflict are likely to arise within a mentorship relationship. Graduate training is difficult (e.g., 39% to 41% of graduate students report symptoms of depression and anxiety in the clinical range; Evans, Bira, Gastelum, Weiss, & Vanderford, 2018). Science is hard and unforgiving. Reviewer 2 will be Reviewer 2. The world often seems to be falling apart. For these reasons and more, it is vital that mentors and mentees are able to communicate with each other. Communication can be fraught, due to wide variety of factors (e.g., histories of oppression related to social identities held by the mentor and mentee). Perhaps the most notable consideration that can influence communication is the power differential that often exists between mentor and mentee. A graduate advisor functioning as a mentor may be invested in a mentee’s scientific development while simultaneously holding the keys to a mentee’s successful completion of their doctoral training. Given the power dynamic, the onus to invite and model transparent communication is primarily on the mentor. In addition, expectations about the frequency, responsiveness, and means of communication should be defined early and upheld. It can be especially helpful for the mentor to initiate conversations regarding the more delicate parts of the relationship.

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search process early and often (e.g., negotiating authorship order).

**Have Fun**
A final suggestion is that the mentor and mentee bear in mind that training in psychotherapy research can (and should) be fun. This echoes the first part of Hurston’s (1996) definition of research as formalized *curiosity*. Those who find themselves drawn to study psychotherapy are often compelled by a genuine curiosity about the human experience and the possibility of healing through interpersonal relationships (e.g., between therapist and client). To inhabit a moment in history where we can explore these questions professionally and scientifically is quite remarkable. Psychotherapy research offers a full-body work-out for the mind and heart, engaging at the intersection of rich theoretical traditions and cutting-edge quantitative and qualitative methods, set against the backdrop of a commitment to promoting human flourishing, reducing suffering, and working towards social justice and inclusivity. If that is not fun, I do not know what is.

**Conclusion**
Mentorship relationships are a primary way that we learn to become psychotherapy researchers (and pretty much anything else). Mentorship relationships can be one of the best parts of our work and training. Yet just like a psychotherapy relationship, smooth sailing is not guaranteed. It is important to recognize that not all mentorship relationships are the aspirational well-oiled machine outlined here. Indeed, evidence suggests that almost 50% of graduate school mentorship relationships are not (at least according to the graduate student; Evans et al., 2018). A final suggestion is that mentors and mentees choose each other wisely and recognize that there may be times when it is appropriate and most supportive to go separate ways. Not all mentorship relationships are a good match and it can be helpful to recognize this early and plan accordingly.

However, my hope is that by pursuing the factors outlined here, mentors and mentees can be better-equipped to spend their energies not on rupturing and repairing their mentorship relationship, but on addressing the important, timely, and fun questions we get to explore as psychotherapy researchers, like what makes psychotherapy work anyways?

**References**
Steve Ragusea, a long-time psychologist friend, keeps reminding me that “clinician burnout” is a major public health hazard in today’s healthcare environment. The National Academy of Medicine’s report “Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being” fully supports his view, finding that between 35 and 54 percent of the nation’s nurses and physicians have substantial symptoms of burnout, with between 45 and 60 percent of medical students and residents reporting similar concerns. Their underlying conclusion: “The high rate of clinician and learner burnout is a strong signal to health care leaders that major improvements in the clinical work and learning environments have to become a national and organizational priority.” We would wonder, however — what have these dedicated clinicians been doing proactively to take care of themselves? Health care providers represent the educated elite of society. Yet, could they learn from the experiences of colleagues such as Mike Sullivan (former of APA) and Dale Smith (Professor of Military Medicine & History at the Uniformed Services University)?

Volunteering for Meals on Wheels. I am writing this update on Martin Luther King, Jr. Day in 2020, which marks the 25th anniversary of its being the only federal holiday designated as a national day of service. “A day on, not a day off” aims to encourage Americans to volunteer on this holiday to improve their communities. I am most fortunate to be able to do this as my part-time unpaid job in retirement. I deliver Meals on Wheels four days a week at lunchtime and enjoy it. I’ve been doing this for 13 years, which was as long as I worked for APA’s Practice Directorate. It’s been just as fulfilling for me as my paid work there was.

The Meals on Wheels program offers volunteers many benefits, of which I would like to mention four. First, it provides the chance to give back to others. Marian Wright Edelman’s observation that “service is the rent we pay for being” has always been a personal aspiration. Meals on Wheels gives volunteers the opportunity to serve others who are in need. Delivering a meal is a small thing, really. But at the same time, it is a big thing because feeding the hungry is a noble calling. Doing it gives meaning and purpose to one’s life.

Second, the Meals on Wheels program makes it easy to volunteer. Volunteers don’t have to buy the food or cook the meals or package them. All we have to do is pick up our meals and deliver them. Third, the Meals on Wheels program makes a big difference in the lives of so many elderly, frail, and home-bound seniors. Volunteers see this firsthand. Getting a hot meal every day saves many people from going hungry. It makes it possible for some home-bound persons to remain in their own homes rather than be institutionalized. It gives many isolated elderly people daily contact with another human being.

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Fourth, the Meals on Wheels program gives volunteers a chance to get to know their communities better, and to do other helpful things. For example, my wife Susan was delivering meals to an endearing lady named Louise who lived on a street with three abandoned houses. The vacant buildings were an eyesore and a safety threat. Susan made persistent calls to the city government and got all three houses torn down. One of Louise’s neighbors then planted a vegetable garden there. On one of my routes, a very bright man named David had been down on his luck for years. He was estranged from his family. He was trying unsuccessfully to subsist on Social Security of $511 a month, far below the federal poverty level. I was able to help David increase his income by almost $3,000 a year. All I had to do was print out applications for benefits programs he was entitled to but not receiving. That extra income afforded him more dignity and less hardship.

Being in a position to do extra things like these is all due to local Meals on Wheels programs. Senior Resources is the nonprofit organization in Columbia, South Carolina that operates my program. Each year their volunteers deliver almost 170,000 meals to over 1,000 clients, driving over 55,000 miles. These are remarkable numbers for a small city, yet funding shortfalls mean there is always a waiting list to receive meals. Nationally, the crisis is alarming with 5.5 million seniors being food insecure and often socially isolated and financially strained. I recommend the Meals on Wheels program as a volunteer opportunity to anyone who can spare a couple of hours once a month, or once a week, or more. Truly, “It is better to light one candle than to curse the darkness” (the Christophers)” (Mike Sullivan).

A few months ago, I asked another friend and colleague at USU, Dale Smith, to coffee and he declined “because he was to be in prison that day” – a response which begged further inquiry. Dale told me he participated in a Christian Interdenominational ministry program called Kairos and went into a local prison twice a year for a long weekend to provide this ministry. I was intrigued and asked for more information: did they stay the whole time, what was the nature of the program? Dale told me of Kairos International and its local branch, Kairos of Maryland. Kairos is an international program that started in Florida in the 1970’s; it is now in over 400 correctional institutions in 36 states and nine other countries. It has three components: Kairos Inside (a four-day intensive ministry in the prisons — the volunteers go to a local motel each night), Kairos Outside for the spouses of those incarcerated; and Kairos Torch, a one on one mentoring program for young (under 25 of age) offenders to help them reintegrate into society. It has 13 staff members and approximately 30,000 volunteers who contribute over three million hours of service each year.

The central theme of the ministry is “Listen, listen, love, love” and centers on the idea that most prisoners are isolated and feel abandoned. By listening to their concerns and affirming by their presence that the individuals are loved by God and their fellow man. The goal is to build a transforming community in the prison thru Kairos alumni joining a weekly, prisoner run, meeting called “Pray and Share.” The “Prayer and Share” sessions have outside volunteers as guests of the prisoners to continue the theme of “Listen, listen, love, love.” Does it matter? Dale tells me that wardens in multiple prisons have affirmed that as the Kairos Christian community inside a prison grows and begins to gain influence, the incidence of violence de-

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creases. In a study of 505 inmates released from Florida prisons, the recidivism rate was only 15.7% among those who had participated in one Kairos session, and just 10% among those who had participated in two or more Kairos sessions. The non-Kairos control group in the study had a recidivism rate of 23.4%. In Maryland, where the state is having great difficulty in recruiting and retaining correctional officers, the Kairos of Maryland program in 10 institutions for both men and women is building pro-social character and behaviors and changing the community.

I cannot help but wonder if those who find themselves feeling increasingly overwhelmed by the day-to-day pressures of their current employment environment would take the time to reflect upon what is really most important to them—perhaps by becoming engaged in meaningful volunteer activities such as those described above by dedicated colleagues—that the reported rate of clinician and learner burnout would be significantly lower. Randy Phelps, another former senior staff member in the APA Practice Directorate, is now the CEO of Give an Hour. By the end of last year their licensed mental health providers had topped 300,000 hours of free mental health services (valued at $30 million) for Veterans, military personnel, and their families. In 2015, they expanded their services to address the mental health needs of other populations including at risk teens, survivors of gun violence, and those affected by natural and man-made disasters. There are clearly many opportunities for those colleagues willing to reach out and address society’s pressing needs.

The National Academies of Sciences, Engineering, and Medicine (NASEM) released its workshop proceedings Multigenerational Approaches to Fostering Children’s Health and Well-Being: The Opioid Crisis as a Case Study at the end of last year. “The opioid crisis affecting countless families throughout the United States has caught the attention of groups spanning the sectors of health care, education, social services, criminal justice, and even business and labor. According to the Centers for Disease Control and Prevention from 1999 to 2017, more than 700,000 people died from a drug overdose. On average, 130 people die every day from an opioid overdose in the United States. Within these average numbers, certain populations are being affected more than others. According to the National Institute for Children’s Health Quality: ‘The crisis is especially prevalent in rural and economically disadvantaged communities where poverty is associated with poor physical and mental well-being, health access is limited, opioid prescription rates are higher, and treatment programs are few.’ Children are one of the most vulnerable populations caught in this public health crisis, as a growing number are sent to live with other relatives or placed in foster care following the death of a parent or a parent’s inability to continue as a primary caretaker while in recovery.” For those colleagues who take the time to reflect, they will find that there are numerous venues where they can contribute their needed skills.

Reflections from the Past: When I became President of APA in 1987, several major problems were facing us. One of the most important was that having assumed ownership of Psychology Today, we were fast approaching bankruptcy. In dire financial straits, we decided to sell the magazine. We went further to sell our buildings and begin the search for a new building site. We found an excellent location where our magnificent

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building now stands and acquired another building close by.

At that time, many of our officers and members believed the governance system of APA to be inefficient and outdated. For several decades, various Committees and Task Forces had proposed new models for reorganization, all of which had been met with failure. A new working group was formed and delivered yet another proposed model of governance for APA, a federation model. Most science-oriented members of the Association supported the proposal but practitioners were opposed. The plan failed when put to a vote by members. Disappointed by the outcome, many academics and psychological scientists left APA and established what is now APS, the Association for Psychological Science.

I proposed the first Opening Ceremony of our Convention. I would regularly hold meetings to try to establish more positive relationships with our counterparts such as Psychiatry and Nursing. I represented APA in various capacities including international meetings. I testified before Congress for increased funding for psychology and the social sciences and for increased attention to and support of efforts to combat the AIDS epidemic. I marched with psychologists and allies in one of the earliest demonstrations for LGBT rights. I proposed a Task Force on Women and Depression. Excerpts from the findings were printed on the first page of The New York Times as well as across many other newspapers. Task Force members appeared on major television shows. Media coverage was the most APA had ever received and a book covering the work of the Task Force was published. During that time, women and minorities were underrepresented in APA. Perhaps the actions for which I am most proud, were my overall efforts to recruit and maintain more women and minorities into the Association and the governance.

Being President of APA was both exhilarating and humbling. Members of APA appeared to support me, and it was a delight to work with the officers and staff of the Association. I made close friends and enjoyed meeting psychologists from other nations and other mental health organizations. It was a busy and exciting year and I will be eternally grateful for the opportunity to have served” (Bonnie Strickland). “Your dreams come true.”

Aloha,

Pat DeLeon, 
former APA President – Division 29
It is a real honor to be nominated as a candidate for the role of President-Elect of the Society for the Advancement of Psychotherapy. I have been involved with the Society for several years now as a member, board member, and committee chair, and consider it my professional home. As a psychologist in independent practice in Honolulu, Hawaii for over 30 years, and an adjunct faculty member of the Clinical Studies Program of the Psychology Department at the University of Hawaii, I don’t imagine that many will know me, so I will try to introduce myself here.

In my practice, I am a generalist dealing with individuals, couples, and families in psychotherapy, and I also work with elderly and disabled patients in long-term care facilities. Each type of work involves different ethical and cultural considerations. I have developed experience with issues arising from contested divorce, child custody, and conflictual parenting matters. I have sought out training in these areas throughout my career and try to remain current with developments in the field through journals and conferences. I have had the opportunity to work with many families going through these large transitions as a psychotherapist, custody evaluator, parenting coordinator, and educator to the Family Law Section of the Hawaii Bar Association. As the chair of the Hawai’i Psychological Association’s Ethics Committee, I have dealt with complaints and questions about psychologists’ actions and inactions in these highly contested cases and have conducted several professional educational workshops with esteemed colleagues for psychologists practicing in this arena. I have served as an expert witness to the Family Court on divorce, custody, and domestic violence.

To combat the potential for isolation as a sole private practitioner, I have been actively engaged in the profession of psychology at the State and National level. In addition to seeking my own continuing education, I consider providing workshops and talks to my colleagues an important aspect of protecting the profession and the public from the issues arising from lack of contact with other professionals.

I have been involved with the Hawaii Psychological Association in multiple roles including President, and currently serve as chair of the Ethics Committee and the Continuing Education and Convention Committee. This has given me the opportunity to consider a broad range of issues, particularly those arising in rural communities and in diverse multicultural settings. I am currently also serving on the Hawai’i State Board of Psychology, towards the end of my second term, and am a past chair.

Within APA, I served as Hawaii’s delegate to the Council of Representatives, member and co-chair of the Rural Health Committee, and member of the Continuing Education Committee. Within the academic community in Hawai’i, I teach as a clinical faculty member in the psychology department, and served for several years as one of two psychologist members of the Kapi‘olani Medical Center for Women and Children’s IRB, reviewing medical

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research proposals, focusing on the protection of vulnerable populations.

Working as a full-time psychotherapist in Hawai‘i provides me with a very diverse perspective on individuals, families, parenting, and the role of culture in psychotherapy. The population of Hawaii is the most ethnically and culturally diverse in the nation; there is no distinct majority group. About 39% are of Asian ancestry (Japanese, Chinese, Filipino, Korean), 25% Caucasian from all over the world, 10% Native Hawaiian or other Pacific Islanders, 9% Hispanic, under 2% African American, and less than 0.5% Native American or Alaska Native; and about 25% of all Hawaii residents are of multi-ethnic background. In addition, Hawaii—outside of the main city of Honolulu and the larger towns on each island—is a rural, multi-island community with all the additional challenges of isolation and lack of access to resources. Psychologists strive to adjust these special circumstances while remaining ethically centered.

If I were fortunate enough to be selected as President-elect, I would wish to focus of the issues of promoting public knowledge of psychotherapy and increasing access to care within a multicultural framework.

Thank you for considering me for this role.

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**Clara Hill, PhD**

We ask our clients to reflect on their motives for their actions so it’s only fair that I reflect on my motives for running for president and try to be honest so that you know what you’re getting if you vote for me.

When I was asked to run for president I was flattered but ambivalent. On the one hand, I have a lot going on in my life and don’t need to add another thing. Although supposedly semiretired, I am busier than ever with research projects and enjoying them immensely. My research is intellectually stimulating and I think I can make a difference in adding to the science base of psychotherapy.

On the other hand, I am not doing much for the profession of psychotherapy right now. I have enjoyed being president of the Society for Psychotherapy Research and editing two journals, so I know that I like contributing on this larger level. In the long run, I decided that I have something to offer if I were to become the President and decided to run.

I would like to:

- Think of ways to help practitioners feel less isolated and more a part of the community of Division 29
- Build more resources for clients and the lay public
- Advocate for changes to continuing education requirements
- Advocate that therapists engage in lifelong supervision
- Advocate for a new initiative on Psychotherapy Techniques that Work, similar to Norcross’s excellent work on Psychotherapy Relationships that Work.
I am honored to be nominated for re-election as Secretary of APA Division 29. I have greatly appreciated the opportunity to serve in this leadership role since 2018 and to bring an early career psychologist perspective to our Division’s Executive Board. It would be a privilege to do so for another term. My commitment to the integration of psychotherapy science and practice began as a graduate student at UMass Amherst where my work focused on the influence of patient expectations on psychotherapeutic change. In my current position at VA Boston, I remain dedicated to the advancement of psychotherapy through my work adapting treatments for use in integrated medical settings, educating and consulting with staff, providing patient care, and supervising clinicians-in-training. I also teach psychotherapy courses and maintain active involvement in other psychotherapy-oriented professional associations.

I feel particularly indebted to Division 29 for awarding me the 2012 Donald K. Freedheim Student Development Award, as well as publishing my work in the Division’s journal, *Psychotherapy*, and the Division-sponsored book, *Psychotherapy Relationships that Work*. Thus, I am enthusiastic about the prospect of continuing to give back to the Division through this leadership position. In a second term as Secretary, I would build on my contributions, including maintaining our Society’s records, developing a new Division logo, and organizing our Board diversity retreat.

Beyond Division 29, I have utilized my strong organizational skills in diverse administrative contexts, such as coordinating multi-site research trials, implementing national VA health initiatives, and organizing international research meetings. If re-elected, I will aim to streamline voting procedures and increase student and early career psychologist membership. I would also continue to bring great enthusiasm to the position, as I strongly believe in the Division’s mission to advance the science, practice, and teaching of psychotherapy. Thank you for your consideration!

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As the practice, education, and training of psychotherapy along with practice-based and conceptual scholarship have been the central cornerstones of my career, it is an honor and privilege to stand among highly qualified others for election to serve as Secretary for the Society for the Advancement of Psychotherapy. The Society and the American Psychological Association and the world at large are amid significant transformations. Within SAP, the numerous initiatives and member facing services require tremendous coordination and creativity. Externally, an ethics code undergoing revision, a new consensually-developed strategic plan are just a few of the transformative processes that contextualize psychotherapy. Developments in technology and AI will provide yet un-

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dreamed-of possibilities. Moreover, changes in the context and funding for both the practice of and research on psychotherapy remain in state of high fluidity. As the secretary role provides essential support to SAP, understanding such perspectives are helpful.

I believe that my experiences on the Governance Board of Division 29 as well as Executive Boards of Divisions 17 (Counseling) and 13 (Consulting) along with my APA roles [past Chair of the APA Board of Professional Affairs, past Chair of the APA Membership Board, a member of the APA Board of Directors these past three years, and now a member of the Policy & Planning Board] have given me the knowledge and skills, as well as the connections with key groups and individuals, to enable me to be effective in supporting, advancing and advocating for the priorities of the Society. I pledge to support the further development of the many awesome programs and resources the Society is currently offering and has plans to expand upon. Leveraging new technologies—those that exist and those to come in the near future—offers significant promise for yet further advancement.

Barbara Thompson, PhD

I am honored and excited to be nominated for Secretary of the Society for the Advancement of Psychotherapy (SfAP). I was initially drawn to the Society because it fit with my personal focus on psychotherapy practice, training and supervision, and psychotherapy research. After I received my Ph.D. in Counseling Psychology from the University of Maryland, I embarked on a varied career path that has included running acute care clinical programs, teaching graduate level counseling, providing supervision to doctoral students and spending over 25 years in private practice. In addition, I have collaborated over the years on many psychotherapy research studies on varied topics including misunderstanding events, client reactions, self disclosure, and therapist needs.

In the past 8 years, I served on the SfAP Board as the representative of the Professional Practice domain and more recently as a member of that Committee and the Membership Committee. Working with the Society has given me the opportunity to be a voice for other psychotherapy practitioners and to witness a wonderful transition as the Society became more diverse, expanded our membership to international members and non-psychologists, and upgraded our website. I have been amazed at how much expertise, knowledge, and resources SfAP has to offer practitioners.

If elected as Secretary, I would continue to work toward making our Society and the resources we have more accessible to other psychotherapists, psychotherapy researchers, and trainers/supervisors by encouraging current and relevant material on our website, promoting an expanded membership, and facilitating practice-rich continuing education offerings. I believe that my passion about psychotherapy, experience and commitment to improving the practice of psychotherapy creates a solid foundation from which to serve as Secretary for the Society.
I never see myself as a leader but a team player. I enjoy working in groups with colleagues pursuing meaningful professional activities. In the past few years as the Chair of our Society’s Committee of International Affairs, I have the opportunity of working with a large group of SAP members toward internationalization. Our committee, composed of eleven psychotherapy scholars and two graduate students from 6 countries, reached several goals including bringing SAP to one international conference outside the U.S. per year, building an international liaison program, organizing one international program for APA convention each year, and establishing partnership with non-U.S. based professional entities to enlarge SAP presence in other countries (we have successfully built one such partnership). These achievements were exciting, but the joy of doing so with great colleagues is no less significant. Thus I want to help build international relationships for more SAP members. As our current domain representative is retiring from the position, I want to step up and run to fill the vacancy, so we can keep the momentum about carrying out a number of new committee initiatives including connecting SAP members with diverse expertise with the need internationally.

I am a Chinese American woman, and received a doctoral degree in counseling psychology and social psychology from University of Maryland. I started my professional career in University of Missouri at its counseling center and in its academic department, then joined counseling psychology faculty at University of Missouri Kansas City. Currently I am a professor of counseling psychology and Director of Training for our APA accredited doctoral program at the University of Kansas. I have been involved in various service roles within APA, including being a council member, a commissioner on the Commission of Accreditation, and a member of the Committee on International Relations in Psychology (CIRP).
“How much does psychotherapy cost? Who has access? How do practitioners from diverse backgrounds think about healthcare? What kind of healthcare system best addresses our nation’s mental health needs? As Social Justice Domain Representative, I will tackle these questions and position our Division as a leader in discussions of healthcare reform within APA and society at large.

My work in APA governance has focused on addressing the needs of practitioners and the communities they serve through attention to public policy, clinical practice, and social justice.

As liaison of Division 39 (Psychoanalysis) to the Committee on Ethnic Minority Affairs from 2013 to 2020, I helped craft policy on research, training, and practice across APA, while providing feedback to APA agenda items to enhance their cultural inclusiveness and address questions of racial and economic equity.

More recently, I served as Chair of the Professional Practice Committee of Division 29 (Psychotherapy) from 2019-2020, where I developed programming on building a sustainable, socially conscious private practice within our broken healthcare system.

As a practitioner I serve predominantly patients of color, and provide consultation to human rights organizations on racial trauma, burn out, and vicarious traumatization. Lastly, I train future psychotherapists at the New School for Social Research in New York City, where I’m also an activist and artist in the Puerto Rican community addressing issues of mental health, race, and economic justice.

As Domain Representative, I will form a taskforce exploring the impact of our healthcare system on psychotherapy. This will involve a mixed-methods study combining an evidence-informed review of research, alongside a brief interview with practitioners on their experience with the healthcare system, and what they believe will need to change. That way, we can begin to imagine what a different and better system can look like to provide psychotherapy for all.”

Daniel Gaztambide, PsyD
**Dr. Rosemary E. Phelps**

is a professor of Counseling Psychology, director of the UGA Preparing Future Faculty (PFF) in Psychology Program, Director of Training in Counseling Psychology doctoral program, and coordinator of the Human Services minor in the Department of Counseling and Human Development Services at the University of Georgia. Dr. Phelps received her bachelor’s degree in Psychology and master’s degree in Guidance and Counseling from The Ohio State University, and her Ph.D. in Counseling Psychology from the University of Tennessee, Knoxville. She is the recipient of the 2010 American Psychological Association’s (APA) Distinguished Contributions to Education and Training in Psychology Award and is an APA Fellow (Division 17: Society of Counseling Psychology). Dr. Phelps received the 2016 Ohio State University College of Education Career Achievement Alumni Award. Her 30+ year career has involved teaching, research, and practice related to diversity and social justice issues, ethnic and racial identity development, and professional and career issues for students and faculty of color. Currently, Dr. Phelps’s research focuses on the unique and varied experiences of African Americans in both personal and professional domains that affect psychological well-being. Her professional activities have included national and regional membership and leadership positions including member of the APA Education and Training Awards Committee, chair of the Ethnic and Cultural Diversity Committee, Program Chair of APA Division 17, chair of the Minority Interest Group and the Committee on Equality and Professional Opportunity (CEPO)/PSI CHI Undergraduate Research Program of the Southeastern Psychological Association (SEPA), and President of SEPA in 2018. Dr. Phelps’s career has been spent training mental health professionals to be committed to culturally responsive practice and understanding that social justice not only involves societal inequities due to economics and environmental factors but also due to biases and prejudices related to various types of diversity (e.g., race, ethnicity, gender, sexual orientation, disability, religion). “It would be an honor to serve the Society for the Advancement of Psychotherapy in the capacity of Public Interest and Social Justice Domain Representative to further promote understanding and action related to social justice concerns in society and around the world.”
Brief Statement about the Grant Program
The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually by the Society for the Advancement of Psychotherapy to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three $5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

Eligibility
All graduate students, predoctoral interns, postdoctoral fellows, and doctoral-level researchers with a promising or successful record of publication are eligible for the grant. The research committee reserves the right not to award a grant if there are insufficient submissions or submissions do not meet the criteria stated.

Submission Deadline: April 1, 2020

Request for Proposals
CHARLES J. GELSO, PH.D. GRANT

Description
This program awards grants for research projects in the area of psychotherapy process and/or outcome.

Program Goals
• Advance understanding of psychotherapy process and/or psychotherapy outcome through support of empirical research
• Encourage talented graduate students towards careers in psychotherapy research
• Support psychologists engaged in quality psychotherapy research

Funding Specifics
• Three (3) annual grants of $5,000 each to be paid in one lump sum to the researcher, to the researcher’s university grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities. A researcher can win only one of these grants (see Additional Information section below).

• Funds must be transferred to the researcher, university grants and contracts office, or to an incorporated company by December 15 of the year in which the grant award notification is made.

Eligibility Requirements
• Demonstrated or burgeoning competence in the area of proposed work

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• IRB approval must be received from the principal investigator’s institution before funding can be awarded if human participants are involved

• The same project/lab may not receive funding two years in a row

• Applicant must be a member of the Society for the Advancement of Psychotherapy (Division 29 of APA). Join the Society at http://societyforpsychotherapy.org/

**Evaluation Criteria**

• Conformance with goals listed above under “Program Goals”

• Magnitude of incremental contribution in topic area

• Quality of proposed work

• Applicant’s competence to execute the project

• Appropriate plan for data collection and completion of the project

**Proposal Requirements for All Proposals**

• Description of the proposed project to include, title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)

• CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities

• A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.

• Timeline for execution (priority given to projects that can be completed within two years)

• Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)

• Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

• No additional materials are required for doctoral level psychologists who are not postdoctoral fellows

• **Graduate students, pre-doctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.**

**Additional Proposal Requirements for Graduate Students, Pre-doctoral Interns, and Postdoctoral Fellows:**

• Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work

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Graduate students and pre-doctoral interns must also submit 2 letters of recommendation, one from the mentor who will be providing guidance during the completion of the project and this letter must indicate the nature of the mentoring relationship.

Postdoctoral fellows must submit 1 letter of recommendation from the mentor who will be providing guidance during the completion of the project and this letter should indicate the nature of the mentoring relationship.

Additional Information

- After the project is complete, a full accounting of the project’s income and expenses must be submitted within six months of completion.
- Grant funds that are not spent on the project within two years must be returned.
- When the resulting research is published, the grant must be acknowledged.
- All individuals who directly receive funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31).

Submission Process and Deadline

- All materials must be submitted electronically.
- All applicants must complete the grant application form, in MSWord or other text format.
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file.
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email).
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Patricia T. Spangler at patricia.spangler.ctr@usuhs.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.
2020 Norine Johnson Psychotherapy Research Grant for Early Career Psychologists

Brief Statement about the Grant:
The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually by the Society for the Advancement of Psychotherapy to Early Career Psychologists (within 10 years post earning the doctoral degree), provides $10,000 toward the advancement of research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, psychotherapy process, or psychotherapy outcomes.

Eligibility
Early Career (within 10 years post earning the doctoral degree) Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: April 1, 2020

Request for Proposals
NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT for Early Career Psychologists

Description
This program awards grants to early career psychologists (ECPs) for research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, psychotherapy process, or psychotherapy outcomes.

Program Goals
• Advance understanding of psychotherapy (psychotherapy relationship, process, and/or outcomes) through support of empirical research
• Encourage early career researchers with a successful record of publication to undertake research in these areas

Funding Specifics
• One annual grant of $10,000 to be paid in one lump sum to the researcher, to the researcher’s university grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see Additional Information section below).
• Funds must be transferred to the researcher, university grants and contracts office, or to an incorporated company by December 15 of the year in which the grant award notification is made.

Eligibility Requirements
• Early Career (within 10 years post earning the doctoral degree), Doctoral-level researchers

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• Demonstrated competence in the area of proposed work
• IRB approval must be received from the principal investigator’s institution before funding can be awarded if human participants are involved
• The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
• The selection committee may choose not to award the grant in years when no suitable nominations are received
• Researcher must be a member of the Society for the Advancement of Psychotherapy. Join the society at http://societyforpsychotherapy.org/

Evaluation Criteria
• Conformance with goals listed above under “Program Goals”
• Magnitude of incremental contribution in topic area
• Quality of proposed work
• Applicant’s competence to execute the project
• Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals
• Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
• CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
• A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
• Timeline for execution (priority given to projects that can be completed within 2 years)
• Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
• Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information
• After the project is completed, a full accounting of the project’s income and expenses must be submitted within six months of completion

continued on page 65
• Grant funds that are not spent on the project within two years of receipt must be returned

• When the resulting research is published, the grant must be acknowledged by footnote in the publication

• All individuals directly receiving funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31)

Submission Process and Deadline
• All materials must be submitted electronically at the same time

• All applicants must complete the grant application form, in MSWord or other text format

• CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file

• Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)

• Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net

• You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.

• Deadline: April 1, 2020

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Patricia T. Spangler at patricia.spangler.ctr@usuhs.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.
The Diversity Research Grant for early career psychologists was established to foster the promotion of diversity within the Society for the Advancement of Psychotherapy (APA Division 29) and within the profession of psychotherapy.

The Society may award annually one $1,000 Diversity Research Grant to an early career psychologist (within 10 years of graduation) who is currently conducting research or an applied project that promotes diversity, as outlined by the American Psychological Association (APA). According to the APA, diversity is defined as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.

The Diversity Research Grant is expected to be used to support the completion of an ECP’s psychotherapy research or psychotherapy project. The grant may be used to fund:

- supplies used to conduct the research or project;
- training needed for completion of the research or project; and/or
- travel to present the research (such as at a professional conference).

The applicant must be a member of the Society for the Advancement of Psychotherapy. The recipient of the grant will be expected to present his or her research results in a scholarly forum (e.g., presentation at an APA Annual Convention, in the Society’s journal, Psychotherapy, or other refereed professional journal) or the Psychotherapy Bulletin.

One annual grant of $1,000 will be paid in one lump sum to the researcher, to his or her university’s grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities. All grant recipients will be required to complete an IRS form W-9 before funds are issued.

THE APPLICATION MUST INCLUDE:

- A 1-2 page cover letter describing how the applicant’s work embodies the Society’s interest in promoting diversity in the profession of psychotherapy and how the funding will be used to support the applicant’s work;
- A 1-page document outlining a detailed budget;
- A 5-10 page research proposal
- 1 letter of recommendation from someone familiar with the applicant’s work

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SELECTIONS CRITERIA:
• Consistency with the Diversity Research Grant’s stated purposes;
• Clarity of the written proposal;
• Scientific quality and feasibility of the proposed research project;
• Budgetary needs for data collection and completion and presentation of the project;
• Potential for new and valuable contributions to the field of psychotherapy; and
• Potential for final publication or likelihood of furthering successful research in topic area.

Awardee must be a member of the Society for the Advancement of Psychotherapy (APA Division 29)

SUBMISSION PROCESS AND DEADLINES:
• All materials must be submitted electronically at the same time
• All applicants must complete the grant application form, in MSWord or other text format
• CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
• Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
• Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
• You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.
• Deadline: April 1, 2020. Incomplete or late application packets will not be considered.

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Diversity Domain Representatives Manijeh Badiee, PhD (mbadiee@csusb.edu); Susan Woodhouse PhD (ssw212@lehigh.edu); and or Committee Chair Sheeva Mostoufi, PhD (sheeva.mostoufi@gmail.com)

ADDITIONAL INFORMATION
• After the project is complete, a full accounting of the project’s income and expenses must be submitted within six months of completion.
• Grant funds that are not spent on the project within two years must be returned.
• When the resulting research is published, the grant must be acknowledged.
• All individuals who directly receive funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st).
The Diversity Research Grant for pre-doctoral candidates was established to foster the promotion of diversity within the Society for the Advancement of Psychotherapy (APA Division 29) and within the profession of psychotherapy.

The Society may award annually two $2,000 Diversity Research Grants to pre-doctoral candidates (enrolled in a clinical or counseling psychology doctoral program) who are currently conducting dissertation research that promotes diversity, as outlined by the American Psychological Association (APA). According to the APA, diversity is defined as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.

The Diversity Research Grant is expected to be used to support the completion of a pre-doctoral candidate’s dissertation work. The grant may be used to fund:

- supplies used to conduct the research;
- training needed for completion of the research; and/or
- travel to present the research (such as at a professional conference).

The applicant must be a member of the Society for the Advancement of Psychotherapy. The recipient of the grant will be expected to present his or her research results in a scholarly forum (e.g., presentation at an APA Annual Convention, the Society’s journal, *Psychotherapy*, or other refereed professional journal) or *Psychotherapy Bulletin*.

Two annual grants of $2,000 will be paid in one lump sum to the researcher, to his or her university’s grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities. All grant recipients will be required to complete an IRS form W-9 before funds are issued.

**THE APPLICATION MUST INCLUDE:**

- A 1-2 page cover letter describing how the applicant’s work embodies the Division’s interest in promoting diversity in the profession of psychotherapy and how the funding will be used to support the applicant’s dissertation work;
- A 1-page document outlining a detailed budget;
- A 5-10 page research proposal (alternatively, a Dissertation Proposal may be submitted, regardless of length);
- 1 letter of recommendation from the applicant’s current direct supervisor or advisor; and
- 1 letter from the applicant’s dissertation advisor or director of clinical training certifying that the applicant is currently in the process of completing research for the dissertation.

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SELECTIONS CRITERIA:
• Consistency with the Diversity Research Grant’s stated purposes;
• Clarity of the written proposal;
• Scientific quality and feasibility of the proposed research project;
• Budgetary needs for data collection and completion and presentation of the project;
• Potential for new and valuable contributions to the field of psychotherapy; and
• Potential for final publication or likelihood of furthering successful research in topic area.

Awardee must be a member of the Society for the Advancement of Psychotherapy (APA Division 29)

SUBMISSION PROCESS AND DEADLINES:
• All materials must be submitted electronically at the same time
• All applicants must complete the grant application form, in MSWord or other text format
• CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
• Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
• Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, asnmgmt1@cox.net
• You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please re-submit.
• Deadline: April 1, 2020. Incomplete or late application packets will not be considered.

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Diversity Domain Representatives Manijeh Badiee, PhD (mbadiee@csusb.edu); Susan Woodhouse PhD (ssw212@lehigh.edu); and or Committee Chair Sheeva Mostoufi, PhD (sheeva.mostoufi@gmail.com)

ADDITIONAL INFORMATION
• After the project is complete, a full accounting of the project’s income and expenses must be submitted within six months of completion.
• Grant funds that are not spent on the project within two years must be returned.
• When the resulting research is published, the grant must be acknowledged.

All individuals who directly receive funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st).
The Society for the Advancement of Psychotherapy student award competitions include four awards for the best papers submitted on specific topics and two standard awards:

**DONALD K. FREEDHEIM STUDENT DEVELOPMENT PAPER AWARD**
Best paper on psychotherapy theory, practice, or research

**DIVERSITY PAPER AWARD**
Best paper on issues of diversity in psychotherapy

**MATHILDA B. CANTER EDUCATION AND TRAINING PAPER AWARD**
Best paper on education, supervision, or training of psychotherapists

**JEFFREY E. BARNETT PSYCHOTHERAPY RESEARCH PAPER AWARD**
Best paper addressing psychotherapist factors that may impact treatment effectiveness and outcomes

**PRACTICE AWARD**
Awarded to candidate who best demonstrates commitment to the practice of psychotherapy and exemplary achievement in clinical work

**TEACHING/MENTORSHIP AWARD**
Awarded to candidate who best demonstrates commitment to teaching and mentorship in the context of psychotherapy and related fields

What are the benefits to you?
- Cash prize of $500 for the winner of each contest. Certificate and check presented at the Society’s Awards Ceremony at APA Convention.
- Enhance your curriculum vitae and gain national recognition.
- Abstract will be published in the *Psychotherapy Bulletin*, the official publication of SfAP/Division 29.

What are the requirements?
- All applicants must be members of the Society for the Advancement of Psychotherapy. Join at www.societyforpsychotherapy.org
- Papers, clinical practice, and teaching/mentorship must be based on work conducted by the applicant during his/her graduate studies
- See detailed award descriptions and requirements at https://societyforpsychotherapy.org/members/student-portal/awards/

Submissions should be emailed to:
Carly Schwartzman, Chair, Student Development Committee, Society for the Advancement of Psychotherapy, at cschwartzman@albany.edu

Deadline is April 1, 2020
MEMBERSHIP APPLICATION

The Society meets the unique needs of psychologists interested in psychotherapy. By joining the Society for the Advancement of Psychotherapy, you become part of a family of practitioners, scholars, and students who exchange ideas in order to advance psychotherapy. The Society is comprised of psychologists and students who are interested in psychotherapy. Although the Society is a division of the American Psychological Association (APA), APA membership is not required for membership in the Society.

JOIN THE SOCIETY AND GET THESE BENEFITS!

FREE SUBSCRIPTIONS TO:

- Psychotherapy
  This quarterly journal features up-to-date articles on psychotherapy. Contributors include researchers, practitioners, and educators with diverse approaches.
- Psychotherapy Bulletin
  Quarterly newsletter contains the latest news about Society activities, helpful articles on training, research, and practice. Available to members only.

EARN CE CREDITS

- Journal Learning
  You can earn Continuing Education (CE) credit from the comfort of your home or office—at your own pace—when it’s convenient for you. Members earn CE credit by reading specific articles published in Psychotherapy and completing quizzes.

DIVISION 29 PROGRAMS

- We offer exceptional programs at the APA convention featuring leaders in the field of psychotherapy. Learn from the experts in personal settings and earn CE credits at reduced rates.

SOCIETY INITIATIVES

- Profit from the Society initiatives such as the APA Psychotherapy Videotape Series, History of Psychotherapy book, and Psychotherapy Relationships that Work.

NETWORKING & REFERRAL SOURCES

- Connect with other psychotherapists so that you may network, make or receive referrals, and hear the latest important information that affects the profession.

OPPORTUNITIES FOR LEADERSHIP

- Expand your influence and contributions. Join us in helping to shape the direction of our chosen field. There are many opportunities to serve on a wide range of Society committees and task forces.

DIVISION 29 LISTSERV

- As a member, you have access to our Society listserv, where you can exchange information with other professionals.

VISIT OUR WEBSITE

www.societyforpsychotherapy.org

MEMBERSHIP REQUIREMENTS: Doctorate in psychology • Payment of dues • Interest in advancing psychotherapy

Name ___________________________________________ Degree ____________________
Address ___________________________________________________________________
City _______________________________________ State ________ ZIP ________________
Phone _________________________________ FAX ________________________________
Email ___________________________________________ If APA member, please provide membership #
Member Type: [ ] Regular [ ] Fellow [ ] Associate
[ ] Non-APA Psychologist Affiliate [ ] Student ($29)
[ ] Check [ ] Visa [ ] MasterCard
Card # __________________________________________________ Exp Date _____/_____
Signature ___________________________________________

Please return the completed application along with payment of $40 by credit card or check to:
The Society for the Advancement of Psychotherapy’s Central Office,
6557 E. Riverdale St., Mesa, AZ 85215
You can also join the Division online at: www.societyforpsychotherapy.org
Psychotherapy Bulletin is the official newsletter of the Society for the Advancement of Psychotherapy of the American Psychological Association. Published online four times each year (spring, summer, fall, winter), Psychotherapy Bulletin is designed to: 1) inform the membership of Division 29 about relevant events, awards, and professional opportunities; 2) provide articles and commentary regarding the range of issues that are of interest to psychotherapy theorists, researchers, practitioners, and trainers; 3) establish a forum for students and new members to offer their contributions; and, 4) facilitate opportunities for dialogue and collaboration among the diverse members of our association.

Psychotherapy Bulletin welcomes articles, interviews, commentaries, letters to the editor, book reviews, and SAP-related announcements. Please ensure that articles conform to APA style; graphics, tables, or photos submitted with articles must be of print quality and in high resolution. Complete Submission Guidelines and the online submission portal can be found at http://societyforpsychotherapy.org/bulletin-about/ (for questions or additional information, please email Lynett.HendersonMetzger@du.edu with the subject header line Psychotherapy Bulletin). Deadlines for submission are as follows: February 1 (#1); May 1 (#2); August 1 (#3); November 1 (#4). Past issues of Psychotherapy Bulletin may be viewed at our website: www.societyforpsychotherapy.org. Other inquiries regarding Psychotherapy Bulletin (e.g., advertising) or the Society should be directed to Tracey Martin at the Society’s Central Office (assnmgmt1@cox.net or 602-363-9211).
ANNOUNCEMENT of our next international conference program: The International Domain of Div. 29 Society for the Advancement of Psychotherapy (SAP) is organizing a conference trip to the 32nd International Congress of Psychology in Prague, The Czech Republic, July 19 – 24, 2020. The program committee (Drs. Rodney Goodyear, Keeyeon Bang, and Changming Duan) will help organize symposia, round-tables, debates, or other group programs. They will be sending you invitation for joining us in this effort soon through Divisional listserv. Meanwhile our social co-chairs are Drs. Lauren Behrman and Maria del Pilar Grazioso, who will be planning for a reception at the conference for all our divisional members and guests. See the flier for the conference information. Please visit the website for more information: https://www.icp2020.com/

Hope to see you in Prague!