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BULLETIN

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Advancement
of Psychotherapy

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SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
American Psychological Association
6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

PSYCHOTHERAPY BULLETIN

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CONTENTS

PRESIDENT'S COLUMN

Jennifer L. Callahan, PhD
University of North Texas – Denton, TX

My first lessons in self-care as a core professional competency were unwanted and unexpected. After a "normal" pregnancy, I went into labor five days past my due date and navigated to the hospital in the middle of the night under blizzard conditions. I made it to the hospital, but by the time I got there, my labor pains have changed. Pain is such a subjective experience that I cannot really describe clearly how the pain changed, but I can describe my changing cognitions about the pain. I remember repetitively thinking "hurry up" in an almost mantra-like cadence en route to the hospital because the pain was not coming in rhythmic waves anymore; it was frightening and unremitting. Unintentionally narrowing my focus on that simple, though silent plea was all I could muster as my body felt beyond my control. As my labor progressed, my daughter went into distress and she died before I could deliver her. Her loss was…and is…devastating. I was not useful to anyone, including myself, for a long time.

Although my experience is personal, I find myself reflecting on it because t he meta-issues are timely and globally salient. At the time of my writing this column, the number of confirmed COVID-19 cases within the United States has passed the one million mark. Unwanted. Unexpected. Inherently transformative. Devastating. To address the mental health needs of our population, we first need to embrace self-care as a foundational professional competency. If we are to be useful to others, we must prioritize our self-care.

On behalf of your clients, and in a spirit of genuine concern, I am asking you to take a moment to engage the reality that you may not be engaging in self-care sufficiently. For many members of our Society, entire practices have been transformed to telepsychotherapy in recent weeks, treatment with current clients has intensified under the weight of new stressors, income and expenditures have shifted, and/or relationships professionally and personally have distanced. The average age of our Society membership suggests most members fall in a COVID-19 high risk category. While Santana and Fouad (2017) assert competent self-care to be an ethical imperative, the collective press created by these immediate realities is significant. Attending to self-care may feel somehow self-*ish* when so many are depending upon us.

In fact, self-care is *not* easy, even under more typical conditions. Self-care competency is more difficult to attain than many of the psychotherapy competencies we spend years of formal training developing. In an empirical study of professional competencies, item difficulty levels placed self-care firmly in the middle of a broad range of foundational and functional professional competencies (Price et al., 2017). Further, self-care deficits are a leading contributor to impaired professional functioning (El-Ghoroury et al., 2012). Sleep hygiene, social support, emotional regulation, acceptance; all are predictive of subjective stress (Myers et al., 2012).

Being truly competent necessitates taking enough time to evaluate our own

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self-care as a multidimensional construct, spanning cognitive, emotional, relational, physical, and, in some cases, spiritual domains (Ayala et al., 2017; Santana & Fouad, 2017). Taking a moment to focus self-evaluative attention to each self-care domain may reveal unevenness. While we may be doing well in some aspects of self-care, others may be neglected. Taking a moment to fearlessly inventory our self-care in each area is time well spent. For those who feel selfish taking that time away from others, I remind you: *this is not about you*. While I obviously want you to be well, in this column *I am taking the role of advocating on behalf of your clients*. In a randomized trial, clients who were blind to condition perceived their psychotherapist as significantly more effective in session (d = .52) when the psychotherapist took just a few minutes of self-care to center themselves before starting the session (Dunn et al., 2013). You want to take good care of your clients? Take good care of you.

Needless to say, the entire world has changed since I wrote my presidential candidate statement two years ago. At that time, I shared with you my hopes of getting needed resources into the hands of professionally isolated providers working with underserved populations. It saddens me to come the realization that those words have come to accurately describe nearly all of our Society membership. Although unwanted and unexpected, I am embracing the inherently transformative aspect of this new reality while aiming to keeping my former vision intact. I want to close this column by updating you briefly on those efforts and how they may be of benefit to you.

In the early pandemic weeks, I worked on developing a clinic manual and disseminating resources to you, via our Society listserv, that were (1) psychotherapy specific or (2) appropriate for those trying to run a practice while also having children at home. Parents, please do not be insulted, but I view you as underserved/under-resourced professionals if you have child(ren) who are too young to reasonably self-direct themselves long enough for you to run a telepsychotherapy session with a client. As the pandemic persists and possible vaccines and/or treatments remain fairly distal hopes, I have been cross-tapering crisis resource and dissemination efforts with longer term efforts.

In particular, I have been ramping up resources to facilitate high quality care across what is increasingly likely to become a protracted period of reliance on telepsychotherapy. Critical to those efforts, I want to alert you that the forthcoming June issue of *Journal of Psychotherapy Integration* (JPI) will be a special issue on "Telepsychotherapy in the Age of COVID-19." As some of you may know, I am the current Editor for JPI, which is an APA publication that is sponsored by the Society for the Exploration of Psychotherapy Integration (SEPI). If you are not already aware, our Society has enjoyed a close working relationship with SEPI for a long time. Our Society reviews and provides CE credit for programming at the SEPI annual meeting and each Society sponsors an award in the other.

Over the past 6 weeks, I have been cross-pollinating my resource development and dissemination vision as President of our Society with my role as Editor of JPI to develop the special issue on "Telepsychotherapy in the Age of COVID-19." When it became clear that we had more good papers than space to publish, I reached out to former Society President Jeff Zimmerman, who is Editor for an-

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other APA journal: *Practice Innovations* (PI). Jeff, per usual, was fantastic to work with and committed PI to rapidly publishing a companion section in the June issue of PI. I am committed to continuing to work across the remainder of this year to realize the vision I promised as a presidential candidate, while being firmly grounded in the challenges facing us today.

In closing, I am going to recycle the final paragraph from my last presidential column. It seems even more apropos now than it did then: "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 that brings psychotherapists at every career stage together in meaningful connections with one another" (Callahan, 2020, p. 3). Until next time, take good care of yourself.

Author's Note:
Have thoughts to share? Feel free to email me at Jennifer.Callahan@unt.edu and keep the dialogue going.

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"In the space between chaos and shape, there was another chance." – Jeanette Winterson

To say that the current climate is characterized as chaotic and challenging is an understatement. As we disseminate this issue, we reflect on the many Division 29 and SAP Members whose personal and professional selves are impacted by COVID 19 and the social movements associated with the oppression and murder of Black and Indigenous people of color. As an editorial team, we are thinking of you as you navigate the systems you are a part of and we are hopeful that we can come together as a community to support one another and to foster growth within and outside of our organization.

In this second edition of the year, we have articles for you to view that broach contemporary issues such as the use of telehealth, a column from our President, Jennifer Callahan, and descriptions of the Division Awards and the winners selected for 2020. For the upcoming issue, we want to remind you of the special focus of the year, "The Person of the Psychotherapist: What We Bring to the Room." In the context of the pandemic and broad socio-political tensions, many of you are being exposed to painful and traumatic events that may well shape the way you engage with clients, think about clinical work, and formulate research questions. Accordingly, we invite you to integrate your personhood into the pieces you submit so that we can explore together how to take action as a division. Our engaging and dynamic publications rely on the inclusion of your perspectives and we hope your voice will be represented in the editions that remain for 2020.

It is with deep gratitude that we thank all of you who are operating as essential personnel. We also want wish to extend our appreciation to the readers, contributors, and Division members and staff who have made the *Psychotherapy Bulletin* a continued success. For submission guidelines or to write for the *Bulletin*, please visit our website (http://societyforpsychotherapy.org/bulletin-about/). We do wish to highlight our revised timeline for 2020 submissions. **The remaining deadlines for 2020 will be July 15th and October 15th.** Please reach out with questions to joanna.drinane@utah.edu and we look ahead to joining as a community and using the Bulletin as a means for shared expression.

Thank you,
Joanna, Stephanie, Salwa, and Kate ■

Predicting the therapist effect: Study rationale and what we have learned without even looking at the data

Simon B. Goldberg, PhD
University of Wisconsin-Madison
Madison, WI

Author note: The author would like to thank the Society for the Advancement of Psychotherapy for support of this research through the 50th Anniversary Research Grant. The author is grateful for ongoing discussions with William Hoyt, Jesse Owen, Tony Rousmaniere, Zac Imel, David Atkins, Timothy Anderson, Betty VanLeuven, Bruce Wampold and others regarding this study and its design. The author is grateful to Wing Ng, Dan Fitch, and Robin Goldman for their assistance building the data collection platform and to Anthony Flynn and Ilsa Valdez for assisting with data collection. Correspondence regarding this article can be addressed to Simon B. Goldberg, Department of Counseling Psychology, 335 Education Building, 1000 Bascom Mall, University of Wisconsin, Madison, WI, 53706. Email: sbgoldberg@wisc.edu

Applied Impact Statement:
This article describes a study funded by Division 29 that seeks to better understand what makes therapists effective. The importance of this line of inquiry is addressed, along with the rationale for a fully remote study design. In addition, early lessons learned through the planning and data collection process are discussed.

Keywords: therapist effects; online data collection; multimodal assessment; collaboration; Facilitative Interpersonal Skills task

At the time of this writing, an estimated one-third of the world's population is in "lockdown" due to a novel coronavirus (Kaplan et al., 2020). In addition to the loss of life and physical health consequences, the economic and psychological impact of the virus and these containment measures has already been massive and may well be felt for years to come (Brooks et al., in press; Jones et al., 2020).

It would seem tone-deaf to not acknowledge the widespread human suffering at this moment in history, whether in the form of illness, unemployment, or racism (Bui & Wolfers, 2020; Tavernise & Oppel, 2020). This period represents perhaps the most rapid change in human social behavior that has ever occurred (D. Coogan, personal communication, March 27, 2020) and may initiate a mental health crisis (World Health Organization, 2020).

The current and impending psychological pain highlights the hugely important role that mental health providers play. Psychotherapy and psychotherapists will be essential for the collective healing from this pandemic. Thankfully, there is longstanding evidence that psychotherapy is generally effective (Smith & Glass, 1977; Wampold & Imel, 2015). However, there is room for improvement, and unfortunately, many do not benefit (e.g., due to premature termination; Swift & Greenberg, 2012). The questions then become: How can we

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make psychotherapy more effective? And, how can we best support our patients in these times and in all times?

Most readers of the *Psychotherapy Bulletin* are likely already convinced that the therapist matters. But this is not just our bias; there is strong scientific evidence that this is the case. Two recent meta-analyses have sought to quantify the degree of variance in patient outcomes attributable to the therapist (i.e., the therapist effect; Baldwin & Imel, 2013; Johns et al., 2019). Both studies found that therapists account for approximately 5% of the variance in patient outcomes. Although 5% may seem small, bear in mind that this effect size is not wildly different from that linking therapeutic alliance and outcome (i.e., 7.7%; Flückiger, Del Re et al., 2018) and is roughly five times greater than that attributable to differences between psychotherapies (i.e., 1%; Wampold & Imel, 2015; Wampold et al., 1997).

Research estimating the size of the therapist effect has been essential for advancing our scientific understanding of psychotherapy. Yet simply saying that therapists account for variance in patient outcomes is akin to saying that diet accounts for variance in health. One still needs to know what to eat or not eat. Crucial next steps for work in this area include determining precisely *what* therapist characteristics predict this variation and, ultimately, how these therapist-level factors can be selected for and augmented through training.

Although consensus has not been reached on the characteristics of highly effective therapists (Wampold & Imel, 2015), psychotherapy researchers have been investigating the relationship between therapist characteristics and patient outcomes for decades. In the past 40 years, many therapist-level variables have been explored, from therapists' personal therapy (Garfield & Bergin, 1971) and performance on cognitive tasks (Mintz et al., 1976) to interpersonal skills (Anderson et al., 2009) and professional self-doubt (Nissen-Lie et al., 2013). This literature has been systematically reviewed in two recent studies. Lingiardi and colleagues (2017) examined the association between therapists' subjective and therapy-nonspecific characteristics with patient outcomes in psychodynamic psychotherapy. Across 30 studies, they found the most consistent evidence for therapists' interpersonal skills and interpersonal functioning. Patients of therapists who were more affiliative and more interpersonally skilled tended to have better outcomes. Heinonen and Nissen-Lie (in press) reviewed 31 studies examining therapists' professional and personal characteristics, finding performance-based measures of professional interpersonal skills to be one of the most consistent predictors of patient outcomes. Self-rated social skills, in contrast, did not predict outcomes.

The studies reviewed by Lingiardi and colleagues (2017) and Heinonen and Nissen-Lie (in press) provide an important foundation for clarifying what may account for the therapist effect. However, this literature has substantial shortcomings. Both systematic reviews remarked on methodological limitations, including the use of small samples (of therapists and patients per therapist; Heinonen & Nissen-Lie, in press) and the wide variability in predictors examined (Lingiardi et al., 2017), with an associated small number of direct replications. In addition, with some notable exceptions (Anderson et al., 2009; Schöttke et al., 2017), many studies used self-report measures with known biases (e.g., social desirability). Further, variation in analytic methods and inconsistent use of standardized effect sizes makes it difficult to deter-

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mine the consistency or magnitude of the association between therapist factors and patient outcomes. At the end of the day, we, as a field, remain without clear empirical guidance specifying precisely which therapist characteristics are most important. The current study is designed to address some of these limitations in the hopes of clarifying measurable therapist characteristics that relate to treatment outcome.

Method

Participants

In partnership with Drs. Jesse Owen and Mark Kopta at CelestHealth, recruitment has occurred through clinics using the Behavioral Health Measure (BHM; Kopta et al., 2015). In addition, we have partnered with Drs. Robbie Babins-Wagner and Amy Bender at the Calgary Counselling Centre. All staff therapists and trainees at partnering sites are eligible to participate in the study. Data collected from therapists will later be matched with patient outcome data routinely collected at participating sites. We aim to recruit ≥ 100 therapists whose responses will then be associated with data from their patients (anticipated patient $n \geq 1000$). This target sample size of therapists would provide adequate power (beta = .80) based on a three-level power analysis that assumes a therapist intraclass correlation of .05 (Baldwin & Imel, 2013), 10 patients per therapist, 8 sessions per patient (Goldberg et al., 2018), and a small to moderate effect size ($r \geq .11$, $d \geq 0.22$).

Procedure

Therapist recruitment is occurring through emails sent by clinic directors at partnering clinics. Study staff direct participants to an online survey that includes approximately two hours of self-report questionnaires and behavioral tasks. Participants are compensated $200 for their time.

Measures

In planning this study, we aimed to collect a wide variety of therapist variables that have been previously shown to predict patient outcomes or are theorized to be linked with patient outcomes. Recent reviews of the literature on therapist characteristics and patient outcomes highlight therapists' interpersonal skills as one of the more consistent predictors. Therefore, a primary measure we are collecting is the Facilitative Interpersonal Skills task (FIS; Anderson et al., 2009). The FIS involves collecting participants' verbal responses to a series of video-based vignettes depicting challenging moments in therapy. Responses are then coded along several domains (e.g., empathy, emotional expression). We have also included self-report and behavioral measures designed to assess component parts of the FIS (e.g., verbal fluency, empathy).

A second primary task we are using is the Multicultural Orientation task (MCO; Owen et al., 2018). Similar to the FIS, the MCO involves viewing a series of video-based vignettes to which participants are asked to respond. These vignettes depict multiculturally salient moments in therapy. Just as for the FIS, we have included other self-report and behavioral measures to more richly assess participants' multicultural orientation.

Data Analytic Plan

Data will be analyzed using multilevel models that account for the nesting of patients within therapists. In these models, therapist characteristics will be entered as predictors of patient outcomes (e.g., change in outcome measures, early termination). We plan to examine potential interactions between patient demographics and therapist characteristics as predictors of outcomes through random slope models (e.g., Thompson et

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al., 2018). Further, we plan to use these data to continue the development of machine learning algorithms to automate the scoring of the FIS (Goldberg et al., in press). In keeping with recent efforts to increase transparency and replicability in psychology and science broadly, we plan to pre-register primary study hypotheses before data analysis (Open Science Collaboration, 2012).

Results

We are still actively in the process of data collection for this study. As we have not yet pre-registered our study hypotheses, we have not begun analyzing our data. Nevertheless, we have learned a lot through the design and initiation of this study.

The Importance of Collaboration and Clinical Partners

This project, like so many, has resulted from the combined efforts of many individuals. The individuals noted above and in the acknowledgments have provided a great deal of encouragement and feedback that have been vital for the design and execution of this study.

As discussed elsewhere (McAleavey et al., 2015), partnerships between researchers and clinics are oftentimes complex for a wide variety of reasons. One lesson we have learned through engaging in these partnerships is the central importance of clinic director buy-in and commitment to supporting and encouraging research among their staff. As evidence for this, we began our recruitment efforts by contacting clinic directors at 15 clinics using the BHM. Of these, therapists from five clinics completed the measures, resulting in a sample of 17 participants. Committed to obtaining a sample of therapists that would allow adequate power to detect small to moderate associations between therapist characteristics and patient outcomes, we then expanded our recruitment by reaching out to a clinic director with whom we have formerly collaborated. This expansion has resulted in an additional 40 participants (Figure 1).

Data collection has likely been more successful since adding our collaborator's site in part because it is a large clinic with many therapists. Many therapists at this center are in training and may, therefore, be more motivated by the compensation provided and able to devote two hours of their own time to complete our study. It also seems likely that recruitment has been successful due to the established partnership between the clinic director and our staff. This existing relationship may support the sense of shared mission and shared ownership that McAleavey et al. (2015) discussed as crucial for these partnerships.

Technical Partners

With our goal of collecting a multimodal assessment battery with a variety of self-report and behavioral measures, a second equally important partnership has been with a technical team. This partnership has involved collaboration with developers of the performance tasks noted above. In addition, developing our assessment delivery platform was a protracted process, during which we received guidance from programmers with expertise in online behavioral tasks. We conducted several rounds of pilot testing of our platform and made a series of changes based on the feedback we received. We established a collaboration with Theravue.com in order to use their electronic deliberate practice platform for delivering the FIS and MCO online. While the two-hour battery remains a substantial time commitment, we have found that most participants are able to complete the assessments without technical issues. The piloting process delayed

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the initiation of data collection somewhat, but we are hopeful it will ultimately produce a larger sample, cleaner data, and a more robust scientific product.

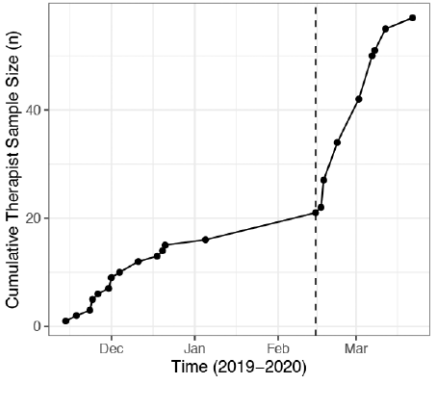
Discussion

The current study follows in a long tradition of psychotherapy research seeking to identify therapist characteristics that predict patient outcomes. This work aims both to replicate previous findings by evaluating measures that have been previously linked to patient outcomes (e.g., FIS; Anderson et al., 2009) and to extend this research by addressing several methodological shortcomings of the existing literature (e.g., small sample sizes, reliance on self-report measures, limited range of constructs assessed).

We hope that this study can help clarify what it is that makes effective therapists effective. In other words, we hope to find out what predicts the therapist effect. Of course, this is only an initial step towards the ultimate goal of reducing the burden of mental illness. Depending on what this study and similar efforts reveal, we may uncover certain capacities that could be selected for at the start of graduate training (e.g., through administering an interpersonal skills task as part of the admissions process). Other characteristics could be augmented through targeted training (e.g., mindfulness skills; Pereira et al., 2017) or built into training programs (e.g., deliberate practice; Chow et al., 2015). And yet other characteristics may interact with patient factors and could be used to support efforts to match therapists and patients, providing treatment that considers patient variability (i.e., precision medicine; Collins & Varmus, 2015).

A primary limitation of the current study is its correlational nature. Even if we are able to identify a clear set of therapist characteristics, they will simply be those associated with patient outcomes. Thus, a key future direction will be establishing a causal relationship between potentially malleable therapist characteristics and patient outcomes. Future randomized controlled trials could examine interventions aimed at these characteristics. Results from these experimental studies could then inform training efforts. This may be an ambitious goal, but certainly not outside the realm of possibility for the next decades of psychotherapy research. And, most importantly, these efforts may provide an empirically grounded route for improving the treatment outcomes and lives of our patients, during whatever challenging times the future may hold for human beings on this planet.

Figure 1. Therapist sample size over our initial academic year of recruitment. Dashed line indicates when data collection began at the center where a close collaborator is the director.



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Exploring the downstream effects of silence around religion and spirituality in counseling training programs

Erin M. Buttars
Joanna M. Drinane
University of Utah
Salt Lake City, UT

My name is Erin, and I am working towards my doctorate degree in counseling psychology. I was drawn to this field because of my interest in the complex identities that shape the human experience. Each identity we hold creates a unique perspective through which we view the world. In some aspects, our identities are easily celebrated. Sometimes they are silenced. I have experienced a silencing of certain aspects of my identities dependent upon the context I find myself in. In particular, my identity as a religious individual has led to a dissonance between myself and my work. It feels as though there are certain spaces not necessarily conducive to a full disclosure of that invisible status. My guess is that this experience is more common than previously thought.

My hope in writing this paper is to engage the division in productive dialogue about the education, training, and therapeutic approach to religious, spiritual, and secular identities. In reviewing the literature and conversing with colleagues, it appears as though the ball is being dropped in this area. I hope to call attention to the disconnect between what is modeled versus what is asserted as an appropriate multicultural orientation.

I wanted to begin by sharing my personal narrative and the questions driving my curiosity for this topic. I identify as a member of the Church of Jesus Christ of Latter-day Saints (i.e. Mormon, LDS). Being from a small town in Idaho, most people I associated with were also members, the major exception being my teachers. It was in seventh grade that I discovered the palpable tension around that identity. While the majority of my town had been uplifted and connected through their membership, many had been spurned. I quickly picked up on the notion that it was easier to be Mormon in certain spaces over others. There were moments when it was empowering to share my beliefs, and there were instances when it did not feel good to admit, but my understanding of the greater forces at play was in its infancy.

When I graduated from high school, most of my peers enrolled in church-affiliated institutions or served proselytizing missions. I did not. I left to attend school in Cleveland, Ohio where I was one of two Mormon undergraduates. My first few interactions in college taught me that most people did not know what a Mormon was. They did not carry the assumptions or opinions I had learned to dodge growing up. I had the opportunity to take control of the narrative and introduce this aspect of my identity without all of the associated animosity. But I was still cautious. I was still hesitant to bring my full self into the room out of fear—fear that within the

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walls of a liberal university, my identification with a conservative religion would diminish the value of my contributions. I learned that this affiliation within the institution of higher education did not lend power in light of it being a privileged, Christian identity.

After graduation, I returned home to Idaho to prepare applications for graduate school. Within a year, I was accepted into a counseling psychology program in Salt Lake City, Utah, the epicenter of the LDS faith. After so many years of getting to introduce and define my faith, I was back where everyone knows what a Mormon is and almost everyone has an opinion about it. In Utah, religion is salient and tangible. Membership in the LDS is the overwhelming majority and can be found at the pinnacles of power. Utah is a place where the lines between church and state are increasingly blurred, where religion can weave its way into nearly every conversation. Despite the overwhelming influence of the church across most domains, higher education is still firmly planted in liberal soil.

When I began my Ph.D. program, I encountered what I can only describe as a light switch effect. I experienced going from full disclosure of my affiliation, surrounded by individuals who shared that identity, to total concealment. Because of its pervasiveness, identifying as LDS within a liberal program felt sabotaging. I want to make it absolutely clear that I did not experience blatant hostility from my faculty or peers, but I was still aware of the potential costs connected to sharing that identity. I did not want the assumptions associated with that status to be placed on me, so I remained silent in conversations around that topic. I was afraid that in owning that identity, others would believe me to be close-minded and ignorant. What I observed was a relative silence around religious and spiritual (R/S) identities within classes and faculty interactions. I attributed this silence to the relative ease with which religion entangled itself into most conversations and policies outside of school, so perhaps it did not have a place here. Therefore, I chose to hold my identity close and mostly concealed.

At the end of my first semester, I found myself on the receiving end of a religious microaggression, named as one by the person who committed it, my professor. It feels odd to claim experiencing a microaggression since my identity falls within the Christian majority. Nonetheless, it was one. When my professor discovered I was Mormon, I was met with shock and silence. Her reaction reinforced why I had refrained from fully revealing that identity. I was worried that I would be asked to choose either secularity or religiosity, convinced that an integration of these two identities was impossible. I felt terrified and completely convinced that I would be seen differently for my beliefs. I am happy to share that I was wrong.

From that encounter, my professor and I began exploring the conversation around R/S identities in counseling psychology training programs. Through her, I was connected to an academic who is actively studying this phenomenon. During our conversations, I discovered that my experience was not unique. Instead, it was a frequent occurrence across many institutions. This sparked an interest in understanding how individuals, perhaps with different backgrounds, navigate similar situations. What is the cost of students' identity concealment as future therapy providers? What are the upstream effects resulting in the modeling and instruction students receive around this identity status?

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It is evident that the R/S identities individuals hold are not as readily integrated into the training program experience. Just as we are challenged to think critically about other identities, I think there is also a need to think critically and holistically about R/S identities. I recognize that a host of other invisible identities are in a similar position. The constraints that training programs face are real. It is not possible to devote adequate attention to each and every identity status our clients will hold. As such, I want to specifically focus on R/S identities and incite meaningful conversation around our field's current approach to them.

From a historical standpoint, psychology as a field has pathologized religion, especially as it worked for recognition as a scientific discipline (Haug, 1998). In a survey assessing religiosity of university and college professors, psychologists were found to be the least likely to believe in God or endorse religious adherence (Gross & Simmons, 2007). The emphasis on being scientific may have created the resistance toward the explicit integration of R/S identities within the training framework (Coon, 1992; Miller & Thoresen, 2003). However, Gallup polls from 1992 to 2012 support a widespread religious affiliation in America. Results indicate that anywhere from 79-88% of Americans assert that religion is either "important" or "very important" to them (Gallup, 2012). While 75% of Americans report that their religion influences their approach to life, only 35% of psychologists surveyed agreed (Delaney et al., 2007). In particular, research by Hathaway et al. (2004) indicates that psychologists discuss religion and spirituality with less than 30% of their clients. This discrepancy in importance suggests that R/S issues may be underexplored within the therapeutic setting.

In light of the importance religion and spirituality have in the lives of the general population, it feels imperative that therapists feel confident in reflecting and understanding the R/S factors at play in a client's life and how they influence their worldview. Therapists have a responsibility to help clients build awareness around the complex intersection of their various identities and their well-being (Aponte, 1996; Hoffman et al., 2005). However, Schulte et al. (2002) found that although trainees are empathetic toward the importance of R/S for their clients, they report feeling incompetent in addressing R/S topics with them. Furthermore, in a sample of psychologists from APA Divisions 12, 36, and 45, Crook-Lyon et al. (2012) report that 76% of psychologists feel that R/S is inadequately addressed. Furthermore, Schulte et al. (2002) reported that 82% of training directors report that their programs do not sufficiently address this identity status. These findings speak to an institutional failure in trainee preparation around clients' religious and spiritual identities.

While several studies have shown the importance religion and spirituality have within clients' lives, there appears to be a gap in the way training programs include R/S identities within their framework. This gap appears to stem from an intergenerational cycle of avoidance around the topic. What is feeding this cycle is the perpetual lack of training in this area. Due to their own lack of training, faculty and supervisors may feel as ill-equipped and uncomfortable as their students around engaging in R/S discussions (Magoldi-Dopman, 2014). This made me curious about the type of instruction and modeling my peers and I are receiving from faculty both within and outside of the classroom setting. If training directors are indicating lack of adequate coverage on

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this topic, what is contributing to the hesitance around greater R/S inclusion?

A study by Owen and colleagues (2014) found that for clients with high religious commitment, therapist's cultural humility was positively associated with therapy outcomes. For clients where R/S identities were less salient, no association was found between their perception of the therapist's cultural humility and treatment outcomes. A parallel process may exist within training programs. Similar to the therapeutic setting, the salience of different identities may contribute to fluctuation in the amount of attention given to various identity groups within training programs. For secular students, the gap in training attending to R/S identities may not be seen as problematic. The need for greater training in this area may not be viewed as necessary compared to increasing training across other identity groups. For students who do identify as religious, however, the silence around R/S identities may communicate a variety of messages. This relative silence may indicate that the topics of religion and spirituality are inappropriate (Bartoli, 2007; Miller, 2003). Additionally, students may develop the perception that R/S identities are less important when conceptualizing and working with clients (Saunders, 2014). Last of all, the tone and context through which R/S identities enter class discussions may impart the belief that students should conceal their religious affiliation (Magoldi-Dopman, 2014). The downstream effects of student concealment may prove to be an interesting contribution to the literature in this area.

This last concept leaves me with several questions, potential points to explore next. As we know, facilitating therapist self-awareness is crucial; therefore, what consequences arise if students choose to conceal their invisible identities that may be in conflict with the environment around them? How do training programs create a culture where identity exploration actively occurs in classroom discussion, supervision, and daily interactions with peers and faculty? How do we confront the cycle of silence and discomfort in discussing R/S identities to ensure better modeling in conversations about R/S topics? While religious and spiritual salience varies within training programs, how do we as a field better prepare trainees to work with peers and clients for which R/S salience is prominent? I believe there is plenty of work to be done in this area and hopefully something fruitful can come from sharing my thoughts and my story here.

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Society for the Advancement of Psychotherapy

Space, Boundaries, and Presence: Considerations for individual and group therapy using videoconferencing in the time of COVID-19

Beatriz Palma
University of Virginia Counseling and Psychological Services
Charlottesville, VA

Online psychotherapy is not new. Group therapy using videoconferencing is not new. What is new, however, is having to start online treatment for the first time in the midst of a global pandemic.

Usually, before COVID-19, therapists who provided telehealth services had gone through a planned and thoughtful process of figuring out online work, including using HIPAA compliant platforms, creating consent forms for online treatment, and considering the physical space where they would provide such work (e.g., from their home office).

Now, in the time of COVID-19, those of us who are just jumping on the telehealth bandwagon have benefited from the knowledge of pioneers who started this journey before us. However, in this pandemic, many (if not most) psychologists (1) have had to quickly adjust and start providing treatment from home, (2) might not have a previously planned space to engage in online services (e.g., an office), and (3) might be sharing spaces at the same time with many other members of their household. Additionally, therapists might be dividing their time between working from home with other responsibilities (e.g., helping their children with online schooling). Such fast adjustment is happening at the same time that we are holding several reactions and feelings related to this pandemic, such as various concerns, anxieties, griefs, and fears.

Just like us as psychotherapists, patients are also facing challenges related to the uncertainties and physical distance of this pandemic. Thus, online treatment can become a necessary way of providing care for them. Furthermore, online therapy groups can become a uniquely valuable virtual space that provides connection, where there can be shared emotional experiences, growth, and the possibility of receiving and providing support. Such opportunities for treatment can also go hand-in-hand with some challenges for psychotherapy providers. First, state licensing requirements set boundaries regarding who psychologists can work with. Thus, it might not be possible to continue providing care to some of our patients (e.g., students who were seen at a university counseling center who returned to their home states). Additionally, working remotely can have added challenges when risk-related issues arise.

Many authors have discussed and provided helpful guidelines for the delivery of online psychotherapy, including technical, ethical, and legal considerations (e.g., Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013; Maheu, 2019). Anyone who decides to offer psychotherapy

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using videoconferencing should engage in appropriate training (e.g., webinars, readings) before providing such services. In addition to addressing the practical, ethical, and legal considerations of telepsychology, it is important to ponder other aspects that relate to providing these services. In the following paragraphs, I present a brief discussion regarding the concepts of space, boundaries, and presence that are unique to the provision of individual or group psychotherapy via videoconferencing. These concepts might be useful when engaging in such services.

Space, boundaries, and presence when providing online psychotherapy

Before COVID-19, many psychotherapists devoted significant efforts in designing a therapeutic space (e.g., through the choice of furniture, lighting, personal items displayed) that would reflect us and our work, and that would be conducive to the treatment process. Now, in the time of COVID-19, many of us practice therapy from our home, where we might not have been able to create a therapeutic space as intentionally as we previously had. Additionally, many patients are attending therapy via videoconferencing from their homes. As a consequence, we psychotherapists enter into a patient's physical personal space; we have a visual window into aspects of a patient's experience, which before we had only heard about in therapy sessions. In that way, the patient also enters our personal space (which for many providers might have been considered a "private" space before). Therefore, we are faced with the task of creating virtual spaces that do not feel intrusive to the physical spaces we live in.

This issue of space brings up the interconnected issue of boundaries. Setting a specific space from where we can work privately and confidentially is central for the maintenance of boundaries in our work. Before COVID-19, many therapists considered their office as the only space where therapy could take place. Currently, many patients are connecting online from their bedrooms, which could be the only private space in their homes where they might be able to connect with a therapy provider safely. How about therapists? Which spaces in our homes are we using to connect with our patients? How does that choice influence us, our patients, and our work?

Also, space and boundaries are central for our self-care as we provide remote therapy during a pandemic. How can we create separation between work and other aspects of our life when we are working online from home? Some therapists might not have any challenges with this transition, but others might need to have a physical space for work that is separate from other areas.

Recently, an intern I work with pointed out the following: while providing therapy using videoconferencing from our homes, there is a unique experience of having to separate ourselves or disconnect from our own space at home in order to join, connect, and stay present with what is going on with the patient. As therapists, we need to filter what we are paying attention to (e.g., what if, while providing therapy, your dog is scratching the door, or you hear one of your children crying?). In a way, in order to connect with the patient's experience, we must create some distance from our own bodily experience of our surroundings. Some of our patients might be facing a similar experience. Of note is that when therapist and patient are in the same physical space, disruptions during a therapy session (e.g., a knock on the door) become a joint experience and can be easily addressed. However, while pro-

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viding treatment online, two physical and separate spaces are bridged through a shared virtual space, and in order for us therapists to be present and join our patients, we might need to distance from some aspects of our own space.

Another issue that needs to be considered when providing online treatment is this: How can we, as therapists, convey presence when we are bounded by the limitations of virtual space? Interestingly, online treatment using videoconferencing raises a unique paradox: In order to convey the perception of connecting to the patient, in a way, there is disconnection that takes places. Specifically, to show visual connection through a direct gaze, psychotherapists need to look directly towards the camera. While doing so, we might miss seeing the reactions that the patient is having to what we are saying. This online process is a different type of experience in comparison to the one we might have while in person, a few feet apart. Fortunately, several authors have proposed factors that might allow us to increase our presence beyond the virtual distance, such as focusing on facial expressions and using self-disclosure (Weinberg, 2020), and adjusting the body's distance from the camera (Ogden & Goldstein, 2020).

Space, boundaries, and presence when providing group therapy via videoconferencing

During online group therapy, group leaders are no longer in control of the group space as they are when engaging in in-person treatment (Weinberg, 2020). Additionally, as Weinberg (2020) highlights, when engaging in online group psychotherapy, the traditional format of the circle changes, as we appear as rectangles on a screen, and the configuration of such rectangles on the screen will vary from member to member. Therefore, unless we verbalize who we are looking at or identify to whom we are speaking to, other group members will not know with whom we are trying to connect. Thus, this change of space affects even the way in which the group leader and the group members can convey their presence to others and nonverbally relate to one another. Using video conferencing to provide group therapy also brings up the possibility of having parallel streams of communication if group members engage in using the chat option while others are talking. A group leader needs to establish clear boundaries related to ways of communicating (e.g., "use the chat option only to convey that you are having issues with connectivity") so that the virtual space can be established as a space shared by all group members.

When working with an online group, there are potential challenges that may prohibit or affect one's ability to be virtually present and engaged during the session. Some of these difficulties relate to technical issues (e.g., not being able to join the session due to internet problems). One way of establishing clear boundaries and procedures is to state in the informed consent, the steps to take if a group member gets disconnected. However, besides the technical aspects related to connectivity issues, we can have disconnections that mask intrapersonal (individual group member) and/or interpersonal (among the group members) dynamics, and then, the *connectivity* challenges relate to a challenge in *connections*.

Just like with in-person groups, when leading an online group, a therapist needs to remain curious. For example, if a group member sends a message that he/she cannot join the session due to internet issues, or if a group member gets disconnected, it is central for the group

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therapist to ponder whether this connectivity issue is masking a desire to disconnect. Exploration with group members continues to be a key aspect of group treatment, especially in interpersonal process (IP) groups, where such challenges in connectivity can become grist for the mill. Questions that IP group leaders can ask the group member who got disconnected include: How was it to not be able to join the group? Can you explain what feelings arose when you got disconnected? Exploration of the reactions that came up for those who remained in the group is also essential. Weinberg (2020) also raises an important point when he shares a vignette in which a group leader asks a group member to leave a session (e.g., due to confidentiality issues related to the space the group member was using when connecting to the session), and group therapists that provide treatment using video conferencing have to ponder ahead of time how they would manage such cases with the group if such situations arise.

Additionally, due to intense reactions or difficulties in the moment, a group member might decide to leave the shared space (including "storming out") by choosing to virtually disconnect. If this were to happen in person, usually there is a process of getting up and going to the door, which allows others to react, whereas online it can be a simple click that might occur unexpectedly. Group leader(s) have to be especially attuned to the group's reaction to this and process the experience and implications (which might include exploration of fantasies) that this might bring for group members, including how it feels to no longer to have the presence of that group member in the virtual space.

Finally, another key aspect to consider during online group treatment is the possibility for the group leader to have connectivity issues. This is not as challenging if the group is co-led, because if one of the group leaders gets disconnected, the other might remain present and can continue leading. However, if this disconnection were to happen in a group where there is only one group leader, we have the potential of having different group members in a shared space that is "leaderless." How should that be addressed if this happens? Thus, it seems central for therapists to learn about the characteristics of the video conference platform that they are using (e.g., if the host of the meeting gets disconnected, does the group still proceed?) and to plan for how to address possible challenges that might arise during treatment.

Conclusion

The considerations of space, boundaries, and presence are important aspects of psychotherapy work. As we face this pandemic and as therapists are increasingly engaging in providing therapy via video conferencing, the previous experience of shared space, boundaries, and presence in the therapy hour is somewhat shifting. Telepsychology providers need to be aware of the different aspects that relate to the previously mentioned concepts, in order to better plan and also better address challenges when they arise. However, in spite of the adjustments that COVID-19 has brought, the basics of psychotherapy (e.g., being empathic, remaining curious, engaging in exploration, processing any relational challenges that come up) continue to be central in the provision of therapy.

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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!

WASHINGTON SCENE

An Old Cowboy Went Riding Out One Dark and Windy Day

Pat DeLeon, PhD
Former APA President

Spring brought to our nation's Capital the 37th annual APA Practice Leadership Conference (PLC), which is always the highlight of my professional year. I especially appreciate the enthusiastic support of Susan Lazaroff and Dan Abrahamson for sharing this exciting experience with our next generation of military psychology and nursing leaders during their graduate student days at the Uniformed Services University (USU). This year, they joined with 350 engaged colleagues from around the nation. As Jared Skilling, APA Chief of Professional Practice, noted during the Opening Reception: "PLC is a perfect place to hone your professional skills, leadership skills, and advocacy skills and start putting them to work."

Susan Farber of Idaho and Beth Rom-Rymer of Illinois participated on a panel entitled *So You Passed RxP in your State—What's Next?* Sue: "PLC offered a timely presentation of issues that arise after RxP bills are adopted. Most RxP advocates are clinicians who lack experience in setting up bureaucracies. This can lead to unanticipated problems. A few occurred in Illinois and Idaho following RxP enactment. One Idaho issue was a conflict between our open meeting law—a good law that values transparency in government—versus finding a way to allow an advisory committee to discuss various issues on behalf of the board of psychology. It turned out that meetings could only occur when the Bureau of Occupational Licenses could schedule and pay for all the personnel that needed to be present. Two good laws collided, and we are still working it out.

"A second problem was designating channels of communication that worked efficiently when applicants for licensing had questions. For the moment, we are advising applicants for licensure who have fulfilled all of the requirements for endorsement or licensure in Idaho to apply directly to the Idaho Board of Psychologist Examiners. All other questions should go to our newly opened psychopharmacology program: Eric Silk (silkeric@isu.edu), Page Haviland (havivirg@isu.edu), or myself (slf811@aol.com). This program is in the College of Pharmacy and currently is an in-person, full-time two-year program that is 'state of the art.' Students go to class on Thursdays and Fridays and cover their practicum work during the summer. For about the price of a mid-level car, students can graduate in two years while working, and have a master's degree, be prepared for the PEP exam, and have covered all supervised experience.

"Finally, in an exceptional measure, APA President Sandra Shullman is gathering together a group of applied psychology advisors to help states with issues that arise after RxP is adopted. It is impressive how our national organization is assisting our profession to mature into this

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new endeavor" (Sue Farber). For those dedicated to the RxP quest, Beth Rom-Rymer let those attending know that she has decided to run for APA President in the next election cycle.

Jared further opined: "What's ahead for our profession and how we could come together to broaden psychology's impact. PSYPACT is the psychology interjurisdictional compact that allows psychologists to practice telehealth between states that passed the PSYPACT law without needing additional licensure. It's possible that in the near future, more than half of the states might have this law in place. PSYPACT will help improve the accessibility of our services to the public, and especially to rural and underserved communities—communities that really need our care."

Alex Siegel: "Prior to the COVID-19 crisis, few psychologists were aware of what constituted telepsych services. Since February 2020, most psychologists are now aware of telepsych services but now have questions about how to use it or where they could use it to provide electronic services to patients, in particular with regard to inter-jurisdictional practice. This is defined where the psychologist and patient are not in the same jurisdiction. Historically (prior to the pandemic), the psychologist and patient had to be in the same jurisdiction to be able to use telepsych. If they were located in different states, the psychologist typically had to be licensed in both states in order to provide electronic psychological services.

"When the pandemic hit the US, several state governors issued emergency Executive Orders which suspended or relaxed licensure regulations with regard to interjurisdictional telepsych practice. Most of these orders allow licensed psychologists to provide electronic services from where they are located to where the patient is located without having to be licensed in the state where the patient is located. However, not all of these Executive Orders are the same. Some require out-of-state psychologists to register with the distant licensing board before practicing into that state, while others do not require notification. Some orders only allow psychologists to treat existing patients who have moved into their states, while others allow psychologists to see anyone. The Association of State and Provincial Psychology Boards (ASPPB) web site has information pertaining to what states allow/require during the COVID-19 crisis to provide telepsych services into their states. The link can be accessed at: https://www.asppb.net/page/covid19.

"These Executive Orders are an efficient and effective way to allow for psychologists to provide psychological services across state borders. These orders, however, are only temporary and will expire after a certain number of days or when the COVID-19 crisis is over. At that point, those individual state laws and/or regulations pertaining to inter-jurisdictional practice will be once again be enforced and controlling. That is, psychologists will have to go back to following their pre-COVID-19 state laws and/or regulations.

"Fortunately, there is a long-term solution to providing inter-jurisdictional practice without having to be licensed in both states. This is where PSYPACT comes into play, as Jared stated at PLC. PSYPACT allows psychologists to provide electronic telepsych services from one compact state into the receiving compact state where the patient is located. It also allows for temporary in-person, face-to-face practice of psychol-

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ogy from one compact state into the distant compact state where the patient is located. Currently, there are 12 states which have adopted PSYPACT. There is active legislation in 15 additional states. It is hoped that once the crisis is over (and it will be over), that these states and others will realize how practical and useful interjurisdictional practice was to provide psychological services to their citizens to ensure increased access to care and continuity to care. Having the experience of working with telepsych during the COVID-19 crisis, psychologists are encouraged to work with their state psychological associations to let legislators know how important and beneficial it was for their patients to receive psychological services during the COVID-19 crisis and to advocate for the adoption of PSYPACT in their jurisdiction so interjurisdictional telepsych practice can continue" (Alex Siegel [asiegel@asppb.org]).

Warnings from the Past: The recent coronavirus (COVID-19) pandemic prompted me to review the Institute of Medicine (IOM) 1996 report *Healthy Communities: New Partnerships for the Future of Public Health*. More than two decades ago these distinguished experts cautioned: "In recent years, we have witnessed the emergence or re-emergence of infectious diseases such as hantavirus, cryptosporidiosis, *Escherichia. coli* 0157, and Ebola virus." The IOM Committee strongly reaffirmed the importance of an even earlier similar prophetic report. "The public's health depends on the interaction of many factors; thus, the health of a community is a shared responsibility of many entities, organizations, and interests in the community, including health service delivery organizations, public health agencies, other public and private entities, and the people of a community. Within this shared responsibility, specific entities should identify, and be held accountable for, the actions they can take to contribute toward the community's health." "The function of local public health agencies should include an assurance that high-quality services, including personal health services, needed for the protection of public health in the community are available and accessible to all people." "Governmental public health agencies have a unique function in the community: to see to it that vital elements are in place and that the [public health] mission is adequately addressed. These elements include assessment, policy development, and assurance."

The Committee's vision was expressed in the era of increasing managed care and increasing distrust of government. Proponents of managed care argued that its goals and tools were consistent with public health. Many public health professionals indicated concern about managed care organizations' motives and ability to deliver on these promises. Critical to the IOM Committee was the development of the proper kinds of partnerships between managed care organizations and governmental public health departments to make this possible. The Committee further called for training within Schools of Public Health for professionals to work with health service organizations to ensure quality-related personal health services within communities as an essential element in providing for the health of the public.

In retrospect, one could seriously question whether our nation's health policy leadership took seriously the importance of the underlying IOM recommendation that the government must fulfill its responsibility for "society's interest in assuring conditions in which people can be healthy." Nevertheless,

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giving credit where clearly due, in response to the pandemic, the Trump Administration made sweeping regulatory changes, which allowed healthcare practitioners to function to the fullest extent of the education and training, including ordering tests and medications that may have previously required a physician's order. The Centers for Medicare and Medicaid Services (CMS) allowed for more than 80 additional services to be furnished via telehealth with providers being able to bill for telehealth visits at the same rate as in-person visits. Psychological and Neuropsychological Testing and clinical psychological services were specifically authorized, including the provision of e-visits by licensed clinical social workers and clinical psychologists, as Alex discussed above.

Reflections from the Past: "The most rewarding feature of my Presidency was perhaps seeing and working with the massive numbers of volunteers, our colleagues, who are deeply committed to the many causes APA reflects. It was a genuine and humbling privilege to be part of that. Add to that the APA staff, senior but at all levels, who put in very long hours routinely to make APA work so well. For example, the staff routinely give up weekends for Board meetings and prepare detailed reports occupying reams of paper (paper was used in those pre-pdf days, it may have been papyrus, I forget).

"The organization generates many Task Force reports on topics that reflect the diversity of divisions, interests, and priorities. Presidents typically generate a few during their term on issues of concern to them. I tried to read as many of those as I could. I was dazzled with the superb recommendations and thoughtful comments but also lamented that there appeared to me that there were too few efforts to implement the recommendations. Perhaps this was a structural and organizational issue. To my very limited history outside of APA, I would designate strategic planning committees on some issues then 'sunset' the committee once their work was completed. I would follow this up with an implementation committee with budgets, when needed and where possible, to move to palpable change. This response is easy to do in a small organization (e.g., university departments) where there is not the scope of interests and priorities as evident in an organization as APA. That said, a super challenge of APA is managing the diversity of interests, priorities, and actually 'professions,' and one can only marvel at how the organization has so many successes.

"As for my term as President, perhaps only a couple of things endured. I started a new APA journal (*Violence*) that is doing well and an international collaboration for an organization devoted to prevention of violence (with Bob Geffner and Jackie White)—National Partnership to End Interpersonal Violence Across the Lifespan: Global Partners for Peace https://www.npeiv.org/. These have endured and expanded without any influence on my part.

"I see the goals of APA to have palpable impact on improving public life. Since psychology is a science, I would lobby strongly for markers, measures, and indices that convey changes or improvements. For example, we love our evidence-based treatment and evidence-based practice, not at all the same, of course. Yet, the vast majority of people in need of mental health services receive absolutely nothing. And, it would be easy to identify a plethora of other critical issues in which more needs to be done (e.g., ensuring equity of pay among women and men, end to domes-

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tic violence, reduction of stigma, reduction or elimination of corporal punishment in the schools). For me, we ought to do more to make changes the members identify as needed and be sure that any reports, position statements, or messages to our legislators are followed up with stronger strategies to effect genuine change. We have some of the best researchers and data people in science, so evaluation issues are not at all insurmountable. Perhaps to prioritize, we can identify the 'grand challenges' to which we can commit and include in that challenge ways of demonstrating a difference. We are all aware of the maxim, 'First, do no harm.' There is one that guides me and in the spirit of 'improv' in theater, I would add, 'Yes and be sure not to give the illusion of helping,' We collect data and evaluate not so much because that research is important but that people (animals and nature) are too, and we need some assurances that what we do is making a difference" (Alan Kazdin). "Ghost Riders in the Sky" (Johnny Cash).

Aloha,

Pat DeLeon, former APA President – Division 29 – April, 2020

CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY'S PROFESSIONAL AWARD WINNERS!

Jean Carter, PhD – Winner of the Society's Distinguished Psychologist Award

Dr. Jean Carter has maintained a psychotherapy practice in Washington, DC since receiving her Ph.D. in Counseling Psychology in 1980. In her work at the Washington Psychological Center, PC, she offers psychotherapy with individuals and couples, with primary emphases on serious trauma, relationship issues, depression and work stress/vocational adjustment. Additional areas of interest include supervision of psychotherapy practice, grief and loss and issues related to sexual orientation for both individuals and couples. Although she is active throughout psychology, her primary commitment and on-going passion are for the practice of psychotherapy.

Dr. Carter is the Treasurer of the American Psychological Association (2017-2022). She has served as President of three Divisions of the American Psychological Association, on the APA Council of Representatives, as Chair of the Committee for Division/APA Relations and the Committee for the Advancement of Professional Practice and chairs the APA Finance Committee. She was a member of the APA Presidential Task Force on Evidence Based Practice in Psychology and frequently contributes to psychological scholarship through publications and presentations. She is on the editorial board for Professional Psychology: Research and Practice, Journal of Psychotherapy Integration and Practice Innovations. She has served as an Associate Editor for Professional Psychology: Research and Practice and on the editorial boards of The Counseling Psychologist, Psychotherapy and The Journal of Counseling Psychology.

Dr. Carter is a Fellow in five Divisions of the American Psychological Association and is a Distinguished Practitioner of the National Academies of Practice. She has received numerous awards, including the APF Rosalie Weiss Lecture (2017), Distinguished Psychologist (Psychologists in Independent Practice, Division 42 of APA), APA Presidential Citations (the John D. Black Practitioner Award for Outstanding Achievement in the Practice of Psychology, Division of Counseling Psychology (1998), and the Society of Counseling Psychology's Best Practices Award (2008). ■

Michael J. Constantino, PhD – Winner of the Society's Mid-Career Award for Distinguished Scholarship Contributions to the Advancement of Psychotherapy

Dr. Michael J. Constantino is Professor of Psychological and Brain Sciences at the University of Massachusetts Amherst, where he directs the Psychotherapy Research Lab and serves as Graduate Program Director. Dr. Constantino's professional and research interests center on patient, therapist, and dyadic factors in psychosocial treatments; pantheoretical principles of clinical change; and measurement-based care. He has authored or co-authored over 140 journal articles and book chapters, and over 240 professional presentations. He is also co-editor of the book, *Principles of change: How psychotherapists implement research findings in practice*, and the in-preparation *Handbook of psychotherapy* to be published by APA.

Dr. Constantino's work has been recognized internationally, including with his receipt of the American Psychological Foundation's Early Career Award, the Society for the Exploration of Psychotherapy Integration's New Researcher Award, the Society for Psychotherapy Research's Outstanding Early Career Achievement Award, the APA Division 29 (Society for the Advancement of Psychotherapy) Distinguished Publication of Psychotherapy Research Award, and APA and Division 29 fellow status.

Dr. Constantino is Past-President of APA Division 29 and the North American Society for Psychotherapy Research. He is also an Associate Editor for *Psychotherapy*, and a Consulting Editor for the *Journal of Consulting and Clinical Psychology*, *Journal of Psychotherapy Integration*, *Journal of Unified Psychotherapy and Clinical Science*, and *Psychotherapy Research*. ■

Josh Turchan, PhD – Winner of the APF/Society for the Advancement of Psychotherapy Early Career Award

Josh Turchan, PhD is the Training Director and the Assistant Director of Research at Michigan State University's Counseling and Psychiatric Services (CAPS). He holds a master's degree in clinical psychology from the University of Detroit Mercy and a Ph.D. in counseling psychology from Auburn University. As Training Director, Dr. Turchan has expanded the definition of evidence-based practice in training at CAPS to focus on the therapy relationship and created a seminar where he trains interns to focus on evidence-based relationship processes, which emphasizes the importance of responsivity and cultural adaptation in psychotherapy. He recently created a post-doctoral training program where he is the supervisor of the Collaborative/Therapeutic Assessment & Psychodynamic Psychotherapy concentration. As Assistant Director of Research at CAPS, he developed a clini-

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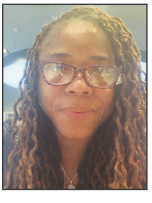
cal research program and is currently examining outcomes and moderators in Interpersonal Process group psychotherapy. Dr. Turchan is an Adjunct Assistant Professor in MSU's Psychology Department and is the Co-Director of the Interpersonal Problems Clinic, a relational psychodynamic psychotherapy training clinic within their Clinical Science Program. Within the Department of Psychology, he is a member of the Interpersonal Process in Psychotherapy Lab where he is part of a team that investigates the psychotherapy relationship.

Broadly speaking, Dr. Turchan's interests focus on the role of the relationship both in psychotherapy and in clinical supervision and how to train clinicians to be aware of these relational dynamics and adapt their interventions accordingly. His research interests focus on the interpersonal processes that occur in the psychotherapy relationship at both the dyadic and the group level. More specifically, he has particular interest in psychoanalytic theory, contemporary psychodynamic treatment and training, personality pathology and assessment, and the intersection and importance of multiculturalism and social justice within these domains. ■



Sheena Demery, PsyD – winner of the Society's Early Career Practitioner Award

As an early career psychologist Dr. Demery has made it a priority to ensure her work and training spans a variety of clinical settings including community mental health, home-based treatment outreach, and private practice. Dr. Demery's clinical practice and passion is in the work with children and adolescents, and ensuring treatment is available and accessible to those in underserved populations and communities.

Dr. Demery received her doctorate in clinical psychology from Pacifica Graduate Institute in Carpinteria, California. She completed her internship in Child, Adolescent and Adult clinical psychology at Family Matters of Greater Washington, where she provided psychological treatment and administered psychological evaluations to patients of all ages. ■

Jacques Barber, PhD – co- winner of the Society's Award for Distinguished Contributions to Teaching and Mentoring

Jacques P. Barber, Ph.D., ABPP is Professor and Dean, Gordon F Derner School of Psychology formerly the Institute of Advanced Studies in Psychology at Adelphi University. He is emeritus professor of psychology in the Department of Psychiatry and in the Psychology Graduate Group at the University of Pennsylvania. He is also Adjunct Professor of Psychiatry at New York University School of Medicine. He is past president of the International Society for Psychotherapy Research and was a recipient of its early career award in 1996 and its Distinguished Research Career Award in 2014. He recently received the Distinguished Psychologist Award from the Society for the Advancement of Psychotherapy (Division 29, 2018) and the Research Award from the Society for Psychoanalysis and Psychoanalytic Psychology (Div 39, 2019). He has been visiting professor at the Department of Clinical Neuroscience of the Karolinska Institute in Stockholm and at two universities in Australia. He is a licensed clinical psychologist in New York and Pennsylvania.

His research focuses on the outcome and process of psychodynamic and cognitive therapies for depression, panic disorder, substance dependence and personality disorders. He has been funded by NIMH and NIDA to conduct randomized clinical trials involving psychodynamic and cognitive therapy. Guided by conceptual models emphasizing both relational and technical factors, his psychotherapy process research examines the impact of the therapeutic alliance and of therapists' use of theoretically relevant interventions on the outcome of different therapies. Outside of treatment research, he has also conducted research on individual core conflicts and metacognition in different populations including Children of Holocaust Survivors. He has published more than 260 papers, chapters and books in the field of psychotherapy and personality. He is mostly proud of the students and post docs he has mentored during his career.

Among his recent books are "*Psychodynamic Therapy: A Guide to Evidence-Based Practice*" and "*Practicing Psychodynamic Therapy: A Casebook (2014)* both with Richard Summers*; Visions in Psychotherapy Research and Practice: Reflections from the presidents of the society for psychotherapy research co-edited with Bernhard Strauss and Louis Georges Castonguay*. "*Echoes of the Trauma: Relationship Themes and Emotions in the Narratives of the Children of Holocaust Survivors"* co-authored with Hadas Wiseman, and *The Therapeutic Alliance: An Evidence-Based Approach to Practice, co-edited with Christopher Muran.* ■

Cheri Marmarosh, PhD – co-winner of the Society's Award for Distinguished Contributions to Teaching and Mentoring

Cheri L. Marmarosh, PhD, is an associate professor of professional psychology at the George Washington University. She graduated from Virginia Commonwealth University in 1996 where she specialized in group psychotherapy. After completing an internship at the University of Delaware's Counseling Center, she completed the individual psychotherapy program at the Institute of Contemporary Psychotherapy and Psychoanalysis and the couples program at the Washington School of Psychiatry. Dr. Marmarosh initiated the Internship at Catholic University's Counseling Center before moving to the George Washington University. She has taught group psychotherapy for more than 20 years, attachment theory and clinical practice for 10 years, and has published more than 40 empirical and theoretical articles that focus on how group and individual psychotherapy facilitate change. Over the years, she has supervised over 50 dissertations and major area papers, mentored graduate student research, and supervised their clinical practice. Dr. Marmarosh is a fellow of APA Division 29 (Society for the Advancement of Psychotherapy) and APA Division 49 (Society of Group Psychology and Group Psychotherapy), and she is the current president of Division 49. She is currently an associate editor of Psychotherapy and the past associate editor of Group Dynamics: Theory, Research, and Practice. She is currently on the editorial board of the International Journal of Group Psychotherapy. Dr. Marmarosh is the lead author of two books, Attachment in Group Psychotherapy (2013, American Psychological Association) and Groups: Fostering a Culture of Change (2013, Sage Publications). Dr. Marmarosh has a private practice in DC where she works with adults, couples, and groups. ■

Rosemary Adam-Terem, PhD – winner of the Society's Distinguished Practitioner Award

Dr. Adam-Terem is a clinical psychologist in independent practice in Honolulu. She works with a wide variety of adult issues and a large proportion of her practice is with women or couples. She has been involved with helping victims of intimate partner violence, families going through divorce, post-partum patients, and has conducted custody evaluations and served as parenting coordinator for the Family Court. A past-president of the Hawai`i Psychological Association (HPA), Dr. Adam-Terem currently serves as membership chair of the Society for the Advancement of Psychotherapy, was formerly the Public Policy and Social Justice domain representative for the Society and will be running for election as president-elect this year. Dr. Adam-Terem is the current chair of HPA's Ethics Committee and heads up the Continuing Education and Convention Committee. She has served on the Hawai`i State Board of Psychology for eight years and is a past chair. ■

WELCOME TO OUR NEW AMPD SCHOLARS!

The Society for the Advancement of Psychotherapy is excited to welcome our two new Advocacy and Mentoring Program for Diversity (AMPD) Scholars! They are Ingrid Hastedt (University of Massachusetts Boston) and Michelle Joaquin (Yeshiva University).

The AMPD Scholars program is our new two-year mentoring program, which was developed as a part of the efforts of the Society for the Advancement of Psychotherapy's Diversity Domain and Diversity Committee to promote diversity and leadership development within the organization and within the areas of psychotherapy research, practice, and education/training.

Dr. Rosemary Phelps was the architect of the program, with the Diversity Domain Representatives and the Diversity Committee Chair providing support for Dr. Phelps' initiative. The Executive Board voted unanimously to support the program, and the competitive application process was completed this spring.

The program was launched in light of two intersecting priorities of the Society (see https://societyforpsychotherapy.org/mission/): (a) to provide opportunities for students and ECPs to connect with the division and further their professional development and (b) to promote diversity and inclusion within our membership, governance, psychotherapy research, training, and practice with a national and global perspective.

The purpose of the Advocacy and Mentoring Program for Diversity (AMPD) is twofold: (a) to provide the opportunity for doctoral students from underrepresented and/or marginalized groups to become familiar with and involved in activities of the Society for the Advancement of Psychotherapy and (b) to provide mentoring and guidance for scholars consistent with their career goals and professional aspirations. As part of this program, AMPD Scholars will work closely with Executive Board members on specific diversity-related projects and ensure implementation of domain specific goals related to diversity and the advancement of psychotherapy. Projects may be in any of the domains represented on the Board of Directors of the Society (i.e., Diversity, Early Career, Education and Training, International, Membership, Professional Practice, Science and Scholarship, Public Interest and Social Justice).

Throughout this program, AMPD Scholars will receive mentoring from Domain Representatives and associated Committee Chairs, and Diversity Committee members. In Year 1, AMPD Scholars will develop a diversity project within their chosen domain through contact with the Domain Representative, Committee Chair, and Diversity Committee members. In Year 2, AMPD Scholars will implement their projects and present their work at the annual APA convention.

The scholars selected have already demonstrated a strong commitment to ps ychotherapy research, practice, and/or training and education, and a strong commitment to diversity, social justice, and advocacy. AMPD scholars have an interest in learning about the leadership of the Society and the various domains of the Executive Board. The Executive Board will work closely with AMPD Scholars to introduce them to the leadership process. They will attend Executive Board Meetings and teleconference with members of the domain of their choice. We are excited to introduce our new AMPD scholars, Ingrid Hastedt and Michelle Joaquin.

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Ingrid Hastedt is a graduate student in the Clinical Psychology Program at the University of Massachusetts Boston. Ingrid was born and raised in Guatemala and came to the U.S. as a young adult. After earning her B.A. in Psychology from Boston College, Ingrid decided to pursue a career in clinical psychology dedicated to serving the Latinx population. Her clinical interests include working with infants, children and families, particularly those with limited access to mental health care, as well as working with children with developmental disorders. Her research interests include health disparities in child mental health, bilingualism and ASD, and bilingual therapy. Additionally, Ingrid is interested in international consultation and collaboration to disseminate evidence-based treatments in her home country as well as to facilitate culturally and linguistically sensitive mental health services for under-served populations.

Michelle Joaquin is a School-Clinical Child Psychology doctoral student at Yeshiva University. She is trained in forensic interviewing, psychological assessment of asylum seekers and psychoeducational assessments. She has worked at Mt. Sinai St. Luke's Hospital, Montefiore Medical Group, Beth Israel Hospital, Safe Horizon, the Center for Attachment Research and the Hispanic Family Mental Health Center. Her current research interests include trauma and immigration. She will complete her trauma-track internship at the University of Southern California's Children's Hospital of Los Angeles.

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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://society forpsychotherapy.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: January 15 (#1); April 15 (#2); July 15 (#3); October 15 (#4). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.societyforpsycho-therapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or the Society should be directed to Tracey Martin at the the Society's Central Office (assnmgmt1@cox.net or 602-363-9211).

Society for the Advancement of Psychotherapy (29)
Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net
www.societyforpsychotherapy.org

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of Psychotherapy

American Psychological Association
6557 E. Riverdale St.
Mesa, AZ 85215

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