Psychotherapy

OFFICIAL PUBLICATION OF THE SOCIETY
FOR THE ADVANCEMENT OF PSYCHOTHERAPY
OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.societyforpsychotherapy.org

BULLETIN

In This Issue

Society for the
Advancement
of Psychotherapy

2020 VOLUME 55, NUMBER 4

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PSYCHOTHERAPY BULLETIN
Published by the
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PSYCHOTHERAPY BULLETIN

Official Publication of the Society for the Advancement of Psychotherapy of the American Psychological Association

Society for the Advancement of Psychotherapy

2020 Volume 55, Number 4

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PRESIDENT'S COLUMN

Jennifer L. Callahan, PhD
University of North Texas

To say that 2020 has been remarkable would be an understatement. It has demanded much of us, across every role we occupy in our diverse lives. Despite the personal and professional challenges your division leadership team has encountered, they have worked hard to model resiliency and accomplish a great deal on behalf of the Society this year. This column shines a light on some of those achievements and is dedicated to them. In addition to working closely with the Officers, Gary VandenBos (President-elect), Nancy Murdock (Past President), Rebecca Amentrano (Secretary), Joshua Swift (Treasurer), Lillian Comas-Diaz (Council Representative) and Gerald Koocher (Council Representative), and Tracey Martin (Central Office Administrator), it has been my absolute pleasure to work with the Domain Representatives and Committee Chairs over the past year. If they were in need, I would share my toilet paper with any one of them![1]

The Diversity Domain (Representatives Manijeh Badiee and Susan Woodhouse, with Committee Chair Sheeva Mostoufi and 2020 Presidential Task Force Chair Rosemary Phelps) launched the inaugural cohort of the Advocacy and Mentoring Program for Diversity (AMPD), recognizing Ingrid Hastedt and Michelle Joaquin as the first AMPD Scholars. Getting the opportunity to learn from them was a truly delightful experience and has me excited for the future of the profession. The Diversity Domain also curated a wonderful contribution to the Bulletin earlier this year on working with clients with disabilities. The Public Interest and Social Justice Domain (Representatives Lavita Nadkarni and Linda Campbell) were instrumental in developing content for the website that has been timely and responsive to the needs of 2020 with topics on collective action and healing, pandemic implications for internship trainees, facing discrimination, taking about race in academia, and identifying actionable steps psychotherapists can take in response to the racial pandemic.

The shift of the APA Convention to a virtual-only event, with only a matter of weeks for the Society to rapidly pivot content, was masterfully tackled by Program Committee Chair James Boswell and Associate Chair Astrea Greig. In all, 26 posters, 8 symposiums, 1 skill-building session, and 1 discussion were able to make the leap to virtual programming through the support and guidance of James and Astrea. As the 2021 Program Chair, Astrea has already begun laying groundwork for a successful convention in any form it must take.

The Psychotherapy Practice Domain (Representative Barbara Vivino and Committee Chair Daniel Gaztambide) persisted despite the challenges with carrying out a survey of psychotherapy needs and did a virtual presentation to the Monterey Psychological Association on politics in mental health practice. They also have continued to build the Division's web presence and to contribute to the *Bulletin* with features on decreasing practitioner isolation, setting and reimagining fee schedules, and examining race in psychotherapy.

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In addition to submitting multiple *Bulletin* articles (dealing with high risk situations; videoconference nuances with respect to boundaries and presence; use of countertransference in the pandemics), The Early Career Domain (Representative Beatriz Palma and Committee Chair Sara Danitz-Steinhart) retitled and shifted online to host a successful "Gab with the Greats" networking event to connect students and early career professionals with notable psychotherapists.

The Education and Training Domain (Representative Marilyn Cornish, Student Representative Carly Schwartzman, and Committee Chair Eric Sauer) presented at the convention's virtual poster session to help current students understand how to get involved with the Society. They also recruited feature articles in the Bulletin on the use of online dating services by mental health professionals and the experience of working with clients' traumatic content in psychotherapy. The Continuing Education Committee (Chair Ken Critchfield) worked closely with Central Office (Administrator Tracey Martin) to secure renewal as an approved CE provider. Moving into 2021, they will be working on securing permission to offer home study CE credits.

The Membership Domain (Representative Jean Birbilis and Committee Chair Rosemary Adam-Terem) continue to innovate in connecting with new and potential members, proposing new pathways to be launched in 2021 (more to come on that next year!). Across the current year, they have revised the membership application, created a website feature, "Why Join?" and have been interviewing psychotherapists for inclusion in a longer, forthcoming, video of the same name.

A subcommittee structure with five active workgroups was developed and mobilized by the International Affairs Domain (Representative Frederick Leong and Committee Co-Chairs Changming Duan and Patrick Leung). The workgroups include conference—programs, conference—social, international research, connection with international students, and future collaboration/relationship building. Look to 2021 for the launch of their Bulletin series on the theme of "Psychotherapy Around the World."

The Science and Scholarship Domain (Representative Patricia Spangler and Committee Chair Jenelle Slavin-Mulford) continued their focus on dissemination throughout the pandemic publishing new works in the Bulletin this year on psychotherapist characteristics as predictive of alliance, the rationale of looking at psychotherapist effects, and exploring mechanisms of change in functional analytic psychotherapy.

The Finance Committee, Chaired by Georita Frierson, worked with Division Treasurer, Joshua Swift, to review investment strategies and update reporting procedures to the Board to provide greater transparency. At the same time, the Fellows Committee, Chaired by Robert Hatcher, identified 6 new Fellows who have been approved by APA: Kenneth Critchfield, Jacqueline B. Persons, P. Scott Richards, Kirk Schneider, K. Mark Sossin, and Robert H. Woody. It is truly our honor to recognize the achievements of these Fellows.

Bob Hatcher deserves a special place of gratitude for his extra service this year, stepping in to Chair Publications. The Society's flagship publication, *Psychotherapy* has had another extraordinary year under Mark Hilsenroth's editorship. This year has been the year

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of long good-bye knowing that his term as Editor-in-Chief concludes with the final issue of 2020. True to what we know of Mark, he has continued working tirelessly in making a smooth transition to Jesse Owen as the next Editor-in-Chief, effective issue 1 of 2021. We cannot thank Mark and his Associate Editors, Jamie Bedics, Stephanie Budge, Cheri Marmarosh, and Jesse Owen, as well as all of the *Psychotherapy* editorial board, enough for their care and expertise. The two-year impact factor reached an all-time high (3.191), as did the five-year impact factor (3.367), with a record number of prior year citations (3,204). As a longtime reader, I can say that *Psychotherapy* is not only a top-notch journal, it is a journal that continually captures content worth savoring. The Society can thank Editor Joanna Drinane, Associate Editor Stephanie Winkeljohn Black, and Editorial Assistants Salwa Chowdhury and Kate Axford, for making *Psychotherapy Bulletin* seem effortless with every issue published on time….during a pandemic!! Kourtney Schroeder became Internet Editor this year and put together a wonderful team with Zoe Ross-Nash as Website Content Associate Editor and Olivia Carelli as Social Media Consultant. In their first year as a team, they met a goal of 40% of authors from *Psychotherapy* and *Psychotherapy Bulletin* contributing companion pieces to the website and saw a 43% increase in website users compared to the prior 6 months.

Thank you to the entire leadership team of the Society of allowing me the opportunity to serve you this past year in advocating and facilitating your initiatives across 2020. I will think of you all, and our most unusual year, with every sip of yerba from my purple mate cup. J

[1]Obviously, this joke will not hold up well in a post COVID-19 pandemic world when the idea of a toilet paper shortage sounds completely ridiculous. Having priority mailed bulk toilet paper to my father, spending more on postage then the cost of the toilet paper itself, I am not joking in apprising the act of sharing a preferred brand of toilet paper as an act of love and appreciation.

EDITOR'S COLUMN

Joanna M. Drinane, Ph.D., Editor
Assistant Professor, Counseling & Counseling Psychology Programs, University of Utah – Salt Lake City, UT

"We are all more simply human than otherwise."
– Harry Stack Sullivan, 1947

This quote, which drove some of the conceptual work of the late Dr. Jeremy Safran, underlies the notion that therapists are part of what he refers to as the "interpersonal field" and they must be keen observers not only of their clients' behavior, but also of their own subjective reactions to it (Safran, 1998). Regardless of who you are, therapist, client, professor, community member, or if you occupy some combination of these roles, the events of 2020 have amplified and shaped your subjective experience. We at the bulletin team hope that the holiday season allows you time to reflect, to take some space for you, and to reassemble after this exceptionally trying year. Through our selection of the special focus for the past four issues, "The Person of the Therapist," we intended to highlight that who you are is intricately woven into the work you do, and we are thankful for the unique contributions you make to this publication and to the Division at large.

This year has been filled with transition at the Bulletin. As we have undergone significant turnover of staff on both the Editorial and Internet Teams, it has taken some time for us to calibrate and refine our processes. We appreciate your patience as our teams have collaborated to establish effective routines to ensure the timely editing (Editorial Team), and subsequent production of the PDF Bulletin (Editorial Team and Tracey Martin) and the E-Bulletin (Internet Editorial Team). We are now fully up and running, and that is in large part due to our Editorial Assistants, Salwa Chowdhury and Kate Axford, to Internet Editor, Kourtney Schroeder, to Associate Editor, Stephanie Winkeljohn Black, and to Resident Bulletin Expert, Tracey Martin. At the end of the year, Salwa will conclude her time on the Editorial Team to pursue other professional interests, and we thank her for her service and share in her excitement about how her career is taking shape. To each and every member of our team, and to the domain representatives and thoughtful authors who submit pieces, we have valued your time and communication of your expertise and look forward to continuing the positive tradition of the Bulletin being an engaging medium for the exchange of ideas.

In this final edition of the year, we have a collection of wonderful articles whose content is broad in scope. You will also find a column from our President, Dr. Jennifer Callahan, which describes the year's activities and accomplishments in depth. The Division's productivity throughout such challenging times is inspiring, and we anticipate the many successes that will come in 2021 and under what we can only hope will be better circumstances. With that said, we welcome your submissions and plan to operate on the following schedule of deadlines: January 15th, April 15th, July 15th, and October 15th. Through your writing and participation in this type of scholarly discourse, we can challenge existing narratives of the roles of psychotherapists in an effort to better serve the communities we are passionate about.

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As the rates of COVID19 continue to rise, we think of those of you operating as essential personnel. We acknowledge that providing any direct care at this time (in person or via telehealth) can be accompanied by emotional fatigue as the fear and stress of the pandemic are shared by clients and therapists alike. It is our goal for the bulletin to serve as an outlet for you as you gain insight, reflect on your experiences, and think critically about systemic changes you want to encourage. For submission guidelines or to write for the *Bulletin*, visit our website at http://societyforpsychotherapy.org/bulletin-about/. Please reach out with questions to joanna.drinane@utah.edu. Wishing you a happy and more than ever, a healthy New Year.

Thank you,
Joanna

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STATEMENT FROM DIVISION 29

The following statement has recently been sent to every state licensing board as well as every state psychological association. It has also been sent to the chair of Association of State and Provincial Psychology Boards (who developed and maintains the licensure examination). Publication of the statement herein is intended to provide a permanent and citable location for reference.

The Society for the Advancement of Psychotherapy (American Psychological Association Division 29) recognizes mental health disparities as directly attributable to lack of access to mental health care, an insufficiently diverse health care workforce, and need for linguistically and culturally competent care (SAMHSA, 2018). As an organization whose mission is to make the benefits of psychotherapy available to all, we reject methods and processes that serve to create or sustain barriers to enter the professional psychology workforce on the basis of race/ethnicity or linguistic biases. We recognize the Examination for the Professional Practice of Psychology (EPPP) as a source of diversity constriction (Sharpless, 2019a; 2019b). We call for (1) planned obsolescence of the current examination, and (2) adherence by ASPPB to measure development guidelines for the evaluation of linguistically and culturally diverse peoples (International Test Commission, 2018) as they work towards creation of a new exam (colloquially referred to as "Part 2").

Further Reading:

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A Better World Is Possible: Psychology's Responsibility to Abolition

Hannah Klukoff, BA
Haleh Kanani, BA
University of Denver

Though they may seem initially like an odd couple, psychology and abolition are inextricably linked. Abolition has meant many things throughout history, and in this paper, it is defined as the dismantling of the prison-industrial complex (PIC) and the creation of structures of accountability and care that are fundamentally non-punitive. Activist and organizer, Rachel Herzing, defines the PIC as "the symbiotic relationship between public and private interests that employ imprisonment, policing, surveillance, the courts, and their attendant cultural apparatuses as a means of maintaining social, economic, and political inequities" (Schenwar & Law, 2020, p. 8). PIC abolition targets the physical sites of jails and prisons, as the name suggests, but its aims are much broader than that; it includes opposing any institutions that operate under a logic of carceral control and supporting systems that meet people's needs—from a pollution-free environment to food and housing. Abolitionist efforts to reduce our reliance on policing and punishment have been active for decades, with communities of color at the forefront of this work. Recent protests in the wake of several highly publicized police murders of Black people have brought abolitionist ideas to a wider audience, and calls to defund the police and redirect funds to community services are no longer seen as ideas belonging to some radical fringe. Many conversations surrounding racial justice have explicitly focused on mental health care and how it can be divorced from its current entanglement with policing. The discipline of psychology undoubtedly has an important role to play in making our society safer, and we argue that that role is not in reforming the current system but in abolishing it.

When we discuss how psychology has an inherent responsibility to work toward prison abolition, the most obvious connection between the two is the field of forensic psychology. Forensic psychology has been defined as "the application of clinical specialties to legal institutions and people who come into contact with the law" (Cronin, 2009, p.5). The American Psychological Association (APA) broadens the definition to include the application of research and scholarship in other fields of psychological study (e.g., cognitive psychology, developmental psychology) to legal issues and questions (Ward, 2013). Either way, it is the direct connection to people who have been swept up into the legal system that makes forensic psychologists (and forensic psychology training programs) uniquely positioned to advocate for abolition.

In forensic psychology training programs, we learn that people with mental illnesses are severely over-incarcerated, at an estimate of two to

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four times the general population (Prins & Draper, 2009). We learn that incarcerated environments are ill-equipped to treat mental illness, and in some cases, even create symptoms of mental illness in people who previously had none (Davies, 2020). We are taught that our places within the field of psychology include, but are not limited to, assisting local police with calls that involve a potential mental health crisis, assessing people for competency to stand trial, providing mental health care within jails and prisons, and working in drug courts. Although these options may allow us to help many individuals, they all operate under the same base assumption that our current systems of policing and incarceration will always need to exist. Most, if not all, career options for a forensic psychologist came to fruition from the realization that mental illness, when accompanied by other important risk factors, greatly increases the likelihood that a person will come into contact with the criminal justice system (Skeem et al., 2008). Thus, forensic psychologists have been at the forefront of advocating for criminal justice reforms that, on the surface, offer a better option than a regular prison sentence for those with mental illness and/or substance use disorders.

In our haste to reform the system by making mental health care a bigger priority in criminal justice reforms, we tend to ignore the fact that a system whose intention is to punish and control will always work against reforms that leave its foundation intact. Clinical professionals that work within correctional settings work hard to provide a much-needed service, but the fact remains that the conditions of incarceration create harm at a rate that would be difficult for any therapist to keep up with, let alone stop. This calls for us to seriously question the underlying goals of the systems in which these programs operate. Just as a therapist is concerned for a client's well-being when they are in the room, so should they be concerned with how the conditions of incarceration are also a detriment to their well-being. Many popular mental health prison reforms attempt to make a carceral system more therapeutic, but the most therapeutic reforms necessitate reducing the scope of the system itself. Forensic psychologists have a unique perspective and wealth of experience to draw upon; they can provide services to people involved in the criminal legal system while simultaneously working to create societal conditions that ensure that no one has to rely on that system to access care.

Although the most direct link between abolition and psychology may lie in forensic psychology, the broader field of clinical psychology must also be examined with a critical eye. Mental hospitals and prisons in the United States developed alongside one another, and in many ways, the logic of psychiatric institutions became a carceral one, prioritizing confinement over care (Chapman et al., 2014). In the mid to late 1800s, as asylums proliferated and subsequently became overcrowded and understaffed, the institutional focus shifted to custodial care, and treatment came to be seen as a lost cause for many of those confined (Braddock & Parish, 2003). A review of articles published from 1844 to 1900 in the *American Journal of Insanity* (renamed the *American Journal of Psychiatry* in 1922) found a host of literature on the architecture and management of asylums, but fewer than ten articles on patient care (Braddock & Parish, 2003). Asylum patients came to be seen as helpless, and confinement was regarded as a necessary action taken both for their own good and for the good of the greater community.

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There is no doubt that modern psychiatric institutions are more humane than early asylums; however, in certain ways, the underlying assumption that individuals with mental illness are a problem to be managed rather than people entitled to quality treatment has not faded. Today, decisions about whether a person should be hospitalized against their will are ostensibly governed by the legal standard of whether there is "clear and convincing" evidence that a person is at imminent risk of harming themselves or others (Mossman et al., 2011). The subjectiveness inherent to that standard and the bias in its implementation is important to note—research indicates that African American and Indigenous populations are disproportionately represented in inpatient settings (Snowden, 2003). Moreover, what of the risk that involuntary hospitalization poses to a person? A 2018 survey of people formerly hospitalized for psychiatric reasons conducted by Mad in America, an organization that seeks to "serve as a catalyst for rethinking psychiatric care," yielded the following results: regarding their time in the psychiatric ward, over half of the respondents described their experience as "traumatic," 37% said they were physically abused in some way (with forced treatment included as an example of physical abuse), and 7% said they were sexually abused (Simonson, 2018). Only 27% said they felt "safe and secure" while on the psychiatric ward, and only 17% said they were "satisfied with the quality of the psychiatric treatment" they received. These numbers are alarming. Patterns of abuse and neglect (including restraints being used as a punishment) within U.S. mental health treatment settings have also been highlighted in reports by the Department of Justice and the United Nations (Hartocollis, 2009; Minkowitz, 2017).

Further, it is worth considering how a treatment that takes place involuntarily may undermine its own aims. For example, research suggests that the therapeutic alliance—a key predictor of positive treatment outcomes—is strengthened when patients are assured that they have input and influence over their own treatment (Safran & Muran, 2000; Applebaum & Gutheil, 1982). Involuntary outpatient treatment has been touted as a favorable alternative to hospitalization and is now allowed by law in 46 states (Carrol, n.d.). Although this option allows individuals to remain in the community, the threat of arrest or hospitalization is never far off. Thus, this reform still effectively denies people their autonomy, which may drive them away from seeking mental health treatment in the long term. Rather than invest in a mental health system that is robustly funded and able to address the various and complex needs of its consumers in earnest, we continuously turn to law enforcement as a delivery mechanism for mental health services.

In light of this evidence of abuse and traumatization, our professional, ethical guidelines compel us to reconsider the way we operate, from the ground up, in order to uphold principles of beneficence, nonmaleficence, and respect for people's rights and dignity (American Psychological Association, 2017). How can we move away from our reliance on forcible confinement and toward forms of care that provide genuine healing? How can we radically expand the forms of non-punitive treatment that exist and ensure that they are accessible to all? How can we make treatment something that people want to seek out when they are in need and something that they can rely on, rather than something that many people have come to fear? These abolition-minded questions apply to all

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of us in the field of psychology, not just those who identify with the subfield of forensic psychology.

Although some hold tight to the view of psychology as an apolitical discipline, history provides many examples to the contrary. Diagnostic labels have long been tied to race and gender-based oppression. Black people are diagnosed with schizophrenia at a rate three to five times higher than white people (Schwartz & Blankenship, 2014). Until 1973, homosexuality was listed as a disorder in the DSM (Braddock & Parish, 2003). However, notably, psychology has also taken explicit political action at critical junctures to promote the common good; the APA contributed an amicus brief to the U.S. Supreme Court in the case of Obergefell v. Hodges to put forth evidence supporting the validity of same-sex partnerships and has made public statements against the use of solitary confinement for juveniles (American Psychological Association, 2015; Anderson, 2017). Although the APA's willingness to offer public positions on criminal justice issues is a welcome step, positions that do not address the root causes of the problems at hand can be seen as somewhat nearsighted. Reforms enacted only for the sake of reform put a glossy finish on institutions that were never meant to better human lives. So, then, reforms for the sake of what? Abolition. If psychology can offer evidence that racial bias is rampant in policing, why then can it not advocate for abolishing the police? If psychology can recognize the immense harms of solitary confinement, why then can it not advocate for the eradication of all forms of confinement disguised as justice? No discipline that deals with the well-being of people can be apolitical, so long as people's lives are impacted by policies. If the field of psychology wants to continue to uphold its goal of bettering human life, it must expand its collective imagination to directly address social determinants of mental health that exist outside the DSM.

As the field of psychology begins to embrace its role in social justice efforts, we must ask whether the changes we advocate for are likely to move us towards the creation of long-lasting healing for individuals and communities or whether they simply make superficial tweaks that leave a system of punishment and control intact. While multifaceted in the questions it poses, PIC abolition makes the definitive statement that human beings do not belong in cages—a statement that directly aligns with psychology's ethics and value system. Yet, there seems to be a disconnect both currently and historically between what the field of psychology preaches and what we practice. Long-standing professionals, first-year undergraduate students, and all psychologically minded people in between are currently in a unique position to consider the ways in which psychology has been complicit in oppression, to listen to those who have been harmed, and to create more modes of treatment and care that respect the autonomy and personhood of the people we serve. Confronting the harm that our current systems inflict on many people is a difficult but necessary first step, which can serve as a catalyst for the growth and development of our field in a positive direction.

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Is the GRE Necessary in Admissions? During COVID-19 and Beyond

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In 2020, the world has been plagued with a pandemic, continued incidents of state-sanctioned violence by police officers toward Black Americans, and natural disasters. During this time, various countries had stay-at-home orders to mitigate the spread of COVID-19. This year has unmasked a multitude of unjust, inequitable, and corrupt systems, necessitated to reflect on the overdue changes our society must make to adapt and survive and offer insight opportunities. Educational systems were disrupted, including colleges and universities, in the way that they operate. In some cases, that could be a good thing. Colleges and universities had to make a complete paradigm shift toward models in which online learning replicates more closely an in-class experience. Despite the modifications, the graduate admissions cycle continues, and students are currently compiling their application materials. Numerous studies have revealed the three critical factors in successful admission applications into psychology graduate programs are undergraduate GPA, letters of recommendation, and scores on the Graduate Records Examination (GRE) (Briihl, 2001; Keith-Spiegel et al., 1994; Landrum & Clark, 2005; Purdy et al., 1989).

Although the GRE is a significant factor in graduate admissions, many graduate degree programs in psychology are reassessing their admissions procedures, given the current state of the world. For instance, given the steady rates of COVID-19 and lack of a treatment or vaccine, many programs will be hosting their interviews virtually. Additionally, as testing centers closed and access to online modalities for the GRE fluctuate by region and on an individual basis, many universities have waived GRE requirements for some or all students for the 2020-2021 admissions cycle (Hu, 2020). However, other faculty and admissions committees across the country are uncertain whether graduate admissions committees should implement this waiver. The present article will address the need to waive the GRE for the current admissions cycle and discuss the importance of weighing the GRE's effectiveness and relevance in the admissions process.

Purpose of Admissions Testing

Historically, almost every graduate degree program in psychology requires the GRE, and the GRE tends to be among the most heavily weighted factors in the admissions process (Norcross et al. 1996; Norcross et al., 2006). The GRE was developed to predict the likelihood of graduate school success. However, much of the research on the GRE is mixed in this assertion. One study argued that the psychology subject test is a more valid predictor of success than the general test (Willingham, 1974).

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Proponents of the test may point out that student experiences and learning vary between undergraduate institutions. In other words, a bachelor's degree in psychology from one institution may represent a different level of preparedness for graduate-level training than the same degree from a different institution. With this in mind, the GRE could serve to provide a standardized appraisal of a student's knowledge in ways that a degree alone cannot (Hu, 2020). After all, the GRE ostensibly exists to determine whether a student is likely to succeed in graduate education. That alone seems reason enough to require that students take the exam, except that the test's validity and predictive value of graduate student performance are controversial. Even Educational Testing Service (ETS), the test creator, acknowledges that the GRE may only have a tenuous connection to student success (Clayton, 2016).

When admissions committees try to figure out which students have the best chance of succeeding, they use many tools. Most colleges and universities request letters of recommendation, transcripts, personal statements, and writing samples in addition to the GRE. They interview students and see if their interests and demeanor will make them good team or lab members and pupils. The admissions process is like a large, healthy breakfast. There need to be multiple components. There should be protein, healthy carbohydrates, and plenty of vitamins. As commercials for sugary breakfast cereals disclaim, the cereal is only one part of a balanced breakfast. However, if your breakfast already includes eggs, fruit, juice, and toast, is there any need for the sugary cereal? We already have plenty of nutritional elements in our admissions meal. We should excise the piece that not only provides little value but actively does harm. Just as Trix does not give any nutrients that toast and fruit cannot provide (while being an active detriment to health), we can already find out what we want to learn from the GRE without creating a barrier to students, including the cost of the exam or risk of health.

Leveling the Playing Field

Reducing barriers to access to graduate education has been a long concern, but it is even more relevant during the current COVID-19 pandemic. While some testing sites have been able to reopen and allow some students to take the test, others are unable to reopen. Access to testing centers varies widely based on state regulations, and internet testing also creates a barrier. Therefore, it is logical to waive the requirement not to deter students who cannot access the test from applying. However, the inherent unfairness of the internet alternative raises a different concern. What if the GRE is too biased to be ethically required? There have long been concerns regarding the GRE's predictive validity. The concerns surrounding testing bias should be no surprise to the psychology community; as has been seen prominently with IQ testing, standardized tests often present problems with cultural sensitivity (Clayton, 2016). Like other injustices that have come into the spotlight, this one has existed long before the time of COVID. Rogers and Molina (2006) note, "Relying less heavily on GRE scores and other more traditional selection criteria seems to be a hallmark of the exemplary institutions' approach to deciding which students they would like to encourage to enter their institution" (p. 154).

Discrimination in testing should matter to anyone in higher education, but psychologists especially should be sensitive to the GRE's flaws and ethical failings. The American Psychological Association's

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ethics guidelines enshrine that psychologists affirm the importance of justice and fairness and that psychology's benefits should be available to all regardless of background (American Psychological Association, 2017). Extrapolating on this principle, it is only ethical that the study of psychology is accessible, regardless of background. Scholars have purported that the GRE suffers from selection bias. Scores are correlated with SES, race, and gender. According to Miller and Stassun (2014), "the GRE is a better indicator of sex and skin colour than of ability and ultimate success" (p. 303). Significant gaps in quantitative scores exist between men and women as well as among ethnic groups, and research by the test developer (i.e., ETS) has shown that the exam underpredicts success for women over 25 (Bleske-Rechek & Browne, 2014; Clayton, 2016). The effects of these disparities are harmful, as they can stymie diversity and keep marginalized and underrepresented groups, such as women, out of STEM (Miller & Stassun, 2014).

Reducing barriers to access to graduate education for underrepresented students is a significant concern at colleges and universities. These institutions often aim to increase students' recruitment and retention. When you factor in application fees, travel expenses, and the cost of the GRE (not to mention the subject test), students are overburdened in general, especially given the current economy. This, in turn, creates an application process that creates barriers for underrepresented and marginalized students, including first-generation students (Burchett & Matthews, 2020). Not only does requiring the GRE conflict with the values upheld by the APA's ethics guidelines, but it is also detrimental to psychology departments and to the science itself. Psychologists have an ethical obligation to counteract the effects of bias in testing.

Conclusion

COVID-related restrictions provide a reprieve in the form of virtual tours and interviews for many students, including the first author. Requiring the GRE during a public health crisis is not only a financial barrier for many students. It may also discourage students from applying due to physical safety reasons. Now is the time to see what accommodations can be made in the graduate admissions process and commit to continuing to evaluate the process even after the current crisis has dissipated. Students should not have to wait for a pandemic to afford the application process, and students certainly should not be judged by their performance on a test that is unfair in the best of times.

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Rethinking How We Teach Socratic Questioning

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Socratic questioning is a transtheoretical omnipresent psychotherapeutic process (Overholser, 2018; Waltman et al., 2020). The notion that corrective learning is essential to psychological healing and growth stems back to the origins of psychotherapy (Alexander & French, 1946); this phenomenon is commonly called the corrective emotional experience (Alexander & French, 1946; Yalom, 1995). From an integrative perspective, the nonbiological elements of a psychiatric disorder are often rooted in a pathogenic underlying belief (Silberchatz, 2005; Weiss, 1993), and bringing about a change to that belief can alleviate suffering, leading to healthy changes in affect, thinking, and behavior. There are different routes to changing underlying beliefs; such as interpersonal learning in a group setting (Yalom, 1995), the therapist's provision of a corrective experience that is counter to early learning (Alexander & French, 1946; Silberchatz, 2005; Weiss, 1993), use of questioning and Socratic Dialogue to help a client see things from a different perspective (Padesky, 1993, 2019; Waltman et al., 2020), or using Socratic questioning to channel inborn knowledge, perhaps from a collective unconscious or spiritual realm (Peoples & Drozdek, 2017).

In the cognitive and behavioral therapies, *guided discovery* and *collaborative empiricism* are parallel terms that describe the process of using collaborative strategies to join with the client in applying scientific curiosity to their thought and behavior patterns (Tee & Kazantzis, 2011). Socratic questioning (also called Socratic dialogue) is a way to engage in collaborative empiricism with your clients. The use of Socratic processes is thought to lead to a deeper level of learning and change (Beck, 2011). Though, empirically, there has been little research done on Socratic questioning (Padesky, 2019). One study has demonstrated that the use of Socratic questioning in the treatment of depression is predictive of symptoms change; further, this relationship holds even after controlling for the relationship (Braun, Strunk, Sasso, & Cooper, 2015). Certainly, further research is warranted, and measures have been developed to aid in that research (Waltman et al., 2020).

Common Pitfalls and Stuckpoints in Learning Socratic Questioning

While Socratic questioning is a transtheoretical psychotherapeutic process, there is some evidence that learning to artfully and competently use Socratic strategies in session is among the hardest skills for a psychotherapist to learn (Waltman et al., 2017). A common pitfall to Socratic questioning is something called *provided discovery* (as opposed to guided discovery); this is where a therapist tries to tell the client the conclusions they should be reaching. Many thought records and attempts at cognitive restructuring focus on trying to show the client why their thinking is distorted (Waltman et al., 2019)—this can be counter collaboration.

Additionally, many therapists fall into the trap of trying to convince the client to see things from their point of view or to guide them to what they think is the

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right answer. This often results in non-collaborative encounters with therapists telling clients how things "really are." Anyone who has been doing therapy for a while can tell you that if you simply give your client the answer, you'll be giving them the same answer week after week after week because it won't really sink in.

A Framework for Socratic Questioning

It can be helpful for clinicians to have a framework for thinking about collaborative empiricism and Socratic strategies. In conjunction with the largest public mental health CBT training initiative in the United States, we have refined our method for teaching Socratic questioning to therapists (Waltman et al., 2020). This framework is a reversal of these mentioned pitfalls. Instead of trying to get the client to see it from our perspective, we instead focus on trying to see it from their perspective and then focus on expanding that perspective together.

Step 1: Focusing

The first step in applying Socratic strategies is to identify the targets for these strategies. In a practical sense, we simply do not have time to address every thought that we think might be distorted. We want to target the thoughts that are central to their problems and related to their core difficulties and underlying beliefs. Often some delving and sifting are required to find the optimal cognition to focus on. This skill requires patience and conceptual skills on the part of the therapist.

Step 2: Phenomenological Understanding

Phenomenology refers to understanding something in both subjective and objective terms. The task of this step is to understand the client and the target cognition. The guiding principle is that people come by their beliefs honestly, and we want to come to understand how it makes complete sense that they came to think that way. This early emphasis on validation is also strategic in that it is relationship-enhancing and can be regulating for the client. In our experience, people are more willing to have an open mind to alternatives when they feel like you have truly and sincerely listened to them.

Step 3: Collaborative Curiosity

While this is functionally the disconfirming evidence step, curiosity is key to this process. Now that we see it from their point of view, we can work to expand that view together. We ask ourselves: "What are they missing?" Functionally, there are two kinds of blind spots: things you don't see and things you don't know. We need to figure out what they are not attending to due to attentional filters as well as the gaps in their experiences that developed as a result of their avoidance patterns. Many great questions and lines of inquiry can often be found from evaluating elements from the previous steps. People tend to twist information to fit into their pre-existing assumptions and beliefs. So, we want to help them mentally take a step back and look at both context and the big picture.

Step 4: Summary and Synthesis

There can also be a pull for the therapist to try and pick a purely positive thought because they might feel better. The trouble with purely positive thoughts or thoughts that are only based on the disconfirming evidence is that they can be brittle if they do not fit the reality of the client's life. Therefore, we are looking to develop new thoughts that are balanced and adaptive. This process involves summarizing both sides of the story and helping the client develop a new, more

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balanced thought that captures both sides. The question we want to ask is whether the new thought is believable. Once we have a summary statement, we want to help them synthesize that with their previous statements and assumptions. How does the new conclusion compare to the initial assumption? And their underlying beliefs? How do they reconcile their previous assumptions and this new evidence? We also want to help solidify these gains by helping the client translate the cognitive shift into behavior change. So, we ask them how they want to put the new thought into practice in the coming week or how they want to test it out in the coming week.

Summary

Meaningful cognitive change is often a process that takes time and effort. There are no shortcuts or "silver bullet" questions a therapist can ask to disprove any and every belief that might come up in therapy. Instead of focusing on taking it slow, being curious, and trying to really understand your client will get you pretty far as a therapist. Change is often incremental.

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The Relationship between Trainee Therapist Personality, Technique Usage, and Perceived Helpfulness

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Author Note: We would like to thank the Society for the Advancement of Psychotherapy (2013 Charles Gelso Grant), the Society for Psychotherapy Research (Small Grant Program) and Augusta University (multiple small grants) for support of this work. Correspondence regarding this article should be addressed to Samantha H. Kunkel, Department of Psychological Sciences, Augusta University, 2500 Walton Way, Augusta GA 30909. Email: skunkel@augusta.edu.

Clinical Impact Statement: This manuscript contributes to psychotherapist training by examining the relationship between trainee therapists' personality, their therapeutic technique usage, and their perception of how helpful they are in their interventions. Data supported the importance of trainees engaging in self-reflection to determine how their personality may influence the way they practice. For example, those high in neuroticism and low in extroversion tended to evaluate themselves more harshly, reducing their confidence in using certain techniques (e.g., helping clients gain new perspectives). Findings also highlight an important area of focus (i.e., trainee personality) for clinical supervisors as they help trainees develop their skills.

Introduction

Research suggests that therapist personality traits impact self-reported theoretical orientation (e.g., Ogunfowora & Drapeau, 2008). For example, studies have shown that therapists who report having a psychodynamic orientation generally report being higher in creativity, intuition, imagination, individualism, anxiety, and introversion (Arthur, 2001). In contrast, Arthur's (2001) research showed that cognitive-behavioral therapists were more conventional, rational, predictable, orderly, and realistic. Other research revealed that therapists who report having a cognitive-behavioral orientation (CBT) score higher on conscientiousness and lower on openness (Buckman & Barker, 2010; Ogunfowora & Drapeau, 2008). Conversely, a psychodynamic orientation is positively related to openness and negatively related to conscientiousness (e.g., Buckman & Barker, 2010; Petronzi & Masciale, 2015). Despite these findings, few studies have explored the extent to which therapist personality translates into actual differences in the interventions used within sessions.

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The present study sought to fill this gap by examining the association between trainee therapist personality traits and their use of a variety of therapeutic techniques within videotaped sessions. We also had trainees rate their perception of the helpfulness of each of their interventions. In order to limit the impact of training effects, we assessed trainees' personality traits during the first week of their graduate program and utilized technique and helpfulness ratings from their first training case.

Based on previous research, we had two main hypotheses. First, we hypothesized that trainees with high self-reported conscientiousness would utilize more action-based techniques, as high levels of conscientiousness have been reported by therapists with a CBT orientation (e.g., Buckman & Barker, 2010). Second, we hypothesized that trainees with high levels of openness would use more insight-based techniques, as research has found that psychotherapy practitioners and therapy students who report high levels of openness are also more likely to endorse a psychodynamic orientation (e.g., Ogunfowora & Drapeau, 2008).

Method

Participants

This study was approved by the university's Institutional Review Board. Data were collected from seven cohorts of graduate trainees (n = 54) enrolled in a Master of Science in Clinical and Counselling Psychology program. The trainee group was 75.9% female, and the mean age was 24.28 (*sd* = 5.46) years old. The racial composition was predominantly European American (63.0%) and African American (20.4%).

Undergraduate students from the same university served as volunteer therapy clients. They were recruited from a course focused on personal growth and exploration. Those who gave informed consent received course credit for participating in four videotaped therapy sessions and reflecting on their experience. All information pertaining to the therapy sessions was kept confidential. The volunteer client group (n = 54) was 66.7% female, and the racial composition was largely European American (42.6%) and African American (38.9%). The mean age of the group was 20.80 (*sd* = 4.05) years.

Procedures

Assessment of Trainee Characteristics

At the beginning of graduate training, all trainees completed a multi-trait, multi-method assessment as part of their personality assessment course. A research assistant unaffiliated with the graduate program administered, de-identified, and scored all of the assessments, including the NEO-Five Factor Inventory-3 (NEO-FFI-3; McCrae & Costa, 2010). All participants consented to have their data used in research on trainee characteristics and the process and outcome of psychotherapy.

Therapy Sessions

In their second semester, trainees took an Introduction to Psychotherapy class that focused on therapeutic technique with a curriculum based on Hill's (2009; 2014) three-stage model of helping. These stages include exploration, which is based on client-centered theory, insight, which is based on psychodynamic theory, and action, which is based on behavioral theory. As a part of this course, trainees conducted four videotaped psychotherapy sessions. Their first session was a 90-minute intake and occurred after students learned the exploration stage. The second and third sessions were both 45 minutes with session two occurring after students learned the

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insight stage and session three after learning the action stage. Session 4 was a termination session and was also 45 minutes. Clients were told they could discuss anything they wished with the exception of information that may require the intervention of a licensed professional (e.g., child and/or elder abuse, suicidality).

All videotaped therapy sessions were supervised by the same course professor, who is a licensed clinical psychologist. The professor has training in humanistic, psychodynamic, and cognitive-behavioral approaches. She identifies as integrative in her approach but with a high emphasis on understanding underlying interpersonal dynamics. Following Sessions 1, 2, and 4, trainees received 90 minutes of group supervision. Trainees also received 90 minutes of individual supervision following Session 3.

Measures

NEO Five-Factor Inventory-3 (NEO-FFI-3)

The NEO-FFI-3 measures five dimensions of personality: neuroticism, extroversion, agreeableness, conscientiousness, and openness to experience (McCrae & Costa, 2010). It contains 60 items rated on a 5-point Likert scale, with 13 items on each of the subscales (Neuroticism, Extroversion, etc.). Coefficient alpha ranged from .72 to .88 in both adolescent and adult samples (McCrae & Costa, 2007).

Helping Skills Measure (HSM)

The HSM is a scale from Hill and Kellems' (2002) Session Process and Outcome Measure (SPOM). It comprises 13 items rated on a 5-point Likert scale (see Table 1 for a complete list of techniques). Factor analysis shows that the items cluster into three subscales (exploration, insight-oriented, and action techniques), all of which had internal consistencies greater than .70 (Hill & Kellems, 2002).

Web Form A: Session Review Form (Web A)

Web A was developed by Hill (n.d.) to aid in the review of therapy sessions. Following the sessions, trainees watched the video and stopped the tape every time they spoke. They notated which, if any, of the HSM techniques they were utilizing and how helpful they thought the interventions were on a scale from 1 (*not at all*) to 10 (*very helpful*). A sum frequency score and an average helpfulness rating was calculated for each technique (see Table 1). Web A ratings following Session 3 were utilized in the current study because trainees had learned all of Hill's (2009, 2014) therapeutic techniques by this time and we did not want to use ratings from the termination session.

Data Analysis

To ensure that results were meaningful across multiple trainees and to limit Type II error with our small sample, we only included techniques rated one or more times by at least 50% of therapists (see Table 1). To test our hypotheses, we then used the Pearson Product Moment Correlation Coefficient to determine the relationship of the five facets of the NEO-FFI-3 to technique usage and helpfulness (see Table 2).

Results

The means and standard deviations for all facets of the NEO-FFI-3 were within the average range except for openness 60.63 (8.41), which was slightly above average. Only exploration techniques 1 and 5; insight techniques 2, 6, 10, and 13; and action technique 3 were used by 50% or more of trainees at least once (see Table 1). All other techniques were excluded from further analyses due to their lower usage.

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Pearson Correlations on Technique Usage, Helpfulness, and Personality (See Table 2)
Only one significant correlation was found between technique usage and NEO facets. Specifically, as trainees reported greater conscientiousness, they reported pointing out clients' contradictions in thoughts, feelings, and behaviors less often in session (r = -.31, $p < .05$). Using Cohen's (1988) criteria, this effect is considered moderate. In addition, two significant correlations with moderate effects emerged relating to helpfulness ratings and trainee personality. Specifically, trainees who reported greater levels of neuroticism felt less helpful when working with clients to gain new perspectives (r = -.31, $p < .05$). Secondly, as trainees' levels of extroversion increased, they felt more helpful when working with clients to gain new perspectives on their problems (r = .41, $p < .01$).

Discussion
Our study examined the relationship between trainees' personality characteristics, technique usage, and helpfulness ratings. Results suggest that trainees' personalities may be related to technique usage and perception of techniques' helpfulness. However, none of our hypotheses were supported. First, contrary to our first hypothesis, we did not find an association between trainee conscientiousness and the use of action techniques. The lack of support for this hypothesis could be explained by trainees using action techniques infrequently. Low usage could reflect a lack of client readiness for change due to the short duration of the therapy.

Importantly, we did find that as trainees reported greater conscientiousness, they were less likely to indicate using techniques to "help clients see contradictions in their thoughts, feelings, and/or behaviors." Interestingly, this insight technique also had the lowest helpfulness ratings out of all the included techniques. These findings may relate to Hill's (2014) recommendation that helpers be careful in using insight skills because they can damage the therapeutic relationship if there is inadequate trust. Because trainees were exposed to Hill's (2014) recommendation in their therapy course, highly conscientious trainees may have more carefully and less frequently used confrontational techniques (e.g., insight techniques such as the one noted).

Our second hypothesis was that trainees with high levels of openness would use more insight techniques. However, our results showed no associations between openness and any of the insight techniques utilized. This null association could be due to technique usage being measured after only three sessions as well as Hill's (2014) suggestion that trainees use insight skills carefully and infrequently, especially if a positive therapeutic alliance is not solidified.

While no relationships were found between openness and insight techniques, we found associations between insight technique helpfulness ratings and other personality traits. Specifically, as trainees' self-reported neuroticism increased, they perceived their attempts to help clients gain new perspectives on their problems as less helpful. This finding could indicate that trainees with high levels of neuroticism are more self-critical. This would fit with research that shows a positive correlation between neuroticism and self-criticism (Bagby & Rector, 1998; Thompson & Zuroff, 2004). This association also may be related to trainees finding insight techniques more intimidating and challenging to implement. Indeed, trainees are often reluctant to use insight techniques out of fear of damaging the therapeutic relation-

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ship (Hill, 2014). These concerns may lead trainees with higher neuroticism to perceive their use of this more difficult technique as less helpful.

Finally, helping clients to gain new perspectives on their problems was related to extroversion. Specifically, highly extroverted trainees rated this technique as more helpful than did their less-extroverted counterparts. This fits with research showing that high extroversion predicts higher levels of self-esteem (Niazi & Mehmood, 2017) and lower levels of comparative self-criticism (Thompson & Zuroff, 2004). Thus, extroverted individuals may perceive their offering new perspectives as more helpful due to these characteristics.

Conclusions and Future Directions

The findings from this study suggest that at the earliest stages of training, beginning therapists higher in conscientiousness may use less confrontational techniques. This aligns with Hill's (2014) suggestion that insight skills be used carefully due to the potential for damaging the therapeutic relationship. Moreover, beginning trainees higher in neuroticism and lower in extroversion may view their use of insight techniques as less helpful. This finding is consistent with trainees high in neuroticism being more self-critical (e.g., Thompson & Zuroff, 2004) as well as the difficulty of using insight techniques (Hill, 2014). These results highlight the need for trainees to develop an awareness of how their own personalities may impact the way they practice.

Future research should examine the association between therapist personality and technique usage, both in trainee and professional samples. Using performance-based personality measures should also be explored. Lastly, studies should examine the level of agreement between trainees, clients, and supervisors on perceived helpfulness and technique ratings to gain a broader understanding of techniques' helpfulness and trainees' conceptualization of the technique used.

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The Double-Edged Sword of Social Media During Quarantine

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As therapists and as people, we are acutely aware of the many sources of distress impacting psychological wellbeing, stressors which have been exacerbated as the global pandemic shut down the world and forced us to adopt social distancing measures. However, since March, I have observed and cultivated insight into a unique source of distress that is emerging among the clients I see as a part of my private practice. I'll start with an example from one client who stated, "I've been having a lot of insomnia this past week. And, well, I know what's causing it, but it's stupid." When he shared this, he seemed sheepish and embarrassed to talk about this issue in therapy, although it was clearly impacting his psychological and physical health. "I know it shouldn't be a big deal, but I just couldn't stop thinking about what this guy posted on Facebook about COVID. It was just so wrong, like factually inaccurate, and it didn't seem to matter what I said, he just refused to hear me." This client, who has a career in the medical industry, went on to describe his ruminating thoughts, with shock and despair that someone in his social circle would accept the misinformation prevalent on social media. His story piqued my curiosity about the effects of social media consumption on mental health during this particularly isolated and polarized time in United States history.

Through the summer and fall, as the election has drawn nearer, a number of my clients have shared similar stories of anxiety, frustration, and ruminating thoughts related to social media platforms and content with which they engage. Another person with whom I work is a long-term civil rights activist who is well-seasoned in the art of engaging with those who view the world differently than she does. However, even she has begun to struggle with managing anxiety and exhaustion. In August, she shared, "I got so angry I almost threw my phone out the window. I know some of these people from the community—they're not bots or trolls—and they're using these ridiculous political memes as the foundation of their beliefs. How do I argue with that?" The frustration and reactivity she felt occurred in the privacy of her home and without a true forum for conflict resolution.

It should be no surprise that the current national and global climate of fear has contributed to widespread mental health challenges. Since March, our nation has faced a relentless global pandemic, wide and public recognition of the pervasive nature of systemic

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racism, civil rights protests, and an ever-increasing political and ideological divide leading up to the presidential election. However, it is not these events on their own that have been identified by my clients as the sources of distress. Rather, it is the way these events are being presented and discussed on social media that has created a significant sense of turmoil. As I began to track the emergence of these conversations in session, I was left wondering what makes social media a unique stressor during this tumultuous time. Is there something inherently stressful about sharing and receiving information through social media that is harder for people to manage? Is it a situational stressor related to our inability to interact with each other in person? Are we spending more time on social media due to social distancing, and is that leading to greater amounts of exposure to misinformation and divisiveness? And as a therapist, how can I best support my clients as they process the emotions they feel in response to what they see?

As I began exploring this issue, I found that the trends I was observing in my caseload are not unique. In fact, I want to highlight some striking findings from a series of polls that call attention to various dimensions of the lived experiences of people during the pandemic who are consuming social media.

- "One-third of Americans reported experiencing high levels of psychological distress at some point during the extended period of social distancing (Pew Research Foundation, May 2020)."
- "Seventy-eight percent of U.S. adults believe that false or inaccurate information about the coronavirus has been a major problem. Most of the rest say it has been a minor problem." These opinions held true despite political affiliation, and 68% of participants identified social media as the main source of this misinformation (Jones, 2020).
- "74% of Americans are very concerned about the spread of misinformation on the internet (Knight Foundation, March 2020)."
- "More Americans say it is harder (62%) rather than easier (36%) to be well-informed because of all the sources of information available (Knight Foundation, August 2020)."
- "More than two-thirds of U.S. adults (68%) say that the 2020 U.S. presidential election is a significant source of stress in their life … regardless of political affiliation (American Psychological Association, October 2020)."

Prior to these trends which have been documented in 2020, much of the research I encountered addressing social media-related distress focused on the addictive aspects of scrolling, the fear of missing out (FOMO), and privacy concerns. These aspects are certainly still relevant in our current situation, but over the past six months, the purview of social media-related distress has broadened and seems to be extending to subsets of clients who did not previously report experiencing it. What is happening today may be an extension of a phenomenon termed "social media fatigue," which is defined as negative feelings of exhaustion and being overwhelmed resulting from information and communication overload through using social media (Bright et al., 2015). The increase in sociopolitical and pandemic specific content being disseminated may be heightening this sense of overload.

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Moreover, several studies have shed light on who is at higher risk of social media fatigue and ways to better manage it. Bright et al. (2015) found that users who had a high degree of self-efficacy in using social media and those who viewed social media as a helpful resource experienced higher rates of social media fatigue. These findings suggest that individuals who feel comfortable using social media and have positive views of it, tend to spend significantly more time on social media sites, thereby increasing their risk of communication and information overload. It is likely that the confidence these individuals feel may prevent them from being aware of the risk of such overload. Talwar et al. (2019) found that users who had a strong desire to authenticate the information they encounter online also experience higher levels of fatigue. This has come up with my clients as well. One client reported, "I wasted a whole hour searching fact-checking websites to see if this post was true or not, and afterward I felt awful. I wish I had used that time to work around the house or practice some self-care." A recent study by Islam et al. (2020) expanded on this search for risk factors, identifying that individuals who have poor self-regulation skills are at greater risk of social media fatigue. This study found that individuals who are characterized as "explorers," meaning those who have a desire to seek out novel topics and content with curiosity and openness, are at a greater risk of social media fatigue as well. While we typically think of these traits as being positive, they may not be serving people under these specific circumstances.

Social media consumption during these trying times may actually be a double-edged sword.

A Gallup poll published in May 2020 found that "seventy-four percent of Americans who use social media say it has been 'very' or 'moderately' important to them personally as a way to stay connected with people who are close to them that they may not be able to see in person during the coronavirus situation." Indeed, people are reliant on social media to maintain contact with loved ones. Therefore, along with the challenges posed above, people have a need for connection that is difficult to meet in other ways when many families, friends, and colleagues must engage with one another from a distance.

With this complex issue in mind, it is important for psychotherapists to consider how best to support clients with social media-related distress and social media fatigue. In my personal experience with clients around this issue, many people have identified embarrassment about the degree to which they are impacted by negative experiences on social media. It is important to validate the frustration, exhaustion, and stress that can result from online interactions, as well as to provide psychoeducation on the risk factors that may lead some clients to heightened levels of distress and fatigue (e.g., dedicating time to authenticating news stories). Cultivating self-regulation skills may assist clients in setting healthy boundaries around the amount of time and the ways in which they engage with social media. The challenging truth is that how we advise our clients during these trying times is often what we ourselves need to hear. It is human for us and for our clients to need social connection, and we must be careful and clear about how it impacts us.

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Society for the Advancement of Psychotherapy

The Psychology of Hypogonadism: Silencing the Stigma

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Abstract
Hypogonadism is a little-known endocrine condition that is not easily noticed by psychologists and other medical professionals. The disease can have a strong psychological and physical impact upon those who contend with it. This paper offers an overview of the condition and suggests some interventions for clinicians who work with the patients who have it. Hypogonadism occurs when the body fails to produce the necessary amount of sex hormones, and this lack of hormone production has a wide range of effects on the mind and the body alike. Additionally, there is often a stigma attached to the condition. As such, psychologists and other mental health professionals should be aware that clients may experience some discomfort when discussing or disclosing their hypogonadism.

The Psychology of Hypogonadism: Silencing the Stigma

Description of the Condition

Hypogonadism, a chronic endocrine disorder, occurs when the body does not produce the necessary amount of sex hormones. Both males and females contend with this condition. When males fail to produce enough testosterone or when females do not create an appropriate amount of estrogen, then they have hypogonadism (Basaria, 2014; Sargis & Davis, 2018). Patients can have one of two types of hypogonadism. The first type, primary hypogonadism, indicates that a physical problem exists with the testes in men or with the ovaries in women, as these are the structures responsible for producing testosterone and estrogen, respectively. The second type of hypogonadism, secondary hypogonadism, indicates that another area of the body, such as the pituitary gland, has malfunctioned while it tries to support the production of sex hormones. In a twist that can further complicate patients' feelings about the condition, it is not unusual for patients not to know whether their hypogonadism is primary or secondary. Frequently, it proves impossible to pinpoint the exact causes of the disorder (Basaria, 2014; Sargis & Davis, 2018).

Hypogonadism can strike anyone, and it has surprisingly wide-ranging implications for the patients who have it (Sargis & Davis, 2018). The only way for physicians to know that a patient actually has hypogonadism is to have them undergo a blood test that looks for lower levels of testosterone in males and lower levels of estrogen in females (Basaria, 2014). Despite this easy detection method, hypogonadism is a complex disorder with a deep psychological impact. Patients can experience infertility, which is oftentimes how the condition is discovered in younger adults (Lee & Ramasamy, 2018; van den Akker, 2012). The condition frequently masquerades as Major Depressive Disorder and those who have it experience the same brain fog and difficulty concentrating that those with depression do (Smith et al.,

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2017; Zitzmann et al., 2012). Additionally, individuals with hypogonadism often experience a decreased sex drive and an overall loss of energy. In males, night sweats and hot flashes are common (Llaneza, 2017).

Not only can hypogonadism create psychological difficulty for those who have it, but also, it can put significant physical challenges in a person's way. For example, men may develop osteoporosis, have weaker muscles, and decreased growth of facial hair (Goldset et al., 2017; Grotts et al., 2018). Physical problems are especially prevalent if especially if an individual develops the condition before puberty. For instance, it is possible that a boy's voice may not deepen, or an individual may present physically as neither obviously male nor obviously female (Hewitt & Warne, 2009; van den Akker, 2012). These challenges can negatively impact a person's self-esteem, self-image, and overall sense of well-being (Sargis & Davis, 2018). As such, health psychologists can play a critical role in improving the lives of patients with hypogonadism.

Hypogonadism: Implications for Psychology

When viewed through a psychological lens, one can readily see that hypogonadism impacts many facets of the lives of those who contend with it. The condition impacts different people in a variety of ways, and it is possible for two people to have the same type of hypogonadism but display their symptoms differently. Additionally, children and teenagers with hypogonadism face a different set of psychosocial pressures and concerns than older adults with the condition do (Hewitt & Warne, 2009; Korenman et al., 2018; Wu et al., 2010). For example, teenagers going through puberty may not develop as secondary sex characteristics as quickly as their same-aged peers (Hewitt & Warne, 2009) while older people's only visible symptom may be muscle weakness, which is a symptom that does not necessarily suggest hypogonadism (Korenman et al., 2018). Health psychology reminds medical professionals to remember that the developmental stage can impact how a person responds to the psychosocial impact of hypogonadism. No matter what age they happen to be, patients with hypogonadism often experience "feelings of isolation, shame, and alienation" (Dwyer et al., 2019, p. 1) for two major reasons.

One such reason that patients struggle with the psychological effects of hypogonadism is that the condition is not terribly well-known, even among medical professionals. Dwyer et al. (2019) observed that individuals with hypogonadism "often experience a 'diagnostic odyssey' including incorrect diagnoses, incomplete information, delays in finding expert care…and misleading or frankly incorrect advice along the way…Such experiences can significantly erode patient confidence in healthcare providers…and affect quality of life" (p. 3). Given the frustrating nature of this condition, it makes sense that health psychologists should intervene to help people to cope with it.

Another reason that individuals with hypogonadism have a difficult time getting the appropriate care is that a social stigma is attached to the condition (Orshan et al., 2009). Hypogonadism encompasses some of the most intimate areas of an individual's life. For example, individuals may worry that others will question their gender or sexual identity if they reveal their personal struggles with the condition; people with hypogonadism may feel concerned that they will be judged negatively if others learn of their fertility problems

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(Dwyer et al., 2015). Additionally, hypogonadism has a major effect on mood, and a stigma still exists around mood disorders (Turriff et al., 2011). As such, individuals with hypogonadism frequently contend both with the stigma of having a mental health condition and the dual stigma of having a disorder linked to sexual characteristics (Barag et al., 2019; Orshan et al., 2009; Sumko et al., 2014).

Interventions for Treatment

When it comes to working with clients with hypogonadism, psychologists have the opportunity to implement a variety of interventions simply because patients display the condition in a variety of ways. Four of the most common components of the disease include infertility, obesity, mood dysregulation, and difficulty concentrating on tasks (Etoga et al., 2019; van den Akker, 2012). These are seemingly disparate symptoms; yet, psychology offers tools for dealing with all of them. As such, health psychology interventions relating to these symptoms can directly benefit patients with hypogonadism. Furthermore, to contend with hypogonadism successfully, patients need health psychologists to give them education about the physical and psychological effects of this chronic condition.

Psychologists can help patients comply with the prescribed medication regimens, which prove critical in the treatment of this disorder. Males with hypogonadism are prescribed testosterone, which can come in a variety of forms, including injections (Korenman et al., 2018). Females with the condition are usually prescribed estrogen, which usually comes in pill form. Adherence to medication is important for hypogonadism patients, as missed doses of medication can undo progress in treatment (Korenman et al., 2018; Schoenfeld et al., 2013). Additionally, since hypogonadism patients often cope with comorbid mood disorders, physicians often prescribe antidepressants for them (Khera et al., 2011; Walther et al., 2019). As such, medications must be managed carefully and monitored for side effects.

While medication adherence certainly helps treat the disorder, it is not enough to treat its psychological effects. Weight loss is one intervention that can help patients with hypogonadism to begin to feel better. Damas-Fuentes and Tinahones (2018) suggested that patients contending with hypogonadism adopt an exercise regimen; make dietary changes; and consider bariatric surgery if necessary. Corona et al. (2013) observed that "hypogonadism can be considered as one of the many adverse consequences of…obesity. Body weight loss and lifestyle interventions should be the first approach offered to obese hypogonadal men" (p. 168). Especially for men, weight loss is a highly recommended intervention for patients with hypogonadism. Weight loss can increase the amount of testosterone that a man produces (Damas-Fuentes & Tinahones, 2018). Losing weight can also help patients to avoid sleep apnea, which often accompanies both obesity and hypogonadism (Carrageta et al., 2019; Corona et al., 2013).

Individuals with hypogonadism often struggle with body image issues (Dwyer et al., 2015) and see themselves as having less social support than people without hypogonadism do (Orshan et al., 2009). As such, group psychotherapy can help people to feel less isolated and more connected with others who have the same condition. Dwyer et al. (2015) found that: "Conducting patient focus groups brought together isolated patients and provided them an opportunity to discuss…problems, share

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experiences, and seek support" (p. 39). A psychoeducational group that deals with the psychosocial impact of hypogonadism would have a beneficial effect on those who participate in it, especially if the group is conducted by a health psychologist who is qualified to educate patients about hypogonadism.

In addition, health psychologists can help clients with hypogonadism to combat the cognitive fog, which usually accompanies the condition (Lasaite et al., 2013). Psychologists can teach patients with hypogonadism how to employ simple strategies, such as time management techniques and list-making skills, in order to be more organized and focused (Lasaite et al., 2013). Although these practices designed to improve executive functioning seem elementary, they can help people to feel more successful in the present and more in control of their plans for the future.

Summary

Patients being treated for hypogonadism are coping with a complicated chronic condition with symptoms that vary from person to person. Health psychologists can help patients with hypogonadism to cope with a set of symptoms that prove simultaneously psychologically distressing and physically painful. Not only can health psychologists assist patients with the day-to-day concerns associated with the condition, but also, they can provide specific interventions for some of the major challenges posed by the disease.

Psychologists prove integral to integrated care, as they help with the adjustment to a condition and the alterations in identity that come with having a significant illness. Psychologists possess a powerful platform for reducing the stigma associated with the disease. Perhaps most importantly, psychologists can also bridge a chasm between patients and their doctors when they speak about hypogonadism, which is a disease that is often unfamiliar to all parties involved.

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BOOK REVIEW

The Tough Standard: A Book Review
Book Authors: Ronald Levant and Shana Pryor

Anna Edelman, MS
University of Denver

With *The Tough Standard*, Ronald Levant and Shana Pryor address an overdue public health concern – the intricate relationship between masculinity and violence. As the public eye has turned to the problematic nature of traditional masculine ideologies within our culture in recent years, *The Tough Standard* is a timely and much-needed evidence-based analysis of the serious consequences of masculinity on individuals of all genders. While a plethora of literature has solidified the negative consequences associated with rigid conformity to traditional masculine norms (e.g., higher rates of mental health distress, substance abuse, interpersonal conflict, chronic stress, and physical health concerns) (O'Neil, 2012; Wong et al., & Miller, 2017), Levant and Pryor clearly and decisively organize this evidence to elevate the conversation around violence and manhood. As Levant and Pryor state, there is a "tough standard" for men in America today, and many traditional ways of being and manners of coping are no longer cutting it. Through this text, lay and academic readers alike are able to delve into complex conversations around masculinity and gain insight into alternative, positively adapted ways of experiencing and understanding masculinity in an ever-changing world.

Dr. Ronald Levant has been a preeminent figure in the psychology of men and masculinities and planted the seeds of his life's collection of work on questioning the harsh socialization of men decades ago through his dedication to advancing feminism and equity between genders. Dr. Levant's compendium of research on studying traditional masculinity, masculine role norms, masculine alexithymia, and advancing clinical treatment of men's issues is woven through *The Tough Standard*. This allows readers to experience the unifying thread of passion and advocacy for men and women, which has permeated Dr. Levant's prolific career. Shana Pryor, MA, brings a trauma-focused lens to the work with her distinctive background in advocacy and working to reduce sexual violence on college campuses and beyond. She has honed her expertise to focus on the determinantal impact of traditional masculinity on male survivors of sexual violence, and it appears that this expertise, in addition to her role as a long-time leader in Dr. Levant's research lab, has created a seamless partnership between Dr. Levant and Ms. Pryor and produced an engaging and invaluable text on the current state of masculinity.

The social construction of masculinity is thoroughly explained, and a primer on theories of masculinity, the measurement of traditional masculinity, and the consequences of masculinity are offered. Through the articulate metaphor of masculinity as a prison for men, the specific linkages between masculine norms, ideologies, and gender role con-

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flict and gun violence, physical violence, and sexual violence are explored. The compassion the authors feel for men can be felt throughout every chapter, with sensitivity to cultural identities, positive aspects of masculinity, and the difficulty men may feel when "incarcerated by their emotions." The authors weave in and out of research-supported statements and personal experiences, bringing a personal lens to many of the concepts without losing valuable empirical support. Furthermore, they manage to succinctly explicate ambiguities in the literature of masculinity and translate scientific data and theory to approachable conclusions linking traditional masculinity to current issues men and women are facing. For example, Dr. Levant and Ms. Pryor elegantly explore research on the role of testosterone in aggressive behaviors as well as social learning and gender norms. Thus, readers are able to access the difficulties of differentiating between biological or social etiologies of various aspects of gender while still engaging fully with the material.

Those interested in delving into this book can find various specific topics of interest by focusing on singular chapters or chose to immerse themselves in the book as a mono-experience. Specifically, Chapters Two and Three are an excellent introduction to the foundation of research and theory in the study of the psychology of men and masculinities. Chapter Four is a detailed review of former and current tools for measuring masculine ideologies, norms, and gender stress/conflict. While the addition of this chapter is understandable, from both a desire to lift the curtain on many iconic studies as well as highlight Dr. Levant's body of work, readers with less of a statistical bent may choose to simply skim or pass over this section. The authors assume a basic to moderate understanding of research design and statistical analyses and for those individuals reading *The Tough Standard* in order to gain more insight into violence and manhood, these sections may prove slightly weightier.

Dr. Levant and Ms. Pryor's thoughtful analysis of factors contributing to violence sheds a bright light on a significant crisis in our society. They have developed several hypotheses to help explain the vast disparities in men as perpetrators of violence versus women. Specifically, in Chapter Five, they describe the underlying role of shame as a major motivator in men's need to publicly engage in acts of traditional masculinity to maintain their confidence in their gender identity. Physical acts of violence by men, they state, can partly be understood by the interaction of shame with perceived threats to one's sense of masculinity. In the same chapter, Dr. Levant and Ms. Pryor provide extremely insightful analyses of high-profile school shooters by applying the foundational theories of traditional masculinity to each perpetrator of a school shooting and allow readers to truly synthesize knowledge across the book. Through this analysis, the authors summarize, "school shooters appear to have a strong need to keep their emotions under control, which reflects the restrictive emotionality/ emotional control of four popular masculinity measures." Here again, we see the critical importance of considering traditional and restrictive masculine norms in our current climate, as the vast majority of research and theory on school shooters has failed to incorporate.

The Tough Standard does have intentional mentions of diversity and intersectional considerations peppered throughout the

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chapters, with varying levels of integration. Research suggests that the more privilege individuals hold, the more uncomfortable or avoidant they may be of information related to inequity and privilege (Conway et al., 2017). From a reader's perspective, it appears that Dr. Levant and Ms. Pryor worked to balance the incorporation of multicultural perspectives while remaining mindful of differing levels of awareness and critical consciousness. While *The Tough Standard* is thus not able to comprehensively address the true intersectional nature of masculinity in a holistic manner, the authors are appealing to a wide audience, which enables a specific focus on problematic aspects of masculinity.

The Tough Standard is a perfect book for individuals new and familiar with this field, as Dr. Levant and Ms. Pryor fuse a strong foundation of research with perceptive theoretical hypotheses to truly gain a new understanding of the role of masculine socialization in violence within the U.S. This text would also serve as an excellent accompaniment to any undergraduate or graduate course on gender or masculinity, bringing a welcoming and accessible tone while integrating decades of research and theory. There are various nuggets of enlightenment into men's lived experience, shedding empathy and insight into the "prison of masculinity" for researchers, clinicians, professors, students, parents, women, and men alike.

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Society for the Advancement of Psychotherapy

WASHINGTON SCENE

Sunrise Doesn't Last All Morning

Pat DeLeon, PhD
Former APA President

Since having retired from the U.S. Senate staff after 38+ years, I have had the very rewarding opportunity to be actively engaged with the graduate students at the Uniformed Services University (USU), thereby experiencing higher education from an entirely different vantagepoint. Our colleagues in the health professions represent society's educated elite. Accordingly, we have a unique societal obligation to provide visionary leadership in addressing our nation's most pressing needs. Our collective experience with today's COVID-19 pandemic should bring this readily home to every one of us. How could so many of our nation's children face food insecurity? The United States is one of the richest nations in the world. And yet, in 2015, more than 9.6 million children lived in families with annual incomes below the poverty line, with approximately 2.1 million living in "deep poverty." Not surprisingly, the highest rates of poverty were found among Hispanic, African American, and American Indian/Alaskan Native families. This should be deeply concerning to all of us as the science makes clear that poverty during pregnancy and childhood is directly tied to poor health and developmental outcomes, thus significantly contributing to health disparities which are all too evident.

The Public Policy Process

From our perspective, education and having caring role models are the key to a healthy society. At USU, we have been pleased to be able to coordinate a small, interactive Public Policy seminar every semester, targeting the students and faculty from psychology and the Daniel K. Inouye Graduate School of Nursing (GSN). Our goal has been to expose these future leaders to the personal stories of outstanding role models who have gone before them. An unanticipated benefit of the pandemic has been our ability to conduct the seminar in a virtual format, utilizing Zoom technology, and thus capitalizing upon a significantly wider range of guest speakers and attendees. This semester we were able to have a former Secretary of the Department of Veterans Affairs (VA), former APA President, Phil Zimbardo; and one of the founding champions of the field of Health Psychology, Margaret Chesney. Later on, we expect to hear from Shawnna Chee, the psychologist serving on the US Comfort as it served those directly impacted by the pandemic. Throughout the speakers' journeys, several reoccurring themes become evident. For example, one really cannot control the specifics of how one's professional future might evolve – unexpected opportunities frequently arise for those with vision; one's environment is critical; and, persistence, being present, and possessing resilience makes a significant difference.

Christy Anne Velasquez (Major, USAF, NC): As a graduate student at the USU Graduate School of Nursing, I have the opportunity to be a teaching assistant for our Public Policy seminar, learning

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about diverse health topics and professions, to include nursing, psychologists and physicians. Each guest speaker has helped me understand the different roles, contributions, and challenges of their profession. Our recent prominent speaker, distinguished social psychologist Philip Zimbardo, joined our seminar with a groundbreaking attendance from across the country. His seminar was an hour-long open forum where faculty, students and guests discussed the importance of his works (such as Discovering Psychology and the Stanford Prisoner Experiment), and asked compelling questions about past works, his current effort with the Heroic Imagination Project, and his perspective on current national events. This engaging and enlightening experience taught me the value of his contributions to psychology, as well as the importance of critical and systematic thinking and remaining resilient during challenging times. We all want to thrive today and the day after and we must continue asking ourselves 'how,' 'what,' 'why,' and 'how can we solve this problem as heroes.' That is what critical thinking will do for us now and for the future."

Victoria Philippon, M.S. (PhD student, University of Central Arkansas): When I was completing my undergraduate studies, I was first introduced to Phil Zimbardo in my Introduction to Psychology course. I was excited to learn more about his research, including his focus on heroic behaviors. My research interest includes re-entry and reintegration for criminal justice involved populations, specifically strengths-based approaches to address these areas. The information discussed, I believe, could inform future work with criminal justice involved populations in an effort to support them after they are released and prevent them from becoming negatively involved with the system to begin with. I attended Margaret Chesney's presentation as she discussed the unique obstacles she overcame as a woman in psychology. As a female professional myself, I found it particularly inspiring to engage with someone who has broken the glass ceiling and helped made my presence a possibility. She applied to PhD programs when women were not given opportunities to attend and doors were closed due to sexism. I was truly inspired and encouraged by what she overcame and all she has accomplished. Her presentation was also informative as she is one of the top scholars in the field of integrative medicine, having served as the Deputy Director of the National Institutes of Health's Center for Complementary and Integrative Health. She discussed the cost of pain to society during her presentation, reporting that billions of dollars, between $560-$630 billion, are spent nationally in pain management efforts each year. With pain being one of the biggest instigators for people to explore integrative healthcare approaches, one would expect the immense cost to decrease with the utilization of alternative, nonpharmacological approaches. I was especially interested in her desire to promote health and well-being as it reflects my strengths-based approach. I am interested in applying such a strengths-based approach to justice-involved persons. Each week, the speakers constantly open my eyes to new impacts of health policy on society, as well as on healthcare professionals." Near the end of our session, the grandfather of Health Psychology, former APA President Joe Matarazzo joined us. Joe (who was on the inaugural USU Board of Regents) and David Krantz, former President of Division 38 (Health Psychology) and former Chair of the Department of Medical and Clinical Psychology at USU, provided engaging

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insights into the creation and development of the field and the university over the decades.

Nurse Managed Health Care

Tine Hansen-Turton is a long-time colleague who served as the Executive Director of the National Nursing Centers Consortium for 18 years. She then moved to the front-line, where for the past four years, she has served as CEO for Woods Services. For over 25 years, Tine has worked to promote nurse-led care, having founded two national organizations advancing nurse practitioners as primary care providers and advocating for scope of practice policy changes for nurse practitioners nationally. Interestingly, Woods established a Nursing Fellows Program two years ago, which has been held for two cycles with 11 Fellows, four of whom have since entered BSN, Master's, or Doctoral programs in nursing with partial scholarship support from Woods, and moved into advancing leadership roles.

Woods Services is a 501(c)(3) non-profit population health management and advocacy organization that along with its five affiliate organizations provides innovative, comprehensive and integrated health, education, housing, workforce, behavioral health and care coordination services to 18,000 children and adults with intellectual and developmental disability, autism, severe behavioral challenges, mental health disorders, and brain injury who have complex medical and behavioral health care needs.

Nurses have always been the backbone of care for the 700 children and adults with intellectual disabilities requiring complex care who Woods serves at its main location in Langhorne, PA. However, the team of nurses, 70 strong, has transformed along with the rest of Woods along its trajectory to becoming a population health organization. The approach to care delivered by nurses lends itself well to the integrated and interdisciplinary health care model which Woods has developed over the last several years. Nurses have emerged as leaders at Woods.

The role of nurses at Woods is critical, given their focus on holistic patient care, education, and care coordination. Furthermore, integrated care at Woods means interdisciplinary team-based care, including nurse-led primary care, nurse-led psychiatry, neurology, dentistry, orthopedics, ophthalmology, radiology, and nursing. In addition, health services are coordinated by nurse navigators, a new role for us as of this year, with the allied health team – physical, occupational, and speech therapists. Bringing on both family nurse practitioners and psychiatric nurse practitioners at the Medical Center at Woods, which serves as the umbrella for our health care services, has been a game-changer. Two years ago, Woods, in partnership with Pennsylvania's largest Medicaid insurer, launched a Patient-Centered Medical Home initiative with the goal of improving care and reducing emergency room (ER) visits and hospitalizations – and with it the cost of care. Our results after one year were promising – hospitalizations alone were reduced 39%. Primary care visits were increased and care coordination improved. The team of nurse managers also provided education and training for the nearest ER, which had two positive results. First, because of increased knowledge about the special needs of the complex population we serve, ER visits less frequently resulted in hospitalizations. Second, the ER has created a sensory-friendly waiting room for patients with autism, reducing anxiety, stress and negative behavior. We seek to

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build on these promising results by expanding our expertise through nurse-led telehealth to people with intellectual disabilities who reside in group homes or with family caregivers who struggle to access care.

Woods is in the process of implementing a nurse-led telehealth program to provide primary and specialty care for people with intellectual disabilities and autism who continue to be an underserved population, and who experience barriers to care and significant health disparities. The telehealth program will expand our Patient-Centered Medical Home model, initially reaching 750 people with complex needs who we and our affiliates currently serve in Greater Philadelphia. This model is rooted in tenets common to the holistic nature of nursing—a focus on the whole person, patient education, and care coordination. Our strong team of 70 nurses and nurse practitioners are well positioned to carry out this program. More than eight million people in the United States have an intellectual disability, and 35% of this population has co-occurring mental health disorders, which put them at even greater risk of poor health outcomes. With the rapidly increasing rates of autism spectrum disorder diagnoses, this is a growing population with some of the greatest unmet health care needs in the country. People with intellectual disorders, autism and complex medical conditions struggle to find providers who will take Medicaid, and who can accommodate communication, behavioral, and mobility needs at their practices. Woods' nurse-led telehealth initiative will be sustainable, and has the potential to scale up to reach a large vulnerable population, including rural residents, which disproportionately uses the ER and is often left out of mainstream services.

Recalling the Past

VA Psychology historian, Rod Baker, shares my enthusiasm for ensuring that our next generation of healthcare leaders appreciate the historical efforts of those that came before them. Accordingly, we were very pleased to learn that our longtime colleagues Ron Breazeale and Jeff Matranga have recently published *DIRIGO: MePA AND ITS PRESIDENTS* on the 70th Anniversary of the founding of the Maine Psychological Association, as reflected in the lives of its Presidents. "Our Presidents are a relatively diverse lot. Most are "from away." Our first President, Dr. Norman Munn, surely fits that description. He was from Australia; after spending many years in the US lecturing, teaching, and writing, he returned to Australia to retire. But some, like Dr. David Booth, were born, educated, and lived out their lives in Maine. Now we said *relatively* diverse. To our knowledge, a person of color has never been President of the Association, and it was not until 1989 when the first woman [Anne L. Hess, PhD] was elected President. Since that time, eight more women have served in that role."

"All things must pass."

— George Harrison

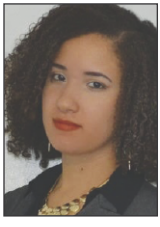
Aloha,

Pat DeLeon

Society for the Advancement of Psychotherapy

AMPD SCHOLARS PROFILE

The Diversity Domain is excited to announce the launch of the Advocacy and Mentoring Program for Diversity (AMPD) program initiated by Rosemary Phelps. This program provides the opportunity for two advanced graduate students to join SAP, receive mentorship from the Diversity Domain and other Board members, work on a project with a domain of their choice, receive $1,000 funding, and present their projects at the American Psychological Association conference. The first two AMPD scholars are Michelle Joaquin and Ingrid Hastedt. Below is a profile of these accomplished scholars written in their own words. We are excited to welcome them to the Society of Psychotherapy.



Michelle Joaquin

I am a first-generation, Dominican, cis-female, heterosexual woman raised in the Washington Heights section of New York City. I am also a fifth-year school-clinical child psychology doctoral student at Yeshiva University's Ferkauf Graduate School of Psychology. Currently, I am completing the trauma-track internship at the University of Southern California: Children's Hospital of Los Angeles. My primary clinical and research interest is to work with marginalized community members and survivors of traumas that include sexual abuse, physical abuse and migration-related trauma exposures.

Career Goals

I aspire to work in urban hospital settings that serve individuals from marginalized groups. And I would like to contribute to the clinical psychology literature that takes up how intersecting features of patients' and clinicians' identities affect mental health outcomes.

Commitment to Psychotherapy Research, Practice, and Training and Education

I approach patients with an empathic, culturally sensitive and trauma-informed manner. Within the Latinx community, mental health services are often stigmatized and underutilized. As a result, I aim to provide evidence-based services to marginalized communities such as therapy, psychological assessments, school evaluations and advocacy.

Experiences in Psychotherapy Research, Practice, and Training and Education

I am trained in forensic interviewing, psychological assessment of asylum seekers and psychoeducational assessments. I have worked at Mt. Sinai St. Luke's Comprehensive Adolescent Rehabilitation and Education Service (CARES), Montefiore Medical Group's Behavioral Health Integration Program (BHIP), Montefiore Medical Center's Group Attachment Based Intervention (GABI), Beth Israel Hospital, Safe Horizon, the Center for Attachment Research and the Hispanic Family Mental Health Center.

In my psychotherapy research and practice, I focus on the mental health of low-income Latinx and Black individuals with histories of trauma. I have worked in labs and clinical settings that focused on alcohol and substance use, child and adolescent trauma, pediatric behavioral health and attachment. I am preparing a manuscript regarding the impact of post-traumatic stress symptoms on the academic functioning of Latinx students and another manuscript that concerns therapists' culture-based countertransference. My experiences have allowed me to continue to explore the role of trauma and poverty on mental health.

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Commitment to Diversity, Social Justice, and Advocacy

Mental health outcomes are connected to the systemic effects of bias and discrimination on underserved-community members. This state of affairs motivates my psychotherapy research, practice and training with underrepresented groups. I aim to use my role as a psychologist in training to help remedy social injustice.

I am also committed to diversity and social justice because they influence mental health outcomes for patients and their families. I am particularly interested in publishing research regarding disadvantaged groups that have historically been overlooked in the clinical psychology literature.

Experiences in Diversity, Social Justice, and Advocacy

Through my doctoral dissertation research, I piloted Spanish parent groups for children who struggle with disruptive behaviors, while focusing on their economic disparities and trauma histories. I have served as a mentor in a mentorship program for Latinx undergraduates who wish to apply for doctoral programs. I co-led multiple presentations on the topic of immigration for community members, undocumented individuals, doctoral students and medical professionals. I organized a panel discussion, at the Stern College for Women, on clinical considerations regarding treating immigrant and refugee populations. And I was invited to participate on a multidisciplinary panel regarding culturally responsive integrated primary care.

In my clinical and research endeavors, I have been similarly focused on underserved communities. I have provided short-term trauma focused counseling in the Bronx which is a predominately Latinx and Black community. I have co-facilitated parent groups that were largely composed of homeless and marginalized persons with a range of psychiatric disorders. I have conducted Spanish psychoeducation evaluations and used the results in Committee of Special Education (CSE) meetings to advocate for monolingual-Spanish-speaking caregivers. I have conducted multiple comprehensive forensic, psychosocial evaluations of undocumented families. And, I have provided therapy and collaborated with Latinx and Black families with numerous psychosocial stressors in multiple settings, such as hospital settings, private practice, day treatment center and school settings. In these settings, I witnessed the ways that language barriers can hinder access to appropriate services, leave individuals feeling disempowered and result in ineffective interventions.

Interest in SAP and AMPD Program

I am interested in the Advocacy and Mentoring Program for Diversity (AMPD) Scholars program in the Society for the Advancement of Psychotherapy because as a member I can continue to combine my commitments to diversity, social justice and advocacy with my development as a clinical psychologist. I joined the AMPD program because I would like to promote the advancement of psychotherapy through promoting diversity within psychotherapy itself. And I am also interested in the AMPD program because I would like to receive mentorship since I have had limited access to mentorship programs throughout my career.

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Ingrid Hastedt

I am a fourth-year graduate student in the Clinical Psychology program at the University of Massachusetts Boston. I was born and raised in Guatemala, and came to the U.S. to pursue undergraduate studies at Boston College. I have lived in Boston ever since, and it is now a second home for me.

Career Goals

I aim to pursue a clinical career as a psychologist working with children and families. I hope to provide therapy and/or assessment for children from underserved populations in the US, particularly those that are Spanish-speaking. Additionally, I hope to establish relationships with mental health providers in Guatemala and collaborate to fill gaps in service needs, such as ASD diagnostic services.

Commitment to Psychotherapy Research, Practice, and Training and Education

My primary career goal is to practice psychotherapy and assessment for children, and I am committed to serving those who are traditionally underserved. Particularly, I am committed to providing culturally and linguistically sensitive treatment and assessment to Spanish-speaking children. During my graduate studies, I will conduct research on the process of conducting therapy bilingually, and on the experiences of these therapists. Through this research, I aim to improve our ability to train and educate bilingual therapists.

Experiences in Psychotherapy Research, Practice, and Training and Education

My experiences in psychotherapy practice have been rich and varied. I have considerable experience conducting Autism diagnostic assessments and cognitive assessment with young children, including Spanish-speaking children. Additionally, I have experience providing therapy in a college counseling center, a community mental health center, and an intensive outpatient program. My past experiences in psychotherapy research include research on health disparities in ASD, specifically with bilingual children with ASD. My current research focuses on the experiences and training needs of bilingual therapists in the U.S.

Commitment to Diversity, Social Justice, and Advocacy

As a psychologist-in-training, I am committed to continue educating myself on issues of diversity and social justice, and to use my various roles to advocate for those in need. I am committed to providing culturally-sensitive treatment, and engaging in research that promotes social justice and advocacy and benefits marginalized populations.

Experiences in Diversity, Social Justice, and Advocacy

Through the program at UMass Boston, I have had the opportunity of engaging in several activities related to social justice and advocacy including courses and extracurricular activities. I have been a member of our diversity committee, an entity that discusses social justice and diversity issues and plans initiatives to address these issues on our campus. This year, I was elected as a member of "Bridging Perspectives," a committee in my program called that offers consultation and mediation services for students to address and process interpersonal issues related to social justice and diversity.

Interest in SAP and AMPD Program

I am very excited to join the Society of Psychotherapy and the AMPD program

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specifically because of the incredible mentoring opportunities that it provides. I am eager to learn from seasoned psychologists and to develop leadership skills that I can use to advocate for the population that I work with. Additionally, I am excited about developing a project that will address some of the social justice and diversity issues that I am passionate about.

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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).

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We'd love to hear from you!