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PRESIDENT'S COLUMN

Shout Out to All Those Who Contribute to SfAP

Clara E. Hill, Ph.D.
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In this column, I want to highlight all the wonderful work that so many of our colleagues are doing to contribute to the vitality of the Society for the Advancement of Psychotherapy (SFAP). It truly is a labor of love, and I want to thank all of you for your vision and enthusiasm.

We have Domains, Standing Committees, ad hoc Committees, and Task Forces to organize all the activities of the organization. Domain representatives are elected, committee chairs and members are appointed. The domain reps and committees within each area work closely together. Each of these areas contribute articles to the Psychotherapy Bulletin highlighting topics that are of particular interest to their subgroups. In this column, I am just providing a shout out to all the domain reps and committee chairs, and I also want to give a shout out to the typically 5 to 10 division members who serve on each committee. And with continued involvement in the Society, we hope to mentor each of these committee members to move up to becoming committee chairs and domain reps.

Before I give shout outs for all the wonderful work that all of our domains/committees are doing, I want to describe our overall initiative to examine ourselves and the SFAP in terms of cultural awareness. In preparation for a session at our October in-person fall Board meeting at which Dr. Stephanie Fryberg will be meeting with us for a day, we spent time at the spring Board meeting talking about our hopes and aspirations for increasing diverse representation and cultural awareness. Based on this challenging and stimulating discussion, all domain/committee areas have been tasked with developing plans for what they can do to make SFAP more inclusive and representative and a home for all.

First, I want to highlight the publications of society. The Publication Board, last year under Bob Hatcher, and now under Terry Tracey, oversee the diverse set of publications that we offer members. Our journal *Psychotherapy* flourished under Mark Hilsenroth's incredible tenure and now is in the capable hands of Jesse Owen. We had another record-breaking year for our journal, with the 9th year in a row with over 200 manuscripts submitted! The *Psychotherapy Bulletin*, under the capable guidance of Joanna Drinane, continues to publish exciting, groundbreaking articles highlighting the range of topics in psychotherapy. Our website, undertaken by the Internet Editor Kourtney Schroeder has been revamped and is user-friendly and chock full of important information.

The Program Committee, with Astrea Greig as Chair and Jamie Bedics as Co-Chair, have had the huge job of putting together the convention program for the August APA convention. We have 15 hours of outstanding programming for this year's probably virtual convention. We'll be keeping you more informed about the program as the time grows nearer.

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In the area of Professional Practice, we have an active group of practitioners headed up by Barbara Vivino (Domain Rep) and Barbara Thompson (Committee Chair, previously held by Daniel Gaztambide). Their latest project is a series of videos on topics relevant to practice. These appear on the website and cover topics such as race, setting fees, self-care, and reaching underrepresented groups.

The Science and Scholarship area, under the leadership of Patricia Spangler (Domain Rep) and Jenelle Slavin-Mulford (Committee Chair), has been focused on giving out much-needed grants to enhance scholarship related to psychotherapy.

The Education and Training Committee, under the leadership of Marilyn Cornish (Domain Rep) and Eric Sauer (Committee Chair), are thinking about some exciting possibilities of webinars that we could offer free for our members. And relatedly, Ken Critchfield has done a great job as Chair of our Continuing Education Committee.

The Membership Committee, with Jean Birbilis (Domain Rep) and Rosemary Adam-Terem (Committee Chair), have been actively thinking about ways to recruit members. Some wonderful ideas include reduced or free membership for students, who are the future of the organization.

The Student Development Committee, headed by Lei Sun (Domain Rep, recently Carly Schwartzman) has an active agenda and an incredible list of students from the various doctoral programs who are active and eager to get more students involved. This committee is currently reviewing applications for our four student paper awards and two active student awards.

The Diversity group, with Manijeh Baidee and Susan Woodhouse (Domain Reps), and Sheeva Mostoufi (Committee Chair, recently held by Lavita Nadkarni) have been actively involved in developing mentoring programs. They have selected and are currently mentoring two Advocacy and Mentoring Program for Diversity (AMPD) scholars: Ingrid Hastedt and Michelle Joaquin, in their exciting projects.

In the closely related Public Interest and Social Justice area, headed up by Rosemary Phelps (Domain Rep) and Linda Campbell (Committee Chair) in collaboration with Susan Woodhouse, there is a major emphasis on psychotherapy for marginalized populations.

The International group, with Changming Duan as the Domain Rep (Fred Leong retiring), is incredibly active, with Domestic Committee Co-Chair (Lauren Behrman) and International Committee Co-Chair (Maria del Pilar Grazioso) and committee members from all over the world. They are actively involved in mentoring and encouraging representation at international congresses.

The Early Career group, headed by Beatriz Palma (Domain Rep, recently Sara Danitz) and Andres Perez-Rojas (Committee Chair), have likewise been thinking actively about ways to make SFAP warm and welcoming for young professionals. They sponsored the "Gab with the Greats" at the last APA as a way of connecting young professionals with more seasoned professionals. And they are talking about ways of providing mentoring as a way of fostering growth and development.

Bob Hatcher has been Chair of the Fellows Committee for many years. This committee is important so that we can recognize the talent of our members.

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We also have had a number of committees and task forces busily working on hot topics. Lillian Comaz-Diaz (along with Fred Leong) is working to develop a series of books on psychotherapy. Stewart Cooper, with the able help of Jeff Barnett, Bea Palma, and Tracey Martin, have developed some needed Bylaws changes, that you will be reviewing and voting on soon. Gerry Koocher graciously agreed to chair the Award Committee and has already ably (in conjunction with a committee) handled a round of awards. Armand Cerbone has agreed to chair a task force to nominate more SFAP members to APA Boards and Committees. Jennifer Callahan has also thankfully agreed to continue on in 2022 as Past-President so that we have a full Presidential Trio.

Thanks also to our Secretary Stewart Cooper (replacing Becca Armetrano) who diligently keeps minutes of all our meetings, to our Treasurer Joshua Swift who manages all our finances with the help of the Finance Committee (chaired by Georita Frierson), and to our Council Representatives Gerry Koocher and Lillian Comas-Diaz. And a major shout out to Tracey Martin who really runs the whole SFAP. What would we do without her?

Finally, for my presidential Initiative, SFAP approved a task force co-led by myself and John Norcross for a project following up on the highly successful three editions of *Psychotherapy Relationships that Work*. This time we are focused more specifically on *Psychotherapy Skills and Methods that Work*. The Task Force is co-sponsored by the Society for Counseling Psychology, Society for Psychotherapy Research, and the Society for the Exploration of Psychotherapy Integration. We have a contract with Oxford University Press for a book and an agreement to subsequently publish condensed article in *Psychotherapy*. We are very excited to have 30 chapters commissioned with experts in the field reviewing the evidence for specific skills (e.g., challenges, advice) and methods (e.g., cognitive restructuring, mindfulness) used frequently across orientations in psychotherapy.

I also want to thank all the Committee members, as it is so important to have so many of you involved.

If you would like to get involved in SFAP, we welcome you and encourage you to contact a committee chair to let them know about your interest and availability (emails are on the website).

Let's all work to enhance the science and practice of psychotherapy!

Society for the Advancement of Psychotherapy

EDITOR'S COLUMN

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"We long to return to normal, but **normal led to this**."

— Ed Yong,
Science Journalist
for *The Atlantic*

Hello Division 29 and SAP Membership! In addition to the warm weather and the blooming flowers, spring has been accompanied by the slow reopening of many spaces and places that we hold dear. Our professional lives too will begin to feel more engaging as we get opportunities to convene in person for conferences, meetings, and social events. As we patiently await these chances to connect personally and intellectually, we hope that *The Psychotherapy Bulletin* will continue to serve as a mechanism for you to keep current with the happenings of the Division and to disseminate your work and ideas.

With the time that remains in 2021, it is our intention as an editorial team to reflect upon and integrate the sentiment expressed above in the quote from Ed Yong. Many people are celebrating the experience of returning to "normal" (e.g., seeing clients in an office and teaching students in a classroom), but it is essential that we as a Division remain oriented to the ways that our definition of normal has contributed to vast, systemic inequities in the care and education we provide. With this in mind, we implore you to write pieces tackling the special focus for the year: "Social Justice in Psychotherapy: Bringing Advocacy and Interdisciplinary Perspectives to the Forefront." How can we cultivate a new normal that centers the voices of marginalized individuals and groups? What steps can we take to diversify the membership of our Division and increase representation in our professional community? It is through action, advocacy, and scholarly work that we can use this important juncture in history to change the trajectory of the future.

Thank you to all who make *The Psychotherapy Bulletin* a success (readers, authors, Division members, and more!). To write for the *Bulletin*, please visit our website (http://societyforpsychotherapy.org/bulletin-about/). Our remaining schedule of deadlines for 2021 will be July 15th, and October 15th. As a logistical note, after discussion with the Publications Board, it was decided that *Bulletin* will no longer accept book reviews. Accordingly, this will be the last issue to contain one. If you have any questions about this policy change or anything else, please reach out to joanna.drinane@utah.edu. We look ahead to a productive year with many innovative viewpoints communicated!

Thank you,
Joanna

Society for the Advancement of Psychotherapy

SPECIAL FOCUS SUBMISSION

Social Justice Considerations of a Remote Psychology Admissions Process: COVID-19 Era and Beyond

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Abstract: This paper identifies several advantages and disadvantages of a remote psychology admissions process with respect to social justice considerations. The authors offer their perspectives on how potential disadvantages to a remote admissions process can be addressed to promote inclusion and equity for the graduate student and trainee population. Specifically, the authors provide suggestions regarding high-speed internet access, addressing biases in the admissions process favoring in-person interviewees, and enabling applicants to assess program culture and climate. This paper concludes with a call to action to develop social-justice oriented solutions to ensure a safer, more inclusive, and equitable academic pipeline.

Clinical Impact Statement: This manuscript outlines the advantages and disadvantages of a remote admissions process from a social justice perspective. Specific suggestions to address disadvantages of a remote model, in order to promote trainee inclusion and equity, are provided to those who interview, educate, and train graduate students.

Keywords: social justice, equity, internship, graduate students, remote admissions, COVID-19

The COVID-19 pandemic has presented new challenges on a global scale. The virus emerged in late 2019 and has continued to impact the world and United States greatly. Like many institutions, universities were required to transition to a work-from-home model. Psychology doctoral programs were impacted by this change, such that many trainees began conducting teletherapy and attending telesupervision for the first time in their academic careers. Many clinical psychology doctoral and internship sites made similar shifts (Goghari et al., 2020). In response to the pandemic, the American Psychological Association and Association of Psychology Postdoctoral and Internship Centers (APPIC) Board of Directors has strongly recommended exclusive use of virtual, remote, and online technology for the entire duration of the 2020-2021 admissions interview process (APPIC, 2020). Although a remote interview process may have initially presented challenges, some believe this is an opportunity for growth, especially in that it may facilitate a more equitable admissions process (Bell et al., 2020). In fact, some programs had already moved to a remote interview process prior to the pandemic either because of their geographic

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location or due to a desire to align with a social justice model (Bell et al., 2020).

From a social justice perspective, there are several advantages of a remote interview process. First, a remote process allows clinical trainees and other professionals to follow social distancing requirements. Social distancing maintains safety by reducing the likelihood of acquiring the COVID-19 virus. This is particularly salient for medically vulnerable applicants, applicants from communities disproportionately impacted by COVID-19, and applicants who have traditionally had limited access to high quality healthcare, including Black, Indigenous, and People of Color (BIPoC). Second, beyond COVID-19 considerations, in-person interview requirements maintain ableism, with disabled trainees experiencing more travel-related and housing barriers. Third, a remote interview process would limit scheduling conflicts that arise due to multiple interview offers or the need to balance competing life demands. Inflexible program expectations and scheduling conflicts are often a barrier to pursuing secondary education in psychology (Pham et al., 2020). Conceivably, this barrier would disproportionately affect specific subgroups of the trainee population, such as those caring for children, trainees with other family commitments, or financially under-resourced trainees who do not have the privilege to take leave from work. Fourth, a remote interview process reduces the financial burden of attending in-person interviews. Financial instability of many students has been heightened as a result of the pandemic, which has been acknowledged by the Council of Chairs of Training Councils (CCTC) and APPIC (Bell et al., 2020). More pervasive economic disparities, including a lack of generational wealth and multidimensional poverty experienced by minoritized communities, exist within and apart from the pandemic. Financial instability due to the pandemic may compound financial burden on minoritized trainees who were already under-resourced. Remote interviews remove the cost of travel, lodging and other accommodations, a figure that could easily be in the thousands of dollars. Further the benefits of in-person interviewing is limited, considering traditional pre-admission interview methods for medical school—a close proxy for clinical psychology programs—may lack validity (Kreiter & Axelson, 2013). In sum, there are compelling reasons to consider adopting a remote admission process at the graduate, internship and postdoctoral fellowship level in future cycles to enhance equity and representation throughout the academic pipeline.

Despite the advantages of a remote internship interview process pre-pandemic, students tend to prefer an in-person format (APPIC, 2016). It is essential to understand why this trend may exist, particularly from a social justice perspective. One possible reason for this apparent discrepancy between student preference and the advantages of remote interviews is that a remote internship interview may not entirely address issues related to access. For example, students living in remote areas or unable to afford costly, high-speed internet may not have the ability to participate in seamless video-conferenced interviews which not only disrupts the interview but can inadvertently reflect poorly on the applicant. Therefore, limited access to high-speed internet would disadvantage students who live in rural areas or are financially under-resourced. A second reason for why students may prefer an in-person format is that students who can attend in-person interviews are often perceived (consciously or uncon-

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sciously) to be more committed to and viewed more positively by a program. Although financially detrimental or unfeasible, under-resourced trainees who are often from minoritized backgrounds may still prefer in-person interviews given existing biases in the admissions process. This may be driven by beliefs that in-person interviews may help mitigate negative perceptions and increase their already lessened chances of acceptance.

Thirdly, students may prefer an in-person format because it allows them to gauge the environment, climate, and culture of the site. Minoritized trainees experience prejudice, overt and covert racism, and discrimination throughout their academic careers (Pham et al., 2020). One study interviewed Black school psychology graduate students to better understand attrition. These students attributed attrition to cultural mismatch and microaggressions (Proctor and Truscott, 2012). Thus, minoritized trainees may be particularly mindful in how they assess inclusive culture and their potential quality of life and safety during training, including how they will be perceived and treated within and outside of the program. For example, successful recruitment of minoritized students is often facilitated when ethnic minoritized faculty and students are well-represented (Muñoz-Dunbar & Stanton, 2009), as this may be one indicator of a safe and tolerant environment for minoritized applicants. These assessments of program culture may be more difficult in remote interviews, as compared to in-person interviews, as they can limit access to broad interactions with faculty, staff, and students (i.e., informal social gatherings), thereby limiting the ability to gauge representation.

Simply because the potential disadvantages of a remote interview model exist does not mean the model should be abandoned. Rather, ways to overcome these new barriers within the remote-interview model should be explored. Potential considerations include:

1. ***High-speed internet access***:

   (a) Clearly communicate an expectation to applicants and faculty that internet connectivity issues should not reflect poorly on applicants.

   (b) Provide resource lists, including local universities or libraries, that offer loaner laptops and/or high-speed internet access.

   (c) Do no limit remote interviewing to videoconferencing and allow applicants to use telephones when needed.

2. ***Biases in admission and favoring in-person interviewees***:

   (a) A universal shift to a remote model will remove pressure on minoritized and financially under-resourced applicants to attend for fear it may impact prospects of being selected. The most impactful effect on equity would result from all sites embracing a remote model.

   (b) Transparency, structure, and standardization in the review process and selection criteria is needed. A clear, standardized selection protocol (which removes other mechanisms of oppression such as utilizing the GREs) will facilitate the use of discretion elimination and prevent subjective biases favoring those interviewing in-person and non-minoritized applicants. Additionally, asking all applicants the same questions, using rubrics to score applicants and their re-

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sponses, and exposing applicants to the same places and information should be adopted. Some of these things may be easier accomplished through remote interviews. For instance, a standard tour of the campus or city can be filmed and shared with all applicants.

3. ***Assessing environment and program climate and culture***: a clear statement should be made to applicants on a program's commitment to social justice followed by an interview experience that thoughtfully integrates diversity and inclusion.

   (a) Programs should consider a designated time for a diversity panel discussion (consider allowing applicants to send in anonymous questions and topics to be addressed). Fostering an interviewing culture to support frank discussions around equity-related issues will empower both trainees and interview sites to speak candidly about the climate.

   (b) Consider highlighting ways to engage in diversity, equity, inclusion, and social justice such as program, department, or university/hospital committees and/or the presence of affinity groups.

   (c) Include discussions around mechanisms of inclusive supervision and fostering multicultural competence through outreach efforts to and the treatment of diverse patient populations, as well as the formal didactics offered by the program.

   (d) Applicants should have scheduled meetings with minoritized faculty and students.

   (e) Schedule informal gatherings in which applicants can meet faculty, staff, and students not on their interview schedule and gauge representation within the training program. Remote group interactions naturally lend themselves to more structure, so ensuring everyone can interact with each other may be easier accomplished remotely than in-person. This may also be more inclusive to applicants with social anxieties and applicants from cultural backgrounds that do not emphasize assertiveness.

   (f) Ask applicants if there are particular individuals with whom they would like to meet with.

   (g) Provide a contact list of trainees whom applicants can reach out to, if desired, with regard to inclusion, climate, and culture (e.g., trainees who are parents, trainees who identify as gender non-conforming and/or LGBTQ+, racially and ethnically minoritized trainees, trainees who are in relationships, trainees who are moving on their own, etc.).

   (h) Review current procedures and methods with regard to trainees safely sharing feedback, grievances, or concerns and how these would be addressed.

These considerations are not perfect nor an inclusive list of solutions. However, as a field that has struggled with representation—we can come together to develop social justice-oriented solutions that make each stage of our academic pipeline more safe, inclusive and equitable. We must commit ourselves to fostering the careers of and retaining our minoritized trainees, which begins with admissions.

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References

Association of Psychology Postdoctoral and Internship Centers (2020). *APPIC Recruitment and Selection Guidance for 2021-22*. Retrieved from https://www.appic.org/News-Articles/ArtMID/1931/ArticleID/9/APPIC-Recruitment-and-Selection-Guidance-for-2021-22

Association of Psychology Postdoctoral and Internship Centers. (2016). *2016 APPIC match: Survey of internship applicants Part 1: Summary of survey results*. Retrieved from https://www.appic.org/Internships/Match/Match-Statistics/Applicant-Survey-2016-Part-1

Bell, D. J., Self, M. M., Davis, C., Conway, F., Washburn, J. J., & Crepeau-Hobson, F. (2020). Health service psychology education and training in the time of COVID-19: Challenges and opportunities. *The American Psychologist, 75*(7), 919–932. https://doi.org/10.1037/amp0000673

Goghari, V. M., Hagstrom, S., Madon, S., & Messer-Engel, K. (2020). Experiences and learnings from professional psychology training partners during the COVID-19 pandemic: Impacts, challenges, and opportunities. *Canadian Psychology/Psychologie Canadienne, 61*(3), 167-189. http://dx.doi.org/10.1037/cap0000250

Kreiter, C. D., & Axelson, R. D. (2013). A perspective on medical school admission research and practice over the last 25 years. *Teaching and Learning in Medicine, 25*(Suppl. 1), S50–S56. https://doi.org/10.1080/10401334.2013.842910

Muñoz-Dunbar, R., & Stanton, A. L. (1999). Ethnic diversity in clinical psychology: Recruitment and admission practices among doctoral programs. *Teaching of Psychology, 26*(4), 259-263.

Pham, A. V., Lazarus, P., Costa, A., Dong, Q., & Bastian, R. (2020). Incorporating social justice advocacy and interdisciplinary collaborative training in the recruitment and retention of diverse graduate students. *Contemporary School Psychology*, 1-14.

Proctor, S. L., & Truscott, S. D. (2012). Reasons for African American student attrition from school psychology programs. *Journal of School Psychology, 50*, 655- 679. https://doi.org/10.1016/j.jsp.2012.06.002

Society for the Advancement of Psychotherapy

Multi-Theoretical Training as Responsive Treatment: An International Example

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Context

Before psychotherapy, there often comes a phone consultation. When I ask prospective clients how they felt about prior therapy, the most common account is of a therapist whom they regarded as a kind, non-judgmental listener, but not much else. They wonder if they were properly challenged, if there could have been more guidance, or if their clues were heard.

The second most common response I hear is that there was a heavy therapist focus on solutions; an assumption, they felt, that if their symptoms disappeared, they'd be "cured." Some people say they had hoped therapy would be an exploration of their personality and unique circumstances. Instead, it felt like an opportunity for the therapist to demonstrate competence.

Thirdly, some prospective clients didn't care for experiential exercises in prior therapy. Some were directed to access deep emotion, some to practice mindfulness, some to enact relationships. These strategies felt hackneyed, they said, especially when no rationale was made transparent. Clients said they felt cared-for but wondered about therapist expertise.

Of course, a client not enjoying therapy doesn't necessarily mean a poor treatment choice. On occasion, it actually indicates a wise, strategic choice. But perhaps more likely, a skilled therapist applied their usual theoretical orientation rather than flexing to the individual. Multi-Theoretical (integrative) training may have enabled that therapist to depart from their usual approach.

Individualizing treatment isn't easy. We're introduced to a palette of theoretical orientations early in grad school. In some programs, we learn a few orientations in-depth. In others, we learn a broad spectrum. We then determine the right fit but do not always have structured help discerning when that approach would be contraindicated. Good supervision helps tremendously with developing an ear for what occurs in our sessions, but our blind spots may actually widen as our identification with one theoretical orientation deepens.

We are human: our vision is guided by what we're good at. Therapist adaptability does not guarantee we transcend bias, establish rapport or make culturally responsive choices. Still, these become more likely when we hear clearly what happens in our sessions. Hall et al. (2016) as well as Smith and Trimble (2016) found that interventions adapted to culturally-based issues tend to be more effective than orthodox interven-

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tions are. Thus, integrative training could really bear fruit.

We encourage graduate and internship training that's quite specific to clinical choice points; "perceiving forks in the road." Knowing when and how to reach beyond one's usual therapeutic approach is an advanced skill. Supervisors are especially valuable with assistance expanding therapist repertoire when they've heard or observed sessions.

Both authors spoke with people in Indonesia about their attitudes towards mental health. Interviewees kindly provided an international example of how small insights might inspire therapist adaptability.

Indonesian Perspectives

Our conversations with people in Indonesia were anecdotal but were meaningful to our understanding of their experience. Though Indonesia is majority Muslim, over 6,000 of its 17,000+ islands are inhabited, so diverse religious and ethnic groups exist. We exercise caution about generalizations. That said, some themes emerged from our interviews.

Whether Javanese or Indo-Chinese, Christian or Muslim, affluent or underprivileged, native to Jakarta, Yogyakarta, or Bali, the people we spoke with agreed that mental illness is often attributed to the action of an external force like the will of a spirit. There is stigma for families with mental illness. Explanations for unusual behavior beyond individual control help families save face.

Worries about mental illness as stigma are well-founded in Indonesia. In a practice called *pasung*, people exhibiting bizarre behavior are vilified, imprisoned, and in some cases shackled. Though *pasung* is more common in less developed regions, interviewees reported that the shame underlying this practice is felt across socioeconomics.

One interview was with a Christian, Indo-Chinese woman in her twenties who was educated and affluent. This woman had Bipolar I disorder. She explained that her family knew she saw a psychiatrist, but they insisted her symptoms were a conflict between her spirit and her dead aunt's ghost. The family asked her to frame symptoms this way, too. This woman explained that she believes bipolar disorder to be a medical condition but finds it easier to preserve her parents' honor by agreeing that it's a ghost.

Preventing shame or "saving face" is so vital, she said, that her parents know she abuses benzodiazepines to cope with her symptoms, but they prefer that she continue substance use to her publicly acknowledging illness.

We also learned that it's fairly common for Indonesians to view emotional concerns of any severity as quite stigmatizing. Even moderate anxiety and depression go untreated if these normal, neurotic conditions are conflated with something like schizophrenia, which could mean shameful *pasung* (imprisonment).

One interviewee in semi-rural Indonesia had lost her son in a volcanic eruption. Her auntie made contact with the university Public Health faculty, requesting outreach. The woman's panic, self-harm, and flashbacks felt unnatural to her, and she was unfamiliar with post-traumatic stress. Faculty suggesting a possible way of looking at her symptoms—that anxiety is the body's logical response to a disaster in the natural world, outside of her mind—reduced her panic.

Given the risk of minor emotional health issues signaling major mental illness to

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the community, therapy utilization in Indonesia is very low. In fact, even Indonesia's less economically developed neighbor, the Philippines, has twice its mental health professionals per capita (Sebayang et al., 2018). Such a discrepancy suggests that more culturally relevant services might increase utilization.

Of course, learning a bit about a group norm cannot describe any one individual's beliefs. Nagayama Hall and colleagues (2021) add that the *cultural* relevance of interventions doesn't necessarily mean *personal* relevance for a particular client. Nevertheless, insight increases the likelihood of thoughtful choices.

Adaptation Brainstorm

Practice multi-theoretical treatment planning. What interventions might you consider for this client:

Female, mid-30s, married to a man, identified with traditional Indonesian culture. Grieving the loss of her only son, age 7, in an earthquake, she presents with panic attacks, self-harm, nightmares, and flashbacks.

What orientations(s) do your ideas represent? Are these your usual intervention choices, or are some adapted to this client?

Below is one brainstorm; your own may look drastically different.

Acceptance and Commitment— Describe the values you aspire to. Behavioral activation to help with impulsivity.

Contextual— Discuss parenting identity. Is losing a son diminished status? How to be responsive to family and they to you.

Cognitive Behavioral— Skills for managing anxiety, to build alliance. Explore self-talk re: fear of future (Indonesia suffers many natural disasters.)

Dialectical Behavior— Mindfulness to tolerate flashbacks, diffuse self-harm impulses. Discuss flashbacks as emotional re-experiencing.

Dreamwork— Skills for changing the ending scenes of dreams, practice lucid dreaming.

Existential/Logotherapy— What do you believe happens after someone dies? Do you believe this loss occurred for a reason? Does love provide meaning in life?

Humanistic/Person-Centered— Invitation to describe son and her relationship with him. Tell the full story: what happened in the earthquake? Explore client beliefs about the meaning of her symptoms. Remain present for a gradual alliance.

Interpersonal/Relational— Express appreciation that coming for therapy is not the norm and requires courage. Model openness about any therapist/client differences. Ask if she would like the therapist to direct our focus.

Motivational Interviewing— Assess client interest in the various ways we might produce change. For example, does she have the most energy for telling her story, symptom reduction, interpersonal problem-solving, spiritual meaning, psycho-education, grieving? Follow client motivations; roll with resistance.

Problem Solving— Invite the client to describe the problem(s) from her worldview. If she'd like, collaborate on what to say to the community that will save face for the family.

Psychodynamic— Would feeling better over time make you feel worse? Inquire about survivor guilt. Discuss new relationships with her living children.

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Systems— Inquire about family strengths and expectations of her. Explore family's beliefs about the root of her symptoms; differ from own beliefs? Explore generational issues.

Gestalt— Wouldn't utilize?
Rational Emotive— Wouldn't utilize?
Object Relations— Wouldn't utilize?
Emotion-Focused Therapy (EFT)— Wouldn't utilize?
Feminist Therapy— Wouldn't utilize?

EMDR— Am not qualified. Refer?
Exposure Therapy— Am not qualified.
Psychoanalytic— Am not qualified.
Art Therapy— Am not qualified.
Narrative Therapy— Am not qualified.
Hypnotherap — Am not qualified.

Some clinicians would choose entirely different therapies for this client. Some would apply the therapies above quite differently. Some clinicians would choose similar interventions but consider them examples of different therapies. Realizing that the very same intervention may reflect diverse approaches and be applied with different intent is integrative training in a nutshell. Theoretical orientations are not categorical, not even close.

Cultural differences are not categorical, either. Side-stepping embarrassment is the human condition. For example, we heard about parents externalizing mental illness (just like in Indonesia) from a Euro-American, mid-twenties, coping with Bipolar I Disorder. She is transitioning male to female, and her parents have declared her symptoms to be the result of the hormone therapy (despite her diagnosis long pre-dating her gender transition). Empathy will always be a valuable guide to our treatment choices. Indeed, therapist education is not sufficient for culturally relevant choices (Nagayama et al., 2021). Clearly, multi-theoretical training would be an improvement but not a fix.

Practice Grid

One way to begin integrative training is to pose two important questions, applying these to as many theoretical orientations as possible until you have created a long grid. While serving as a Training Director, one of the authors facilitated this exercise with Pre-Doctoral Interns and Psychology Staff.

The two questions:

1. A _____ therapy approach might be a good match for a therapist whose strengths include _____. It might be more of a challenge for a therapist who _____.

A few therapist characteristics to consider: comfort with strong emotion, ability to analyze patterns, sense of humor, understanding dynamics, knowledge of stress reduction techniques, diagnostic skills, interpersonal warmth, bravery, understanding of inequity issues, ability to provide structure, comfort with silence, tabooed topics, spirituality, etc.

2. A _____ therapy approach might be a good choice for a client who _____. It might be a riskier choice for a client who _____.

A few client characteristics to consider: trauma history, substance use, sense of humor, verbal vs. cognitive strengths, coping style, attachment style, maturity of defenses, understanding of irony and metaphor, level of daily functioning, need for medication, need for support vs. challenge, psychological-mindedness, etc.

The response to this training exercise was unusually energetic, even appreciа-

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tive. Having "no right answer" makes the process frustrating for some, but therapist self-awareness of a need for concreteness (or abstraction) is itself useful for multi-theoretical training.

Core Skill

The point of being adaptable clinically, from our perspective, is not the specific therapies chosen or identifying as "integrative," but rather just having our bases covered. Think of this core skill as having some left brain and some right brain strategies to offer our clients.

Ideally, mental health professionals have enough range to:

- Help clients understand relationship dynamics and learn to catch irrational thoughts.
- Help clients feel respected, heard, and whole and teach them to regulate how much they feel when challenged.
- Help clients understand their needs and know how to initiate behavior change.
- Help clients articulate emotion and appreciate the impact of injustice.
- Help clients develop coping strategies and grieve disappointments.

We aspire to help clients who are compartmentalized and those who are dysregulated. To assist those who love structure and those who rebel against it. To be effective with clients who think the way we do and those who see things differently. This ability to stretch is the core skill.

We don't propose that graduate training cover a vast number of theoretical orientations. Rather, we can cover our bases loosely, fostering therapist development of some emotion-focused, some solution-focused, and some insight-oriented strategies. If you prefer, that's some left brain and some right-brain ways of helping.

Recommendations

1. Consider introducing clinical flexibility graduate year two and returning to it for internship. None of us can be expected to flex our treatment style until (1) we have a treatment style and (2) are able to perceive decision points in the session.

2. Invite discussion in courses and supervision. What's a bigger risk? Breadth (being multi-theoretical) at the expense of depth, or depth (single orientation) at the expense of breadth? These both confer strength; any reason we can't have both?

3. Create some version of the Practice Grid exercise above. Seminar participants articulate the therapist skills they believe work well with each theoretical orientation and those they may need to develop. Repeat the process, matching approaches to client needs. This exercise requires an instinctive feel for diverse therapies, pattern recognition, and some vision. It's difficult but fun; allow generous time for discussion.

4. Create some version of the Adaptation Brainstorm exercise above. Briefly describe a fictitious client, perhaps different from the therapist on some dimension, then imagine treatment planning utilizing elements of multiple therapies.

5. Generate hypotheticals for discussion to illuminate the blind spots associated with any single theoretical orientation. How might a psychoanalytic approach miss opportunities for skill-building? How might a problem-solving approach neglect gender issues?

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How might a cognitive behavioral approach discourage deep emotion? How might a person-centered approach fall short when a client is in crisis?

6. Play with interesting therapy combinations. How might Humanistic and DBT strategies team up to increase client self-esteem? How might Existential and Rational Emotive approaches combine to help clients bear disappointment? How might Gestalt and Systems therapies together produce amazing family insights?

7. In supervision, help advanced students develop a secondary or tertiary approach that complements their primary theoretical orientation. Ideally, any experienced therapist has some comfort with accessing emotions, analyzing cognitions, facilitating insight, recognizing patterns, teaching behavioral strategies, and building a meaningful relationship. It's about covering our bases, not about theoretical orientation, *per se*.

8. Avail yourself of fabulous training resources. Brooks-Harris & Gavetti (2001) offer a handbook for practicum teaching of micro-skills. Norcross & Popple (2016) wrote a guide to integrative supervision. Comprehensive texts include: Brooks-Harris (2007), Prochaska & Norcross (2018), Hawkins & Ryde (2019), Beutler & Clarkin (2014), Norcross & Cooper (2021), and Ingram (2011).

9. Join the *Society for the Exploration of Psychotherapy Integration*. SEPI's membership is international, their discussions inter-disciplinary, and their tone welcoming; this may be your new favorite conference. The SEPI website also provides training resources, including integrative course syllabi.

Dynamic Benefits

We hope that multi-theoretical planning earns a place in the graduate training curriculum. Learning clinical flexibility is a dynamic, unfolding process—like therapy itself—that improves our chances of helping a variety of people. Integrative thought is a rigorous and creative undertaking, but we find it engrossing to teach and to learn.

References

Beutler, L.E. & Clarkin, J.F. (2014). *Systematic treatment selection: Toward targeted therapeutic interventions.* Routledge. https://doi.org/10.4324/9781315803746

Brooks-Harris, J.E. (2007). *Integrative multitheoretical psychotherapy.* Cengage Learning.

Brooks-Harris, J.E. & Gavetti, M.F. (2001). *Skill-based psychotherapy integration: A practicum handbook of intermediate microskills.* Counseling Center Village: www.ccvillage.buffalo.edu/training-resources

Castro, F.G., Barrera, M., Jr., & Holleran Steiker, L.K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology, 6,* 213-219. https://doi.org/10.1146/annurev-clinpsy-033109-132032

Hall, G.C.N., Ibaraki, A.Y., Huang, E.R., Marti, C.N. & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy, 47,* 993-1014. https://doi.org/10.1016/j.beth.2016.09.005

Hawkins, P. & Ryde, J. (2019). *Integrative psychotherapy in theory and practice.* Jessica Kingsley Publishers.

Ingram, B.L. (2011). *Clinical case formulations: Matching the integrative treatment plan to the client.* Wiley Publishing.

continued on page 17

Jenkins, N. (2016, March 21). *Thousands of mentally ill Indonesians are imprisoned in shackles, report says.* Time. https://time.com/4265623/indonesia-mental-illness-chains-pasung-hrw/

Nagayama Hall, G.C., Berkman, E.T., Zane, N.W., Leong, F.T.L., Hwang, W., Nezu, A.M.,

Maguth Nezu, C., Hong, J.J., Chu, J.P. & Huang, E.R. (2021). Reducing mental health disparities by increasing the personal relevance of interventions. *American Psychologist 76* (1), 91-101. https://doi.org/10.1037/amp0000616

Norcross, J. C. & Cooper, M. (2021). *Personalizing psychotherapy: Assessing and accommodating patient preferences*. American Psychological Association. https://doi.org/10.1037/0000221-000

Norcross, J.C. & Goldfried, M.R. (Eds.). (2019). *Handbook of Psychotherapy Integration, 3rd edition.* Oxford University Press. https://doi.org/10.1093/med-psych/9780190690465.003.0001

Norcross, J.C. & Popple, L.M. (2016). *Supervision essentials for integrative psychotherapy*. American Psychological Association. https://doi.org/10.1037/15967-000

Prochaska, J.O. & Norcross, J.C. (2018). Systems of psychotherapy: A transtheoretica analysis. Oxford University Press. https://doi.org/10.1093/med-psych/9780190690465.003.0008

Sebayang, S.K,. Mawarpury, M., & Rosemary, R. (2018, November 6). Less than 1,000 psychiatrists for 260 million Indonesians. *The Jakarta Post.*

Smith, T. B., & Trimble, J. E. (2016). *Foundations of multicultural psychology: Research to inform effective practice.* American Psychological Association https://doi.org/10.1037/14733-000

Reflections on the Plague Year: Conducting Psychotherapy Research during the COVID-19 Pandemic

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"I had two important things before me: the one was the carrying on my Business and Shop, which was considerable, and in which was embarked all my Effects in the World; and the other was the Preservation of my Life in so dismal a Calamity as I saw apparently was coming upon the whole City, and which, however great it was, my Fears perhaps, as well as other Peoples, represented to be much greater than it could be."

—Daniel Defoe
A Journal of the Plague Year, 1722

Marking a full year since the start of the public health emergency and massive social upheaval caused by COVID-19 led me to read Defoe's *A Journal of the Plague Year,* an account of the 1655 Great Plague of London. It details a number of parallels with our current pandemic: the tracking of the plague's spread from parish to parish, the shutting up of homes and public places, the grimness of the rising death count, the weeping and lamentation upon the death of loved ones, and both the public's fear of the disease and their resistance to government measures to contain its spread. But the passage that's resonating for me right now is in the epigraph, above. It describes the tension Defoe's narrator felt between his desire to stay in his community and maintain his saddlery business and his fear of the disease and death he risked by not fleeing the plague-stricken city. In the current pandemic, psychotherapy practitioners and researchers also are driven to sustain our work, and though we have the safe haven of online interactions, the shift to a virtual workspace has presented its own set of challenges, questions about how the pandemic has altered our processes, and speculations about what the new normal will be.

Although much attention has been given to COVID-19's impact on psychotherapy providers, comparatively little has been written about how the pandemic has affected the conduct of psychotherapy research. Studies that were under way at the start of the pandemic have undergone fundamental changes as COVID-related restrictions at most research institutions have remained in place over the past year. The purpose of this article is to provide examples of adaptations some researchers have made, the challenges encountered in amending study methods, and some potential opportunities stemming from the changes. Several colleagues have generously provided examples from their own experiences in sustaining their research during the COVID-19 year, including study pauses, changes in participant recruitment, the shift to virtual therapy sessions, the impact on data collection and analysis, and the creation of hybrid procedures to enable biomarker data collection.

Research Pauses

Most of the colleagues I contacted

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reported a pause in their research at the start of the pandemic, some because their institution halted in-person research or therapy and others because it took some time to manage the logistics of moving to virtual sessions and data collection. All reported that their institutional review boards were responsive to protocol changes; some experienced a delay but ultimately received approval for COVID-related amendments. The length of time research was paused ranged from no time at all to more than one year. Harold Chui, assistant professor in the educational psychology department at The Chinese University of Hong Kong and member of Division 29's Research Committee, reported that he was not able to collect data from his clinic from March to December 2020. One Division 29 grant recipient had to request two no-cost extensions because his data collection requires international travel to an area with high COVID case rates, delaying his data collection by at least one year. My current study, a pilot trial of a novel therapy for trauma-related nightmares, was paused for two months by the university's order that all non-COVID-related research be halted. Once research was allowed to resume, the university and site IRBs quickly approved our COVID-altered protocol. We also are requesting a no-cost extension on our grant to extend our data collection time. Thus, having psychotherapy research activities halted was common among those contacted. Some were able to resume quickly whereas others remain on hold due to pandemic conditions at their study sites.

Impact on Participant Recruitment

For some studies, participant recruitment has been hampered significantly by the pandemic environment. For my study, our most productive approach has been to set up an information table in a high-traffic area of the hospital where research assistants can meet potential participants, provide information about the study, and collect contact information. Our tabling at Walter Reed National Military Medical Center was of course halted at the start of the pandemic because of the public health risk, and the current health protection condition level has precluded our return to in-person recruiting. This has reduced our recruiting numbers substantially and has led us to develop online advertising and recruiting approaches, including use of social media, local intranets, and listservs. In addition to the loss of in-person recruiting, potential participants we contact by text or phone seem more reluctant to follow up after prescreening calls or virtual screening visits, causing further decline in recruiting numbers. One other researcher has had similar difficulties with recruitment, with potential participants seeming less responsive to online recruiting approaches.

Other researchers indicated they had no decrease in recruitment. Joshua Swift, associate professor of clinical psychology at Idaho State University and Division 29 treasurer, reported that he doesn't believe the pandemic harmed recruitment and perhaps even improved recruiting for their online studies because there were no in-person studies to compete with. Based on these comments, then, one positive impact of the pandemic on participant recruiting is that it has compelled researchers to broaden their approaches to recruitment and that these techniques may have value after the pandemic restrictions are lifted.

Shift to Virtual Sessions

All of the researchers reported shifting to virtual sessions. The availability of Zoom, Google Meet, and other online platforms facilitated the logistics of the change. Clara Hill, professor of counsel-

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ing psychology at the University of Maryland and president of Division 29, reported no pause in research activity at the Maryland Psychotherapy Clinic and Research Lab, which she attributes to the university switching to Zoom, which enabled their smooth transition to virtual sessions. Other researchers also reported that the shift was relatively smooth. For my study, the change to virtual sessions had some initial glitches, including one participant lacking broadband access in their home and the research team taking some time in figuring out how to smoothly transition the session from a research assistant who does informed consent to the assessor for clinical interviews to the therapist for treatment and then back to the research assistant. We have found that giving each team member an estimated time to stand by and then instant messaging them at the time of transition has worked fairly smoothly.

In addition to mastering the logistics of conducting virtual sessions, developing the therapy relationship virtually is more challenging than it is in person. The therapists and assessors in our study have noted that it can be difficult to read a participant's facial expressions and body language. The technology also introduces an audio time lag, which can cause participants and therapists to talk over each other or create unintentional, awkward silences. There are occasional signal disruptions, which causes gaps in communication and requires the therapist to ask the participant to repeat themselves. In addition, participants can be distracted when they are in their home by family members, pets, onscreen message notifications, text messages, and other environmental stimuli not present in an in-person therapy setting.

The positive aspects of virtual sessions are, of course, the convenience of not having to travel to the study site and having the capacity to reach a geographically broader pool of participants. In addition, being compelled to conduct psychotherapy research virtually has created a large population of virtual therapy dyads, giving us the opportunity to vastly expand research on virtual therapy process and outcome.

Data Collection and Analysis

Sessions are not the only component of psychotherapy research that have gone virtual; transitioning to online data collection also has forced a steep learning curve. Jenelle Slavin-Mulford, associate professor in the psychological sciences department at Augusta University and chair of Division 29's research committee, stated that their lab missed several weeks of data collection at the start of the pandemic while they figured out the logistics of transitioning their study online. Because her current study will include data from both in-person and virtual sessions, she says she will need to assess whether and how the virtual sessions are different from the in-person and will have to covary those factors out.

Harold Chui reported that his research team uses Zoom's recording feature to record sessions for future coding and analysis, and that they are collecting pre- and post-session self-report data via Qualtrics. He also noted that they have had a lot more missing data since the move to online data collection, which will likely extend his data collection period. Joshua Swift stated that he expects his data analysis will be much more complex because the recorded Zoom sessions give a smaller picture of the client (typically just head and shoulders), so that coders can't view the same amount of detail as they can in recordings of in-person sessions, and this makes it harder to pick up body lan-

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guage and other nuances. In addition, he stated that it's difficult to tell whether pauses are due to connectivity issues or just natural pauses in the therapist-client interaction. For my own study, we had been using digital audio recorders to record in-person sessions, and after shifting to virtual sessions, we attempted using the same recorders but found that the sound quality was quite poor. We have since switched to using the Google Meet recording feature, which has produced much clearer recordings, making coding and adherence checks go much more quickly.

Lab Management

Given all of the adaptations described thus far, it's no surprise that managing lab procedures have changed significantly. Jenelle Slavin-Mulford reported that her lab manager had to learn their new online data collection method. Clara Hill stated that the biggest shift in her lab was that therapists had to assume all administrative duties, including giving measures, turning on recording devices, and uploading recordings to the university's secure system, which has added considerable time to each session. She said they also had to implement a different payment system because they had previously accepted only cash and checks, and since the pandemic have had to set up online payments through the university.

Biomarker Data Collection

An increasing number of psychotherapy studies are integrating biomarker data collection into their protocols, a component that is obviously problematic in a pandemic environment. Two of my colleagues had biomarkers in their protocols when COVID hit. One made the decision to simply halt his study, and the other amended his protocol to omit biosample collection and proceeded with virtual therapy sessions and psychometric data collection. For the pilot trial my team is conducting, we distribute wristband devices for continuous physiologic data collection and collect blood samples at three visits for genetic and inflammatory marker assay. Because these biomarkers are essential to the study, we needed to retain them and so came up with a hybrid of in-person and virtual study visits. The study was originally designed with 10 in-person visits, including screening and follow-up. We have amended it so that six of the visits are now virtual and four are completed in-person in our study offices. These in-person visits are when participants receive or return the wristband devices and give blood samples. To prepare for the visits, all surfaces and equipment are sanitized prior to participant arrival. The research assistant and the participant are masked and meet in person briefly as the research assistant escorts the participant to a laptop in one room and then goes to their own laptop in another room to conduct equipment orientation and administer measures virtually. When these are complete, the therapist enters the video session and conducts the therapy. When the therapy session is complete, the therapist alerts the research assistant, who escorts the participant to the phlebotomy clinic for the blood draw. When the blood draw is complete, the research assistant walks the samples to the lab, where they are centrifuged and stored for later assay. All personnel are masked and observe physical distancing. Although the revised procedures are more burdensome, we've been able carry them out fairly smoothly. In one respect, pandemic restrictions have made our procedures a bit easier. With most of the therapists in our suite working from home, the additional office space needed to keep the research assistant and participant separate

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is always available. It isn't yet clear when restrictions will be lifted or whether we will return to in-person sessions even if they are lifted, given the convenience that virtual sessions afford. The amended procedures have demonstrated that biomarker collection is possible even under pandemic restrictions.

Conclusion

It's been a long, strange year. Though our COVID-19 pandemic experiences differ in many ways from the plague year endured by Defoe's 17th century London saddler, we share the uncertainty wrought by a public health crisis and consequent major changes in how we live and how we do our work. It's my hope that relating the challenges that I and some of my colleagues encountered during the pandemic year provides a sense of commonality. I also hope that sharing how we adapted our studies may stimulate other researchers to consult with each other when considering how best to adapt their current studies and, as they look to the future, to investigate new topics and constructs that may arise as a result of the pandemic.

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Reference

Defoe, D. (2011). *A journal of the plague year*. Digireads.com Publishing. (Original work published in 1722).

A Clinician's Cognitive Dissonance: Ethical Considerations When Responding to Self-harm Within a Correctional Context

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What leads a person to engage in self-harm behaviors has long perplexed psychologists. People identify various reasons for engaging in self-harm, which include transforming their emotional pain into physical pain, channeling anger, escaping from recurring traumatic thoughts/feelings, and regulation of affect (Whisenhunt et al., 2016; White et al., 2003). Self-harm is commonly confused with suicidal intent. The American Psychiatric Association makes an important distinction between the two by establishing a new term: non-suicidal self-injury (NSSI). NSSI is recognized in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and defined as "deliberate self-inflicted harm that isn't intended to be suicidal" (APA, 2015). Despite the distinction between self-injury and suicide, it is important to note that NSSI and suicide attempts often co-occur, with NSSI being a precursor to suicidality (Pompili et al., 2015). NSSI and suicidality occur at an alarming rate in correctional settings, creating not only an ethical issue for clinicians but also a human rights issue. It is imperative that self-harm amongst incarcerated populations be examined to initiate systemic change.

Self-Harm and Suicide in Correctional Settings

Little research is available regarding NSSI within correctional contexts; however, a study by Dixon-Gordon et al. (2012) noted between 7% and 48% of individuals in correctional settings engaged in NSSI behaviors—far more than the average 4% of adults in the general population. Additionally, the percentage of those who engage in NSSI behaviors in correctional settings increases when the person also has a diagnosed mental illness (Dixon-Gordon et al., 2012).

Utilizing data from the Bureau of Justice Statistics, the Prison Policy Initiative found that suicide was the leading cause of death in jails for over ten years, with over a third of all jail deaths in 2013 being attributed to suicide. Additionally, they found 40% of people who die by suicide in jail do so within seven days of admission (Prison Policy Initiative, 2015). Therefore, it is important for clinicians to recognize those most at-risk for NSSI/suicidality within correctional settings. Ramluggun (2011) identifies those most at-risk as "young, unmarried white people who are awaiting sentence or in their first seven days in prison, or they are people with long sentences and histories of violent offending, sexual abuse, psychiatric or personality disorders, or substance misuse" (p. 2).

Currently, NSSI and suicide attempts are handled controversially within correctional settings. Mental health professionals working in corrections are ethically challenged as the field increasingly "deemphasizes treatment and emphasizes security and custodial concerns" (Weinberger & Sreenivasan, 1994,

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p. 161). This dichotomy creates an environment with rigid explanations—correctional staff typically label behaviors as manipulative, whereas mental health professionals consider them a product of stress, incarceration trauma, and/or mental illness. Improper assessment of the intentions of NSSI and suicide attempts can be mitigated by proper education of all correctional staff (Weinberger & Sreenivasan, 1994). Previous studies have demonstrated that these behaviors are frequently perceived negatively by correctional staff, especially when the behaviors are infrequent, deemed non-severe, and performed by an incarcerated person labeled "disruptive" (Marzano et al., 2011). The question that arises out of this environment is, should these behaviors be considered a punishable or treatable act?

In correctional contexts, NSSI behaviors are too often considered punishable acts. A study by Marzano et al. (2011) found that 85% of people incarcerated found officers' responses to self-harm unhelpful, and 67% found healthcare staffs' responses to self-harm unhelpful. These negative responses contribute to further and more severe self-harm and inhibit support seeking, as well as reinforce low self-esteem and poor self-worth (Marzano et al., 2011). Staff attitudes create an environment where NSSI are handled as punishable acts (e.g., observation cells), and the institutional protocols that follow such behaviors reinforce this. Psychiatric correctional staff faces a "restricted range of therapeutic options on account of the prison regime," where ethical dilemmas ensue (Bell, 1999, p. 724). The most common and readily available clinical intervention is the use of observation cells, which are isolated cells where people who are incarcerated are stripped of regular clothes, bedding, personal belongings, etc., for suicide prevention. The use of observation cells is problematic for many reasons, one being that this form of "prevention" is considered a punishment by those subjected to it. The risk of being placed in an observation cell discourages incarcerated people from disclosing NSSI and/or suicidal ideation (Bell, 1998). Little empirical research exists assessing the efficacy of isolation as a means of suicide prevention. However, there is substantial research on the effects of isolation on the general prison population. Those who have been subjected to isolation reported more adverse physical and mental outcomes, including measurable changes in brain functioning, depression, memory difficulties, anxiety, hallucinations, appetite and sleep disturbances, hygiene issues, disorganization, and social withdrawal (Gendreau et al., 1972; Haney, 2003; Lovell, 2008; Stuker et al., 1991). In isolation units, "the stress, lack of meaningful social contact, and unstructured days can exacerbate symptoms of illness or provoke reoccurrence," with more suicide attempts occurring within isolation units (Metzner & Fellner, 2013, p. 316-317). If these conditions exacerbate suicidality in the general population, how are they supposed to benefit those who are actively suicidal?

Ethical Considerations

When clinicians in correctional settings are addressing NSSI, the American Psychological Association's (APA) ethical guidelines, specifically principle 3.04 Avoiding Harm, are important to evaluate. It is difficult to wage harm reduction within corrections which, at its core, is intended to inflict harm and be punitive. Guideline 3.04 binds psychologists to a code of conduct in which they avoid and minimize harm, as well as "do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering,

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whether physical or mental, is intentionally inflicted on a person" (APA, 2017). An American Civil Liberties Union (ACLU) briefing stated that "the shattering impacts of solitary confinement are so well-documented that nearly every federal court...has ruled that placing people with severe mental illness in such conditions is cruel and unusual punishment in violation of the U.S. Constitution" (ACLU, 2014, p. 7). Isolation is associated with suicidality and worsening mental health (Calati et al., 2019; Metzner & Fellner, 2013). Observation cells teeter on a thin line between preventing suicide at all costs and violating inmates' basic human rights, dignity, and privacy (Bell, 1998).

Psychologists continued use of observation cells as a means of prevention may violate APA ethical guidelines. Psychologists are advised to stress the urgency of reform upon their professional organizations, emphasizing that "it is not ethically defensible for health care professionals to acquiesce silently to conditions of confinement," as these conditions impose direct harm to clients (Metzner & Fellner, 2013, p. 319). Professional organizations should, in turn, use their position of authority to mobilize an interdisciplinary, nationwide reimagining of isolation. It has never been viable for clinicians to remain complicit in the wake of client harm.

Recommendations and Conclusion

Aside from striving to provide ethically competent clinical work, psychologists should advocate for systemic change. One recommended alternative to isolation is the implementation of first-night services (Ramluggun, 2011). Prison Advice and Care Trust (PACT), a national charity in the United Kingdom that provides numerous services within prisons, created a first night service. The goal of PACT's first night service is to "reduce the high levels of anxiety and distress that are known to trigger self-harm and suicide, experienced by some prisoners in the early days of custody" (PACT, n.d., para. 1). Upon a person's arrival to prison, they would be met with a first night worker, who would conduct risk and other mental health assessments, as well as address any other needs and concerns, such as those relating to children, family members. First night workers are at the frontline of educating people who have recently been sent to prison on their rights and providing available resources. PACT also w orks with the general prison population to select and train certain individuals to become PACT Peers. PACT Peers act as a continuation of the support the first night service provides. A study conducted by the Prison Reform Trust compared four male and female prisons to determine the effects of first-night services. Two of the observed prisons implemented first-night services, and the other two prisons had not. Findings of the study showed that "emotional distress amongst prisoners was significantly reduced" in the two prisons that utilized PACT's first-night services (PACT, n.d., Figure 2). It is recommended that prisons put into practice a first night service to protect an at-risk group.

While the creation of specially trained units is feasible for short-term goals, what is most imperative in creating meaningful, lasting reform is improved mandatory mental health training for all correctional staff. In some settings, correctional psychologists are required to attend training in which there is no distinction between mental health and other correctional staff. This highlights the omnipotence of the security vs. treatment model, illustrated by the notion that all staff is "considered correctional officers first and foremost" (Weinberger

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& Sreenivasan, 1994, p. 162). If general staff training is the same for all correctional employees, it is reasonable to suggest that all employees receive mental health training in addition to their regular training. While correctional officers have started to receive basic mental health training over the past few years, it is not enough.

Parker (2009) evaluated the benefits of providing correctional officers with adequate mental health training. Correctional officers employed through the Indiana Department of Corrections in the special housing ("supermax") unit in the Carlisle facility received mental health training created by the Indiana chapter of the National Alliance on Mental Illness (NAMI-Indiana). This 5-week training provided correctional officers with ten hours of specialized mental health training. In an evaluation of officers' reactions to the training, results revealed the training was well-received by participating officers. Furthermore, after the first training session, "the total number of incidents, the use of force by the officers, and battery by bodily waste all declined significantly" (Parker, 2009, p. 640). This trend continued after the completion of the training program. Not only did providing mental health training make the prison a safer work environment for officers, but it also made prison a safer living environment for people who are incarcerated.

Lastly, it is important to advocate for the reimagining of isolation as a means of NSSI and suicide prevention. The negative effects of isolation on physical and mental health are well-documented and clearly explored in literature. What has not been thoroughly considered are alternatives to isolation. Rawlings and Haigh (2018) explored alternatives to this problematic prevention protocol. In the late 18th century, England created the *therapeutic community* (TC). Currently, "democratic TCs" are used in some English prisons to assist those with complex psychological needs, with the goal of creating an environment where individuals are empowered to become active members for the betterment of themselves and the community. In general, TCs share five core qualities: belonging, safety, openness, participation, and empowerment (Rawlings & Haigh, 2018). Taking this idea one step further are *psychologically informed planned environments* (PIPEs). PIPEs are residential prison services that seek to reduce reoffending and "improve psychological health and well-being" (Rawlings & Haigh, 2018, p. 344). These environments are often run through a designated wing by specially trained correctional, medical, and mental health staff. PIPEs aim to smooth a person's transition into prison life. Rawlings and Haigh (2018) noted, "PIPEs work with the most difficult and disruptive prisoners from mainstream incarceration and at the same time offer them the kind of support which can help them through a pathway of intervention, something which mainstream custodial environments are not always psychologically equipped to provide" (pp. 344-345). Why then, when humane alternatives exist, does the American prison system continue to rely on ill-equipped, punitive, and inhumane modes of NSSI prevention? It is psychologists' responsibility to advocate for more ethically and clinically sound treatment methods and prevention protocols.

References

American Civil Liberties Union. (2014). *The Dangerous Overuse of Solitary Confinement in the United States.*

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. http://

continued on page 27

www.apa.org/ethics/code/index.html
American Psychological Association. (2015). Who self-injures? *Monitor on Psychology, 46*(7), 60.
Bell, D. (1999). Ethical issues in the prevention of suicide in prison. *Australian and New Zealand Journal of Psychiatry, 33*(5), 723-728. https:// doi. org/10.1080/j.1440-1614.1999.00635.x
Calati, R., Ferrari, C., Brittner, M., Oasi, O., Olié, E., Carvalho, A.F., & Courtet, P.P. (2019). Suicidal thoughts and behaviors and social isolation: A narrative review of the literature. *Journal of Affective Disorders, 245*, 653667. https://doi.org/10.1016/j.jad.2018.11.022
DeAngelis, T. (2015). A new look at self-injury. *Monitor on Psychology, 46*(7), 58.
DeAngelis, T. (2015). Who self-injures? *Monitor on Psychology, 46*(7), 60.
Dixon-Gordon, K., Harrison, N. & Roesch, R. (2012). Non-suicidal self-injury within offender populations: A systematic review. *International Journal of Forensic Mental Health, 11*(1), 33-50. https://doi.org/10.1080/14999013.2012.667513
Grendeau, P., Freedman, N.L., Wilde, G.J., & Scott, G.D. (1972). Changes in EEG alpha frequency and evoked response latency during solitary confinement. *Journal of Abnormal Psychology, 79*(1), 54-59. https://psycnet.apa.org/doi/10.1037/h0032339
Haney, C. (2003). Mental health issues in long-term solitary and "supermax" confinement. *Crime & Delinquency, 49*(1), 124–156. https://doi.org/10.1177/0011128702239239
Lovell, D. (2008). Patterns of disturbed behavior in a supermax population. *Criminal Justice and Behavior, 35*(8), 985–1004. https://doi.org/10.1177/0093854808318584
Marzano, L., Ciclitira, K., & Adler, J. (2011). The impact of prison staff responses on self- harming behaviours: Prisoners' perspectives. *British Journal of Clinical Psychology, 51*(1), 4-18. https://doi.org/10.1111/j.2044-8260.2010.02007.x
Metzner, J.L., & Fellner, J. (2013). Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics. In Grodin, M.A., Tarantola, D., Annas, G.J., & Gruskin, S. (Eds.) *Health and Human Rights in a Changing World*. (pp. 316-321). Routledge.
Parker, G.F. (2009). Impact of a mental health training course for correctional officers on a special housing unity. *Psychiatric Services, 60*(5), 640-645. https://doi.org/10.1176/ps.2009.60.5.640
PACT. (n.d.). *First Night and Early Days in Custody*. https://www.prisonadvice.org.uk/first-night-and-early-days-in-custody
Pompili, M., Goracci, A., Giordano, G., Erbuto, D., Giardi, P., Klonsky, E.D., & Baldessarini,
R. J. (2015). Relationship of non-suicidal self-injury and suicide attempt: A psychopathological perspective. *Journal of Psychopathology, 21*(4), 348-353.
Prison Policy Initiative. (2015, August 4). *New BJS report shows suicide in jails is a national crisis*. https://www.prisonpolicy.org/blog/2015/08/04/bjs_jail_suicide/
Ramluggun, P. (2011). Beyond observation: Self-harm in prisons. *Mental Health Practice, 14*(9), 16-20. https://doi.org/10.7748/mhp2011.06.14.9.c8523
Rawlings, B., & Haigh, R. (2018). Therapeutic communities and planned environments for serious offenders in English prisons. *BJPsych Advances, 23*(5), 338-346. https://doi.org/10.1192/apt.bp.115.015636

continued on page 28

Sutker, P.B., Winstead, D.K., Galina, Z.H., & Allain, A. N. (1991). Cognitive deficits and psychopathology among former prisoners of war and combat veterans of the Korean conflict. *The American Journal of Psychiatry, 148*(1), 67-72. https://doi.org/10.1176/ajp.148.1.67

Weinberger, L.E., & Sreenivasan, S. (1994). Ethical and professional conflicts in correctional psychology. *Professional Psychology: Research and Practice, 25*(2), 161-167. https://doi.org/10.1037/0735-7028.25.2.161

Whisenhunt, J.L., Stargell, N., & Periessy, C. (2016, July 24). *Addressing ethical issues in treating client self-injury. Counseling Today.* https://ct.counseling.org/2016/07/addressing-ethical-issues-treating-client-self-injury/

White, E.V., McCormick, L.J., & Kelly, B.L. (2003). Counseling clients who self-injure: Ethical considerations. *Counseling and Values, 47*(3), 220-229. https://doi.org/10.1002/j.2161-007X.2003.tb00268.x

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Transitioning to Virtual Space: Teletherapy in the Time of COVID-19

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In an effort to curb the transmission of the coronavirus disease (COVID-19) that emerged in late 2019, the use of telehealth technology became a necessity for individuals in need of healthcare services to communicate with their healthcare providers (Wosik et al., 2020). Teletherapy, which is a form of telehealth, uses online video conferencing to provide interactive psychological treatment between therapists and patients (Tse et al., 2015). Previous literature has shown that a good working alliance can be virtually established (Norwood et al., 2018). During the COVID-19 lockdown in March 2020, a psychotherapy research program at a major metropolitan medical center in New York City began to offer teletherapy services. Accordingly, a large number of patient-therapist dyads were forced to transition abruptly to this virtual setting. The present study addresses how these dyads adjusted to treatment while facing unprecedented global disruption. This study involved a semi-structured interview and qualitative analysis with the aim of exploring how the transition to teletherapy was experienced by therapists and patients in this program and how this influenced the working alliance.

Method

Participants

The participants in the study included therapists and patients who were participating in the Brief Psychotherapy Research Program affiliated with Mount Sinai Beth Israel (see Muran, 2002; Muran et al., 2018). A total of 10 participants were selected for the study, including five therapists and five patients. Two of the therapists were psychiatry residents, and three were advanced doctoral students in clinical psychology. Their ages ranged between 29 and 32 (M=32.4, SD=1). Four identified as female and one as "other." Four identified as White, one Latinx. The patients' ages ranged between 20 and 76 (M=40.4, SD=19.7). Among them, three were male, one female, one identified as nonbinary. Four patients identified as White and one as Latinx.

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Procedures and Data Collection

All participants experienced a transition from in-person psychotherapy to teletherapy, having completed at least two in-person sessions before the transition. Only completed cases were selected. Among the 16 identified participants (eight dyads), 10 agreed to participate in the study. Qualitative data were obtained through a semi-structured interview with each of the participants. Each person was interviewed by one of the researchers over the online video conferencing platform Zoom for a duration ranging between 15 minutes and 40 minutes. The interview questions were developed collaboratively by the three researchers, who were all doctoral students in clinical psychology. Each interview began with a standard introduction, an orientation question about the therapy, followed by specific questions targeting the transition to teletherapy and its impact on the working alliance. Follow-up and open-ended questions were used to facilitate the discussion. All the interviews were recorded digitally and transcribed verbatim using the software TranscribeMe. Consent for the interview and recording was sought at the beginning of each interview.

Data Analysis

In this study, Interpretive Phenomenological Analysis (IPA) was used to analyze the data. It was developed by Smith et al. (1995) as a distinctive qualitative approach to explore individuals' idiographic subjective experiences and is widely accepted by healthcare disciplines, including clinical psychology (Biggerstaff & Thompson, 2008). The transcripts of each participant's interviews were analyzed by each member of the research team who followed the steps of reading and re-reading the transcripts, noting significant units, identifying emerging themes, and grouping the themes into clusters. Next, consensus meetings were held between the researchers to ensure agreement on the theme clusters. Those that were agreed upon by at least two of the three members were retained on the final list. Lastly, all the theme clusters were further examined and classified in consensus, which resulted in a total of 16 higher-order, superordinate themes. These themes were classified into three groups based on their occurrence: highly common themes (6-9 occurrences), moderately common themes (3-5 occurrences), and unique themes (1 occurrence).

Results

Highly Common Themes

Teletherapy did not affect the working alliance

More participants reported that there was no influence on the alliance in terms of affective bond and agreement on treatment tasks and goals. For example, when asked whether teletherapy has impacted his treatment goals, one patient reported, "I would say really the virtual versus the in-person maybe didn't really change what we were discussing or what my issues were." More generally, one therapist stated that "I don't know that I would say anything about the virtual aspect of our treatment changed the working alliance. I think it's just the alliance evolved throughout the therapy like it would."

Teletherapy has potential

There were some therapists who are proponents of teletherapy due to its convenience and flexibility in terms of scheduling that can "dramatically expand[s] access to mental health services." Additionally, one therapist reported that he virtually shared his process notes with his patient while in session, which was not something he would have done with in-person ther-

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apy. This highlighted the benefit of teletherapy as being a useful therapeutic tool which "is actually really cool and probably something [he] should take more advantage of with future clients." Patients also reported that they were more open to it as it can serve as an alternative for in-person therapy, even though in-person therapy is still preferred. For example, one patient stated, "I would say ultimately it made me much more open to teletherapy, even if I still would prefer an in-person session."

Negative aspects of teletherapy

Despite some positivity and potential, participants noted negative aspects of teletherapy which include but are not limited to them finding it less effective, difficult to connect emotionally, and an impoverishment of the therapy process. Three therapists reported that they felt teletherapy was less effective, with one stating, "I just felt I wasn't as effective…I just felt like I couldn't quite connect with [my patient] in the same way that we did when we were in person." Another therapist reported that her patient thinks doing "telehealth would be an impoverishment of the process," while she also felt that it "definitely compromised [the process]," with part of the reason being "it was hard to get to emotional topics" when using this form of treatment.

Teletherapy altered the ritual, process and frame of therapy

Participants noted how teletherapy changed the rituals of going to see a therapist were changed; namely, the physical therapy space was altered, the boundaries loosened, and therapist self-disclosure increased. For example, one patient believed that "there is a certain ceremony to going in-person to the office, getting in that space and having that private space" after he transitioned to teletherapy. Similarly, one therapist compared the difference between "a process for him to get on a train and come to [place] and wait in a waiting room" versus "just clicking, 'Hello,' on Zoom or Skype." Regarding boundaries, one therapist reported that her patient introduced her to people she knew when she was passing her neighborhood one time. Still, one therapist ended up giving her Google Voice number to her patient, which led them to have "a more interactive sort outside of session."

Teletherapy caused a felt distance between the therapist and patient, which at times was liberating

Interestingly, participants reported that the lack of physical presence in teletherapy made it easier for them to communicate and express themselves without fear of judgment. For example, one patient found that "the less present the other person is, the easier it is to say whatever comes to mind without worrying about whether there's a reaction or not." Some therapists also expressed similar views, as one of them pointed out, "there's kind of that distance there, so it might be a little bit more liberating. He might have let his guard down a little bit."

Something ineffable is lost with teletherapy

According to some participants, the subtleties of in-person therapy were lost in a virtual setting, although it was difficult for them to articulate what specifics about the visceral presence of the person were missing in teletherapy. One patient stated that "there's some connection that's hard to explain from being in the same room as someone when you're sharing a physical space." A therapist described teletherapy as "doing that stuff over the screen is just not the same."

Moderately Common Themes

Switching to teletherapy caused a restarting of the working alliance

Some participants reported feeling a change in the working alliance after

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transitioning to teletherapy. For example, one therapist stated that she and her patient "definitely had to restart and rebuild" their alliance. This feeling was shared by a patient who found the transition to be difficult because he felt as though he and his therapist were "kind of resetting the relationship a little bit."

Lack of visual cues with teletherapy
Teletherapy may have compromised participant's perception of each other. This was reported by two therapists, with one saying that she was unable "to get a good read" on her patient in that she could not observe her patient's "non-verbal affect and gestures." Three patients also reported this theme, with one stating that "there's a lot of cues that she [therapist] was able to spot that maybe aren't as conveyed as effectively" with teletherapy.

COVID-19 impacted the treatment
This theme illustrated how COVID-19 enhanced the bond between some therapists and their patients as well as affected the goals of treatment. For example, one therapist stated that "the stress of COVID sort of brought us closer." Another therapist stated that COVID-19 affected her patient's treatment goal of working on his social and performance anxiety at his workplace because he became "more comfortable communicating virtually rather than in-person" after he had to work at home during the quarantine.

Therapist role shifted during teletherapy
Interestingly, some patients and therapists reported that the role of "therapist" changed during the transition to teletherapy. For example, a therapist stated that he got "into a kind of coaching, problem-solving mindset in a virtual session," which he would not have gotten into had he been in the same room as the patient. A patient also described that the use of teletherapy resulted in the "normalizing of one's therapist and making them into more of a person" since they had therapy sessions from their home.

Privacy/safety concerns in doing teletherapy
This theme was reported by two patients, with one stating that he was living with his parents during the quarantine and did not "want them to hear everything that I'm saying," while the other stated that he was living with his girlfriend and that having therapy at home "doesn't even feel like a totally safe space to talk." This theme was supported by a therapist who stated that her patient would at times "get interrupted" by her younger siblings since "she was very much responsible for caring for" them.

Unique Themes
Unique themes included the following (which are listed here due to space restrictions): *Teletherapy buffered therapist feelings after a missed session from the patient*; *No difference between in-person therapy and teletherapy*; *Therapist "checked-in" more with the patient after switching to teletherapy to assure mutual understanding*; and *Therapist believed having more initial in-person sessions would have strengthened the alliance in the alliance in teletherapy* (see Table 1 for all the unique themes and supported responses).

Table 1
Response Examples by Category

Category	Response Example
Unique Themes	
(A) Teletherapy buffered Th feelings after a missed session or a no-show from the patient	Therapist: "Sorry to be really honest about feeling like getting to miss a session. But it did sort of buffer the impact of the no shows, which was sort of a threat throughout her treatment, so in that way it was better. "
(B) No difference between in-person therapy and teletherapy	Patient: "I just felt like everything felt like a normal therapy situation."
(C) Therapist "checked-in" more after switch to teletherapy to assure mutual understanding	Therapist: "Maybe checking in a little more--that's the only thing I can think about. Like, 'Oh, did you get that?' Or doing more check-ins."
(D) Therapist believed more in-person sessions would have strengthen the alliance in teletherapy	Therapist: "I could have been more attuned, or our bond could have been stronger if we had more in-person sessions."

One participant response was provided for each theme.

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Discussion

In considering the working alliance according to Bordin's (1979) formulation, namely as a combination of shared tasks and goals and the quality of a shared bond, the researchers were able to capture the shift from different angles. Interestingly, when participants were asked outright about changes in the working alliance, nine participants reported that *teletherapy did not affect the working alliance* (highly common). However, when asked more specifically about the goals, tasks, and bonds, participants reported that *COVID-19 affected the goals of treatment* (moderately common) that *solidarity in COVID-19 enhanced the bond between therapist and patient* (moderately common), and that there was *an increased focus on tasks as compared with the process of therapy* (moderately common). In this way, there is a misalignment between the overall sense of change that was directly reported versus the specific components of the alliance when asked to elaborate.

Another interesting finding was that some therapists became more relaxed in upholding the frame of therapy and maintaining boundaries with their patients. It is possible that since the virtual environment of therapy was taking place in the therapist's personal space, they felt more relaxed and in a less rigid role than they would have felt if they were doing therapy in a professional setting. This may be related to why one therapist reported feeling less disappointed after a no-show in teletherapy, as she might have felt easier to transition to her own space during that freed-up hour. Another significant finding was that there seemed to be something "ineffable," or indescribable, about the visceral presence of the other that cannot be reinvented in the virtual setting, which may be the *lack of visual cues* or the *felt distance between therapist and patient*.

In thinking about potential limitations to this study, some of the interviews took place months after treatment was completed. Furthermore, the researchers were unable to contact several of the participants, which results in unmatched dyad interviews. The exploratory nature of the present study lends itself to implications of further research. While COVID-19 required that in-person therapy be transitioned to telehealth, it allowed for teletherapy to be considered as a viable alternative option. Now that patients and therapists alike have become somewhat habituated to teletherapy, there is room to expand upon therapist training opportunities to offer therapy virtually.

References

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, *5*(3), 214-224. https://doi.org/10.1080/14780880802314304

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252–260. https://doi.org/10.1037/h0085885

Muran, J. C. (2002). A relational approach to understanding change: Plurality and contextualism in a psychotherapy research program. *Psychotherapy Research, 12*(2), 113–138. https://doi.org/10.1080/713664276

Muran J.C., Safran J.D., Eubanks C.F., & Gorman B.S. (2018). The effect of alliance-focused training on a cognitive-behavioral therapy for personality disorders. *Journal of Consulting and Clinical Psychology*, 86, 384–397. https://doi.org/10.1037/ccp0000284

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continued on page 34

lins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. *Clinical psychology & psychotherapy*, *25*(6), 797–808. https://doi.org/10.1002/cpp.2315

Smith, J. A., Harré, R., & Van Langenhove, L. (Eds.). (1995). *Rethinking methods in psychology*. Sage.

Tse, Y. J., McCarty, C. A., Stoep, A. V., & Myers, K. M. (2015). Teletherapy delivery of caregiver behavior training for children with attention-deficit hyperactivity disorder. *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association*, *21*(6), 451–458. https://doi.org/10.1089/tmj.2014.0132

Wosik, J., Fudim, M., Cameron, B., Gellad, Z. F., Cho, A., Phinney, D., Curtis, S., Roman, M., Poon, E. G., Ferranti, J., Katz, J. N., & Tcheng, J. (2020). Telehealth transformation: COVID-19 and the rise of virtual care. *Journal of the American Medical Informatics Association: JAMIA*, *27*(6), 957–962. https://doi.org/10.1093/jamia/ocaa067

A REVIEW

The Art of Bohart: Person-Centered therapy and the Enhancement of Human Potential, by Arthur C. Bohart

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It is rare when a collection of a single author's papers is neither disjointed or repetitious. So, it was a particular delight to read "The Art of Bohart." It is also a particularly apropos title. Although he acknowledges a keen understanding of the science of therapeutic approaches, Bohart argues that it is the artistry that makes the process engaging and beautiful. Science can provide us with the tools, but only when they are used in personal, creative ways, do they make a true long-lasting impact.

I have personally heard Dr. Bohart deliver papers several times. I have even had an opportunity to present a point-counterpoint dialogue at a few conferences. Each of his lectures was well-crafted, full of useful material and poignant. He can be spellbinding in his balance of erudition, composition and "down-home" openness. So it is with the papers in this book. Each article/chapter is well constructed, reader-friendly and contains considerable depth of insight into what is rightfully called the "Art of therapy."

Although every paper offers pearls of understanding about the process of psychotherapy and the core of what makes therapy work, two stood out significantly for me: Chapter 3, *Further meditations on clients' wisdom* and Chapter 10, *Listening as being: an alternative to hope*. Both chapters take unique perspectives on what might initially seem to be well-known constructs and re-examines them through the prism of true deep listening, witnessing and being a companion on the path of self-regulation and growth.

It would be easy to conclude that he was playing word games here and essentially hashing over his personal viewpoint on a familiar theme, but as I got into the chapters and his arguments, I became aware of the depth of his understanding and power of the presentation. In exploring wisdom and hope (and I might add intimacy) in his unique manor, he provides a more nuanced understanding as well as a novel perspective on what works in therapy and why.

Over the course of the collection, in the process of describing the essence of therapy and the artistry involved, Bohart manages to make Rogerian, person-centered work both rebellious and radical (portrayals I suspect make him proud).

Repeatedly, through various lenses, he depicts the salience of the relationship, of witnessing and being with clients, allowing them to activate their personal healing and acceptance mechanisms, rather than being prescriptive and interventionist. He makes a powerful argument by referencing both the evidence-based literature and his personal experience. Indeed, it is a rare collection of professional work that is so confessional. This is particularly effective in that he engages in a parallel process, using personal vignettes while eluci-

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dating individual client's subjective experience.

So, what is it that the *Art of Bohart* asks of the reader (and those so fortunate to have been in the audience for presentations of his papers)? He asks that therapists forego preset notions of what they presume is best for the client, and instead, enter carefully and empathically into the client's world and in doing so, help clients activate their own healing and insight. It is clearly a greater challenge than a "tab-in-slot" approach. By engaging with clients in this manner, our natural egos and desire to problem-solve are seen as impediments, rather than benefits to the actual therapy.

He believes that the client who lives in the present has the capacity to make the best of their awareness and life, and he contrasts it to those who look for "the answer" in the past as a detective might, or to hope for a specific (potentially) unfulfillable future endeavor. Instead, it is the focus on the present and on *being* that allows for a richer fuller life.

He is not alone in making this assertion. Many phenomenologists have postulated it similarly (Buber, (1937/1970; Binswanger, 1963; Shapiro, 2016). Viktor Frankl (1959; 2006) argued persuasively that even in a concentration/death camp, inmates who found small pieces of beauty (a bird, a love they carried) were more likely to survive those horrors. Frankl poignantly avowed that we have no control over what happens in our lives, we only have the power to determine how we will perceive those events and the attitude we have.

It is no surprise that Rogers also had such a powerful interaction with Martin Buber (Cissna and Anderson, 1994) whose characterization of the I-thou moments in relationship "encounter" involves a way of being fully with another and as much as possible losing the boundaries between them.

At times, this book has a certain Cervantes' (2000) quality. Bohart sometimes begins his presentations sounding a bit like a psychotherapeutic Don Quixote. He knows that he is struggling against trends and forces in the field, and yet, he makes a very powerful counter argument to approaches to therapy that are deductive and prescriptive. He doesn't offer a series of techniques as the essence of the best of psychotherapy. He offers instead core principles that begin inductively and makes each client the expert on a personal theory of being and of change. Like Senor Quixote, it is in the process that truth lies, not in the outcome.

For therapists who desire to become artists in the field, this is a lovely read and a worthwhile collection. I suspect that each re-reading of the chapters will add depth as people grow in the field.

References

Binswanger, L. (1963) *Being-in-the-World*, (J Needleman transl.) Basic Books.

Buber, M.(1937/1970) I and *thou* (W. Kaufman, transl.). Scribner.

Cervantes, M.D. S. *Don Quixote de la Mancha* (Rutherford Transl.) (2000) Penguin Books.

Cissna, K.N. & Anderson, R. (1994) The 1957 Martin Buber-Carl Rogers dialogue as dialogue, *Journal of Humanistic Psychology*, 34(1), 11-45.

Frankl, V. E. (1959) Man's search for meaning (Kushner, Transl.) Simon and Schuster

Shapiro, J.L. (2016) *Pragmatic Existential Counseling and Psychotherapy: Intimacy, intuition and the search for meaning*. Sage.

"The Future's in the Air. Can Feel it Everywhere"

Pat DeLeon, PhD
Former APA President

An Exciting Vision for the Future — Senior Administration: Today the Veterans Administration (VA) provides care at 170 Medical Centers and 1,074 outpatient sites. The 2018 VA Projection Model developed estimates there were 19.5 million Veterans in 2020 and that by 2048 the number will be 13.6 million, a 43% decline. This year, 2021, there are approximately 18 million Veterans. Nine million of them are enrolled with the VA and about 6 million actually receive care from the VA.

In contrast, the Military Health System (MHS) provides in-patient care at 51 hospitals (currently about 16 of these hospitals are outside the continental United States), 424 medical clinics and 248 dental clinics worldwide. There are about 1.4 million active-duty military and 331,000 reserve component personnel. The MHS also provides health care to family members of active duty, to retired personnel and their family members, surviving family members and others identified as eligible in the Defense Enrollment Eligibility Reporting system. This care is available (with certain limitations and co-payments) now through the TRICARE health plan. In 2001, TRICARE benefits were extended to retirees and their dependents over 65 in a program called Tricare for Life system (TFL)—bringing the total population eligible for care through the MHS to about 9.5 million. Estimates now are that about 6.5 million use their MHS benefit.

In contrast to the VA which is projected to see a 43% decline in eligible beneficiaries by 2048, the military health system beneficiary population will remain essentially constant at about 9.5 million unless there is a significant change in the size of the active and/or reserve components. Currently this appears unlikely.

The VA has a very large and aging infrastructure. It has fixed treatment facilities in every continental state and shares facilities with the military in Alaska and Hawaii. In addition, there are a few joint VA-DOD medical facilities in some continental states. For political reasons the VA infrastructure is unlikely to shrink. Even now parts of it are not being used at capacity. Perhaps it is time to start considering opening some VA facility care to MHS eligible beneficiaries in areas remote from MHS fixed facilities but near under-utilized VA facilities? — Harold Koenig, former US Navy Surgeon General

NASEM: The National Academies of Sciences, Engineering, and Medicine's (NASEM) Forum for Children's Well-Being conducted a virtual workshop in September, 2020. APA's Brian Smedley, along with several of his psychology colleagues, was an active participant in *Reimaging a System of Care to Promote the Well-Being of Children and Families*. Highlights of the workshop: the true impacts

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of COVID-19 on children and families may not be fully known until after the pandemic ends, but many agree that a new system of care is needed to promote the well-being of children and families in the pandemic's aftermath. The keynote speakers focused on addressing the need to dismantle structural racism through a systemic approach. Brian, in particular, argued for the importance of *place* as a way to frame race and focused on actionable opportunities to demonstrably improve conditions for health equity.

Challenges with equity begin early in life; Black babies are still more than twice as likely to die as White babies. For every dollar made in a White household, Hispanic American households make $0.73 and Black American and Native American households make $0.59. Racial inequities in socio-economic status (SES) are not reflective of a broken system. We have a carefully crafted system that is working exactly as it was designed, successfully implementing social policies, many of which are rooted in racism. Higher levels of economic, psychological, physical, and environmental stress have major adverse health consequences. Stressors in early life and adulthood can be passed on to future generations. For example, research showed that every police shooting of an unarmed Black male was associated with worsening health for the entire Black population in that state. A key step would be to raise the level of awareness about the extent of the problem; how racism has become embedded within our culture and how negative stereotypes develop.

Brian called attention to residential segregation, emphasizing that it set the stage for many racial inequities in other areas beside health. There is a geography of opportunity related to where people live. It is abundantly clear that a disproportionate cluster of health risks and a lack of resources predominate in the spaces where people of color live, all of which are tied to policy decisions. Segregation restricts socioeconomic mobility by creating public schools that are more under-resourced, have fewer employment opportunities, and result in small value appreciation on real estate in minority neighborhoods. African Americans are five times less likely than White Americans to live near supermarkets and more likely to live near fast food and liquor stores. Their spaces have fewer parks and green spaces and are more likely to be exposed to environmental hazards. There are various opportunities in economic systems for improvement that could contribute to reducing wealth disparities. These require innovative solutions to the current systems that begin with support at the foundation: the home.

What can be done? Brian urged a focus on prevention, particularly where people live, work, play, and study. And, there is a need for multiple strategies across sectors, including a significant investment in early childhood education. A central theme throughout the workshop was that the COVID-19 pandemic has pulled back the curtain on racial disparities within our current health system. There was a call for a New Paradigm for Improving Maternal and Child Health at the National Level. Our colleague concluded that there is an opportunity to move forward as a more equitable nation with the development of a sustained, long-term policy agenda and the simultaneous use of both *place-based* and *people-based* strategies to address structural racism for the greatest change.

Early Career: "With encouragement and guidance from my public policy mentor Russell Lemle, I discovered that my en-

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ergy and passion for improving mental health policy was valued. I volunteered for and was selected as Division 55 (Psychopharmacology) co-chair of the APA convention committee (thanks to Neal Morris) and was subsequently elected to the Division's Executive Board. Colleagues from these experiences helped me expand my involvement to other opportunities and provided support. For example, I applied and was chosen to be the student member for the inaugural year of the APA Advocacy Coordinating Committee, which led to writing a book chapter with former University of New Mexico President Bob Frank. My work on the APA convention was recognized by a colleague who nominated me for the APA Board of Convention Affairs. Although I was not elected, this led to an offer to join the APA Central Programming Group that provides peer review for cross-divisional programming and recommends Keynote speakers for the APA Convention."

"I found that after applying to competitive training opportunities, I was often invited to interviews where I was asked about my 'unusual' accomplishments. Through my APA activities I was also staying up-to-date on current events in Psychology, which helped me view myself as part of our professional community. As I look back while nearing the end of my formal training journey, it is hard to imagine who I would have become without these experiences and mentorships along the way, for example, from former APA President Tony Puente. I would strongly urge students and early career colleagues with a budding interest in public policy to become actively engaged in APA and its Divisions, and, of course, in our State Associations."

(Joanna Sells, Uniformed Services University (USU) graduate)

Enjoyable Memories of Practice Visionaries from the Past: On June 17, 1994, APA President "Dr. Bob" Resnick and I attended the graduation ceremony at the Walter Reed Army Medical Center. Navy Commander John Sexton and Lt. Commander Morgan Sammons became the first graduates of the Department of Defense Psychopharmacology (PDP) training program, under the aegis of Ron Blanck, future US Army Surgeon General and Chairman of the USU Board of Regents. As Steve Ragusea constantly emphasizes, they proved *to psychology* that our profession could learn to prescribe safely, effectively, and in a cost-effective manner.

From John: "It is wonderful to see the steady progression of prescription privileges (RxP). While writing that first prescription as an independent provider on February 10, 1995, I had my doubts about the survivability of psychology RxP given the intense opposition to this effort by psychiatry. Psychologists have prevailed because we saw the advantages of learning to prescribe, even though one might never acquire the certification. Those undertaking this arduous process realize the advantages of being a clinician with much deeper knowledge. We know we can better spot the 'psychological masquerade,' where one in seven patients who enter counseling have an organic basis for their psychological disturbance. Those psychologists learning to prescribe look at patients differently. No matter what theoretical orientation we had as psychologists, we learned to also look at such things as a patient's hair growth, skin pallor, and breathing rate. Those on the front lines realize we have become the 'full-service mental health provider' in doing psychological testing, psychotherapy, and psychopharmacologic

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and health promotion interventions as needed. I strongly encourage any psychologist who is sitting on the fence about acquiring the skill to prescribe to step into RxP training and experience how this exponentially increases one's skill as a clinician."

March 27, 1999. "Dear Pat: It was really a coincidence being in Hawaii at the same time you were. Once again we enjoyed the Halekulani where true service is still very much alive. Thank you for the APA Presidential Citation for the Dirty Dozen from Dick Suinn. This is the occasion of its 30th Anniversary. Interestingly, the early meeting to capture the APA Presidency was held in Honolulu. This is the original list of the very first Dirty Dozen, and although it is 14 rather than 12, it might be said that an APA dozen follows the same number as a dozen bagels in Brooklyn. Here is the list (including 3 deceased): Theodore F. Blau; Nicholas A. Cummings; Raymond Fowler; Melvin Gravitz; Ernest Lawrence; Marvin Metsky; A. Eugene Shapiro; Robert Weitz; Jack G. Wiggins; Rogers H. Wright; Francis Young. In Memorium —C.J. Rosencrans, Jr.; S. Don Schultz; Max Siegel."

"If the citation could be prepared somewhat in the fashion of the Broom Closet Society where all the names are listed together on one sheet, I would take it upon myself to have 14 copies reproduced in color, one for each member (including the deceased for whom I would locate an heir to send it to). The 11 living members have all indicated they will be in attendance, with the presentation being made on Thursday, the night before the APA convenes its convention in Boston. Ray Fowler has suggested the making of a lapel pin, an idea I understand is being implemented. Again, thanks for undertaking this." —Nick Cummings

"Where the children of tomorrow share their dreams with you and me" (Scorpions)

Aloha, Pat DeLeon, former APA President – Division 29 – April, 2021

ALL SESSIONS ON SATURDAY, AUGUST 14TH

Poster Session (F): I
Participant/1stAuthor/Title

Susanna A. Kahnke, MS, University of Kansas
Development of the Feminist Therapy Attitudes Scale

Miral Malik, MEd, MA, George Washington University
Online Supervision During Covid-19: Adjusting in a Time of Crisis

Cordaris O. Butler, MS, University of Kansas (KU)
Perceived Therapist Cultural Humility/Therapy Outcomes for African Americans From White Therapist

JungSu Oh, PhD, Eastern Illinois University
Analyzing Psychotherapy Transcripts Using an Automated Text Analysis and Visualization Technique

Carin Lefkowitz, PsyD, Uniformed Services University of the Health Sciences
Facilitating the Implementation of Evidence-Based Psychotherapies During the Covid-19 Pandemic

Kimberly A. Sikorski, BS, University of Massachusetts Amherst
Replicating Patient-Level Moderators of IPT and CBT's Comparative Efficacy for Depression

Rachel Hughitt, MS, University of Denver
The Impact of Cultural Ruptures in Jail Settings

Yeji Son, MA, University of Iowa
Does the Alliance-Outcome Relationship Differ Across Telepsychology Modalities: A Meta-Analysis

Edmund W. Orlowski, BA, University at Albany–State University of New York
Do Discrepant Expectations for Couple Therapy Predict an Unbalanced Working Alliance?

Sabina Musliu, MA, University of Denver
Anxiety and the Associated Comorbid Disorders: Predicting Therapy Outcomes Using Cluster Analysis

Monica S. Vel, BS, Stanford University
Identifying Evidence-Based Mental Health Interventions That Address the Covid-19 Pandemic

Averi N. Gaines, BA, University of Massachusetts
Patient-Therapist Expectancy Convergence and Outcome in Naturalistic Psychotherapy

Averi N. Gaines, BA, University of Massachusetts, Amherst, MA
Change in Satisfaction With Social Support as a Common Outcome in Ipt and Cbt for Depression

Poster Session, continued on page 42

Poster Session, continued from page 41

Nicholas J. Brewster, BA, University of La Verne
Public Trust in Mental Healthcare Professionals and Therapy

Andrew Dimmick, BS, University of North Texas
Early Therapeutic Alliance as a Predictor of Treatment Outcomes in Psychotherapy

Lindsay A. Phillips, PsyD, Marywood University and Independent Practice, Scranton, PA
Independent Practitioners' Experience in Initial Months of the Covid-19 Pandemic

Jasmine R. Davis, MS, University of Denver
Two's Company, Three's a Crowd? An Empirical Exploration of Split Alliances in Couples Therapy

Minsun Lee, PhD, Seton Hall University
Resolution of Bicultural Conflict in Multicultural Counseling: A Task Analysis

Danielle Schweitzer, Rowan University
Psychologist Use and Attitudes Toward Mobile Applications: A Nationally Representative Sample

Andrea E. Castro, University of La Verne
The Effect of Ethnicity on Perception of Mental Health Promotion

Lauren Zaeske, MS, University of Kansas
Guidelines for Therapist Self-Disclosure of Language Proficiency in Bilingua Therapy

Kelley Quirk, PhD, Colorado State University
In-Session Mindfulness of Therapists in Training

Jean M. Birbilis, PhD, University of St. Thomas
Telehealth, Psychotherapy, and Pandemic

Katherine E. Axford, MA, University of Utah
Agreement of Therapist Skill Use With Self-Reported Theoretical Orientation

Debora B. Handojo, MA, Loma Linda University
Power Dynamics in the Dyadic Therapeutic Relationship

Peter J. Jankowski, PhD, Danielsen Institute, Boston, MA
A Latent Change Model Exploring Virtue and Well-Being in Psychodynamic Psychotherapy

Session ID: 508
Symposium: Positive Psychology, Virtue, and Flourishing in Psychotherapy: Research-Practice Integration
Cochairs: Jesse Owen, PhD, University of Denver
Steven J. Sandage, PhD, Boston University
Participant/1stAuthor
Jesse Owen, PhD, University of Denver
Title: *Therapists' and Trainees' Perceptions of Flourishing in Training and Practice*

Todd J. Farchione, PhD, Boston University
Title: *Trajectories of Change in Well-Being During Cognitive-Behavior Therapies for Anxiety Disorders*

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Sarah Crabtree, PhD, Boston University
Title: *Mental Health, Well-Being, and Experiences of the Covid-19 Pandemic: A Clinical Mixed Methods Study*

Michael J. Constantino, PhD, University of Massachusetts
Title: *Therapist Self-Perceived Competencies as a Determinant of General Between-Therapist Effects*

Discussant: Karen W. Tao, PhD, University of Utah

Session ID: 511
Symposium: How Do Therapists Influence Cultural Processes? Applied Examples and Methods for Training
Chair: Joanna M. Drinane, PhD, University of Utah
Participant/1stAuthor
Laurice M. Cabrera, MS, University of Utah
Title: *Intersectional Identity Conflicts in Psychotherapy: An Unexplored Facet of Cultural Process*

Wing M. Ng, MS, University of Utah
Title: *The Effects of Simulation Based Training With Feedback on Counselor's Multicultural Counseling Skill*

Jeffrey Grimes, MEd, University of Iowa
Title: *Whose Multicultural Orientation Matters More? Effects of Group and Leader MCO*

Discussant: Karen W. Tao, PhD, University of Utah

Session ID: 514
Symposium: Rolling for Recovery: Therapeutic Applications of Tabletop Role-Playing Games
Cochairs: Allison Battles, PhD, Minneapolis VA Health Care System, Minneapolis, MN
Jared Kilmer, PhD, Minneapolis VA Health Care System, Minneapolis, MN
Participant/1stAuthor
Allison Battles, PhD, Minneapolis VA Health Care System, Minneapolis, MN
Title: *Program Evaluation of a Therapeutically Applied Role Playing Game Group Therapy With Veterans*

Elizabeth Kilmer, PhD, Game to Grow, Kirkland, WA
Title: *The Game to Grow Method of Therapeutically Applied Role-Playing Games*

Megan Connell, PhD, Southeast Psych, Charlotte, NC
Title: *Applied Gaming Groups: Therapeutic Applications and Models of Training*

Conference Sessions, continued on page 44

Conference Sessions, continued from page 43

Session ID: 517
Symposium: Reducing Health Disparities: Characterizing Therapists Successful With Low-SES Populations
Chair: Louise A. Douce, PhD, Ohio State University, retired
Participant/1stAuthor
Linda F. Campbell, PhD, University of Georgia
Title: *Overcoming Classism and Other Barriers to Psychotherapy for People Living in Poverty*

Iva Greywolf, PhD, Self-Employed Consultant, Roseberg, OR
Title: *Practicing Psychotherapy Outside the Box and Beyond the 50-Minute Hour*

Susan S. Woodhouse, PhD, Lehigh University
Title: *Effective Therapist Characteristics With Rural and Low SES Populations*

Christianne Connelly, MA, University of Georgia
Title: *Training in Rural and Low-Income Communities: A Student Perspective*

Session ID: 527
Symposium: Developments in Measurement-Based Care: Telehealth, Payment Models, and Practice-Oriented Research
Chair: James F. Boswell, PhD, University at Albany, SUNY
Participant/1stAuthor
Bruce L. Bobbitt, PhD, Minnesota Psychological Association, Minneapolis, MN
Title: *Key Issues in Value-Based Care and Measurement-Based Care*

Caroline V. Wright, PhD, APA, Washington DC, DC
Title: *The Role of Measurement-Based Care in Demonstrating Quality to Payers*

James F. Boswell, PhD, University at Albany, SUNY
Title: *Empirical and Conceptual Developments in Measurement-Based Care Implementation Research and Practice*

Gayle E. Brooks, PhD, Renfrew Center, Coconut Creek, FL
Title: *Quality Monitoring in Eating Disorder Treatment Centers and Sustaining Care During the Pandemic*

Session ID: 515
Symposium: Decolonial Psychotherapy: Healing in Context
Chair: Lillian Comas-Díaz, PhD, Independent Practice, Washington, DC
Participant/1stAuthor
Lillian Comas-Díaz, PhD, Independent Practice, Washington, DC
Title: *Decolonial Psychotherapy*

Hector Y. Adames, PsyD, Chicago School of Professional Psychology
Title: *A Unified Framework of Decolonial Psychology*

Daniel Gaztambide, PsyD, Independent Practice, New York, NY
Title: *Decolonial Psychoanalysis*

Laura S. Brown, PhD, Independent Practice, Seattle, WA
Title: *Decolonial Feminist Therapy*

Conference Sessions, continued on page 45

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Session ID: 516
Symposium: Using Progress Feedback to Enhance Outcomes of Psychotherapy
Cochairs: Kim de Jong, PhD, Leiden University, Leiden, Netherlands and Catherine F. Eubanks, PhD, Yeshiva University
Participant/1stAuthor
Kim de Jong, PhD, Leiden University, Leiden, Netherlands
Title: *Using Progress Feedback to Improve Outcomes: A Multilevel Meta-Analysis*

Wolfgang Lutz, PhD, Trier University, Trier, Germany
Title: *Prospective Evaluation of a Clinical Decision Support System Inpsychological Therapy*

Jaime Delgadillo, PhD, University of Sheffield, Sheffield, United Kingdom
Title: *Cost-Effectiveness of Feedback-Informed Psychological Treatment: Evidence From the IAPT-FIT Trial*

Discussant: Catherine F. Eubanks, PhD, Yeshiva University

Session ID: 510
Symposium: Using Deliberate Practice to Enhance Graduate Training: A Study and a Demonstration
Chair: Hanna Levenson, PhD, Wright Institute
Participant/1stAuthor
Meredith A. Martyr, PhD, University of Minnesota—Twin Cities
Title: *Qualitative Results of the Deliberate Practice Study: What Did the Students Say?*

D. Martin Kivlighan III, PhD, University of Iowa
Title: *Quantitative Results of the Deliberate Practice Graduate School Study*

Hanna Levenson, PhD, Wright Institute
Title: *The Goals and Methodology of the DP Graduate School Study With a DP Live Demonstration*

Tony Rousmaniere, PsyD, University of Washington
Title: *The Goals and Methodology of the DP Graduate School Study With a D P Live Demonstration*

Discussant: Hanna Levenson, PhD, Wright Institute

Session ID: 512
Symposium: Treatment Failure in Psychotherapy: Perspectives on Premature Termination
Chair: George Silberschatz, PhD, Independent Practice, San Francisco, CA
Participant/1stAuthor
James McCollum, PhD, San Francisco Psychotherapy Research Group, San Francisco, CA
Title: *Contextualizing Treatment Failure Within the Patient's Plan for Therapy*

David Kealy, PhD, University of British Columbia, Vancouver, BC, Canada
Title: P*reventing Treatment Failure: An Evidence-Based Case Study of Coaching and Premature Termination*

Xiaochen Luo, PhD, Santa Clara University
Title: *A Comparison of Patient's Coaching Behavior and the Rupture-Repair Framework*

Discussant: Shigeru Iwakabe, PhD, Ochanomizu University, Tokyo, Japan

Conference Sessions, continued on page 46

Conference Sessions, continued from page 45

Session ID: 509
Symposium: Defining and Implementing Principles of Change: A New Partnership Between Clinicians and Researchers
Cochairs: Louis G. Castonguay, PhD, Penn State University and Michael J. Constantino, PhD, University of Massachusetts Amherst
Participant/1stAuthor
Louis G. Castonguay, PhD, Penn State University
Title: *Revisiting Empirically Based Principles of Change*

Catherine S. Spayd, PhD, Duncansville Professional Center, Duncansville, PA
Title: *Implementing Principles of Change in the Treatment of Anxiety: A Cognitive Behavioral Perspective*

Eva D. Papiasvili, PhD, Columbia University in the City of New York
Title: *Implementing Principles of Change in the Treatment of Anxiety: A Psychoanalytic Perspective*

Igor Weinberg, PhD, McLean Hospital, Harvard University
Title: *Implementing Principles of Change in the Treatment of Anxiety: An Integrative Approach*

Benjamin Johnson, PhD, RICBT Cognitive Behavioral Therapy and Coaching, North Kingstown, RI
Title: *Implementing Principles of Change in Treating Depression: A Cognitive Behavioral Perspective*

Dina Vivian, PhD, Stony Brook University
Title: *Implementing Principles of Change in Treating Depression: An Integrative Perspective*

Session ID: 513
Symposium: What Have We Learned From Expert Supervisors in Action? Empirical Studies and a Video Illustration
Chair: Hanna Levenson, PhD, Wright Institute
Participant/1stAuthor
Hanna Levenson, PhD, Wright Institute
Title: *The APA Expert Psychotherapy Supervision Video Series: A Description and Video Illustration*

Benjamin Feldman, BA, Wright Institute
Title: Corrective Experiences in Psychotherapy Supervision: Implications for Learning and Supervising

Meital Bendet, MA, Wright Institute
Title: *What Expert Supervisors Do: Findings From Use of the Supervisor Intervention Scale*

Discussant: Arpana G. Inman, PhD, Ohio State University

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We'd love to hear from you!