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BULLETIN

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*Improving Programming for Military Families Using Community Based Participatory Research*

Society for the Advancement of Psychotherapy

2022 VOLUME 57, NUMBER 3

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Department of Psychology
University of Maryland
College Park, MD 20742
Ofc : 301-405-5791
cehill@umd.edu

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Jean M. Birbilis, PhD
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1000 LaSalle Ave., MOH 217
Minneapolis, Minnesota 55403
Ofc: 651-962-4654
jmbirbilis@stthomas.edu

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stewart.cooper@valpo.edu

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Pocatello, ID 83201
Ofc: 208-282-3445
joshua.keith.swift@gmail.com

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UNT Department of Psychology
Terrill Hall, Room 376
1155 Union Circle #311280
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Jennifer.Callahan@unt.edu

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*Public Interest and Social Justice*
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rephelps@UGA.EDU

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921 The Alameda #109
Berkeley, CA 94707
Ofc: 510-303-6650
bvivino@aol.com

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The George Washington University
Professional Psychology
Washington DC 90008
Office: 301-728-0410
marmaros@gwu.edu

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Office of Patient Centered Care
VA Boston Healthcare System
1400 VFW Parkway
West Roxbury, MA 02132
rametrano@gmail.com

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Beatriz Palma, PhD, 2020-2022
University of Virginia - Counseling and Psychological Services (CAPS)
400 Brandon Ave.
Charlottesville, VA 22908
Ofc: 434-243-5150
bip8x@virginia.edu

*Science and Scholarship*
Patricia Spangler, PhD, 2020-2022
Center for the Study of Traumatic Stress
Department of Psychiatry
Uniformed Services University
Henry M. Jackson Foundation for the Advancement of Military Medicine
6720 Rockledge Drive, Suite 550
Bethesda, MD 20817
Ofc: 240-620-4076
patricia.spangler.CTR@usuhs.edu

*Diversity*
Susan Woodhouse, PhD, 2020-2022
Department of Education and Human Services Lehigh University
111 Research Drive
Bethlehem, PA 18015
Ofc: 610-758-3269
Woodhouse@lehigh.edu

*Diversity*
Sheeva Mostoufi, PhD, 2022-2024
Old Town Psychology
1216 King Street, Suite 200
Alexandria, VA 22314
sheeva.mostoufi@oldtownpsychology.com

*International Affairs*
Changming Duan, PhD, 2021-2023
Dept. of Psychology and Research in Education
University of Kansas
Lawrence, KS 66054
Ofc:785-864-2426
duanc@ku.edu

### APA Council Representatives

Lillian Comas-Diaz, PhD, 2020-2022
908 New Hampshire Ave NW Ste 700
Washington, DC
Ofc: 202-775-1938
lilliancomasdiaz@GMAIL.COM

### Student Representative

Lei Y. Sun, M.S.Ed. 2021-2022
University of Miami
Dept of Educational and Psychological Studies
5202 University Drive
Coral Gables, FL 33146
Ofc: 305-284-6160
l.sun6@umiami.edu

## STANDING COMMITTEES

**Continuing Education**
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kenneth.critchfield@yu.edu

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Chair: Wonjin Sim, Ph.D.
wsim0930@gmail.com

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drkathrynkline@gmail.com

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melissa_jones@byu.edu

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laurenbehrman@gmail.com

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mpgrazioso@PROYECTOAIGLE.ORG.GT

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drbarb@comcast.net

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jmbirbilis@stthomas.edu

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agreig@challiance.org

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jawolf@smcm.edu

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Chair: Harold Chui
haroldchui@CUHK.EDU.HK

**Social Justice**
Chair: Linda Campbell, PhD
lcampbel@uga.edu

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

**EDITOR**
Joanna M. Drinane, PhD
joanna.drinane@utah.edu

**CONTRIBUTING EDITORS**
**Diversity**
Sheeva Mostoufi, PhD and
Susan Woodhouse, PhD

**Education and Training**
Cheri Marmarosh, PhD and
Melissa Jones, PhD

**Ethics in Psychotherapy**
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**STAFF**
**Central Office**
Tracey Martin
6557 E. Riverdale St.
Mesa, AZ 85215
Ofc: 602-363-9211
assnmgmt1@cox.net

**Website**
www.societyforpsychotherapy.org

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## PRESIDENT'S COLUMN

# Training and Supervision

*Clara E. Hill, Ph.D.*
*Professor, University of Maryland – College Park, MD*

In this column, I want to give a shout-out to a new book that you all should read if you are interested in the training and supervision of and the practice of psychotherapy… and I imagine that is almost everyone in the Society for the Advancement of Psychotherapy. The book is edited by Louis Castonguay and myself and based on a set of conferences about training and supervision held at Penn State University. A group of scholars met to review what we know about training and supervision. We then all committed to writing a theoretical or empirical chapter about training and supervision. Three years later, we met to talk about progress and what we were learning. And then again two years later, we met to formulate conclusions about what we had learned and develop implications for the field. The book, to be published by the American Psychological Association, will appear in 2023. The citation is:

> Castonguay, L. & Hill, C. E. (Eds.) (in press). *Being and becoming a psychotherapist: Training and supervision*. Washington DC: American Psychological Association.

In the first chapter, 10 trainers and supervisors from different theoretical orientations and countries (Louis Castonguay, James Boswell, Franz Caspar, Myrna Friedlander, Beatriz Gomez, Adele Hayes, Martin Grosse Holtforth, Stanley Messer, Michelle Newman, and Bernhard Strauss) describe the competencies required for practicing clinicians around the world and the methods that are used for training therapists.

In the next chapter, Sarah Knox and I provide a summary of the existing evidence about training and supervision for undergraduate and graduate students. We have a good evidence base for helping skills training and need more evidence for client outcomes for supervision.

In the subsequent chapter, Katie Aafjes-van Doorn and Jacques Barber describe some of the benefits that clinicians may gain from post-graduate educational experiences, such as an "antidote" to the loss of professional knowledge during one's career. They then review the empirical evidence for a variety of such experiences, including conferences and workshops (in person and online), supervision, peer supervision, online supervision, and personal therapy.

Michael Constantino, James Boswell, Alice Coyne, Marvin R. Goldfried, and Louis G. Castonguay then describe how therapists can be trained to identify a range of markers of interventions and to respond to them in ways that are likely to be clinically successful.

In the next chapter, Catherine Eubanks, Christopher Muran, and Lisa Wallner Samstag describe a training program specifically aimed at teaching and supervising trainees in identifying various markers of alliance ruptures and in using different types of interventions to resolve such ruptures.

Jeffrey Hayes, Claire Cartwright, and Fanghui Zhao suggest in their chapter that emotional regulation and self-refection skills are at the core of the management of countertransference. They also present a

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pilot study to assess the impact of reflective practice on trainees' management of their countertransference reactions.

William Stiles, Jordan Bate, and Timothy Anderson describe new developments related to responsiveness in psychotherapy, and elaborate their theory based on qualitative analysis of the experience of three therapists (with various level of training) who participated in a training workshop.

Martin and Dennis Kivlighan provide a description of deliberate practice. They also present additional data from an experimental study on the use of deliberate practice for training graduate students in using immediacy.

Wolfgang Lutz, Anne-Katharina Deisenhofer, Brigit Weinmann-Luz, and Michael Barkham describe a training clinic that integrates (and contributes to) advances in empirical knowledge, computer technology, and statistical analyses.

Matteo Bugatti, Zac Imel, and Jesse Owen review how training and supervision have been transformed by advanced technology, presenting cutting edge technological systems based on artificial intelligence and machine learning that are aimed at fostering various skills (e.g., open-ended questions) and interventions (e.g., motivational interviewing).

Myrna Friedlander, Laurie Heatherington, Sarah Knox, Catherine Eubanks, Lynne Angus, Mengfei Xu, and I present a qualitative investigation of the direct and indirect effects of formal supervision during graduate training. We found a variety of obstacles as well as benefits of supervision for both trainees and clients.

Ryan Kilcullen, Louis Castonguay, Dever Carney, Katherine Davis, Natalie Pottschmidt, Samuel Knapp, Corrie Jackson, Neil Hemmelstein, and Ann Marie Frakes then present a study on the feasibility and helpfulness of peer supervision for early career psychologists, revealing factors that can hinder peer supervision as well as benefits for early career therapists.

Next, Barry Farber and Daisy Ort examine the effects of informal supervision, which refers to guidance and support about clinical work that therapists receive by someone else than formal or peer supervisors, especially in terms of the provision of emotional support. Given that informal supervision seems to occur a lot, we need to know more about it.

Laurie Heatherington, Jacques Barber, Ryan Kilcullen, Louis Castonguay, Katherine Davis, Peter Barry, and Dennis Kivlighan present the results of a national survey of directors of clinical training programs about the positive (e.g., relational skills) and hindering (e.g., arrogance, narcissism) personal qualities of applicants. They also surveyed the methods used to evaluate candidates in their respective training program.

Bernhard Strauss and Dominique Frenzl argue in the following chapter that we need to give more attention to training students about preventing harmful or negative effects in therapy. The authors review the prevalence of various adverse effects, the occurrence of malpractice and boundary violations, and negative experiences during training and supervision.

In the next chapter, Sarah Knox, Heidi Zetzer, Barry Farber, Catherine Eubanks, Timothy Anderson, and I disclose key experiences of faith and doubt throughout our childhood and adulthood that influenced us in our work as trainers and supervisors. We emphasize the need for growing tolerance to ambiguity and uncertainty, as well as the value of collaboration with others.

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The book ends with conclusions derived from the previous chapters and discussions at the Penn State Conference. We summarize what we have learned and offer clinical, research, and policy implications. We hope to inspire others to continue this important work so that we can advance the field of training and supervision. Although challenging to conduct such research, we clearly need more evidence for how to train and supervise students.

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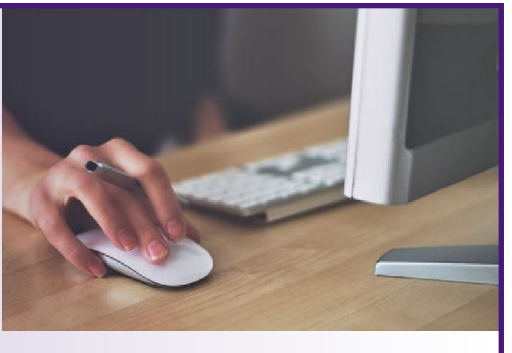

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# EDITOR'S COLUMN

*Joanna M. Drinane, Ph.D., Editor*
*Assistant Professor, University of Utah*
*Salt Lake City, UT*

Greetings Division 29 and SAP Membership! Happy summer!

"How can psychology majors be depressed? Like bro, just look at your notes" -@gdarling14

This quote, from a tweet that has been shared across the internet, highlights the expectation that we, as psychologists and mental health professionals, should have the tools to prevent our own distress. That said, as the new academic year begins, it comes with a host of persistent fears and a sense of exhaustion from, but not limited to, gun violence, racism, and changes in access to abortion. Clients come to us to seek refuge, but we are not immune to the impact of social injustice and even though we learn mechanisms of protection throughout our education, it can be difficult to implement them in response to chronic stress. We encourage you to talk about your contemporary professional experiences, how you respond to them, and how you cope with them. The Bulletin is a space where you can do so, and reach a vast audience of students, providers, academics, and consultants, all who may need connection and recognition about what it means to engage in practice and research in 2022.

Since the start of the year, we have sought to broaden our audience and to increase representation among contributing authors. In this third issue, there are pieces from domain representatives, and there are also four featured articles from members of the Division who engage with our publication. In addition to the presidential column by Dr. Clara Hill, we call your attention to an engaging submission led by Abby Blankenship and colleagues entitled, "Improving Programming for Military Families Using Community Based Participatory Research." This piece employs methods that involve stakeholders, which makes it a valuable and informative read, and we hope for more contributions like it.

For the last issue of the year, we seek submissions that fit with the special focus for 2022, "Technology and Psychotherapy: Strategies for Increasing Access and Equity." Content related to this theme, or that which addresses your curiosity related to how we understand the process and outcome of therapy during this difficult time will be welcomed. Your engagement makes for valuable discourse, and it is our hope that it leads to informed action. To write for the Bulletin, please visit our website (http://societyforpsychotherapy.org/bulletin-about/). The final deadline for 2022 will be October 15th. Please reach out with questions to joanna.drinane@utah.edu.

Thank you!

Joanna

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# The Practice of Telepsychology: Ethical, Legal, and Clinical Issues

*Jeffrey E. Barnett, PsyD, ABPP*
*Nada Jokhadar*
*Loyola University Maryland*

**The Practice of Telepsychology: Ethical, Legal, and Clinical Issues**

The use of telepsychology by psychotherapists has increased in recent decades (Glueckauf et al., 2018). It provides greater access to psychotherapy, such as for those who live in areas where needed treatment services are not available and for those who are homebound or who lack access to adequate transportation. It also can be more cost-effective than in-person psychotherapy for both clients and psychotherapists alike.

In response to the onset of the COVID-19 pandemic, online clinical practice quickly increased from 7.1% of psychotherapists to 85.5% of psychotherapists in the United States (Pierce et al., 2020). This rapid shift from in-person to online psychotherapy was an appropriate response to safety concerns caused by the pandemic. It helped ensure that those who were in treatment at the time of the onset of COVID would not have their treatment abruptly ended and those in need of psychotherapy (a need that has increased since the start of the pandemic) would have access to it.

The rapid transition to providing online psychotherapy to clients likely caught many psychotherapists feeling unprepared and raised many questions and challenges for them (Khatib et al., 2021). These include:

- knowing what ethics standards and guidelines are available to help guide psychotherapists toward ethical and competent telepsychology practice,
- knowing which hardware and software are needed and how to effectively use them,
- knowing how to transition effectively from in-person to online services to include knowing what fees to charge for the services provided,
- understanding and addressing confidentiality and common threats to privacy in the online environment,
- knowing how to modify the informed consent process to address issues relevant to online services,
- being familiar with the most current literature on the effectiveness of various psychotherapy treatments via different online media and making informed decisions about who may be appropriately treated online,
- planning for timely and relevant responses when clients experience a crisis, and
- knowledge of laws relevant to the practice of telepsychology in one's own state, province, or territory, and those relevant to inter-jurisdictional practice.

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While safety concerns secondary to the COVID-19 pandemic have driven psychotherapy into the online environment, this may not be a temporary situation, even if in-person treatment becomes viable again. Many individuals are finding the ease and convenience of online psychotherapy to be beneficial to them. Likewise, many psychotherapists also find online psychotherapy to be a great convenience and report viewing it positively and being open to its future use (Békés & Aafjes-van Doorn, 2020). This brief article offers an introduction to the legal, ethical, clinical, and practical issues relevant to the provision of telepsychology services.

**Legal Issues**

The practice of telepsychology brings with it several important legal issues. By definition, telepsychology means that the psychotherapist and client are not in the same location. While many clients live locally and were previously treated in-person, telepsychology's expanded reach enables psychotherapists to treat clients across state lines. This interjurisdictional practice brings with it several challenges. Since the practice of psychology is regulated by each state, unless one is granted an exception, one must be licensed where the psychotherapist is located and where the client is located. At the beginning of the pandemic many states loosened this restriction and allowed health professionals licensed in any state to provide professional services in their state, both in-person and virtually. These allowances were time limited and many of them have expired, so it is important to check the website of the psychology licensing board in the client's state to see if this exception still exists.

It is recommended that psychotherapists always confirm with potential clients where they are located to determine if the psychotherapist is legally authorized to provide this treatment. Fortunately, the Association of State and Provincial Psychology Boards (ASPPB) has developed PsyPACT, an interjurisdictional practice credential that at present allows a psychologist licensed in one state to practice (in-person or virtually) in 27 other states, with additional states likely to be included in this interstate compact in the near future. See https://psypact.site-ym.com/page/psypactmap for more information about PsyPACT and the states currently participating in it. For psychologists licensed in one of these states, participation in PsyPACT offers a cost-effective means of practicing virtually in numerous other states without needing to go through the time consuming and expensive process of becoming licensed in each of these other states individually.

Even if one has the legal authority to provide psychotherapy in another state there are additional legal issues to consider. Of greatest importance is knowledge of laws in the client's state relevant to mandatory reporting requirements. States typically have laws that require breaching confidentiality under certain circumstances such as to report the suspicion of abuse or neglect of minors and of older adults or vulnerable adults, and when clients disclose an intent to harm an identifiable victim or group of victims, yet laws vary by state. It is recommended that psychotherapists ensure their familiarity with relevant laws in the states where their clients are located and follow them as is required. When conflicts between state laws arise, consultation with colleagues with legal expertise is recommended.

**Before Treating Clients**

Prior to offering telepsychology services psychotherapists should familiarize

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themselves with telepsychology options. A wide range of software options exist for video conferencing, each offering different features. Reading reviews of these options, discussing preferences with colleagues, and trying out options and assessing them for ease of use may be helpful prior to selecting one. It is essential to ensure that the option selected is HIPAA-complaint and that the vendor provides you with a Business Associates Agreement in which HIPAA compliance for protecting confidential client information is stated (HIPAA Journal, 2022).

It is important to become skilled with any technology used, to include developing comfort utilizing all its features. Conducting practice sessions with a colleague can be helpful in this regard. Many clients may not have familiarity with the technology being used and may need instruction by the psychotherapist at the outset of treatment as well as assistance should technology-related difficulties occur over the course of treatment. Thus, in addition to one's clinical competence, technological competence is important to possess as well. Numerous online treatments for a wide range of clinical presentations have been studied and new studies are published daily. Psychotherapists should familiarize themselves with this literature, staying current with it, to ensure that treatment offered have the needed research evidence.

**Informed Consent to Telepsychology**

As with in-person treatment it is important to engage in a comprehensive informed consent process with clients "as early as is feasible in the therapeutic relationship" (APA, 2017). In addition to all issues typically addressed, issues specific to the provision of telepsychology should be included as well. Be sure to address which technologies may be utilized for which purposes (e.g., administrative versus clinical purposes). For example, one might limit clinical interactions to video conferencing and telephone and only use e-mail and text messaging for administrative purposes such as scheduling and changing appointments. Additionally, the level of responsiveness from you they can anticipate should be addressed. For instance, if you only respond to voicemail messages, e-mails, and text messages during certain hours, this should be clearly stated so that clients do not have unrealistic expectations about responsiveness. Many today expect near-instantaneous responses to text messages, something not reasonable to expect of their psychotherapist. Psychotherapists should also inform clients about financial policies to include if e-mail exchanges and phone calls in-between sessions are billed separately or included in the fee paid for each treatment session. The possibility that lapses in the technology being used may occur during online treatment sessions should be addressed as well so that clients and psychotherapists will have an agreed upon plan should loss of connectivity occur during a psychotherapy session (e.g., having the client call the psychotherapist's cell phone number).

Numerous resources exist to assist psychologists to modify and update their informed consent practices to ensure they include issues relevant to the practice of telepsychology. Several sample documents are available on the website of The Trust (https://www.trustinsurance.com/). These include a sample Telepsychology Informed Consent document and a sample Electronic Communication Policy (https://parma.trustinsurance.com/Resource-Center/Document-Library-Quick-Guides). Further, it is recommended that psychotherapists, whether practicing online or in-person,

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include a Social Media Policy in their informed consent process. One excellent sample policy is available on the website of Dr. Keely Kolmes at https://drkkolmes.com/writing/social-media-policy/.

**Social Media Interactions with Clients**
Clients who participate in social media in their personal lives may naturally assume that they will be able to interact with their psychotherapist in this manner as well. Psychotherapists should consider social media interactions with clients carefully (e.g., accepting friend requests from clients) and think of online relationships as similar to in-person ones. Social media interactions with clients should be considered as boundary and multiple relationship issues, with particular attention being paid to the potential for inappropriate self-disclosure on the psychotherapist's part. Younggren and Gottlieb (2004) provide the following questions to ask oneself when considering if entering into a second relationship with a client is advisable:

1. Is entering into a relationship in addition to the professional one necessary, or should I avoid it?
2. Can the dual relationship potentially cause harm to the patient?
3. If harm seems unlikely or avoidable, would the additional relationship prove beneficial?
4. Is there a risk that the dual relationship could disrupt the therapeutic relationship?
5. Can I evaluate this matter objectively?

It is recommended that psychotherapists consider such issues prior to them arising. Developing a social media policy and reviewing it with each client at the beginning of treatment will help establish appropriate boundaries and expectations from the outset.

**Assessing and Responding to Clients' Treatment Needs**
As with in-person treatment, it is important to assess each new client's treatment needs and ensuring that we possess the needed clinical competence to assist each client. Additionally, we want to confirm that *how* we are providing treatment will be consistent with their treatment needs. This includes the use of telepsychology. Not all clients can be effectively treated via telepsychology; some may need inpatient or another level of treatment that cannot be offered virtually. Some clients may be better treated via one telepsychology modality over another, and the most appropriate option should be recommended (e.g., video conferencing, telephone, e-mail, or text messaging). Of course, access to the recommended technology must be considered as well. While videoconferencing may be optimal for a particular client, if that client does not have access to the Internet, this will not be a viable option and the use of the telephone may be an option to consider.

Confirming each client's location at the beginning of the professional relationship is important for several reasons. In addition to confirming licensing requirements, there are clinically relevant issues to consider as well. Psychotherapists should be prepared for possible client crises during the course of treatment. While some crises may be addressed directly with the client online, knowledge of resources in the client's local community is essential. Since some online clients will not be located in one's local community, some research will need to be done at the outset of treatment to learn of emergency resources in their community.

**Addressing Confidentiality**
Psychotherapists should use all available means of protecting each client's

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confidentiality. This includes using virus, malware, and firewall protections and keeping them up to date. Further, when notified of the presence of an update to the operating system one is using, it should be downloaded immediately. Often, these updates are fixes to gaps found in the system's security and are essential for protecting confidentiality.

Educate clients about threats to confidentiality associated with telepsychology. This includes technological issues and the physical setting where they will be during sessions. Ensure that each client is in a location where privacy can be maintained during the treatment session and where the risk of interruptions will be minimized. It may be helpful to have the client scan the room with their video camera so you can see the setting in which they are located during the psychotherapy session. When working with children and adolescents, it may be especially important to do this to ensure that family members are not present but off-screen during the session.

Clients should also be informed of the risks inherent in the use of public WiFi for their internet connection. It is strongly recommended that password protected WiFi be used due to the lack of security with public WiFi. When using e-mail to communicate with clients, encryption is recommended due to security risks associated with e-mail use. At a minimum, each psychotherapist's electronic devices should be password protected. Beyond this, the use of multi-level authentication is recommended where after entering one's password there is a multidigit code sent to one's cellphone or through one's e-mail that also must be entered. Further, all treatment records must be stored securely and similarly protected from unauthorized access.

**Apps**

Mobile mental health applications (apps) for smartphones and tablets are widely used, with more than 10,000 of them available at present (Marshall et al., 2020). Many clients may be utilizing them prior to entering psychotherapy and at times psychotherapists will want to recommend their use to clients as an adjunct to psychotherapy. But not all apps are created equally and very few have been studied for their usefulness or effectiveness, with many not providing intended results and some being counterproductive to treatment goals (Wasil et al., 2021). One recent study found that only 2.08% (21/1009) of available psychosocial wellness and stress management apps have published, peer-reviewed evidence of feasibility and/or efficacy (Lau et al., 2020). It is recommended that psychotherapists ask each client about any app use and for those used by clients, to download the app, try it out to assess its relevance and usefulness, and see what research, if any, exists to support its use. Psychotherapists should endeavor to recommend apps to clients that have empirical evidence for their use and that that are likely to support the work being done in treatment.

**Additional Guidance**

Telepsychology has many potential benefits, to include providing clients with access to needed psychotherapy they might not otherwise have been able to receive. It also presents several challenges to include the technology, ethics, legal, and other issues addressed above. While the APA Ethics Code is being revised, at present it does not specifically address telepsychology other than stating that the Ethics Code applies to all professional services provided regardless of the medium used. Psychologists are referred to the APA Telepsychology Guidelines (APA, 2013) for additional

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guidance on the issues addressed in this brief article. An additional useful resource is the APA's Office and Technology Checklist for Telepsychological Services (APA, 2020).

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# Membership in Professional Organizations: Benefits and Recommendations

*Nicholas R. Morrison, Ph.D.*
*Westfield State University*

*Rebecca M. Ametrano, Ph.D.*
*Boston University School of Medicine*

Oftentimes, guidance around professional development can be circumscribed to a particular domain of psychology (e.g., clinical practice, research, teaching) or area of focus (e.g., internship opportunities, considerations in telehealth). We would like to broaden this guidance to talk about professional development in the context of becoming involved in professional organizations. The two authors of this article are both active members of Division 29 (Society for the Advancement of Psychotherapy) of the American Psychological Association (APA) and were members of the same clinical psychology doctoral program.

As early career psychologists, we would like to reflect upon how we have contributed to professional organizations and how we have benefitted in return; we will use our experiences within Division 29 to identify concrete examples. Although we anticipate engaging in professional service throughout our careers, we would like to reflect on our joint experiences to impress upon graduate students and early career psychologists the tangible benefits of professional service and membership in professional organizations.

**Getting Involved Early**

As early career psychologists, it is still quite clear which aspects of our clinical and academic training contributed to the successes that led us to where we are today. Any graduate student can readily describe these various facets of training, including didactics, practica, clinical supervision, and research mentorship. However, one of the under-recognized (and under-utilized) components of graduate education is professional development in the form of experience with professional organizations.

Perhaps one of the simplest ways to become exposed to professional organizations during graduate school is through the award process. Unless the graduate program and/or the student's mentor bring awareness of the various awards and grants offered by professional organizations, students may not consider these opportunities. We would encourage students to look broadly at professional organizations that are consistent with their interests. For example, students might consider reviewing the various Divisions of APA and see what piques their interest. We would also encourage students to recognize that professional organizations offer all sorts of award opportunities. For example, in addition to the four student research paper awards offered by Division 29, it also offers a Student Excellence in Practice Award and Student Excellence in

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Teaching-Mentorship Award. Each author of this article was fortunate enough to have been awarded a student research paper award, which laid the groundwork for our involvement in Division 29. These awards are on top of the grant opportunities available to students. It does not matter whether your interests are in teaching, research, or practice, professional organizations offer awards as an excellent first step to become acquainted with institutions outside of the graduate program.

Once a student has found a professional organization that maintains values and priorities consistent with the student's, the student might consider becoming involved with committee work. For example, Division 29 offers a particularly salient opportunity for students through the Student Development Committee. This committee is what gave this author (NRM) his start in professional service! However, we would encourage students to remain open to other committees they may not have previously considered. Committees are regularly looking for the fresh perspectives that students bring to the mix, and student participation on the Membership Committee, Education and Training Committee, or any of the other Division committees is a win-win for both the student and the Division.

So why would a student want to consider participation in one of these committees on top of their graduate school responsibilities? In addition to the new line on the curriculum vitae, a number of benefits present themselves. First, the student develops a host of new network connections. This author (NRM) was a former Student Representative and Chair of the Student Development Committee, and in this role was able to interact with psychologists involved in primarily practice-oriented careers or teaching-oriented careers. As someone who was grappling with what to do with my career upon graduation, the ability to speak with psychologists outside of my program who were engaged in the day-to-day tasks of roles I was interested in pursuing was invaluable. Additionally, participation in committee work afforded me the opportunity to develop leadership abilities in the context of professional service. It cannot be overstated how helpful it can be to hear perspectives from those at diverse programs and/or stages of life, and to brainstorm creative solutions as part of a team. This work has been foundational as I (NRM) consider the role of service in my current position as a tenure-track assistant professor.

**Early Career Opportunities**

When transitioning from graduate student to early career psychologist (ECP), the opportunities for involvement in professional organizations expand further. For example, as an ECP member of Division 29, one has the chance to become involved in Division leadership through serving as a Domain Representative (an elected position) or being appointed as a Committee Chair. It is valuable to note, being involved in the Division early in training, as described previously in this article, can help facilitate moving into these leadership roles later. Opportunities often breed opportunities, which may be especially relevant in a somewhat small Division in which members are often familiar with one another and their respective work. I (RMA) was an active graduate student member of the Division. Once I completed my postdoctoral fellowship, I was asked to run for an open position on the Executive Board by a mentor who was also serving in a leadership role. I was subsequently elected to the position, and I feel confident that if I had not been an active student member, this

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opportunity would not have presented itself so early in my career (or possibly not at all). Following my service on the Executive Board, I had the chance to run for a Domain Representative position, which has allowed me to continue my involvement in Division work.

There are many benefits to becoming involved in professional organizations as an ECP. One of the key incentives is the ability to be involved in making policy changes at various levels of an organization. In Division 29, for example, serving in a leadership role allows for voting on Division issues like who should receive awards and grant funding each year or whether membership should be expanded to undergraduate students (an initiative that author NRM spearheaded). Further, being part of Division leadership also allows for input into higher level APA decision-making and policy changes, such as by providing feedback about the organization's strategic plan, through endorsing APA presidential candidates, and assisting with yearly convention planning, to name a few.

Another benefit that comes from participation in professional organizations as an ECP is the potential for professional advancement. Being involved in committee work and/or being elected to leadership roles can help bolster tenure packages for those in academia and may lead to financial incentives for those working in medical centers or the private sector (both of which are true for the writers of this article). For those in private practice, the diverse network of professionals on the Board can help to increase referrals through networking.

As was discussed in the context of student involvement in organizations, professional networking is also a fundamental benefit of being involved as an ECP. Connecting with individuals across settings, institutions, and geographic locations can have wonderful professional benefits (e.g., help to identify mentors or mentees, learn new skills, partner together on projects, increase access to job opportunities, gain new ideas/perspectives, etc.). When I (RMA) served on the Executive Board of the Division, I acquired many new leadership skills that contributed to my later advancement into a Training Director role at my current institution. Further, if one is in a leadership position within Division 29, there is often the chance to attend an in-person board meeting at least once per year. This affords the opportunity to connect face-to-face and work strategically over the course of several days on Division tasks as well as other professional projects, which can be invaluable for professional development. For example, I (NRM) am in the beginning stages of starting a private practice; given the networks I was able to establish through my committee work, I was able to reach out directly to multiple middle- and senior-career psychologists I had collaborated with on projects for recommendations regarding the start-up of my business and recommendations for resources and best practices.

**Recommendations and Conclusions**

In light of our experiences, we have several recommendations for those interested in professional service and those who mentor them. First, for mentors, we would encourage you to serve as a role model for your mentee. If you are mentoring a graduate student, consider setting aside time to explicitly discuss professional service opportunities. If you direct a lab or practice in a niche clinical area, consider generating a spreadsheet with awards and professional opportunities former students have pursued over the years. These mentorship opportunities can continue beyond graduate

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school as well. We would encourage senior colleagues to involve junior colleagues in their professional organizations. This may be especially helpful for ECPs who have transitioned into a job or role that includes skill sets they may not have developed in the past (e.g., assistant professors new to teaching/advising, clinicians new to practice in a primary care setting). Help them to consider the resources and benefits that come from involvement in professional organizations they may not have previously considered.

Lastly, for all individuals in the field, across all levels of training and career stages, we encourage you to get involved. We did not expect to take the professional trajectories that we did but have been grateful not only for the benefits of professional membership in organizations like Division 29, but also for the privilege of what we have been able to give back. We encourage openness to new experiences within professional organizations and participation throughout one's career. We hope you will consider this tradition of service in our field!

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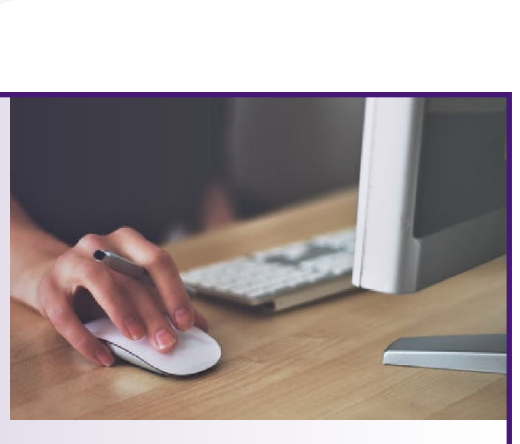

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# FEATURE

## Revisions to our Ethics Code: A Work in Progress

*David Jull-Patterson, PhD*
*California Northstate University*

We live in interesting times, professionally, with the revision of the *Ethical Principles of Psychologists and Code of Conduct* ("Ethics Code" or "Code") currently underway. This document forms a foundational function of our work, and its changes provide us an opportunity to evaluate our profession from the viewpoint of where we have been as well as where we want to go and who we want to be. As former APA president Jessica Henderson Daniel described when she announced the membership of the task force charged with conducting the revision, "The task force is charged with creating a code that is transformational and that remains a leading practical resource regarding ethics for psychological science, education and practice while retaining those aspects of our Ethics Code that serve the public and our discipline and profession well" (APA, 2018). The Ethics Code Task Force (ECTF) is approximately halfway through its work, and as the liaison to the ECTF from the California Psychological Association, I'd like to give you a glimpse of how the task force has incorporated its charge, the areas that are being reviewed and revised (the last such comprehensive effort was completed in 2002), the current state of the work…and how you can influence the direction the new code will take.

In a presentation to the APA Council of Representatives meeting that took place during February 26–28, 2021, the ECTF chair, Linda Campbell (2021) provided an update on the first two years of the task force's work. She contextualized the work as having three major functions: (1) revising the code so that it is visionary and transformational; (2) taking a collectivist approach, considering context, culture, family, community, and society; and (3) creating a fundamental resource regarding ethics for psychological science, education, and practice. With those in mind, the ECTF started their work by doing an environmental scan, tracking the ethics trends and occurrences in APA's internal and external environment. This was accomplished by soliciting comments from APA Boards and Committees, APA divisions, ethnic minority psychology associations, state provincial territories, state, provincial, and territorial psychological associations, and The Association of State and Provincial Psychology Boards. They also reviewed psychology and other health professions' ethics codes from around the world, as well as the APA guidelines. In particular, they reviewed both the population-focused guidelines (i.e., guidelines on working with persons with disabilities (APA, 2012)) and the skills-focused guidelines (i.e., guidelines on child protection evaluations (APA, 2013)) to see what recommendations they might find that could possibly be moved from aspirational statements into enforceable standards.

I mention this background because it provides an important context within which to examine the proposed changes to the ethics code so far. For instance, there are now eight principles (an increase from the current five principles)

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that provide aspirational direction for psychologists: Beneficence and Nonmaleficence; Human and Civil Rights; Integrity; Interrelatedness of People, Systems, and Environment; Professionalism and Responsibility; Respect for the Welfare of Persons and Peoples; Scientific Mindedness; and Social Justice. Some of these are in the current code, while some, like the ones focused on the environment and on social justice, are added to reflect the increased awareness on the organizational level of the salience of these issues for psychologists. As a liaison to the ECTF, at the end of each task force working session, I get to attend an informational meeting which is designed for the representatives of state associations, division representatives, and other liaisons from a variety of psychology-related organizations. During these times, the task force also asks the liaisons for their opinions on what they've heard as well as messages for the task force from the constituents of the organizations the liaisons represent. We heard about discussions within the committee about the designation and form of these principles, and we had similar discussions in the liaisons' meeting. I have noted that often a conversation at one liaisons' meeting will have an impact on the subsequent work of the committee. The responsiveness of the committee to feedback has been gratifying to see.

While there are still ten standards, there are shifts in the organization as well as topics. In alphabetical order, the ten new standards are: Assessment; Competence; Confidentiality; Informed Consent; Professional Responsibility; Psychotherapy; Intervention and Consultation; Relationship with the Public; Scientific Integrity and Research; Teaching, Training, and Supervision; and Technology. It is a coincidence that there are ten standards proposed for the new code, which matches the number of standards in the current code. One of the things that is different here is that the task force has worked to bring details currently spread across the code under one specific standard, i.e., Professionalism and Responsibility. This standard will address issues of confidentiality, multiple relationships, consultation, and competence. One discussion I've found very interesting is the focus on structuring the Technology standard in such a way that it will provide guidance about technological innovations that aren't even invented yet. This focus on creating a code that is visionary is particularly evident in the drafting of this standard, and it is a consistent approach throughout the work of the committee: make the code useful now as well as later and provide a resource for psychologists that is robust yet flexible.

There are three sections of the revised code that will be new. One is the inclusion of a glossary. This helps psychologists understand the meaning of words that may be defined in different ways by different psychologists. This glossary will provide a central resource where we can understand how the ethics code utilizes words, leading to less ambiguity in comprehension and application. A second section provides a specific ethical decision-making model. The task force is reviewing a number of models (and there is no shortage of these) to glean what is most helpful about them. The model that is ultimately used in the revision may be something already designed, or it may be an amalgam of different models that task force members design specifically for inclusion in the code. As a professor, I am very enthusiastic about this addition; students (as well as licensed psychologists) don't always utilize a way to think systematically about an ethics conundrum they are experiencing. The provision and uti-

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lization of a decision-making model helps us address difficult situations in a way that is thorough and thoughtful.

The third new section is actually something that will be interwoven throughout the standards. The task force is planning to provide a short explanation about how each standard is an expression of different principles, as appropriate. One of my favorite classroom activities during an ethical case discussion is to ask my students to identify the principle that is being expressed in a standard. This helps them understand how the aspirational principles are incorporated in the enforceable standards. By adding the explanatory section to each standard, the ECTF assists all psychologists in refraining from taking a "floor approach" (Handelsman et al., 2005) to our ethical thinking and maintaining an aspirational orientation to our work. It will also provide a context that deepens our professional approach and lead to more ethically thoughtful responses to situations that may be confusing or problematic.

***You have a role to play.*** As I mentioned earlier, the work of the ECTF is about halfway finished. You have an important part to play in that work by providing your own ideas, questions, opinions, and experience to the task force, thereby improving the revision of our ethics code. I've mentioned that the task force seriously considers the feedback they are presented, and that process continues. Consider the areas where the code has been less than helpful to you or provided exactly the guidance you needed. Let the ECTF know about that, how you envision a change, or ensure a specific section is kept in the new code. This ongoing constituent provision of feedback during the revision process is unique, and I hope that each of you will contribute your own perspective on a document that informs your work daily. Your questions, concerns, and recommendations are taken seriously by the task force members, and your voice will join a chorus of psychologists dedicated to making the next ethics code a document that is responsive to our needs while providing guidance in ethically complex situations. You can use this link: https://www.apa.org/ethics/task-force/code-revision-feedback to provide the feedback, and I encourage you to do so. Be part of the change you would like to see.

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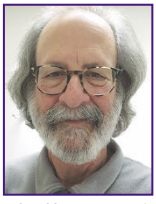
Society for the Advancement of Psychotherapy

# FEATURE

## Comments on Doing Video Psychotherapy

*Steven J. Hendlin, Ph.D.*



It has been about two and a half years since the beginning of COVID, which mandated the suspension of in-person psychotherapy contact, forced the rapid closing of offices, and ushered in a mass migration to video psychotherapy. For some colleagues, the change has become permanent, as they have terminated their physical office leases and are now dedicated solely to video practice. They view the change as a positive one, allowing them to practice from home with a greater degree of freedom to create a better work-personal life balance and save the costs of office rental and related expenses.

In focusing on greater freedom and flexibility, it is easy to overlook or minimize some of the adjustments necessary for video psychotherapy to be effective. And it is also easy to lose consideration of what may be sacrificed therapeutically by not meeting patients face-to-face in an office setting, especially for those whose theoretical orientation and practice tools hinge on in-person contact.

After 43 years of doing psychotherapy face-to-face in a private practice office setting, it was an abrupt and unwelcomed adjustment for me—as it was for many—when COVID forced us to rapidly learn to work through video platforms. For those of us who hadn't been conversant with online video interaction, it required learning new tools, like Zoom, in order to make the transition. Considerations such as contracting with new patients, digital payment, lighting, camera location, beginnings and endings of an hour, family and pet distractions, background screens, personal appearance, and various technical interruptions and glitches that may occur as part of the digital connective process all had to be faced and resolved for the sessions to be productive.

**Positive Aspects of Video Psychotherapy**

1. *Convenience and safety.* Some patients, especially those who were already conversant with online video platforms through their work, welcomed meeting this way. They no longer had to drive to my office. This, combined with no longer commuting to their physical office space, made staying safe from COVID easier and work more convenient. The convenience became so pronounced over the last two years that companies of all kinds are now having challenges getting people to come back to the physical office. We hear of cases where some have quit their jobs if their employer refused to let them continue working online from home, at least part of the week.

Some longer-term patients initially missed the direct interaction of meeting in the consulting room. But in the early months of the pandemic, when the initial shock and fear of contracting COVID was at its height, they didn't have the luxury to think about what may be lost by not meeting in person. Most quickly adjusted to the increased ease of not having to leave their home. Meeting online became welcomed, and most did not complain of any less value in losing

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the in-person contact between us. The only people who mentioned it were new patients who were forced to have their initial sessions via Zoom. These people were asked to fill out intake forms online and return them, and to pre-pay for the initial session instead of paying by check, as they normally would, after the intake hour in the office.

Another unanticipated convenience of the switch to video psychotherapy has been the method of payment for treatment. Before COVID, I was paid almost exclusively by personal check or cash, as I do not accept credit card or insurance payments. After COVID, I began using Zelle, which is a direct bank-to-bank payment offered by most major banks. Now, my practice is nearly one hundred percent payment through Zelle. While it is faster and more confidential since I no longer have to drive to the bank with hard-copy checks, it does require monitoring to ensure the digital payment is made. Since my standard policy is for patients to pay at the time of service, this was not asking them to pay any differently than usual. It did mean explaining to patients how to pay through Zelle just before or after a session. I do not like to keep track or follow up on who hasn't paid, and, with occasional reminders, patients have all been compliant in paying in a timely fashion.

2. *Greater Geographical Access to Psychotherapy Services*. The pandemic acted as a lightning bolt, igniting the geographical broadening of psychotherapy. Suddenly, a much larger pool of licensed psychologists and mental health professionals of all stripes were available to deliver online services. Intra-state and inter-state laws and licensing board guidelines were loosened to address the crisis. Remote areas of the United States that had little or no access to in-person services could now find a psychotherapist from the comfort of their own home. Now that technology has brought everyone with cable or digital phone line access, this "quick and easy delivery" model enabled anyone who wanted services to obtain them.

One of the basic issues now being hashed out by stakeholders is how various mental health providers, state and federal laws, and ethics organizations will try to regulate a technology that I do not believe was meant to be contained by state boundaries. The beauty of the internet is that, with sufficient bandwidth, I can talk to you from your home in Switzerland and see and hear you as if you're down the street. *If ever in human history there was a technology that transcended artificially drawn state, national and international borders, the digital/ethernet world is it.*

So, if psychologists—often more careful and overly self-regulating and self-restricting than other professions—try to limit who can see a patient in another state and grant rights only to those who pass their requirements, the profession again risks being left behind, as other professions throw caution to the wind and let the ethical chips fall where they may. This, in fact, is what is already happening. Those designating themselves as coaches, counselors, or various other licensed and unlicensed providers will work with anyone anywhere and not feel restricted by state, national, or ethical concerns.

*3. Seeing patients in their "natural habitat."* In the initial sessions following the switch to video therapy, some patients were eager to show me their home surroundings. Using a cell phone for his connection, one walked through his kitchen, which was under renovation and had been a topic of his concern.

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Some showed off their pets. Seeing how they relate to their dog in real-time is more powerful than just watching a cell phone video of it. In fact, it made me begin to wonder how beneficial it might be to have *all* patients show me around their house using a cell phone. I would have access to a slice of their life in a way that is more "real" than what they may *tell* me about how they live and the fantasy I may construct from it. Some worried about whether their office space or wherever they were sitting was clean and orderly and whether I might judge them for being sloppy.

One long-time patient allowed her adolescent children to walk into her office and interrupt the session on a few occasions. Since one of her challenges was in setting and maintaining boundaries in the home for her kids and having them respect those boundaries, she demonstrated in front of my eyes how this was played out by not keeping them out of her office during our sessions. Watching kids come through the door with no regard for interrupting their mother when she was online was far more revealing than being told about it. I then used this interruption to discuss why she wouldn't lock the door so they did not have access during her work or a session.

Some wanted to show off art objects or furniture in their office or other rooms in the house that they were proud of and wanted me to see. This would have been possible *in vivo* had we not been doing video therapy.

While I do not allow eating during an in-office session, some would nibble during an online session. While I chose not to comment on their eating, I did make a mental note of it. It became obvious that the level of comfort in their own homes changed some of their habits during our sessions. As was common during the pandemic, most everyone dressed more casually for video sessions, wearing clothes they would not be wearing in an office visit.

4. *Viewing my own behavior in real-time.* I use a desktop iMac in my home office and fill most of the 27-inch monitor with the Zoom interface. I open two equal-sized windows, either stacked or side-by-side, one showing the patient and one showing myself. What was new for me compared to in-office sessions was the ability to glance at myself and notice my reactions to statements by the patient. For example, I noticed a slight smirk of my mouth when I heard something that sounded questionable. I knew that I made this smirk in the office but was never able to actually see it in action as I could on the screen. I also noticed an occasional tilt of my head when listening. So, immediate visual feedback of oneself while interacting clearly is one of the positives of video contact. One may see on the screen forced smiles, over-emotional reactions, fidgeting, and distractions that would not be visually reflected in real-time in the consulting room.

5. *Revealing my personal home office space.* I made the decision not to use one of the prefabricated static background privacy screens available on Zoom. The background in my home office is made up of a floor-to-ceiling wall of built-in bookshelves. The shelves are filled with books, rows of journals, and personal memorabilia, including photos. For the first time in my career, I chose to share this home office background. While it still appears professional, it does reveal more personal objects than patients would see in my office consulting room. Almost no one has commented, except to be surprised at what appears to them to be a vast library collection. I would label this personal revelation of my home library a

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minor positive resulting from video psychotherapy in that it did show patients something about my personal possessions that they otherwise would not have seen. I have no bookshelves in my away-office, so seeing my home office bookshelves may at least leave an impression that I have done some studying and reading in my life.

6. *Increased flexibility in location and scheduling*. As mentioned, using video therapy offers flexibility for patients. They may choose to connect via desktop, laptop, or phone. They may be sitting in a home office, outside on a patio, in a closet for privacy, or in their car. Because I only use my desktop at home for video sessions, it is not as flexible for me. In fact, because my desktop is in my home office, doing video therapy has now required more careful planning on my part. I must coordinate the scheduling of in-office sessions and the scheduling of video sessions in my home office. Fortunately, my home office is a few minutes away from my outside office, so it is not all that challenging. The positive aspect of this is that I end up with a greater window to schedule patients for video therapy, sometimes meeting earlier in the morning that I normally would in my outside office setting. This results in greater accommodation to patient preferences in scheduling.

7. *Recording of sessions for analyzing interaction*. With Zoom, it is possible to record sessions. So far, I haven't used this feature. But as a training tool, having it available is a plus, since it is not as easy to employ in my away-office. For graduate students being supervised,it could surely be a valuable adjunct in the psychotherapy learning process.

8. *Paradoxical sense of intimacy and distance*. When I asked my wife, also a clinical psychologist, how she experienced the difference between video therapy and being in the office, she said that she felt both a sense of intimacy and distance online. Intimacy, in the direct camera to camera, face-to-face focus, where it is easier to make eye contact with patients because you are looking directly at their face rather than their whole body, as you would in the office. However, the eye contact on the screen is not as direct or penetrating as it would be in person. As mentioned, there is also the intimacy of being invited into their home, where they are sharing something of their personal space. And distance, in the sense that they can't see how you are dressed from the waist down and you are not "exposed" in the same way you are as in the stimuli in the consulting room. What is lost, of course, are the body movements that would help convey a more complete picture of their reactions to the interaction.

**Negative Aspects of Video Psychotherapy**

*1. Technical glitches*. The most obvious and persistent negative of doing video psychotherapy is the interruption caused by audio and video glitches in the online connection. Because of poor signal location, not fast enough computer speed or enough memory, simultaneous over-use of the bandwidth by family members, or other reasons, the lags of speech and freezing of the video picture can compromise the best efforts being made by both patient and therapist.

These interruptions interfere with the focus on the conversation and attenuate the typically smooth back and forth interaction between patient and therapist that occurs in the office consulting room. For example, there have been times when the freezing of audio or video has been bad enough that we had to terminate the connection and resort to speak-

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ing on the phone. Too often, short glitches have meant filling in the patient's words by using context to decipher what has been lost. This requires attention focused on understanding the meaning of what is being said rather than enhancing the quality of contact with the patient.

While these glitches may occur on any platform being used by therapist and patient, they seem to happen more often with patients using a cell phone for their connecting device. For example, wanting privacy, some choose to have our session using their phone from their car. While the use of the phone was convenient for them, it tended to have technical glitches associated with it, as patients would be parked in places with poor cell reception. This meant interruptions in the contact, which made more intense focusing on content problematic. It also meant that every time a call came into them during our session, the picture would go off until the call was ended by the patient. Most seem to value the ease of having the session where they choose more than worrying about technical glitches. But there is no question that interruptions like this—especially when they repeatedly occur throughout a session—limit the patient's ability to focus attention compared to not having to deal with this in a quiet and undisturbed office setting.

Sounds from the desktop or laptop announcing newly arriving emails, texts, or other kinds of application pop-ups are another distractor for both patient and therapist. These distractions, while not as severe as loss of sound or picture freezing, still limit one's ability to concentrate. Lighting, shadows on the patient's face, the focus of the camera, and other details that are part of online interaction all become potential issues that rarely, if ever, become considerations in an office consulting room.

2. *Loss of pre-session preparation.* Patients tend to mentally prepare for their sessions. One of the reasons for having consistent sessions on the same day and time on a weekly basis is that they can anticipate the session and organize their thoughts around topics of concern. Part of this forethought takes place driving to the session and sitting in the waiting room. This forethought is less likely to happen when they are busy with video-conferencing meetings or household chores prior to our session. Many come to the video session with their attention still on whatever project they had just been working on. Because it may take some time to become fully present, this tends to make for less organized and productive digital sessions.

3. *Restriction of therapeutic experimentation.* If your theoretical orientation is one in which you help focus the patient's attention on here-and-now behavioral experimentation, your ability to do this will be hampered by not being in an office face-to-face with the patient. For example, doing Gestalt "empty-chair" work will be difficult and awkward via a video screen compared to being in an office. While the video camera keeps the patient's face in full view, much of the rest of the body is not viewed. Making comments on nervous gestures, breaks in eye contact, reactions to the therapist, and various suggestions for experiments for the patient to try all will be impossible or at least more difficult to do through a video screen. While the greater number of psychotherapists practice from some form of cognitive-behavioral perspective, those who are more eclectic in approach may find that their bag of therapeutic tools is limited by not being face-to-face in an office setting with the patient. Even simple experimentation, like showing a patient a relaxation breathing technique, will be more trying via a screen.

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I have found it useful to notice how the patient glances around the office, looks at the artwork, averts eye contact when uncomfortable, or moves their eyes up to a corner quadrant when deliberating. Due to room lighting, eyeglasses, shadows, glare, or other factors, much of this is not going to be readily visible to me when on video. While some of the information may be noticed, interrupting the flow of dialogue to point it out to the patient is clearly more trying when online. This discourages a therapist with an experimental orientation from utilizing these skills and tools.

4. *The healing power of embodied presence is diminished.* What I have noticed in the last two years of doing video psychotherapy is that my own embodied presence—the patient's sense of my physical and mental energy or "vibration" in the room and its impact—simply is nowhere near the same as meeting in person. Some of my presence will come through the video contact, but it just cannot compare to our meeting in the office. Does the convenience to the patient of not leaving the comfort of their home outweigh the impact of my presence? Many would say it does. But this loss is of concern to me, especially for those who are contemplating or have already given up their physical office space and made the switch to doing only video psychotherapy. *When you give up your power of embodied presence, you give up one of the important healing tools of the psychotherapy relationship.*

**Should You Give Up an Outside Office?**

There are now a growing number of mental health companies offering "counseling" or "coaching" online via email, video, text, cellphone apps, and phone contact. They appeal to mostly younger generations who grew up online and are comfortable utilizing services in which they never actually meet in person the "service provider" with whom they may be engaged. These services are usually at a low to moderate cost. They all are taking advantage of what is possible when personal problem solving, advice giving, and various techniques and mental, emotional and spiritual tools may be transmitted via telehealth-video rather than in person. Because so much of our lives are now lived digitally in some form, it has lessened the perceived importance and necessity for personally meeting with people in an office setting.

What impact is this having, and will it have on how psychotherapy services are delivered? Is it the wave of the future as young and old psychotherapists alike march inexorably toward the *metaverse*, in which we spend more of our lives in a digitally created world than we do in the real world? Is it a good idea for people to be investing time and money in the metaverse, where you can actually pay large sums to own a restaurant, gas station, shop, building, or home in a "desirable location" in what is a captivating make-believe world? Teens and young adults are flocking to lose themselves in this digital world, as they tire of the daily challenges, perceived or actual failures, and disappointments in the real world. While it is certainly understandable they may be disgusted by what they see in the real world, why not orient them to try and make it better to live rather than escape it through a headset that whooshes them away into an artificial world? It is one thing to spend some time engaged in "social media," play games online, or even use the virtual world to help deal with psychological issues. It is another to transition to a greater commitment of time, money, and emotional investment in the realms of virtual and augmented reality than is made in the everyday world.

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You can bet your digital dollar that the very same real-world issues that disgust those flocking to the metaverse will raise their ugly head in the metaverse. For example, there are already reports from women that their initial entrance into the virtual world may be threatening. Their avatars are being accosted as soon as they enter a scenario with male avatars. Males offer them liquor and ask them to loosen their self-protection by turning off the physical safe space around their avatar, which then permits them to be accosted by the male. Assault, abuse, and even rape are how they are welcomed into virtual reality.

My point is that if the world we live in is likely to become more digital and less actual, the transition from a physical office to a digital video connection is consistent with this movement.

If you are toward the later part of your practice career or practice in a more rural area, it may make economic and practical sense to eliminate a physical office space. But until there is no further "face validity" in maintaining a physical office, it is premature to make the move simply because the pandemic pushed us into video psychotherapy. One of the ways psychologists may distinguish themselves from the torrent of online providers is by offering a physical office presence to meet in person. Having an office is a sign of integration into the local community, offering a presence that signifies a commitment to practice and to offering the fullest possible array of ways to meet and provide psychotherapy. Up to now, not having a physical office has connoted not being integrated into one's community. We'll see how this may change over the next few years, as the pandemic hopefully has less influence on how we meet with patients.

I will not be on the planet long enough to see how much influence the digital world ultimately has on our lives and on the practice of clinical psychology. Perhaps it's because I've been in the full-time private practice trenches for the last 45 years, but I can't imagine that what comes through a Zoom video screen could ever be as powerful as what happens face-to-face in the office. Maybe virtual and augmented reality will come close to duplicating it as we strap on the headset and take a ride into the wild make-believe made oh-so-real. And the next generation of psychotherapists may never know the wonder of what happens when the chemistry is right in the consulting room.

***Steven Hendlin is a clinical psychologist and author in Newport Beach, Calif.***

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# FEATURE

## Involving Concerned Others in the Treatment of Suicidal Patients

*Samuel Knapp, Ed.D., ABPP*

Suicides occur from a congruence of many factors including the quality and amount of social support an individual receives. Fortunately, several treatments have strong support for their effectiveness in reducing suicide attempts including cognitive behavior therapy, dialectical behavior therapy, and the collaborative assessment and management of suicide among others (Calati & Courtet, 2016). Whatever intervention psychologists use, however, they need to consider the role of family members or significant others (concerned others) in psychotherapy. Often the involvement of concerned others can make the difference between an effective and futile intervention. But psychologists need to decide carefully if or how to involve concerned others because some might not have the desire or skills necessary to help the patient and others will only be able to help if the psychologist guides them appropriately. This article will first review the importance of social relationships for suicidal patients and then consider when and how to integrate concerned others into treatment.

### Interpersonal Relationships and Suicide

Loneliness increases the risk of suicide (McClelland et al., 2020). Married persons have lower rates of suicide than unmarried persons (Øien-Ødegaard et al., 2021). When identifying their reasons for living, suicidal patients often identified their obligations to others, their responsibility to their children, or even their concern for their pets (Bryan, 2021). Interpersonal stressors often precipitate suicide attempts. Stone et al. (2018) identified relationship problems as precipitants in 42% of all suicide attempts. These precipitants could involve the loss of a relationship (e.g., physical relocation, separation, divorce, death), the threatened loss of a relationship, or a decline in the quality of the relationship such as could occur with arguments with loved ones. Suicide notes often reference loneliness (Synnott et al., 2018). Poor relationships involving lack of closeness, hostile or critical comments, or partner abuse may increase the risk of suicide (Kazan et al., 2016). Given the close connection between loneliness, interpersonal strife and suicide, it is not surprising that the interpersonal theory of suicide focuses on relationships including *perceived burdensomeness* (the perception that "one is a burden to others and that one's friends, family, or society generally would be improved if the individual were to die;" Tucker et al. 2018, p. 427-428) and *thwarted belongingness* ("a perception of a lack of desired, reciprocally caring relationships and an unmet desire to belong;" Tucker et al., 2018, p. 427).

### Integrating Concerned Others into Suicide Interventions

Given the strong link between social relationships and suicide, it makes sense that psychologists consider involving

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concerned others into the treatment of suicidal patients. Concerned others can urge patients to get into or to stay in psychotherapy, participate in the development of the patient's safety plan and lethal means counseling, offer distractions that could help interrupt suicide crisis states, monitor patients who are in a suicidal crisis, provide a sense of belongingness and reasons for living, offer emotional support, give practical assistance, or give feedback on how the patient is progressing in psychotherapy. Patients often indicated that the involvement of others was pivotal in keeping them alive, although some said that it could be harmful as well (Hom et al., 2020).

**Whether to Involve Concerned Others in Treatment**

Some patients may not wish to involve others for reasons reflecting their misperceptions or distorted beliefs. For example, some patients may not wish to burden others with their problems. This may reflect a sense of perceived burdensomeness, so it is especially important for psychologists to discuss this with their patients as well as other nonrational reasons for rejecting the involvement of concerned others.

At other times patients may not wish to involve family members or others who have shown insensitivity, a lack of concern, or malice toward the patient. In extreme cases they may have harshly criticized, bullied, or physically abused the patient. Or they may endorse stigmas associated with suicide, such as the belief that suicidal persons are selfish or cowardly, or that people should manage their problems by themselves and not go for treatment (Hom et al., 2020). Even well-meaning family members may cause more harm than good if they believe in the tough love approach, overstep their boundaries, or act in hurtful, intrusive, or unwelcomed ways.

As with all major decisions in psychotherapy, psychologists need to consider the perspectives of their patients very highly. Psychologists should overturn the wishes of the patient to involve concerned others only under extreme circumstances, such as when involving them would be the only way to ensure the safety of the patient and other means to ensure safety are not feasible.

**How to Involve Concerned Others**

If psychologists and patients decide to involve concerned others into psychotherapy, then they may wish to discuss the goals for the meeting before it begins. Psychologists need to orient the concerned others to their role in psychotherapy which is to benefit the patient. If psychologists anticipate that the concerned others will be involved frequently in psychotherapy, then they may wish to describe to all parties how they will manage communications with the concerned other. Psychologists might say, for example, that they accept information from the concerned other if the patient gives consent. But psychologists should not promise that they will always keep all information received as confidential and withhold the source from the patient. Psychologists do not want to be in a situation in which concerned others gave crucial information about the patient and then added the caveat—"but don't tell him I said so." Conversely, concerned others should not be in a position where they gave information expecting it to be held in confidence, but then were told that it will not be held in confidence. Many psychologists manage this situation by saying that they will disclose the information only if, on the balance, it is in the patients' best interest to do so.

When psychologists meet with concerned others for the first time, they may

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learn that they feel shocked (if they recently learned about the suicidal crisis), traumatized (for example if they saw their loved one attempt suicide), or relieved (that others have identified this as a problem that they have suspected). If their loved one has been suicidal for a long time, they may feel fatigue from dealing with their anxiety or anger. Psychologists may need to balance the acknowledgement of and respect for the emotional state of the concerned other with the need to focus on the wellbeing of their patients.

Bryan and Rudd (2018) suggested that psychologists offer patients the option of having a concerned other discuss their safety plan with them. Safety plans are collaboratively developed and brief interventions that guide patients on how to protect their safety when they fear that they will be entering into a suicide crisis state. Safety plans may include identification of signs warning of an impending suicidal crisis, reasons for living, distracting activities, persons to reach out to for support, lethal means counseling, and crisis response services.

Safety plans reduce suicide attempts by an average of 43% (Nuij et al., 2020). Also, patients tend to find that safety plans helped them. For example, three fourths of respondents found that "doing things with other people" was either "somewhat helpful" or "very helpful" in helping manage their suicidal thoughts (Simon et al., 2016, p. 1027). In addition, safety plans also include contacting others for support if the distracting activities do not reduce the suicidal crisis sufficiently. These may or may not include family members. An equal number of respondents found talking to family members as helpful as found it not helpful for them to manage suicidal thoughts (Simon et al., 2016), but talking to peers also helped many. Safety plans include the option of calling the psychologist or a crisis service so that the concerned others are not the only ones responsible for the patient's safety.

Lethal means counseling can be part of the safety plan or an activity that is conducted separately. The goal of lethal means counseling is to create a barrier between the patients and their preferred means of suicide. Because suicidal crisis states are usually time limited, by the time the patients have identified another way to kill themselves, the suicidal crisis has passed. Patients almost never substitute other ways to kill themselves (*means substitution*). Psychologists need to ensure that concerned others cooperate with the lethal means safety plans.

Psychologists could also involve concerned others in psychotherapy in other ways. Although relationships involve many complex issues, often suicidal patients benefit from learning how to express their distress and to inform their concerned others on how they might be helpful. For men, this may mean teaching them to diverge from the cultural stereotype of being independent and self-sufficient (Fogarty et al., 2017). Also, psychologists may need to address other communication issues because even well-meaning family members may come across as overly protective or intrusive, thus creating more friction. Negative communications, such as criticism, withdrawal, or escalating arguments can increase distress and exacerbate the risk of suicide. In a pilot study focusing on marital communication to prevent suicide, the veteran participants reported less suicidal ideation and less perceived burdensomeness (Khalifian et al., 2021).

Finally, if the concerned others are involved consistently in psychotherapy,

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questions sometimes arise as to how much the psychologist should focus on the wellbeing of the concerned others. Because the psychotherapist may show concern for their feelings and solicit their input it is possible that the concerned others may think of themselves as co-equal patients in the treatment and that the psychologist has fiduciary obligations to them as well as to the identified patient. So, if the course of treatment consistently veers toward the needs of the concerned other at the expense of the patient, then psychologists can gently remind them of their role which is to focus on the needs of the patients and discuss options for them to receive the treatment they need. Psychologists who decide to treat both a suicidal patient and their concerned other at the same time may find themselves in a conflict of interest. For example, the psychologist does not want to be in a position where they are treating a patient who wants desperately for the marriage to succeed while treating the patient's spouse who is equally desperate for the marriage to end.

**Summary Bullets**

- Concerned others can often, but do not always, contribute to effective psychotherapy.
- Psychologists should defer to patient preferences in whether or how to involve concerned others.
- Psychologists should focus on clarifying roles and expectations when involving concerned others in treatment.

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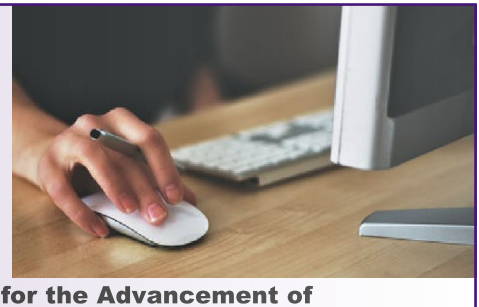

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# FEATURE

## Improving Programming for Military Families Using Community Based Participatory Research

*Abby E. Blankenship, Vanessa M. Jacoby, Carolina Gutierrez, Samantha Meek, Hyunjoon Choi, Geony Yoo, Allah-Fard M. Sharrieff, Stacey Young McCaughan, Alan L. Peterson, Ellen R. DeVoe, for the STRONG STAR Consortium*

Community-based participatory research (CBPR) is a scientific approach that involves engaging key stakeholders in the research process. CBPR enhances access, engagement, and responsiveness to behavioral health programming, especially for underserved or specialized populations with unique cultures and needs. The unique stressors associated with the deployment cycle (DeVoe & Ross, 2012) and the nuances of military culture make U.S. military families a prime example of a specialized population. The current study used a CBPR approach to understand barriers to engagement in a family prevention program designed to support active duty military families with deployment.

Approximately 3 million service members have deployed post-9/11 (DoD, 2016). The deployment cycle involves (1) preparation, (2) completion, (3) returning home, and (4) the reintegration period. The deployment cycle is a chronic stressor that can negatively impact each family member, as well as parental functioning, parent-child attachment, and family relationships (Institute of Medicine, 2010). Strong Families Strong Forces (SFSF) was originally designed as a post-deployment program and was found to reduce parenting stress and distress in a sample of National Guard/Reserve families following reintegration (DeVoe et al., 2016). A second randomized clinical trial was conducted with active duty military families (DeVoe, NCT03045159), focusing on supporting families throughout the entire deployment cycle.

Active duty military families have unique barriers that may limit their ability to participate in prevention programs, including long duty hours, frequent training, lack of support to attend non-essential appointments, and frequent deployments. To address the barriers associated with prevention programming, "weekend retreats" are made available (e.g., Davis et al., 2012). Condensed weekend formats aim to deliver family education while minimally interfering with military duties. Our research team adapted the SFSF 8-module reintegration program into a weekend retreat and conducted an open trial to determine if this delivery method was feasible and acceptable. Although 185 families expressed interest in participating in the weekend retreat, 16 families consented to participate, and only four families completed some or all of the retreat. Program attendees indicated "good" satisfaction with the program ($M = 3.5$ out of 4) on the Client Satisfaction Question-

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naire (CSQ-8; Larsen et al,. 1979). These findings indicated that while participants were generally satisfied with the program, the delivery method was not feasible. Given this, it was determined that a CBPR approach was needed to better understand and respond to the barriers to participating in family programming. Findings from this study will be used to adapt SFSF programming to be more feasible, accessible, and culturally attuned to active duty military families.

Our research questions included (1) What interested active duty military families in participating in a SFSF weekend retreat?; (2) What were the barriers to participating in a SFSF weekend retreat for active duty military families?; and (3) What recommendations do active duty military families have regarding how to engage and retain families to participate in a SFSF weekend retreat?

**Method**

Participants were nine active duty Army service members or their spouses who belonged to one of two groups: (1) participants who consented to participate in the SFSF weekend retreat but didn't attend the retreat, or (2) participants who had engaged in SFSF programming using the weekly standard delivery model.

Potential participants were contacted by phone and invited to participate in the study. All interviews were conducted by master's- or doctoral-level behavioral health providers, and eligible participants received compensation for their time. All interviews were recorded and transcribed. The qualitative interview questions were limited, open-ended, and designed to elicit responses to our research questions. The interview questions were as follows: What made you or would make someone interested in participating in a SFSF weekend retreat? Why did you decide not to participate, or why would someone decide not to participate in a SFSF weekend retreat? What do you think are the biggest barriers for active duty military families to participate in programming like SFSF? What recommendations do you have to better recruit and retain active duty military families to participate in a SFSF weekend retreat?

The study used a general inductive approach (Thomas, 2006) which is a commonly used strategy for the qualitative analysis of a program or intervention in health and social sciences. The transcripts were repeatedly read by a doctoral-level psychologist (A) and a bachelor's-level research assistant (B) to develop upper-level categories which were derived from the content of our research questions. Our upper-level categories included reasons for interest, barriers, and program recommendations. Then, lower-level categories were derived from multiple readings of the transcripts (see Table 1). Text was segmented, and a doctoral-level psychologist (C) and a bachelor's-level research assistant (B) read the segmented text and independently coded the segments consistent with the lower-level codes. Coders A, B, and C discussed discrepancies and came to an agreement on the final codes to ensure consistency.

Table 1. Higher Level and Lower-Level Categories

| | |
|---|---|
| Reasons for Interest | |
| | Skill Building |
| | Full Family Approach |
| | Get Away |
| Barriers for Participating | |
| | Active Duty Commitments |
| | Parental Burden |
| | Hesitancy/Lack of Motivation |
| | Weekends Not Convenient |
| | General Scheduling Difficulties |
| Program Recommendations | |
| | Command Support |
| | Appealing to Children |
| | Better Advertising |
| | Better Incentives |
| | True Get Away |

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**Findings**

***Reasons for Interest***

The most appealing aspect of the SFSF weekend retreat was the opportunity to learn how to develop skills to facilitate reintegration. "During the deployment, me and my husband were having a situation. We were trying to get as much help as we can…for us to reintegrate properly or better…The people that you have…are very prepared to help and give the perfect tools for families to work." The second most cited reason for participating in the retreat was an attraction to the full family approach. Active duty spouses often reported feeling "left out" or "in the dark" during the reintegration process. "I like the fact that the focus was on reintegration when it comes to the whole family. On the military side, the soldier is pretty much taken care of….the rest of the family members are just left in the dark with everything. And, so it is great for spouses and children even to know what to expect with reintegration." Finally, simply advertising our program as a "retreat" helped generate motivation to inquire about the program. "I think the word choice of the event was great…whenever I hear the word retreat it does pique my interest."

***Barriers to Participating***

Active duty military status and associated roles and responsibilities were cited as the number one barrier to participating in the weekend retreat. In particular, the unpredictable nature of active duty service made it hard to commit to participating or necessitated canceling participation. One active duty father said, "Planning. It's honestly just trying to be able to plan around what you think the Army schedule's gonna be, and then it changes so frequently that it's hard to make plans." The parental burden was another highly cited reason for not participating in the retreat. This was especially true for families with children of different developmental levels and abilities, and there was concern about how to keep all children happy during the two-day retreat. "We have three kids total…I was thinking it was really going to be overwhelming trying to accommodate everybody while also trying to make sure my son [with a blood disorder] was okay…it was going to be a stressful situation." Participants reported that there might be a hesitancy to participate in the SFSF weekend retreat because of stigma or a lack of motivation. "I believe the number one reason would be the actual marriage situation…they [military families] may feel like they don't want to invite a third person…[then] they have to deal with a situation when they would rather not." Families expressed that weekends are inconvenient and were cited as "time to relax" and "free time." Finally, there were general scheduling difficulties that impacted participation. There were weekends when we only recruited one family. Our team would cancel the retreat and reschedule the family for the next month. This frequently led to family drop out. "We canceled first, and then…you didn't have the quorum, and then they canceled."

***Program Recommendations***

Obtaining command support was the top recommendation made by military families to better engage their community. "I would say have some kind of memorandum so they can actually participate in their jobs, but their job is aware so they can make the time to do it." Others detailed how commanders could support through incentives. "If [the commander] were to say, 'Hey, whoever participates in this will get Monday off or [physical training] off for the week.' Little incentives like that coming from the commander, so they

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know…the commander buys into this." Parental burden was cited as a significant barrier to participation, and many families recommended appealing to a broader age range of children while allowing parents to "keep an eye" on their children. "Integrating more activities. Things where the kids could do other things where the parents could still see the kids. Not take the kids totally out of the room." Active duty spouses provided a number of advertising suggestions, including "spouse social media pages," "targeting battalions who are reintegrating," and "having an actual service member who has done [the program] provide their opinion" in a public forum. Although we provided a financial incentive, military families recommend other types of incentives. "You give out vouchers for local kid's places…or everybody that comes to the retreat [is eligible] the next weekend to [attend] community BBQ or a splash pad event." The location for our weekend retreat was a large conference room on Fort Hood. While we had activities for children and gave parents the same to speak frankly about their reintegration experiences, it was not a "getaway." As such, active duty families recommended making our weekend retreat a *true* getaway. "To be able to get out, have expenses paid for somewhere that's not in [the area]—whether it's 15, 20 miles away, somewhere where we can just go and have fun and be together and learn something new because it's a very stressful lifestyle."

**Discussion**

Our findings indicated that the opportunity to learn skills while including the entire family in the process was the most attractive aspect of participating in a SFSF weekend. We recommend that similar programming use a whole family model and highlight the skills that will be learned during initial engagement with potential families. Military families overwhelmingly expressed that the biggest barriers to engagement were balancing the responsibilities of active duty service and parenting. This was especially true for parents with children with special needs. Regarding military responsibilities, families recommended obtaining leadership support. While this was part of our process, we learned that command acknowledgment of support did not "trickle down" to families. In future Strong Families Programming, our team will place more emphasis on ensuring command support is communicated to families. This may include collaborating with the command to offer incentives for participating. Families recommended that a greater focus on child involvement during the retreat would ease worries about balancing parenting responsibilities while trying to participate. While our retreat invited families with children of all ages, it limited the ability to focus heavily on child involvement as the children were at varying developmental stages. To respond to this concern, our future SFSF retreats will be divided into different weekends for differing ages, with programming specific to that developmental stage. Finally, families expressed that the location of the event was not attractive and suggested a location outside of the local area. Our findings suggest an appealing location may be a necessary component for recruitment and retention. Thus, future SFSF retreats will focus on "quality over quantity," reducing the number of weekends available but increasing the desirability of participating.

Funding for this research was provided through a Charles J. Gelso, Ph.D., Psychotherapy Grant, Division 29, Society for the Advancement of Psychotherapy. The views expressed herein are solely those of the authors and do not reflect

***continued on page 36***

an endorsement by or the official policy of the U.S. Army, the Department of Defense, or the U. S. Government.

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Society for the Advancement of Psychotherapy

# WASHINGTON SCENE

## "I once did know a president. Away down south, in Texas": Unprecedented Opportunities—For Those with Vision

*Pat DeLeon, PhD*
*Former APA President*

Perhaps more than ever before, this Administration has highlighted for the nation the critical importance of mental and behavioral health. Last year, U.S. Public Health Surgeon General Vivek Murthy released his Advisory—*Protecting Youth Mental Health*. "(T)he challenges today's generation of young people face are unprecedented and uniquely hard to navigate. And the effect these challenges have had on their mental health is devastating…. It would be a tragedy if we beat back one public health crisis only to allow another to grow in its place…. If we seize this moment, step up for our children and their families in their moment of need, and lead with inclusion, kindness, and respect, we can lay the foundation for a healthier, more resilient, and more fulfilled nation."

The U.S. House of Representatives often serves as an accurate barometer of society's expectations and concerns. During their consideration of the Fiscal Year 2023 National Defense Authorization Act, the Committee with jurisdiction included several provisions addressing the mental and behavioral health needs of the military and their families. The Uniformed Services University (USU) was tasked with establishing graduate degree-granting programs in counseling and social work; the clinical psychology graduate program to be expanded; and, for the first time, including a pay-back requirement for civilians for a duration at least equivalent to the length of time they were enrolled. The House further directed the establishment of a curriculum and certification program to train civilian mental health professionals and students with the specialized knowledge to treat Service Members, Veterans, and their families. And, the Committee requested a briefing on the potential utilization of chaplain programs to reduce suicide and improve behavioral health care. The underlying policy question for psychology and for the other mental health disciplines is whether their educational leadership will affirmatively respond to today's impressive and evolving societal need by significantly increasing their training capacity; perhaps, as Morgan Sammons and former APA President Ron Levant have proposed, by both increasing their class size *and* reducing the present length of training?

Beth Rom-Rymer: "In 2014, I was introduced to graduate students Diane Alexander and Molly Schnell who were doing groundbreaking research at the Center for Health and Wellbeing at the Princeton School of Public and International Affairs on the effect that advanced nurse practitioners, with independent prescriptive authority, would have on population health. Health economists found that in the states in which advanced nurse practitioners could independently prescribe, the suicide rate plummeted by a remarkable 12%. Reports of psychological disturbance symptomatology also decreased by

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10%. Their research has been published and cited widely, most recently in the *Journal of Health Economics*.

This research has significant import for the impact that licensed prescribing psychologists could have on the frighteningly high suicide rate and opioid addiction epidemic in the United States today. To specifically measure this potential impact, the Illinois Association of Prescribing Psychologists, with Leila Ellis-Nelson as Principal Investigator, and with support from APA's Health and Healthcare Financing Office, has undertaken an extensive research program, nationwide, to assess the effectiveness of licensed prescribing psychologists, as reported by their patients; from psychologist self-report; and from a review of treatment outcomes. Learning from population and clinical research can well inform today's extraordinary, licensed clinical and prescribing psychologists, as they pursue excellence in their life's work, dedicated to their patients."

**Biofeedback 50 Years Later**

It has always been our view that competent clinicians should strive to develop as comprehensive a "tool box" as possible in order to effectively address the unique and personal needs of their clients. When we first began serving on the U.S. Senate staff, Senator Inouye attempted to ensure that the Department of Defense CHAMPUS program would reimburse for biofeedback services. Unfortunately, the week of the Appropriations Committee "mark-up" the cover of one of the popular media magazines featured a biofeedback patient with a magnitude of wires attached to his head. Not surprisingly, the Committee Members found it difficult to embrace this service. Over the years, we enjoyed working closely with Francine Butler, CEO of the Biofeedback Society, now the Association for Applied Psychophysiology and Biofeedback (AAPB).

Francine: "I had the pleasure of attending the 50th anniversary meeting of AAPB two years ago. What an exceptional opportunity as I had been with the organization since its inception. It grew rapidly from 'way out' and New Age flowing robes to a modality that today provides treatment in many stress-related disorders from pain to incontinence and other clinical disorders. Credentialing has grown from offering one general biofeedback certification to four, adding Neurofeedback, Pelvic Muscle Dysfunction and Heart Rate Variability. Insurance coverage is improved but still provides challenges. Once used as the stereotype 'mind-body training,' long time practitioner Robert Whitehouse explains 'I prefer to describe it's use as normalizing and optimizing physiology and mind-body function.' One can only imagine what the next decade will bring."

**Individuals Making a Significant Difference**

For more than a decade, Shirley Higuchi has been bringing to APA's attention the most unfortunate internment experiences of Japanese Americans during World War II *and* its potential implications for our nation today. As children, Shirley's parents had been interned at Heart Mountain. Following her mother's wishes, she has worked tirelessly to memorialize the incarceration for many of us in the APA governance at this now National Historical Landmark. In 2011, APA President Melba Vasquez personally participated in the opening of its Interpretative Learning Center. APA CEO Arthur Evans and his wife and separately my wife and I visited Heart Mountain at later dates—finding it most impressive and deeply moving.

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Melba: "The dedication of the Heart Mountain Interactional Learning Center was an inspirational three days. Tom Brokaw delivered a wonderful talk on Friday night of the event. Former Republican U.S. Senator Alan Simpson and former Democratic Secretary of Commerce and then Secretary of Transportation Norm Mineta spoke together Saturday morning during the dedication. They shared an amazing story about how Norm Mineta, a 12 year-old-Japanese Boy Scout interred at the Heart Mountain concentration camp, and Alan Simpson, a Boy Scout in Cody near there, met when the two Boy Scout troops got together for competitions (after some tough negotiations from the Boy Scout leaders). The two met again decades later, when each was in the Senate and House of Representatives and cosponsored the bill that provided retribution for Japanese Americans, signed by Ronald Reagan in 1988; and a letter of apology, signed two years later by George Bush in 1990. The two men, Simpson and Mineta, truly loved each other. Their talk made us all laugh and cry. Then Hawaii Senator Daniel Inouye also spoke and gave an amazing story about how he left Hawaii to go to war for the United States, where he lost his right arm. Then he returned to the United States where he was treated so badly. My spouse Jim and I felt extremely touched and transformed by the experiences of the dedication over that three day period. It was one of the most powerful experiences of my APA Presidency, and I felt so fortunate to have participated."

On June 13, 2022, Shirley was part of a small select group of Asian American leaders invited by President Biden for the signing of HR 3525, legislation that authorized a Commission to study the creation of an Asian American History Museum. She attended in her role as the Chair of the Heart Mountain Wyoming Foundation, which operates a museum on the site of the concentration camp for Asian Americans where her parents met during World War II. Her latest mission is the creation of the Mineta-Simpson Institute, which honors the lives and careers of Secretary Norman Mineta and Senator Simpson, who first met as Boy Scouts at Heart Mountain in 1943.

"I was very pleased by President Biden's commitment to telling the accurate history of the contributions made by Asian Americans, Native Hawaiians and Pacific Islanders to the United States. For too long, that history has either been distorted or ignored, and the wave of anti-Asian attacks following the COVID outbreak makes it even more important to detail the impact made by these communities to the United State." Shirley noted that those of us from Hawaii should especially appreciate the President's heartfelt comments regarding his good friend Senator Daniel K. Inouye, who, in 1987, chaired the President's first Presidential campaign.

**The Pioneer Prescribing Psychologist**

Earlier this year. Cheryl Hall informed us that her beloved Texas colleague Floyd L. Jennings had passed away. Floyd was authorized, along with his Nurse Practitioner-Mental Health Practitioners, under a "standing order," by the Santa Fe Indian Hospital (USPHS-Indian Health Service) bylaws to prescribe psychotropic medications (March, 1986). As he described during one of our USU Policy seminars, this was not a clinical responsibility he had sought. When he asked the IHS medical director "why?" he was informed: "Because there is a need and we have been unsuccessful in securing psychiatric consultants to the tribal communities," When he shared this IHS development with the New Mexico Psychological Association Ethics

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Committee, they responded "It appears from your statements that you are practicing within relevant APA ethical principles in your employment by the Indian Health Service. The Ethics Committee, however, believes it is unable to make a definitive statement about the ethics of psychologists, or any particular psychologist, prescribing medications because psychology has not adopted any standards of education or practice as reference criteria."

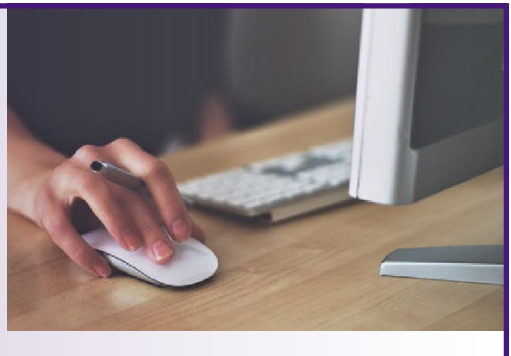
During Floyd's tenure he had some 378 patient contacts, only 95 of which involved prescription of psychotropic agents; 46% of these contacts were on an inpatient basis. There were no serious side effects requiring medical interventions—medical consultation was common. "I must add, however, that I did spend some time attempting to alleviate problems caused by less than appropriate treatment by my physician colleagues."

We worked closely with Floyd, through the Senate Select Committee on Indian Affairs, and assured him that the Director of the IHS and its General Counsel were appraised of his actions. As his contributions became increasingly public, the IHS Medical Director received approximately 5,000 complaints from psychiatric colleagues—informing me that some of these were from his grammar school classmates. To place Floyd's vision in context, the first two DOD prescribing psychologists, Morgan Sammons and John Sexton, graduated from their training program in June, 1994. Our sincerest appreciation to Floyd L. Jennings who truly paved the way for psychology's prescribing future. "The eyes of Texas are upon you, 'Till Gabriel blows his horn" (Hank Thompson).

Aloha,

Pat DeLeon, former APA President – Division 29 – July, 2022

Society for the Advancement of Psychotherapy



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# 2023 NOMINATIONS BALLOT

*Dear SAP (Division 29) Colleague:*

The Society for the Advancement of Psychotherapy (APA Division of Psychotherapy, 29) seeks nominations of creative individuals and great leaders! We would like both new and experienced voices to advance our increasingly important work on behalf of psychotherapy. The SAP Board encourages candidates from diverse backgrounds to seek nomination.

**NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY (APA DIVISION 29)**

The offices open for election in 2023 are:

- President-elect
- Secretary
- Domain Representative for International Affairs
- Domain Representative for Public Interest and Social Justice

*All persons elected will begin their terms on January 2, 2024*

A Domain Representative is a voting member of the Board of Directors. The open positions will be responsible for initiatives and oversight of the Society's portfolio in the respective Domains. Candidates should have demonstrated interest, expertise, and investment in the area of their Domain. Candidates should review the Society's fiduciary duty and conflict of interest policies and must complete the fiduciary questionnaire prior to being included on the slate. Detailed descriptions of the duties and responsibilities for each position are available on request from the Society's central office: assnmgmt1@cox.net.

The Society's eligibility criteria for all positions are:

1. Candidates must be Members or Fellows of the Society.
2. No member may be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for a position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.
5. All terms are for three years, except President-elect, which is one year (and then proceeds to President for one year and Past President for one year).

**The deadline for receipt of all nominations ballots is October 15, 2022.**

As per the Society's Bylaws, you may email your nominations to: assnmgmt1@cox.net. Please put SAP/DIVISION 29 NOMINATIONS in the subject line the email. You may also mail your nominations to Society for the Advancement of Psychotherapy, 6557 E. Riverdale St., Mesa, AZ 85215

If you would like to discuss your own interest or any recommendations for nominations, please contact the Society's Chair of Nominations and Elections, Dr. Tony Rousmaniere at trousmaniere@gmail.com

Sincerely yours,

| *Clara Hill* | *Jean Birbilis* | *Tony Rousmaniere* |
|---|---|---|
| President | President-elect | Chair, Nominations Committee |

## - - - - - - - - - - - - - - - NOMINATIONS - - - - - - - - - - - - - -

President-elect

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Secretary

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Domain Representative
Public Interest & Social Justice

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Domain Representative
Public Interest & Social Justice

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Name (Printed) _____

Signature _____

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Division29
Central Office
6557 E. Riverdale St.
Mesa, AZ 85215

# JOIN US IN CONGRATULATING THE 2022 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY STUDENT AWARD WINNERS!

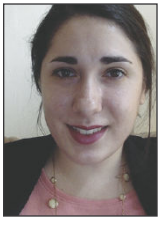
**MATHILDA B. CANTER EDUCATION AND TRAINING STUDENT PAPER AWARD**

Jolin Yamin is a clinical psychology doctoral candidate at Wayne State University in Detroit, MI. She recently finished her doctoral internship at University of Chicago Medicine and will soon begin her post-doctoral fellowship at Beth Israel Deaconess Medical Center. Her research interests include studying interventions for trauma- and stressor-related conditions, as well as developing and testing effective clinical training approaches. She is also interested in the dissemination of experiential and emotion-focused therapies.

**DONALD K. FREEDHEIM STUDENT DEVELOPMENT AWARD**

Marisol Meyer is a fifth-year doctoral student in counseling psychology at the University of Miami in Coral Gables, Florida. She graduated from Dartmouth College, earning honors for bachelor's degrees in psychology and anthropology. During her time as a doctoral student, she has been a proud member of the Challenging Racism and Empowering Communities through Ethnocultural Research (CRECER) lab in which she conducts research related to community-based, culturally responsive mental health interventions. This research specifically focuses on how unique community strengths and evidence-informed/evidence-based practice can be coalesced and leveraged to promote psychological wellness. Marisol has coordinated and co-designed interventions and curricula addressing community-selected topics such as trauma-informed mental health support, emotion socialization, and ethnic racial identity development. These programs have reached community-leaders, teachers, healthcare professionals, caregivers, and youth. Her experience engaging with community needs through research and intervention have given her experience in program manualization and adaptation. Relatedly, Marisol's clinical work has focused on the implementation of culturally responsive, empirically-based intervention with ethnically, racially, and socioeconomically diverse clients in community-based mental health centers, academic health centers, and forensic settings.

For more information about Marisol and her work, please visit: https://marisollmeyer.wixsite.com/blog.



**DIVERSITY STUDENT PAPER AWARD WINNER**

Adela Scharff is a doctoral candidate at the University at Albany (SUNY) and is currently completing her clinical internship at Northwestern University. Her research interests include exploring the role of identity characteristics such as race, gender, and sexual orientation in psychotherapy, treatment of trauma-related disorders,

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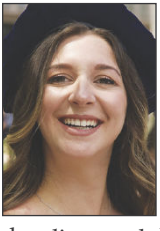
and naturalistic psychotherapy outcome research. Clinically, she is particularly interested in working with LGBTQ populations and other patients from minoritized backgrounds and in trauma-focused psychotherapy.

**JEFFREY E. BARNETT STUDENT PAPER AWARD WINNER**

Averi Gaines is a fourth-year graduate student in Clinical Psychology at the University of Massachusetts Amherst. In 2017, Averi graduated with honors from Haverford College with a BA in Psychology. After graduating, she worked as a Clinical Research Coordinator in the Center for Psychotherapy Research at the University of Pennsylvania in Philadelphia, PA. Averi began her graduate work at UMass in 2019, and she was awarded a Graduate Fellowship during her first year. Her research centers on patient, therapist, dyadic, and systemic factors that influence psychotherapy processes and outcomes. Her work has been disseminated at professional conferences and in peer-reviewed journal articles and book chapters.



**STUDENT EXCELLENCE IN PRACTICE AWARD**

Dr. Zoe Ross-Nash (she/hers) is originally from Allendale, New Jersey and earned her bachelor's degree in Psychology with a minor in Human Service Studies and Dance from Elon University. Dr. Ross-Nash earned her PsyD in Clinical Psychology at Nova Southeastern University and completed an APA accredited internship at the University of California, Davis in the Eating Disorder Emphasis. Dr. Ross-Nash believes that the relationship between the client and therapist is a key element to taking steps towards growth. She aims to create a safe and warm space for clients to feel open in collaboratively exploring their vulnerability and be empowered in their strengths.

Dr. Ross-Nash seeks to understand what happened to her clients in context of their histories and identities, not what is wrong with them.

**STUDENT EXCELLENCE IN TEACHING/MENTORSHIP AWARD – CO-WINNER**

Nadia Alsamadi is a Palestinian-American clinical psychology doctoral student at Loyola University Maryland. In August 2022, Nadia will begin her predoctoral internship training at the VA Sepulveda Ambulatory Care Center in Los Angeles, California, and will graduate with her PsyD in 2023. Most recently, Nadia has worked as a supervised psychotherapist in private practice and an adjunct undergraduate psychology professor while completing an externship at the Johns Hopkins Physical Medicine and Rehabilitation inpatient program. She has a wide variety of clinical experiences and most enjoys working with LGBTQ+, first-generation American, and Arab clients. Nadia especially appreciates her work mentoring and collaborating with undergraduate psychology students. She hopes to use her career to continue teaching and providing affirming care from a culturally humble lens.

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**STUDENT EXCELLENCE IN TEACHING/MENTORSHIP AWARD – CO-WINNER**

Judy Gerstenblith, M.S. (she/her)

Judy is a sixth-year counseling psychology doctoral student at the University of Maryland (UMD). She is currently completing her internship in the Counseling Center at Pace University in New York City. During graduate school, she has worked as an individual therapist at the University of Maryland Counseling Center, the Catholic University of America Counseling Center, and the Maryland Psychotherapy Clinic and Research Lab, and as a group therapist at the Eating Recovery Center. Judy has taught Basic Helping Skills: Research and Practice and The Psychology of Interpersonal Relationships to upper-level UMD undergraduate students. Her research interests include the process of therapy for religious/spiritual clients, training therapists, the impact of clinical supervision on client outcome, the role of attachment in the therapeutic relationship, and the ways in which therapists work with dreams and meaning in life in psychotherapy. Judy hopes to pursue a career that integrates therapy, teaching, research, and supervision. In addition to her professional interests, Judy enjoys playing with her nephews and nieces, waterskiing and kayaking, and cheering on UMD's basketball teams! ■

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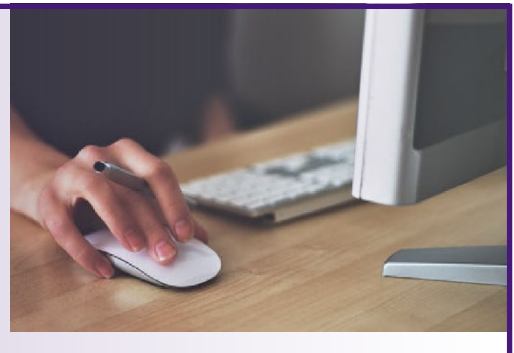

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## APA SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
# STUDENT EXCELLENCE IN TEACHING AND MENTORSHIP AWARD – REFLECTIONS

*Nadia Alsamadi*

I am quite humbled to be recognized for my contributions to teaching and mentorship. Teaching and mentorship figures have been fundamental in shaping my education and fueling my passion for psychotherapy. Deepening the teacher-student relationship into mentor-mentee allowed me to feel accepted, valued, and affirmed as an ethnic and sexual minority in a field dominated by Eurocentric voices. As a graduate student, I have started developing my own teaching and mentorship practice, drawing upon principles modeled by central figures in my education, my peers, and integrating my own unique values and perspectives.

So much of my teaching practice is an amalgamation of what I've learned from these central figures. I drew upon the styles, practices, and energies from my current professors who not only connected students to the material, but cultivated emotional connections within the classroom. My peers are also invaluable contributors to my teaching practice because they share feedback about which methods are the most helpful and supportive in our education, and areas where professors could be more sensitive, accommodating, effective, or engaging. My professors and peers would both agree, however, that multiculturalism and humility should be fundamentally infused into every classroom interaction.

Visibility and celebration of minoritized identities is a foundational aspect of my teaching and mentorship philosophies. I hope that my intentional openness about my Palestinian and queer identities shows students that diverse voices are valued and deserve to take up space in psychology and academia. Some of the most meaningful classroom moments happen when students feel safe to connect with each other through shared vulnerability in discussing their cultural and social identities. In particular, witnessing the passion and connection of two queer students who were assisting with my dissertation project that focused on Black lesbian women, was an incredibly special and vitalizing experience. I've also learned from my students' and their practice of vulnerability about the importance of non-defensive and humble discussion of privileged identities, oppression, intersectionality, and making mistakes. I still have deep and continuous growth to engage in with regards to cultural humility and must intentionally work towards holding myself accountable in the classroom and beyond.

In reflection, teaching the course subject and lecture material is not necessarily the only rewarding aspect of being a teacher and mentor. These topics are perhaps a conduit to the most fulfilling part of teaching—the vulnerability, emotional connections, and interpersonal learning that occurs within student/professor relationships. For any graduate students entering the classroom as a professor, I invite you to consider the ways your own mentors instilled passion, motivation, confidence, openness, and the safety to be vulnerable within you. Harness that energy and pair it with your own unique strengths and knowledge to create a classroom environment that nurtures connections and celebrates diversity. ■

**Student Excellence in Teaching and Mentorship Award – Reflections, *continued***

*Judy Gerstenblith*

Thank you to Division 29 for the Student Excellence in Teaching and Mentorship Award. I want to express my sincere gratitude to my teachers and mentors who have led by example and empowered me to work with the next generation of mental health professionals.

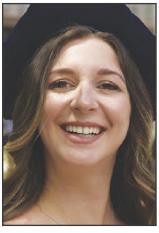
I believe that the heart of teaching involves developing a relationship with each student that invites them into deep curiosity and critical analysis. I encourage my students to take ownership of their learning so that they can continue the learning process beyond the classroom and after the end of the semester. I also try to open them up to the possibility that their learning can deeply influence the ways in which they interact with the world. And just as I believe they will be profoundly changed by the learning process, I also witness how their unique contributions meaningfully change the field of psychology.

In the classroom, I work to cultivate an environment of mutual respect and reciprocal feedback, with clear expectations and a balance of support and challenge. I center my students' experiences and aim to provide and receive consistent and thorough feedback. When appropriate, I use class time to process the feedback, discuss group dynamics, and develop a plan for improvement. I strive to establish transparency through a comprehensive syllabus, a strong rationale for course activities, and frequent communication of updates. I have found that students not only benefit from understanding how each concept connects to the broader learning outcomes, but also from intentionally reflecting on how the material relates to their personal lives. I work to provide a balance of structure and flexibility, and strongly encourage students to discuss their particular goals and needs with me throughout the semester. Lastly, I value empathically guiding students through the inevitable tension that can arise in any learning environment.

As a counseling psychology doctoral student at the University of Maryland, I feel fortunate to have served as a teaching assistant and an instructor of record for several courses. My favorite course to teach is Basic Helping Skills: Research and Practice, as it truly combines my passion for teaching with my love of psychotherapy. Students appreciate actually practicing helping skills, implementing theory and conceptualization for perhaps the first time. They often develop intimate connections with their classmates and lab leaders, allowing them to experientially engage in the helping process as both "helpers" and "clients." In addition to classroom teaching, I enjoy teaching and mentoring graduate students in my program, undergraduate students working at the Maryland Psychotherapy Clinic and Research Lab, and graduate psychology students through Division 29's Mentorship Program.

For those interested in teaching, I encourage you to seek mentors who support your teaching interests, speak to graduate students in your programs who have incorporated teaching into their schedules, and use your networks to attain further resources and connections. Try to gain a variety of teaching experiences and, if possible, learn about teaching methodology. May we all merit the privilege of learning from our students! ■

## APA SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY
# STUDENT EXCELLENCE IN PRACTICE AWARD – REFLECTIONS



*Zoe Ross-Nash*

One must responsibly wear the letters that come after their name when their title is "therapist." Clinical excellence extends far beyond the therapy room. Mentorship, leadership, professional and collegial relationships, passion for the field, and authenticity are key qualities of a well-rounded clinician.

Mentorship while in a training program is one of the most important avenues for development. Finding supervisors who have achievements akin to your goals, and values congruent with your ideals fosters a vital learning opportunity. Study under someone who has a career, reputation, and life that you can see and want for yourself.

Professional and collegial relationships are also incredibly helpful. The people in your graduate program are the ones supporting you through the long emotionally and physically exhausting training days, cheering you on through your dissertation, and crossing the stage with you on graduation. Your classmates will turn into referrals, references, and consultants in the future. These relationships during your training years can have career long impacts.

Student leadership can help trainees better navigate delicate power dynamics. It can teach useful skills to approach conflict resolution; those that can be later called upon when managing a therapeutic rupture. Additionally, leadership can be an example of advocacy, such as spearheading efforts to dismantle systems that first brought folks to therapy.

Passion for the field can include engaging with research and applying it to clinical work, having an intellectual curiosity and reading a book about a population you have not worked with, or even providing psychoeducation to peers who are not in the psychology field. Clinical excellence requires sense of self, community, and purpose.

Authenticity is an enormously valuable, but incredibly difficult requirement. Therapy is one of the few occupations where our own histories, thought processes, beliefs, and moods can impact the work we do. Bringing our full self into the room is a scary risk, but it is the same risk we expect of our clients, which can elicit beautiful outcomes.

My work with the eating disorders is an example of embodying these five facets of clinical excellence. Growing up training as a ballerina and having a family of fitness instructors and athletes, I saw how these systems not only maintained, but capitalized on the manifestation of disordered eating. My mentor assisted me in finding a platform to educate communities and incorporate my colleagues to ensure space for voices with identities different than my own. As a leader, I had made

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presentations with fitness communities to improve the narrative supporting exercise, weight, and food. I showed passion for field by providing psychoeducational resources to other clinicians on providing eating disorder-informed care. My authenticity in my own body was the thread that connected and amplified my relationships with not only clients but also other humans.

As I graduated, I reflected, "what's next?" Balancing between being a desire for growth and improvement while celebrating how far I have come is a difficult feat. My recommendation is for trainees to remember both sides of that dichotomy are equally as valuable. ■

## CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY INTERNATIONAL RESEARCH GRANT WINNER

Akansha Goyal is a MPhil Clinical Psychology Trainee at ABVIMS & Dr. Ram Manohar Lohia Hospital, India. She holds a Master's degree in Clinical Psychology from Amity University and a Bachelor's degree in Botany from Delhi University. She has been awarded a meritorious scholarship during post graduation. She has cleared the National Eligibility Test and also cleared the exam for Junior Research Fellowship. She is keen to work on the psychological concerns faced by LGBTQ+ populations and develop treatment plans in this area. ■

# ABSTRACTS FOR THE 2022 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY STUDENT PAPER AWARD WINNERS

## Jeffrey E. Barnett Psychotherapy Research Student Paper Award

*Averi Gaines*

***"Patient–Therapist Expectancy Convergence and Outcome in Naturalistic Psychotherapy"***

Prior social psychological research illustrates that people in close relationships tend to become more similar in their experiences and beliefs over time, which is associated with a number of positive relational outcomes. Given that patients and therapists develop close relationships in psychotherapy, such *dyadic convergence* processes may play out across treatment and influence therapy-specific outcomes. While some research has explored patient-therapist convergence on ratings of the therapeutic alliance, to date, no prior work has examined the presence and potential utility of *belief* convergence in psychotherapy. Using multilevel structural equation modeling, the present study aimed to examine whether patients and therapists demonstrated significant convergence on their outcome expectation (OE) across treatment and whether such a process was associated with better symptomatic/ functional outcomes in naturalistic psychotherapy. There was no significant average pattern of patient-therapist OE convergence over the course of treatment ($g_{100}$ = 0.01, *SE* = 0.03, *p* = .690), and when OE convergence did occur, it did not associate with better posttreatment outcome ($g_{020}$ = 2.37, *SE* = 10.28, *p* = .818). However, replicating prior research, higher early patient OE (on its own) was associated with better posttreatment outcome at the between-dyad level ($g_{050}$ = -0.04, *SE* = 0.01, *p* = .007). These findings lend support to OE being more of a facilitative patient factor than a relational process factor.

## Mathilda B. Canter Education and Training Student Paper Award

*Jolin Yamin*

*"Experiential Training in Disclosure Elicitation and Emotional Awareness and Activation: A Randomized Test"*

Effective exposure and emotion-focused interventions for trauma and psychological conflicts are underutilized. This study developed and tested an experiential training condition that integrated deliberate practice, live supervision, and feedback to improve therapists' skill in: a) eliciting patient disclosure of stressful experiences, b) responding to defenses against disclosure, and c) finding and encouraging patients' adaptive emotions. Mental health trainees (N = 102) were randomized to experien-

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tial or standard training (interactive lecture) conditions, both of which were single, 1-hour individual sessions administered remotely. Participants responded to video-clips of actors portraying challenging therapy situations before and after training and at 5-week follow-up. Responses were videorecorded and coded for the three skills using a structured manual. Repeated measures ANOVA indicated all of the skills increased from baseline to post-training for both conditions, and improvements were largely maintained at follow-up. More importantly, compared to standard training, experiential training led to greater improvements in the skill of eliciting disclosure (baseline to post-training time x condition interaction $\eta 2 = .05$, $p = .03$), which was maintained at follow-up ($\eta 2 = .05$, $p = .03$). Experiential training led to comparatively greater increases in the skill of responding to defenses from baseline to post-training (interaction $\eta 2 = .04$, $p = .05$), although this difference was not maintained at follow-up (interaction $\eta 2 = .01$, $p = .28$). Experiential training also led to comparatively greater increases in the skill of finding and encouraging adaptive emotions from baseline to post-training (interaction $\eta 2 = .23$, $p < .001$), although this difference was not maintained at follow-up (interaction $\eta 2 = .01$, $p = .34$). A single, brief experiential training improves mental health trainees' exposure- and emotion-focused skills compared to traditional didactic training. More extensive experiential training may strengthen and prolong such skill retention.

## Donald K. Freedheim Student Development Paper Award

*Marisol Meyer*

*"Best Practice Recommendations for Psychologists Working with Marginalized Populations Impacted by COVID-19"*

Psychologists are in a unique position to collaborate with marginalized individuals navigating the intersection of physical and mental health concerns directly caused by the COVID-19 pandemic, as well as systemic inequity, discrimination, and oppression exacerbated by the COVID-19 pandemic. The current paper reviews three areas of evidence-based clinical practice and provides recommendations to improve the relevancy of these areas for work with marginalized individuals impacted by COVID-19: The three areas are as follow: (a) developing self-awareness with consideration for how one's social identity interacts with the sociocultural consequences of the COVID-19 pandemic, (b) improve knowledge regarding the interaction between the social consequences of the COVID-19 pandemic and long-standing forms of systemic oppression, and (c) identify interventions that are responsive to both client culture and contextual limitations imposed by the COVID-19 pandemic. Psychologists that engage with these recommendations may improve their ability to accurately recognize the interactions of the COVID-19 pandemic and enduring systemic oppression, while collaborating with their clients to promote psychological healing in a culturally responsive, physically safe, and accessible manner.

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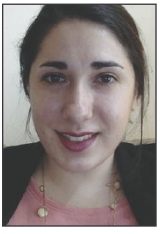

## Diversity Student Paper Award

*Adela (Dela) Scharff, M.A.*

*"Supporting Black Clients After Public Anti-Black Violence: Therapist Practices and Perspectives"*

Racial trauma refers to emotional injury resulting from exposure to racist violence, whether directly or vicariously experienced. One manifestation of anti-racism for therapists is effectively supporting Black clients coping with the impacts of police brutality and anti-Black violence. This survey study investigated N = 91 therapists' perceptions of a variety of five potential interventions that could be used to support Black clients experiencing racial trauma related to media coverage of violence against Black individuals, along with the potential influence of professional characteristics on these perceptions. Volunteering therapists completed an online survey that included a hypothetical client scenario. Therapists were then asked to rate their perceptions of different intervention types, specifically: emotional expression, value-guided action, coping skills, cognitive restructuring, and self-disclosure responses. Therapists rated the emotional expression response option as the most helpful, followed by value-guided action and coping skills. Self-disclosure and cognitive restructuring were viewed as less helpful, yet non-White therapists rated the use of self-disclosure more positively than White therapists. The degree to which one endorsed being influenced by CBT was significantly and positively associated with positive perceptions of the values, cognitive restructuring, and coping therapist response options. In contrast, the degree to which one endorsed being influenced by psychodynamic therapy was negatively associated with perceived helpfulness of values and coping-focused therapist responses. Additional research is needed to explore clients' perceptions of the degree of support and helpfulness of varied therapeutic responses in these contexts. ■

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*Psychotherapy Bulletin* welcomes articles, interviews, commentaries, letters to the editor, book reviews, and SfAP-related announcements. Please ensure that articles conform to APA style; graphics, tables, or photos submitted with articles must be of print quality and in high resolution. Complete Submission Guidelines and the online submission portal can be found at http://societyforpsychotherapy.org/bulletin-about/ (for questions or additional information, please email Joanna Drinane joanna.drinane@utah.edu with the subject header line *Psychotherapy Bulletin*). Deadlines for submission are as follows: January 15 (#1); April 15 (#2); July 15 (#3); October 15 (#4). Past issues of Psychotherapy Bulletin may be viewed at our website: www.societyforpsychotherapy.org. Other inquiries regarding Psychotherapy Bulletin (e.g., advertising) or the Society should be directed to Tracey Martin at the Society's Central Office (assnmgmt1@cox.net or 602-363-9211).

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Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: assnmgmt1@cox.net
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*We'd love to hear from you!*